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STATEMENT OF FACTS

South-central Ohio is a beautiful, but rugged, part of the state. Adams, Brown and Highland counties are no different. Hard along the Ohio River, the area is hilly with winding two-lane roads and no four-lane expressway. More than 94% of each of the counties is devoted to either small agricultural endeavors or covered by forested lands. It has some of the highest unemployment and lowest wages in the state. Without major transportation, resources, or industry, it is an economically depressed area of the state (Tr. 18-20, 392; T.C. Supp. 132, 272).

In 2001, three public hospitals in the area, Brown County Hospital, Adams County Hospital, and Highlands District Hospital, and Health Service of Ohio, Inc., a federally-chartered agency charged with bringing medical services to underserved areas of the state, determined to see how they could work together to provide better health education and services to this underserved part of Ohio.¹ Resources were scarce and the population in the area often had to travel more than an hour, to Cincinnati, Portsmouth, or Columbus, to obtain all but the most routine medical care. Out of this need was born the Rural Health Collaborative of Southern Ohio, Inc. (“RHC”)² (Tr. 14, 369-370, 374-375; T.C. Supp. 131, 266, 267-8).

RHC is a nonprofit corporation that is exempt from federal income tax pursuant to IRC 501(c)(3) (Ex. 9, Tr. 46; T.C. Supp. 359-63, 139). Article II (2)(b) of RHC’s articles of incorporation (Ex. 7; T.C. Supp. 333-342) provides that its particular purposes are:

¹ In 2011, Brown County Hospital became a private, for-profit entity. As a result, it has withdrawn from RHC as a member and has not been replaced (Tr. 70-71, T.C. Supp. 145). This unwinding proved more complicated than anticipated and took a great deal of time and resources during 2011 and 2012 to accomplish (Tr. 14-15, 71; T.C. Supp. 131, 145).

² In its brief, the Tax Commissioner repeatedly refers to “RHC Realty.” There is no such entity as “RHC Realty;” rather, this appears to be a transparent attempt by the Tax Commissioner, in the absence of any facts, to characterize RHC in a light more favorable to its position.

- (i) To enhance the quality, availability and efficiency of comprehensive health services for the people of southern Ohio by enabling and mobilizing community partnerships and resources;
- (ii) Identifying and addressing healthcare needs which can be most effectively and efficiently responded to collectively (or “in a collective manner”); and
- (iii) Supporting and furthering the mission of the member organizations.

RHC has engaged in a number of activities with the intent of carrying out these purposes. For example, it has written, received, and administered a number of grants to fund health initiatives in the region (Tr. 378-382, 409; T.C. Supp. 268-9, 276); sponsored or hosted events to promote general or specific health issues including renal disease education (Tr. 382-385, 396, 410; T.C. Supp. 269-70, 273, 276); brought its members together to address health issues common to all residents in the region (Tr. 376, 397-400; T.C. Supp. 268, 273-4), and established a dialysis clinic (which the individual members were unequipped to do) to provide a much-needed service to people in the region who are desperately ill (Tr. 385-386, 391; T.C. Supp. 270, 272). All of these activities are conducted solely for the purpose of carrying out RHC’s charitable purposes, and in fact they do enhance the quality, availability, and efficiency of health services for people in the region (Tr. 47, 70, 78-79, 369-370, 374-376, 382, 391, 396; T.C. Supp. 139, 145, 147, 266, 267-8, 269, 272, 273). Other than those services for dialysis and relying heavily on volunteers, no charges are assessed to individuals to participate in the various activities (Tr. 380-383; T.C. Supp. 269-70), anybody in the region may participate in any of the activities, and nobody has ever been denied participation in any of the activities due to an inability to pay for the activities and services.

The property in question is used as a clinic to provide dialysis services to patients in the area. RHC recognized early in its existence that there was a great need for treatment of end-stage renal disease (ESRD). Due to factors such as poor diets and a lack of economic resources, ESRD is a tremendous problem in the area (Tr. 382; T.C. Supp. 269). There was not a single clinic to provide dialysis treatment in the area. Instead, residents had to travel three times a week, more than an hour each way, to Columbus, Cincinnati or Portsmouth to receive their four-hour treatment. These individuals are deathly sick; they are in a toxic condition, have no kidney function and will die without dialysis treatment. In addition, the treatment is physically taxing. It involves removing, scrubbing, and returning all the blood in the patient's body during a treatment. Although neither RHC, nor its members, had the resources or expertise to establish or operate a dialysis facility, in keeping with its mission to improve the availability and delivery of health care services to area, the decision was made by RHC to move forward (Tr. 74, 386-387; T.C. Supp. 146, 270).

Although its resources were limited, RHC was not deterred. Land was donated, a federal grant was obtained to fund construction, and a qualified partner was found to operate the clinic: Dialysis Clinic, Inc. ("DCI"), a Tennessee non-profit corporation that is exempt from federal income taxes (Tr. 22, 388-389; T.C. Supp. 133, 271; Ex. 5, RHC Supp. 8-10).

The property in question is slightly over 2 acres in area and is improved with a one-story brick building. This building is used as a dialysis clinic to provide dialysis services to residents of the area (Ex. 12, Tr. 20-21, 191-194; T.C. Supp. 376-8, 132, 175-6). Dialysis services require tremendous infrastructure in the form of pure water and electricity; hence, there was no existing building that was suitable and there was a tremendous cost to constructing the building. Because RHC and its members lacked the expertise to provide dialysis services themselves, it engaged in

a wide-ranging search to identify a third party to operate the clinic. Ultimately, it chose DCI to do so. The choice was based on a number of factors. First, DCI had the expertise to operate the clinics. Second, due to its nonprofit status and charitable direction, RHC felt comfortable that DCI would treat the patients at the clinic appropriately. Finally, DCI, unlike at least one for-profit enterprise, was willing to take on the financial risk of operating a clinic in such a down-trodden area (Tr. 193, 389-391, 404-405; T.C. Supp. 175, 271, 275).

DCI is a Tennessee nonprofit entity organized for three main purposes. First it provides medical treatment for individuals suffering ESRD in underserved areas. Second, it provides educational activities on the prevention and treatment of ESRD, including the facilitation of organ transplant. Third, it also provides grants to nonprofit, mostly educational institutions to support research in the prevention and treatment of ESRD (Tr. 103-104, 106-111, 115, 139, 185; T.C. Supp. 153-6, 162, 173).

Save for the dialysis services, all its activities are provided free of charge to all who wish to partake in them. All of its services, including dialysis services, are provided without regard to the ability of the participant to pay for them; and nobody has ever been refused service because the individual was unable to pay for them (Tr. 142; T.C. Supp. 163; Exs. 1-2, RHC Supp. 1-7).

The clinic at Seaman is operated by DCI pursuant to a lease with RHC (Tr. 23-25, Ex. 10; T.C. Supp. 133, 363-73). Under the terms of the lease, DCI may only use the property to operate a dialysis clinic. The rental rate was set at a level intended to cover the costs associated with the operation of the clinic. However, except for 2009, the rental income to RHC has never exceeded the costs associated with the clinic. Hence, the rent has been re-negotiated on two occasions to reduce or delay expected increases in rent (Ex. 10, Tr. 189-190, 24; T.C. Supp. 363-73, 174-5,

133). Since it commenced operations, RHC has lost money every year on the clinic except 2009, for a total of \$436,890 (Ex. 11, Tr.31-45; T.C. Supp. 375, 135-8).

DCI typically provides services to an average of 18 patients per month at the facility. Due to the poor economic conditions in the area, approximately 75-80% of the patients receiving treatment at the clinic participate in the Medicare or Medicaid programs. Other patients may have third-party insurance coverage, while a few patients are responsible for the full cost of their treatment (Tr. 200, 203-215, Ex. 13; T.C. Supp. 177, 178-81, 380).

The Medicare and Medicaid programs place strict limitations on the total charges that may be levied for services; on the amount that the programs will pay; and on the amount, if anything, that may be charged to patients or third parties. Federal law imposes severe penalties on providers who provide any sort of financial inducements to patients or caregivers to obtain services from patients who participate in the programs. As a result, the amounts for which the patients are responsible under these programs may not be waived, and collection efforts must be had, unless the patient can demonstrate financial indigence. In cases where indigence is demonstrated, some or all of the patient's portion of the charges may be written off (Tr. 219-231; T.C. Supp. 182-5).

DCI extends this same courtesy to all its patients. That is, if a patient can demonstrate need, DCI will provide services at a reduced rate, or will waive the patient's share of the cost entirely. Indeed, DCI has an entity-wide policy of providing service to all patients who need it without regard to their ability to pay for it (Tr. 141-142, 142-149; T.C. Supp. 162-4). In the *only* instance in which litigation collection efforts were pursued for a failure to pay, it was done because the patient had fraudulently hidden insurance proceeds that could have paid for the services (Tr. 171-172; T.C. Supp. 170).

This practice to serve all patients who need treatment regardless of their ability to pay for the services received is followed at the clinic at Seaman, such that the clinic has provided a total of at least \$147,344.41 in uncompensated care at the clinic since 2006 (Ex. 14; T.C. Supp. 382-386). In addition, the administrator of the clinic, Mr. Mazon, testified that no patient had ever been turned away by the clinic because the patient was unable to pay for services, and provided several examples of patients that had been provided treatment when payment or coverage had not been determined and was not assured (Tr. 231-233; T.C. Supp. 185). As a result, DCI has lost over \$1.2 million on its operations at Seaman since the clinic opened in 2006 (Tr. 15, 251-267; T.C. Supp. 131, 190-4).

RHC filed its application for real property tax exemption for the clinic on November 8, 2006. Almost six years later, on June 20, 2012, the Tax Commissioner finally issued its Final Determination, denying exemption solely because it was determined that DCI was not a charity in *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St. 3d 215, 2010-Ohio-5071, 938 N.E.2d 329. RHC appealed the decision to the Board of Tax Appeals (“BTA”). Contrary to the statement at page six of the Tax Commissioner’s brief *no* discovery was conducted in this case on behalf of the Tax Commissioner pursuant to the Board’s rules. The BTA conducted two days of hearings in February and March 2014 and issued its decision on May 8, 2014. In its decision, the BTA first determined based upon the evidence that was presented that RHC was indeed a charitable institution. It also determined that (i) the clinic was made available under RHC’s direction and control; (ii) operation of the clinic was incidental to, and in furtherance of, RHC’s charitable purposes, and (iii) the property was used without a view to profit. All of these conclusions were likewise based upon the evidence that was presented without contradiction by the Tax

Commissioner at the BTA's evidentiary hearing. As a result, the BTA determined that the dialysis clinic was entitled to tax exemption pursuant to R.C. 5709.12 and 5709.121(A)(2).

The Tax Commissioner disagrees with the findings of the BTA and has brought this appeal urging this Court to ignore the evidence presented to, and the factual findings made by, the BTA and to reverse its decision.

LAW AND ARGUMENT

PROPOSITION OF LAW:

Property belonging to a charitable institution that is made available under the direction or control of the institution for use in furtherance of or incidental to its charitable purposes and not with a view to profit is used exclusively for charitable purposes and is exempt from taxation pursuant to R.C. 5709.12 and 5709.121(A)(2).

The issue presented by this case is whether the dialysis clinic located at Seaman, Ohio, is entitled to tax exemption pursuant to R.C. 5709.12 and 5709.121(A)(2). Based on two days of testimony and over 25 exhibits, the BTA determined that (i) RHC is a charitable institution under Ohio law, and (ii) the dialysis clinic was made available under RHC's direction or control for use in furtherance of or incidental to its charitable purposes and not with a view to profit.

Consequently, following this Court's decisions in *Cincinnati Nature Ctr. Assn. v. Bd. of Tax Appeals*, 48 Ohio St. 2d 122, 357 N.E.2d 381 (1976), *Cincinnati Community Kolliel v. Testa*, 135 Ohio St. 3d 219, 2013-Ohio-396, 985 N.E.3d 1236, and many, many cases in between the BTA concluded that the clinic qualified for exemption under the provisions of R.C. 5709.12 and 5709.121(A)(2).

Being dissatisfied with the BTA's decision, the Tax Commissioner appealed this case. Because this Court does not sit as a super board of tax appeals and will not reverse factual determinations that are based upon evidence in the record, the Tax Commissioner has tried to cast the BTA's decision as erroneous as a matter of law. However, the Tax Commissioner

devotes four pages to an introduction in which he argues about the facts of the case; 18 ½ pages of “Statement of Facts”; and 21 pages to “Argument” in which that official largely contests the factual conclusions that were made by the BTA. At the end of the day, the conclusions are inescapable that the Tax Commissioner is contesting the BTA’s factual findings, that the BTA’s factual conclusions are supported by evidence in the record, and that the BTA correctly applied the pertinent law in reaching its decision that the property was entitled to exemption pursuant to R.C. 5709.12 and 5709.121(A)(2). Thus, its decision is both reasonable and lawful, and the Tax Commissioner’s protestations to the contrary must be rejected.

A. Standard of Review

On appeals from the BTA, the duty of this Court is to determine whether the BTA’s decision is reasonable and lawful. R.C. 5717.04; *Satullo v. Wilkins*, 111 Ohio St. 3d 399, 2006-Ohio-5856, 856 N.E.2d 954, ¶ 14. In making that determination, the Court does not sit “as a ‘super’ Board of Tax Appeals or as a trier of fact *de novo*.” *Youngstown Sheet & Tube Co. v. Mahoning Cty. Bd. of Revision*, 66 Ohio St. 2d 398, 400, 422 N.E.2d 846 (1981). Factual findings made by the BTA are to be affirmed if they are supported by reliable and probative evidence and its determinations regarding the credibility of witnesses and its weighing of the evidence “are subject to a highly deferential abuse-of-discretion review on appeal.” *Worthington City Schools Bd. of Edn. v. Franklin Cty. Bd. of Revision*, 129 Ohio St. 3d 3, 2011-Ohio-2316, 949 N.E.2d 986, ¶ 18. However, if the BTA bases its decision on an incorrect legal conclusion, that decision will be reversed. *The Chapel v. Testa*, 129 Ohio St. 3d 21, 2011-Ohio-545, 950 N.E.2d 142, ¶ 9.

With this standard in mind, we turn the Court’s attention to the BTA’s analysis and decision.

B. Real Property Tax Exemption Under R.C. 5709.12 and 5709.121

R.C. 5709.12 and 5709.121 authorize the exemption from property taxes where the property is used exclusively for charitable purposes. R.C. 5709.12 provides in part, “Real and tangible personal property belonging to institutions that is used exclusively for charitable purposes shall be exempt from taxation.” R.C. 5709.121(A) provides in part:

Real property and tangible personal property belonging to a charitable or educational institution or to the state or a political subdivision, shall be considered as used exclusively for charitable or public purposes by such institution, the state, or political subdivision, if it meets one of the following requirements:

* * * *

(2) It is made available under the direction or control of such institution, the state, or political subdivision for use *in furtherance of or incidental to* its charitable, educational, or public purposes and not with a view to profit.
(emphasis added)

This Court has explained the interrelationship between these two sections many times. R.C. 5709.12 provides an exemption for property that is used exclusively for charitable purposes, regardless of the status of the owner. R.C. 5709.121 explains situations in which property that is owned by a charitable institution, or by the state or a political subdivision of the state, may be considered to be used exclusively for charitable, educational, or public purposes for purposes of R.C. 5709.12. Thus, the charitable nature of the owner is not relevant for purposes of R.C. 5709.12, but is an essential prerequisite for R.C. 5709.121. *Community Health Professionals, Inc. v. Wilkins*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478, ¶¶ 17, 18; *Olmsted Falls Bd. of Edn. v. Tracy*, 77 Ohio St. 3d 393, 396, 674 N.E.2d 690 (1997); *Episcopal Parish of Christ Church, Glendale, v. Kinney*, 58 Ohio St. 2d 199, 200-201, 389 N.E.2d 847 (1979).

For more than 140 years, this Court has recognized that “charity” for purposes of statutes relating to exemptions from property taxation is more than mere alms-giving.

The meaning of the word “charity,” in its legal sense, is different from the signification which it ordinarily bears. In its legal sense it includes not only gifts for the benefit of the poor, but endowments for the advancement of learning, or institutions for the encouragement of science and art, and, it is said, for any other useful and public purpose.

Gerke v. Purcell, 25 Ohio St. 229, 1874 Ohio Lexis 174 (1874).

In 1966, this Court articulated a similar definition of “charity” as:

[T]he attempt in good faith, spiritually, physically, intellectually, socially and economically to advance and benefit mankind in general, or those in need of advancement and benefit in particular, without regard to their ability to [pay], and without hope or expectation, if not positive abnegation, of gain or profit.

Planned Parenthood Assn v. Comm’r, 5 Ohio St. 2d 117, 214 N.E.2d 222 (1966), syllabus.

In addressing a claim under R.C. 5709.121(A)(2), this Court has established a three-part test for exemption. The property must (1) be under the direction or control of a charitable institution or state or political subdivision, (2) be otherwise made available “for use in furtherance of or incidental to” the institution’s charitable or public purposes, and (3) not be made available with a view to profit. *Cincinnati Nature Ctr. Assn. v. Bd. of Tax Appeals*, 48 Ohio St. 2d 122, 125, 357 N.E.2d 381 (1976),³ *Warman v. Tracey*, 72 Ohio St. 3d 217, 648 N.E.2d 833 (1995); *Community Health Professionals, Inc.* 113 Ohio St. 3d 432, 2007-Ohio-

³ At the time of the decision in *Cincinnati Nature Ctr. Assn.*, the language currently found in R.C. 5709.121(A)(2) was lodged in R.C. 5709.121(B).

2336, 866 N.E.2d 478, at ¶ 19; *Cincinnati Community Kollect*, 135 Ohio St. 3d 219, 2013-Ohio-396, 985 N.E.2d 1236, ¶ 26.

With this framework, the decision of the BTA is both reasonable and lawful.

1. RHC is a charitable institution.

As noted in *Community Health Professionals, Inc.*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478, ¶¶ 17, 18 and its predecessors and progeny, the first question under R.C. 5709.121(A)(2) is whether the owner of the property, RHC, is a charitable institution. An institution is charitable when it is organized for charitable purposes, and where its core activities constitute charity as defined under Ohio law. *OCLC Online Computer Library Ctr., Inc. v. Kinney*, 11 Ohio St. 3d 193, at 201, 464 N.E.2d. 572 (1984).

