

# Differential Charging to Medicare and Self-Pay and Commercial Customers

by

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## I. Recent Developments

- A. *Bitter Pill*, Time Magazine (March, 2013)
  1. Allegations throughout that the uninsured and the underinsured are being price gouged when they receive hospital services because they pay on the basis of full charges.
- B. United States Of America, et al. v. Huron Consulting Group, Inc., et al. (SDNY, March, 2013). Allegations that False Claims Act liability attaches to increasing charges more than costs. Court suggested that, while a bad practice, it is not unlawful.
- C. Healthcare Reform
  1. Removes annual and lifetime limits applicable to many commercial insurance policies as of 2014, meaning that individuals who may have been subjected to full charges previously for some portion of their care will now be covered for their entire treatment regimen.

## II. Medicare Use of Charges to Determine Reimbursement

- A. Inpatient and outpatient outliers.
  - In general, these are claim-specific payments for unusually expensive cases. Providers obtain a portion of the amount of costs incurred in excess of the sum of the case rate and a threshold amount<sup>1</sup>. Costs are determined by taking a provider's charges for an admission and multiplying these charges by a percentage, called the cost-to-charge ratio ("RCC"), which is determined through a review of the provider's cost report.
- B. New technologies
  - For certain new medical devices, providers are entitled to a separate payment in addition to the APC rate that is based on the provider's charge for the item multiplied by its outpatient RCC.
  - Inpatient add-on payments for new technologies are subject to charges reduced to costs, subject to a cap at the estimated cost of the technology.

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<sup>1</sup> Inpatient case rates are referred to as diagnosis-related groups ("DRGs") and outpatient case rates are referred to as ambulatory payment classifications ("APCs").

- C. Organ acquisition costs.
  - Organ acquisition costs are determined by multiplying accumulated charges in various cost centers by the applicable RCC to determine total costs, which are then divided by the number of organs to which they apply to generate an average organ cost.
- D. For certain suppliers, such as clinical laboratories, Medicare pays at the lower of the provider's charge or the fee schedule amount.
- E. For non-Medicare patients, self-pay patients and some commercial insurers may pay on a percent of charge basis.

### III. Laws and Regulations Governing Charges

- A. Definitions of charges
  - 1. Cost Apportionment Context. “Charges means the regular rates for various services which are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.” 42 C.F.R. § 413.53(b).
  - 2. Lower of Cost or Charges Context. “Customary charges means the regular rates that providers charge both beneficiaries and other paying patients for the services furnished to them.” 42 C.F.R. § 413.13.
- B. Relationship of charges to costs
  - 1. Medicare traditionally used charges as a statistic to determine Medicare's share of costs in the cost “apportionment” process. 42 C.F.R. § 413.53(b).
  - 2. Although this has become less significant as almost all hospital components have gone to a prospective payment system, the cost report, consistent with applicable regulations and Program Reimbursement Manual provisions, still calculates cost based on charges.
    - a. According to the Provider Reimbursement Manual, “[t]o assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs.” Provider Reimbursement Manual I, § 2203.
    - b. Defining charges for the purpose of the apportionment formula, the Provider Reimbursement Manual states that “[c]harges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.” Provider Reimbursement Manual I, § 2202.4.
  - 3. Thus, in some cases, charges play a crucial role in: (a) determining the cost of services; and (b) determining which of these costs apply to Medicare patients.

4. Despite ambiguous language in the Provider Reimbursement Manual to the contrary, CMS has never required that the provider's RCC be consistent across each item or service it furnishes.
    - a. According to the Provider Reimbursement Manual, "[s]o that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services." Provider Reimbursement Manual I, § 2203.
    - b. This provision could be interpreted as requiring that a provider's charge structure does not result on an aggregate basis in an allocation to Medicare of a disproportionate amount of charges relative to the items and services furnished to Medicare beneficiaries, which would result in disproportionate payments for these items and services, to the extent that the provider is receiving cost reimbursement for these services.
  5. The apportionment process still affects organ acquisition costs.
- C. Relationship of Medicare charges to charges for other payors.
1. Among the parties subject to exclusion from the Medicare program are "[a]ny individual or entity that . . . has submitted or bills or requests for payment (where such bills or requests are based on charges or cost) under [Medicare] or a State health care program containing charges . . . for items or services furnished substantially in excess of such individual's or entity's usual charges . . . for such items or services, unless . . . there is good cause." 42 U.S.C. § 1320a-7(b)(6).
- D. There is no general principle that a provider cannot increase charges. In fact, just the opposite principle holds true.
1. "While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program." Provider Reimbursement Manual, § 2203.

