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CLIENT ALERT

OIG Allows Providers to Share a Portion of Reimbursements with Patients

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On December 28, 2020, the Office of Inspector General for the U.S. Department of Health and Human Services ("OIG") published Advisory Opinion 20-07,[1] approving a proposal whereby certain health care facilities and clinicians could use an online platform to disburse, to patients and the patients' payors, a portion of the reimbursement the facilities and clinicians receive for claims where Medicare is a secondary payor. This favorable opinion represents a remarkable departure from OIG's typical approach to providers' waiver or reduction of cost-sharing amounts, which OIG historically has limited to circumstances in which patients have demonstrated financial need. Although advisory opinions may legally be relied upon only by the parties requesting them, advisory opinions provide insight regarding how OIG might analyze similar arrangements.

The Proposed Arrangement

The requestor of Advisory Opinion 20-07 stated that it currently operates an online platform that lists, with certain categorical exceptions, all facilities and clinicians with a National Provider Identifier ("Providers"), as well as certain information about each Provider, including their rates for specified services. Through its existing platform, the requestor allows Providers to disburse a portion of paid claims to patients and non-governmental third-party payors for diagnostic, procedural, and surgical care that is both elective and episodic ("Eligible Care"). Under the current arrangement, the amount the Providers disburse may be higher than the patients' cost-sharing obligations for the Eligible Care.

Under the proposed arrangement, the requestor would establish a separate user pathway solely for patients who have Medicare as a secondary payor, through which Providers could offer potential disbursements to such patients and their third-party payors for Eligible Care. The requestor would retain a portion of the Providers' disbursements as an administrative fee. Patients who elect to join the new platform would provide their insurance information, which the requestor would use to provide

[1] See https://oig.hhs.gov/fraud/docs/advisoryopinions/2020/AdvOpn20-07.pdf.

estimates of the patients' anticipated out-of-pocket costs for Eligible Care. Patients could use the platform to search for and compare Providers and view potential disbursement amounts. The default sort order for search results would be based upon the Provider's distance from the patient's address; patients would not be able to sort or filter results to view only those Providers offering disbursements. Patients using the platform also would have access to a care concierge team that would, among other services, help patients identify available Providers and book appointments. In addition, the platform would provide patients with a personalized dashboard that would display information including the patients' deductible balances and the estimated amounts they would pay for a specified service, taking into account any potential disbursement. Patients who do not receive any disbursements from a Provider would not be charged any fee to use the platform.

Providers could offer disbursements to patients only for Eligible Care that a practitioner has determined is medically necessary. Disbursements could be calculated either as a percentage of the total amount the Provider would be entitled to receive for the Eligible Care, a fixed dollar amount, or a fixed amount that is subtracted from the amount the Provider is entitled to receive for the Eligible Care. Patients who wish to receive Eligible Care for which a Provider has offered a disbursement would notify the Provider through the platform; if the Provider agrees to provide the Eligible Care with the potential disbursement, the patient and Provider would enter into an agreement through the platform that would obligate the Provider to send the disbursement to the requestor if all of the patient's payors responsible for payment satisfy certain prompt payment and hassle-free processing requirements. The requestor would retain 33 percent of the disbursement as payment for its services, and would then distribute 50 percent of the remaining balance to the patient, and the other 50 percent to the patient's payors. Importantly, in contrast to the requestor's current arrangement, under the proposed arrangement the amount a patient could receive as a disbursement would be capped at the amount of the patient's cost-sharing obligations for the Eligible Care. The requestor stated that it would donate any amounts due to the patient that exceeded the patient's cost-sharing obligation to a health care-related charity.

OIG's Analysis

OIG noted that the proposed arrangement would generate three remunerative streams that implicate the federal anti-kickback statute, which makes it a criminal offense to knowingly and willfully offer or receive remuneration to induce or reward the referral of federally reimbursable items or services.[2] First, OIG noted that the disbursements the Providers offer to patients would constitute remuneration from the Providers to patients and their primary payors, and that such disbursements may be offered to induce patients to self-refer to the Providers. Second, OIG stated that the 33 percent of each disbursement the requestor would retain as an administrative fee for the services it provides to patients would constitute remuneration from the patients to the requestor in return for the requestor's arranging for the purchasing or ordering of federally reimbursable services. And finally, OIG asserted that the patients' ability to use the platform—including its concierge team and personalized dashboard—for free would

[2] 42 U.S.C. 1320a-7b(b).

constitute remuneration from the requestor to patients who do not receive disbursements, and that such remuneration could be an inducement to purchase services through the platform in the future.

Despite finding that the proposed arrangement would implicate the anti-kickback statute, OIG ultimately concluded that it would not impose sanctions on the requestor in connection with the proposed arrangement for a number of reasons, including that the proposed arrangement:

1) **Would Differ from Routine Cost-Sharing Waivers:** Under the proposed arrangement, patients would pay their cost-sharing obligations and would not receive any disbursement unless and until the payors responsible for payment satisfy certain prompt payment and hassle-free processing requirements. Furthermore, the proposed arrangement would apply only to patients who have Medicare as a secondary payor, and not to all federal health care program beneficiaries.

2) **Would Be Unlikely to Interfere with Clinical Decision-Making:** OIG contrasted the proposed arrangement to arrangements under which patients purchase prepaid coupons, noting that, in circumstances where patients prepay for a service, Providers may feel pressured to render that service. In contrast, under the proposed arrangement, Providers could determine that a service other than the service the patient sought through the platform is more appropriate, with no negative financial impact to the patient.

3) **Would Be Unlikely to Result in Increased Prices:** OIG noted that the various methodologies for calculating any disbursements due would be based on the amounts the Providers are entitled to receive for Eligible Care, as opposed to the amounts that the Providers may bill for Eligible Care.

4) **Would Not Steer Patients to Certain Providers:** OIG cited to certain aspects of the platform's presentation of search results as safeguards, including the fact that the default sort order would be based on the Providers' distance from the patient's address.

OIG also assessed the proposed arrangement under the Beneficiary Inducements Civil Monetary Penalty, which prohibits a person or entity from offering or providing any remuneration to a Medicare or Medicaid beneficiary that the offeror knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier,[3] but declined to impose sanctions on the requestor for the same reasons it cited in its analysis under the anti-kickback statute.

Takeaways

With this opinion, OIG appears to have shown a willingness to open the door for certain health care facilities and clinicians to compete for patients' business based on price,

[3] 42 U.S.C. 1320a-7a(a)(5).

albeit with respect to only a very limited subset of federal health care program beneficiaries. And although OIG took great pains to distinguish the disbursements that could be made under the proposed arrangement from routine copayment waivers, this opinion suggests that OIG may be bending slightly from its historically inflexible approach in circumstances where such waivers would not impact clinical decision-making, would not result in patient steering, and would not increase costs to the federal health care programs. Of particular importance was OIG's cautionary footnote that it likely would have reached a different conclusion if the proposed arrangement allowed for disbursements to patients in excess of patients' cost-sharing amounts.

Finally, while OIG's perspective certainly is valuable, Providers and those contracting with them also must consider any applicable state laws, including any applicable state anti-kickback provisions, that could impact arrangements that are similar in nature to the proposed arrangement.

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This Client Alert was authored by **Jennifer E. Michael.** *For additional information about the issues discussed in this Client Alert, please contact the author or the Epstein Becker Green attorney who regularly handles your legal matters.*