Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

Winter Conference
Wednesday, February 18, 2026
10:15am-11:30am

1c. The OIG Will See You Now: Understanding the US HHS Office of Inspector General

Presented by:

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TAHCH Winter Conference 2026
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The OIG Will See You Now

Understanding the US HHS Office of Inspector General

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Disclaimer

This outline is provided as general information only. It does not constitute legal advice and should not be used as a substitute for seeking legal counsel. Because legal advice must be tailored to the specific circumstances of each case, nothing provided should be used as a substitute for advice of competent counsel. We are attorneys, but we are not your attorney, and outcomes may differ depending on specific facts.

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Overview

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What is the HHS OIG?

U.S. Department of Health and Human Services
Office of Inspector General

Independent oversight agency

Established under the Inspector General Act of 1978

Mission:

Protect the integrity of HHS programs and the health and welfare of program beneficiaries through audits, investigations, and enforcement actions

Key Statistics (FY 2023)

- Expected return on investment: **$6+ for every $1 spent**
- Annual savings to federal programs: **Over $4 billion**
- Criminal and civil actions: **900+ cases**

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Mission & Core Responsibilities

Enforce Compliance

Ensure compliance with federal healthcare laws and regulations

Promote Efficiency

Improve the economy, efficiency, and effectiveness of HHS programs

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Organizational Structure

Key Supporting Offices:

- Office of External Affairs
- Office of Management and Policy
- Office of Chief Information Officer
- Regional Offices across the United States

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Legal Authorities & Statutory Framework

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Statutory Authority

Inspector General Act of 1978
Establishes OIG independence and authority to conduct audits and investigations

Social Security Act
Authorizes OIG to exclude individuals/entities from federal healthcare programs

False Claims Act (31 USC §3729-3733)
Provides civil remedies for false claims submitted to government programs

Anti-Kickback Statute (42 USC §1320a-7b)
Prohibits remuneration to induce referrals for items/services covered by federal programs

Stark Law (42 USC §1395nn)
Prohibits physician self-referrals for certain designated health services

Civil Monetary Penalties Law (42 USC §1320a-7a)
Authorizes imposition of civil monetary penalties for various violations

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Enforcement Powers

The OIG has broad enforcement authority including:

- Subpoena authority
- Access to all HHS records and documents
- Authority to administer oaths and take testimony
- Power to exclude individuals and entities from federal programs
- Ability to impose civil monetary penalties
- Authority to negotiate Corporate Integrity Agreements (CIAs)
- Coordination with Department of Justice for criminal prosecutions

Note: OIG actions are independent from HHS management and not subject to departmental approval

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Core Functions & Operations

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Audits

Office of Audit Services (OAS)

Conducts independent financial and performance audits of HHS programs

Types of audits:

- Financial statement audits
- Contract and grant audits
- Performance audits of program operations
- Single audits of state and local governments

Focus areas:

- Medicare and Medicaid payment accuracy
- Provider billing practices and compliance
- Program integrity and internal controls
- Grant administration and financial management

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Investigations

Office of Investigations (OI)

Healthcare fraud:	False billing, upcoding, unbundling
Patient abuse and neglect:	In nursing homes and healthcare facilities
Kickbacks and illegal remuneration:	Referral arrangements, marketing schemes
Product substitution:	Providing lower-cost items than billed
Theft of program funds:	Embezzlement, identity theft
Prescription drug diversion:	Illegal distribution of controlled substances

OI works closely with DOJ, FBI, and other law enforcement agencies on criminal cases

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Exclusions & Sanctions

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What Are Exclusions?

Exclusion: Administrative sanction prohibiting an individual or entity from participating in federal healthcare programs

Consequences of exclusion:

- No payment from Medicare, Medicaid, or other federal programs
- Applies to all items and services furnished by excluded party
- Hiring excluded individuals can result in civil monetary penalties
- Listed on OIG's List of Excluded Individuals and Entities (LEIE)

Critical Compliance Requirement

Healthcare entities must screen all employees, contractors, and vendors against the LEIE database. Failure to do so can result in significant penalties and liability. Screen upon hire and monthly thereafter!

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Types of Exclusions

Mandatory Exclusions

Minimum 5-year exclusion for:

- Conviction of program-related crimes
- Patient abuse or neglect convictions
- Felony healthcare fraud
- Felony controlled substance convictions

OIG has no discretion—MUST exclude!

