Individual Liability for Medicare Overpayment Claims

(February 24, 2015): Medicare recently finalized regulations allowing enrollment as a Medicare provider to be denied if any owner or control person of the enrolling provider is affiliated with another provider which owes money to Medicare. These regulations are based on sections of the 2010 Affordable Care Act (ACA). They provide CMS an indirect means to penalize individual owners for unpaid debts owed to Medicare by their provider companies, but are more narrowly written than the ACA requires, and are likely only a 1st step in implementing the screening required by the ACA. Additionally, owners of health care companies with Medicare overpayments also need to consider whether there is individual liability exposure for the company's Medicare debt.

I. Background on the Medicare overpayments Individual Liability Issue:

This article is an update of an earlier article on this website addressing individual liability for Medicare overpayment claims, originally published in April 2012. That article examined the liability that individual owners of provider companies can have for Medicare overpayment claims against their providers, and advised that although CMS and Medicare contractors have limited means to collect providers' overpayment balances from their owners, they may in the future punish the owners indirectly by sanctioning other provider companies they own. Portions of the Workplan published by HHS's Office of Inspector General in 2011 clearly pointed in that direction.

II. Recent Development -- Issuance of a New Final Rule:

The Secretary of Health, Education and Welfare published a *Final Rule*[2] amending Medicare Regulations at 42 CFR 405, 424 and 498 effective Feb 3, 2015. The Final Rule conformed closely to the *Proposed Rule* published April 29, 2013, despite substantial public comment. While this Final Rule included regulation changes on a number of Medicare topics, of interest here is the provision allowing CMS and its contractors to deny enrollment in Medicare programs to a provider if any owner previously owned another provider having unpaid debts owed to Medicare.

III. Specific Provisions:

Medicare Regulations at 42 CFR 424.530(a)(6) have now been amended to allow CMS to deny a provider or supplier's enrollment in the Medicare program if

> ***(a) The enrolling provider or supplier, or any of its owners was previously the owner, directly or indirectly, of another Medicare enrolled provider or supplier;***
>
> ***(b) The other provider or supplier's Medicare enrollment has been terminated or revoked;***
>
> ***(c) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's enrollment termination or revocation;***
>
> ***(d) The Medicare debt has not been fully repaid; and***
>
> ***(e) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse. In making this determination, CMS considers the following factors:***
>
> ***(1) the amount of the Medicare debt;***
>
> ***(2) the length and timeframe that the enrolling provider or supplier or its owner was an owner of the prior entity;***
>
> ***(3) the percentage of the enrolling provider, supplier, or owner's ownership of the prior entity;***
>
> ***(4) whether the Medicare debt is currently being appealed; and***
>
> ***(5) whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred.***

A denial of Medicare enrollment under this paragraph can be avoided if the enrolling provider, supplier or owner agrees to a CMS-approved extended repayment schedule for the unpaid debt, or repays it in full.

IV. Narrowed Scope of New Regulation:

As discussed below, the statutory language authorizing the new regulation targets all owners of

providers who are debtors to Medicare. The resulting regulation, however, contains a provision which limits it effect only to certain owners. This is the requirement that the authority to deny enrollment exits only if *the owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's enrollment termination or revocation.* In this context, the verb *left* means *ceased to be an owner*. So, if the owner in question divested himself of his ownership more than a year before the Medicare enforcement process terminates the overpaid provider's enrollment, or keeps his ownership at least a year after termination of enrollment, both of which are plausible circumstances in an overpayment situation, the authority to deny enrollment will not apply. This requirement was not remarked on by the numerous commenters during the proposal period, or otherwise discussed in any CMS releases; and it is unobvious why it was included.

V. Subjective Element in Regulation:

The 5th element required to authorize denial of enrollment, namely *CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse* is clearly subjective. CMS's comments in the Final Rule release explain that this is meant to allow enrollment to proceed if the debt or the ownership in the debtor provider are small, or if similar exonerating circumstances exist. These factors are listed in the regulation as subjects of CMS's subjective consideration without being hard requirements, to allow CMS discretion in the matter. More notably, however, this text tracks the actual authorizing language of the Federal statute quoted below, which phrased the authority as a subjective determination.

