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OIG Says Proposed MCO Incentive Program Protected by AKS Safe Harbor

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In its favorable **Advisory Opinion 18-11**, the OIG explains how a managed care organization's proposed incentive program to pay network providers to increase the amount of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to Medicaid beneficiaries would not violate the Anti-Kickback Statute (AKS). What is interesting about this Advisory Opinion is that the OIG finds that the health plan's proposed arrangement would be protected by the managed care safe harbor for eligible managed care organizations (ECMOs), and there are not many opinions addressing this safe harbor.

Here is a brief run-down of the relevant facts:

- The requestor of the advisory opinion (MCO) is a managed care organization that has entered into a full-risk, capitated contract with the state to provide benefits to Medicaid beneficiaries, including EPSDT services. This contract requires MCO to accept the capitated payment as payment in full for all items and services provided under the contract as well as any administrative costs.
- The state uses a budget-neutral prospective risk adjustment process to account for the relative health of MCO's enrollees and other Medicaid managed care enrollees in establishing its capitation payment rates.
- EPSDT services provide preventive health screenings and services to Medicaid beneficiaries from birth to age 21. The goal is to diagnose and treat children as early as possible so that more serious health problems may be avoided.
- MCO is required under its contract with the state to achieve two specific screening rates for EPSDT-eligible enrollees. Failure to meet these screening rates may subject MCO to liquidated damages imposed by the state program.
- The MCO enters into contracts with providers and clinics to provide health care services to its enrollees. The MCO proposed to enter into agreements with providers to increase the amount of EPSDT services provided to enrollees by providing per-enrollee incentive payments to providers that meet certain benchmarks for increasing the amount of EPSDT services provided.
  - For example, if a provider increased EPSDT services to existing enrollees in 2019 by at least 10 percent from 2018, then that provider would receive a $1 incentive payment per existing enrollee who received the services during 2019.
- Among other things, the MCO certified in its request that the arrangement would be covered by a written agreement signed by the parties, would specify the items and services covered by the agreement, would be for a period of at least one year, and would specify that the party providing the items or services cannot claim payment in any form from another Federal health care program for items or services covered under the agreement. MCO also certified that the proposed incentive program would not provide an incentive to the provider to recruit new Medicaid beneficiaries. See the full set of certified facts in the **Advisory Opinion**.

OIG's Analysis

As a general matter, the MCO proposes to pay remuneration to providers to increase health care services provided to Medicaid beneficiaries, which implicates the AKS. However, the EMCO safe harbor protects payments between EMCOs and their first tier contractors if the arrangement satisfies certain criteria. The OIG made three specific conclusions to determine that the proposed incentive program would be protected under the EMCO safe harbor:

1. **MCO is an "eligible managed care organization" and the providers are "first tier contractors."** The OIG looked directly to the statutory definitions at 42 C.F.R. § 1001.952(t)(2)(ii)(C) and (iii).
2. **The proposed incentive payments would be payments made to provide or arrange for items or services.** Again, the OIG looked to the definition of items or services in 42 C.F.R. § 1001.952(t)(2)(iv) and determined that EPSDT services are, in fact, health care services. However, "payments" is not defined in the safe harbor, and, as the OIG explains:

> ***The EMCO safe harbor was established because many managed care arrangements do not present the same risks of overutilization or increased Federal health care program costs that exist with many fee-for-service payment arrangements…These risks are mitigated regardless of whether payments between an EMCO and its first tier contractors are price reductions provided to the EMCO or payments by the EMCO to the first tier contractors to accomplish certain care delivery goals under a capitated risk contract. The method of payment between the EMCO and the first tier contractor does not change that "the Federal health care programs' aggregate financial exposure is fixed in accordance with its contract with the [EMCO]."…Additionally, there is little risk of overutilization because the EMCO has a strong incentive to monitor the delivery of services to control its costs of care and is contractually obligated to implement a utilization review program.***

3. **The proposed incentive program would satisfy the three standards for arrangements under the safe harbor:**
    1. The proposed incentive would be provided under an agreement that: is written and signed by the parties; specifies the items and services covered by the agreement; is for a period of at least one year; and specifies that the party providing the items or services cannot claim payment in any form from a Federal health care program for items or services covered under the agreement, subject to certain exceptions not relevant here. See 42 C.F.R. §1001.952(t)(1)(i)(A)(1)-(4).
    2. Since the incentive is based on services provided to existing enrollees, the OIG concluded that there would not be any remuneration provided in return for or to induce the provision or acceptance of business (other than the business covered by the agreement) for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis. See 42 C.F.R. § 1001.952(t)(1)(i)(B).
    3. The proposed incentive would not inappropriately increase or shift costs to a Federal health care program given that the MCO is paid a capitated payment and any risk adjustment calculations are budget neutral. See 42 C.F.R. § 1001.952(t)(1)(i)(C).

Of course, the OIG's Advisory Opinion may not be relied on by anyone other than the MCO and carries the usual qualifications. However, it is a helpful analysis and application of the EMCO safe harbor.

Authors

Bridgette A. Keller, Associate

Bridgette A. Keller is a Mintz attorney who applies her experience in health system administration and ethics in health care to her health law practice. She advises health care providers, ACOs, health plans, PBMs, and laboratories on regulatory, fraud and abuse, and business planning matters.