COSMOS
Navigate the Compliance Universe

Compliance Today - December 2019
Beneficiary inducements: Steering clear of civil monetary penalties

By Brett D. McNeal, JD

Brett D. McNeal (brett.mcnealjd@gmail.com) is Associate General Counsel at Lexington Medical Center in West Columbia, SC.

The U.S. Department of Health and Human Services, Office of Inspector General (OIG) published Advisory Opinion (AO) 19-03.[1] There, the OIG delivered a favorable opinion to a nonprofit medical center that had wanted to send its paramedics to the residences of established patients deemed at risk for admission or readmission and to provide a series of services to them without charge. AO 19-03 is notable because it represents one of the few times—in the advisory context, at least—the department, against a specific factual backdrop, explained its views of the Promote Access to Care Exception, which prevents liability for conduct that would otherwise violate the Civil Monetary Penalty Law's (CMPL) prohibition against giving items of value to patients for the purpose of steering them to a particular provider. OIG's position is that the prohibition is implicated only if the inducement is connected with the selection of a particular provider.[2] (The reader should note the availability of a host of other statutory and regulatory exceptions to liability under the CMPL, including any arrangement deemed permissible under the Anti-Kickback Statute (AKS).[3] Before this AO, there were three others, and all were favorable, yet they had differing rationales. OIG did issue other AOs dealing with the Promote Access to Care Exception, but these were published before the department finalized its regulations.[4] This article will walk through the elements of the exception and use the AOs to highlight the variables that drove OIG's analyses, further defining and clarifying OIG's enforcement philosophy in this space.

Congress passed the CMPL in 1981.[5] By then, reports of healthcare fraud and abuse were opening eyes wider in Congress and state legislatures, and Congress feared that a large swath of it was essentially beyond the reach of law enforcement. Not because existing law did not proscribe such behavior in the first place, but because the enforcement of those laws required action to be taken by the Department of Justice (DOJ). The high volume of cases brought to U.S. attorneys for prosecution results in their being able to prosecute only those involving a significant amount of money or warrant imprisonment, which has proven to be an ineffective deterrent to fraudulent practices under the Medicare and Medicaid programs.[6] This heavy reliance on judicial enforcement unavoidably involved a massive concentration of effort and resources by the government, risk of adverse judgment, and evidentiary considerations, among others. It also meant that conduct the OIG found objectionable may go unaddressed if the DOJ declined to pursue that matter. The net effect was that bad actors could navigate in some safe zones and be free from the concern that they'd be held accountable for that behavior. The CMPL empowered OIG to police that behavior themselves through sanctions, penalties, and program exclusion.

The CMPL's original scope was the submission of fraudulent claims. It authorized the OIG to impose penalties up to $2,000 for every claim a person submitted to Medicare or Medicaid for payment for items or services that they didn't actually provide, or if the items or services were not eligible for payment. Also falling within the prohibition were claims submitted to a state under maternal and child welfare grants pursuant to 42 U.S.C. § 701 et seq. and claims submitted in violation of an agreement the person had with the United States or a state agency.[7] OIG could recoup its investigative costs and repair the damage sustained by the government by levying

assessments equal to two times the amount claimed[8] and exclude providers from federal healthcare programs altogether.[9]