Recent Advisory Opinion Shows OIG’s Growing Acceptance of Financial Integration Among Related Entities

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On July 20, the Office of Inspector General of the Department of Health and Human Services (OIG) posted a new Advisory Opinion (the Opinion) addressing a health system’s restructured arrangement to lease employees, and provide other operational and management services, to a related psychiatric hospital (the Arrangement). The Opinion is a notable departure from other recent statements and enforcement actions, and signals a greater flexibility in how related entities may share non-clinical employees and operational expenses. It also shows the OIG’s willingness to consider more practical factors, such as cost reporting requirements and the systemic benefits from integrated entities behaving in cost-efficient ways, when determining the risk presented by an arrangement.

The Opinion concerns a nonprofit health system (System) with a membership interest in the psychiatric hospital (Center). The Center is also part of the System’s integrated health network. The System and the Center are potential referral sources to each other. Currently, both parties have an existing arrangement, whereby the Center leases non-clinician employees and obtains certain other operational and management services from the System, paying the System’s fully loaded costs (e.g., salary, benefits, overhead expenses) plus a two percent administration fee. The Arrangement would continue the same relationship, but the Center would no longer pay the System the administration fee. The parties have asserted, and OIG verified, that the administrative fee is an unallowable cost under applicable Medicare cost-reporting rules, and would not be reimbursable by the Medicare program.

The OIG noted that the new Arrangement, where the System would provide the same services for less aggregate compensation, could raise fair market value (FMV) issues. Such a discount could be considered remuneration in exchange for the Center’s referrals. In addition, the aggregate compensation under the Arrangement can’t be set in advance as the System’s costs, and Center’s needs, may change during the term. Given these issues, the Arrangement would not meet the requirements of the Anti-Kickback Statute (AKS) safe harbor for personal services and management contracts. Nonetheless, given the totality of the circumstances, the OIG concluded that the Arrangement would present a low risk of fraud and abuse and thus OIG would not impose sanctions.

The Opinion described several mitigating factors that, from OIG’s perspective, decreased the Arrangement’s risk of fraud and abuse. Not only did the parties attempt to structure the Arrangement to be in compliance with Medicare cost-reporting rules for related parties, there was also no evidence that the Arrangement was structured to, or actually would, induce referrals. Moreover, the parties pointed to the cost efficiencies of health system integration that would be promoted by the Arrangement, and to the potential indirect benefits (by way of cost savings) to federal health care programs.

The Opinion’s more flexible approach to analyzing the Arrangement stands in contrast to the OIG’s
other recent activities, all of which express a consistent concern with payments between independent actors that are not consistent with FMV. For example, the OIG issued a fraud alert focusing on improper physician financial arrangements on June 9, 2015. The alert encourages physicians to “ensure that [their] arrangements reflect fair market value for bona fide services.” Similarly, the OIG has recently settled with several leased-employee physicians compensated by Fairmont Diagnostic Center and Open MRI Inc. (Fairmont) following Fairmont’s False Claims Act settlement concerning these arrangements. The OIG alleged that full time Fairmont employees, placed in certain physicians’ offices for study-related tasks, were actually performing office functions on the physician’s behalf, which constituted improper remuneration intended to induce referrals. Given this sustained regulatory focus on FMV compensation, health care entities should pay particular attention to the business justifications of their arrangements.

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