Proposed OIG Rules Signal Continued Emphasis On Health Care Fraud Investigations

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In a continued effort to combat health care fraud, the Office of the Inspector General of the Department of Health and Human Services (OIG) recently announced two proposed rules implementing its new and increased powers under the Affordable Care Act (ACA). These proposed rules expand the OIG's power to exclude individuals and entities from participation in federal health care programs. In fiscal year 2013, OIG excluded 3,214 individuals and entities from participation in federal health care programs. This was a 20 percent increase from the number of individuals and entities excluded in FY 2011. Since the enactment and implementation of the ACA, the OIG has made it clear that it will increase fraud investigations and enforcement actions.

Proposed Rule Would Expand OIG's Exclusionary Power

Towards this goal, the ACA provides to CMS and the OIG broader authority to exclude individuals and entities from participating in federal health care programs. The first proposed rule, published on May 9, 2014, expands the OIG's investigatory powers and the bases for exclusion. In particular, the new rule provides an unlimited time period for exclusions. Even where the underlying violation carries a definite statute of limitations, the OIG would have the power to exclude a party no matter how long ago the violation occurred. The proposed rule also expands the permissive exclusionary power of the OIG by allowing exclusion based on false statements, omissions, or misrepresentations of material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a federal health care program. Exclusion bases would also include: (1) failing to grant OIG timely access to records; (2) ordering or prescribing while excluded; (3) failing to report and return an overpayment; and (4) making or using a false record or statement that is material to a false or fraudulent claim. The newly-proposed bases for permissive exclusion also include obstruction of audits in connection with a criminal offense related to any of the other exclusionary bases. This exclusion basis mirrors federal criminal statute 18 U.S.C. § 1518, which makes the obstruction of federal health care investigations punishable by imprisonment. The OIG would also now have the power to issue testimonial subpoenas in investigations involving potential exclusion. Finally, an individual with ownership or control interests in an excluded entity would continue to be excluded from federal health care program participation even if the individual terminated his relationship with the sanctioned entity. The individual will remain excluded for as long as the entity of which he is/was an owner is excluded.

Changes to Civil Monetary Penalty Rules Applicable to Health Care Fraud

In addition to these proposed exclusion bases, the OIG issued a separate proposed rule on May 12, 2014 regarding Civil Monetary Penalties (CMPs). The OIG's proposed rule, among many new penalties, would allow a penalty of $10,000 per day for failure to timely report and return Medicare or Medicaid overpayment and $15,000 per day for failure to grant timely access to records pursuant to an OIG audit or investigation. In calculating the CMP, the OIG considers the monetary injury caused by the prohibited action, including certain mitigating and aggravating dollar-amount thresholds. The proposed rule increases the amount considered as a mitigation factor from $1,000 to $5,000 and the threshold aggravating amount from an unclear "substantial" amount to $15,000 or more. This means that any violation resulting in a less than $5,000 injury would be eligible for a shorter period of mandatory exclusion and any violation resulting in a greater than $5,000 injury would indicate more serious conduct or ill intent. Violations causing a $15,000 injury or greater would trigger the claims-aggravating factor which allows for larger CMPs and longer exclusionary periods. In explaining its motivation, the OIG states that this increase is meant to respond to the reality of the health care industry and to capture those instances of serious misconduct. While this increased threshold may appear to be a softening of enforcement, it is indicative of the OIG's focus on big-money settlements and recovery.

These proposed rules are but one action among many by the OIG and the DOJ that demonstrate the commitment to greater health care fraud enforcement. They highlight the continued need for proactive and efficacious compliance with all federal

rules and regulations.

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