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SESSION 1

The OIG's General Compliance Program Guidance:
"Auld Lang Syne"

January 23, 2025

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Speaker Introductions

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Shannon manages PYA's Regulatory Compliance Services and serves as the Firm's Compliance Officer, in addition to serving as Managing Principal of PYA's Nashville office.

A CPA certified in healthcare compliance, she has more than thirty years' experience in healthcare internal auditing and compliance programs. She advises large health systems and legal counsel in strengthening their compliance programs, and aids in areas of Anti-Kickback Statute and Stark Law compliance.

Shannon also assists health systems regarding compliance with Corporate Integrity Agreements and Non-Prosecution Agreements, conducts health system merger/acquisition/divestiture due diligence activities, and advises health system governing boards on their roles and responsibilities for effective compliance oversight.

Shannon has served as the healthcare compliance and internal audit subject-matter expert for the largest federal compliance co-monitorship of a health system in U.S. history, reporting results to the Department of Justice.

Speaker Introductions

Judith A. Waltz
Partner

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Judith A. Waltz, a partner at Foley & Lardner LLP in San Francisco, and who is chair of the Health Care Practice Group, provides ongoing compliance counseling and Medicare/Medicaid coverage and payment advice.

Judy has negotiated several false claims act settlements and corporate integrity agreements, and assisted clients with government (Medicare, Medicaid, Tricare and HRSA) audits, payment suspensions, pre-pay reviews, proposed CMPs, self-disclosures, appeals of billing privileges revocations and other enrollment disputes, CLIA compliance, and other administrative enforcement actions.

Prior to joining Foley, Judy served as assistant regional counsel for the U.S. Department of Health and Human Services (HHS) in San Francisco, where she primarily handled CMS (then HCFA) Medicare issues, including survey and certification disputes. She has been and is currently recognized by Chambers as a Band 1 outstanding health care attorney for California.

Ms. Waltz is a former Chair of AHLA's Regulatory, Accreditation, and Payment (RAP) Practice Group (2018-2021), and vice chair of RAP (2012-2018).

Presentation Overview

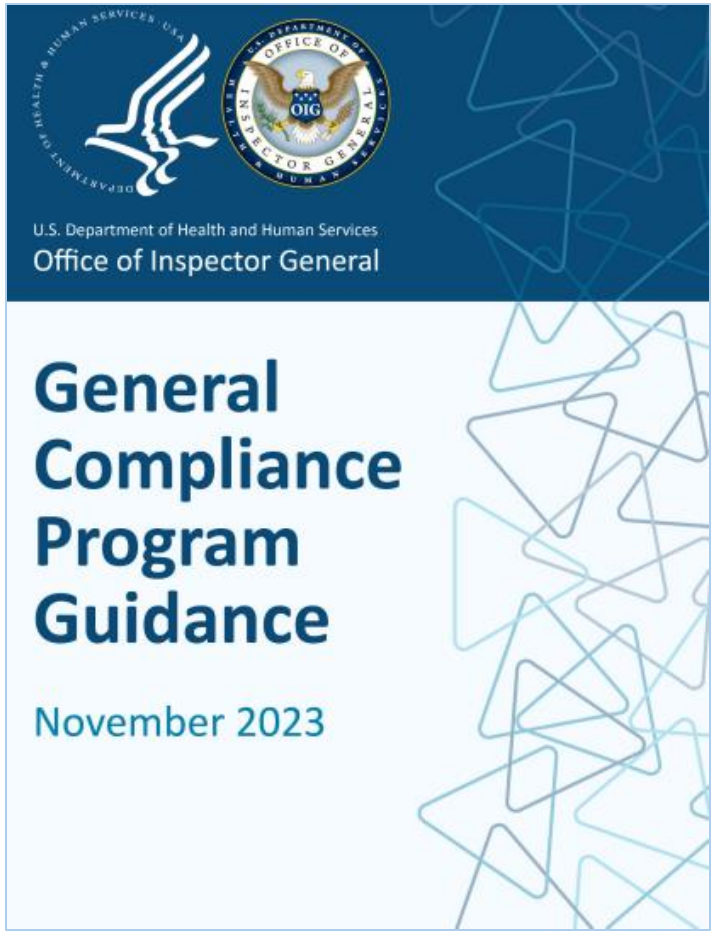
- Today we will cover the following topics:
  - Office of the Inspector General's (OIG) General Compliance Program Guidance (GCPG) implementation best practices identified from serving clients in 2024.
  - Key concepts our various clients are still struggling with and steps they are taking to comply with the GCPG's expectations.
  - An overview of the latest industry segment specific guidance (e.g., Skilled Nursing Facilities).
  - Summary of significant settlements/cases which pressure tested organizations' compliance programs in 2024.