#### **IV. CMS' Outlier Regulation**

- A. In the wake of the controversy surrounding Tenet Hospital's strategy to maximize outlier payments by increasing charges faster than costs increased, Medicare revised its longstanding outlier formula in 2003. The following are the salient points to the revised formula.
- B. Updating Cost-to-Charge Ratios.
  1. Hospitals must use the RCC calculated from the most recent settled or the most recent tentative settled cost report, whichever relates to the more recent cost reporting period.

2. If CMS determines that a hospital's charges indicate excessive increases based on even more recent charge data, CMS may require the Medicare Contractor to base the provider's RCC on this more current data.
3. Providers as well are allowed to request the Medicare Contractor to update their RCC if they can establish that the one used by the Medicare Contractor is inaccurate. Any such requests would require CMS Regional Office approval.

C. Statewide Averages.

1. Statewide averages are no longer used simply due to an extraordinarily low RCC.
2. However, the statewide average would still apply to cases where either: (i) the RCC is extraordinarily high; or (ii) the hospital has not yet filed its first cost report.

D. Reconciliation.

1. Medicare Contractors may recalculate outlier payments upon settlement of the cost report to ensure that they reflect the actual RCC applicable to the cost reporting period in which the payments had been made. Reconciliation is to be performed if outlier payments are more than \$500,000 and the RCC is at least 10% different from the one used to originally make payment.
2. To avoid allowing providers to benefit from the use of any excess outlier payments during the year pending reconciliation upon settlement of the cost report, Medicare Contractors are to charge interest from the midpoint of the cost reporting period forward to the point of repayment.

V. **Establishing Multi-Tiered Pricing Structures**

A. Impact on Cost Apportionment. Medicare expressly allows providers to have multiple charges for the same item, as long as providers "gross up" their charges so that charges can properly be used as a relative value unit that apportions costs accurately.

1. As provided in the Provider Reimbursement Manual, "[a]ll patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions [sic]." Provider Reimbursement Manual I, § 2202.4.
2. For instance, the Provider Reimbursement Review Board has upheld providers' rights to establish discounted flat rates for outpatient surgeries, even when outpatient services were reimbursed on a cost basis. *Oregon 90 Coinsurance Group Appeal v. Blue Cross and Blue Shield Association, Blue Shield of Oregon*, PRRB Case No. 96-029 (April 26, 1996) Medicare and Medicaid Guide (CCH) ¶ 44,168, *rev'd*, HCFA Administrator, June 24, 1996, Medicare and Medicaid Guide, (CCH) ¶ 44,591, and *St. Mary's Hospital and Medical Center v. Blue Cross Blue Shield Association/Blue*

*Cross of California*, PRRB Case No. 98-D45 (April 24, 1998) Medicare and Medicaid Guide (CCH) ¶ 46,271.

