# The OIG Reminds Healthcare Providers of Fraud Risk Factors When Deciding Whether to Exclude a Healthcare Provider or Require a CIA

*By James A. Hoover* November 2018

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With the continued proliferation of qui tam False Claims cases showing no signs of slowing down, not only must providers consider the amount of any monetary settlements, they must also consider whether the Office of Inspector General for the Department of Health & Human Services ("OIG") will require a corporate integrity agreement ("CIA"). The OIG recently published a reminder to all providers of the risk factors it uses when determining whether or not to exclude a provider and/or require a CIA.

As most providers are aware, the False Claims Act ("FCA") is the government's primary civil tool for addressing healthcare fraud. While most FCA cases are resolved through settlements involving monetary payments, the OIG retains the right to determine whether or not to exclude a party and/or require a CIA. Based on the information it gathers in an FCA case, the OIG assesses the future trustworthiness of the settling parties for the purpose of deciding whether to exclude them from the Federal healthcare programs. The OIG applies published criteria to assess future risk and places each party to a FCA settlement into one of five categories on a risk spectrum. OIG uses its exclusion authority differently for parties in each category. OIG bases its assessment on the information OIG has reviewed in the context of the resolved FCA case and does not reflect a comprehensive review of the party.

The OIG has a range of administrative options it can exercise. Depending on the facts and circumstances of the particular case, the OIG will usually pursue one of the following approaches when settling a civil or administrative health care fraud case: (1) exclusion; (2) heightened scrutiny (e.g., implement unilateral monitoring); (3) impose a CIA; (4) take no further action; or (5) in the case of a good faith and cooperative self-disclosure, release 1128(b)(7) exclusion with no integrity obligations.

On April 18, 2016, the OIG published a memorandum titled *Criteria for Implementing Section 1128(b)(7) Exclusion Authority* that sets forth circumstances in which the presumption of exclusion may be rebutted and the non-binding factors the OIG will consider when making a determination whether or not to exclude a defendant. This memorandum describes how the OIG

evaluates risk to the Federal health care programs in using its other available remedies. The memorandum is a useful tool for providers to review and keep in mind when settling any false claims case.

The OIG uses a continuum based on an assessment of future risk to the Federal health care programs by the healthcare provider. The OIG will weigh various factors in its determination of where a person falls on the compliance risk spectrum. In evaluating a person's risk factors, the OIG considers the relevant facts material to each factor to determine how to weigh that risk to the Federal health care programs. For example, some of the factors include: the nature and circumstances of the conduct, the leadership's role in the suspect conduct, the provider's conduct during the investigation, significant ameliorative efforts undertaken by the provider and the provider's history of compliance.

There are two limited circumstances in which the OIG will usually give a person a release of 1128(b)(7) exclusion without requiring a CIA. These are when the person self-discloses the fraudulent conduct cooperatively and in good faith to the OIG or when the person agrees to a CIA and the OIG determines these obligations are sufficient to protect the Federal health care programs.

The April 2016 memorandum is a helpful tool for healthcare providers to help evaluate where their conduct may land on the risk spectrum. This is particularly true if a provider finds itself the subject of a government investigation or FCA lawsuit.

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