PUBLICATION

OIG Advisory Opinion 18-11 Offers Rare Insight to Safe Harbor for Price Reductions Offered to Eligible Managed Care Organizations

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The Office of Inspector General (OIG) confirmed in Advisory Opinion No. 18-11 that the safe harbor for Price Reductions Offered to Managed Care Organizations applies to "any remuneration," not just price reductions or discounts. The OIG reached its conclusion through the application of the safe harbor's vague requirement that neither party shift the financial burden of the agreement to the extent that costs to federal health care programs are increased. Specifically, the OIG allowed the managed care organization to use incentive payments to increase utilization of preventative care services. Given the broad encouragement from CMS and a state Medicaid program to increase such services, however, it is unclear if the lenient treatment of this requirement should be applied in other contexts.

The arrangement under review in Advisory Opinion 18-11 stems from the requirement that Medicaid programs provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to Medicaid beneficiaries under age 21. Under the arrangement, a Medicaid managed care organization that was receiving capitated payments would provide incentive payments to contracted health care providers to increase utilization of EPSDT services by existing enrollees. The providers would receive an extra $1 per existing enrollee for every ten percent increase in EPSDT services provided to existing enrollees, up to $3.

The OIG noted several factors regarding the arrangement's background, which may offer insights into the context in which the OIG made its decision. The advisory opinion mentions the preventative nature of EPSDT services, the capitated nature of the contract, HHS's budget-neutral approach to risk adjustment (where healthier patient populations result in lower capitated payments), and the utilization requirements for EPSDT services in the managed care organization's contract with the state Medicaid program.

After confirming the arrangement met the threshold requirements (that the managed care organization was eligible and the payments were for providing or arranging for services), the OIG examined three of the safe harbor's requirements in greater detail, namely that (1) the parties have a written agreement, (2) in establishing the terms of the agreement there can be no exchange of remuneration to induce the provision or acceptance of business, and (3) neither party shifts the financial burden of the agreement to the extent that increased costs are claimed from federal health care programs.

The OIG swiftly concluded the arrangement met the first two requirements. The arrangement contained a written agreement, including a provision specifying that the provider could not claim payment from federal health care programs for the services provided. The arrangement covered only existing enrollees, thus eliminating the possibility of inducing additional business.

The OIG spent more time in concluding the third requirement had been met. With capitated payments and the arrangement covering only existing enrollees, there was little risk that increased payments would be claimed from federal health care programs during the contract year. However, the OIG acknowledged that the arrangement could lead to higher capitated payments in future years. Nevertheless, because the arrangement could increase the provision of services in line with the state's goal of increasing EPSDT services, any increases in federal health care program costs would "appropriately" reflect increases in the cost of care.

A Narrow Application

The safe harbor at issue has received little previous interpretation. The OIG has mentioned 42 CFR § 1001.952(t) in only one other advisory opinion (OIG Advisory Opinion No. 00-4), and then only in a footnote. The advisory opinion unsurprisingly confirms that the safe harbor covers "any remuneration" (as the regulation states) and not just "price reductions" (as the safe harbor's title might otherwise suggest).

It is not clear that this advisory opinion's approach to cost shifting is applicable in other contexts. The safe harbor requires that "neither party to the agreement may shift the financial burden of the agreement to the extent that increased payments are claimed from a Federal health care program." Yet the OIG acknowledged that increased utilization could increase costs and result in higher capitated payments in future years. The advisory opinion concluded that the requirement was satisfied in this instance, however, because the arrangement would not "inappropriately increase or shift costs to Federal health care programs in future years"; rather, increasing EPSDT services was consistent with state policy, and any increased capitation payments in future years would likely "appropriately reflect increases in the cost of care." What is unclear is whether this lenient reading of the safe harbor will extend to other, less sympathetic circumstances.