- B. Differential between Medicare and Other Payors. When setting negotiated rates with non-Medicare payors, providers must take into account that they can be excluded from the Medicare program for submitting claims for payment containing charges that are “substantially in excess” of their “usual charges”, other than for “good cause”. 42 U.S.C. § 1320a-7(b)(6).
1. Unclear as to how “substantially in excess” and “usual charges” are defined. The OIG has never defined these terms in regulation or in any Federal Register preamble.
  2. OIG Advisory Opinion 98-8. In the arrangement discussed in this opinion, a durable medical equipment (“DME”) supplier proposed to charge Medicare an amount equal to the maximum reimbursement amount allowable under applicable payment regulations. DME reimbursement is capped at a fee schedule amount. The supplier proposed to charge Medicare patients this capped amount. According to the opinion, the supplier’s non-Medicare business consisted largely of “cash and carry” business.
    - a. The OIG considered the prices paid by the “cash and carry” business to be the company’s “usual charges”.
    - b. According to the opinion, the proposed charges to the Medicare program could be 21-32% higher than the prices charged to the “cash and carry” business. This was deemed likely to be “substantially in excess” of usual charges in some cases.
    - c. The OIG acknowledged that the increased cost of doing business with the Medicare program could be considered “good cause”. However, the provider must be able to establish that, after consideration of these costs, its profit margin is roughly the same in its Medicare and non-Medicare business.
    - d. Implicit in this opinion, the OIG has set out that, to be “substantially in excess” of a provider’s usual charges, the charge structure must result in a higher profit margin.
  3. Advisory Letter regarding Discounted Ambulance Services, dated Apr. 20, 2000, and Advisory Letter regarding Clinical Lab Discounts, dated Apr. 26, 2000.
    - a. In both cases, the OIG stated that Section 1320a-7(b)(6) is not implicated “unless a provider’s charge to Medicare is substantially in excess of its median non-Medicare/Medicaid charge.”
      - (1) Implicit in this statement is that “usual charges” is equivalent with “median charge”.
    - b. Since providers need only concern themselves with Medicare payments above their median charge, it is clear that there is no

duty to grant Medicare the provider's lowest price (sometimes referred to as a "Most Favored Nations" provision).

4. Based on this limited guidance, if applicable to DRG payments at all, a provider would need to determine whether its multi-tiered program results in a profit margin from Medicare that is higher than its median profit margin.

- a. Ambiguities in this general principle:

- (1) Would non-Medicare payor payments be compared to Medicare payments or Medicare charges? Obviously, it would be a lot harder to comply with this principle if Medicare charges were to be used as the comparison point. This would also be unfair and ostensibly discordant with the purposes underlying the statute.

- (2) How can this test actually be applied? Non-Medicare provider reimbursement is highly varied. Providers can accept capitation, case-rate payments, etc. It may difficult or impossible to determine what the item-by-item "charges" are in these cases. To determine what constitutes the "median" may require converting payments from all payors to a common charge system. This is certainly impractical, if not impossible.

- (3) Do the profit margins have to be identical, or can they be similar? Also, are profit margins looked at in the aggregate, or could a provider be excluded because the provider has a profit margin on one item under Medicare reimbursement that is slightly higher than its median profit margin for that item? As in all matters involving regulatory discretion, even if the OIG could exclude an entity for a minor difference, it is unlikely to pursue such a matter.

C. Provider Based Clinics

1. Differential charging is beneficial, as commercial pay patients often object to paying hospital coinsurance rates for a service that is often indistinguishable to them from a freestanding clinic service.
2. Medicare allows hospitals to bill private insurers as freestanding, even if they are provider-based.
3. The main provider must nevertheless "hold out" the facility as provider-based to these other payers and their beneficiaries.
4. All Medicare beneficiaries must be treated the same.
5. Charges must be grossed up on the cost report.
6. To the extent that professional fees are paid at a higher global rate, program integrity issues arise as to whether physicians have been unduly enriched.

D. Clinical Lab

1. Hospitals furnishing clinical lab services to “non-patients” (i.e., patients of community physicians) are often competing with commercial laboratories, such as Quest. Hospitals operate at a disadvantage because their charges are higher than the Medicare rate. Although Medicare beneficiaries are indifferent to this rate because they have no coinsurance obligations, commercial pay patients are often charged significantly more from hospital laboratories than from freestanding ones. Yet a hospital’s reduction of its rates to an amount lower than the Medicare rate would result in their capping their payment to that lower rate. Questions thus arise as to whether the hospital can charge differentially to Medicare and other patients.
2. Laws implicated by creating a dual charge structure for Medicare and non-Medicare include:
  - a. Laws pertaining to “customary charges.”
  - b. The “substantially in excess” rule.
  - c. Laws requiring a rational relationship between charges and costs for proper apportionment.
3. To be considered is whether submitting a claim to Medicare for a charge that is only relevant for Medicare beneficiaries is a reflection of the hospital’s true charge, or whether it is “false.”
4. Questions to consider in any such arrangement:
  - a. Does the arrangement pertain only to self-pay patients, or does it include commercial pay as well?
  - b. Are all commercial pay patients benefiting from the structure, or only some payers’ patients?
  - c. How do payers distinguish between hospital full charge services and these discounted services?
  - d. Is there any value being transferred to community physicians in the arrangement?

