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Individual Liability for Medicare Overpayment Claims

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INDIVIDUAL LIABILITY FOR MEDICARE OVERPAYMENT CLAIMS

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I. SCOPE OF THIS ARTICLE

This article addresses the case where an individual or "natural person" owns an interest in a Medicare health care provider that is incorporated[1] under state law as a corporation, limited liability company ("LLC"), limited partnership ("LP"), or another type of legal person. The individual may be a shareholder, member, limited partner, or some corresponding term for an owner of the company, but in all these cases the common factor is limitation of liability of owners.

Owners of providers facing Zone Program Integrity Contractors ("ZPIC")[2] or other Medicare contractor audits or appealing an overpayment demand often ask what risk they face of being held personally liable for the overpayment claims, or otherwise punished personally, if their appeals are unsuccessful. This article uses a hypothetical to explain the extent of such owners' personal liability as a result of a Medicare overpayment claim.*

II. DEFINITION OF OUR CASE

Consider a common scenario in which a provider organized as a corporation or LLC (the "Company") with one or more individual owners (i.e. individual "shareholders" or "members") is enrolled with Medicare, has provided services to Medicare beneficiaries over a substantial period of time, and has received payments from the Medicare contractor. A ZPIC or other contractor, such as a Medicare Recovery Audit Contractor ("RAC")[3] or a Comprehensive Error Rate Testing ("CERT") contractor,[4] then selects the Company for post-payment audit. After reviewing a sample of records, the contractor determines that overpayments have occurred and issues an audit results letter assessing an amount it claims Medicare overpaid in the sample. The contractor also assesses a much larger extrapolated amount it deems Medicare overpaid in all of the Company's Medicare receipts during the period under review. The Medicare Administrative Contractor ("MAC") then makes a written formal demand for refund by the Company of the extrapolated amount.

Assume further that the Company either fails to appeal this overpayment determination, referred to as an "Initial Determination," or appeals and loses. Either way, the Company owes the full extrapolated amount to the Centers for Medicare & Medicaid Services ("CMS"), plus interest that begins to accrue thirty days from the date of the formal demand by the MAC. Also assume that this sum amounts to several years of gross revenues for the Company, and it has no means to repay it. The MAC begins to recoup payments of new Medicare billings by the Company, and the Company shuts down as it exhausts its funds available to cover payroll and operating expenses. Finally, assume, as is commonly the case, that the Company has no significant assets that CMS can seize and liquidate to satisfy the overpayment. Thus, the primary issue is whether the Company's individual owner or owners are on the hook for the unpaid amount of the CMS overpayment claim. A related issue is the potential for liability of other provider entities owned by the same individuals. In other words, under what circumstances can CMS or its contractors lawfully collect the overpayment from the individual owners or their other provider companies? What other sanctions can the government apply against the individuals and affiliates in such a case?

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III. CONCEPT OF LIMITED LIABILITY

In the United States and most Western legal systems the concept of incorporation of a business is available to shield its owners from claims for the business's debts. This is the concept of "limited liability," meaning the owners' personal liability for the debts of the business is usually limited to the amount of the capital they have invested in it. If the business owes money to a creditor, the creditor will have recourse to the business, meaning the money and other assets the business itself owns. In this way, the creditor can collect the capital the owner has bound up in the business, but the creditor has no right to make the owner pay from his own assets.

IV. THRESHOLD RULE OF LIMITED LIABILITY; EXCEPTIONS AND "PIERCING THE CORPORATE VEIL"

The general rule of limited liability applies to CMS and its contractors when dealing with shareholders of incorporated health care providers, just as it does to other creditors. No statute or case law makes owners of incorporated health care providers personally liable for their companies' debts to CMS, except in certain very narrow circumstances that apply to all debtors and creditors. These circumstances are no more likely to arise in the health care industry than elsewhere.

