Healthcare Finance and the Anti-Assignment Provisions of Medicare and Medi-Cal

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Most healthcare providers obtain financing either by pledging their accounts receivable as collateral for secured loans, or by factoring their accounts receivable.[1] Both types of financing involve assignments of property interests. However, a secured lender lends against the accounts and is granted a security interest in the accounts, while both the accounts and the collections on the accounts continue to be owned by the borrower. An accounts receivable factor purchases the accounts at a discount and thereafter owns both the accounts and the collections on the accounts.[2]

It is widely believed that the Medicare and Medicaid anti-assignment provisions prohibit factoring of government healthcare receivables. That is not true. What the anti-assignment provisions actually do (and the only thing they do) is to prevent the government from making payments under the Medicare and Medicaid programs to anyone other than the provider. The rule is the same for factors as it is for secured lenders, and the compliance methods are identical.

FEDERAL ANTI-ASSIGNMENT PROVISIONS

The Social Security Act and its implementing regulations contain separate anti-assignment provisions for Medicare Part A,[3] Medicare Part B[4] and Medicaid.[5] For Medicare Part A, the statute simply states that a Medicare payment owing to a provider cannot be made "to any other person under an assignment or power of attorney":

> No payment which may be made to a provider of services under this subchapter for any services furnished to an individual shall be made to any other person under an assignment or power of attorney .... [6]

There are exceptions for assignments (1) to a governmental agency or entity, (2) pursuant to the order of a court of competent jurisdiction, or (3) to a billing or collection agent under an agency agreement, provided that the compensation to the agent is unrelated to the amounts of the billings, collections or payments.[7]

An assignment pursuant to a court order is effective only if a certified copy of the court order is filed with the Medicare intermediary or carrier responsible for processing the claim. Notably, a party that receives payment under a court-ordered assignment is jointly and severally responsible with the provider for any Medicare overpayments received by such party.[8]

The anti-assignment provisions for Medicare Part B[9] and Medicaid[10] are the same except that they also permit certain assignments that are specific to the services and billings under those programs, such as (1) by physicians to their employers, (2) under provider or supplier arrangements with a hospital, clinic or other facility, or (3) if an individual receiving care is entitled to direct payment, by the individual to the provider or the supplier.

ASSIGNMENTS FOR SECURITY

The threshold issue for lenders is whether the grant of a security interest in Medicare or Medicaid accounts violates the anti-assignment provisions. This question was definitively settled in favor of secured lenders by the Fifth Circuit's 1986 decision in *In re Missionary Baptist Foundation of America, Inc.*[11]

In *Missionary Baptist*, a group of nursing homes in Texas granted a security interest to their bank lender in all accounts, including Medicaid accounts. In the ensuing chapter 11 case, the trustee brought an adversary proceeding against the bank to invalidate the security interests on the ground that the grant of the security interests violated the Medicaid anti-assignment provisions under both federal and state law.

To resolve this question, the Fifth Circuit looked to the legislative history regarding the purpose of the anti-assignment provisions and held that Congress enacted the provisions solely in order to prevent factoring of Medicare and Medicaid accounts:

An examination of the legislative history of this provision reveals that its purpose was to prevent "factoring" agencies from purchasing Medicare and Medicaid accounts receivable at a discount and then serving as the collection agency for the accounts. Congress was concerned that direct payment of funds to these factoring agencies was resulting in "incorrect and inflated claims."[12]

The court further held that to the extent that the Texas Medicaid statute contained broader prohibitions on assignment of Medicaid accounts, the state statute must yield to the federal scheme. To hold otherwise would "undercut a vital means of financing medical assistance for the needy."[13]

Subsequent court decisions have uniformly held that based on the legislative history, Medicare and Medicaid accounts can serve as collateral for secured loans without violating the anti-assignment provisions under state or federal law.[14]

CALIFORNIA ASSIGNMENTS FOR SECURITY

California has its own anti-assignment statute, Cal. Welf. & Inst. Code § 14115.5, which provides as follows:

> Moneys payable or rights existing under [the Medi-Cal program] shall be subject to any claim, lien or offset of the State of California, and any claim of the United States of America made pursuant to federal statute, but shall not otherwise be subject to enforcement of a money judgment or other legal process, and no transfer or assignment, at law or in equity, of any right of a provider of health care to any payment shall be enforceable against the state, a fiscal intermediary or carrier.[15]