VI. Statutory Authority; Disclosure and Screening Requirements in Statute:

The authority to deny enrollment because of an affiliated provider's debt to Medicare is part of Section 6401[3] of the Affordable Care Act[4], which requires Medicare providers and suppliers to disclose any current or previous affiliation (directly or indirectly) with those who owe money to Medicare. Specifically, it provides

> ***(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment …shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider … or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program, has been excluded from participation under [Medicare], the Medicaid program … , or the CHIP program under title XXI, or has had its billing privileges denied or revoked. [emphasis supplied]***

Section 6401 authorizes denial of enrollment based on these disclosures with the following language:

> ***(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).***

In addition to requiring disclosure of affiliated providers with debts to Medicare, Section 6401 also requires Medicare to conduct certain screening of providers and suppliers. The statute does not state what providers and suppliers must be screened for, but merely gives examples. It requires that

Such screening—

> ***(i) shall include a licensure check, which may include such checks across States; and***
>
> ***(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—***
>
> ***(a) a criminal background check;***
>
> ***(b) fingerprinting;***
>
> ***(c) unscheduled and unannounced site visits, including pre-enrollment site visits;***
>
> ***(d) database checks (including such checks across States); and***
>
> ***(e) such other screening as the Secretary determines appropriate[5].***

Other parts of Section 6401(a)(3) make clear that the screening is to apply to enrolling providers,

previously enrolled providers, and during any periodic revalidation of enrollment.

VII. Affiliated Debt Disclosure via Form 855:

The CMS Final Order release mentions that CMS Form 855 is the form affected by this regulation. This is the multi-use form required to be filed by providers for initial enrollment, to report changes of certain organization information including ownership, to request CMS approval of any change of ownership, to re-validate enrollment or terminate it. Form 855 is the obvious place to require the disclosure mandated by ACA Sec. 6401. As of this writing (February 20, 2015) Form 855 contains no questions about debts owned by other providers and suppliers under common ownership with the signer of the form. Very probably such a question will be added, but even without it CMS could probably rely on its own ability to "connect the dots" between information already called for in this form, and data it has on providers and suppliers which owe it money, to learn of any debts owed by affiliates.

In this regard, the existing language of Form 855 requires that all direct and indirect owners of each provider and supplier be identified by name and Taxpayer Identification Number, or (as applicable) Social Security Number. If the owners are enrolled in Medicare themselves, their NPI and enrollment numbers are required. With this information in CMS's hands from the enrolling provider or supplier, it must be a simple matter to conduct database searches comparing it with the identifiers of providers and suppliers owing money to Medicare, to determine if any of the enroller's affiliates are among these debtors. If a connection is established this way, the enrollment denial rules in the regulation could then be applied to deny the enrollment.

VIII. Practical Application of New Regulation:

As of this writing, there is no public report of any application of the new provisions of 42 CFR §424 to an actual provider enrollment situation, so no one knows how strictly it will be enforced once a debt to Medicare owed by an affiliate of an enrolling provider is identified. Particularly, it is not known how the factors in the subjective 5th element of the new provision will be interpreted, for example, what dollar amounts of affiliate debt, or what ownership percentages in the debtor, will be judged too small to "pose an undue risk of fraud, waste and abuse." It will also be instructive to learn if such judgments will be made by enrollment contractors or an organ of CMS.

IX. Future Enforcement Against Owners of Debtors to Medicare:

What is clear is that this new regulation and authority is not the final step in CMS efforts to sanction owners and affiliates of medicare overpayment debtors. Considering the portions of ACA Section 6401 requiring screening of existing as well as enrolling Medicare providers and suppliers, it is likely that future regulations will authorize revocation of enrollment of existing providers and suppliers under common ownership with such debtors. The database searches mentioned above could be conducted on the owner identification information CMS already maintains on its current

enrollees, comparing it to the identifiers of providers and suppliers owing Medicare money, to terminate their enrollment when a connection is found, and thus extend Medicare's efforts to punish owners of debtors to its program. We note that the current-year Work Plan published by CMS's Office of Inspector General provides, under a section captioned **"Provider Eligibility":**

We will determine the extent to which and they way in which CMS and its contractors have implemented enhanced screening procedures for Medicare providers pursuant to the ACA, § 6401[6]***.***

This new regulation, and the clear announcements by CMS officials, suggest that efforts by the agency and its contractors to reach beyond its debtor companies, and sanction their owners and affiliates, will continue.

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[2]. The Final Rule was published Dec 5, 2014 in Vol. 79, No. 234 of the *Federal Register* at page 72500.

[3]. Now codified at 42 USC §1395cc(j).

[4]. Public Law 111-148 enacted March 23, 2010. It may be noted that the provision of law under discussion was enacted 2 years before this writer's article predicting it, but like much of that statute, was completely unknown to the writer or the public at the time.

[5]. ACA §6401(a)(3).

[6]. HHS OIG Work Plan, FY 2015, Medicare Program section, pg. 22.