NO. CAAP-17-0000432

IN THE INTERMEDIATE COURT OF APPEALS OF THE STATE OF HAWAI'I

FREDERICK NITTA, M.D., Appellant, vs. DEPARTMENT OF HUMAN SERVICES, STATE OF HAWAII, AND PANKAJ BHANOT, DEPUTY DIRECTOR, Appellee.	Civil No. 16-1-0297 APPEAL FROM 1) DECISION AND ORDER ON APPEAL, FILED ON APRIL 12, 2017 2) JUDGMENT, FILED MAY 9, 2017 CIRCUIT COURT OF THE THIRD CIRCUIT HONORABLE GREG K. NAKAMURA

[PROPOSED] *AMICUS CURIAE* BRIEF BY THE HAWAII MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION

CERTIFICATE OF SERVICE

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EXHIBIT "A"

[PROPOSED] *AMICUS* BRIEF OF HAWAII MEDICAL ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION[1]

I. INTRODUCTION: THE CRITICAL PHYSICIAN SHORTAGE IN HAWAII

It's an issue that affects anyone in need of medical care in Hawaii. There has been an ongoing physician shortage in Hawaii, and its only getting worse. As of 2016, the resident population for the State of Hawaii was 1,428,557,[2] and yet, there are only 2,806 licensed physicians practicing in Hawaii and caring for Hawaii's patients.[3] According to the University of Hawaii John A. Burns School of Medicine's Area Health Education Center, the state is nearly

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[1] The Hawaii Medical Association ("HMA") and the American Medical Association ("AMA") appear herein on their own behalves and as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and the state medical societies. Its purpose is to advance the interests of patients and physicians in the state and federal judicial systems.

[2] Census, DEPARTMENT OF BUSINESS ECONOMIC DEVELOPMENT, http://census.hawaii.gov/home/population-estimate/ (last visited September 27, 2017).

[3] See *University of Hawaii System Annual Report to the 2016 Legislature on Findings From the Hawaii Physician Workforce Assessment Project*, December 2015, https://www.hawaii.edu/offices/eaur/govrel/reports/2016/act18-sslh2009_2016_physician-workforce_annual-report.pdf. The HMA and AMA note that the background policy material presented here regarding Hawaii's physician shortage and health care system does not compromise facts that are part of the Record on Appeal. Rather, these public policy points are more like "legislative facts" that courts may take notice when "faced with...deciding upon the constitutional validity of a statute [or regulation], or the interpretation of a statute [or regulation]...and the policy is thought to hinge upon social, economic, political, or scientific factors." Hawaii Rules of Evidence 201, commentary (quotation omitted). Moreover, appellate courts may also take notice of "adjudicative facts" where a fact is "not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court, or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." *Id.* Rule 201(b). "[A]n appellate court may take judicial notice of a fact despite the failure of the trial court to do so." *Id.* cmt. (citing *Application of Pioneer Mill Co.*, 53 Haw. 496, 497 P.2d 549 (1972)). The background information presented here qualifies under either standard; HMA, AMA, and the parties have presented arguments regarding the interpretation and application of 42 C.F.R. § 447.400 to Hawaii's local physicians, and these public policy background facts are adopted from public filings and sources whose accuracy cannot be reasonably questioned.

900 doctors short of the amount it should have based on the population.[4] The shortage is up nearly 20% from 742 in 2013, and 43% from 622 in 2012.[5]

The future workforce numbers are sobering. A best case scenario is that by 2020, Hawaii will have a shortage of 800 physicians.[6] A worst case scenario is a shortage of 1.500 physicians. Among the physician specialties with the greatest shortage is primary care - 25% of the doctor shortfall is primary care providers.[7] Indeed, all counties, which include the Big Island, Kauai, Maui, and Oahu, are in greatest need of primary care physicians.[8]

Hawaii's residents suffer from the physician shortage. Many patients, especially on the neighboring islands, wait four or five months to get an appointment.[9] On the Big Island, it can be two to three times more difficult to find a primary care physician.[10] Because residents are often unable to wait for medical attention, residents are thus forced to instead seek care at the nearest hospital emergency room. Consequently, residents pay upwards of $600-$800 for an emergency room visit, as opposed to an average co-pay of $15-$50 for a visit to a primary care physician.