The principal exceptions to the rule of limited liability of shareholders are collectively known as "piercing the corporate veil." Under certain circumstances, courts will allow creditors of an insolvent corporation, LLC, or other legal entity to reach through the corporate structure and collect their debts from shareholders or similar owners.[5] Notably, however, CMS and its contractors rarely seek to pierce the corporate veil, as courts tend to disfavor the practice and narrowly interpret common law governing the area. While an exhaustive discussion of this topic is beyond the scope of this article, courts have cited numerous factors to justify imposing liability on shareholders for corporate debts, including the following:

A. Defective Incorporation

Failure to meet legal statutory requirements for organizing the corporation or LLC can and will result in shareholders being liable for corporate debts. Without compliance with the requirements for incorporation, no corporation ever exists in the first place to shield the shareholders from liability.

B. Ignoring the Separateness of the Corporation

Entering into contracts and otherwise transacting business variously in a corporate name and an individual name can justify piercing the corporate veil. Likewise, commingling corporate and individual assets, or transferring assets without formalities between company and owner, or company and a sister company, can yield the same result.

C. Significant Undercapitalization

A corporation must have a reasonably sufficient amount of capital to pay its expected debts. Failure to do so is grounds to impose liability on the shareholders. Undercapitalization is normally difficult to prove, as courts determine the adequacy of capital at the time it is injected, not when the liability arises. Further, courts tend to defer to any good-faith estimate of how much capital will be needed.

D. Excessive Dividends or Other Payments to Shareholders

When owners are actually working for a corporation they can in most cases pay themselves whatever compensation is even remotely fair, as long as it is clearly characterized as salary or wages. Dividends and other non-compensation distributions, however, are judged very differently, and can safely be taken out by shareholders only to the extent of profits. When shareholders take non-compensation distributions in excess of profits, these distributions constitute a return of capital and can give rise to an undercapitalization claim by any corporate creditor who is subsequently not paid.[6] If such distributions are made when the corporation is actually insolvent, the creditors' claims against the shareholders will be almost impossible to defend.

E. Misrepresentation and other Unfair Dealings with Creditors

Dishonesty and false statements to corporate creditors, asset concealment, and other deceptive

practices can make shareholders liable for corporate debts.

F. Absence or Inaccuracy of Records

If corporate records go missing or prove to be inaccurate, they can form a basis to pierce the corporate veil, especially if they hinder a creditor's collection efforts against the corporation.

G. Failure to Maintain Ongoing Legal Requirements

Each state's statutes impose annual franchise fees and various report-filing requirements on corporations and similar entities. Although these have generous grace periods and cure provisions, if they are neglected long enough, the corporation or LLC will legally cease to exist and shareholder liability will result.[7]

Given any of the above factors, CMS and its Medicare contractors can seek to pierce the Company's corporate veil and collect the overpayment from the Company's owners. These circumstances, however, are not typical for health care providers and are easily avoided. Veil piercing depends on facts that by their nature are difficult to prove in a court of law, often involve subjective judgments, and in most cases are subject to dispute. The burden of proving the facts is always on the creditor. Correspondingly, courts tend to disfavor veil piercing claims and narrowly construe the applicable law, so veil piercing has a reputation as a difficult remedy to invoke successfully.

V. RULES IN BANKRUPTCY

While CMS enjoys certain advantages and unique rights under U.S. bankruptcy laws, it does not have any advantage over other creditors in reaching the pockets of shareholders of a bankrupt company.

A basic rule in bankruptcy is that filing a petition automatically halts or "stays" all acts by creditors to collect debts which pre-date the petition.[8] Since 2005, this "automatic stay" has been ruled not to impair CMS's right to exclude providers from its programs.[9] Additionally, federal case law appears to hold that the automatic stay does not prevent CMS and its contractors from recoupment against new Medicare billings by a provider in bankruptcy.[10] But no bankruptcy law gives Federal health care programs special debt collection rights against shareholders of providers, so CMS and its contractors, like other creditors, can collect Medicare overpayments from shareholders and other owners of a bankrupt entity only in the veil piercing circumstances described above, which are narrowly-drawn and strictly interpreted against the creditor.

