Ambiguities Sow Confusion Concerning Enhanced Payments to Medicaid Primary Care Providers under the ACA

Leonardo M. Tamburello

by Leonardo M. Tamburello, Esq.

Increasing Medicaid beneficiary access to primary care services is one of the signature ambitions of the Affordable Care Act. Section 1202 of the Healthcare Education and Reconciliation Act of 2010 (the "Statute") attempts to achieve this goal by increasing payments to qualified primary care providers for selected primary care services provided in 2013 and 2014.[1]

Eligibility & Administrative Requirements

To qualify for these so-called "Enhanced Payments," providers must self-attest that: (1) they are Board-certified and specialize in family medicine, general internal medicine, pediatric medicine, or any subspecialty within those designations recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties; or (2) at least 60 percent of their paid Medicaid claims for the prior calendar year were for eligible E&M or vaccine administration services as defined by the Statute. ("Qualified Services").[2] Qualified Services performed by non-physician practitioners (such as advanced practice nurses, nurse midwives and physician assistants) count towards this 60 percent threshold, provided that they were provided under the personal supervision of an eligible physician who accepts professional and legal liability for the services provided by the non-physician practitioner.[3]

Of course, reimbursement (including Enhanced Payments) is appropriate only where providers have delivered services in accordance with their managed care contract and Medicaid requirements. Consequently, in the event of an audit which requires setoff or recoupment, the Enhanced Payments related to ineligible services would also be subject to repayment.[4] At the moment, Enhanced Payments have been authorized for Qualified Services performed in 2013 and 2014, but CMS has indicated a willingness to extend Enhanced Payments indefinitely, assuming Congressional funding materializes.[5] Services through a federally-qualified health clinic (FQHC), rural health clinic (RHC), or performed for clients in standalone non-Medicaid programs such as Children's Health Insurance Program (CHIP), are not eligible for Enhanced Payments.[6]

Though Enhanced Payments are funded exclusively by the federal government, CMS has given individual states and managed care organizations ("MCOs"), prepaid inpatient health plans, and prepaid ambulatory health plans broad discretion in their administration.[7] For example, the Enhanced Payments may be made as "either add-ons to existing rates or as lump sum payments," made no less than quarterly.[8] This has led to varying (and sometimes inconsistent) approaches among states and MCOs. It has also confusion among providers and their employees. Although CMS issued rulemaking guidance which makes clear that MCOs are "required by regulation and contract to ensure that eligible primary care providers receive the appropriate rate increase for primary care services rendered,"[9] it did not specifically define the term "provider" in this context.

Nonetheless, some MCOs have stepped in and defined that term to exclusively mean "rendering provider."[10] This definition completely disregards the fact that the "rendering provider" may be an employee of a group provider; that the group provider is most likely the contracting party with the MCO; and in most cases there is an employment contract between the group provider and the rendering physician which addresses the manner in which reimbursement for professional services is treated.

Unwarranted MCO Requirements Create Confusion

Horizon NJ Health, ("Horizon") has taken the position that "[t]he enhanced payment[s] must ultimately be paid to

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the physician rendering the service so the individual physician, not the group practice, is receiving the benefit of the enhanced rate."[11] To this end, HNJH requires groups providers sign a "Group Attestation" in which they

> Certify that all ACA authorized enhanced reimbursement amounts may be paid to the group's Tax Identification Number, and the group, as required under the ACA, will distribute individual payments to the rendering provider in the group.[12]

Neither Horizon, CMS, nor New Jersey Medicaid have publicly identified any basis in the ACA or the Final Rule[13] to support the position that all Enhanced Payments must be made to rendering physician employee of a group practice, despite the Group Attestation's clear mandate to that effect. Indeed, there is no legal requirement for such action, either in the ACA or the regulations implementing the Enhanced Payments. Moreover, neither the Statute nor the implementing regulations discuss the most common group employer scenario whereby a group provider employs the rendering physician through a contract contains a provision which assigns all revenue generated by their professional activities to the group.[14]

The closest that the regulations come to addressing this point is a statement concerning salaried county-employed doctors, saying that "[i]f, as a condition of employment, the physician agrees to accept a fixed salary amount then we expect an appropriate adjustment to the salary to reflect the increase in payment."[15] There is absolutely no discussion of how this "appropriate adjustment" should be calculated or what effect terms of an existing employment contract might have on the situation. Into this vacuum, Horizon has invented the Group Attestation language above and interjected itself into a private contract between the group employer and its individual physician employees.

Both federal and state regulators are aware of group attestations such as Horizon's. Nonetheless, CMS appears content not to intervene, so long as the MCOs themselves do not retain any of the Enhanced Payments.[16] Similarly, New Jersey Medicaid seemingly does not find Horizon's requested Group Attestation objectionable or problematic.