There are a number of issues contributing to the problem. For one, Hawaii has one of the oldest physician workforces in the nation; the physician average age in Hawaii is 54.9 compared

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[4] *See id.*

[5] *See id.*

[6] *See id.*

[7] *See id.*

[8] *See id.*

[9] *See id.*

[10] *See id.*

to a national average of 51.[11] In 2015, 711 of the state's physicians were over 65 years of age.[12] As these physicians retire, the shortage becomes more severe. Other problems include the state's high cost of living and the costs to pay for medical school.[13]

The principal issue, however, is a lack of funding, both at hospitals and in private practice. Even though Hawaii is in need of 900 physicians, hospitals are financially able to only hire 100.[14] This means that the remaining 800 physicians that this state needs must open or work in private practice. Many physicians, however, opt not to pursue private practice for good reason. The administrative overhead costs associated with private practice are considerable, and primary care physicians in private practice are barely scraping by. As a result, physicians must adjust their business models. This often means a decision to no longer take on any new Medicaid patients.

Indeed, the physician shortage is especially detrimental to Hawaii's Medicaid beneficiaries, particularly those in rural areas, as more physicians make the difficult decision to deny new Medicaid patients. The already critical physician shortage only worsens if the State of Hawaii Department of Human Services continues with its recoupment efforts against physicians who provided primary care services to Medicaid beneficiaries. These physicians rely on the

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[11] *See* Kelley Withy, Priscilla Mapelli, John Perez, Ariel Finberg, and Josh Green, *Hawai'i Physician Workforce Assessment 2016: Improvement in Physician Numbers but Physician Suicides of Concern*, HAWAII JOURNAL OF MEDICINE AND PUBLIC HEALTH (March 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5375006/.

[12] *See id.*

[13] *See id.*

[14] *See University of Hawaii System Annual Report to the 2016 Legislature on Findings From the Hawaii Physician Workforce Assessment Project*, December 2015, https://www.hawaii.edu/offices/eaur/govrel/reports/2016/act18-sslh2009_2016_physician-workforce_annual-report.pdf.

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reimbursements made under the Affordable Care Act to sustain their medical practices. This is consistent with the Act's purpose - to "benefit physicians that provide primary care services to the Medicaid population."[15]

The residents of Hawaii cannot afford to lose any more of its physicians. The Hawaii Medical Association ("HMA"),[16] on behalf of the local physicians in its membership, and the American Medical Association ("AMA")[17] submit this *amicus brief*.[18] The HMA and the AMA request this Court remand this matter against Appellant Dr. Frederick Nitta with instruction to vacate the decisions of the Circuit Court and the State of Hawaii Department of Human Services.

II. ISSUES PRESENTED

Amicus will address Appellant's points on appeal.

III. ARGUMENT

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[15] *See* H.R. Rep. No. 111-299, pt. 1, at 617-19 (2009).

[16] *See* HAWAII MEDICAL ASSOCIATION, http://www.hawaiimedicalassociation.org/ (last visited September 27, 2017). The HMA is part of the American Medical Association and is the parent organization for Hawaii's five component medical societies that operate independently, but in a network with the HMA Honolulu County Medical Society, Hawaii County Medical Society, Kauai County Medical Society, Maui County Medical Society, and the West Hawaii Medical Society. The HMA has served Hawaii since 1856 and is dedicated to serving physicians, their patients, and the community through representation, advocacy, and public service. The HMA actively participates in the development of health policy for the State of Hawaii and advocates for policies that promote the achievement of health equity, especially in communities that have limited access to medical services.

[17] *See* AMERICAN MEDICAL ASSOCIATION, http://www.ama-assn.org/ (last visited September 27, 2017). The AMA is the largest association of physicians and medical students in the United States. For more than 170 years, the AMA has played a crucial role in the development of medicine in the United States. The AMA continues to create a healthier future for patients, including being at the forefront of advocating against racial and ethnic disparities in health care.

[18] Rule 28(g) of the Hawaii Rules of Appellate Procedure requires that an amicus brief comply with applicable provisions of subsection (b)" of Rule 28. Rule 28(b) sets forth the required sections for an opening brief. Accordingly, this amicus brief contains the applicable sections as described in Rule 28(b)(1), (7), (8), and (9).

Title XIX of the Social Security Act is a program that provides medical assistance for certain individuals and families with low income and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States in the provisions of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people.

The Med-QUEST Division within the Department of Human Services is responsible for the overall administration of the Medicaid Program in the State of Hawaii. Specific responsibilities include the application, determination of eligibility, and furnishing of Medicaid.

The recoupment relates to enhanced Medicaid payments paid to primary care providers ("PCPs") as part of the Affordable Care Act. The Centers for Medicare & Medicaid Services ("CMS"), an agency of the federal Department of Health and Human Services, promulgated regulations by adding requirements through the regulatory rulemaking process that:

1) Arbitrarily seeks to limit who qualifies as an eligible physician based upon "**practice characteristics**"; and

2) Arbitrarily cuts off increased Medicaid payments for any non-board certified physician by utilizing "paid billing codes" in the sixty percent threshold calculation, rather than conducting a full audit of services "**provided in a managed care environment**" by that physician.