VI. FEDERAL AGENCY PRACTICE ON PURSUING INDIVIDUAL LIABILITY

Federal agencies are not as a rule aggressive in collection of their debt claims, and CMS is no exception. For example, in government loan programs where shareholders are required personally to guarantee the debt, once corporate assets are exhausted in default cases, federal agencies rarely pursue the guarantors' personal credit and discourage their contractors and even private holders of government-guaranteed loans from doing so.[11] With this in mind, it should be no surprise that most federal agencies seldom if ever seek to pierce any corporate veil.[12] As noted, veil piercing is difficult because it involves many ambiguities and is dependent on individual facts and circumstances; government agencies are reluctant to risk the time and resources required. Government agencies also fear the adverse publicity that regularly arises from collection efforts against individuals. While federal authorities might pursue such remedies in an extreme case or under the glare of unusual publicity, they are otherwise unlikely to do so.[13]

VII. SUCCESSOR LIABILITY

The individual owners in the hypothetical will not be able to continue in the health care industry using the Company itself as a practice vehicle. They may wish to organize and capitalize another entity to provide the same or a similar type of services. In what circumstances can new entities organized by the owners after the Company's demise be held liable for the Company's overpayment obligation? This area of the law is referred to as "successor liability," and it provides remedies that allow creditors to pursue the new entity in some cases. Like veil piercing, this remedy is an exception to the general rule of limited liability of corporate owners, is available to creditors in certain narrow circumstances, and is not specific

to government creditors or health care provider debtors.

Successor liability flows from state statutes and state court case rulings that allow the creditors of a debtor company to collect their debt claims from another company to which one or more assets of the debtor have been transferred, if it is a successor to the original debtor. The exact circumstances that make the other company a successor vary from state to state. In most states the law gives a list of elements that can establish successor status, but uses a balancing test, meaning there is no concrete rule of which or how many elements must be satisfied to prove a claim. The creditor sues the transferee company to initiate such a claim, and the court hearing the case decides not only which elements are present, but also whether they are enough to make the defendant a successor.[14] But if a creditor can prove enough of them, it can obligate the transferee to pay the debt.

Elements commonly listed to impose liability on the transferee of a debtor's assets include (i) common ownership (whole or part) between the original debtor and the separate company; (ii) the transferee was established to hinder the creditors of the debtor; (iii) the original debtor and the transferee company provide the same goods or services; (iv) the same or recognizably similar company name or DBA; (v) same business location; (vi) same customers or customer sources; (vii) same officers or managers; (viii) same employees; and (ix) the transferee pays other debts of the original debtor, or states that it will do so. In most cases, one or two elements alone will usually be insufficient to establish liability.[15]

Successor liability is not as uniformly disfavored in courts as veil piercing but remains uncommon in practice. Like veil piercing, it is rarely used by federal agencies and contractors. Whether any specific circumstances will make a transferee company liable as a successor to another is beyond the scope of this article; nonetheless, asset transfers between commonly-owned companies occur frequently yet may not easily be identifiable as such to a non-lawyer. In the hypothetical, the Company's owners may be sorely tempted to use the same business location or same employees or managers in the new provider as in the Company, and may wish to have the new entity collect unpaid receiveables. Any of these steps could subject the new entity to the overpayment, or to any other creditor claim. Successor liability can be invoked against pre-existing entities under common ownership with the Company as well. Owners of health care providers having other companies subject to any Medicare contractor collection action need to avoid any such transfers scrupulously. They can make their other provider liable in common for an overpayment claim.

VIII. OTHER GOVERNMENT SANCTIONS AGAINST OWNERS AND AFFILIATES FOR NON-PAYMENT BY AN INCORPORATED PROVIDER

Pursuing owners personally for repayment of a provider's overpayment liability isn't the only sanction CMS and its contractors might logically seek to apply to punish non-payment. Excluding related persons and companies from health care program participation comes to mind. This could take at least three forms, each of which we will examine in turn.

A. Exclusion of Individual Owners

The authority for HHS to exclude both companies and individuals from involvement in its health care programs has been established at the statute, regulation, and policy manual levels.

