Pricing, Transparently and Opaquely

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Agenda

- Caption Contest!
- Overview of price transparency for hospitals.
- NSA update.
- General principles on pricing/risks of inconsistent pricing.
- Overview of some antitrust issues.
- Any legal question you want! New MN law? SNF Staffing? Stump me!

Nursing Home Staffing

- A proposed rule issued 9/1 would require:
  - *minimum nurse staffing standards of 0.55 hours per resident day (HPRD) for Registered Nurses (RNs) and 2.45 HPRD for Nurse Aides (NAs);*
  - *a requirement to have an RN onsite 24 hours a day, seven days a week and*
  - *3) enhanced facility assessment requirements.*
- This is more than MN's 2 hours of nursing staffing per resident.
- It is ONLY proposed. Comments due MONDAY!

Pricing Transparency

- 45 CFR Part 180, 84 Fed. Reg. 65524, Nov. 27, 2019 requires hospitals to disclose pricing.
- Shoppable services must be publicly disclosed.
- Provide machine readable data.
- Initial CMP of $300 a day increased to up to $5,500 for hospitals with more than 550 beds.

Key Terms

- **De-identified maximum** (minimum) negotiated charge means the highest (lowest) charge that a hospital has negotiated with all third-party payers for an item or service.
- **Discounted cash price** means the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.

Key Terms

- **Gross charge** means the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.
- **Machine-readable format** means a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats.

Key Terms

- **Shoppable service** means a service that can be scheduled by a healthcare consumer in advance.

Key Terms

- **Standard charge*** means the regular rate established by the hospital for an item or service provided to a specific group of paying patients. This includes **all of the following** as defined under this section:

1. *Gross charge.*
2. *Payer-specific negotiated charge.*
3. *De-identified minimum negotiated charge.*
4. *De-identified maximum negotiated charge.*
5. *Discounted cash price.*

* *Note the singular. Super, super confusing!*

Subpart B – Public Disclosure Requirements

- § 180.40 General requirements.
- A hospital must make public the following:

  *a) A machine-readable file containing a list of **all standard charges for all items and services** as provided in § 180.50.*

  b) A consumer-friendly list of standard charges for a limited set of shoppable services as provided in§180.60.

Operationalize This?

- Two separate requirements: publishing “standard charges” and displaying “shoppable services.” In lieu of a list of shoppable services, hospital may use an internet based price estimating tool for 70 specified shoppable services and at least 230 additional shoppable services.
- Must be prominently displayed on the website, accessible to the public without charge or registration.

Operationalize This?

- The list for all service must include: Gross charge for inpatient and outpatient care, payer specific negotiated charge for each payer, de-identified maximum and minimum negotiated charges and the discounted case price.

Authority: 42 U.S.C §300gg-18(e)

(e) Standard hospital charges — Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title.

MN Atty General, 501(r) and The New MN Law.

- Under Pressure or Ice, Ice Baby?
- Did you sign the AG Agreement?
- Are you a hospital? Pay attention to 144.587-589
- Are you a 501(c)(3) hospital? Pay attention to 501(r)
  - Community Needs assessment
  - Financial Assistance/Emergency Care Policies before “extraordinary collection actions.”
  - Limits on Charges
  - Billing policy limits.

Extraordinary Collection Actions

- Selling an individual’s debt.
- Reporting to a credit agency/bureau.
- Deferring or denying medically necessary care because of non-payment.
- Any formal legal proceedings.

Reasonable Efforts

- The date of the first post-discharge bill begins a 120-day notification period and a 240-day application period.
- Notify the patient of the financial assistance policy, permit them 120 days to react.
- They have 240 days from the date of the initial bill to complete it.
- Still must provide 30 days before initiating an ECA
- If you aggregate encounters, the period begins with the most recent episode in the bundle.

NSA Update

- The Texas Medical Association is racking up big wins, BUT they are mostly about IDR.
- NSA investigations are happening. Mostly failure to give GFE, balance billing louse ups. Have you trained your billing folks to be wary of balance billing for ED visits?
- If the patient isn’t using insurance for a service by a licensed health professional, there must be a GFE.
- The government position on ambulance transfers is wrong.