The Appellee State of Hawaii Department of Human Service's arbitrary and capricious interpretation and application of the CMS Final Rule and guidance to Hawaii's Medicaid program cannot be understated. If adopted by this Court, local physicians will fall victim to Appellee's endeavors to recoup from physicians the increased payments made under the Medicaid Enhanced Payment Statute. Consequently, the people of Hawaii will suffer as

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physicians will be forced to either deny vital medical services or risk closing their practices due to recoupment.

Here, Appellee's Med-Quest Division seeks to recoup $205,220.86 for primary care services provided by Dr. Frederick Nitta, a physician board certified in obstetrics and gynecology, to Medicaid beneficiaries in East Hawaii.[19] East Hawaii is designated as a Health Professional Shortage Area ("HPSA") for primary care by the Health Resources Services Administration[20] and as such, Dr. Nitta provides vital services to vulnerable populations with limited access to medical care. However, Appellee's recoupment efforts and subsequent denial of reimbursements for treatment and care jeopardizes Dr. Nitta's ability to continue to pay his staff and costs for the operation of his practice. If Dr. Nitta is forced to close his practice, his patients may be unable to find any other physicians in East Hawaii due to the critical shortage of primary doctors there.

A. Appellee State of Hawaii Department of Human Services' interpretation and application of the Final Rule and CMS guidance to Hawaii's local physicians is arbitrary and capricious because it provides it with unfettered discretion to determine physician eligibility.

On March 30, 2010, President Barack Obama signed the Health Care and Education Reconciliation Act of 2010 (the "Act") into law. The Act was passed by means of the reconciliation process in order to amend the Patient Protection and Affordable Care Act ("ACA"), which had been signed into law the week before. Among other provisions, the Act provided that physicians would receive increased Medicaid payments for certain primary care

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[19] HMA and AMA adopt and incorporate the Record herein.

[20] *See* U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES HRSA DATA WAREHOUSE, http://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx (last visited September 27, 2017).

services for the years 2013 and 2014. Specifically, the Medicaid Statute required enhanced payments for "primary care services" performed by "physician[s] with a **primary specialty designation** of family medicine, general internal medicine, or pediatric medicine."[21] The purpose of the Medicaid Statute was to benefit physicians that provide primary care services to the Medicaid population by increasing payment rates. The legislative history accompanying the Medicaid Statute indicates that the enhanced payments were meant to address Medicaid reimbursement rates for primary care services that were substantially lower than the Medicare rates for the same services.[22] Congress stated that the enhancements were necessary because:

> These low Medicaid payment rates do not provide adequate incentives for physicians to participate in Medicaid, limiting access to physicians' services by Medicaid beneficiaries. In addition, low Medicaid payment rates discourage young physicians and other health professionals from entering careers in primary care, undermining efforts to address the shortage of primary care practitioners in many areas of the country.[23]

The legislative history further indicates that Congress intended the enhanced payments to apply broadly to "primary care services furnished by **any participating physician or health professional, not just a primary care physician or professional**[.]"[24]

On November 6, 2012, the Centers for Medicare & Medicaid Services ("CMS"), a part of the Department of Health and Human Services, adopted the Final Rule, codified at 42 C.F.R. § 447.400(a)(2). The Final Rule states:

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[21] 42 U.S.C. § 1396a(a)(13)(C).

[22] *See* H.R. Rep. No. 111-299, pt. 1, at 617-19 (2009).

[23] H.R. Rep. No. 111-299, pt. 1, at 617-19 (2009).

[24] *Id.* at 618 (emphasis added).

> (a) States pay for services furnished by a physician as defined in § 440.50 of this chapter, or under the personal supervision of a physician who self-attests to a specialty designation of family medicine, general internal medicine or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA). Such physician then attests that he/she:
>
> > (1) Is Board certified with such a specialty or subspecialty and/**or**
> >
> > (2) Has furnished evaluation and management services and vaccine administration services under codes described in paragraph (b) of this section that **equal at least 60 percent of the Medicaid codes he or she has billed** during the most recently completed CY or, for newly eligible physicians, the prior month.
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> (b) At the end of CY 2013 and 2014 the Medicaid agency must review a statistically valid sample of physicians who received higher payments to verify that they meet the requirements of paragraph (a)(1) or (2) of this section.[25]

In addition to the Final Rule, CMS published guidance to the Final Rule by issuing Questions and Answers ("Q&A") sets.[26] These Q&A sets established standards for a state to review physician eligibility under the Final Rule ("PCP Program").[27]

Q&A Set IV provides:

> 2) If a physician is board certified in a non-eligible specialty (for example dermatology) but practices in the community as for, example, a family practitioner and attests to meeting the 60 percent claims threshold, are we expected to audit his or her practice and, if so, how?

