HEALTH LAW ALERT

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CMS Expands its Arsenal Against Providers

Effective November 4, 2019, the Center for Medicare Medicaid Services ("CMS") will have the power to deny enrollment and revoke a provider's participation in Medicare, Medicaid and Children's Health Insurance Program (the "Programs") for, affiliations with another provider that has one or more of the following "disclosable events": (1) owes an unpaid debt to any of the Programs (including debts that are being repaid under a payment plan or debts that are being appealed) that has been referred to Treasury; (2) has been excluded from any Program; (3) is under a payment suspension; or (4) had its enrollment denied, revoked or terminated (voluntarily or involuntarily). In addition, the enrollment bar that is imposed on revoked providers, has been increased from three years to ten years.

CMS is focusing on affiliations that include but are not limited to ownership, management and reassignment relationships. CMS claims that it needs broad authority to deny enrollment and to revoke providers so that it can identify and remove any provider who poses an undue risk of fraud, waste or abuse based on such provider's affiliation with another provider who has experienced one of more of the disclosable events. As of this date, CMS will only require disclosure of these relationships upon request. However, CMS warns that this will be subject to change when CMS revises its enrollment forms to include disclosure of these relationships and the facts underlying a disclosable event.

CMS claims that prior to exercising its discretion to revoke a provider, it will take a number of factors into consideration, including but not limited to the following: (1) the duration of the affiliation; (2) whether the affiliation still exists and, if not, how long ago it ended; (3) the degree and extent of the affiliation; (4) if applicable, the reason for the termination of the affiliation; (5) in the case of unpaid debt, the amount of the debt and whether it is being repaid; and (6) any other evidence that CMS deems relevant to its determination. Among those things that are missing from the factors that CMS may take into consideration is the fact that a revocation can wreak havoc on a medical career.

It is important for providers to understand that revocations are reportable to the National Practitioner Databank, which is queried by every hospital in connection with an application for privileges, as well as by commercial insurance companies, malpractice insurers and government agencies that have jurisdiction over physician licenses. Moreover, a revocation can and likely will result in termination of employment and of hospital privileges, since maintaining participation in the Medicare program is a pre-condition to most provider employment agreements and most medical staff by laws. A Medicare revocation will also subject the provider to preclusion, which is the termination of the provider's participation in all Medicare Advantage programs as well as the right to prescribe for beneficiaries of Medicare Part D.

This raises concerns for physicians who own or manage affiliated providers with disclosable events and creates a significant risk to providers who are merely in reassignment relationships, which arise in provider employment relationships, where the parties may not be privy to each other's disclosable events. Nevertheless, CMS has determined that a disclosing provider will be held to have known or that he should have known about his affiliate's disclosable event. CMS ignores the fact that the only disclosable event that is publicly available, is an exclusion. Unpaid debts, suspensions of payment, revocations of individual providers and voluntary terminations of participation are not in the public record. Regardless, the new law appears to create a duty upon all providers, to know whether an affiliated entity has a disclosable event that may need to be reported to CMS.

In addition to the foregoing, CMS has determined to subject owners of professional entities to penalties that were previously unavailable to CMS absent due process. Previous to the effective date of this law, owners and managers of professional entities were protected by the concept of the "corporate veil". The "corporate veil" treats entities as persons in their own right and efforts to attack an entity owner, also known as "piercing the corporate veil" is generally possible only when criminal conduct, fraud or other similar conduct by the individual owners can be proved. This may have stymied efforts by CMS to collect overpayments from some professional entities but it protected many other individual owners of professional entities who disputed CMS's overpayment demands but got stuck in an appeal process that is stacked against the provider. It is interesting to note that the appeals process generally yields few if any reversals in the first two stages of appeals (which can take upwards of 6-18 months to complete), but after a hearing before an administrative law judge the chances for reversal is as high as 54%. Unfortunately, as one waits for an appeal from an overpayment to be heard by an administrative law judge, CMS has the right to, and does enforce collection actions, including referring the debt to the Department of Treasury and offsetting funds from current claims made in recoupment of the debt.

It is impossible to determine just how CMS will use this powerful new tool in its arsenal. Until the appeals start to be decided and the case law begins to be established, the disclosure or failure to disclose an affiliation with a provider that has a disclosable event will have a far-reaching and long lasting effect on a provider's ability to practice medicine. For this reason, providers who have or are about to enter into an affiliation or who are going to be enrolling or revalidating enrollment as participating providers after November 4, 2019 should consult with a health care attorney to ensure that they understand their risks and obligations.

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