Knowledge Checking The Knowledge Check

Knowledge check

Carlos is a 62-year-old male with employer-sponsored health coverage. He is involved in a ski accident and sustains multiple injuries. He is taken to the closest hospital, which is out-of-network. He undergoes surgery to repair multiple leg fractures. Once he is stable and out of surgery, he is counseled on the option to transfer care to another local in-network hospital for the duration of his recovery. His treating physician determines the safest form of transport, given his medical state, would be via ambulance. Carlos knows that the hospital he is in has an excellent reputation and wishes to stay there for his recovery. The hospital provides a written notice and gets his written consent to waive his balance billing protections under the No Surprises Act. He remains inpatient for two additional days and is ultimately discharged to home.

Does the No Surprises Act's prohibition on balance billing for emergency services apply to all days of care Carlos received from this hospital?

Knowledge Checking The Knowledge Check

Knowledge check answer

Yes.

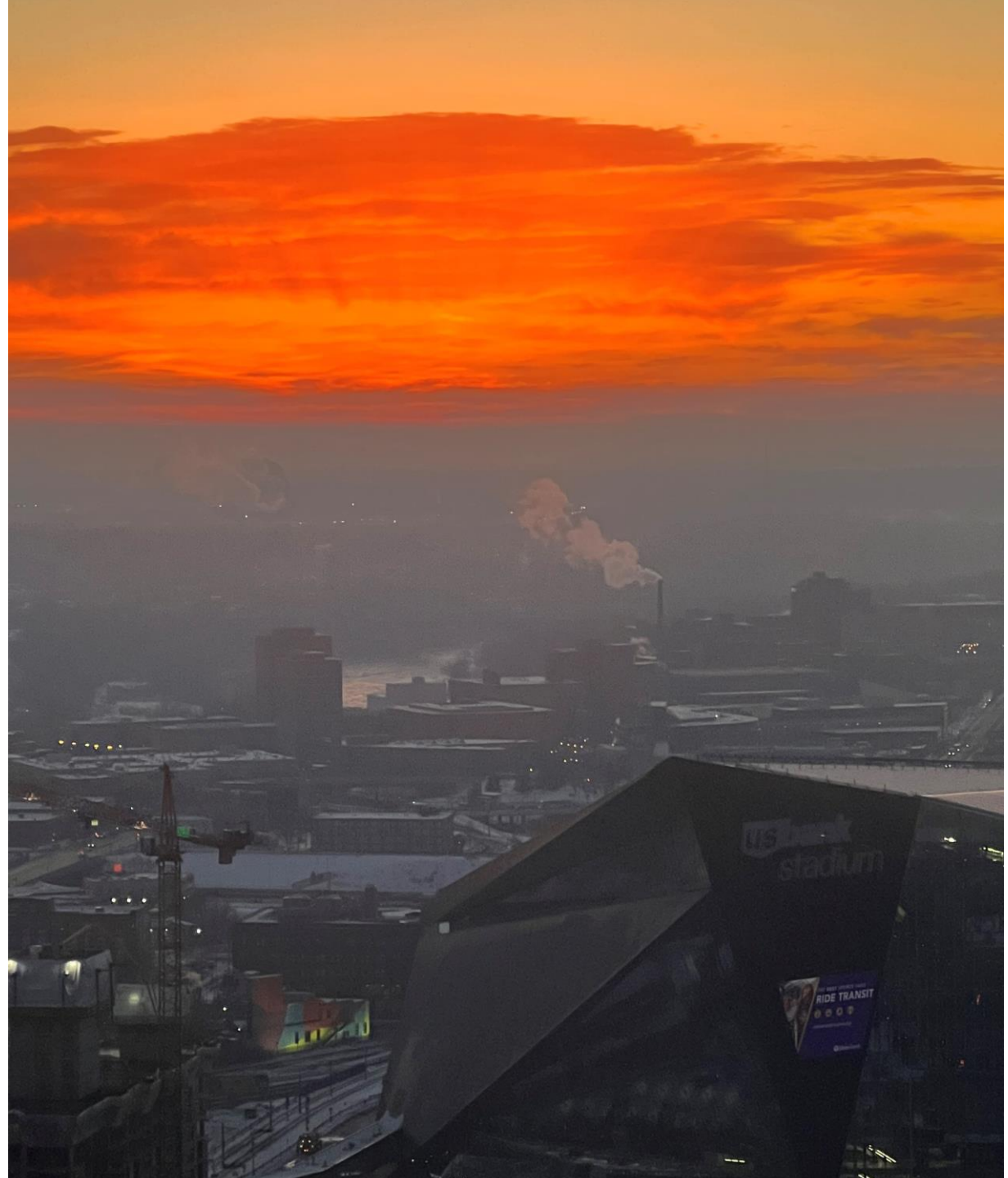
The hospital is banned from balance billing Carlos for items and services provided prior to his being stabilized. The hospital is also banned from balance billing him for post-stabilization services provided after surgery, despite obtaining written consent from Carlos to waive his balance billing protections under the No Surprises Act. Because he could only safely be transferred via ambulance, the hospital can't seek consent from him to waive his balance billing protections under the No Surprises Act specific to post-stabilization services. In the event that an individual requires medical transportation to travel, including transportation by either ground or air ambulance vehicle, the individual is not in a condition to receive notice or provide consent.

