PUBLICATION

Advisory Opinion 16-10: OIG Approves Transportation Assistance Program [Ober|Kaler]

2016

On October 3, 2016, the U.S. Department of Health & Human Services, Office of the Inspector General (OIG), issued an advisory opinion approving a local health care district's proposal to cooperate with another district to jointly fund the cost of a transportation education program and a related subsidy for certain needy patients' transportation costs (Proposed Plan). In Advisory Opinion 16-10 [PDF], the OIG determined that the Proposed Plan would not constitute grounds for the imposition of sanctions under the civil monetary penalty (CMP) prohibition against inducements to beneficiaries or under the anti-kickback statute (AKS).

The requestor, referred to as “District A,” is a local health care district in an underserved area, which operates a hospital and a clinic within the district (Clinic 1), as well as a clinic located 25 miles away (Clinic 2) in the neighboring District B (a local health care district that does not own or operate health care facilitates, but which does promote community health and wellness programs). Under the Proposed Plan, District A and District B will establish a transportation program to educate and assist patients who receive services at Clinic 2 (located within District B) get back and forth to District A's hospital or Clinic 1 for follow-up care. The types of transportation available include charity services and private contractors, as well as local and regional bus and curb-to-curb programs. District A will hire a transportation coordinator to build a database of available transportation options and to educate patients regarding the use of such transportation options, as well as programs that offset transportation costs. The Proposed Plan will not be advertised but it will be offered to all patients at Clinic 2 who need follow-up care at the hospital, and staff will refer patients to the coordinator for assistance. District A will pay for the equipment and supply costs of the coordinator, and District B will pay for office space and utilities for the coordinator.

Additionally, District A and District B will split a subsidy for qualified patients unable to afford travel costs between Clinic 2 and the hospital. Those patients must complete an application and a financial assessment form, and subsidy decisions will consider a matrix based on a multiple of the federal poverty guidelines, taking into account household income and size. Any patient approved for subsidies may only use the transportation operated by the County's Transportation Commission, and the approval is only good for three months, after which re-application is required. Transportation fees associated with the subsidy range from $.50 to $2.50 per trip. District A and District B will split the cost of the subsidies to District B's residents, and District A would fully fund the subsidies for all other patients at Clinic 2 who qualify for transportation assistance.

The OIG analyzed the Proposed Plan as involving two possible streams of remuneration: (1) remuneration between District A and District B, and (2) remuneration from the Districts to their patients. Regarding the first stream, involving the Districts sharing salary, costs, overhead, and subsidies associated with the transportation coordinator and financial assistance, the OIG concluded that remuneration does indeed flow between the Districts and, further, District B is a potential referral source for District A because its community outreach efforts may direct patients to Clinic 2. District B, though, does not have any health care facilities and thus does not receive referrals from District A. Despite the referrals from District B to District A, the OIG found a low risk of improper referrals or inducement because the patients at Clinic 2 have already selected District A's services at the time they qualify for transportation education and assistance, which involves transporting patients to District A's hospital. Importantly, both Districts are public agencies charged with providing health care to their residents and providing assistance in the operation of facilities and services.

Meanwhile, regarding possible remuneration to patients, the OIG determined that the transportation education service to patients is not remuneration, as it simply involves an explanation to a patient about available transportation options. But the subsidies to financially needy patients constitute remuneration under the AKS and the CMP. Still, the OIG found a low risk of fraud and abuse in the subsidies for a number of reasons.

First, reiterating the notion that both Districts are public agencies supported by taxpayer funds, the OIG noted that the Proposed Plan helps residents of both Districts. The residents of District B need assistance reaching health care services not provided by District B, and they are already patients of District A at the time they receive the subsidy. Second, the cost of the subsidies is relatively modest, ranging from $.50 to $2.50, and the subsidy is limited to certain types of transportation and only available to the needy. Finally, the Proposed Plan will not be advertised or targeted to particular patients or beneficiaries. This combination of factors presented a low risk of improper patient recruitment or inducement.

Ober | Kaler's Comments

It is interesting that the Advisory Opinion does not discuss whether other health care facilities are closer than District A's hospital. In any event, the OIG's ultimate conclusion is not particularly surprising. The requestor is a public agency, and the goal is to increase the accessibility of health care services in an underserved area. Given these facts, it is unlikely that the approach outlined in the advisory opinion can be replicated elsewhere.