Auld Lang Syne

OIG's GCPG

- Published November 2023

https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf



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Key Insights Noted in the GCPG

Quality	Reporting Relationship	Compliance Committee	Board
↑ Intersection w/Compliance	= CCO should not **be nor report to GC**	↓ Member attendance included in performance and compensation evaluations	= Meet w/CCO at least quarterly, and include executive session ↓ Evaluate risk assessment process ↓ Receive annual reports detailing effectiveness in addressing risks

Key Insights Noted in the GCPG (continued)

Training

- ↑ Ensure method for attendees to question content
- ↑ Participation is condition of continued employment and/or engagement
- ↓ Compliance Committee delivers training to normalize compliance culture

Investigations

- ↑ Compliance Officer involved in all compliance investigations where Counsel takes lead

Incentives for Compliance

- = Additional compensation, significant recognition, or other encouragement – Compliance Officer and Compliance Committee should:
  - Devote time, thought, and creativity re: incentivizing compliance activities
  - Assess whether other incentive plans can be achieved while operating in an ethical and compliant manner (*e.g., sales goals, admission goals, etc.*)

Other Compliance Considerations

Quality & Patient Safety
↑ Quality and patient safety oversight integrated into compliance program
↑ Board requires regular reports from Senior Leadership with quality/patient safety oversight, in conjunction with Compliance Officer reports
↑ Compliance Committee includes members responsible for quality assurance, patient safety and adequacy of patient care
= Compliance Work Plan includes quality audits and reviews
↓ Compliance Committees assess nursing, therapy, and clinical services staffing
↑ Compliance Officers develop productive/collaborative working relationships with Clinical and Quality Leadership for compliance and be informed of internal audits

Other Compliance Considerations (*continued*)

Compliance Risk Assessment	Fraud, Waste, & Abuse (FWA)	Private Equity & Other Private Investors	Payment Incentives & Financial Arrangements
↑ Ensure medical necessity, patient safety, quality issues are included in risk universe	↑ New health care industry entrants and new models of care **require understanding** of applicable FWA laws	↑ "Follow the money." Government bodies carefully scrutinize operations and incentive structures, especially investors providing management services	= Clear understanding of all incentives within all entities • Fee-for-Service (*overutilization*) • Capitation (*stinting on care*) • Quality of care (*gaming of data*) = Ongoing monitoring of referral source financial arrangements

GCPG Implementation Best Practices 2024

1. Greater awareness by Governance regarding appropriate reporting relationships (e.g., report directly to the CEO with independent access/reporting to the board directly and NOT reporting to Legal).
2. Greater *demonstrated* engagement by the Compliance Committee(s) – Board level and entity level.
3. Active engagement by the Compliance Committee in overseeing/participating in the risk assessment process.
4. Various multi-disciplinary committees with active Compliance involvement – ERM, Quality, Root Cause Analysis, Data Governance, Artificial Intelligence, Change Management.
5. Vendor/Third-Party Risk Assessment and Mitigation awareness has increased.
6. Governance (Board/Board Subcommittee) greater awareness of compliance program oversight and accountability.
7. Creative compliance training curriculums and delivery mechanisms.
8. Key compliance controls inventory by department.

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OIG's Nursing Facility Industry Segment-Specific Compliance Program Guidance (NF ICPG)

November 2024

OIG's Industry Specific Compliance Program Guidance: Nursing Facility *(Nov. 2024)*

- First in an expected series of guidance addressed to specific sectors
  - Expected to be addressed to Managed Care plans
- Applies to:

SNF (Soc. Sec. § 1819)

NF (Soc. Sec. § 1919)

Dually-certified facility

Single facilities

Chains

Managing and operating companies

Entities that own nursing facilities

OIG's NF ICPG: Nursing Facility

- November 2024
- First in an expected series of guidance addressed to specific sectors.
  - Next one expected to be addressed to Managed Care plans.
- Applies to a SNF (Soc. Sec. § 1819), a NF (Soc. Sec. § 1919), and a dually-certified facility; applies to single facilities, chains, managing and operating companies, and entities that own nursing facilities.

