Report on
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Medicaid Exclusion Rule Is Repealed, but Medicare Recoupment Provision Looms

Hospitals and other health care organizations are no longer at risk of Medicaid exclusion if one of their entities owes the program money. The Medicare and Medicaid Extenders Act of 2010 (HR 4994) retracted a health reform law provision that required states to throw providers and suppliers out of Medicaid if an entity they own, control or manage has an overpayment that is declared delinquent by HHS or a state Medicaid program.

But Congress left intact CMS's new Medicare recoupment powers for use against related providers and suppliers, which is a version of robbing Peter to pay Paul, if they have the same tax identification number.

The Medicare and Medicaid Extenders Act, signed by President Obama on Dec. 15, was the vehicle by which Congress delayed for another year the statutory 25% Medicare physician payment cut. But the legislation also tinkered with other Medicare and Medicaid provisions.

Notably, it eliminated the Medicaid exclusion language that has baffled lawyers because it forced states to wield a weapon, apparently without discretion, when providers had unreturned overpayments, even when the circumstances did not rise to the level of fraud. "Congress probably didn't realize how onerous it was" when it included the provision in the health reform law, says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. "It took away the latitude the government had in dealing with entities with multiple organizational components and would have had an impact on access" to Medicaid services.

Sec. 6501 of the health reform law required states to exclude individuals or entities from Medicaid if they own, control or manage an entity that (1) "has unpaid overpayments"; (2) is suspended, excluded or terminated from Medicaid; or (3) "is affiliated with an individual or entity that has been suspended or excluded from participation."

Waltz says this would have "multiplied the impact of the action the government could have taken" in such situations. Instead of being confined to punishing only the entity with unreturned overpayments, states could have gone after the controlling entity. For example, if one hospital in a health system or hospital chain had an outstanding balance, the statute on its face seemed to require states to kick its corporate parent out of Medicaid, "with a snowball effect for the rest of the organization," she says.

This provision was already a consideration in settlement negotiations, Waltz says. Historically, when certain organizations faced criminal charges, they worked out a deal with the government whereby a subsidiary would take the fall and the parent organization would enter into a civil settlement and corporate integrity agreement. That can save the parent company and affiliated entities from mandatory Medicare and Medicaid exclusion, which, in the case of a pharmaceutical company, for example, may threaten patient access to care by prohibiting payment for all of that entity's drugs, Waltz says. But with the health reform mandate, the government's hands were seemingly tied. The safest option in such circumstances would have been to divest the entity subject to mandatory exclusion rather than let it remain in the corporate family, she says.

Although many grounds still remain for Medicaid exclusion, the provision requiring such exclusion of owned, operated or managed affiliates was stricken by the Medicare and Medicaid Extenders Act. However, under a separate but related provision of the health reform law, providers that are terminated from Medicare or any state Medicaid plan must be terminated by every other state Medicaid plan. CMS must establish a mechanism to share information to ensure that states are able to fulfill this mandate and has gotten the ball rolling *(RMC 6/28/10, p. 1)*.

Medicare Recoupment Authority Got Stronger

And providers and suppliers have to contend with the still-effective Medicare overpayment recoupment provisions of the health reform law. One provision allows CMS to reach into any pocket in an affiliated organization to get its money back, regardless of who owes Medicare, if the entities share a tax identification number. Before, CMS could recover unpaid Medicare overpayments only from related entities if they had the same provider number. That limited Medicare recoupment opportunities because many entities have multiple sites enrolled under the same tax ID but with different provider numbers, Waltz says.

"This gives Medicare a much-enhanced ability to collect overpayments for entities that have multiple locations and multiple provider numbers," Waltz says.

For example, one hospital in a hospital chain may owe money but lack the funds to repay. Now CMS can collect from any other hospital in the chain or from the parent company as long as the tax ID number is the same.

According to Sec. 632 of the health reform law: "The Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any past-due obligations." The term "applicable provider is defined in the law as a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number."

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