In this case, RHC's articles of incorporation indicate it is organized for three main purposes:

- (i) To enhance the quality, availability and efficiency of comprehensive health services for the people of southern Ohio by enabling and mobilizing community partnerships and resources;
- (ii) Identifying and addressing healthcare needs which can be most effectively and efficiently responded to collectively (or "in a collective manner"); and
- (iii) Supporting and furthering the mission of the member organizations.

There is no question but that these purposes comport with the definition of "charity" under Ohio tax law, as defined in *Planned Parenthood Assn.*, 5 Ohio St. 2d 117, 214 N.E.2d 222 (1966), syllabus. These purposes clearly are intended to advance and benefit mankind in general, and those in need of medical assistance in south central Ohio in particular. It also is formed without a view to profit. There are no individual or for-profit shareholders and no

dividends are distributed. Based on these uncontroverted facts the BTA reasonably and lawfully recognized that RHC was organized for charitable purposes.

The BTA then examined the myriad of activities performed by RHC. The record contains evidence aplenty showing how the activities performed by RHC comport with these purposes; that is, its core activities constitute “charity” for purposes of Ohio property tax exemption law. For example, it has written, received, and administered a number of grants to fund health initiatives in the region (Tr. 378-382, 409; T.C. Supp. 268-9, 276); sponsored or hosted events to promote general or specific health issues including renal disease education (Tr. 382-385, 396, 410; T.C. Supp. 269-70, 273, 276); brought its members together to address health issues common to all residents in the region (Tr. 376, 397-400; T.C. Supp. 368, 273-4), and established a dialysis clinic (which the individual members were unequipped to do) to provide a much-needed service to people in the region who are desperately ill (Tr. 385-386, 391; T.C. Supp. 270, 272). All of these activities were conducted solely for the purpose of carrying out RHC’s charitable purposes, and in fact they do enhance the quality, availability, and efficiency of health services for people in the region (Tr. 47, 70, 78-79, 369-370, 374-376, 382, 391, 396; T.C. Supp. 139, 145, 147, 266, 267-8, 269, 272, 273). Other than those services for dialysis and relying heavily on volunteers, no charges are assessed to individuals to participate in the various activities (Tr. 380-383; T.C. Supp. 269-70), anybody in the region may participate in any of the activities, and nobody has ever been denied participation in any of the activities due to an inability to pay for the activities and services.

Based upon the uncontroverted evidence in the record, the BTA reasonably concluded that RHC is organized for charitable purposes under Ohio law, and that its core activities are charitable in nature. The question is not whether the members of this Court, or for that matter,

the Tax Commissioner, might have reached a different conclusion. The question is whether there is evidence in the record that supports the BTA's conclusions. Clearly, there is. The BTA's finding that RHC is a charitable institution is supported by the record; it is both reasonable and lawful. As a result, that finding must be affirmed.

2. The property is made available under the direction or control of RHC.

The next requirement under R.C. 5709.121(A)(2) is that the property in question must be made available under the direction or control of a charitable institution. Under the preceding section of this brief we discussed the BTA's finding that RHC is a charitable institution. The BTA also found that by virtue of the lease between RHC and DCI, the property was made available under the direction and control of RHC.

The two most recent decisions of this Court applying this provision are instructive on this issue. And, not surprisingly, the Tax Commissioner omits any mention either of these two cases, *Community Health Professionals, Inc.*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478, and *Cincinnati Community Kolliel*, 135 Ohio St. 3d 219, 2013-Ohio-396, 985 N.E.2d 1236.

In *Community Health Professionals, Inc.*, the taxpayer was a charitable entity that leased portions of its buildings to other charitable institutions. The activities of the lessees coincided with the charitable purposes of the owner of the building. In applying R.C. 5709.121(A)(2), the Court stated that the relevant inquiry focused on "the relationship between the actual use of the property and the purpose of the institution." 113 Ohio St. 3d 432, 2013-Ohio-396, 866 N.E.2d 478, at ¶ 21. Based upon all the circumstances of the case, the Court agreed that the property, being leased to the other entities that used the building to provide services that promoted health to the community, was made available under the direction and control of the owner, and was used consistent with the purpose of the owner. Therefore, it upheld granting the exemption.

In *Cincinnati Community Kolliel*, the owner of the property was a religious training institution. The property in question was leased to students, who used the building for residential purposes with their families and also to study. This Court concluded that the property was made available under the direction or control of the Kolliel.

These two decisions are consistent with a long line of cases finding that the existence of a lease between the parties was sufficient to support the finding that the property was made available under the direction or control of the owner. See *Case W. Reserve Univ. v. Wilkins*, 105 Ohio St. 3d 276, 2005-Ohio-1649, 825 N.E.2d. 146, ¶ 30 (“There apparently is no disagreement that the House is made available under the direction or control of CWRU, as evidenced by the [Lease] Agreement between CWRU and the House Corporation.”); *Warman v. Tracy*, 72 Ohio St. 3d 217, 648 N.E.2d 833 (1995). Indeed, in *Humane Society Found. of Hancock Cty. v. Tracy*, BTA No. 98-J-884, 1999 Ohio Tax LEXIS 1552 (October 15, 1999), at *4, the Tax Commissioner expressly agreed that the “direction or control” requirement was satisfied by the existence of a lease between the owner and occupant of the property.

In the present case there is a written lease between RHC and DCI (Ex. 10; T.C. Supp. 363-373). The lease provides the basis for DCI to occupy and use the property. It restricts DCI’s use of the property to the operation of a dialysis clinic. Pursuant to the lease, the property is made available under the “direction or control” of RHC. Based upon the existence and terms of the lease and the language in the many cases cited in the preceding paragraph, the BTA reasonably and lawfully determined that the property was made available under RHC’s direction and control.

3. The property is otherwise made available “for use in furtherance of or incidental to” RHC’s charitable purposes.

The next requirement for exemption under R.C. 5709.121(A)(2) is that the property is otherwise made available “for use in furtherance of or incidental to” RHC’s charitable purposes. Once again, the BTA found that this requirement was satisfied based upon the evidence in the record.

In *Cincinnati Community Kolliel*, 135 Ohio St. 3d 219, 2013-Ohio-396, 985 N.E.2d 1236, the owner of the property was a religious training institution. The property in question was leased to students, who used the building for residential purposes with their families and also to pursue their educational studies. This Court specifically rejected any notion of primary use, or any sort of quantitative or qualitative test, noting that the statute contained no such requirement. Rather, the test to be applied was stated thusly, at ¶ 28: “Rather, when considering the question of whether an educational institution uses its property in furtherance of or incidental to its educational purposes, the focus on the inquiry should be on the relationship between the actual use of the property and the purpose of the institution.” Interestingly, this Court cited its holding in *Community Health Professionals, Inc.*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478, for this proposition. The evidence in the record showed that educational activities also took place on the property. These activities had a substantive relationship to the educational purposes of the owner. Therefore, the exemption was granted.

While *Cincinnati Community Kolliel* involved an educational institution, the statute uses the same language with respect to charitable institutions, and the same test should apply.

In this case, RHC’s charitable purposes include programs and activities designed to improve the general health of, and delivery of health services to, the residents of the area. They

also include serving as a vehicle for its members to come together to better meet the health needs of the community. The dialysis clinic fits squarely within these purposes.

Prior to the construction of the clinic, there was a dire need for dialysis services in the area. Dialysis patients are very sick; their kidneys have shut down, and without treatment they will die. Dialysis is an extremely taxing procedure; the patient's blood is totally removed from the patient's body, scrubbed clean, and then returned. The entire process takes about 4 hours per session, three times per week. Travel to Columbus or Cincinnati or Portsmouth turns each treatment into an all-day ordeal for people already in precarious medical states.

None of the members had the financial resources or the expertise to provide a dialysis clinic, yet the need existed. Through RHC, however, they were able to come together to procure the land in the form of a gift, to obtain the funding in the form of a federal grant, to construct the building, and to find somebody, DCI, that had the expertise and financial backing to operate the facility.

Developing a plan to provide services for which there was a desperate need and making that plan a reality fit perfectly with the expressed charitable purposes of RHC: Establishing the clinic enhanced the quality, availability and efficiency of a comprehensive health service; it resulted from identifying and addressing a healthcare need; and it supported the missions of its public member organizations.

The BTA found that establishing the dialysis clinic had a substantive relationship to RHC's charitable purposes. Therefore, it concluded that the third requirement for exemption under R.C. 5709.121(A)(2) was satisfied. That finding is supported by the record.

4. The property is made available to DCI without a view to profit.

The last requirement under this provision is that the property not be used with a view to profit. As RHC has shown, and the Tax Commissioner has stated, the fact that charges are made

for the services conducted on the property is not determinative of the issue. Similarly, the fact that an excess of revenues over expenses might be generated does not defeat a claim for exemption. Rather, all the facts and circumstances must be reviewed. *Community Health Professionals, Inc.*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478. Only if the lease is intended to generate a “profit” for the owner of the property, or if the lessee’s use of the property is intended to generate a “profit” is the requirement is not met. *Anderson/Maltbie Partnership v. Levin*, 127 Ohio St. 3d 178, 2010-Ohio-4910, 937 N.E.2d 547.

As we have shown already, neither RHC nor DCI makes a “profit” from the clinic. The lease is intended to cover the costs of operating the facility. Generally it has not been able to do so. RHC may experience a modest amount of cash flow from the lease on occasion, but any positive cash flow has dwindled as the building has aged and additional maintenance has been required. When all costs are considered, including depreciation, the property has consistently experienced expenses in excess of revenues. There is no evidence that RHC uses any proceeds from the lease for any improper purpose, or that any individual or entity receives undue gain from it.

Clearly DCI does not profit from the use of the building. In fact, since 2006 DCI has experienced expenses over revenues of about \$1.4 million (Tr. 266, Ex. 15; T.C. Supp. 194, 188-9). Even the Tax Commissioner acknowledges that DCI (and RHC) has lost money on the clinic at Seaman every year it has operated.

There is no evidence in the record that either RHC, or DCI, intended the arrangement to generate a profit. There is no evidence in the record that either party has benefitted improperly from the arrangement. Based upon all the facts, again uncontroverted by the Tax Commissioner,

the BTA concluded that the property is not used with a view to profit. Therefore, its decision that this prong of the test is satisfied is reasonable and lawful.

In summary, RHC based its claim of exemption on R.C. 5709.12 and 5709.121(A)(2). It presented voluminous testimony and documentary evidence that addressed the charitable purposes and activities of RHC, its use of the property, and the operation of the clinic by DCI. Based on the evidence that was presented, the BTA concluded that RHC was a charitable institution; and that the property was made available under its direction and control for use in furtherance of, or incidental to, its charitable purposes and not with a view to profit. That is exactly the legal inquiry that is required under *Cincinnati Nature Ctr. Assn.*, 48 Ohio St. 2d 122, 357 N.E.2d 381 (1976). The BTA's decision is reasonable and lawful.

C. The Tax Commissioner's Arguments Are Unavailing

In its brief, the Tax Commissioner spends 40 pages arguing primarily about the facts in the record, taking issue with the BTA's findings, and arguing about what the BTA should have concluded. In the course of doing so, three main arguments are raised. The Tax Commissioner argues that (i) RHC is not a charitable institution; (ii) the decision in *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St. 3d 215, 2010-Ohio-5071, 938 N.E.2d 329, determines as a matter of law that DCI is not a charitable institution and that any property used by DCI as a dialysis clinic does not qualify for the charitable use exemption; and (iii) that divisions (1) and (2) of R.C. 5709.121(A) are mutually exclusive and that where, as here, a lease is involved, exemption may only be granted pursuant to R.C. 5709.121(A)(1). In large part, these arguments are premised upon the Tax Commissioner's view of the facts, a view that varies significantly from that of the BTA. In addition, for the most part any legal conclusions made by the Tax Commissioner are based on its revised version of the facts. At no time does that official argue that the BTA applied the wrong law or analysis to the facts as determined by the BTA. In short, the Tax Commissioner implores

this Court to be a super Board of Tax Appeals and to substitute its judgement for that of the BTA on factual issues. This Court should politely decline that invitation and uphold the reasonable and lawful decision of the BTA that granted tax exemption to the dialysis clinic property in question.

1. RHC is a charitable institution.

At pages 32-40 of its merit brief, the Tax Commissioner takes issue with the finding of the BTA that RHC is a charitable institution. In doing so, that official does not take issue with the legal standard of what constitutes charity under Ohio law, or with the legal standard that determines whether an institution is charitable in nature. Rather, he spends page upon page summarizing, misstating, and recharacterizing the facts as found by the BTA in its decision in order to suit its position. At the end of the day, however, the Tax Commissioner's arguments are without merit. The BTA followed the correct law in the context of the evidence presented to it in determining that RHC was in fact a charitable entity. The holding is reasonable and lawful and should be affirmed.

The Tax Commissioner correctly notes that RHC qualifies as a charitable institution if its core activities are charitable in nature. It then goes on to argue that RHC's core activities are leasing real property; that establishing the clinic was not a charitable activity; that it does not provide unreimbursed care; that the lease provides no benefits to mankind; and that its other activities are inconsequential.

As we demonstrated previously at page ten of this brief, for purposes of real property tax law, charity is not limited to alms-giving. Rather, it includes a broad range of activities that seeks to improve the human condition generally. *Gerke v. Purcell*, 25 Ohio St. 229, 1874 Ohio Lexis 174 (1874); *Planned Parenthood Assn.*, 5 Ohio St. 2d 117, 214 N.E.2d 222 (1966), syllabus. Thus, this Court has concluded that a number of disparate activities may qualify as charity.

American Issue Pub. Co. v. Evatt, 137 Ohio St. 264, 28 N.E.2d 613 (1940) (organization dedicated to discouraging the use of intoxicating beverages qualified); *Highland Park Owners, Inc. v. Tracy*, 71 Ohio St. 3d 405, 644 N.E.2d 284 (1994) (institution that made parkland available to the general public); *Herb Soc. of Am., Inc. v. Tracy*, 71 Ohio St. 3d 374, 643 N.E.2d 1132 (1994) (membership organization dedicated to promoting education about herbs and endowing research grants); *Community Health Professionals, Inc.*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478 (organizations that provided social assistance to mothers and children on federal assistance programs); *Cincinnati Nature Ctr. Assn.*, 48 Ohio St. 2d 122, 357 N.E.2d 381 (1976) (organization devoted to education about ecology and the environment). The list could go on, but the point is obvious: For purposes of Ohio property tax law, charity encompasses a large number of activities that benefit people in general.

In this case, the record is replete with activities conducted by RHC that are intended to benefit the human condition and that are conducted without expectation of gain or profit. They include obtaining grants to fund health initiatives in the community; sponsored or hosted events such as blood drives and health fairs; facilitating cooperation and communication among its members so that scarce resources are wisely allocated in a manner such that health care is improved in the community; and yes, providing a clinic where deathly ill patients suffering from ESRD can obtain dialysis services. Every one of these activities is done in order to improve health and the provision of health care in the community. Every one of these activities in fact does improve health or the provision of health care in the community. The fact that it may rely on volunteers, including individuals employed by its members, is of no consequence; otherwise, any charitable institution that relies on the assistance of volunteers becomes ineligible for exemption.

The BTA weighed the evidence. It applied the appropriate law. It concluded that the evidence supported a finding that RHC was a charitable institution. That should be the end of the inquiry. The Tax Commissioner is arguing the weight and credibility of the evidence. That is not within the scope of this Court's review.

The Tax Commissioner claims that during 2011, 2012 and 2013, rental income from the operation of the clinic constituted the vast majority of RHC's revenues; therefore, RHC's core activity is leasing real property. Looking at any one or two years may make it easy to advance such an argument. However, the BTA looked at all the activities of RHC over eight years, from 2006 through 2014. It also considered the fact that during the three years cited by the Tax Commissioner, one of the original members, Brown County Hospital, became a for-profit entity and had to be unwound from the RHC. This took a great deal of time, effort, and money over this time period, and may have made it difficult for RHC to engage in many other activities. Again the BTA made a "fact intensive decision based upon the totality of the circumstances." Its determination is supported by the evidence in the record.

The Tax Commissioner makes much about the "market-based lease agreement" between RHC and DCI. Testimony in the record indicates that the lease was intended to enable RHC to cover the costs (including depreciation) of operating the clinic. When DCI was unable to generate sufficient revenue to cover those costs, the leasing terms were changed, twice, to reduce the rental payments. The financial documents support the testimony that revenue from the arrangement failed to cover the costs. The arrangement was not market-based, despite how the lease itself may have been entitled.

The Tax Commissioner asserts that establishing the clinic was not a charitable act; that RHC does not provide unreimbursed medical care; and that the lease arrangement is not

beneficial to mankind. We've already addressed the argument that charity consists only of providing unreimbursed health care. RHC has not hung its charitable hat on the unreimbursed health care peg in this case. As to whether establishing the clinic was charitable, or whether leasing the clinic to DCI benefits mankind, perhaps we ought to allow the residents of the areas served by RHC to weigh in. RHC sought the donation of land and a federal grant to fund construction of the clinic; and sought an operator to provide services in this depressed area of the state when its fiscal viability remains in doubt, all so that deathly ill patients who by and large are unable to pay for dialysis services can have access to those services. Perhaps the Tax Commissioner can tell those patients that establishing the clinic, or bringing in DCI to operate the clinic, do not benefit the poor and the ill specifically, or people in general.

Finally, the Tax Commissioner likens this situation to that in *Northeast Oh. Psych. Inst. v. Levin*, 121 Ohio St. 3d 292, 2009-Ohio-583, 903 N.E.2d 1188. In that case, the taxpayer owned a building that it leased to other public entities. It sought exemption under R.C. 5709.121 and based its argument that it was a charitable institution on the facts that it was exempt from federal income taxes under Internal Revenue Code 501(c)(3), and that it leased the property to other charitable entities and used the rental proceeds for other charitable purposes. Its other activity consisted of leasing mental health professionals to other organizations. In that case, there was no evidence that Northeast's own activities were charitable. The BTA found that Northeast failed to qualify as a charitable entity, and this Court affirmed that finding as reasonable and lawful. 121 Ohio St. 3d 292, 2009-Ohio-583, 903 N.E.2d 1188, at ¶ 15.