OIG's NF ICPG: Nursing Facility (*continued*)

- Centers for Medicare and Medicaid Services' (CMS) Requirements of Participation (ROPs) already include a requirement for a compliance and ethics program. OIG emphasizes that compliance with the NF ICPG is voluntary; compliance with the ROPs is mandatory. NF ICPG is intended to be complementary of ROPs.
- Quality of care and quality of life:
  - Quality as a Compliance concern
    - "*[C]ompliance leadership should be working closely with clinical leadership to consider resident care and safety-related concerns as part od a compliance program's oversight responsibility*."
    - Compliance staff should coordinate with quality staff in assessing the effectiveness, reliability, and thoroughness of internal quality control systems in place to promote high quality of care and resident safety.

Current Quality of Care Corporate Integrity Agreements (CIA)

Corporate Integrity Agreement	Related
Providence Health & Services-Washington	Press Release
Universal Health Services, Inc. and UHS of Delaware, Inc.	Press Release
Vanguard Healthcare, LLC, Vanguard Healthcare Services, LLC, Vanguard Financial, LLC, Boulevard Terrace, LLC, Vanguard of Crestview, LLC, Glen Oaks, LLC, Imperial Gardens Health and Rehabilitation, LLC, Vanguard of Memphis, LLC, Vanguard of Manchester, LLC, Elderscript Services, LLC, William Orand, and Mark Miller	N/A
Memphis Operator LLC dba Spring Gate Rehabilitation and Healthcare Center	Press Release
Health Services Management	N/A

https://www.oig.hhs.gov/compliance/corporate-integrity-agreements/quality-of-care.asp

NF ICPG – Common Risk Areas

- **Staffing shortages:** If staffing so low that it leads to grossly substandard care and poor clinical outcomes, the Government may prioritize an enforcement action.
- **Appropriate resident care plans and resident activities:** OIG says it has seen care plans that did not reflect ROPs or resident needs and that services were often not provided in accordance with the care plans.
- **Resident activities:** Provide adequate staff; necessary resources for a program that consistently appeals to residents; activity director who has authority and discretion to develop and implement a rotating schedule of stimulating and creative activities for residents; and explore options for appropriate, person-centered activities.

NF ICPG – Common Risk Areas (*continued*)

- **Changing demographics of NF population:** Develop an assessment process and before admission evaluate the needs of the prospective resident and the services of the facility.
- **Medication management:** Training for facility's consultant pharmacist; review and root cause analysis of medication errors
- **Appropriate use of medications:** Concern as to whether chemical restraints are being employed; concern that NFs may be mis-reporting schizophrenia on the Minimum Data Set to inappropriately impact CMS quality measure on antipsychotic use:
  - Concern with potential conflicts of interest with consultant pharmacists and long-term care pharmacies and possibility of Anti-Kickback Statute (AKS) issues.

NF ICPG – Common Risk Areas (*continued*)

- **Resident Safety:** OIG recommends continual monitoring of adverse events and quality of care issues should help prevent incidents.
- **Staff screening:** If facility submits claim for excluded provider items or services, payment is an overpayment; recommends monthly screening.
- **Emergency Preparedness and Life Safety:** Refers (links) reader to OIG Resources for Emergency Preparedness and Response website.
- **Infection Control:** Should be a priority given increased susceptibility and exposure to infection
- **Facility-Initiated Discharges:** Suggestion that NFs should not be taking patients if they do not have capacity to provide safe and effective care that addresses disorders and behaviors.

