Federal Health Care Program Exclusion Lists and the Employee Screening Process

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Introduction

Which termination or exclusion lists are health care providers required to check when hiring new employees or contractors? The United States Department of Health and Human Services Office of Inspector General (HHS-OIG) and the Centers for Medicare & Medicaid Services (CMS) each have lists. Like the vast majority of states, New York State has its own Medicaid Exclusion List, which is administered by the New York State Office of the Medicaid Inspector General (OMIG). This article is intended to provide some background on federal health care program exclusion lists suggesting a contractor/employee screening process for health care providers.

OIG's Exclusion Authority and a Brief Legislative History of Exclusion From Federal Health Care Programs

The HHS-OIG was established to "identify and eliminate fraud, waste, and abuse" in HHS programs and to "promote efficiency and economy" in HHS operations.[1] The HHS Secretary has delegated authority to OIG to "exclude from participation in Medicare, Medicaid, and other federal health care programs[2] persons that have engaged in fraud or abuse and to impose civil money penalties (CMPs) for certain misconduct related to federal health care programs."[3]

The 1977 Medicare-Medicaid Anti-Fraud and Abuse Amendments, codified at Section 1128 of the Social Security Act ("Act"), first provided for exclusions from Medicaid and Medicare of physicians and practitioners convicted of certain crimes.[4] Then, in 1981, the Civil Monetary Penalties (CMP) Law, codified at Section 1128A of the Act, imposed civil liability—including monetary penalties, assessments and exclusion from federal health care programs—for health care fraud and abuse.[5] Subsequent legislation further strengthened OIG's sanction authority—introducing, for instance, mandatory and discretionary exclusions for certain misconduct,[6] and expanding the scope of exclusion beyond Medicare and Medicaid to all federal health care programs.[7]

Section 1128 of the Act mandates the exclusion of physicians and health care practitioners from federal health care programs for convictions relating to patient abuse, felony health care fraud, felony controlled substance and program-related crimes.[8] Permissive exclusions, whereby OIG *may* exclude physicians and health care practitioners from federal health care programs, include convictions for misdemeanor fraud, obstruction of an investigation or audit, misdemeanor distribution of a controlled substance, exclusion from a state Medicaid program, and default on health and education loan or scholarship obligations, among other things.[9]

Submission of a claim for payment for services rendered by an excluded person to a federal health care program, or causing such a claim to be submitted, is subject to criminal prosecution and/or CMP liability of up to $20,000, an assessment for up to three times the amount of the claim, and denial of future participation in federal health care programs.[10]

The Effects of Exclusion

Federal health care program exclusion has wide-ranging implications for the various parties in the health care services chain. Most directly, no payment shall be made by a federal health care program for any item or service furnished by an excluded individual or entity.[11] The prohibition on payment applies regardless of the type, "whether from itemized claims, cost reports, fee schedules, capitated payments, a prospective payment system or other bundled payment, or other payment system."[12] For instance, "no payment may be made to a hospital for the items or services furnished by an excluded nurse to federal health care program beneficiaries, even if the nurse's services are not separately billed and are paid for as part of a Medicare diagnosis-related group payment received by the hospital."[13] Such nurse would be in violation of his or her exclusion for causing claims to be submitted to federal health care programs while he or she was excluded.[14]

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Additionally, no payment shall be made for any item or service furnished *at the direction or on the prescription* of an individual who is excluded when the person furnishing such item or service knew, or had reason to know, of the exclusion.[15] Thus, to avoid liability, providers that furnish items and services on the basis of orders or prescriptions, such as laboratories, imaging centers, durable medical equipment suppliers and pharmacies, "should ensure, at the point of service, that the ordering or prescribing physician is not excluded."[16]

Further, under Section 1128A of the Act, providers that employ or contract with excluded persons to provide items or services payable by federal health care programs may be subject to CMPs.[17]

> If a health care provider arranges or contracts (by employment or otherwise) with a person that the provider knows or should know is excluded . . . the provider may be subject to CMP liability if the excluded person provides services payable, directly or indirectly, by a Federal health care program.[18]