The basic authority for exclusion is granted to the Secretary of HHS under Sections 1128 and 1156 of the Social Security Act.[16] These sections list all the grounds for which a party may be excluded.[17] Most of these sections are written so that if an entity commits acts that are grounds for exclusion, the owners are likewise at risk.[18] Most of the grounds for exclusion are not relevant here, such as conviction for felonies, or health care related misdemeanors. Three grounds for exclusion, however, relate to providers' services, namely submitting charges to any Federal health care program in excess of the provider's usual charges, furnishing services in excess of the needs of patients, and furnishing services of a quality not meeting recognized professional standards.[19] The lack of medical necessity grounds for denial that

appear in most overpayment cases corresponds to the "furnishing services in excess of the needs of patients" grounds for exclusion. So the question is whether lack of medical necessity of our Company's services is, in and of itself, valid grounds to exclude it, and therefore also exclude its owners?

These service-related grounds for exclusion are addressed in the *Medicare Program Integrity Manual* (the "PIM") in Chapter 4, Sec. 4.19. This section states, "In order to prove such cases, the PSC and the ZPIC BI unit shall document a long-standing pattern of care where educational contacts have failed to change the abusive pattern. Isolated instances and statistical samples are not actionable. Medical doctors must be willing to testify.[20]

Only these service-related grounds for exclusion could plausibly be applied to the facts of our overpayment hypothetical, without serious wrongdoing beyond simple failure to repay. The contractor documentation in a typical post-payment audit would not appear to satisfy the PIM requirement of "document[ing] a long-standing pattern of care where educational contacts have failed to change the abusive pattern."[21] Accordingly, exclusion of the provider and its individual owner does not appear to be a substantial risk in the hypothetical.

B. Bars to Subsequent Applications

In the hypothetical, the individual owners will not be able to continue in the health care industry using the Company itself as a practice vehicle. They may wish to organize and capitalize another entity to provide the same or a similar type of services. What are the risks that CMS and its contractors might punish the Company's failure to satisfy its proven overpayment demand, by barring the enrollment application of the owner's new provider entity?

In order to bar a new provider owned or controlled by owners of the hypothetical defaulting provider, however, CMS and its contractors must be aware of the relationship between the two companies. So the initial inquiry must be whether the new-provider enrollment process will itself call the attention of CMS or its contractors to the relationship between the non-paying Company and the new applicant. This process is largely embodied in the enrollment application document. The current form of Medicare enrollment application for most incorporated providers, CMS-855A requires disclosure of any "Adverse Legal Actions/ Convictions" of individuals with ownership or control of the entity.[22] The Company's owners from the hypothetical would therefore be required to disclose any such as part of the enrollment application. The listing of adverse adjudications that constitute Adverse Legal Actions/Convictions includes most criminal convictions, state license and government program revocations, suspensions, exclusions and debarments, as well as "[a]ny current Medicare payment suspension under any Medicare billing number."[23]

This form does not require the new applicant's owner to disclose the problems of the Company in the hypothetical, or even mention its existence, for two reasons. First, "payment suspension" is a very specific Medicare sanction, and usually not present in an overpayment demand case. Second, the disclosure is explicitly directed at the individual owner, and its wording does not extend it to other entities under the owner's ownership or control. Section 6 of the PIM provides the following:

> 1. Has the individual in Section 6A, under any current or former name or business identity, ever had a final adverse legal action listed on page 16 of this application imposed against him/her?[24]

New program developments in Medicare, however, may change the above situation and extend required disclosures to entities under common ownership or control with new applicants. In its 2013 Work Plan, the HHS OIG proposed the following concerning oversight of "currently not collectible debt":

> [The OIG] will also determine whether [currently not collectible] debtors are closely associated with other businesses that continue to receive Medicare payment. CMS defines a [currently not collectible] debt as a Medicare overpayment that remains uncollected 210 days after the

provider or supplier is notified of the debt and for which recovery attempts by CMS contractors have failed.[25]

No mention is made in the Work Plan of what, if any, sanctions HHS is considering against businesses "closely associated" with defaulting debtors, but affiliates of debtors defaulting on overpayments are clearly a topic of concern to the agency. Program changes on this subject may be forthcoming, and would logically be brought to bear in the new provider enrollment process.