NF ICPG – Risk Areas and Most Relevant Safe Harbors

The following safe harbors are most relevant to nursing facilities:

- Investment interests (42 C.F.R. § 1001.952(a))
- Space rental (42 C.F.R. § 1001.952(b))
- Equipment rental (42 C.F.R. § 1001.952(c))
- Personal services and management contracts and outcomes-based payment arrangements (42 C.F.R. § 1001.952(d))
- Discounts (42 C.F.R. § 1001.952(h))
- Employees (42 C.F.R. § 1001.952(i))
- Managed care and risk-sharing arrangements (42 C.F.R. §§ 1001.952(m), (t), and (u))
- Electronic health records items and services (42 C.F.R. § 1001.952(y))
- Local transportation (42 C.F.R. § 1001.952(bb))
- Care coordination and value-based arrangements (42 C.F.R. § 1001.952(ee), (ff), and (gg))
- Arrangements for patient engagement and support to improve quality, health outcomes, and efficiency (42 C.F.R. § 1001.952(hh))
- CMS-sponsored model arrangements and CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii))
- Cybersecurity technology and related services (42 C.F.R. § 1001.952(jj))

https://oig.hhs.gov/compliance/nursing-facility-icpg/

NF ICPG (p. 45) – “Tunneling” Risk

OIG is concerned that nursing facility owners, operators, and private investors participating in related-party transactions may be engaging in “tunneling”—the practice of misrepresenting or hiding profitability by overstating payments for operational expenses that are funneled to related parties.[71] Tunneling in the nursing facility industry typically appears in: (1) real estate transactions when a nursing facility sells its building and land to a commonly owned company or real estate investment trust and then leases the property back at higher than fair market rates; and (2) arrangements for the outsourcing of administrative or management services with commonly owned companies under which the nursing facility pays higher than fair market rates for those services.[72] This conduct has broad implications for Federal health care programs and enrollees if funds from related-party transactions are used to unjustly profit and enrich nursing facility owners, operators, and investors while allocations for resident care decrease.

https://oig.hhs.gov/compliance/nursing-facility-icpg/

NF ICPG (p. 50) – Focus on Investors

The inclusion of investors in the term "Responsible Individuals" is of paramount importance.

Also, OIG recommends that governing bodies, their members, owners, investors, operators, and executive leadership (Responsible Individuals) demonstrate their commitment to this corporate-level compliance and quality function as described more fully in this section. **The inclusion of investors in the term "Responsible Individuals" is of paramount importance.** OIG recommends that investors—and all Responsible Individuals—maintain as much of a focus on compliance, quality, and safety performance as on financial and profit indicators.

https://oig.hhs.gov/compliance/nursing-facility-icpg/

NF ICPG (p. 50) – Focus on Investors (*continued*)

As a result of OIG's enforcement work and monitoring of Quality of Care CIAs, we believe investors in the nursing facility sector should be actively questioning whether the operating and management companies in their investment portfolios are: (1) complying with Federal health care program requirements and fraud and abuse laws; (2) dedicating the necessary resources to the organization's compliance and quality programs; (3) providing high quality care; and (4) creating a safe and comfortable living environment for all residents. Studies have shown that nursing facilities owned by private equity companies, real estate investment trusts, or other for-profit investment firms had significantly reduced staffing and lower quality ratings.[84]

https://oig.hhs.gov/compliance/nursing-facility-icpg/

NF ICPG Supplement: Reimbursement Overview

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Compliance Focus

Miscellaneous

State Exclusion Checking

- **Federal regulations, 42 C.F.R. § 1003.200(b)(4)**
  - Reflect a civil monetary penalty (CMP) for arranging or contracting (by employment or otherwise) with an individual or entity that the person knows, or should know, is excluded from participation in the federal health care programs (including Medicare and Medicaid).
  - The current amount of the CMP is $24,164.

State Exclusion Checking (*continued*)

- **State-specific laws and lists** are specific to that state's federal health care programs:
  - There may be state-specific CMPs for submitting claims to the state Medicaid program for items or services furnished by an excluded person or entity and/or a penalty for contracting with an excluded person or entity.
  - The state laws and exclusion lists should be checked for each state where items or services are provided, the entity is enrolled in Medicaid, and/or Medicaid claims are submitted (including as an out-of-state provider).