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[25] 42 C.F.R. § 447.400(a)(2).

[26] Increased Medicaid Payment for Primary Care Qs and As, http://www.medicaid.gov/affordable-care-act/provisions/downloads/qs-and-as-on-1202-iii-1-30-13.pdf (last visited September 27, 2017).

[27] 42 C.F.R. § 447.400(a)(2).

> Since the only evidence of eligibility is the self-attestation and claims history, the state would need to take steps to verify the **practice characteristics** of the physician. This **could** be done by determining that the physician represents himself in the community as a family practitioner, as evidence by medical directory listings, billings to other insurers, advertisements, **etc.**

Q&A Set IV merely suggests that the way in which a physician represents himself in the community **could** determine the physicians practice characteristics. Additionally, CMS guidance is silent as to how states weigh each suggested factor, but ultimately gives the state complete discretion to consider other factors not expressly listed by CMS. Indeed, Q&A Set IV suggests practice characteristics **could** be evidenced by medical directory listings, billings to other insurers, advertisements, **etc.**

Appellee took CMS's suggested factors and arbitrarily determined that medical directory listings were the deciding factor of a physician's practice characteristics. While Dr. Nitta was listed as a primary care physician with a specialty in obstetrics and gynecology in numerous medical directory listings, evidence submitted on behalf of Dr. Nitta confirmed Dr. Nitta's practice as a primary care physician. Dr. Nitta is recognized by other doctors and medical providers in the East Hawaii community as a primary care provider and has been accepted and paid by medical insurers as a "primary care physician." Further, at a hearing on the matter, hundreds of people provided written and oral testimony supporting a finding that Dr. Nitta is indeed a primary care physician.

According to the Record, Dr. Nitta is a board certified obstetrician/gynecologist engaged in the private practice of medicine in Hilo, Hawaii. Dr. Nitta's patients consist exclusively of women, over ninety percent of whom receive medical benefits through Medicaid or similar programs. Although many of Dr. Nitta's patients initially seek obstetrics or gynecology care, Dr.

Nitta provides them with primary medical care services. Without Dr. Nitta's primary care services, these patients would have to find and retain additional physicians for their routine internal medicine, pediatric, or family medicine needs. This would be exceptionally difficult in East Hawaii due to the physician shortage in the area - many primary care physicians are no longer accepting new patients.

Rather than consider Dr. Nitta's patients' and the East Hawaii community's testimony on Dr. Nitta's practice characteristics as the ultimate deciding factor, Appellee instead decided to rely primarily on Dr. Nitta's medical directory listings and advertisements. Appellee's interpretation and application of Q&A Set IV allows for such an arbitrary determination, and thus is an unfettered exercise of discretion by Appellee. Accordingly, Appellee is free to find a physician ineligible for the PCP program and liable for overpayment, regardless of whether the physician is providing primary care services to Medicaid patients as intended by the Medicaid Statute. This is contrary to Congressional intent, which indicates that Congress intended the enhanced payments to apply broadly to "primary care services furnished by **any participating physician or health professional, not just a primary care physician or professional**[.]"[28]

B. Appellee's formula to determine the sixty-percent-threshold requirement is in complete disregard for actual medical practice.

Further, Appellee's interpretation and application of CMS guidance regarding the Final Rule's sixty-percent-threshold requirement is arbitrary and contrary to the plain language of the Medicaid Statute which imposed no such limitations on eligibility for the increased Medicaid payments.[29]

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[28] H.R. Rep. No. 111-299, pt. 1, at 618.

[29] *See* 42 U.S.C. § 1396(a)(13)(C).

Federal Register, Vol. 77, No. 215 (2012) contains CMS's interpretation of the Medicaid Enhanced Payment Statute and the Final Rule implementing the statute. The Federal Register contains a "Summary of Final Policy":

> [The Final Rule] requires that physicians self-attest that they are either Board certified in family medicine, general internal medicine, or pediatric medicine or a subspecialty related to those specialties (or subspecialties) or that 60 sixty percent of all Medicaid services they bill, or provide in a managed care environment, are for the specified E&M and vaccine administration codes.[30]

To determine whether a physician has met the sixty-percent-threshold requirement, Appellee utilized "paid billing codes." However, Appellee failed to consider that the use of "paid billing codes" with respect to the sixty-percent-threshold requirement arbitrarily and capriciously harms the very providers that the statute was enacted to benefit. By relying on "paid billing codes," payment under the Final Rule depends not on the percentage of total services provided in a managed care environment by that physician, but as a percentage of all services billed under the physician's provider number, regardless of whether those services were furnished by that physician.