Do They Know What “Or” Means?

- The attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation ***or*** nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition. The attending emergency physician's or treating provider's determination is binding on the facility for purposes of this requirement.
- 42 CFR 149.410(b)(1)

Crossing the Streams?

- Price transparency data may have a large impact on the IDR process.
- Data may affect the Qualified Payment Amount.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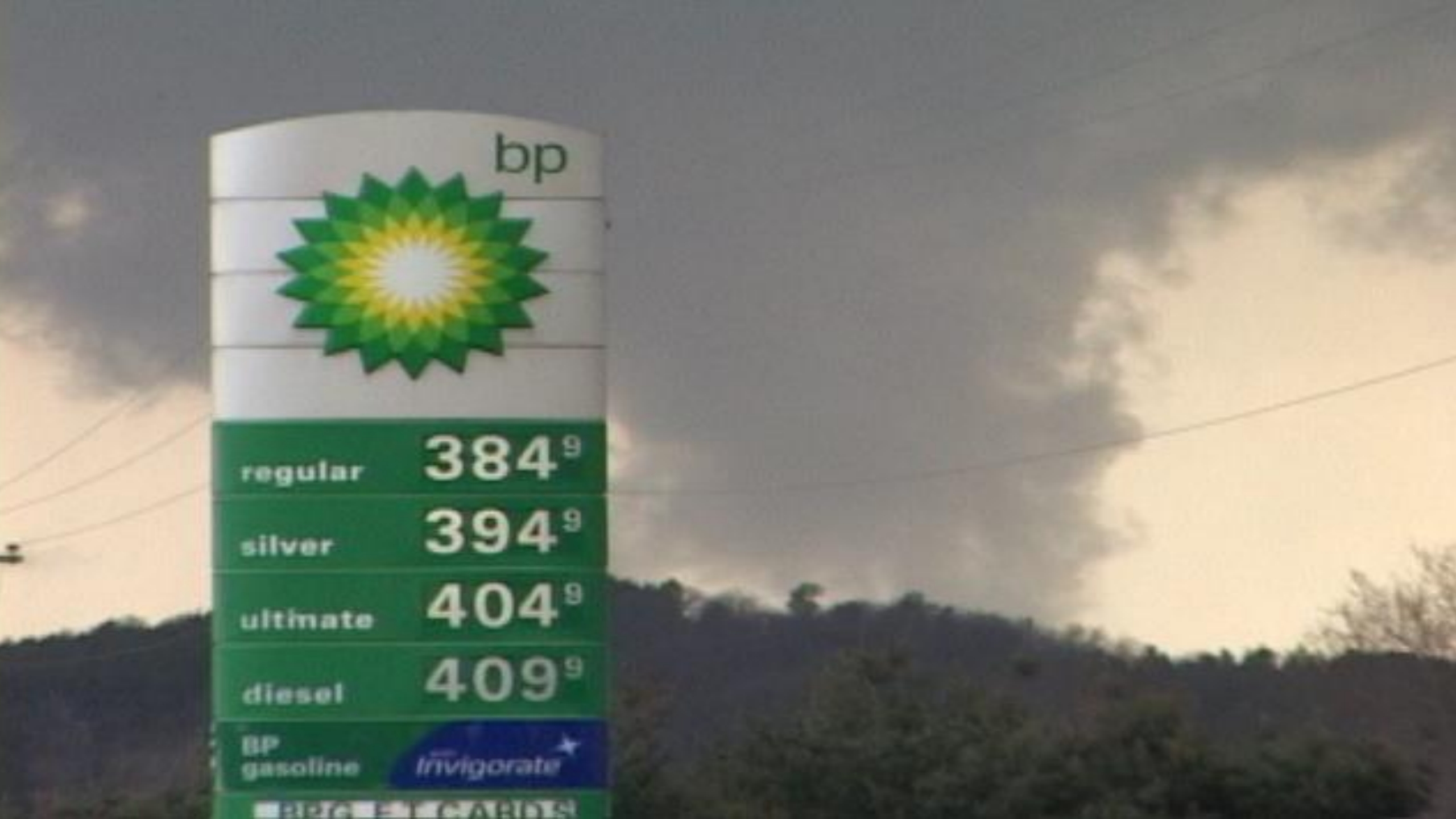
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“Let’s Make A Deal” or “The Price Is Right?”