State Exclusion Checking (*continued*)

- **Medicare Advantage (MA) and Part D**
  - CMS provides a "Preclusion List" to MA plans and Part D plans that precludes payments to individuals or entities included on the list.
  - A preclusion is not the same as an exclusion imposed by the OIG or a termination by a particular state:
    - Moreover, only the MA and Part D plans have access to the preclusion list (meaning that providers and suppliers are not expected to check it).
    - The preclusion list is not applicable to Medicaid.
    - See generally, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Preclusion_List_FAQs.pdf

Collateral Terminations Based on State Exclusions

- **The Affordable Care Act, Section 6501**
  - Amended Social Security Act section 1902(a)(39) to set up a requirement that states shall terminate the individual or entity's Medicaid enrollment when that individual or entity has "for cause" lost their enrollment in another state (in accordance with guidance from CMS as to what that means)
  - See also: 42 C.F.R. § 445.416 ("Must deny enrollment or terminate the enrollment")

Collateral Terminations Based on State Exclusions (*continued*)

- Until such time as the other state(s) take an action to do so, the individual or entity's enrollment in that state remains in place.
- OIG has noted challenges in implementation of section 1902(a)(39)'s collateral termination provision, including confusion as to when a state is obligated to take action.
  - See e.g., OEI-06-12-00030 (Aug. 2015).

Collateral Terminations Based on State Exclusions (*continued*)

- 1902(kk)(6) Reporting of adverse provider actions:
  - The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of CMS, in accordance with regulations of the Secretary.

Administrative False Claims Act

- **Signed by Biden 12/23/2024**
  - 31 U.S.C. §§ 3801-3803, https://uscode.house.gov/
  - Pub. L. 118-159 (Nat. Defense Authorization Act) https://www.govtrack.us/congress/bills/118/hr5009/text
  - Sec. 5203. Administrative False Claims Act of 2023

- **Key change:**
  - Increases limit to $1 million from $150,000 damages
  - Authority delegated to executive agencies (amongst others – see sec. 3801)
  - $5000 CMP per claim in addition to assessment of 2x/claim

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Significant Cases

- *Loper Bright*
- *Jarkesy*
- *Corner Post*

Loper Bright – Recap

- Two fishing companies appealed D.C. Circuit's ruling applying Chevron deference requiring fishermen to pay for the use of compliance monitors on certain fishing boats.
  - Broader challenge to Chevron, arguing it leads to excessive deference to federal agencies, overregulation, abdication of judicial responsibility, and the unwarranted imposition of regulatory enforcement costs.
  - What was "Chevron Deference"?
    - Established in 1984 by the Supreme Court
    - When a "*statute is silent or ambiguous with respect to the specific issue" raised regarding a statute that the agency administers, "the question for the court is whether the agency's answer is based on a permissible construction of the statute*."

Loper Bright – Decision and Guardrails

- **The decision:**
  - Court majority firmly rejected Chevron Deference
  - Administrative Procedure Act (APA) requires courts to exercise their independent judgment in deciding legal questions that arise in reviewing agency action
  - "…*[C]ourts need not and under the APA may not defer to an agency interpretation of the law simply because a statute is ambiguous*."

  - Importantly, however, *Loper Bright* noted that deference may still be afforded agencies in certain instances.
    - First, the Court observed that the APA expressly mandates a deferential standard of review for agency policy-making and fact-finding.
    - Second, *Loper Bright* explained that some statutes are best read to delegate discretionary authority to an agency, in which case a court's role is to merely ensure the agency "*engaged in 'reasoned decision making'" within that authority*.
    - Lastly, *Loper Bright* reaffirmed that an agency's "expertise" remains "one of the factors" that may make an agency's interpretation persuasive.

Loper Bright – Implications

- More legal challenges against HHS's regulations as they are issued.
  - *Loper Bright* expressly stated that it "does not call into question prior cases that relied on the *Chevron* framework," so prior decisions affirming regulations should be stable.
  - Going forward: courts have no "thumb on the scale" in favor of HHS's legal positions, and so litigants may view *Loper Bright* as increasing their odds of success.
  - More uncertainty for providers and suppliers who must determine how to comply with new regulations under challenge and pending, sometimes in multiple courts.