In this case, however, the record is replete with activities conducted by RHC. RHC does not base its claim for exemption upon its federal tax status, the use of the lease proceeds, or the activities of DCI. Rather, its claim is based upon its own activities which are detailed in the

record. Based upon this record, the BTA could reasonably conclude that RHC is a charitable institution.

2. The decision in *Dialysis Clinic, Inc. v. Levin* does not control the result in this case

The Tax Commissioner devotes the bulk of its brief to the argument that this Court's decision in *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St. 3d 215, 2010-Ohio-5071, 938 N.E.2d 329, *as a matter of law* precludes the grant of a property tax exemption in this case. According to the Tax Commissioner, the decision in *Dialysis Clinic, Inc.* conclusively determined that DCI is not a charitable institution and that any use it makes of a property as a dialysis clinic does not qualify as a charitable use of the property. Simply put, this argument is without merit and must be rejected.

We note, first, that the charitable status of DCI and its operations are not an issue under R.C. 5709.121(A)(2). Rather, the question is the charitable status of RHC, and whether its use of the property comports with the provisions of R.C. 5709.121(A)(2). *Community Health Professionals, Inc.*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478; *Cincinnati Community Kollel*, 135 Ohio St. 3d 219, 2013-Ohio-396, 985 N.E.2d 1236. That is the issue that the BTA addressed. However, because the Tax Commissioner devotes the bulk of its brief to addressing the decision in *Dialysis Clinic, Inc.*, RHC is compelled to respond to it.

In *Dialysis Clinic, Inc.*, the question presented to the BTA was whether DCI, the entity that operates the clinic in this case, was a charitable institution and whether its use of a dialysis clinic located in Butler County qualified as charity for purposes of R.C. 5709.12. In that case, the taxpayer provided very little information as to its activities. Instead, it argued that its federal tax exemption conclusively established that it was a charitable institution. It also claimed that so long as the use of its property was incidental to its charitable purposes, it would qualify for

exemption. Finally, in that case the record failed to demonstrate the extent to which, if at all, the activities conducted on the property were provided without regard to the ability of the recipients to pay for them. Based upon the *record presented to it*, the BTA held that the property owner failed to demonstrate either that it was a charitable institution, or that its use of the property was charitable in nature. *Dialysis Clinic, Inc. v. Levin*, BTA No. 2006-V-2389, 2009 Ohio Tax LEXIS 1776 (November 24, 2009), at *24-25. This Court upheld the BTA's decision as a reasonable and lawful determination: "The BTA Acted Reasonably and Lawfully in Determining That DCI is not a Charitable Institution." 127 Ohio St. 3d 215, 2010-Ohio-5071, 938 N.E.2d 329, heading at ¶ 31.

By arguing that the decision in *Dialysis Clinic, Inc.* controls as a matter of law, the Tax Commissioner is effectively seeking to invoke some form of the doctrine of preclusion. Preclusion takes the forms of both claim preclusion, or *res judicata*, and issue preclusion, also known as collateral estoppel. *Grava v. Parkman Twp.*, 73 Ohio St. 3d 379, 653 N.E.2d 226 (1995). *Res judicata* precludes the re-litigation of identical claims. If different claims are presented, but some issues of fact or law are identical, then collateral estoppel precludes the re-litigation of those issues. In both cases, however, there must be an identity of parties, and at least some of the issues, both legal and factual, must be the same. See generally, *State ex rel. Westchester Estates, Inc. v. Bacon*, 61 Ohio St. 2d 42, 399 N.E.2d 81 (1980); *Superior's Brand Meats, Inc. v. Lindley*, 62 Ohio St. 2d 133, 403 N.E.2d 996 (1980); *Hicks v. De La Cruz*, 52 Ohio St. 2d 71, 369 N.E.2d 776 (1977).

In this case, the Tax Commissioner whiffs on all three accounts.

First, there is not an identity of parties between the two cases. In this case, the parties in interest are RHC and the Tax Commissioner. RHC was not involved in *Dialysis Clinic, Inc.*, nor is it in privity with DCI with respect to that case.

Second, there is no identity of the factual issues between the two cases. With respect to property taxes, whether the issue is the value of the property, or its taxable status, each year and each parcel presents a different question of fact. *Olmsted Falls Bd. of Educ.*, 122 Ohio St.3d 134, 2009-Ohio-2461, 909 N.E.2d 597; *Freshwater v. Belmont Cty. Bd. of Revision*, 80 Ohio St. 3d 26, at 29, 684 N.E.2d 304 (1997) (“When the BTA makes a determination of true value for a given year, such determination is to be based on the evidence presented to it in that case, uncontrolled by the value assessed for prior years.”); *Hubbard Press v. Tracy*, 67 Ohio St. 3d 564, 565, 621 N.E.2d 396 (1993) (new determination of the ultimate issue of exempt status of real property not precluded by contrary determination of that issue in a prior tax year); *Episcopal Sch. of Cincinnati v. Levin*, 117 Ohio St. 3d 412, 2008-Ohio-939, 884 N.E.2d 561, at ¶ 23 (“We regard as settled the general proposition that the taxable or exempt status of property should be determined as of the tax lien date, which is January 1 of whatever tax year is at issue”). In this case, different tax years (2004 and 2006) are in issue and different parcels of real property are involved.

Finally, the legal issues involved in the two cases are different. In *Dialysis Clinic, Inc.*, the issue was whether DCI was a charitable institution and whether it used the property for charitable purposes. While reference was made to R.C. 5709.121 generally in discussing what constitutes charity, the legal issue was whether exemption was warranted under R.C. 5709.12. In this case, while exemption is ultimately granted pursuant to R.C. 5709.12, the precise question is

whether *RHC* is using the property for charitable purposes as provided in R.C. 5709.121(A)(2). That legal question was not addressed in *Dialysis Clinic, Inc.*

The practical import of the Tax Commissioner's argument is that to preclude the BTA from considering the evidence and law when different parties, different years, and different properties are in question, "would impair the BTA's plenary authority as a fact-finder to evaluate evidence." *Olmsted Falls Bd. of Edn.*, 122 Ohio St. 3d 134, 2009-Ohio-2461, 909 N.E.2d 597, at ¶ 25. The decision in *Dialysis Clinic, Inc.* is not controlling for the purpose of determining the charitable exemption for RHC, or its use of the property under R.C. 5709.121(A)(2).

In short, if the decision in *Dialysis Clinic, Inc.*, controls here as a matter of law, then it must do so through application of the doctrines of claim or issue preclusion. However, there is no identity of parties; there is no identity of legal issues; and there is no identity of facts, between this case and *Dialysis Clinic, Inc.* Therefore, there is no basis for imposing the rules of law of *res judicata* or collateral estoppel. As a matter of law, the Tax Commissioner's argument fails.

If, instead, the Tax Commissioner takes the position that the decision in *Dialysis Clinic, Inc.* means that as a matter of *stare decisis* DCI is not a charitable institution and its operation of a dialysis clinic does not constitute charity precludes exemption in this case, then not only is the inquiry irrelevant to the determination in this case, but that determination can only be made based upon the analysis of the peculiar facts of the two cases. The BTA ruled that the record in this case, and the record in *Dialysis Clinic, Inc.*, which the Tax Commissioner introduced into evidence in these proceedings (Exs. L, M), disclosed very different facts as to the nature and operations of DCI. The BTA clearly looked at the facts contained in the record of *Dialysis Clinic, Inc.*, and those contained in the record in this case. It weighed the evidence in the two

cases. Even this Court, in its decision in *Dialysis Clinic, Inc.*, commented frequently on the absence of information in that case.

Both Ms. Emler and Ms. Zylstra admitted that the mission, vision, and purposes of DCI had not changed since 2004, and the Tax Commissioner places great stock in those statements. What did change, however, is that unlike the earlier case, there is detailed evidence in this record regarding not only the existence and nature of its mission, vision and purpose, and how those items shape the activities of DCI, but also how each activity helps DCI carry out its charitable purposes. As Ms. Emler testified, it was precisely because DCI did not do a good job of explaining its purposes or activities that she took her current position in 2011 (Tr. 85-86; T.C. Supp. 148-9). Similarly, Ms. Zylstra stated that what has changed since 2004 to 2006 is that DCI does a better job of telling its story (Tr. 180; T.C. Supp. 172). Thus, there is ample evidence in this record, evidence that was missing in the prior case, that supports the finding that DCI is indeed a charitable institution, if that determination must be made.

The issues decided in *Dialysis Clinic, Inc.* have no import to the resolution of this appeal. However, should the Court decide to visit that issue, the Tax Commissioner's argument must be rejected. There is evidence aplenty in the record for this case about the purposes and activities of DCI. The BTA weighed that evidence. It evaluated the credibility of the various witnesses. It determined the evidence to be competent and probative. It determined the evidence was sufficient to support a finding that the decision in *Dialysis Clinic, Inc.* did not apply in this case. That is the BTA's job. This Court will not re-weigh that evidence. Absent a finding of an abuse of discretion, the BTA's factual determinations must be upheld.

3. DCI's operations do not preclude granting a charitable exemption for the dialysis clinic in this case.

The Tax Commissioner makes three other arguments regarding DCI and its operations in its attempt to persuade this Court to reverse the factual findings made by the BTA. Again, it is critical to note that exemption was sought and granted under R.C. 5709.121(A)(2) and the BTA found the use of the property was in furtherance of, and incidental to, the charitable purposes of RHC, and not with a view to profit. The Tax Commissioner never once discusses this provision, the legal test to be applied with respect to the provision, the cases discussing this provision, or the fact that the BTA's decision is premised entirely upon this statutory provision. Under this provision, the status of DCI as a charitable entity, or the nature of its activities, aren't really the issues. *Cincinnati Community Kollel*, 135 Ohio St. 3d 219, 2013-Ohio-396, 985 N.E.2d 1236, at ¶ 21. The extensive discussion of DCI is only relevant with respect to R.C. 5709.121(A)(1). Thus, the many pages devoted to this issue really have no bearing on the case. Again, however, because the arguments have been raised and this Court may address them, we shall respond to them.

- a. The mere presence of third party payers for services and an excess of revenues over expenses do not preclude charitable status.

The Tax Commissioner's first attack to DCI's charitable status is that DCI partakes of federal programs that allow it to generate millions of dollars in profits. DCI has never denied that there are years when it generates an excess of revenues over expenses; however, there are also years, such as 2007 and 2008, when its expenses exceed its revenues (Tr. 115; T.C. Supp. 156; Ex. H, RHC Supp. 11). Moreover, given the huge investment required to establish a dialysis clinic, the fact that DCI typically locates those clinics in underserved areas populated by the poor and the elderly, and the over-all poor medical condition of the people that it treats, it is

not unreasonable for DCI, and charitable entities in general, to maintain reserves to see them through the difficult financial times.

This Court has recognized that the mere existence of an excess of revenues over expenses and maintaining reserves does not defeat the claim that an entity is a charity. *See Community Health Professional, Inc.*, 113 Ohio St.3d 432, 2007-Ohio-2336, 866 N.E.2d 476; *Vick*, 2 Ohio St. 2d 30, 206 N.E.2d 2 (1965). Instead, any excess revenues must be considered in light of the totality of the circumstances. We note that even in 2012 and 2013, when DCI supposedly earned millions of dollars of profit from its activities, the figures represent less than 8% of total program revenues. That is hardly an excessive return given that DCI operates approximately 216 clinics in 28 states (Tr. 141; T.C. Supp. 162; Ex. 1, RHC Supp. 1-4); the economic status, age, and physical condition of the population it serves (Tr. 120-1; T.C. Supp. 157); and the remote areas in which it frequently conducts activities (Tr. 104, 106; T.C. Supp. 153-4). DCI came to Seaman, when a for-profit entity would not, knowing that it would not recover its expenses for several years (Tr. 234, 236; T.C. Supp. 186). In addition, each year many of its clinics fail to generate sufficient revenues to cover their expenses, and DCI never knows from year to year which clinics will experience that fate (Tr. 115-6, T.C. Supp. 156). Given these factors, the generation of reserves is not unreasonable.

The Tax Commissioner has not presented or pointed to any evidence in the record that DCI's reserves are unreasonable, that it uses the revenues in an inappropriate manner or in a manner that does not further its charitable purposes, that there is any private gain, or that it otherwise "profits" from its activities. In fact, the Tax Commissioner cannot establish that the revenues are used for anything other than charitable purposes. Its argument fails.

b. DCI's Indigence Policies Do Not Preclude Exemption

The next claim asserted by the Tax Commissioner is that the indigence policy, embodied in Exhibit 6, precludes the granting of a charitable use exemption. He asserts there is no legal requirement for this language, and that the language therefore precludes a finding that dialysis services are provided to all regardless of their ability to pay. Further, he dismisses the testimony of Ms. Zylstra and Mr. Mazon that there is additional authority for clinic administrators to accept all patients, other than Medicare and Medicaid patients, regardless of their ability to pay in the face of specific examples of its exercise (Tr. 224-232; 142-143; T.C. Supp. 183-5, 163). These arguments miss the point and mischaracterize the purpose of the policy set forth in Exhibit 6, and simply have no merit.

First, let's be clear that at the Seaman clinic, not one patient has ever been turned away because the patient could not pay for services (Tr. 231; T.C. Supp. 185). Mr. Mazon has complete authority in that regard, but will consult with a corporate administrator if providing care at a reduced rate would jeopardize the viability of the clinic (Tr. 232; T.C. Supp. 185). DCI knows that it will not collect every penny from every patient, and it still accepts those patients for treatment. The Tax Commissioner supposes that patients self-select not to seek treatment (T.C. Brief at 19, 28), but not only is that point not supported by any evidence in the record, it is irrelevant. At the Seaman clinic, all patients are afforded treatment without regard to their ability to pay for the services. As a result, DCI is not reimbursed for thousands of dollars of costs associated with treating those individuals (Exs. 14, 15; T.C. Supp. 382-9). Almost 100 years ago, this Court held, "It is sufficient if [the charity] conforms its conduct along the lines of its experience as to the ordinary and usual demand made upon it by charity patients, provided always that it act in good faith and consistent with the purposes of its organization." *O'Brien v.*

The Physicians Hosp. Assn., 96 Ohio St. 1, at 9, 116 N.E. 975 (1917). That is what is done at the clinic in this case.

Regarding the indigence policy that is embodied in Exhibit 6, the policy states that all patients are responsible for the costs of their treatments unless they can demonstrate financial need, in which case those costs will be reduced or eliminated according to their ability to pay. This policy was put in place to comply with Medicare requirements to prevent fraud and abuse, and serves two purposes. It insures that those who can truly afford to pay for treatment do so; at the same time, it provides a process to verify that those who claim an inability to pay truly are unable to do so, in which case some or all of the patient responsibility for cost can be eliminated (Tr. 224-231; 144-149; T.C. Supp. 183-5, 163-4).

The Tax Commissioner clings to the language in the policy it is not a gift and that DCI reserves the right to deny service to patients who are unable to pay for them. He states that there are no federal laws or regulations that require this language, hence exemption should be denied for the facility (Brief at 27). While the express language may not be mandated, its import clearly is required.

42 U.S.C. § 1320a-7b provides for penalties for various activities deemed fraudulent or constituting a kick-back under the Medicare and Medicaid programs. Division (b) effectively prohibits any sort of quid pro quo that would act as an inducement or a referral for Medicare services. However, division (b)(3)(D) provides these provisions will not apply to a waiver of coinsurance by a provider with respect to an individual who qualifies for subsidized services under the Medicare and Medicaid act. The waiver of coinsurance and deductible amounts and the transfer of services for other than fair market value to persons who are able to pay for them are among the activities prohibited by the law. 42 U.S.C. § 1320a-7a(i)(6) and (a)(5).

These provisions are amplified in 42 C.F.R. Part 1001 generally, and 42 C.F.R. § 1001.952(k)(2), specifically. The *Medicare Provider Reimbursement Manual*, Part 3, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items on November 17, 2014, addresses the interplay of bad debts, collection efforts, and indigence, at sections 308, 310, 312, 316 and 328. Finally, the Office of Inspector General has weighed in on this very issue. *OIG Special Fraud Alert* (Dec. 19, 1994), available at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html> on November 17, 2014. The salient points are two: First, financial inducements or gifts of any kind are not permitted. Second, non-Medicare charity write-offs are not allowable costs for Medicare reimbursement calculation purposes and the reimbursement of bad debts or uncollected amounts for allowable costs are neither guaranteed, nor dollar for dollar. In short, a provider is not made whole by Medicare for either bad debts, or for charity write-offs.

Federal law and regulations may not expressly prohibit the language contained in Exhibit 6. However, gifts fall squarely within the type of inducement that federal law and regulations forbid.

Both Mr. Mazon and Ms. Zylstra explained in some detail the purpose, genesis, and operation of the policy set forth in Exhibit 6. It is put in place to conform to Medicare and Medicaid requirements. It insures that those individuals who have the ability to pay in fact do so; it also permits deductions and waivers of amounts for which a patient is responsible if inability to pay is demonstrated, and provides a process for making that determination. In all cases, DCI has served, and continues to serve, all patients even when they are unable to pay for those services.

The question the Tax Commissioner cannot answer is this: When an organization is committed to providing services to all who request them, regardless of their ability to pay for the services, why shouldn't an individual who is able to pay for services, either personally or through a third party, be required to do so? This is not only prudent for the clinic at Seaman, but as noted by the Inspector General it helps to make sure that payments under the federal health care system are made only in those cases where it is appropriate to do so. The policy embodied in Exhibit 6 does exactly that. But, it does not detract from the fact that all patients are treated at Seaman, even when DCI knows it will not receive payment for some portion of the services provided to them.

- c. There is no required threshold of uncompensated care required in order to receive a charitable property tax exemption.

In his final argument, the Tax Commissioner once again attempts to require a threshold level of uncompensated care before property is considered to be used for charitable purposes. That simply isn't the law. See *Bethesda Healthcare, Inc. v. Wilkins*, 101 Ohio St. 3d 420, 2004-Ohio-1749, 806 N.E.2d 142; *Community Health Professionals, Inc.*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478; and *Dialysis Clinic, Inc.*, 127 Ohio St. 3d 215, 2010-Ohio-5071. Instead, the Court requires that such care be made available to the public at large, consistent with its continued operation. *Bethesda Healthcare, Inc.*, at ¶ 38. This principle was recognized almost 100 years ago in *O'Brien v. The Physicians Hosp. Assn.*, 96 Ohio St. 1, at 9, 116 N.E. 975 (1917). It is still valid today.