Permissive Exclusions

OIG has discretion to exclude for:

- Misdemeanor healthcare fraud
- License revocation or suspension
- False claims submissions
- Kickback violations
- Default on health education loans
- Controlling interest in sanctioned entity

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Exclusion Process & Reinstatement

1. **Notice** — OIG issues Notice of Intent to Exclude
2. **Response** — Individual/ entity has 30 days to respond
3. **Decision** — OIG reviews and issues final exclusion notice
4. **Appeal** — Administrative Law Judge hearing available
5. **Publication** — Name added to LEIE database

Reinstatement After Exclusion Period Ends

- Application required after exclusion period ends
- Must demonstrate compliance with program requirements
- OIG evaluates several factors: conduct, rehabilitation efforts, cooperation
- ➢ ***Reinstatement is not automatic—OIG has full discretion to deny!***
- May require integrity agreement or enhanced monitoring

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Compliance Program Guidance

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Compliance Program Guidances (CPGs)

Voluntary guidance documents
Provide recommendations for effective compliance programs

Purpose:

- Help healthcare providers prevent fraud and abuse
- Outline elements of effective compliance programs
- Reduce risk of violations and penalties
- Demonstrate good faith effort to comply with laws

Guidance Available That Are Relevant To Home Health & Hospice:

- OIG Compliance Program Guidance for Home Health Agencies (1998)
- OIG Compliance Program Guidance for Hospices (1999)
- OIG Compliance Program Guidance for Individual and Small Group Physician Practices (2000)
- OIG Compliance Program Guidance for Third-Party Billing Companies (1998)
- OIG Compliance Program Guidance for Durable Medical Equipment, Prosthetics, Orthotics and Supply Industry (1994)

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Seven Elements of an Effective Compliance Program

1	**Written Policies & Procedures**	Standards of conduct and policies addressing risk areas
2	**Compliance Officer & Committee**	Designated oversight and governance structure
3	**Training & Education**	Regular training for all affected personnel
4	**Effective Communication**	Open lines of communication and reporting mechanisms
5	**Internal Monitoring & Auditing**	Regular evaluation of compliance with standards
6	**Enforcement & Discipline**	Consistent disciplinary action for violations
7	**Response & Corrective Action**	Procedures to investigate and remedy problems

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Benefits of Implementing a Compliance Program

Legal Protection

- Demonstrates good faith
- Mitigating factor in penalties
- Support in investigations

Organizational Culture

- Promotes ethical behavior
- Improves employee morale
- Enhances reputation

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Home Health Agency Compliance Guidance

Published: August 1998
Citation: 63 Fed. Reg. 42,410 (Aug. 7, 1998)

Key Risk Areas Identified:

- Billing for services not rendered or not medically necessary
- Improper use of home health versus other levels of care
- Duplicate billing
- Billing for services of a higher level than provided
- Improper patient solicitation activities
- Kickbacks and other illegal remuneration

Access the guidance: https://oig.hhs.gov/documents/compliance-guidance/807/cpghome.pdf

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Hospice Compliance Guidance

Published: November 1999
Citation: 64 Fed. Reg. 54,031 (Oct. 5, 1999)

Key Risk Areas Identified:

- Eligibility determinations and certifications of terminal illness
- Level of care determinations (routine vs. continuous care)
- Changes in ownership and Medicare enrollment
- Medical necessity of services
- Kickbacks for patient referrals
- Inadequate care and quality concerns

Access the guidance: https://oig.hhs.gov/documents/compliance-guidance/803/hospicx.pdf

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Major Update: New Compliance Guidances

November 2023: OIG Published General Compliance Program Guidance (GCPG)
First major update to compliance guidance in 15 years!

The New Two-Tier Structure:
- GCPG: Universal guidance applicable to ALL healthcare entities
- ICPGs: Industry segment-specific guidance for particular provider types

What's New in the GCPG:
- Enhanced focus on annual risk assessments
- Integration of quality of care into compliance programs
- Emphasis on board and executive leadership oversight
- Guidance for both small and large entities
- Updated discussion of the seven elements with modern examples

GCPG replaces previous industry-specific CPGs once new ICPGs are issued

Access: oig.hhs.gov/compliance/general-compliance-program-guidance

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Industry-Specific Guidances (ICPGs)

Published

Nursing Facilities
Published: November 20, 2024

Medicare Advantage
Published: February 3, 2026

Likely Coming in 2026

Hospice
Hospitals
Clinical Laboratories
Pharmaceutical Manufacturer

Additional sectors TBD

What This Means for Home Health & Hospice:
- Your current CPGs (1998 for home health, 1999 for hospice) remain effective
- Use GCPG as your primary compliance resource now
- Align your existing CPG risk areas with the new GCPG framework
- Expect home health and hospice ICPGs in future years
- When new ICPGs are issued, the old CPGs will be archived

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Other Types of OIG Guidance

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Fraud Alerts

Purpose:
Alert healthcare industry and public about fraud schemes that OIG has identified

