Proposed OIG Regulations Seek to Amend "Kiss of Death"

by James A. Robertson, John W. Kaveney and Cecylia K. Hahn

James A. Robertson

John W. Kaveney

Cecylia K. Hahn

On May 9, 2014, the Office of Inspector General ("OIG") of the Department of Health and Human Services ("HHS") published in the Federal Register[1] a set of proposed rule amendments to the regulations relating to the OIG's exclusion authority. The amendments would expand the OIG's exclusion authority, also known in the industry as the "kiss of death" due to the fact that a provider's exclusion from federal programs such as Medicare and Medicaid can often spell doom since these programs are often vital revenue sources for providers.

Presently, if a provider is found to have engaged in any of four grounds for mandatory exclusion, the OIG is required to exclude a provider from federal health care program participation.[2] Mandatory exclusions last a minimum of five years and apply to convictions of the following types of criminal offenses:

1. Medicare or Medicaid fraud, in addition to any other offenses related to the delivery of items or services pursuant to Medicare, Medicaid, SCHIP or other state health care programs;
2. Patient abuse or neglect in connection with the delivery of a health care item or service;
3. Felony convictions, under federal or state law, in connection with the delivery of a health care item or service, for other health care related fraud, theft, or other financial misconduct; and
4. Felony convictions relating to controlled substances and their unlawful manufacturing, distribution, prescription or dispensing.

There are also 16 different permissive exclusion categories which give the OIG discretion to exclude a provider from participation in any federal health care program.[3] Permissive exclusions fall into two categories: (1) "derivative" exclusions that are based on actions previously taken by a court or other law enforcement or regulatory agency; and (2) "affirmative" exclusions that are based on OIG-initiated determinations of misconduct. Permissive exclusions include such events as revocation or suspension of the provider's license, claims for excessive charges or medically unnecessary services, improper kickbacks, controlling a sanctioned entity as an owner, officer or managing employee, and convictions for health care related misdemeanor crimes. While there is no five-year minimum term for permissive exclusions, some categories of permissive exclusions have varying minimum or benchmark exclusion terms.

The OIG's proposed rule amendment would expand the permissive exclusions to include the following additional circumstances as identified in the Affordable Care Act[4]:

1. Conviction of an offense in connection with the obstruction of an audit;
2. Furnishing, ordering, referring for furnishing or certifying the need for items or services for which payment may be made and then failing to supply the requisite payment information;
3. Knowingly making, or causing to be made, any false statement, omission or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or as a supplier under a Federal health care program.

These additional exclusionary circumstances put greater pressure on providers especially with regard to audits. This push to encourage a higher level of cooperation with governmental audits is not surprising given that the OIG, the Department of

Justice and various other federal and state agencies continue to expand their audit efforts to uncover waste, fraud and abuse in the system. Providers will therefore face greater pressure to cooperate with governmental audits now that there is the added threat of exclusion from federal health care programs. Most providers cannot take such a risk and thus are left in the difficult position of deciding when to push back against governmental audits that can easily become burdensome and costly, especially when the agency has targeted a particular individual or entity.

The OIG is also ensuring it is not rushed to make a determination of exclusion when an investigation and/or litigation is ongoing by amending its rules to make clear that any exclusion proceedings will not be subject to the six year statute of limitations period applicable to OIG's other administrative remedies. Consequently, the OIG will not be forced to prematurely act on a determination of exclusion and can allow the investigation and/or litigation to resolve before making a determination. This means that for providers they could be subject to exclusion long after the violation has been resolved or the six year statute of limitation for the underlying violation has passed.

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The OIG's recent proposed amendments are not all detrimental to providers. The OIG is also considering instituting a procedure for early reinstatement of providers excluded due to the loss of their license. The OIG has discretion on whether to exclude a provider that has had its license revoked or suspended for reasons bearing on professional competence, professional performance, or financial integrity. Moreover, in such circumstances a provider typically cannot be reinstated into Medicare until they recover their original lost license. The OIG has rec-ognized that many of the individuals that fall within this circumstance have "los[t] their license permanently, move[d] to another State and obtain[ed] a license there, or do not intend to seek reinstatement of their health care license."[5] These providers may never become reinstated even though the exclusion may no longer be necessary to protect the safety of patients or the integrity of the programs. By way of example, the OIG has recognized as problematic: (1) physicians who have lost their license in one State but then subsequently obtained a license in another state or through another licensing board; and (2) physicians who have changed professions and never intend to regain their original licenses but for whom the exclusion is a permanent obstacle to practicing a new health-care related profession. Consequently, the OIG has recognized that an unfairness exists since mandatory exclusions require only a five-year period of exclusion while permissive exclusions can result in permanent exclusion even though the provider was never charged or convicted of a criminal offense. Thus, the OIG has stated that "[t]o serve the remedial purpose and intent of the statute, we are considering an alternative reinstatement process."[6]

In these circumstances, if the OIG subsequently determines that the provider poses little or no threat to patients or the programs and license reinstatement is extremely unlikely, the OIG is considering a process for "early reinstatement." The discretion is inherent in the permissive exclusion provisions, but the OIG has also expressly been given the authority for such discretion.[7] The OIG proposes an amendment to include a list of factors it will consider in determining early reinstatement. Some of the proposed factors include: (1) the length of time the provider has been excluded; (2) the circumstances of the exclusion; (3) the benefits and risks to the federal health care program; and (4) the existence of any ongoing or pending licensing or investigatory issues.[8] Ultimately, the OIG proposes that providers be eligible for reinstatement under these circumstances after three years or when the individual regains his/her/its healthcare license, whichever comes first.

Through these proposed amendments the OIG has sought to revise and expand its authority to cover these additional areas of concern and to ensure the ability to exclude providers who fail to come in compliance. At the same time, these amendments also pose some practical solutions to rectify circumstances that on their face are unfair and inconsistent with the spirit of the law. It remains to be seen when they will be adopted and how the OIG will put them into practice if adopted.

About the Authors

James A. Robertson is a Partner and head of the health care practice at McElroy, Deutsch, Mulvaney & Carpenter, LLP, with ten offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware, and Colorado. John W. Kaveney and Cecylia K. Hahn are associates in the health care practice of McElroy, Deutsch, Mulvaney & Carpenter, LLP.

Endnotes

1 79 *Fed. Reg.* 26810-26828 (May 9, 2014)
2 42 *U.S.C.* § 1320a-7(a).
3 42 *U.S.C.* § 1320a-7(b).
4 §§6402(d), 6406(c) and 6408(c)
5 79 *Fed. Reg.* 26814
6 79 *Fed. Reg.* 26815
7 42 *U.S.C.* § 1320-7(g)
8 79 *Fed. Reg.* 26823