In the present case, Mr. Mazon provided extensive testimony that no person had ever been turned away from service at Seaman because they couldn't pay for the services and that varying amounts of uncompensated care are provided on a routine basis. The record is devoid of any evidence of even one case where an individual was denied dialysis services because the

patient was unable to pay for them. The Tax Commissioner suggests patients may selectively decide to go elsewhere, but there is not one shred of evidence in the record to support this supposition. The Tax Commissioner's argument has been consistently rejected in the past; it must be rejected here.

On this point the Tax Commissioner is strangely silent with respect to Exhibit 15. Exhibit 15 is a record routinely kept and updated by Mr. Mazon in the ordinary course of his position as clinic administrator. That record clearly shows that the clinic regularly and continuously operates at an excess of expenses over revenues; by the end of 2013, the total amount since 2006 approximated \$1.4 million in uncompensated expense (Tr. 266, Ex. 15; T.C. Supp. 194, 388-9). Factors contributing to this include the cap on allowable costs that will be reimbursed, non-Medicare charity write-offs that are not compensated from any third party as well as the portion of Medicare write-offs that are not recovered from the Medicare bad debt charge.⁴ As required by *O'Brien*, charity is available to the public at large and is provided as it is needed, and there is no evidence in the record to the contrary.

Finally, even though it gives lip service to the rule that third party reimbursement will not defeat a claim for exemption, the Tax Commissioner criticizes DCI because it is reimbursed in large part from federal programs and private insurers. As this Court recognized in *Planned Parenthood Assn.*, 5 Ohio St 2d 117, 214 N.E.2d 222 (1966), *Vick*, 2 Ohio St. 2d 30, 206 N.E.2d 2 (1965), and *Dialysis Clinic, Inc.*, 127 Ohio St. 3d 215, 2010-Ohio-5071, 938 N.E.2d 329, the existence of a third party payor does not defeat the charitable activity. Moreover, in *Dialysis*

⁴ The Tax Commissioner gives the impression that this amount is reimbursed 100% from Medicare. Mr. Mazon and Ms. Zylstra clearly and consistently testified that while some portion of this amount is reimbursed, it is never dollar for dollar (Tr. 166, 299-300; T.C. Supp. 169, 202). See also 42 CFR § 413.89(g), (h)(3), at Appx. 30-31 of Appellant's Brief, disallowing certain expenses for consideration of bad debt reimbursement.

Clinic Inc., at ¶¶ 38, 42, this Court specifically recognized that participation in the Medicare and Medicaid programs was a charitable activity and that reimbursement did not have to be foregone in order to qualify for a charitable use of the property. This suggests that even if DCI recovered 100% of its costs at Seaman, which it does not, its use of the property might nevertheless qualify as charitable in nature. The Tax Commissioner's argument places Ohio law in the interesting position of concluding that participating in Medicare and Medicaid are charitable activities, but complying with the legal requirements of those programs precludes a participant from being a charitable institution. That doesn't make sense.

4. Real property tax exemption under R.C. 5709.121(A)(2) is not precluded by R.C. 5709.121(A)(1) due to the presence of a lease between RHC and DCI. The two provisions are not mutually exclusive.

In the last three pages of its brief, the Tax Commissioner actually raises a legal argument. For the first time in these proceedings it contends that exemption is improper under R.C. 5709.121(A)(2) because of the presence of the lease between RHC and DCI. Where there is a lease, the Tax Commissioner contends the exclusive source of exemption is R.C. 5709.121(A)(1). This argument was not raised below, and from a review of the reported cases, it appears this is the first time the issue has ever been raised. Not only is the argument wrong as a matter of law, but it also is contrary to the Tax Commissioner's own long-standing administrative practice on this issue. It should be rejected.

Statutes are to be applied as enacted; words not used are not to be added, and words included are not to be ignored. *Columbus Suburban Coach Lines, Inc. v. PUCO*, 20 Ohio St. 2d 126, 254 N.E.2d 8 (1969). In this case, there is nothing in the language contained in R.C. 5709.121(A)(2) that indicates the presence of a lease cannot be construed as making the property available under the direction or control of the owner. There is nothing in the statute that provides that in the case of a lease, the sole recourse is R.C. 5709.121(A)(1). That latter provision

contains express language that it is limited to situations involving “a lease, sublease, or other contractual arrangement.” The absence of a lease would, then, preclude application of that division of the statute. But there is nothing to indicate that division (A)(1) is the exclusive provision that applies where a lease is present. The statute does not contain such language, and such language cannot be read into it. *Cincinnati Community Kollect*, 135 Ohio St. 3d 219, 2013-Ohio-396, 985 N.E.2d 1236, at ¶¶ 25, 26.

Equally important, it appears from a review of the reported cases that we could find that the uniform practice of the Department of Taxation has been that the “control or direction” requirement in R.C. 5709.121(A)(2) is satisfied where the property is used by one other than the owner under some sort of lease arrangement. *See, for example, Cincinnati Community Kollect, Community Health Professionals, Inc.*, 113 Ohio St. 3d 432, 2007-Ohio-2336, 866 N.E.2d 478, *Case W. Reserve Univ.*, 105 Ohio St. 3d 276, 2005-Ohio-1649, 825 N.E.2d 146; *Humane Society Found. of Hancock Cty. v. Tracy*, BTA No. 98-J-884, 1999 Ohio Tax LEXIS 1552 (October 15, 1999), *City of Sharonville v. Kinney*, BTA No. 82-G-1367, 1986 Ohio Tax LEXIS 159 (August 5, 1986). As this Court has observed, “[W]here a long-established practice has been followed, such administrative practice does have much persuasive weight especially where the practice has gone on unchallenged for a quarter of a century.” *Ormet Corp. v. Lindley*, 69 Ohio St. 2d 263, 266, 431 N.E.2d 686 (1982), citing *Recording Devices, Inc. v. Bowers*, 174 Ohio St. 518, 190 N.E.2d 258 (1963). Since at least 1986, the Tax Commissioner has acquiesced in the position that the existence of a lease satisfies the direction or control requirement of R.C. 5709.121(A)(2). It should not be heard to take a contrary position now.

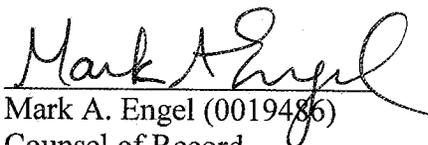
In summary, the Tax Commissioner has not contested the legal standard of what constitutes charity for purposes of R.C. 5709.12 and 5709.121. The Tax Commissioner has not

addressed the BTA's application of R.C. 5709.121(A)(2) or its conclusion that based on the record in this case, tax exemption was warranted. Instead, the Tax Commissioner argues that the decision *Dialysis Clinic, Inc. v. Levin* controls the outcome of this case, and that the BTA should have reached different factual conclusions than it did (even asserting the existence of facts that are not in the record). The first argument is wrong as a matter of law, while the second simply is not within the province of this Court on appeal from the BTA. There is no basis for reversing the decision of the BTA. That decision is reasonable and lawful, and the Tax Commissioner's arguments to the contrary must be rejected.

CONCLUSION

RHC applied for exemption for its dialysis clinic pursuant to R.C. 5709.12 and 5709.121(A)(2). Based on the record before it, the BTA determined that RHC was a charitable institution, that the property was made available under its direction and control for use in furtherance of, or incidental to, its charitable purposes, and not with a view to profit. Thus, the BTA determined the property was entitled to tax exemption under those statutes. That determination is both reasonable and lawful and should be affirmed by this Court.

Respectfully submitted,



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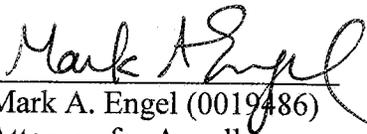
Attorneys for Appellee

Rural Health Collaborative of Southern

Ohio, Inc.

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing Merit Brief of Rural Health Collaborative of Southern Ohio, Inc., Appellee, was mailed this 4th day of December 2014 to Mike DeWine, Attorney General, and David D. Ebersole, Assistant Attorney General, Taxation Section, 25th Floor, 30 East Broad Street, Columbus, OH 43215, attorneys for Joseph W. Testa, Tax Commissioner of Ohio, Appellant.


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APPENDIX

42 USCS § 1320a-7a	App000001
42 USCS § 1320a-7b	App000009
42 CFR § 1001.952	App000013
Medicare Provider Reimbursement Manual, Part 3, available at www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items on November 17, 2014	App000022
OIG Special Fraud Alert (Dec. 19, 1994), available at http://oig.hhs.gov/fraud/ docs/alertsandbulletins/121994.html on November 17, 2014	App000036

42 USCS § 1320a-7a

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*** Current through PL 113-74, with a gap of 113-66 and 113-73, approved 01/16 /2014 ***

TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7. SOCIAL SECURITY ACT
TITLE XI. GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION
PART A. GENERAL PROVISIONS

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42 USCS § 1320a-7a

§ 1320a-7a. Civil monetary penalties

(a) Improperly filed claims. Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that--

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines--

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service--

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified,

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the Federal health care program (as defined in section 1128B(f) [42 USCS § 1320a-7b(f)]) under which the claim was made pursuant to Federal law. [, or]

(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii) [42 USCS § 1395u(b)(3)(B)(ii)], or (B) an agreement with a State agency (or other requirement of a State plan under title XIX [42 USCS §§ 1396 et seq.]) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1) [42 USCS § 1395u(h)(1)], or (D) an agreement pursuant to section 1866(a)(1)(G) [42 USCS § 1395cc(a)(1)(G)];

(3) knowingly gives or causes to be given to any person, with respect to coverage under title XVIII [42 USCS §§ 1395 et seq.] of inpatient hospital services subject to the provisions of section 1886 [42 USCS § 1395ww], information that he knows or has reason to know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII [42 USCS §§ 1395 et seq.] or a State health care program in accordance with this subsection or under section 1128 [42 USCS § 1320a-7] and who, at the time of a violation of this subsection--

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII [42 USCS §§ 1395 et seq.] or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b) [42 USCS § 1320a-5(b)]) of such an entity;

(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act [42 USCS §§ 1395 et seq.], or under a State health care program (as defined in section 1128(h) [42 USCS § 1320a-7(h)]) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII [42 USCS §§ 1395 et seq.], or a State health care program (as so defined);

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f) [42 USCS § 1320a-7b(f)]), for the provision of items or services for which payment may be made under such a program;

(7) commits an act described in paragraph (1) or (2) of section 1128B(b) [42 USCS § 1320a-7b(b)];

(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; [or]

(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;

[(10)](8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

[(11)](9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII [42 USCS §§ 1395w-21 et seq.], prescription drug plan sponsors under part D of title XVIII [42 USCS §§ 1395w-101 et seq.], Medicaid managed care organizations under title XIX [42 USCS §§ 1396 et seq.], and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

[(12)](10) knows of an overpayment (as defined in paragraph (4) of section 1128)(d) [42 USCS § 1320a-7k(d)] and does not report and return the overpayment in accordance with such section;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$ 10,000 for each item or service (or, in cases under paragraph (3), \$ 15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), \$ 10,000 for each day the prohibited relationship occurs; in cases under paragraph (7), \$ 50,000 for each such act, in cases under paragraph (8), \$ 50,000 for each false record or statement, or in cases under paragraph (9), \$ 15,000 for each day of the failure described in such paragraph); or in cases under paragraph (9) [paragraph [(11)](9)], \$ 50,000 for each false statement or misrepresentation of a material

fact). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose; or in cases under paragraph (9) [paragraph [(11)](9)], an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1) [42 USCS § 1320a-7b(f)(1)]) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b) Payments to induce reduction or limitation of services.

(1) If a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who--

(A) are entitled to benefits under part A or part B of title XVIII [42 USCS §§ 1395c et seq., 1395j et seq.] or to medical assistance under a State plan approved under title XIX [42 USCS §§ 1396 et seq.], and

(B) are under the direct care of the physician, the hospital or a critical access hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$ 2,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$ 2,000 for each individual described in such paragraph with respect to whom the payment is made.

(3) (A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of--

(i) \$ 5,000, or

(ii) three times the amount of the payments under title XVIII [42 USCS §§ 1395 et seq.] for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII [42 USCS §§ 1395 et seq.], that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) [42 USCS § 1395f(a)(2)(C) or 1395n(a)(2)(A)] in the case of home health services furnished to the individual.

(c) Initiation of proceeding; authorization by Attorney General, notice, etc., estoppel, failure to comply with order or procedure.

(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under subsection (a) or (b) which--

(A) is against a person who has been convicted (whether upon a verdict after trial or upon

a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and
(B) involves the same transaction as in the criminal action,
the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include--

(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(d) Amount or scope of penalty, assessment, or exclusion. In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (a) or (b), the Secretary shall take into account--

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

(e) Review by courts of appeals. Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court [court] the record in the proceeding as provided in section 2112 of title 28, United States Code. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States

Code.

(f) Compromise of penalties and assessments; recovery; use of funds recovered. Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) (A) In the case of amounts recovered arising out of a claim under title XIX [42 USCS §§ 1396 et seq.], there shall be paid to the State agency an amount bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under title V [42 USCS §§ 701 et seq.], there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 [42 USCS §§ 1395i, 1395t] shall be repaid to such trust funds.

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f) [42 USCS § 1320a-7b(f)]), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Portability and Accountability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) [42 USCS § 1395i(k)(2)(C)].

(4) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

(g) Finality of determination respecting penalty, assessment, or exclusion. A determination by the Secretary to impose a penalty, assessment, or exclusion under subsection (a) or (b) shall be final upon the expiration of the sixty-day period referred to in subsection (e). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment assessed under this section.

(h) Notification of appropriate entities of finality of determination. Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (a) or (b) becomes final, he shall notify the appropriate State or local medical or professional organization, the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h) [42 USCS § 1320a-7(h)]), and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) [42 USCS §§ 1395aa(a), 1396a(a)(33)]) that such a penalty or assessment has become final and the reasons therefor.

(i) Definitions. For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act [42 USCS §§ 1396 et seq.] or designated to administer the State's program under title V or subtitle 1 of title XX of this Act [42 USCS §§ 701 et seq. or 1397 et seq.].

(2) The term "claim" means an application for payments for items and services under a Federal health care program (as defined in section 1128B(f) [42 USCS § 1320a-7b(f)]).

(3) The term "item or service" includes (A) any particular item, device, medical supply, or

service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a Federal health care program (as so defined).

(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under a Federal health care program (as so defined) but does not include a provider, supplier, or practitioner.

(6) The term "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term "remuneration" does not include--

(A) the waiver of coinsurance and deductible amounts by a person, if--

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person--

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts;

(B) subject to subsection (n), any permissible practice described in any subparagraph of section 1128B(b)(3) [42 USCS § 1320a-7b(b)(3)] or in regulations issued by the Secretary;

(C) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996 [enacted Aug. 21, 1996];

(D) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated;

(E) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B); [or]

(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) [42 USCS § 1320a-7b(f)] and designated by the Secretary under regulations);

(G) the offer or transfer of items or services for free or less than fair market value by a person, if--

(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII [42 USCS §§ 1395 et seq.] or a State health care program (as defined in section 1128(h) [42 USCS § 1320a-7(h)]);

(H) the offer or transfer of items or services for free or less than fair market value by a person, if--

(i) the items or services are not offered as part of any advertisement or solicitation;

(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII [42 USCS §§ 1395 et seq.] or a State health care program (as so defined);

(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII [42 USCS §§ 1395w-101 et seq.] or an MA organization offering an MA-PD plan under part C of such title [42

USCS §§ 1395w-21 et seq.] of any copayment for the first fill of a covered part D drug (as defined in section 1860D-2(e) [42 USCS § 1395w-102(e)]) that is a generic drug for individuals enrolled in the prescription drug plan or MA-PD plan, respectively.

(7) The term "should know" means that a person, with respect to information--

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(j) Subpoenas.

(1) The provisions of subsections (d) and (e) of section 205 [42 USCS § 405(d), (e)] shall apply with respect to this section to the same extent as they are applicable with respect to title II [42 USCS §§ 401 et seq.]. The Secretary may delegate the authority granted by section 205 (d) [42 USCS § 405(d)] (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(2) The Secretary may delegate authority granted under this section and under section 1128 [42 USCS § 1320a-7] to the Inspector General of the Department of Health and Human Services.

(k) Injunctions. Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

(l) Liability of principal for acts of agent. A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency.

(m) Claims within jurisdiction of other departments or agencies.

(1) For purposes of this section, with respect to a Federal health care program not contained in this Act [42 USCS §§ 301 et seq.], references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

(2) (A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

(n) Safe harbor for payment of medigap premiums.

(1) Subparagraph (B) of subsection (i)(6) shall not apply to a practice described in paragraph (2) unless--

(A) the Secretary, through the Inspector General of the Department of Health and Human Services, promulgates a rule authorizing such a practice as an exception to remuneration; and

(B) the remuneration is offered or transferred by a person under such rule during the 2-year period beginning on the date the rule is first promulgated.

(2) A practice described in this paragraph [subsection] is a practice under which a health care provider or facility pays, in whole or in part, premiums for medicare supplemental policies for individuals entitled to benefits under part A of title XVIII [42 USCS §§ 1395c et seq.] pursuant to section 226A [42 USCS § 426-1].