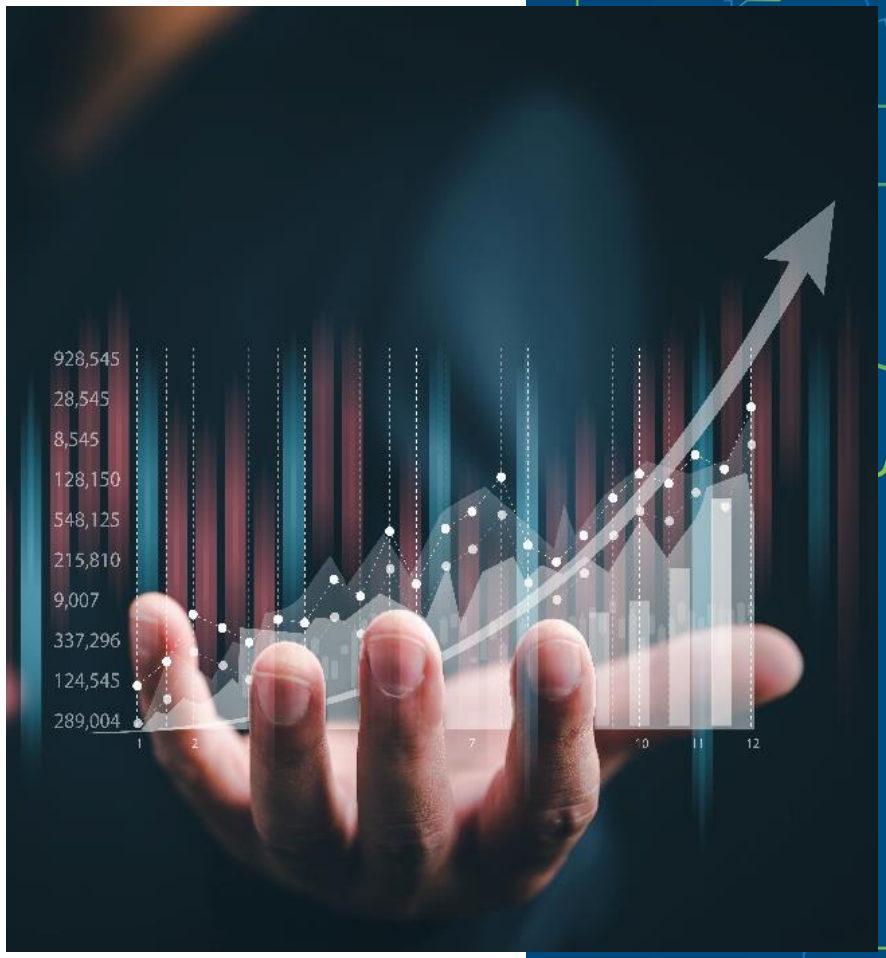
- Inconsistent decisions by courts:
  - Because *Loper Bright* directs courts to exercise independent judgment rather than defer to HHS's interpretations, we expect that courts in different areas of the country may reach differing conclusions regarding HHS regulations.
  - This may make certain geographic locations more advantageous for provider and supplier operations or expansions.

Securities and Exchange Commission v. Jarkesy, et al. – Recap

- After the 2010, the U.S. Securities and Exchange Commission (SEC) could obtain civil penalties against unregistered entities based upon agency proceedings rather than requiring federal court process.
- The SEC brought an enforcement action in 2013 against George Jarkesy, Jr. and Patriot28, LLC, alleging misrepresentation of investment strategies, lying about the identify of the funds' auditor and prime broker, and inflating the funds' [alleged] value to collect larger fees.
- The SEC brought an administrative proceeding before an Administrative Law Judge (ALJ) (not a jury trial in federal court), and the ALJ ordered civil monetary penalties against both parties.
- The parties petitioned for judicial review; the 5th Circuit vacated the final ALJ order, holding that the administrative action violated the U.S. Constitution's Seventh Amendment right to a jury trial. The 5th Circuit denied a request for rehearing en banc, and the Supreme Court granted cert.
- The Question for the Court: Can the SEC be permitted under the Seventh Amendment to force parties to be tried before the agency rather than a jury in federal court?

Jarkesy – Decision

- **The Supreme Court's decision:**
  - SEC's antifraud provisions replicate common law fraud, which must be heard by a jury, because the available civil penalties are punitive rather than restorative or compensatory.
  - Art. III jurisdiction allows Congress to assign certain matters to administrative agencies for adjudication in lieu of a jury trial; the SEC process did not fall into any of the distinct areas of exception and in light of the Seventh Amendment, Congress would be disallowed from removing them from constitutionally mandated judicial procedures.
  - The conclusion: the Seventh Amendment applies, and Jarkesy et al. were entitled to a jury trial.