Notwithstanding this strict prohibition, a provider may employ or contract with an excluded person in limited situations.[19] For example, if federal health care programs do not pay, directly or indirectly, for the items or services being provided by the excluded individual, then a provider that participates in federal health care programs may employ or contract with an excluded person to provide such items or services.[20]

Thus, because providers may be subject to liability for partnering with excluded individuals, all persons that provide items or services payable under federal health care programs should be screened by providers, including employees, contractors, subcontractors and the employees of contractors.[21] "For example, OIG recommends that providers screen nurses provided by staffing agencies, physician groups that contract with hospitals to provide emergency room coverage, and billing or coding contractors."[22]

OIG's List of Excluded Individuals/Entities

In order to avoid potential liability, OIG urges health care providers and entities to check the OIG List of Excluded Individuals/Entities (LEIE) prior to hiring or contracting with individuals or entities.[23] The LEIE includes:

1. The name of the excluded person at the time of the exclusion;
2. The person's provider type;
3. The authority under which the person was excluded;
4. The state where the excluded individual resided at the time of exclusion, or the state where the entity was doing business; and
5. National Provider Identifier (NPI).[24]

The LEIE is updated monthly, and OIG recommends that providers screen individuals prior to hiring or contracting, and then regularly afterwards, to ensure compliance.[25]

OIG recommends that providers use the LEIE as the primary source of information about OIG exclusions because it is maintained by OIG; updated monthly; and provides important details, including the statutory basis for the exclusion action, the person's occupation at the time of exclusion, the person's date of birth and address information.[26] Also, OIG staff are able to provide support with respect to the LEIE, such as responding to questions and verifying information regarding persons identified on the LEIE.[27]

It is also important for providers to consult the lists published by the state Medicaid programs to which the providers submit claims for items or services that are paid for by that state's Medicaid program, in addition to the LEIE. The various state agencies administering or supervising the administration of state health care programs ("State Agencies") may prosecute and sanction providers on their own initiative when state law authorizes them to do so.[28] They may also extend exclusions beyond the time periods imposed by OIG.[29] The regulations governing state–initiated exclusions from Medicaid are clear that "the provisions of these regulations are minimum requirements.[30] Even when OIG exercises its permissive exclusion authority based on a state Medicaid program exclusion, there may be some delay between the effective date of the state Medicaid program exclusion and an exclusion by the OIG, and the posting of the exclusion to the LEIE.[31]

State Agency Termination Reporting Under the Patient Protection and Affordable Care Act

Section 6501 of the Patient Protection and Affordable Care Act (ACA) amended Section 1902(a)(39) of the Act to require *State Agencies* to terminate the Medicaid participation of any individual or entity that is terminated under Medicare or any other state plan, where such termination is included by the HHS Secretary in a database or similar system.[32] Terminations have the same effect as an exclusion, as no federal health care program payments can be paid for services provided by a terminated individual.[33]

The ACA requires that CMS establish a process for sharing information about terminated providers.[34] To meet this requirement, CMS developed a web-based application called the Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS). States were intended to download information regarding terminated providers in other states and to upload infor-

mation regarding their own terminations.[35] State Agencies were encouraged by CMS to report provider terminations to populate MCSIS, but were not mandated.[36]

In 2012, CMS issued guidance emphasizing that it is only interested in being notified of "for cause" terminations, which constitute instances when "a State Medicaid program, [Children's Health Insurance Program (CHIP)], or the Medicare program has taken action to revoke a Medicaid or CHIP provider's or Medicare provider or supplier's billing privileges and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired."[37] As a rule, "for cause" does not include "any voluntary action taken by the provider to end its participation in the Medicaid program, except where that 'voluntary' action is taken to avoid sanction."[38]

According to CMS, examples of "for cause" terminations include:

1. Providers that are terminated by State Medicaid Agencies because they have engaged in fraudulent conduct;
2. Providers that are terminated by State Medicaid Agencies due to abuse of billing privileges, e.g., billing for services not rendered or for medically unnecessary services;
3. Providers that are terminated by State Medicaid Agencies due to misuse of their billing number;
4. Providers that are terminated by State Medicaid Agencies due to falsification of information on enrollment application or information submitted to maintain enrollment; and
5. Providers that are terminated by State Medicaid Agencies due to continued billing after the suspension or revocation of the provider's medical license.[39]

Despite CMS's attempts to maintain a database of Medicaid terminations to help State Agencies comply with Section 1902(a)(39) of the Act, MCSIS was rife with problems, and OIG was critical of CMS's efforts. In March 2014, OIG published *CMS's Process for Sharing Information About Terminated Providers Needs Improvement*, which found that MCSIS had no records for 27 State Agencies; only about one-third of the 6,439 records in MCSIS related to providers terminated "for cause"; over half of MCSIS records did not contain NPIs; and only one-third of MCSIS records identified provider types.[40] OIG recommended that CMS "(1) require each State Medicaid agency to report all terminated providers, (2) ensure that the shared information contains only records that meet CMS's criteria for inclusion, and (3) take action to improve the completeness of records shared through the process."[41]

CMS took the advice and "implemented procedures intended to improve the completeness of the records, such as requiring States to submit a copy of the Medicaid termination letter issued to the provider as well as

information such as the provider's NPI or SSN."[42] It also began reviewing each termination to assure that it meets CMS criteria for inclusion in the Termination Notification database.[43]

Still, in August 2015, OIG released a report entitled *Providers Terminated From One State Medicaid Program Continued Participating in Other States*, which found that, among other things, 12% of providers who were terminated for cause from State Medicaid programs in 2011 continued participating in Medicaid in other states.[44] OIG recommended that CMS "(1) work with States to develop uniform terminology to clearly denote terminations for cause, (2) require that State Medicaid programs enroll all providers participating in Medicaid managed care, and (3) furnish guidance to State agencies that termination is not contingent on the provider's active licensure status."[45]

In response to the draft OIG report, *CMS System for Sharing Information About Terminated Providers Needs Improvement*, CMS responded that it had phased out MCSIS and transitioned to the One Program Integrity (OnePI) portal on November 25, 2013.[46] Still in use today,[47] OnePI allows for state-to-state information on terminated providers to be securely shared by CMS, state Medicaid, and CHIP staff.[48] OnePI allows State Agencies to view and download Medicare revocations, previous MCSIS data, and state Medicaid terminations.[49]

Conclusion

When hiring employees or contractors to provide services that are payable by a federal health care program, New York health care providers should screen employees and contractors using OIG's LEIE database, the Medicaid Exclusion List (MEL) administered by OMIG, and the lists published by any other state Medicaid programs to which provider submits claims. Section 1902(a)(39) of the Act requires State Agencies, not providers, to terminate the participation of any individual or entity that is terminated under Medicare or any other state plan, where such termination is included by the HHS Secretary in a database or similar system. Thus, OMIG bears the responsibility for utilizing available CMS resources, such as OnePI, to populate the MEL with individuals and entities that have been excluded under other states' plans. Reviewing other states' databases may result in over-exclusion, as other states may report terminations or exclusions beyond the scope of what is required under New York State or federal law.