Perils of Signing the "Group Attestation"

Despite the regulatory indifference to Horizon's unfounded demand that group providers sign a sworn statement that they will pay all Enhanced Payment amounts to rendering physician employees, signing the Group Attestation has potentially perilous consequences far beyond the obvious one of depriving the group provider of the increased funding to which it is entitled under the ACA. Group providers who sign Horizon's attestation may face a recoupment or setoff[17] from the payer, in addition to potential exposure under the False Claims Act if a future audit determines that the Enhanced Payments were not passed down to the rendering physicians.[18]

Moreover, requiring that the rendering physician receives the Enhanced Payment does nothing to advance the Statute's stated goal of enhancing Medicaid beneficiary access to primary care services. In contrast, depriving a primary care group of the ACA's financial benefits encourages the hiring of fewer, not more, doctors; because all medical practices must be owned by licensed physicians, Horizon's attestation encourages owners of primary care providers to act as the rendering physicians themselves, rather than using salaried physicians or non-physician practitioners to increase access. Thus, the Group Attestation may have the complete opposite effect from that intended under the ACA by curtailing (rather than expanding) Medicaid beneficiary access to primary care services.

Requiring that Enhanced Payments be made to rendering physicians also fails to recognize the entrepreneurial risk taken by physicians who form group practices that provide primary care services to Medicaid beneficiaries; it also deprives them of obtaining any relief from the loans or personal guarantees they have assumed in doing so.

In addition, by signing Horizon's Group Attestation, a group provider could be potentially creating an ambiguity concerning terms of employment with their contracted employee physicians as to whether the Enhanced Payments should be treated differently from other revenue generated by employee physicians, which is typically assigned to the group. It may be argued that by signing the Group Attestation, the group provider is expressing agreement or intent that Enhanced Payments should be treated differently from all other forms of remuneration, (*i.e.*, given to the rendering physician). Potentially, this may create unnecessary disputes between group employer and employee physicians over entitlement to the Enhanced Payments, particularly if the employee-physician's employment contract predates the Statute's enactment and/or does not specifically address the issue of Enhanced Payments or compensation under the ACA.

Risk Avoidance and Mitigation Strategies

Providers should think carefully and consult with experienced healthcare counsel before signing any attestation or amendments to their provider agreement addressing the disposition of Enhanced Payments under the ACA. If they decide to do so, it should be with a full understanding that they could be creating an expectation that the entire Enhanced Payment will be turned over to the rendering physicians, and that if they fail to do that, there are unpredictable and potentially serious consequences that may follow. In

appropriate circumstances, a group provider may consider an attestation that pursuant to the employment contract between the itself and its rendering employee physicians, the latter have assigned all rights to reimbursement for professional services to the former, which includes that related to the Enhanced Payment.

Given the dearth of regulatory leadership and lack of explicit authority to address the common situation where a group provider employs salaried physicians whose employment contracts provide for the assignment to the group of all remuneration received as a result of professional activities, prudence suggests that some portion of the Enhanced Payments should be shared with the salaried employed physicians (and other non-physician professionals) who provided Qualified Services which led to the Enhanced Payment either through direct or deferred compensation. In addition, the remainder of the Enhanced Payment should be used by the group practice to further the Statute's stated goal of increasing access to primary care services for Medicaid beneficiaries. This can take a variety of forms including the purchasing of new equipment, hiring new employees, expanding office hours, or retiring debt related to the operation of the practice. In the event of an audit, clear documentation evidencing the disposition of the Enhanced Payment should be maintained in accordance with the group's document retention practices.

Summary

While Enhanced Payments under the ACA are powerful incentives for primary care providers to expand their Medicaid services, providers should nevertheless act cautiously and insure full eligibility and compliance with CMS directives as well as contractual requirements. Anytime a signed attestation is requested, a provider should carefully scrutinize the representations it contains, and consider consulting with experienced healthcare counsel for specialized advice. As discussed above, the basis for the Group Attestation appears dubious at best and could lead to serious compliance issues including setoff and recoupment, as well as exposure and civil monetary penalties under the False Claims Act.

Endnotes

[1]42 U.S.C. § 1396a(a)(13)(C).
[2]77 Fed. Reg. at 66675. 42 U.S.C. § 1396a(jj).
[3]77 Fed. Reg. at 66677.
[4]77 Fed. Reg. 66681.
[5]42 U.S.C. § 447.400(d); 77 Fed. Reg. at 66673.
[6]77 Fed. Reg. at 66676, 66672.
[7]77 Fed. Reg. at 66671 and 66680.
[8]77 Fed. Reg. at 66679.
[9]77 Fed. Reg. at 66680.
[10] http://www.horizonnjhealth.com/sites/default/files/ACA-Reimbursement-Group-Attestation-Form.pdf
[11]http://www.horizonnjhealth.com/for-providers/aca-enhanced-pcp-reimbursement-payments
[12]http://www.horizonnjhealth.com/sites/default/files/ACA-Reimbursement-Group-Attestation-Form.pdf
[13]77 Fed. Reg. 6669-66701
[14]77 Fed. Reg. 66680.
[15]77 Fed. Reg. 66680.
[16]77 Fed. Reg. 66680.
[17]42 C.F.R. 405.370.
[18]31 U.S.C. § 3729.

About the author

Mr. Tamburello is of counsel in the Healthcare Practice Group at McElroy, Deutsch, Mulvaney & Carpenter, LLP in Morristown. He concentrates his practice on the representation of healthcare providers in a variety of litigation and dispute resolution contexts including medical malpractice defense, compliance, audits, fraud and abuse, and privacy and information security.

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