Means already exist – such as simple data mining – for CMS and its contractors to identify other providers under common ownership with a defaulting provider.[26] With or without changes coming from the Work Plan, there is a substantial risk that in our hypothetical, CMS or its contractors would become aware of the connection between the new application and the Company's unsatisfied overpayment.

Grounds for denial of enrollment are similar to grounds for exclusion.[27] They include felony convictions and program debarments, as well as exclusions of "[a] provider, supplier, an owner, managing employee, an authorized or delegated official, medical director, supervising official, or other health care personnel furnishing reimburseable Medicare services who is required to be reported on the enrollment application."[28] Further, denial of enrollment based on an existing overpayment is expressly mentioned in this regulation: "(6) Overpayment. The current owner (as defined in § 424.502), physician or nonphysician practitioner has an existing overpayment at the time of filing of an enrollment application."[29] This provision does not include the Company's overpayment in our hypothetical as grounds for denial of the new provider's enrollment, and no other part of the regulation appears to do so either. So it appears that even if CMS or its contractor is aware of the affiliation of the Company and the new entity, it could not deny the new enrollment. In practice, however, it is highly likely the agency would strive to find other grounds for denial in such a case, and the affiliation with the Company would make enrollment extremely difficult for the new provider entity. Additionally, changes to the Medicare enrollment process resulting from the OIG Work Plan discussed above could include an expansion of the grounds for denial of enrollment to include overpayments by entities under common control with the applicant.

C. Sanctions Against Companies Under Common Ownership or Control

If we add to the hypothetical another existing health care provider business that is incorporated as an entity separate from the Company but under common ownership or control, another question arises: what are the risks that CMS and its contractors might punish a failure to satisfy a proven overpayment demand with sanctions against the other existing Medicare provider entity? In the veil piercing and successor liability topics above, we noted that such acts as ignoring the formalities of legal separateness between the Company and the other provider entity, and transferring assets between them, can allow creditors such as CMS and its contractors to pursue their debt claims against both entities. But as also noted in that topic, such remedies are hard to invoke, disfavored by courts in practice, and seldom used by government agencies. So our inquiry turns to exclusion of the other entity from government programs and revocation of its Medicare enrollment.

Section 1320a-7(b)(8) of the Social Security Act allows incorporated entities to be excluded if a five percent or more owner or control person has been excluded. The Company's owners will own the other entity in our hypothetical, so if the conduct of the Company were grounds to exclude the owners, § 1320a-7(b)(8) would allow the other entity to be excluded likewise. But as discussed in (a), above, the PIM exclusion requirements make it unlikely that the exclusion sanction could be applied in a normal overpayment case. Likewise, the regulations governing revocation of enrollment do not identify an overpayment by a provider under common control as grounds for revocation.[30] Accordingly, no clear avenue exists under current Medicare law and policy to exclude or revoke the enrollment of the commonly owned provider in our hypothetical.

IX. CONCLUSION

In sum, the established legal rule of limited liability of owners of incorporated businesses appears to be alive and well in the Medicare service provider area,

and federal agencies and their contractors by and large respect it. The separateness of legally distinct incorporated businesses under common ownership also remains in effect. However, these rules have significant exceptions.

Owners of incorporated health care provider entities, absent some written agreement to the contrary, are insulated from personal liability for overpayment obligations owed by their companies to Federal health care program authorities by the same state laws which insulate them from their companies' other debts. Generally, federal health care laws do not change these rules. If your company's assets are insufficient to satisfy its debts, procedures exist for federal claimants (like other creditors) to try to reach through your company and pursue your personal credit to satisfy their claims. But this requires a lawsuit to be filed against you personally; the laws of the states specify only certain narrow circumstances where they can be successful. Accordingly, creditors rarely try to "pierce the corporate veil," and this is probably more true of federal creditors than private ones.