Endnotes

1. OIG, Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, 1 (May 8, 2013), https://oig.hhs.gov/exclusions/files/sab-05092013.pdf.
2. *See* OIG, *supra* note 1, at 2, n.1 ("A Federal health care program is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, and that is funded directly, in whole or in part, by the U.S. Government or a State health care program (except for the Federal Employees Health Benefits Program) (section 1128B(f) of the Social Security Act (the Act)). Among the most significant Federal health care programs are Medicare, Medicaid, TRICARE, and the veterans' programs.").
3. OIG, *supra* note 1, at 1.
4. OIG, *supra* note 1, at 4; 42 U.S.C. § 1320a-7.
5. OIG, *supra* note 1, at 4; 42 U.S.C. § 1320a-7a.
6. *See, e.g.*, Medicare and Medicaid Patient Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 680; Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066; Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010 (ACA), Pub. L. No. 111-152, 124 Stat. 1029; *see also* OIG, *supra* note 1, at 5.
7. *See, e.g.*, Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996); Balanced Budget Act (BBA) of 1997, Pub. L. No. 105-33, 111 Stat. 251; *see also* OIG, *supra* note 1, at 5.
8. 42 U.S.C. § 1320a-7(a).
9. 42 U.S.C. § 1320a-7(b); *see, e.g.*, OIG, Criteria for Implementing Section 1128(b)(7) Exclusion Authority (Apr. 18, 2016), https://oig.hhs.gov/exclusions/files/1128b7exclusion-criteria.pdf; 42 C.F.R. § 1001.601.
10. OIG, *supra* note 1, at 9.
11. 42 C.F.R. § 1001.1901(b)(1)(i).
12. OIG, *supra* note 1, at 6.
13. *Id.*
14. *Id.*
15. 42 C.F.R. § 1001.1901(b)(1)(ii).
16. OIG, *supra* note 1, at 8.
17. 42 U.S.C. § 1320a-7a(a)(6).

    (Any person . . . that . . . arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1320a-7b(f) of this title), for the provision of items or services for which payment may be made under such a program . . . shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $20,000 for each item or service[.]).
18. OIG, *supra* note 1, at 11.
19. OIG, *supra* note 1, at 12.
20. *Id.*
21. OIG, *supra* note 1, at 11:

    (A provider could be subject to CMP liability if an excluded person participates in any way in the furnishing of items or services that are payable by a Federal health care program. CMP liability would apply to the furnishing of all of the categories of items or services that are violations of an OIG exclusion, including direct patient care, indirect patient care, administrative and management services, and items or services furnished at the medical direction or on the prescription of an excluded person when the person furnishing the services either knows or should know of the exclusion. CMP liability could result if the provider's claim to the Federal health care program includes any items or services furnished by an excluded person, even if the excluded person does not receive payments from the provider for his or her services (e.g., a non-employed excluded physician who is a member of a hospital's medical staff or an excluded health care professional who works at a hospital or nursing home as a volunteer). An excluded person may not provide services that are payable by Federal health care programs, regardless of whether the person is an employee, a contractor, or a volunteer or has any other relationship with the provider.)

See OIG, Exclusions Program, https://oig.hhs.gov/exclusions/index.asp (last visited Feb. 22, 2021) ("Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP). To avoid CMP liability, health care entities should routinely check the list to ensure that new hires and current employees are not on it"); OIG, *supra* note 1, at 15-16.

22. OIG, *supra* note 1, at 16.
23. OIG, The Effect of Exclusion From Participation in Federal Health Care Programs, Special Advisory Bulletin (Sept. 1999), https://oig.hhs.gov/exclusions/effects_of_exclusion.asp (last visited Feb. 25, 2021).
24. *See* OIG, LEIE Downloadable Databases, https://oig.hhs.gov/exclusions/exclusions_list.asp (last visited Feb. 22, 2021).
25. OIG, *supra* note 1, at 16.
26. OIG, *supra* note 1, at 17.
27. *Id.*
28. Health Care Programs: Fraud and Abuse; Amendments to OIG Exclusion and CMP Authorities Resulting From Public Law 100-93, 57 Fed. Reg. 3298, 3322 (Jan. 29, 1992).
29. Health Care Programs: Fraud and Abuse; Amendments to OIG Exclusion and CMP Authorities Resulting From Public Law 100-93, 57 Fed. Reg. 3298, 3322 (Jan. 29, 1992); *see, e.g.*, 18 N.Y.C.R.R. § 515.7:

    (Upon receiving notice that a person has been found to have violated a State or Federal statute or regulation pursuant to a final decision . . . where the violation resulting in the final decision or determination would constitute an act described as professional misconduct or unprofessional conduct by the rules or regulations of the State Commissioner of Education or the State Board of Regents . . . the department may immediately sanction the person and any affiliate).
30. 42 C.F.R. § 1002.5; *see also* 42 C.F.R. § 455.452 ("Nothing in this subpart must restrict the State Medicaid agency from establishing provider screening methods in addition to or more stringent than those required by this subpart").
31. Section 1128(b)(5) Act; 42 C.F.R. § 1001.601.
32. CMS, Affordable Care Act Program Integrity Provisions - Guidance to States -- Section 6501 - Termination of Provider Participation under Medicaid if Terminated under Medicare or other State Plan, CPI-B 12-02 (Jan. 20, 2012), at 1-2, https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-20-12.pdf. (alternative cite: ¶ 350,339 PPACA GUIDANCE TO STATES SECTION 6501-TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN, Healthcare Compl. Rep. P 350339); 42 U.S.C. § 1396a(a)(39), (§ 1902(a)(39) of the Social Security Act); *see also* 18 N.Y.C.R.R. § 515.8.
33. Ctrs. for Medicare & Medicaid Servs., Medicaid Program Integrity Education Podcast: Exclusions and Terminations Part 2 Transcript (Sept. 2015), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/podcast-Exclusions-and-Terminations-Part-2-transcript-[September-2015].pdf (citing 42 U.S.C. § 1396a(a)(39)); *see also* CMS, Frequently Asked Questions Section 6501 of the Affordable Care Act (May 2011), https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-Term.pdf:

    (For purposes of section 6501, a 'termination' occurs when the State terminates the participation of a Medicaid or CHIP provider from the program or the Medicare program has revoked a Medicare provider or supplier's billing privileges, and the provider has exhausted its appeal rights or the timeline for appeal has expired. Generally, 'exclusion' from participation in a federal health care program, including Medicare, Medicaid, and CHIP is a penalty imposed on providers and suppliers by the Department's Office of Inspector General (HHS-OIG). Individuals and entities may be excluded from participating in federal health care programs for misconduct ranging from fraud convictions to patient abuse to defaulting on health education loans. We recognize, however, that certain States give the same meaning to the terms 'exclusion' and 'termination' and these actions; therefore, ultimately result in the provider's involuntary departure from the Medicaid program or CHIP.).
34. OIG, CMS's Process for Sharing Information About Terminated Providers Needs Improvement, OEI-06-12-00031, at 2 (Mar. 2014).
35. CMS, *supra* note 32, at 3.
36. OIG, Providers Terminated From One State Medicaid Program Continued Participating in Other States, Report No. OEI-06-12-00030, 8 (Aug. 2015), https://oig.hhs.gov/oei/reports/oei-06-12-00030.pdf ("Most of the available data sources are designed for purposes other than identifying providers terminated for cause, and therefore do not attempt to identify all such providers. Although the CMS Termination Notification database is designed for this purpose, States' participation is encouraged, rather than required."); *id.* at 3 ("In March 2014, OIG recommended that CMS require State Medicaid agencies to report all terminations for cause. We reiterate this prior recommendation as we found the lack of a comprehensive data source of providers terminated for cause creates a challenge for State Medicaid agencies.").
37. CMS, *supra* note 32, at 1-2.
38. CMS, *supra* note 32, at 2.
39. CMS, *supra* note 32, at 2-3.
40. OIG, *supra* note 34, at 2.
41. *Id.*
42. OIG, Providers Terminated From One State Medicaid Program Continued Participating in Other States, OEI-06-12-00030, at 4 (Aug. 2015).
43. OIG, *supra* note 42, at 4.
44. OIG, *supra* note 42.
45. OIG, *supra* note 42, at 3.
46. OIG, *supra* note 34, at app. B.
47. *See* U.S. Dep't of Health & Human Servs., Medicare Program Integrity Manual Chapter 2—Data Analysis, Rev. 10365, at 9 (Oct. 2020).
48. OIG, *supra* note 34, at app. B.
49. *Id.*