**VI. Medicare Payments Based on Indigent Care**

- A. Meaningful use payment formula is as follows:

Incentive Amount = [Initial Amount] x [Medicare Share] x [Transition Factor]

Initial Amount = \$2,000,000 + [\$200 per discharge for the 1,150<sup>th</sup> – 23,000<sup>th</sup> discharge]

Medicare Share =  $\text{Medicare} / (\text{Total} * \text{Charity Care}) = [M / (T * C)]$

M = [# of Inpatient Bed Days for Part A Beneficiaries] + [# of Inpatient Bed Days for MA Beneficiaries]

T = [# of Total Inpatient Bed Days]

C = [Total Charges – Charges for Charity Care\*] / [Total Charges]

\*If data on charity care is not available, then the Secretary would use data on uncompensated care as a proxy. If the proxy data is not also available, then "C" would be equal to 1.

B. Medicare DSH revisions

1. DSH payments to be reduced by 75%.
2. The 75% reduction is to be included in a national pool, which will be reduced in proportion to the reduction in the uninsured population nationwide.
3. The reduced pool will be allocated to hospitals in proportion to the amount of uncompensated care they furnish, as compared with total uncompensated care nationwide.
4. Unclear which of the following will be included:
  - a. Charity care
  - b. Bad debt
  - c. Payer shortfalls
5. Likely will use S-10 data for the first two of these, but not the last.

C. Worksheet S-10

1. Definitions:
  - a. Uncompensated care—Charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.
  - b. Charity care—Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. "For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt."
  - c. Non-Medicare bad debt—Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim.

- d. Non-reimbursable Medicare bad debt—The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are **not** reimbursed by Medicare under the requirements of §413.89.
2. Relevant statistics:
- a. Charity care cost
    - (1) Total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility.
    - (2) For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, this is the patient's total charges.
    - (3) For patients covered by a public program or private insurer with which the provider has a contractual relationship, these are the deductible and coinsurance payments required by the payer.
    - (4) Excludes physician and other professional services.
    - (5) Excludes discounts not meeting the hospital's charity care criteria or patients given courtesy discounts.
    - (6) Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.
    - (7) Multiply by RCC
    - (8) Subtract out payment received
  - b. Non-Medicare uncompensated costs
    - (1) Unreimbursed Medicare and other bad debt.
    - (2) Use full charges, multiplied by RCC, and subtracting out payer payments for each of these programs.
3. Issues with the S-10 include:
- a. RCC does not include GME payments
  - b. Based on date of service, and not date of write-off
  - c. Charity care only includes patient liable portion, and no payer shortfalls, even when such payment is minimal

## **VII. Permitted Discounts to the Uninsured**

- A. CMS position
  - 1. Must gross-up to full charges on the cost report

2. Collection efforts to Medicare must be no *less* than to other beneficiaries (but can have less restrictive efforts for non-Medicare beneficiaries, including the uninsured)
3. Substantial discounting to the uninsured, including the non-indigent, does not render a hospital's charge structure entirely fictitious

B. OIG position

1. OIG's concern is with copay waivers serving as an inducement to Medicare beneficiaries to use an entity or individual's services.
2. By statute, improper copay waivers can result in civil monetary penalties.
3. OIG has determined, consistent with the statute, that copay waivers are allowed if:
  - a. There is an individualized determination of financial need;
  - b. The determination is based on uniformly applied criteria;
  - c. The financial need criteria are reasonable; and
  - d. The policy is not advertised.
4. To determine whether, financial need criteria are reasonable, OIG suggests considering the following:
  - a. local cost of living;
  - b. patient's income, assets, and expenses;
  - c. patient's family size; and
  - d. scope and extent of a patient's medical bills.