HISTORY:

(Aug. 14, 1935, ch 531, Title XI, Part A, § 1128A, as added Aug. 13, 1981, P.L. 97-35, Title XXI, Subtitle A, ch 2, § 2105(a), 95 Stat. 789; Sept. 3, 1982, P.L. 97-248, Title I, Subtitle B, § 137(b)(26), 96 Stat. 380; July 18, 1984, P.L. 98-369, Division B, Title III, Subtitle A, Part I, § 2306(f)(1), Part II, § 2354(a)(3), 98 Stat. 1073, 1100; Oct. 21, 1986, P.L. 99-509, Title IX, Subtitle D, Part 2, §§ 9313(c)(1), 9317(a),(b), 100 Stat. 2003, 2008; Aug. 18, 1987, P.L. 100-93, § 3, 101 Stat. 686; Dec. 22, 1987, P.L. 100-203, Title IV, Subtitle A, Part 2, Subpart C, § 4039(h)(1), Subtitle B, Part 2, § 4118(e)(1)(A), (B), (6)-(10), 101 Stat. 1330-81, 155; July 1, 1988, P.L. 100-360, Title II, Subtitle A, § 202(c)(2), Title IV, Subtitle B, § 411(e) (3), (k)(10) (B)(I), (III), (D), 102 Stat. 715, 775, 795; Oct. 13, 1988, P.L. 100-485, Title VI, § 608(d)(26) (H)-(K), 102 Stat. 2422; Dec. 13, 1989, P.L. 101-234, Title II, § 201(a)(1), 103 Stat. 1981; Dec. 19, 1989, P.L. 101-239, Title VI, Subtitle A, Part 1, Subpart A, § 6003(g)(3)(D)(i), 103 Stat. 2153; Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 3, §§ 4204(a)(3), 4207(h), Subtitle B, Part 4, Subpart C, § 4731(b)(1), Subpart E, § 4753, 104 Stat. 1388-109, 1388-123, 1388-195, 1388-208; Oct. 31, 1994, P.L. 103-432, Title I, Subtitle C, § 160(d)(4), 108 Stat. 4444; Aug. 21, 1996, P.L. 104-191, Title II, Subtitle D, §§ 231(a)-(e), (h), 232(a), 110 Stat. 2012, 2014, 2015; Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle C, § 4201(c)(1), Subtitle D, § 4304(a), (b), Ch 3, § 4331(e), Subtitle F, Ch 2, § 4523(c), 111 Stat. 373, 383, 396, 449; Oct. 21, 1998, P.L. 105-277, Div J, Title V, Subtitle B, § 5201(a), (b)(1), 112 Stat. 2681-916.)

(As amended March 23, 2010, P.L. 111-148, Title VI, Subtitle E, §§ 6402(d)(2), 6408(a), Subtitle H, § 6703(d)(3)(B), 124 Stat. 757, 770, 804.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

References in text:

"Section 1833(t)(5)(B)", referred to in subsec. (i)(6)[(E)](D), is § 1833(t)(5)(B) of Act Aug. 14, 1935, ch 531, which was redesignated § 1833(t)(8)(B) of such Act by Act Nov. 29, 1999, P.L. 106-113, Div B, § 1000(a)(6) [Title II, §§ 201(a)(1), 202(a)(2)], 113 Stat. 1536, 1501A-336, 1501A-342, and appears as 42 USCS § 1395i(t)(8)(B).

The "Health Insurance Portability and Accountability Act of 1996", referred to in this section, is Act Aug. 21, 1996, P.L. 104-191, 110 Stat. 1936. For full classification of such Act, consult USCS Tables volumes.

Explanatory notes:

At the end of subsec. (a)(1)(D), ", or" has been inserted in brackets to indicate the probable intent of Congress so substitute such matter for the concluding period.

The word "or" has been enclosed in brackets in subsec. (a)(8) to indicate the probable intent of Congress to delete it.

The bracketed paragraph designators "(10)", "(11)", and "(12)" have been inserted in para. (a) in order to maintain numerical continuity.

In the concluding matter of subsec. (a), the bracketed words "paragraph [(11)](9)" have been inserted in brackets to indicate to which of the two paras. (9) Congress probably intended to refer.

The bracketed word "court" has been inserted in subsec. (e) to indicate the capitalization probably intended by Congress.

The word "or" has been enclosed in brackets in subsec. (i)(6)(E) to indicate the probable

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*** Current through PL 113-74, with a gap of 113-66 and 113-73, approved 01/16 /2014 ***

TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7. SOCIAL SECURITY ACT
TITLE XI. GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION
PART A. GENERAL PROVISIONS

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42 USCS § 1320a-7b

§ 1320a-7b. Criminal penalties for acts involving Federal health care programs

- (a) Making or causing to be made false statements or representations. Whoever--
- (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f)),
 - (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
 - (3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,
 - (4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,
 - (5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or
 - (6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX [42 USCS §§ 1396 et seq.], if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917 (c) [42 USCS § 1396p(c)],

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any other person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than \$ 25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$ 10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other

provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) Illegal remunerations.

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$ 25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$ 25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if--

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1861(u) [42 USCS § 1395x(u)]), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

(D) a waiver of any coinsurance under part B of title XVIII [42 USCS §§ 1395j et seq.] by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act;

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 [note to this section] or in regulations under section 1860D-3(e)(6) [1860D-4(e)(6)] [42 USCS § 1395w-104(e)(6)];

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 [42 USCS § 1395mm] or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or

utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide;

(G) the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost-sharing imposed under part D of title XVIII [42 USCS §§ 1395w-101 et seq.], if the conditions described in clauses (i) through (iii) of section 1128A(i)(6)(A) [42 USCS § 1320a-7a(i)(6)(A)] are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1860D-14(a)(3) [42 USCS § 1395w-114(a)(3)]), section 1128A(i)(6)(A) [42 USCS § 1320a-7a(i)(6)(A)] shall be applied without regard to clauses (ii) and (iii) of that section);

(H) any remuneration between a federally qualified health center (or an entity controlled by such a health center) and an MA organization pursuant to a written agreement described in section 1853(a)(4) [42 USCS § 1395w-23(a)(4)];

(I) any remuneration between a health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) [42 USCS § 1396d(l)(2)(B)] and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity; and

(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D-14A(g) [42 USCS § 1395w-114a(g)]) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D-14A [42 USCS § 1395w-114a].

(c) False statements or representations with respect to condition or operation of institutions. Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1876(b) [42 USCS § 1395mm(b)]) for which certification is required under title XVIII [42 USCS §§ 1395 et seq.] or a State health care program (as defined in section 1128(h) [42 USCS § 1320a-7(h)]), or with respect to information required to be provided under section 1124A [42 USCS § 1320a-3a], shall be guilty of a felony and upon conviction thereof shall be fined not more than \$ 25,000 or imprisoned for not more than five years, or both.

(d) Illegal patient admittance and retention practices. Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under title XIX [42 USCS §§ 1396 et seq.], money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a medicaid managed care organization under title XIX under a contract under section 1903(m) [42 USCS § 1396b(m)] or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under title XIX [42 USCS §§ 1396 et seq.], any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient's continued stay in such a facility,
when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$ 25,000 or imprisoned for not more than five years, or both.

(e) Violation of assignment terms. Whoever accepts assignments described in section 1842(b)(3)(B)(ii) [42 USCS § 1395u(b)(3)(B)(ii)] or agrees to be a participating physician or supplier under section 1842(h)(1) [42 USCS § 1395a(h)(1)] and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$ 2,000 or imprisoned for not more than six months, or both.

(f) "Federal health care program" defined. For purposes of this section, the term "Federal health care program" means--

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code [5 USCS §§ 8901 et seq.]); or

(2) any State health care program, as defined in section 1128(h) [42 USCS § 1320a-7(h)].

(g) Kickbacks. In addition to the penalties provided for in this section or section 1128A [42 USCS § 1320a-7a], a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code [31 USCS §§ 3721 et seq.].

(h) Intent. With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

HISTORY:

(Aug. 14, 1935, ch 531, Title XI [XVIII, Part C] [XIX], § 1128B [1877(d)] [1909], as added Oct. 30, 1972, P.L. 92-603, Title II, §§ 242(c), 278(b)(9), 86 Stat. 1419, 1454; Oct. 25, 1977, P.L. 95-142, § 4(a), (b), 91 Stat. 1179, 1181; Dec. 5, 1980, P.L. 96-499, Title IX, Part A, Subpart II, § 917 in part, 94 Stat. 2625; July 18, 1984, P.L. 98-369, Division B, Title III, Subtitle A, Part I, § 2306(f)(2), 98 Stat. 1073; Aug. 18, 1987, P.L. 100-93, §§ 4(a)-(d), 14(b), 101 Stat. 688, 689, 697; Dec. 22, 1987, P.L. 100-203, Title IV, Subtitle A, Part 2, Subpt. C, § 4039(a), Subtitle C, Part 2, § 4211(h)(7), 101 Stat. 1330-81, 1330-206; July 1, 1988, P.L. 100-360, Title IV, Subtitle B, § 411(a)(3)(B), 102 Stat. 768; Dec. 19, 1989, P.L. 101-239, Title VI, Subtitle A, Part 1, Subpart A, § 6003(g)(3)(D)(ii), 103 Stat. 2153; Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 2, Subpart B, §§ 4161(a)(4), 4164(b)(2), 104 Stat. 1388-94, 1388-102; Oct. 31, 1994, P.L. 103-432, Title I, Subtitle B, Part II, § 133(a)(2), 108 Stat. 4421; Aug. 21, 1996, P.L. 104-191, Title II, Subtitle A, § 204(a), Subtitle B, § 216(a), 110 Stat. 1999, 2007; Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle C, § 4201(c)(1), Subtitle H, Ch 1, § 4704(b), Ch 4, § 4734, 111 Stat. 373, 498, 522; Dec. 8, 2003, P.L. 108-173, Title I, § 101(e)(2), (8)(A), Title II, Subtitle D, § 237(d), Title IV, Subtitle D, § 431(a), 117 Stat. 2150, 2152, 2213, 2287.)

(As amended March 23, 2010, P.L. 111-148, Title III, Subtitle D, § 3301(d)(1), Title VI, Subtitle E, § 6402(f), 124 Stat. 468, 759.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

References in text:

The "Public Health Service Act", referred to in this section, is Act July 1, 1944, ch 373, 58 Stat. 682, which appears generally as 42 USCS §§ 201 et seq. For full classification of such Act, consult USCS Tables volumes.

Explanatory notes:

In subsec. (b)(3)(E), "1860D-4(e)(6)" has been inserted in brackets to indicate the section reference probably intended by Congress.

TITLE 42--PUBLIC HEALTH

CHAPTER V--OFFICE OF INSPECTOR GENERAL--HEALTH CARE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR part 1001 is amended as set forth below:

1. The heading for part 1001 is revised to read as follows:

PART 1001--PROGRAM INTEGRITY--MEDICARE AND STATE HEALTH CARE PROGRAMS

2. The authority citation for part 1001 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320a-7, 1320a-7b, 1395u(j), 1395u(k), 1395y(e), and 1395hh, and section 14 of Public Law 100-93, unless otherwise noted.

3. Section 1001.1 is revised to read as follows:

§ 1001.1 Scope and purpose.

(a) This part sets forth provisions for the detection of fraud and abuse in the Medicare and certain State health care programs. It implements statutory sections, specifically identified in each subpart, aimed at protecting the integrity of the Medicare and certain State health care programs.

(b) This part also sets forth provisions addressing the OIG's authority to exclude any individual and entity that it determines has committed an act described in section 1128B of the Social Security Act, subject to the exceptions set forth in this part.

4. A new Subpart E is added to read as follows:

Subpart E--Permissive Exclusions

Sec.

1001.951 Fraud, kickbacks and other prohibited activities.

1001.952 Exceptions.

Sec.

1001.953 OIG report on compliance with investment interest safe harbor.

Subpart E--Permissive Exclusions

§ 1001.951 Fraud, kickbacks and other prohibited activities.

The OIG may exclude any individual or entity that it determines has committed an act described in section 1128B of the Social Security Act, subject to the exceptions set forth in § 1001.952.

§ 1001.952 Exceptions.

The following payment practices shall not be treated as a criminal offense under section 1128B of the Act and shall not serve as the basis for an exclusion:

(a) Investment Interests. As used in section 1128B of the Act, "remuneration" does not include any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor as long as all of the applicable standards are met within one of the following two categories of entities:

(1) If, within the previous fiscal year or previous 12 month period, the entity possesses more than \$50,000,000 in undepreciated net tangible assets (based on the net acquisition cost of purchasing such assets from an unrelated entity) related to the furnishing of items and services, all of the following five applicable standards must be met--

(i) With respect to an investment interest that is an equity security, the equity security must be registered with the Securities and Exchange Commission under 15 U.S.C. 78l(b) or (g).

(ii) The investment interest of an investor in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be obtained on terms equally available to the public through trading on a registered national securities exchange, such as the New York Stock Exchange or the American Stock Exchange, or on the National Association of Securities Dealers Automated Quotation System.

(iii) The entity or any investor must not market or furnish the entity's items or services (or those of another entity as part of a cross referral agreement) to passive investors differently than to non-investors.

(iv) The entity must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(v) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment of that investor.

(2) If the entity possesses investment interests that are held by either active or passive investors, all of the following eight applicable standards must be met--

(i) No more than 40 percent of the value of the investment interests of each class of investments may be held in the previous fiscal year or previous 12 month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity.

(ii) The terms on which an investment interest is offered to a passive investor, if any, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be no different from the terms offered to other passive investors.

(iii) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.

(iv) There is no requirement that a passive investor, if any, make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.

(v) The entity or any investor must not market or furnish the entity's items or services (or those of another entity as part of a cross referral agreement) to passive investors differently than to non-investors.

(vi) No more than 40 percent of the gross revenue of the entity in the previous fiscal year or previous 12 month period may come from referrals, items or services furnished, or business otherwise generated from investors.

(vii) The entity must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(viii) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

For purposes of paragraph (a) of this section, the following terms apply. Active investor means an investor either who is responsible for the day-to-day management of the entity and is a bona fide general partner in a partnership under the Uniform Partnership Act or who agrees in writing to undertake liability for the actions of the entity's agents acting within the scope of their agency. Investment interest means a security issued by an entity, and may include the following classes of investments: Shares in a corporation, interests or units of a partnership, bonds, debentures, notes, or other debt instruments. Investor means an individual or entity either who directly holds an investment interest in an entity, or who holds such investment interest indirectly by, including but not limited to, such means as having a family member hold such investment interest or holding a legal or beneficial interest in another entity (such as a trust or holding company) that holds such investment interest. Passive investor means an investor who is not an active investor, such as a limited partner in a partnership under the Uniform Partnership Act, a shareholder in a corporation, or a holder of a debt security.

(b) Space Rental. As used in section 1128B of the Act, "remuneration" does not include any payment made by a lessee to a lessor for the use of premises, as long as all of the following five standards are met-

(1) The lease agreement is set out in writing and signed by the parties.

(2) The lease specifies the premises covered by the lease.

(3) If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.

(4) The term of the lease is for not less than one year.

(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.

For purposes of paragraph (b) of this section, the term fair market value means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in

whole or in part under Medicare or a State health care program.

(c) Equipment rental. As used in section 1128B of the Act, "remuneration" does not include any payment made by a lessee of equipment to the lessor of the equipment for the use of the equipment, as long as all of the following five standards are met--

- (1) The lease agreement is set out in writing and signed by the parties.
- (2) The lease specifies the equipment covered by the lease.
- (3) If the lease is intended to provide the lessee with use of the equipment for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such interval.
- (4) The term of the lease is for not less than one year.
- (5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.

For purposes of paragraph (c) of this section, the term fair market value means the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party (either the prospective lessee or lessor) would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare or a State health care program.

(d) Personal services and management contracts. As used in section 1128B of the Act, "remuneration" does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following six standards are met--

- (1) The agency agreement is set out in writing and signed by the parties.
- (2) The agency agreement specifies the services to be provided by the agent.
- (3) If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.
- (4) The term of the agreement is for not less than one year.
- (5) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.
- (6) The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

For purposes of paragraph (d) of this section, an agent of a principal is any person, other than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.

(e) Sale of practice. As used in section 1128B of the Act, "remuneration" does not include any payment made to a practitioner by another practitioner where the former practitioner is selling his or her practice to the latter practitioner, as long as both of the following two standards are met--

(1) The period from the date of the first agreement pertaining to the sale to the completion of the sale is not more than one year.

(2) The practitioner who is selling his or her practice will not be in a professional position to make referrals to, or otherwise generate business for, the purchasing practitioner for which payment may be made in whole or in part under Medicare or a State health care program after one year from the date of the first agreement pertaining to the sale.

(f) Referral services. As used in section 1128B of the Act, "remuneration" does not include any payment or exchange of anything of value between an individual or entity ("participant") and another entity serving as a referral service ("referral service"), as long as all of the following four standards are met--

(1) The referral service does not exclude as a participant in the referral service any individual or entity who meets the qualifications for participation.

(2) Any payment the participant makes to the referral service is assessed equally against and collected equally from all participants, and is only based on the cost of operating the referral service, and not on the volume or value of any referrals to or business otherwise generated by the participants for the referral service for which payment may be made in whole or in part under Medicare or a State health care program.

(3) The referral service imposes no requirements on the manner in which the participant provides services to a referred person, except that the referral service may require that the participant charge the person referred at the same rate as it charges other persons not referred by the referral service, or that these services be furnished free of charge or at reduced charge.

(4) The referral service makes the following five disclosures to each person seeking a referral, with each such disclosure maintained by the referral service in a written record certifying such disclosure and signed by either such person seeking a referral or by the individual making the disclosure on behalf of the referral service--

(i) The manner in which it selects the group of participants in the referral service to which it could make a referral;

(ii) Whether the participant has paid a fee to the referral service;

(iii) The manner in which it selects a particular participant from this group for that person;

(iv) The nature of the relationship between the referral service and the group of participants to whom it could make the referral; and

(v) The nature of any restrictions that would exclude such an individual or entity from continuing as a participant.

(g) Warranties. As used in section 1128B of the Act, "remuneration" does not include any payment or exchange of anything of value under a warranty provided by a manufacturer or supplier of an item to the buyer (such as a health care provider or beneficiary) of the item, as long as the buyer complies with all of

the following standards in paragraphs (g)(1) and (g)(2) of this section and the manufacturer or supplier complies with all of the following standards in paragraphs (g)(3) and (g)(4) of this section--

- (1) The buyer must fully and accurately report any price reduction of the item (including a free item), which was obtained as part of the warranty, in the applicable cost reporting mechanism or claim for payment filed with the Department or a State agency.
- (2) The buyer must provide, upon request by the Secretary or a State agency, information provided by the manufacturer or supplier as specified in paragraph (g)(3) of this section.
- (3) The manufacturer or supplier must comply with either of the following two standards--
 - (i) The manufacturer or supplier must fully and accurately report the price reduction of the item (including a free item), which was obtained as part of the warranty, on the invoice or statement submitted to the buyer, and inform the buyer of its obligations under paragraphs (a)(1) and (a)(2) of this section.
 - (ii) Where the amount of the price reduction is not known at the time of sale, the manufacturer or supplier must fully and accurately report the existence of a warranty on the invoice or statement, inform the buyer of its obligations under paragraphs (g)(1) and (g)(2) of this section, and, when the price reduction becomes known, provide the buyer with documentation of the calculation of the price reduction resulting from the warranty.
- (4) The manufacturer or supplier must not pay any remuneration to any individual (other than a beneficiary) or entity for any medical, surgical, or hospital expense incurred by a beneficiary other than for the cost of the item itself.