As an example, the Final Rule does not account for the fact that many physicians practicing primary care sometimes bill under the physician's provider number for a reasonably large volume of ancillary services (i.e., urine testing, blood work, X-rays) furnished by other professions under the physician's supervision. Further, group practices with more than one physician sometimes bill for ancillary services under the group provider number. These practices skew the ratio used to calculate the sixty-percent-threshold in a way that creates an inaccurate classification of these physician practices in the context of the Final Rule and

[30] 77 Fed. Reg. 215, 66675 (Nov. 6, 2012) (emphasis added).

inappropriately excludes them from receiving enhanced Medicaid payments.

As another example, consider a common scenario in which a female Medicaid beneficiary visited her primary care provider for an annual check-up. If the physician ordered a pregnancy test and a simple blood test to check for anemia - both processed by the staff but billed under the physician's provider number - then 66 percent of codes billed for that visit would not constitute billing codes designated under the Final Rule. As a result of including non-professional ancillary services in the denominator of the sixty-percent-threshold calculation, the physician would be ineligible for the increased payment under the Final Rule, despite the undisputable facts that the physician fits squarely within the parameters of the Medicaid Enhancement Statute and provided primary care services to a Medicaid beneficiary, which Congress incentivized with the Medicaid Enhancement Statute.

Dr. Nitta met the sixty-percent-threshold based on allowed charges. According to the Record, an experienced and highly regarded medical billing and coding expert testified that she conducted a full audit of Dr. Nitta's patient records, not merely the billing records, and concluded that well over sixty-percent of Dr. Nitta's time and work was spent providing primary care treatment and services to Medicaid beneficiaries

Accordingly, Appellee's use of "paid billing codes" rather than a full audit of a physician's patient records in consideration of services provided in a managed care environment is a manipulation that produces absurd results contrary to the intent of the Medicaid Enhanced Payment Statute.

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IV. CONCLUSION

Dr. Nitta practices in East Hawaii which has been designated as a health professional shortage area ("HPSA").[31] According to the State of Hawaii, Department of Health Office of Primary Care and Rural Health:

> A HPSA means any of the of the following which has a shortage of health professionals: (a) an urban or rural area which is a rational service area for the delivery of health services, (b) a population group, or (c) a public or nonprofit private medical facility. HPSAs are divided into three major categories according to the type of health professional shortage: primary care, dental or mental health HPSAs.[32]

Dr. Nitta is but the first of many local physicians who will be found ineligible under the PCP Program by Appellee State of Hawaii Department of Human Services because of Appellee's arbitrary and capricious interpretation and application of the CMS's Final Rule and Q&A sets. This does not bode well for Hawaii's people and their ability to access vital medical services, especially in light of the shortage of primary care physicians in Hawaii.

At the time of submission of this brief, Appellee's Med-Quest Division seeks recoupment from another physician in a designated HPSA in Kauai. It is inevitable that more local physicians will be notified that substantial amounts are owed to Appellee for alleged overpayment, and consequently, local physicians will be forced to make the difficult choice of denying medical services or risk closing their practices. This consequence illustrates the arbitrary and capricious nature of Appellee's determination, in direct contravention to the

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[31] *See* U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES HRSA DATA WAREHOUSE, http://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx (last visited September 27, 2017).

[32] *See* STATE OF HAWAII DEPARTMENT OF HEALTH OFFICE OF PRIMARY CARE AND RURAL HEALTH, http://health.hawaii.gov/opcrh/home/health-professional-shortage-area-hpsa/ (last visited September 27, 2017).

purpose of the Medicaid Enhancement Payment Statute, which was to encourage physicians to provide primary care services to the Medicaid population. The HMA and AMA submits that because access to primary care is critical for ensuring continuity of care, improving overall health, and reducing health care costs, Appellee's interpretation and application of the CMS Final Rule and guidance cannot be allowed to prevail to the detriment of Hawaii's people and their health.

Hawaii cannot afford to lose or discourage primary care providers. For the reasons set forth above, HMA and AMA respectfully requests this Court remand this case against Appellant Dr. Frederick Nitta with instructions to vacate the decisions of the Circuit Court and the State of Hawaii Department of Human Services.

DATED: Honolulu, Hawaii, _____, 2017.

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