The most likely situation where an insolvent provider's creditor can successfully reach the personal credit of the owner is when the owner has taken dividends and other sums from the company which cannot be characterized as salary or compensation for employment, at times when the debtor company was already insolvent. Likewise, the most likely way a new provider company being organized by an existing provider's owner can become liable to its creditors is for assets to be transferred from the old provider to the new. Owners of multiple providers should consult legal counsel to examine all dealings between them for successor liability and similar issues whenever one provider becomes liable for overpayments, because many risk-creating activities will not be recognizable as such without legal training.

In addition to debt collection risks, HHS can exclude owners of providers from Federal health care programs, which operates to exclude other provider entities under common ownership. The available grounds for exclusion, however, do not normally arise in an overpayment case. Similarly, HHS regulations provide for the revocation of the enrollment of health care providers in certain cases. The grounds for revocation do not include a defaulted overpayment by a separate provider under common control.

The main area of risk for the affiliates of a defaulting provider subject to an overpayment is the enrollment application by a new provider entity under common ownership. While the strict wording of the current enrollment application form does not require disclosure of the overpayment situation in our hypothetical, and overpayment by a commonly-owned provider is not currently a listed basis for denial of the new enrollment, in practice the existence of a defaulted overpayment obligation poses a substantial risk to any related party's enrollment. Initiatives are under way inside HHS that could change these risks to certainties.

[1] The term "incorporated" will be used here to refer to the legal process of creating any form of legal entity providing limited liability to its owners (e.g. limited partnerships and LLCs) not just to the creation of a corporation.

[2] ZPICs are contractors dedicated to program integrity by handling functions such as audits, medical reviews, and potential fraud and abuse investigations consolidated into a single contract. Medicare Program Integrity Manual, CENTERS FOR MEDICARE & MEDICAID SERVICES, Ex. 1 (Dec. 28, 2012), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83exhibits.pdf.

[3] RACs focus on identifying and recovering improper Medicare payments through the efficient detection and collection of Medicare overpayments. *See* Ctrs. for Medicare & Medicaid Servs., *Recovery Audit Program*, CMS.GOV (last updated Mar. 13, 2013), http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/rac/. Unlike ZPICs, RACs are paid on a contingency basis and focus more on fraud.

[4] CERT contractors measure improper Medicare payments. The CERT program uses random samples to select claims and is therefore often unable to label a claim fraudulent. *See* Ctrs. for Medicare & Medicaid Servs., *Comprehensive Error Rate Testing (CERT)*, CMS.GOV (last updated Mar. 13, 2013), *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html?redirect=/CERT/.

[5] *See* Walkovszky v. Carlton, 18 N.Y.2d 414, 418-19 (1966) (refusing to pierce the corporate veil on account of undercapitalization alone); Sea-Land Servs., Inc. v. Pepper Source, 941 F.2d 519 (7th Cir. 1991) (finding that the corporate veil will be pierced when there is no separation between the corporation and its owner and when a fraud or injustice would result if the veil were not pierced).

[6] This practice is harder to defend than a claim for initial undercapitalization, because in this case there is evidence that at the time of organization, the owners believed the capital later taken out was needed in the business.

[7] Failure to hold annual meetings or keep corporate minutes has seldom been the basis for shareholder liability.

[8] 11 U.S.C. § 362.

[9] 11 USC § 362(b)(28)

[10] *See* In re Slater Health Center, Inc., 398 F.3d 98, 104-05 (1st Cir. 2005) (allowing CMS to recoup money as an adjustment for a Medicare overpayment, even though the provider was in bankruptcy). The US Bankruptcy Code does not explicitly address recoupment, and the *Slater* ruling may not apply in all circumstances. Among other things, its application turns on the overpayment and the new billing being part of the "same transaction." Otherwise, the contractor's claim against the new billing is a setoff that is specifically addressed in the Code and is generally halted in bankruptcy by the automatic stay. *See, e.g.*, In re University Medical Center, 973 F.2d 1065, 1073 (3rd Cir. 1992) (holding that a debtor hospital's claim that HHS violated the automatic stay by withholding payments for Medicare services rendered after debtor hospital filed for bankruptcy arose under the Bankruptcy Code).