For purposes of paragraph (g) of this section, the term warranty means either an agreement made in accordance with the provisions of 15 U.S.C. 2301(6), or a manufacturer's or supplier's agreement to replace another manufacturer's or supplier's defective item (which is covered by an agreement made in accordance with this statutory provision), on terms equal to the agreement that it replaces.

(h) Discounts. As used in section 1128B of the Act, "remuneration" does not include a discount, as defined in paragraph (h)(3) of this section, on a good or service received by a buyer, which submits a claim or request for payment for the good or service for which payment may be made in whole or in part under Medicare or a State health care program, from a seller as long as the buyer complies with the applicable standards of paragraph (h)(1) of this section and the seller complies with the applicable standards of paragraph (h)(2) of this section:

- (1) With respect to the following three categories of buyers, the buyer must comply with all of the applicable standards within each category--
 - (i) If the buyer is an entity which reports its costs on a cost report required by the Department or a State agency, it must comply with all of the following four standards--
 - (A) the discount must be earned based on purchases of that same good or service bought within a single fiscal year of the buyer;
 - (B) the buyer must claim the benefit of the discount in the fiscal year in which the discount is earned or the following year;
 - (C) the buyer must fully and accurately report the discount in the applicable cost report; and

(D) the buyer must provide, upon request by the Secretary or a State agency, information provided by the seller as specified in paragraph (h)(2)(ii) of this section.

(ii) If the buyer is an entity which is a health maintenance organization or competitive medical plan acting in accordance with a risk contract under section 1876(g) or 1903(m) of the Act, or under another State health care program, it need not report the discount except as otherwise may be required under the risk contract.

(iii) If the buyer is not an entity described in paragraphs (h)(1)(i) or (h)(1)(ii) of this section, it must comply with all of the following three standards--

(A) the discount must be made at the time of the original sale of the good or service;

(B) where an item or service is separately claimed for payment with the Department or a State agency, the buyer must fully and accurately report the discount on that item or service; and

(C) the buyer must provide, upon request by the Secretary or a State agency, information provided by the seller as specified in paragraph (h)(2)(ii)(A) of this section.

(2) With respect to either of the following two categories of buyers, the seller must comply with all of the applicable standards within each category--

(i) If the buyer is an entity described in paragraph (h)(1)(ii) of this section, the seller need not report the discount to the buyer for purposes of this provision.

(ii) If the buyer is any other individual or entity, the seller must comply with either of the following two standards--

(A) where a discount is required to be reported to the Department or a State agency under paragraph (h)(1) of this section, the seller must fully and accurately report such discount on the invoice or statement submitted to the buyer, and inform the buyer of its obligations to report such discount; or

(B) where the value of the discount is not known at the time of sale, the seller must fully and accurately report the existence of a discount program on the invoice or statement submitted to the buyer, inform the buyer of its obligations under paragraph (h)(1) of this section and, when the value of the discount becomes known, provide the buyer with documentation of the calculation of the discount identifying the specific goods or services purchased to which the discount will be applied.

(3) For purposes of this paragraph, the term discount means a reduction in the amount a seller charges a buyer (who buys either directly or through a wholesaler or a group purchasing organization) for a good or service based on an arms length transaction. The term discount may include a rebate check, credit or coupon directly redeemable from the seller only to the extent that such reductions in price are attributable to the original good or service that was purchased or furnished. The term discount does not include--

(i) Cash payment;

(ii) Furnishing one good or service without charge or at a reduced charge in exchange for any agreement to buy a different good or service;

(iii) A reduction in price applicable to one payor but not to Medicare or a State health care program;

(iv) A reduction in price offered to a beneficiary (such as a routine reduction or waiver of any coinsurance or deductible amount owed by a program beneficiary);

(v) Warranties;

(vi) Services provided in accordance with a personal or management services contract; or

(vii) Other remuneration in cash or in kind not explicitly described in this paragraph.

(i) Employees. As used in section 1128B of the Act, "remuneration" does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare or a State health care program. For purposes of paragraph (i) of this section, the term employee has the same meaning as it does for purposes of 26 U.S.C. 3121(d)(2):

(j) Group purchasing organizations. As used in section 1128B of the Act, "remuneration" does not include any payment by a vendor of goods or services to a group purchasing organization (GPO), as part of an agreement to furnish such goods or services to an individual or entity as long as both of the following two standards are met--

(1) The GPO must have a written agreement with each individual or entity, for which items or services are furnished, that provides for either of the following--

(i) The agreement states that participating vendors from which the individual or entity will purchase goods or services will pay a fee to the GPO of 3 percent or less of the purchase price of the goods or services provided by that vendor.

(ii) In the event the fee paid to the GPO is not fixed at 3 percent or less of the purchase price of the goods or services, the agreement specifies the amount (or if not known, the maximum amount) the GPO will be paid by each vendor (where such amount may be a fixed sum or a fixed percentage of the value of purchases made from the vendor by the members of the group under the contract between the vendor and the GPO).

(2) Where the entity which receives the good or service from the vendor is a health care provider of services, the GPO must disclose in writing to the entity at least annually, and to the Secretary upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity.

For purposes of paragraph (j) of this section, the term group purchasing organization (GPO) means an entity authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services for which payment may be made in whole or in part under Medicare or a State health care program, and who are neither wholly-owned by the GPO nor subsidiaries of a parent corporation that wholly owns the GPO (either directly or through another wholly-owned entity).

(k) Waiver of beneficiary coinsurance and deductible amounts. As used in section 1128B of the Act, "remuneration" does not include any reduction or waiver of a Medicare or a State health care program beneficiary's obligation to pay coinsurance or deductible amounts as long as all of the standards are met within either of the following two categories of health care providers:

(1) If the coinsurance or deductible amounts are owed to a hospital for inpatient hospital services for which Medicare pays under the prospective payment system, the hospital must comply with all of the

following three standards--

(i) The hospital must not later claim the amount reduced or waived as a bad debt for payment purposes under Medicare or otherwise shift the burden of the reduction or waiver onto Medicare, a State health care program, other payers, or individuals.

(ii) The hospital must offer to reduce or waive the coinsurance or deductible amounts without regard to the reason for admission, the length of stay of the beneficiary, or the diagnostic related group for which the claim for Medicare reimbursement is filed.

(iii) The hospital's offer to reduce or waive the coinsurance or deductible amounts must not be made as part of a price reduction agreement between a hospital and a third-party payor.

(2) If the coinsurance or deductible amounts are owed by an individual who qualifies for subsidized services under a provision of the Public Health Services Act or under titles V or XIX of the Act to a federally qualified health care center or other health care facility under any Public Health Services Act grant program or under title V of the Act, the health care center or facility may reduce or waive the coinsurance or deductible amounts for items or services for which payment may be made in whole or in part under part B of Medicare or a State health care program.

§ 1001.953 OIG report on compliance with investment interest safe harbor.

Within 180 days of the effective date of this subpart, the OIG will report to the Secretary on the compliance with §§ 1001.952(a)(2)(i) and 1001.952(a)(2)(vi).

Dated: July 19, 1991.

R.P. Kusserow,

Inspector General, Department of Health and Human Services.

Approved: July 22, 1991.

Louis W. Sullivan,

Secretary.

[FR Doc. 91 -17891 filed 7-26-91; 8:45am]

CHAPTER III
BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES

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300. PRINCIPLE

Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Program.

302. DEFINITIONS

302.1 Bad Debts.--Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

302.2 Allowable Bad Debts.--Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

302.3 Charity Allowances.--Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

302.4 Courtesy Allowances.--Courtesy Allowances are reductions in charges by the provider in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs are not considered courtesy allowances.

302.5 Deductible and Coinsurance Amounts.--Deductible and coinsurance amounts are amounts payable by beneficiaries for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and coinsurance amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital extended care services, home health services, out-patient services, and medical and other health services furnished by a provider of services.

304. BAD DEBTS UNDER MEDICARE

Bad debts resulting from deductible and coinsurance amounts which are uncollectible from beneficiaries are not includable as such in the provider's allowable costs; however, unrecovered costs attributable to such bad debts are considered in the Program's calculation of reimbursement to the provider.

The allowance of unrecovered costs attributable to such bad debts in the calculation of reimbursement by the Program results from the expressed intent of Congress that the costs of services covered by the Program will not be borne by individuals not covered, and the costs of services not covered by the Program will not be borne by the Program. Payment for

deductibles and coinsurance amounts is the responsibility of the beneficiaries. However, the inability of the provider to collect deductibles and coinsurance amounts from beneficiaries of the Program could result in part of the costs of covered services being borne by others who are not beneficiaries of the Program. Therefore, to assure that costs of covered services are not borne by others because Medicare beneficiaries do not pay their deductibles and coinsurance amounts, the Medicare Program will reimburse the provider for allowable bad debts, not to exceed the total amount of unrecovered costs of covered services furnished to all beneficiaries. In the determination of unrecovered costs due to bad debts, the Medicare Program is considered as a whole without distinction between Part A and Part B of the Program.

305. EFFECT OF THE WAIVER OF LIABILITY PROVISION ON BAD DEBTS

A. Beneficiary Liability.--The waiver of liability provision of the law protects a beneficiary from liability for payments to a provider for noncovered services when (1) the services are found to be not reasonable and necessary or to involve custodial care (i.e., excluded from coverage under section 1862(a)(1) or (9) of the Social Security Act), and (2) the beneficiary did not know or could not reasonably be expected to have known that the services were not covered. Where the beneficiary had knowledge that the services were not covered, liability will remain with the beneficiary.

B. Provider Not Accountable.--The program will reimburse the provider for the services if the provider did not know and could not reasonably be expected to have known that the services were not covered and the beneficiary had no knowledge as described in paragraph A. If the provider has such knowledge, it will assume accountability for the noncovered services. Where neither the provider nor the beneficiary is found accountable, the provider's charges for the services and the patient days are recorded as Medicare charges and Medicare patient days. The provider is entitled to collect from the beneficiary the amounts that would have represented the deductible and coinsurance amounts. If these amounts are not collected, they can be reimbursed under the Medicare bad debt provision (see 304) since the effect of the waiver of liability provision is to reimburse the provider as it would have been reimbursed had the services been covered.

C. Provider Accountable.--Where the provider is found accountable, any bad debts the provider experiences from such a program decision (i.e., those charges the provider cannot collect from the beneficiary) cannot be reimbursed under the Medicare bad debt provision as defined in §302. Provider costs attributable to these noncovered services furnished a beneficiary where the beneficiary's liability to the provider has been waived must be included in a provider's total costs for cost report purposes. The provider's charges for the services and the patient days must be shown as non-Medicare charges and non-Medicare patient days. The provider is nevertheless entitled to collect from the beneficiary the amounts that would have represented the deductible and coinsurance amounts had the services been covered. If these

amounts are not collected, however, they cannot be reimbursed under the Medicare bad debt provision since they apply to services held to be not covered. (See §306 below.)

306. BAD DEBTS RELATING TO NONCOVERED SERVICES OR TO NONBENEFICIARIES

If a beneficiary does not pay for services which are not covered by Medicare, the bad debts attributable to these services are not reimbursable under the Medicare program. Likewise, bad debts arising from services to non-Medicare patients are not reimbursable under the program.

Services which are not covered are defined generally in the following Health Insurance Manuals:

<i>CMS-Pub. 10</i>	Hospital Manual - §260
<i>CMS-Pub. 11</i>	Home Health Agency Manual - §§230 and 232
<i>CMS-Pub. 12</i>	Skilled Nursing Facility Manual - §240

308. CRITERIA FOR ALLOWABLE BAD DEBT

A debt must meet these criteria to be an allowable bad debt:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts. (See §305 for exception.)
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

310. REASONABLE COLLECTION EFFORT

To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)

A. Collection Agencies.--A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters,

telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

B. Documentation Required.--The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

310.1 Collection Fees.--Where a provider utilizes the services of a collection agency and the reasonable collection effort described in §310 is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects \$40 from the beneficiary, and its fee is 50 percent, the agency keeps \$20 as its fee for the collection services and remits \$20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency (\$40) in the patient's account receivable and records the collection fee (\$20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

310.2 Presumption of Noncollectibility.--If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

312. INDIGENT OR MEDICALLY INDIGENT PATIENTS

In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:

A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and

D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures. (See §322 for bad debts under State Welfare Programs.)

314. ACCOUNTING PERIOD FOR BAD DEBTS

Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, the provider should have the usual accounts receivable records-ledger cards and source documents to support its claim for a bad debt for each account included. Examples of the types of information to be retained may include, but are not limited to, the beneficiary's name and health insurance number; admission/discharge dates for Part A bills and dates of services for Part B bills; date of bills; date of write-off; and a breakdown of the uncollectible amount by deductible and coinsurance amounts. This proposed list is illustrative and not obligatory.

316. RECOVERY OF BAD DEBTS

Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case where the amount was uncollectible.

Where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period.

Where the provider was not reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are not reduced.

320. METHODS OF DETERMINING BAD DEBT EXPENSE

320.1 Direct Charge-Off.--Under the direct charge-off method, accounts receivable are analyzed and a determination made as to specific accounts which are deemed uncollectible. The amounts deemed to be uncollectible are charged to an expense account for uncollectible accounts. The amounts charged to the expense account for bad debts should be adequately identified as to those which represent deductible and coinsurance amounts applicable to beneficiaries and those which are applicable to other than beneficiaries or which are for other than covered services. Those bad debts which are applicable to beneficiaries for uncollectible deductible and coinsurance amounts are included in the calculation of reimbursable bad debts. (See §§300, 302.2, 314, and 316.)

320.2 Reserve Method.--Bad debt expenses computed by use of the reserve method are not allowable bad debts under the program. However, the specific uncollectible deductibles and coinsurance amounts applicable to beneficiaries and charged against the reserve are includable in the calculation of reimbursable bad debts. (See §308.)

Under the reserve method, providers estimate the amount of bad debts that will be incurred during a period, and establish a reserve account for that amount. The amount estimated as bad debts does not represent any particular debts, but is based on the aggregate of receivables or services.

322. MEDICARE BAD DEBTS UNDER STATE WELFARE PROGRAMS

Prior to 1968, title XIX State plans under the Federal medical assistance programs were required to pay the Part A deductible and coinsurance amounts for inpatient hospital services furnished through December 31, 1967. Any such deductible or coinsurance amounts not paid by the State were not allowable as a bad debt.

Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. For example, a State which covers hospital care for only 30 days for Medicaid recipients is not obligated (unless made part of the State title XIX plan) to pay all or part of the Medicare coinsurance from the 61st day on. For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.

Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not

allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §312 or, if applicable, §310 are met.

In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible or coinsurance because of a State payment "ceiling." For example, assume that a State pays a maximum of \$42.50 per day for SNF services and the provider's cost is \$60.00 a day. The coinsurance is \$32.50 a day so that Medicare pays \$27.50 (\$60.00 less \$32.50). In this case, the State limits its payment towards the coinsurance to \$15.00 (\$42.50 less \$27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met.

If the State is not participating under title XIX, but State or local law requires the welfare agency to pay the deductible and coinsurance amounts, any such amounts are not includable in allowable bad debts. If neither the title XIX plan nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no requirement that the State be responsible for these amounts. Therefore, any such amounts are includable in allowable bad debts provided that the requirements of §312 or, if applicable, §310 are met.

324. PROVIDER-BASED PHYSICIANS--PROFESSIONAL COMPONENT NOT A BAD DEBT

The professional component of a provider-based physician's remuneration is not recognized as an allowable bad debt in the event the provider is unable to collect the charges for the professional services of such physicians. Bad debts are recognized only if they relate to a provider's "allowable"

costs. "Allowable" costs pertain only to covered services for which the provider can bill on its own behalf under Part A and Part B. They do not pertain to costs of services the provider might bill on behalf of the provider-based physician. Technically, the professional component is a physician charge, not a provider cost. Thus, considering physician reimbursement as a provider cost in determining allowable bad debts would not be in conformance with the law.

326. APPLYING COLLECTIONS FROM BENEFICIARIES

When a beneficiary or a third party on behalf of the beneficiary makes a partial payment of an amount due the provider, which is not specifically identified as to which debt it is intended to satisfy, the payment is to be applied proportionately to Part A deductibles and coinsurance, Part B deductibles and coinsurance and noncovered services. The basis for proration of partial payments is the proportionate amount of amounts owed in each of the categories.

328. CHARITY, COURTESY, AND THIRD-PARTY PAYER ALLOWANCES--COST TREATMENT

Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs. Charges related to services subject to these allowances should be recorded at the full amount charged to all patients, and the allowances should be appropriately shown in a revenue reduction account. The amount reflecting full charges must then be used as applicable to apportion costs and in determining customary charges for application of the lower of costs or charges provision.

Example - The provider entered into an agreement with a third-party payer to render services at 25 percent below charges. Accordingly, for an X-ray service with a charge of \$40, the provider billed the third party payer \$30. The charge of \$40 would be used to apportion costs and the \$10 allowance would be recorded in a revenue reduction account.

331. CREDIT CARD COSTS

Reasonable charges made by credit card organizations to a provider are recognized as allowable administrative costs. Credit card charges incurred by a provider of services represent costs incurred for prompt collection of accounts receivable. These charges have come to be recognized as a substitute for the costs that would otherwise be incurred for credit administration (e.g., credit investigation and collection costs).

332. ALLOWANCE TO EMPLOYEES

Allowances, or reduction in charges, granted to employees for medical services as fringe benefits related to their employment are not considered courtesy allowances. Employee allowances are usually given under employee hospitalization and personnel health programs.

The allowances themselves are not costs since the costs of the services rendered are already included in the provider's costs. However, any costs of the services not recovered by the provider from the charge assessed the employee are allowable costs.

332.1 Method for Including Unrecovered Cost.--The unrecovered cost of services furnished to employees as fringe benefits may be included in allowable costs by treating the amount actually charged to the employees as a recovery of costs. Where the cost of the service exceeds the amount charged to the employee, the amount charged to the employee would be applied as a reduction in the costs of the particular department(s) rendering the services. If costs should be apportioned by the RCCAC Method, all charges related to employees' services would be subtracted from the total charges used to apportion such costs, so that unrecovered costs relating to employees' allowances would be apportioned between Medicare patients and other patients. Likewise, where an average cost per diem is used to apportion costs, the days applicable to the employees who received the allowances should be removed from the total days used to apportion costs.