Examples relevant to home health and hospice:

- Fraud Alert on Joint Venture Arrangements (1989)
- Fraud Alert on Arrangements for Services to Nursing Facilities (1996)
- Fraud Alert on Telemarketing by DME Suppliers (1998)
- Fraud Alert on Laboratory Payments to Referring Physicians (2014)
- Fraud Alert on Speaker Programs (2020)

View all fraud alerts: https://oig.hhs.gov/compliance/alerts/

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Special Advisory Bulletins

Purpose:
Provide guidance on specific practices that may implicate fraud and abuse laws

Notable bulletins:
- Patient Referral Services (1994)
- Prescription Drug Marketing Schemes (1994)
- Gainsharing Arrangements (1999, updated 2020)
- Offering Gifts and Other Inducements to Beneficiaries (2002)
- Contractual Joint Ventures (2003)
- Laboratory Payments to Referring Physicians (2014)

View all special advisory bulletins: https://oig.hhs.gov/compliance/alerts/other-guidance/

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OIG Work Plan

Updated throughout the year

Purpose:
Outlines OIG's priorities for audits, evaluations, and investigations in the coming year

Why it matters:
- Shows what OIG will be focusing on
- Helps providers identify compliance risk areas
- Indicates potential areas for increased scrutiny
- Essential reading for compliance officers

View current Work Plan: https://oig.hhs.gov/reports/work-plan/

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Recent Work Plan Focus: Home Health & Hospice

Home Health

Recent focus areas:

- Therapy services billing
- Patient eligibility verification
- Homebound status reviews
- Face-to-face encounters
- Outlier payments
- Low utilization payment adjustments
- Telehealth services
- Ownership changes

Hospice

Recent focus areas:

- General inpatient care claims
- Live discharge reviews
- Long hospice stays
- Physicians' certifications
- Continuous home care
- Respite care
- Marketing practices
- Quality of care concerns

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Advisory Opinions

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Advisory Opinions

Formal written opinions
Issued by OIG regarding application of fraud and abuse laws

Purpose:
Allow parties to receive guidance on whether existing or proposed business arrangements comply with:

- Anti-Kickback Statute
- Civil Monetary Penalties Law
- Exclusion authorities
- Stark Law (self-referral)

Who Can Request?

- Individuals or entities
- Actual or proposed arrangements
- Requesting party must be involved

Legal Protection

- Binding on OIG and parties
- Safe harbor from prosecution
- Valid if facts are accurate

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Advisory Opinion Process

1. Submission	Written request with detailed facts and legal analysis
2. Review	OIG evaluates completeness and jurisdictional requirements
3. Analysis	OIG analyzes arrangement under applicable statutes
4. Opinion	Written opinion issued within 60 days
5. Publication	Redacted version published on OIG website

CRITICAL: Always involve experienced healthcare counsel before requesting an Advisory Opinion

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Recent Advisory Opinion: AO 25-12

Posted: January 5, 2026 | UNFAVORABLE OPINION

Topic: Home care agency proposal to offer sign-on bonuses to prospective employees

The Arrangement:

- Agency would market sign-on bonuses to attract caregivers
- Prospective employees would primarily be family members of clients
- These family members often select the home care agency on behalf of clients
- Services would be reimbursed by state Medicaid program

OIG Conclusion: VIOLATES BOTH
1. Anti-Kickback Statute: Inextricable link between employment bonus and referral of family member
2. Beneficiary Inducements CMP: Bonus likely to influence caregiver's choice of agency for family member

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Key Takeaways from AO 25-12

Why This Matters for Home Health & Hospice Agencies:

Employment Safe Harbor Exception Does Not Apply
OIG found the bonus advertisement operates as a solicitation for referrals before employment begins, creating heightened risk compared to typical sign-on bonuses

Practical Implications:

- Be cautious with recruitment bonuses when targeting family caregivers
- Ensure bonuses are not tied to choice of agency for family member's care
- Structure recruitment to target broad pool of candidates
- Avoid advertisements that could be perceived as upfront payments
- Document legitimate business purposes for any recruitment incentives

Remember: *Advisory opinions are binding only on the requestors and based on specific facts provided. However, this opinion provides important guidance for similar arrangements.*

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Key Takeaways for Home Health & Hospice

1. OIG has independent oversight authority with significant enforcement power
2. Review the specific Compliance Program Guidance for your sector (1998 for home health, 1999 for hospice)
3. Screen all employees, contractors, and vendors against the LEIE database monthly
4. Monitor the annual OIG Work Plan for current audit and investigation priorities
5. Stay informed about Fraud Alerts and Special Advisory Bulletins relevant to your operations
6. Consider requesting an Advisory Opinion for questionable business arrangements
7. Implement the seven elements of an effective compliance program
8. Proactive compliance is far less costly than reactive enforcement

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OIG Self-Disclosure Protocol

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OIG Self-Disclosure Protocol (SDP)

Created: 1998 | Last Updated: November 2021

Purpose:
Allows providers to voluntarily disclose self-discovered evidence of potential fraud involving federal healthcare programs. ***NOT*** for standard or routine billing errors.