The state and federal courts that have considered Section 14115.5 have uniformly acknowledged that the statute permits assignments of Medi-Cal accounts for security and have instead focused on questions of whether claims of the State of California or the federal government can defeat an otherwise valid security interest in Medi-Cal accounts. In *Manalis Finance Co. v. Gedulig*,[16] the California Court of Appeal held that a tax levy on a hospital's Medi-Cal accounts by the California Department of Employment Development (EDD) prevailed over the pre-existing perfected security interests in the accounts held by the hospital's secured lender.[17] A contrary result with respect to claims of the federal government was reached by the Ninth Circuit in *Manalis Finance Co. v. United States*[18] where the court held that a subsequently arising tax claim of the Internal Revenue Service prevailed over the secured lender's perfected security interests in the very same hospital's Medi-Cal accounts. As explained by the federal District Court for the Central District of California in *Bank of America N.T. & S.A. v. United States*:

> Cal. Welf. & Inst. Code § 14415.5 was intended only to relieve the administrative burdens of the State and insurance carriers in dealing with third-party claims made directly against them for Medi-Cal payments owed to providers. Section 14115.5 was never intended to, nor did it diminish, alter, or negate the underlying property rights of the Bank as third-party assignee [for security] of the accounts receivable.[19]

Thus, California's anti-assignment statute, like the federal Medicaid statute, does not prohibit security interests in Medi-Cal accounts, although claims of the State of California will prevail over an otherwise valid security interest in Medi-Cal accounts.[20] Claims of the federal government do not have priority over a valid security interest in Medi-Cal accounts by reason of Section 14415.5, although filed federal tax liens do have priority over secured advances made more than 45 days after the filing of the tax lien (or earlier if the secured lender has actual notice or knowledge of the filing of the tax lien) pursuant to the Federal Tax Lien Act.[21]

FACTORING

There are only two reported decisions (and no California decisions) that directly consider whether factoring of Medicare and Medicaid accounts violates the anti-assignment provisions. Together, the cases clearly demonstrate what kind

of factoring structure is prohibited, and what kind is not.

The first case, a 1976 decision of the Southern District of New York, *Professional Factoring Service Assoc. v. Mathews*,[22] analyzed a factoring facility in which Medicaid claims were submitted by the factor in the name of the provider, and payments were made by checks payable to the provider. The checks, however, were not mailed to the provider but directly to the factor, who was able to cash them because of a power of attorney given to it by the provider. The *Professional Factoring* court held that this kind of factoring arrangement was as subject to abuse as factoring arrangements in which providers assigned their Medicaid claims to factors, and the factors submitted the claims and subsequently received payments in their own names. Both types of factoring were equally subject to the same evil, namely "inflated and fabricated billings by factors."[23]

The Seventh Circuit's 2004 decision in *DFS Secured Healthcare Receivables Trust v. Caregivers Great Lakes, Inc.*[24] analyzed a factoring facility that was structured very differently from the factoring facility in *Professional Factoring*. In *DFS*, the factor purchased "the right to receive the proceeds of collections of [Medicare and Medicaid accounts] when such collections were received by [the provider]." In exchange, the factor made immediate cash payments to the provider of 71.5% of the value of the accounts, and the provider was required to pay the factor 2.5% interest for each month that the accounts payable to the provider remained unpaid (a 30% annual interest rate).[25]

The *DFS* court held that a purchase of the right to receive the proceeds of collections of Medicare and Medicaid accounts is not void for illegality, provided that the payments by the government are made in the first instance to and in the name of the provider:

> On its face, this statute stands only for the proposition that Medicare funds cannot be paid directly by the government to someone other than the provider, but it does not prohibit a third party from receiving funds if they first flow through the provider. Before this statute, health care providers assigned their right to Medicare receivables to third parties which then submitted incorrect and inflated claims to be paid in their own names, creating administrative nightmares and overpayments ..... Therefore, Congress passed this statute to remedy this problem by ensuring that payments would be made directly to healthcare providers. However, nothing suggests that Congress intended to prevent healthcare providers from assigning receivables to a non-provider. ... [W]e remain unconvinced that this "factoring" agreement ... was illegal.[26]

Thus, the Seventh Circuit expressly held that factoring, if properly structured so that payment first flows through the provider, does not violate the anti-assignment provisions.

Since *DFS*, courts that have discussed the anti-assignment provisions (although not in the factoring context) have all followed DFS in emphasizing that the anti-assignment provisions only prevent Medicare and Medicaid funds from being paid to someone other than the provider. They do not prohibit a third party from receiving the funds under an assignment after the funds have flowed through the provider.[27]

WHY THE MISCONCEPTIONS?