[11] Gerri Detweiler, *What to Do if You Can't Make Your SBA Loan Payments*, CREDIT.COM (May 30, 2011), http://blog.credit.com/2011/05/what-to-do-if-you-cant-make-your-sba-loan-payments/ (explaining that while the Small Business Administration can seize debtors personal collateral in the event of a default, in practice it encourages the lending bank to work out a reasonable settlement).

[12] The notable exception to this rule is the Internal Revenue Service's pursuit of shareholders to collect corporate tax liability. The IRS has in recent years successfully pierced the corporate veil in a number of well-publicized cases.

[13] In over thirty years of representing participants in Federal programs, I have never been involved in any case where such a remedy was sought against a client or any other individual.

[14] *See, e.g.*, Cab-Tek v. E.B.M. Inc., 153 Vt. 432 (Vt. 1990).

[15] Typical statements of state successor liability rules can be found in Marks v. Minn Mining & Mfg. Co., 187 Cal. App. 3d 1429 (Cal. Ct. App. 1986) and Sweatland v. Park Corp., 587 NYS 2d 54 (App. Div. 1992).

[16] 42 USC §§ 1320a-7 and 1320c-5.

[17] For a helpful chart from HHS OIG that lists all of the bases for exclusion, see *Exclusion Authorities*, DEP'T OF HEALTH & HUMAN SERVS. (last visited April 8, 2013), https://oig.hhs.gov/exclusions/authorities.asp.

[18] The recurring text appears, for example, in 42 USC § 1320a-7(b)(6). That section provides that the Secretary of HHS may exclude "Any individual or entity that the Secretary determines... has furnished or *caused to be furnished* ... items or services to patients substantially in excess of the needs of such patients...." Since owners of a provider entity are normally in control of it, if the entity has done the described act, the owner can be said to have *caused* the act, and is therefore subject to the same grounds for exclusion [emphasis added].

[19] 42 USC § 1320a-7(b)6).

[20] Ctrs. for Medicare & Medicaid Servs., *Medicare Program Integrity Manual*, CMS.GOV, Ch. 4, § 4.19.2 (Dec. 28, 2012), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf.

[21] Notably, no practitioner at this health care law firm has seen exclusion attempted or threatened against the provider or its owners in a simple overpayment case.

[22] *See Medicare Enrollment Application: Institutional Providers, CMS-855A*, CENTERS FOR MEDICARE & MEDICAID SERVICES § 6, *available at* http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf.

[23] *See id.* at § 15 (extending the required disclosure to all subsequent periods, effectively making it an Evergreen requirement).

[24] *Id.* at § 6.

[25] *Office of Inspector General Work Plan: Fiscal Year 2013*, DEP'T OF HEALTH & HUMAN SERVS. at 38 (2013), *available at* https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf. The OIG's FY 2012 Work Plan contained an identical provision. *See Office of Inspector General Work Plan: Fiscal Year 2012*, DEP'T OF HEALTH & HUMAN SERVS. at I-32 (2012), *available at* https://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf.

[26] For example, CMS-855 program application forms have long required owners of all applicants to be identified by name and Social Security Number. Cross-checking these identifiers against identifiers of owners from the CMS-855 of defaulting debtors could easily be implemented.

[27] *See* 42 C.F.R. § 424.530(a); *see also* Medicare Program Integrity Manual, CENTERS FOR MEDICARE & MEDICAID SERVICES, Ch. 15.8 (Dec. 28, 2012), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf.

[28] 42 CFR § 424.530(2).

[29] *Id.* at § 424.530(6). The regulation defining the term "owner" includes holders of five percent greater ownership interests. Grounds for denial of enrollment based on payment suspension are set forth in nearly identical language in § 424.530(7).

[30] *See* 42 CFR § 424.535. Note that this revocation regulation includes a grounds for revocation corresponding to § 424.530(a)(2) (felony conviction, debarment or suspension by the provider, its owner or key personnel) but no grounds for revocation corresponding to § 424.530(a)(6) (existing overpayment by the provider or its owner).