Jarkesy – Implications

- HHS relies heavily upon CMPs for enforcement actions.
  - CMS has been delegated the responsibility for implementing CMPs that involve program compliance.
  - The OIG has been delegated the responsibility for implementing CMPs that involve threats to the integrity of the Medicare or Medicaid programs (i.e., those that involve fraud or false representations).
- See chart/table for listing of CMPs for all components of HHS (including but not limited to OIG and HHS) and current penalty amounts: 45 C.F.R. § 102.3.
  - Note that there are several statutory bases creating specific CMPs.
  - Any challenge under Jarkesy will require separate analysis.

Jarkesy – Implications (*continued*)

- **OIG:** More than 40 CMP authorities including:
  - False or fraudulent claims
  - Kickbacks
  - Beneficiary inducement
  - Employing or contracting with excluded person
  - Ownership, control, or management while excluded
  - Ordering or prescribing while excluded
  - Knowing false statement on application, bid or contract to participate or enroll
  - Knowing retention of overpayment
  - Grant or contract fraud

- **CMS:** 34 authorities listed in the Medicare Program Integrity Manual, Chap. 4. Sec. 4.11.5.1 (may be an incomplete list), including:
  - Violations of the assignment agreement
  - New CMPs for Covid-19 related conduct for nursing facilities and laboratories

Corner Post v. Board of Governors of the Federal Reserve System – Recap

- Debit card transactions require merchants to pay an “interchange fee” to the bank that issued the card.
- In 2011 Congress the Federal Reserve Board promulgated regulations setting a maximum interchange fee of $0.21 per transaction plus .05% of the transaction’s value.
- In 2021, Corner Post (a convenience store that opened in 2018) joined a suit brought against the Board under the APA.
  - The complaint challenged the regulation on the ground that it allows higher interchange fees than the statute permits.

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Corner Post v. Board of Governors of the Federal Reserve System – Recap (*continued*)

- **28 U.S.C. § 2401(a):** "*every civil action commenced against the United States shall be barred unless the complaint is filed within six years after the right of action first accrues*."
  - District Court dismissed the suit as time barred under 28 U.S.C. § 2401(a).
  - The Eighth Circuit affirmed.
  - The Supreme Court reversed and held that an APA claim does not accrue [start] for purposes of 28 U.S.C. § 2401(a)'s default 6-year statute of limitations until the plaintiff is injured by final agency action, not when the agency action became final under the APA.
- **<u>Note</u>: some provisions specific to HHS actions may limit impact of Corner Post.**

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Recent Settlements with Compliance Implications

- The Radiology Group/CEO
- CRMC/ Chesapeake Regional Hospital
- Linh Cao Nguyen, M.D.
- McKinsey & Company (Purdue Pharma)
- Coordinated Care Health Solutions, LLC
- UT Health Science Center at Houston

Settlement: The Radiology Group/CEO

- **U.S. Department of Justice press release March 28, 2024**
  - Atlanta, Georgia teleradiology company that provides diagnostic radiology services to hospitals, urgent care centers, and primary care physician centers located across the country.
  - Settlement resolves claims that The Radiology Group and Lalaji violated the False Claims Act by fraudulently billing federal health care programs when the U.S.-based radiologist just “rubber stamped” interpretation reports prepared by contractors in India, who were not permitted to practice medicine in the United States or bill federal health care programs.
  - Government further alleges misrepresentation re: who actually rendered the radiology services when seeking payments and improperly sought reimbursement for services furnished entirely by persons located outside of the United States in violation of applicable statutes and regulations.
  - Settlement $3.1 million, included “extensive factual admissions regarding their conduct”

https://www.justice.gov/usao-sdny/pr/us-attorney-announces-31-million-false-claims-act-settlement-radiology-company-and-its

CRMC Indictment: Hospital Indicted for Health Care Fraud Involving Unnecessary Surgical Procedures and Initial Public Offering (IPO) Rule

- **DOJ press release January 8, 2025**
  - As alleged in the indictment, CRMC, formerly known as Chesapeake Regional Hospital, granted privileges to Javaid Perwaiz from 1984 until his arrest in 2019, despite knowing that Perwaiz' privileges had been terminated at another hospital for performing unnecessary surgeries and that he was convicted of two federal felonies in 1996.
  - From 2010 to 2019, CRMC allegedly received approximately $18.5 million in reimbursements from health care benefit programs for surgical and obstetric procedures Perwaiz performed at the facility.