Notwithstanding *DFS* and the absence of any contrary authority in the caselaw, many in the healthcare financing industry continue to believe that factoring violates the anti-assignment provisions. One possible reason is that the stated legislative purpose of the anti-assignment provisions, as discussed in *Missionary Baptist*, was to prevent factoring of Medicare and Medicaid accounts. However, as demonstrated in *DFS*, a factoring facility can be structured so that the perceived evils that factoring might cause – submission of incorrect and inflated claims, and administrative problems as to which entity the government should pay or from which it should collect overpayments – do not exist when the payments first flow through the provider.

Other possible reasons for the belief that factoring violates the anti-assignment provisions may arise from misinterpretations of the Medicaid anti-assignment regulations and the Medicare Claims Processing Manual (*MCPM*). The Medicaid anti-assignment regulations include an express prohibition on payment to factors:

> *Prohibition of payment to factors.* Payment for any service furnished to a beneficiary by a provider may not be made to or through a factor, either directly or by power of attorney.[28]

However, this language does not make factoring of Medicaid accounts illegal. It merely requires that payment by the government not be made to or through a factor.

The *MCPM*, issued by the Centers for Medicare & Medicaid Services (CMS),

contains what appears to be an express anti-factoring prohibition:

> Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.[29]

The purpose of the *MCPM*, however, is to serve as a statement of CMS policy with respect to processing of Medicare claims, and to provide instructions to providers and suppliers and the carriers that process Medicare claims.[30] It does not have the force of law. Viewed in this context, the "anti-factoring" language in the *MCPM* only expresses CMS's policy that regardless of a provider or supplier's contractual financing arrangements, purchases of Medicare accounts will not be recognized for purposes of payment of Medicare claims.

This interpretation of the *MCPM* is consistent with the Seventh Circuit's interpretation of the anti-assignment provisions in *DFS*. It is also consistent with CMS's own Provider Reimbursement Manual (*PRM*).

CMS RECOGNITION OF FACTORING

Section 219 of the *PRM* expressly recognizes that healthcare providers may use their receivables to obtain financing either through secured loans or factoring. If the financing is a loan, the interest on the loan is an allowable expense in the provider's Medicare cost report.[31] If the financing is through a discounted sale of the provider's receivables (*i.e.*, factoring), the costs associated with the sale are not allowable expenses in the cost report. Section 219 provides in pertinent part as follows:

> In accounts receivable financing, the intermediary must first determine if the arrangement represents a sale of receivables or if it is a loan. If it is a loan, the interest incurred on the loan is an allowable expense if it is necessary and proper as defined in §§202.1, 2020.2 and 202.3. The interest on the loan is the discount on the advance on the receivables (e.g., 10 percent where a provider receives 90 cents on the dollar).
>
> If the intermediary determines that the arrangement is a sale, the costs associated with the sale are not allowable expenses. The provider has opted to receive payment prior to collection on the account.[32]

Cases interpreting Section 219 of the *PRM* have focused on determining whether a financing arrangement is a secured loan or a sale of accounts pursuant to the standards set forth in the Statements of Financial Accounting Standards issued by the Financial Accounting Standards Board.[33] Uniformly, both the Provider Reimbursement Review Board and the District Courts have recognized that a provider may obtain financing by selling (factoring) its Medicare accounts.[34]

Notably, the last sentence of Section 219 admonishes both intermediaries and providers that notwithstanding CMS's recognition of the sale of accounts as a proper accounts receivable financing arrangement, Medicare will not pay amounts due to a provider to anyone other than the provider:

> With regards to accounts receivable financing, note that, except as specified in 42 CFR 424.73, Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement.[35]

This clear statement of policy unequivocally supports the Seventh Circuit's decision in *DFS*. The anti-assignment provisions do not prohibit factoring. They only require that any factoring arrangement be structured so that Medicare and Medicaid funds are initially paid to and flow through the provider.

COMPLIANCE

The standard method for complying with the anti-assignment provisions, which is equally applicable to secured lenders and factors, is the double lockbox.[36] Under the double lockbox arrangement, the lender establishes a government lockbox and lockbox account in the name of the provider (for payment of Medicare, Medicaid and other government accounts) and a non-government lockbox and lockbox account in either the name of the provider, the lender or both (for payment of all other accounts). The lender also typically requires that the provider execute standing instructions to the lockbox bank providing for a daily sweep of all funds received in the government lockbox account to either the non-government lockbox account or another deposit account subject to the control of the lender.

Both the government and non-government lockbox accounts are subject to deposit account control agreements (DACAs) among the provider, the lender and the lockbox bank. However, the DACA for the government lockbox account must contain a provision specifying that the provider retains the ultimate right to direct the

disposition of funds in the government lockbox account. Thus, the provider has the right to rescind the sweep instructions and direct disposition of funds received in the government lockbox account (usually after 10 to 30 days' notice to both the lender and the lockbox bank) regardless of whether the rescission is a violation of the loan agreement between the provider and the lender. The DACA with respect to the non-government lockbox account is subject only to instructions by the lender.