Who Can Use It:
- Healthcare providers and suppliers
- Pharmaceutical and device manufacturers
- Any entity subject to OIG Civil Monetary Penalties
- Home health and hospice agencies

CRITICAL: Do not attempt self-disclosure without experienced legal counsel!

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Benefits of Using the Self-Disclosure Protocol

Avoid Exclusion	Generally, OIG will NOT seek exclusion for providers who self-disclose (absent aggravating circumstances)
Reduced Penalties	Typically 1.5x single damages vs. 3x (treble damages) in government-initiated cases
No CIA Required	Usually resolved without requiring a Corporate Integrity Agreement
60-Day Rule Suspension	Suspends obligation to return overpayments within 60 days while SDP is pending

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When to Consider Self-Disclosure

Common Scenarios for Home Health & Hospice:

- Systematic billing errors or upcoding discovered
- Employed or contracted with excluded individuals
- Claims submitted without proper documentation
- Services billed that were not medically necessary
- Anti-Kickback Statute violations identified
- Homebound status documentation failures (home health)
- Terminal illness certification issues (hospice)
- Face-to-face encounter requirement violations
- Improper level of care determinations
- Marketing arrangements that violate federal law

If you discover any of these issues, STOP. Consult with experienced healthcare counsel before taking any action, including self-disclosure.

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The Self-Disclosure Process

1. **Discovery & Investigation**
   Internal audit identifies potential problem
   Conduct thorough internal investigation with counsel
2. **Legal Analysis**
   Attorney evaluates whether conduct violates federal law
   Determine if SDP is appropriate option
3. **Initial Submission**
   Submit disclosure through OIG website within 90 days
   Include: entity info, conduct details, estimated damages
4. **OIG Review**
   OIG reviews submission for completeness
   May accept, request more info, or reject
5. **Full Investigation**
   Complete internal investigation within 90 days of submission
   Calculate damages (all claims or statistical sample)
6. **Negotiation & Settlement**
   OIG reviews findings and proposes settlement
   Negotiate terms, payment schedule if needed
7. **Resolution**
   Execute settlement agreement
   Pay agreed amount (typically 1.5x single damages)

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Resources & Contact Information

General Resources:
OIG Website: https://oig.hhs.gov
LEIE Database: https://exclusions.oig.hhs.gov
Fraud Hotline: 1-800-HHS-TIPS (1-800-447-8477)

Home Health & Hospice Specific:
Home Health CPG: https://oig.hhs.gov/documents/compliance-guidance/807/cpghome.pdf
Hospice CPG: https://oig.hhs.gov/documents/compliance-guidance/803/hospicx.pdf

Additional Guidance:
Advisory Opinions: https://oig.hhs.gov/compliance/advisory-opinions/
Work Plan: https://oig.hhs.gov/reports/work-plan/
Fraud Alerts: https://oig.hhs.gov/compliance/alerts/#special-fraud-alerts
Self-Disclosure Protocol: https://oig.hhs.gov/compliance/self-disclosure-info/

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The Critical Role of Healthcare Attorneys In Compliance

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Why Attorney Involvement is Critical

Attorney-Client Privilege
- Investigations conducted under attorney supervision are protected by privilege
- Documents and communications can't be discovered by government
- Critical for frank assessment of potential violations

Strategic Decision-Making
- Not all problems require self-disclosure
- Attorney helps evaluate alternatives (CMS contractor disclosure, voluntary refund, etc.)
- Determines whether conduct actually violates law

Technical Expertise Required
- SDP submissions have specific requirements
- Damage calculations must be statistically valid
- Must properly identify violated statutes
- Negotiating with OIG requires experience

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When to Involve an Attorney

Involve Healthcare Counsel BEFORE:

- Requesting an Advisory Opinion
- Starting any internal compliance investigation
- Discovering potential billing errors or fraud
- Learning you may have hired an excluded individual
- Identifying potential Anti-Kickback Statute violations
- Considering self-disclosure to OIG
- Responding to a government audit or investigation
- Receiving a subpoena or Civil Investigative Demand
- Implementing new business arrangements with referral sources
- Conducting high-risk audits of billing practices

The earlier you involve counsel, the better protected you are

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Questions?

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