CRMC Indictment: Hospital Indicted for Health Care Fraud Involving Unnecessary Surgical Procedures and IPO Rule (*continued*)

- CRMC also allegedly defrauded Medicare, Medicaid, TRICARE, Anthem, Optima, Humana, Cigna, Aetna, United, and others to obtain reimbursements for obstetric deliveries that were elective inductions for no medical reason before 39 weeks of gestation, contrary to medical necessity and the standard of care.
- CRMC allegedly submitted such reimbursements itself, and aided and abetted Perwaiz to do the same.
- The indictment alleges CRMC knew that Perwaiz routinely and knowingly misclassified inpatient only surgeries as outpatient procedures but allowed him to continue performing these surgeries. CRMC also allegedly knew that certain health care benefit programs would not reimburse a hospital for an inpatient procedure performed on an outpatient basis, that the majority of private health care benefit programs reimbursed such procedures at a significantly lower rate, and that inpatient surgeries required an increased level of scrutiny.

https://www.justice.gov/usao-edva/pr/chesapeake-hospital-indicted-healthcare-fraud-involving-unnecessary-surgical

Sentencing: “Incident to” Services

- **DOJ press release October 24, 2024**
  - The fraudulent claims identified a medical doctor as the treating provider when, in fact, another provider such as a nurse practitioner, social worker, unlicensed psychology intern, or wound care nurse provided the service independently.
  - By billing the medical service as if it were provided by a physician, Nguyen falsely inflated the amount his company was to be paid for the service.
  - The total loss to the insurance companies from Nguyen’s scheme was approximately $3.7 million.
  - As part of his sentence, Nguyen was ordered to pay over $1.1 million in restitution to the private insurance companies.
  - Nguyen also was required to pay over $2.5 million to the government in a separate civil agreement.

https://www.justice.gov/usao-az/pr/arizona-doctor-sentenced-prison-health-care-fraud

Guilty Plea: Personal Accountability for Senior Partner of Consultant (Obstruction of Justice)

- **DOJ press release January 10, 2025**
  - A former senior partner at McKinsey & Company, a global management consulting firm based in New York, N.Y., that last month agreed to pay $650 million to resolve criminal and civil investigations into the firm's consulting work with opioids manufacturers, including Purdue Pharma, L.P., pled guilty today to obstructing justice related to his work on Purdue matters.

https://www.justice.gov/usao-wdva/pr/former-senior-partner-mckinsey-company-pleads-guilty

FCA Complaint: Personal Accountability
Lab Director Named as Defendant

- **DOJ press release December 4, 2024**
  - Complaint alleges:
    - Coordinated Care Health Solutions (CCHS) purports to perform lab testing services ordered by third-party practitioners.
    - Wallis was employed by CCHS as its laboratory director, a management official who directed operations, supervised the laboratory employees, including HS billing supervisor.
    - November 2018 through 2021, disguised non-reimbursable urine drug tests as blood tests to by-pass Oklahoma Medicaid's prior authorization requirement.
    - CCHS submitted, and Wallis caused the submission of, claims for payment to Oklahoma Medicaid misrepresenting services performed, including services not rendered.
    - Tests not ordered, ordered/billed through impermissible blanket directives, and/or not medically reasonable and necessary.

https://www.justice.gov/usao-wdok/pr/united-states-and-state-oklahoma-file-false-claims-act-complaint-against-okc

OIG Self-Disclosure CMP:
Incorrect Rendering Provider or Not Meeting Coverage Criteria

- **October 23, 2024**
  - After it self-disclosed conduct to OIG, The University of Texas Health Science Center at Houston (UT), Texas, agreed to pay $48,634.47 for allegedly violating the Civil Monetary Penalties Law.
  - OIG alleged that UT submitted claims for services:
    - As if they were personally performed by a UT physician practitioner when the practitioner was in fact, away on paid time off; and
    - Performed by the practitioner that otherwise did not meet Medicare and Medicaid criteria or conditions of payment.

https://oig.hhs.gov/fraud/enforcement/university-of-texas-health-science-center-at-houston-agreed-to-pay-48000-for-allegedly-violating-the-civil-monetary-penalties-law-by-submitting-claims-that-identified-the-incorrect-rendering-provider-or-did-not-meet-coverage-criteria/

Questions?

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