This double lockbox arrangement satisfies the anti-assignment provisions because it ensures that Medicare and Medicaid payments are made to and in the name of the provider, or in the language of the *DFS* court, "first flow through the provider" before being transferred to the lender. Notably, the arrangement also satisfies the directives of the *MCPM*, which includes the additional requirement that a lender that is also the lockbox bank must waive its right of offset against Medicare payments.[37]

Although seldom used in practice, a single lockbox arrangement would comply with the anti-assignment provisions if the single lockbox and lockbox account (for payment of both government and non-government accounts) are in the name of the provider and structured in the manner described above with respect to the government lockbox and lockbox account under a double lockbox arrangement. Lenders generally do not favor a single lockbox arrangement, however, because they do not wish to forego the more direct rights of collection, control and foreclosure on non-government accounts that are available with the establishment of a separate non-government lockbox and lockbox account in the name of the lender.

CONCLUSION

Compliance with the anti-assignment provisions is critical for both providers and lenders (and providers and factors) because CMS may terminate a Medicare provider agreement if the provider "executes or continues a power of attorney, or enters into or continues any other arrangement, that authorizes or permits payment contrary to [the anti-assignment provisions]."[38] Fortunately, the courts have interpreted the anti-assignment provisions in a manner that enables both secured lenders and factors to provide much needed financing to healthcare providers.

ABOUT THE AUTHOR

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ENDNOTES

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2 Article 9 of the Uniform Commercial Code (UCC) governs both security interests in accounts and sales of accounts. *See, e.g.*, UCC § 1-201(b)(35) (defining "security interest" to include "any interest…of a buyer of accounts…in a transaction that is subject to Article 9"); UCC § 9-102(a)(12) (defining "collateral" as "[t]he property subject to a security interest…. The term includes…accounts…that have been sold."); UCC § 9-102(a)(28) (defining "debtor" to include a seller of accounts"); UCC § 9-102(a)(73)(D) (defining "secured party" to include "a person to which accounts…have been sold"); UCC § 9-109(a)(3) (stating that Article 9 applies to "[a] sale of accounts").

3 Medicare Part A covers inpatient hospital and critical access hospital care, skilled nursing facility care, some home health agency services, and hospice care.

4 Medicare Part B covers physician services, hospital outpatient department services, ambulatory surgical centers, laboratory services, some home healthcare, physical and occupational therapy, and durable medical equipment, prosthetics, orthotics and supplies.

5 Medicaid is a federal and state-funded program administered by participating states that finances healthcare for low income individuals. States receive federal matching funds and are free to design their own programs provided that they cover certain federally mandated services and administer their programs within federal requirements.

6 42 U.S.C. § 1395g(c).

7 *Id.*; 42 C.F.R. § 424.73.

8 42 C.F.R. § 424.90.

9 42 U.S.C. § 1395u(b)(6); 42 C.F.R. §§ 424.73, 424.80 and 424.90.

10 42 U.S.C. § 1396a(a)(32); 42 C.F.R. § 447.10.

11 796 F.2d 752 (5th Cir. 1986).

12 *Id.* at 757 n.6, *citing Danvers Pathology Assocs., Inc. v. Atkins*, 757 F.2d 427, 430 (1st Cir. 1979).

13 *Id.* at 758.

14 *E.g., Lock Realty Corp. IX v. U.S. Health, LP*, No. 3:05-CV-715, 2007 U.S. Dist. LEXIS 14578, at *15 (N.D. Ind. 2007); *In re East Boston Neighborhood Health Ctr. Corp.*, 242 B.R. 562, 573 (Bankr. D. Mass 1999); *In re American Care Corp.*, 69 B.R. 66 (Bankr. N.D. Ill. 1986); *Qualix Care. L.P. v. Everglades Reg'l Med. Ctr., Inc.*, 232 A.D.2d 323, 648 N.Y.S.2d 580 (N.Y. App. Div. 1996); *Snowden Inv. Co. v. Sci-Wentzville Care Ctr., Inc.*, 896 S.W.2d 732 (Mo. Ct. App. 1995); *Bank of Kansas v. Hutchinson Health Servs., Inc.*, 735 P.2d 256 (Kan. Ct. App. 1987).

15 Medi-Cal is California's version of Medicaid.

16 47 Cal. App. 3d 672, 121 Cal. Rptr. 93 (Cal. Ct. App. 1975).