Where the amount charged to an employee exceeds the costs of the services provided, there is no unrecovered cost and, therefore, no cost of fringe benefit. In this case, the amount charged to the employee is not offset against the department costs and the charges for the services given to the employee are not deleted from the total charges. The services furnished to employees are treated the same as services furnished to any other patients.

A. Example (Where Departmental Costs are Equivalent to 90% of Charges).-

	<u>Gross Charges</u>	<u>Costs</u>
Other than Employees		
Medicare-----	\$ 900	
Non-Medicare-----	1,800	
	<u>\$2,700</u>	
Employees	300	
Total-----	<u>\$3,000</u>	<u>\$2,700</u>
Computation of employee fringe benefit (30% discount):		
To be collected--70% of \$300		(\$210)
Cost applicable to service provided (90% x \$300)		270
Unrecovered Cost-----		<u>\$ 60</u>
Total charges-----	\$3,000	Total costs \$2,700
Less: Employee charges-----	<u>300</u>	Employee payment <u>210</u>
		(Amount charged)
Adjusted charges-----	<u>\$2,700</u>	<u>Adjusted cost \$2,490</u>

Payment by Medicare-- $900/2700 \times \$2,490 = \830

The unrecovered cost of \$60 remains in the departmental costs and is apportioned among the users of the department other than employees.

B. Example (Where Departmental Costs are Equivalent to 50% of Charges).--

	<u>Gross Charges</u>	<u>Costs</u>
Other than Employees		
Medicare-----	\$ 900	
Non-Medicare-----	1,800	
	\$2,700	
Employees-----	300	
Total-----	<u>\$3,000</u>	<u>\$1 500</u>
Computation of employee fringe benefit (30% discount):		
To be collected--70% of \$300		(\$210)
Cost applicable to service provided (50% x \$300)		<u>150</u>
Excess of amount charged to employees over cost		<u>\$ 60</u>
Unrecovered Cost-----		None
Payment by Medicare (900/3,000 x \$1,500)--		\$ 450

334. EXAMPLES: COMPUTATION OF BAD DEBTS REIMBURSABLE UNDER THE PROGRAM

334.1 Computation under Part A.-- Under Part A, deductible and coinsurance amounts are subtracted from the program's share of allowable costs in determining the amount reimbursable. Therefore, any uncollectible deductible and coinsurance amounts under Part A represent unrecovered costs to the provider. Bad debts reimbursable under the program are included in Medicare reimbursement under part A as follows:

Cost of covered services for Medicare patients-----		\$160,000
Deductible and coinsurance billed to Medicare patients (from provider's records)-----	\$8,500	
Less: Allowable bad debts for deductible and coinsurance less amount recovered in excess of costs under Part B-----	<u>1,500</u>	<u>7,000</u>
Balance due provider for covered services-----		<u>\$153,000</u>

(See § 334.2, Example C, for offset to allowable bad debts.)

334.2 Computation Under Part B.-- Under Part B, the amount reimbursable by the program (exclusive of bad debts) is determined by applying 80% to the reasonable cost of covered services furnished to beneficiaries, after application of the deductible provisions. The remaining 20% of the reasonable cost should be recovered from the beneficiary through the coinsurance amount of 20% of the charges. Where the provider's charges exceed costs, coinsurance amounts contain an amount in excess of costs. Where charges are lower than costs, coinsurance amounts are less than the equivalent percentage of costs. Since the program reimburses the provider for the unrecovered costs resulting from beneficiaries' allowable bad debts, a calculation must be made to determine whether or not there are any such unrecovered provider costs and whether and to what extent the provider may be reimbursed for bad debts in order to offset any such unrecovered costs.

Where the provider recovers an amount in excess of the total Part B costs of the Medicare program reimbursement by the program, together with deductibles and coinsurance amounts collectible from beneficiaries, allowable bad debts under Part A are reduced by the amount of this excess.

The cost reports provide a special schedule for making this calculation.

The following examples illustrate the method to be used and the results that could be obtained under the different conditions.

A. Example: Provider Charges Higher Than Costs--Part B Services.--

1. Total gross charges, all patients -----	\$180,000
2. Total program charges-----	45,000
3. Percent of program charges-----	<u>25%</u>
4. Total cost of covered services -----	<u>\$150,000</u>
5. 25% of cost applicable to beneficiaries -----	\$ 37,500
6. Less: Deductibles billed to beneficiaries -----	2,000
7. Net Cost-----	<u>\$ 35,500</u>
8. 80% of net cost applicable to program -----	\$ 28,400
9. Less: Amount received or receivable from <i>contractor</i> or SSA -----	<u>25,560</u>
10. Balance due provider or program -----	\$ 2,840
11. Add: Reimbursable bad debts (line 20 below) -----	2,500
12. Balance due provider or program (line 20 plus 11)-----	<u>\$ 5,340</u>

Computation of Reimbursable Bad Debts

13. Total costs applicable to Part B -----	\$ 37,500
14. Less: 80% of net costs applicable to Part B -----	28,400
15. Balance of costs to be recovered from beneficiaries -----	<u>\$ 9,100</u>

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16.	Deductible and coinsurance to beneficiaries (\$2,000 plus \$8,600) -----	\$ 10,600
17.	Less: Uncollectible deductible and coinsurance -----	4,000
18.	Net deductible and coinsurance billed to beneficiaries (if line 18 is equal to or greater than line 15, do not complete lines 19 and 20)-----	<u>\$ 6,600</u>
19.	Unrecovered costs from program (\$9,100 minus \$6,600) (line 15 less line 18)-----	\$ 2,500
20.	Reimbursable bad debts (lesser of line 17 or line 19)-----	<u>\$ 2,500</u>

B. Example: Provider Charges Lower Than Costs--Part B Services.--

1.	Total gross charges, all patients -----	\$180,000
2.	Total program charges -----	45,000
3.	Percent of program charges -----	25%
4.	Total cost of covered services -----	<u>\$200,000</u>
5.	25% of cost applicable to beneficiaries-----	\$ 50,000
6.	Less: Deductibles billed to beneficiaries -----	\$ 2,000
7.	Net Cost-----	<u>\$ 48,000</u>
8.	80% of net cost applicable to program -----	\$ 38,400
9.	Less: Amount received or receivable from <i>contractor</i> of SSA-----	34,560
10.	Balance due provider or program -----	\$ 3,840
11.	Add: Reimbursable bad debts (line 20 below) -----	4,000
12.	Balance due provider or program (lines 10 plus 11)-----	<u>\$ 7,840</u>

Computation of Reimbursable Bad Debts

13.	Total costs applicable to Part B-----	\$ 50,000
14.	Less: 80% of net costs applicable to Part B-----	38,400
15.	Balance of costs to be recovered from beneficiaries-----	<u>\$ 11,600</u>
16.	Deductible and coinsurance billed to program (\$2,000 plus \$8,600) -----	\$ 10,600
17.	Less: Uncollectible deductible and coinsurance -----	4,000
18.	Net deductible and coinsurance billed to beneficiaries (if line 18 is equal to or greater than line 15 do not complete lines 19 and 20)-----	<u>\$ 6,600</u>
19.	Unrecovered costs from program (\$11,600 minus \$6,600) (line 15 less line 18)-----	\$ 5,000
20.	Reimbursable bad debts (lesser of line 17 or line 19)-----	<u>\$ 4,000</u>

C. Example: Provider Charges Higher than Costs--Part B Services Collections by Provider Exceed Costs.--

1.	Total gross charges all patients -----	\$180,000
2.	Total program charges -----	45,500
3.	Percent of program charges -----	<u>25%</u>
4.	Total cost of covered services -----	\$150,000
5.	25% of cost applicable to beneficiaries-----	\$ 37,500
6.	Less: Deductible billed to beneficiaries -----	2,000
7.	Net Cost-----	<u>\$ 35,500</u>
8.	80% of net cost applicable to program -----	\$ 28,400
9.	Less: Amount received or receivable from intermediary or SSA-----	<u>25,560</u>
10.	Balance due provider or program -----	\$ 2,840
11.	Add: Reimbursable bad debts (line 20 below) -----	-0---
12.	Balance due provider or program (lines 10 plus 11)-----	<u>\$ 2,840</u>

Computation of Reimbursable Bad Debts

13.	Total costs applicable to Part B-----	\$ 37,500
14.	Less: 80% of net costs applicable to Part B-----	28,400
15.	Balance of costs to be recovered from beneficiaries-----	<u>\$ 9,100</u>
16.	Deductibles and coinsurance billed to beneficiaries (\$2,000 plus \$8,600) -----	\$ 10,600
17.	Less: Uncollectible deductible and coinsurance -----	1,000
18.	Net deductible and coinsurance billed to beneficiaries-----	<u>\$ 9,000</u>
19.	Unrecovered costs from program (line 15 less line 18) -----	\$ (500)
20.	Reimbursable bad debts (less of line 17 or line 19) -----	<u>-0---</u>

* Amount collected in excess of costs is transferred to computation of reimbursable and bad debts under part A and reduces allowable bad debts under Part A. (See § 334.1.)

[Federal Register: December 19, 1994]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Publication of OIG Special Fraud Alerts

AGENCY: Office of Inspector General, HHS.
ACTION: Notice.

SUMMARY: This Federal Register notice sets forth the 5 previously-developed Special Fraud Alerts issued directly to the health care provider community by the HHS Office of Inspector General (OIG). In keeping with the OIG's goal and intent of publicizing its concern about possible widespread and abusive health care industry practices, and seeking wider dissemination of this information to the general public, we are republishing the main content of these Special Fraud Alerts in the Federal Register. This notice also serves to alert the general public of our intention to publish all future OIG Special Fraud Alerts in this same manner, in addition to the current method used to distribute this material to Medicare and State health care program providers.

FOR FURTHER INFORMATION CONTACT: Joel J. Schaer, Legislation, Regulations and Public Affairs Staff, (202) 619-0089.

SUPPLEMENTARY INFORMATION:

I. Background

The Use of Fraud Alerts by the OIG

Over the years, the OIG has used fraud alerts as a vehicle to identify fraudulent and abusive practices within the health care industry. The majority of these fraud alerts are disseminated internally to the OIG's Office of Investigations and other agencies within the Department. However, the OIG has also developed and issued Special Fraud Alerts intended for extensive distribution directly to the health care provider community.

Special Fraud Alerts

Since 1988, the OIG has issued 5 ``Special Fraud Alerts'' addressing specific trends of health care fraud and certain practices of an industry-wide character. Specifically, the OIG Special Fraud Alerts have served to provide general guidance to the health care industry on violations of Federal law (including various aspects of the anti-kickback statute), as well as to provide additional insight to the Medicare carrier fraud units in identifying health care fraud schemes.

In developing these Special Fraud Alerts, the OIG relies on a number of sources, such as studies or management and program evaluations conducted by the OIG's Office of Evaluation and Inspections. In addition, the OIG may consult with experts in the subject field, including those within the OIG, other agencies of the Department, other Federal and State agencies, and from those in the

health care industry.

The Nature of Past Special Fraud Alerts

For the most part, the OIG Special Fraud Alerts have been reserved for national trends in health care fraud and have addressed potential violations of the Medicare and State health care programs' anti-kickback statute. The Special Fraud Alerts have addressed the following topic areas that could violate the anti-kickback statute:

- Joint venture arrangements;
- Routine waiver of Medicare Part B copayments and deductibles;
- Hospital incentives to referring physicians;
- Prescription drug marketing practices;
- Arrangements for the provision of clinical laboratory services.

II. Federal Register Publication of Special Fraud Alerts

In the past, the OIG has always printed and distributed copies of these Special Fraud Alerts directly to all Medicare program providers. While the OIG Special Fraud Alerts have been designed to be available to all affected program providers, we believe it is useful to publicize these various issues and concerns involving potential abusive health care industry practices to a more widespread audience. For this reason, we are using this Federal Register notice as a vehicle to reprint the substance of the 5 previously-issued Special Fraud Alerts cited above. It is our intention to use this same Federal Register form for publishing future Special Fraud Alerts developed by the OIG.

Because each of the previously-developed Special Fraud Alerts contained a similar brief narrative as to the nature of the OIG and a description of the Medicare and Medicaid anti-kickback statute, we will first summarize and set out this material in one section, as it is germane to all 5 subject issuances. Following that will be the main body and content of each of the Special Fraud Alerts. Lastly, we have provided the general information set forth in each of these Special Fraud Alerts addressing information on how to report information on suspected violations.

The OIG Special Fraud Alerts

A. General Background

The Office of Inspector General was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse and waste in Health and Human Services programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. To help reduce fraud in the Medicare and Medicaid programs, the OIG is actively investigating violations of the Medicare and Medicaid anti-kickback statute, 42 U.S.C. Section 1320a-7b(b).

What Is the Medicare and Medicaid Anti-Kickback Law?

Among its provisions, the anti-kickback statute penalizes anyone who knowingly and willfully solicits, receives, offers or pays remuneration in cash or in kind to induce, or in return for:

A. Referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service payable under the Medicare or Medicaid program; or

B. Purchasing, leasing or ordering , or arranging for or recommending purchasing, leasing or ordering, any goods, facility, service or item payable under the Medicare or Medicaid program.

Violators are subject to criminal penalties, or exclusion from participation in the Medicare and Medicaid programs, or both. In 1987, section 14 of the Medicare and Medicaid Patient and Program Protection Act, PL 100-93, directed this Department to promulgate "safe harbor" regulations, in order to provide health care providers a mechanism to assure them that they will not be prosecuted under the anti-kickback statute for engaging in particular practices. The Department published 11 final "safe harbor" regulations on July 29, 1991 (42 CFR 1001.952, 56 FR 35952), and two more on November 5, 1992 (42 CFR 1001.952, 57 FR 52723). The scope of the anti-kickback statute is not expanded by the "safe harbor" regulations; these regulations give those in good faith compliance with a "safe harbor" the assurance that they will not be prosecuted under the anti-kickback statute.

B. Special Fraud Alert: Joint Venture Arrangements
(Issued August 1989)

The Office of Inspector General has become aware of a proliferation of arrangements between those in a position to refer business, such as physicians, and those providing items or services for which Medicare or Medicaid pays. Some examples of the items or services provided in these arrangements include clinical diagnostic laboratory services, durable medical equipment (DME), and other diagnostic services. Sometimes these deals are called "joint ventures." A joint venture may take a variety of forms: it may be a contractual arrangement between two or more parties to cooperate in providing services, or it may involve the creation of a new legal entity by the parties, such as a limited partnership or closely held corporation, to provide such services. Of course, there may be legitimate reasons to form a joint venture, such as raising necessary investment capital. However, the Office of Inspector General believes that some of these joint ventures may violate the Medicare and Medicaid anti-kickback statute.

Under these suspect joint ventures, physicians may become investors in a newly formed joint venture entity. The investors refer their patients to this new entity, and are paid by the entity in the form of "profit distributions." These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary program expenditures.

The questionable features of these suspect joint ventures may be reflected in three areas:

- (1) The manner in which investors are selected and retained;
- (2) The nature of the business structure of the joint venture; and
- (3) The financing and profit distributions.

Suspect Joint Ventures: What To Look For

To help you identify these suspect joint ventures, the following are examples of questionable features, which separately or taken together may result in a business arrangement that violates the anti-

kickback statute. Please note that this is not intended as an exhaustive list, but rather gives examples of indicators of potentially unlawful activity.

Investor

- Investors are chosen because they are in a position to make referrals.
- Physicians who are expected to make a large number of referrals may be offered a greater investment opportunity in the joint venture than those anticipated to make fewer referrals.
- Physician investors may be actively encouraged to make referrals to the joint venture, and may be encouraged to divest their ownership interest if they fail to sustain an "acceptable" level of referrals.
- The joint venture tracks its sources of referrals, and distributes this information to the investors.
- Investors may be required to divest their ownership interest if they cease to practice in the service area, for example, if they move, become disabled or retire.
- Investment interests may be nontransferable.

Business Structure

- The structure of some joint ventures may be suspect. For example, one of the parties may be an ongoing entity already engaged in a particular line of business. That party may act as the reference laboratory or DME supplier for the joint venture. In some of these cases, the joint venture can be best characterized as a "shell."
- In the case of a shell laboratory joint venture, for example:
 - It conducts very little testing on the premises, even though it is Medicare certified.
 - The reference laboratory may do the vast bulk of the testing at its central processing laboratory, even though it also serves as the "manager" of the shell laboratory.
 - Despite the location of the actual testing, the local "shell" laboratory bills Medicare directly for these tests.
- In the case of a shell DME joint venture, for example:
 - It owns very little of the DME or other capital equipment; rather the ongoing entity owns them.
 - The ongoing entity is responsible for all day-to-day operations of the joint venture, such as delivery of the DME and billing.

Financing and Profit Distribution

- The amount of capital invested by the physician may be

disproportionately small and the returns on investment may be disproportionately large when compared to a typical investment in a new business enterprise.

- Physician investors may invest only a nominal amount, such as \$500 to \$1500.
- Physician investors may be permitted to ``borrow'' the amount of the ``investment'' from the entity, and pay it back through deductions from profit distributions, thus eliminating even the need to contribute cash to the partnership.
- Investors may be paid extraordinary returns on the investment in comparison with the risk involved, often well over 50 to 100 percent per year.

C. Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B
(Issued May 1991)

To help reduce fraud in the Medicare program, the Office of Inspector General is actively investigating health care providers, practitioners and suppliers of health care items and services who (1) are paid on the basis of charges\1\ and (2) routinely waive (do not bill) Medicare deductible and copayment charges to beneficiaries for items and services covered by the Medicare program.

\1\This fraud alert is not intended to address the routine waiver of copayments and deductibles by providers, practitioners or suppliers who are paid on the basis of costs or diagnostic related groups. The fact that these types of services are not discussed in this fraud alert should not be interpreted to legitimize routine waiver of deductibles and copayments with respect to these payment methods. Also, it does not apply to a waiver of any copayment by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act.

What Are Medicare Deductible and Copayment Charges?

The Medicare ``deductible'' is the amount that must be paid by a Medicare beneficiary before Medicare will pay for any items or services for that individual. Currently, the Medicare Part B deductible is \$100 per year.

``Copayment'' (``coinsurance'') is the portion of the cost of an item or service which the Medicare beneficiary must pay. Currently, the Medicare Part B coinsurance is generally 20 percent of the reasonable charge for the item or service. Typically, if the Medicare reasonable charge for a Part B item or service is \$100, the Medicare beneficiary (who has met his [or her] deductible) must pay \$20 of the physician's bill, and Medicare will pay \$80.

Why Is it Illegal for ``Charged-Based'' Providers, Practitioners and Suppliers to Routinely Waive Medicare Copayment and Deductibles?

Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.

A "charge-based" provider, practitioner or supplier is one who is paid by Medicare on the basis of the "reasonable charge" for the item or service provided. 42 U.S.C. 1395u(b)(3); 42 CFR 405.501. Medicare typically pays 80 percent of the reasonable charge. 42 U.S.C. 1395l(a)(1). The criteria for determining what charges are reasonable are contained in regulations, and include an examination of (1) the actual charge for the item or service, (2) the customary charge for the item or service, (3) the prevailing charge in the same locality for similar items or services. The Medicare reasonable charge cannot exceed the actual charge for the item or service, and may generally not exceed the customary charge or the highest prevailing charge for the item or service. In some cases, the provider, practitioner or supplier will be paid the lesser of his [or her] actual charge or an amount established by a fee schedule.

A provider, practitioner or supplier who routinely waives Medicare copayments or deductibles is misstating its actual charge. For example, if a supplier claims that its charge for a piece of equipment is \$100, but routinely waives the copayment, the actual charge is \$80. Medicare should be paying 80 percent of \$80 (or \$64), rather than 80 percent of \$100 (or \$80). As a result of the supplier's misrepresentation, the Medicare program is paying \$16 more than it should for this item.

In certain cases, a provider, practitioner or supplier who routinely waives Medicare copayments or deductibles also could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7b(b). The statute makes it illegal to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them.

At first glance, it may appear that routine waiver of copayments and deductibles helps Medicare beneficiaries. By waiving Medicare copayments and deductibles, the provider of services may claim that the beneficiary incurs no costs. In fact, this is not true. Studies have shown that if patients are required to pay even a small portion of their care, they will be better health care consumers, and select items or services because they are medically needed, rather than simply because they are free. Ultimately, if Medicare pays more for an item or service than it should, or if it pays for unnecessary items or services, there are less Medicare funds available to pay for truly needed services.

One important exception to the prohibition against waiving copayments and deductibles is that providers, practitioners or suppliers may forgive the copayment in consideration of a particular patient's financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and copayments must be made. Otherwise, claims submitted to Medicare may violate the statutes discussed above and other provisions of the law.

What Penalties Can Someone Be Subject to for Routinely Waiving Medicare Copayments or Deductibles?

Whoever submits a false claim to the Medicare program (for example, a claim misrepresents an actual charge) may be subject to criminal, civil or administrative liability for making false statements and/or submitting false claims to the Government. 18 U.S.C. 287 and 1001; 31 U.S.C. 3729; 42 CFR 1320a-7a). Penalties can include imprisonment, criminal fines, civil damages and forfeitures, civil monetary penalties

and exclusion from Medicare and the State health care programs.

In addition, anyone who routinely waives copayments or deductibles can be criminally prosecuted under 42 U.S.C. 1320a-7b(b), and excluded from participating in Medicare and the State health care programs under the anti-kickback statute. 42 U.S.C. 1320a-7(b)(7).

Finally, anyone who furnishes items or services to patient substantially in excess of the needs of such patients can be excluded from Medicare and the State health care programs. 42 U.S.C. 1320a-7(b)(6)(B).

Indications of Improper Waiver of Deductibles and Copayments

To help you identify charge-based providers, practitioners or suppliers who routinely waive Medicare deductibles and copayments, listed below are some suspect marketing practices. Please note that this list is not intended to be exhaustive but, rather, to highlight some indicators of potentially unlawful activity.

- Advertisements which state: ``Medicare Accepted As Payment in Full,`` ``Insurance Accepted As Payment in Full,`` or ``No Out-Of-Pocket Expense.``
 - Advertisements which promise that ``discounts`` will be given to Medicare beneficiaries.
 - Routine use of ``Financial hardship`` forms which state that the beneficiary is unable to pay the coinsurance/deductible (i.e., there is no good faith attempt to determine the beneficiary's actual financial condition).
 - Collection of copayments and deductibles only where the beneficiary has Medicare supplemental insurance (``Medigap``) coverage (i.e., the items or services are ``free`` to the beneficiary).
 - Charges to Medicare beneficiaries which are higher than those made to other persons for similar services and items (the higher charges offset the waiver of coinsurance.)
 - Failure to collect copayments or deductibles for a specific group of Medicare patients for reasons unrelated to indigency (e.g., a supplier waives coinsurance or deductible for all patients from a particular hospital, in order to get referrals).
 - ``Insurance programs`` which cover copayments or deductibles only for items or services provided by the entity offering the insurance. The ``insurance premium`` paid by the beneficiary is insignificant and can be as low as \$1 a month or even \$1 a year. These premiums are not based upon actuarial risks, but instead are a sham used to disguise the routine waiver of copayments and deductibles.
- D. Special Fraud Alert: Hospital Incentives to Physicians
(Issued May 1992)

Why Do Hospitals Provide Economic Incentives to Physicians?

As many hospitals have become more aggressive in their attempts to recruit and retain physicians and increase patient referrals, physician incentives (sometimes referred to as ``practice enhancements``) are becoming increasingly common. Some physicians actively solicit such

incentives. These incentives may result in reductions in the physician's professional expenses or an increase in his or her revenues. In exchange, the physician is aware that he or she is often expected to refer the majority, if not all, of his or her patients to the hospital providing the incentives.

Why Is it Illegal for Hospitals to Provide Financial Incentives to Physicians for Their Referrals?

The Office of Inspector General has become aware of a variety of hospital incentive programs used to compensate physicians (directly or indirectly) for referring patients to the hospital. These arrangements are implicated by the anti-kickback statute because they can constitute remuneration offered to induce, or in return for, the referral of business paid for by Medicare or Medicaid. In addition, they are not protected under the existing "safe harbor" regulations.

These incentive programs can interfere with the physician's judgment of what is the most appropriate care for a patient. They can inflate costs to the Medicare program by causing physicians to overuse inappropriately the services of a particular hospital. The incentives may result in the delivery of inappropriate care to Medicare beneficiaries and Medicaid recipients by inducing the physician to refer patients to the hospital providing financial incentives rather than to another hospital (or non-acute care facility) offering the best or most appropriate care for that patient.

Suspect Hospital Incentive Arrangements--What To Look For

To help identify suspect incentive arrangements, examples of practices which are often questionable are listed [below]. Please note that this list is not intended to be exhaustive but, rather, to suggest some indicators of potentially unlawful activity.

- Payment of any sort of incentive by the hospital each time a physician refers a patient to the hospital.
- The use of free or significantly discounted office space or equipment (in facilities usually located close to the hospital).
- Provision of free or significantly discounted billing, nursing or other staff services.
- Free training for a physician's office staff in such areas as management techniques, CPT coding and laboratory techniques.
- Guarantees which provide that, if the physician's income fails to reach a predetermined level, the hospital will supplement the remainder up to a certain amount.
- Low-interest or interest-free loans, or loans which may be "forgiven" if a physician refers patients (or some number of patients) to the hospital.
- Payment of the cost of a physician's travel and expenses for conferences.
- Payment for a physician's continuing education courses.

- Coverage on hospitals' group health insurance plans at an inappropriately low cost to the physician.
- Payment for services (which may include consultations at the hospital) which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of services rendered.

Financial incentive packages which incorporate these or similar features may be subject to prosecution under the Medicare and Medicaid anti-kickback statute, if one of the purposes of the incentive is to influence the physician's medical decision as to where to refer his or her patients for treatment.

E. Special Fraud Alert: Prescription Drug Marketing Schemes
(Issued August 1994)

How Does the Anti-Kickback Law Relate to Prescription Drug Marketing Schemes?

In recent years, prescription drug companies in the United States have increased their marketing activities among providers, patients and suppliers such as pharmacies. Many prescription drug marketing activities go far beyond traditional advertising and educational contacts. Physicians, suppliers and, increasingly, patients are being offered valuable, non-medical benefits in exchange for selecting specific prescription drug brands. Traditionally, physicians and pharmacists have been trusted to provide treatments and recommend products in the best interest of the patient. In an era of aggressive drug marketing, however, patients may now be using prescription drug items, unaware that their physician or pharmacist is being compensated for promoting the selection of a specific product. Prescription drugs supplied under one of these programs are often reimbursed under Medicaid. Among the specific activities, which the OIG has identified, are the following actual cases:

- A "product conversion" program which resulted in 96,000 brand-name conversions. In this scenario, for instance, Drug Company A offered a cash award to pharmacies for each time a drug prescription was changed from Drug Company B's product to Drug Company A's product. The pharmacies were induced to help persuade physicians, who were unaware of the pharmacies' financial interest, to change prescription.
- A "frequent flier" campaign in which physicians were given credit toward airline frequent flier mileage each time the physician completed a questionnaire for a new patient placed on the drug company's product.
- A "research grant" program in which physicians were given substantial payments for de minimis recordkeeping tasks. The physician administered the drug manufacturer's product to the patient and made brief notes, sometimes a single word, about the treatment outcome. Upon completion of a limited number of such "studies," the physician received payment from the manufacturer.

If one purpose of any of these marketing schemes is to induce the provision of a prescription drug item reimbursable by Medicaid, then the criminal anti-kickback statute is implicated. There is no statutory exception or "safe harbor" to protect such activities. Thus a physician, pharmacy or other practitioner or supplier receiving payment under these activities may be subject to criminal prosecution and exclusion from participation in the Medicare and Medicaid programs.

A marketing program that is illegal under the anti-kickback statute may pose a danger to patients because the offering or payment of remuneration may interfere with a physician's judgment in determining the most appropriate treatment for a patient. Further, where the patient is a Medicaid beneficiary, these drug marketing practices may increase the Federal government's costs of reimbursing suppliers for the products. The OIG is investigating various drug marketing schemes, and enforcing the anti-kickback laws where these practices affect the Federal health care programs.

What To Look For

Generally, a payment or gift may be considered improper under 42 U.S.C. 1320a-7b(b) if it is:

- Made to a person in a position to generate business for the paying party;
- Related to the volume of business generated; and
- More than nominal in value and/or exceeds fair market value of any legitimate service rendered to the payer, or is unrelated to any service at all other than referral of patients.

OIG investigation may be warranted where one or more of the following features is present in prescription drug marketing activities:

- Any prize, gift or cash payment, coupon or bonus (e.g., airline discounts and related travel premiums), offered to physicians and/or suppliers (including pharmacies, mail order prescription drug companies and managed care organizations) in exchange for, or based on, prescribing or providing specific prescription products. These items are particularly suspect if based on value or volume of business generated for the drug company.
- Materials which offer cash or other benefits to pharmacists (or others in a position to recommend prescription drug products) in exchange for performing marketing tasks in the course of pharmacy practice related to Medicare or Medicaid. The marketing tasks may include sales-oriented "educational" or "counseling" contacts, or physician and/or patient outreach, etc.
- Grants to physicians and clinicians for studies of prescription products when the studies are of questionable scientific value and require little or no actual scientific pursuit. The grants may nonetheless offer substantial benefits based on, or related to, use of the product.
- Any payment, including cash or other benefit, given to a patient, provider or supplier for changing a prescription, or recommending or requesting such a change, from one product to another, unless the payment is made fully consistent with a "safe harbor" regulation, 42 CFR 1001.952, or other Federal provision governing the reporting of prescription drug prices.

F. Special Fraud Alert: Arrangements for the Provision of Clinical Lab Services

(Issued October 1994)

How Does the Anti-Kickback Statute Relate to Arrangements for the Provision of Clinical Lab Services?

Many physicians and other health care providers rely on the services of outside clinical laboratories to which they may refer high volumes of patient specimens every day. The quality, timeliness and cost of these services are of obvious concern to Medicare and Medicaid patients and to the programs that finance their health care services. Since the physician, not the patient, generally selects the clinical laboratory, it is essential that the physician's decision regarding where to refer specimens is based only on the best interests of the patient.

Whenever a laboratory offers or gives to a source of referrals anything of value not paid for at fair market value, the inference may be made that the thing of value is offered to induce the referral of business. The same is true whenever a referral source solicits or receives anything of value from the laboratory. By "fair market value" we mean value for general commercial purposes. However, "fair market value" must reflect an arms length transaction which has not been adjusted to include the additional value which one or both of the parties has attributed to the referral of business between them.

The office of Inspector General has become aware of a number of practices engaged in by clinical laboratories and health care providers that implicate the anti-kickback statute in this manner. Below are some examples of lab services arrangements that may violate the anti-kickback statute.

Provision of Phlebotomy Services to Physicians

When permitted by State law, a laboratory may make available to a physician's office a phlebotomist who collects specimens from patients for testing by the outside laboratory. While the mere placement of a laboratory employee in the physician's office would not necessarily serve as an inducement prohibited by the anti-kickback statute, the statute is implicated when the phlebotomist performs additional tasks that are normally the responsibility of the physician's office staff. These tasks can include taking vital signs or other nursing functions, testing for the physician's office laboratory, or performing clerical services.

Where the phlebotomist performs clerical or medical functions not directly related to the collection or processing of laboratory specimens, a strong inference arises that he or she is providing a benefit in return for the physician's referrals to the laboratory. In such a case, the physician, the phlebotomist, and the laboratory may have exposure under the anti-kickback statute. This analysis applies equally to the placement of phlebotomists in other health care settings, including nursing homes, clinics and hospitals.

Furthermore, the mere existence of a contract between the laboratory and the health care provider that prohibits the phlebotomist from performing services unrelated to specimen collection does not eliminate the OIG's concern, where the phlebotomist is not closely monitored by his [of her] employer or where the contractual prohibition is not rigorously enforced.

Lab Pricing at Renal Dialysis Centers

The Medicare program pays for laboratory tests provided to patients with end stage renal disease (ESRD) in two different ways. Some laboratory testing is considered routine and payment is included in the composite rate paid by Medicare to the ESRD facility which in turn pays

the laboratory. Some laboratory testing required by the patient is not included in the composite rate, and these additional tests are billed by the laboratory directly to Medicare and paid at the usual laboratory fee schedule price.

The OIG is aware of cases where a laboratory offers to perform the tests encompassed by the composite rate at a price below fair market value of the tests performed. In order to offset the low charges on the composite rate tests, the ESRD facility agrees to refer all or most of its non-composite rate tests to the laboratory. This arrangement appears to be an offer of something of value (composite rate tests below fair market value) in return for the ordering of additional tests which are billed directly to the Medicare program.

If offered or accepted in return for referral of additional business, the lab's pricing scheme is illegal remuneration under the anti-kickback statute. The statutory exception and "safe harbor" for "discounts" does not apply to immunize parties to this type of transaction, since discounts on the composite rate tests are offered to induce referral of other tests. See 42 CFR 1001.952(h)(3)(ii).

Waiver of Charges To Managed Care Patients

Managed care plans may require a physician or other health care provider to use only the laboratory with which the plan has negotiated a fee schedule. In such situations, the plan usually will refuse to pay claims submitted by other laboratories. The provider, however, may use a different laboratory and may wish to continue to use that laboratory for non-managed care patients. In order to retain the provider as a client, the laboratory that does not have the managed care contract may agree to perform the managed care work free of charge.

The status of such agreements under the anti-kickback statute depends in part on the nature of the contractual relationship between the managed care plan and its providers. Under the terms of many managed care contracts, a provider receives a bonus or other payment if utilization of ancillary services, such as laboratory testing, is kept below a particular level. Other managed care plans impose financial penalties if the provider's utilization of services exceeds pre-established levels. When the laboratory agrees to write off charges for the physician's managed care work, the physician may realize a financial benefit from the managed care plan created by the appearance that utilization of tests has been reduced.

In cases where the provision of free services results in a benefit to the provider, the anti-kickback statute is implicated. If offered or accepted in return for the referral of Medicare or State health care plan business, both the laboratory and the physician may be violating the anti-kickback statute. There is no statutory exception or "safe harbor" to immunize any party to such a practice because the Federal programs do not realize the benefit of these "free" services. See 42 CFR 1001.952(h)(3)(iii).

Other Inducements

The following are additional examples of inducements offered by clinical laboratories which may implicate the anti-kickback statute:

- Free pick-up and disposal of bio-hazardous waste products (such as sharps) unrelated to the collection of specimens for the outside laboratory.
- Provision of computers or fax machines, unless such

equipment is integral to, and exclusively used for, performance of the outside laboratory's work.

- Provision of free laboratory testing for health care providers, their families and their employees.

When one purpose of these arrangements is to induce the referral of program-reimbursed laboratory testing, both the clinical laboratory and the health care provider may be liable under the statute and may be subject to criminal prosecution and exclusion from participation in the Medicare and Medicaid programs.

G. Reporting Information

What To Do If You Have Information About Suspect Activities or Arrangements

If you have information about health care providers, practitioners, entities or other persons engaging in these types of activities or arrangements described above, contact any of the regional offices of the Office of Investigations of the Office of Inspector General, U.S. Department of Health and Human Services, at the following locations:

Regions	States served	Telephone
Boston.....	MA, VT, NH, ME, RI, CT.....	617-565-2660
New York.....	NY, NJ, PR, VI.....	212-264-1691
Philadelphia.....	PA, MD, DE, WV, VA.....	215-596-6796
Atlanta.....	GA, KY, NC, SC, FL, TN, AL, MS (No. District).	404-331-2131
Chicago.....	IL, MN, WI, MI, IN, OH, IA, MO....	312-353-2740
Dallas.....	TX, NM, OK, AR, LA, MS (So. District).	214-767-8406
Denver.....	CO, UT, WY, MT, ND, SD, NE, KS....	303-844-5621
Los Angeles.....	AZ, NV (Clark Co.), So. CA.....	714-836-2372
San Francisco.....	No. CA, NV, AZ, HI, OR, ID, WA....	415-556-8880
Washington, DC.....	DC and Metropolitan areas of VA and MD.	202-619-1900

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June Gibbs Brown,
Inspector General.

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