17 *See also In re Civic Ctr. Hosp. Found.*, Bankr. No. 4-76-1196HN, 1977 U.S. Dist. LEXIS 15695 (N.D. Cal. 1977) (holding that a trustee in bankruptcy under the former Bankruptcy Act was subrogated to the rights of the State of California as an unsecured creditor for purposes of avoiding a lender's security interest in Medi-Cal accounts).

18 611 F.2d 1270 (9th 1980), *aff'g* 442 F. Supp. 579 (C.D. Cal. 1977).

19 No. CV78-2709-PMT(TX), 1979 U.S. Dist. LEXIS 10058, at *4 (C.D. Cal. 1979).

20 *See also* California Attorney General Opinion No. 81-502, 1981 Cal. AG LEXIS 21 (1981) (concluding that a California county may pledge its Medi-Cal accounts as security for a loan).

21 26 U.S.C. § 6323(c). *See generally* 2 Clark, *The Law of Secured Transactions Under the Uniform Commercial Code* §§ 5.01 *et seq.* (3d ed. 2015).

22 422 F. Supp. 250 (S.D.N.Y. 1976).

23 *Id.* at 256.

24 384 F.3d 338 (7th Cir. 2004).

25 *Id.* at 340-41.

26 Id. at 350.

27 *Lock Realty Corp. IX v. U.S. Health, LP*, No. 3:05-CV-715, 2007 U.S. Dist. LEXIS 14578, at *6-*7 (N.D. Ind. 2007); *In re Parkview Adventist Med. Ctr.*, Chapt. 11 Case No. 15-20442, 105 Bankr. LEXIS 2617, at *9-*12 (Bankr. D. Me. 2015); *By Your Side Homemaker & Companion Servs., LLC v. Agency of Aging of S. Cent. Conn., Inc.*, No. NNHCV106013214S, 2013 Conn. Super. LEXIS 267, at *16-*19 (Conn. Super. Ct. 2013); *Florida Corp. Funding, Inc. v. Always There Home Care, Inc.*, No. 0005691/2008, 2011 N.Y. Misc. LEXIS 1471, at *22-*25 (N.Y. Sup. Ct. 2011). *See also Pharmacy Advantage, Inc. v. A & C Health Care Servs., Inc.*, No. C062923, 2010 Cal App. LEXIS Unpub. 6954, at *15-*16 (Cal. Ct. App. 2010) (invalidating an order appointing a receiver over a pharmacy to the extent that the order permitted the receiver "to take possession of accounts receivable from Medi-Cal").

28 42 C.F.R. § 447.10(h).

29 *MCPM*, CMS Pub. 100-04 § 30.2.5.

30 *MCPM*, CMS Pub. 100-04 § 01.

31 Medicare fiscal intermediaries (now Medicare Administrative Contractors (MACs)) make interim payments to providers based on an estimation of actual costs. 42 U.S.C. § 1395g(a); 42 C.F.R. § 413.64. After the close of the provider's fiscal year, the provider submits an annual cost report to its fiscal intermediary to account for the cost of services allocated to Medicare. 42 C.F.R. § 413.20(b). The fiscal intermediary conducts an audit of the report, determines which costs are "allowable," and if necessary, makes a retroactive adjustment for overpayment or underpayment. 42 U.S.C. § 1395h, 42 C.F.R. §§ 405.1803(a), 413.64(f). *See, e.g., Fajardo Home Care, Inc. v. Levitt*, Civil No. 04-2433 (SEC/JAF), 2009 U.S. Dist. LEXIS 21569, at *2-*6 (D.P.R. 2009).

32 *PRM*, CMS Pub. 15-1 (formerly HCFA Pub. 15-1) § 219.

33 FAS 140 (formerly FAS 125 and FAS 77).

34 In all three reported decisions, the financing arrangement was determined to be a sale not a loan. *Fajardo Home Care, Inc. v. Levitt*, Civil No. 04-2433 (SEC/JAF), 2009 U.S. Dist. LEXIS 21569 (D.P.R. 2009); *Intercounty Total Health Care v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 2000-D78 (2000) (involving a California home health agency); *Barton Creek Health Care, Inc. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 98-D53 (1998).

35 *PRM*, CMS Pub. 15-1 (formerly HCFA Pub. 15-1) § 219.

36 *See* Kimberly Easter Zirkle, *"Not So Perfect: The Disconnect Between Medicare and the Uniform Commercial Code Regarding Health-Care-Insurance Receivables,"* 9 N.C. Banking Inst. 373, 380-83 (2005).

37 *MCPM*, CMS Pub. 100-04 § 30.2.5.

38 42 C.F.R. § 424.74.

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