- There are two ways to buy a good or service:
  - *Explicit agreement on terms.*
  - *Implied contract.*
- Implied contracts are rare in any other industry.
- If parties disagree about a term in an implied contract, a court will impose a “reasonable” result.
- Can you name another situation where people typically pay a percentage of billed charge?

I'll Have What She's Having…

- How much can a patient/payor using an implied contract rely on the terms of your actual contracts?
- How much can a patient/payor using an implied contract rely on discounts to others with implied contracts?
- How much can a patient/payor using an express contract rely on your discounts to others?

Peril of the Percentage

- Your “standard charge” for a service is $5,000. A patient without insurance is eligible to pay 70% as payment in full. What is your charge for the service? (Show your work!)

  A. $5,000.

  B. $3,500.

  C. What the “average patient” pays?

  D. We need more information.

Can I Have Different Prices For Different Patients?

- Absolutely. Every organization has multiple charges for identical services.
- Beware of catchy phrases like “you can’t discriminate.”
- Inconsistent pricing for services isn’t inherently “illegal,” but there are collateral consequences, including claims of fraud.

Can I Have Different Prices For Different Patients?

- Note that Robinson-Patman prohibits price discrimination for **goods**. We often speak of “items and services” but they are different!!
- If you provide a discount to a cash paying walk-in, why is an auto insurer not entitled to the same rate?
- Many seemingly logical justifications run afoul of the law or your contracts.

The Discount Is Because…

- Timing. They paid the day of service. (So if they paid 1 day late, there is a large financial penalty??)
- Administration. We didn’t have to bill them. (Do your contracts forbid billing fees?)
- Fairness. Self-pay shouldn’t have to pay more than insurers pay. (Reasonable, but is ANYONE paying the billed charge?)

I Have To Give Medicare My Lowest Price, Right?

- Wrong. Medicare pays the lower of:
  - *Actual charge.*
  - *Fee schedule amount.*
  - *Usual and customary charge.*
- Usual and customary charge is defined as your median (50th percentile) charge. Medicare Claims Processing Manual, Ch. 23, §80.3.1.

42 CFR § 405.503(b)

- This regulation defines “customary charges” as “the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service.”

Actual Charges May Vary

If the individual physician or other person varies his charges for a specific medical procedure or service, so that no one amount is charged in the majority of cases, it will be necessary for the carrier to exercise judgment in the establishment of a “customary charge” for such physician or other person. In making this judgment, an important guide, to be utilized when a sufficient volume of data on the physician's or other person's charges is available, would be the median or midpoint of his charges, excluding token and substandard charges as well as exceptional charges on the high side. A significant clustering of charges in the vicinity of the median amount might indicate that a point of such clustering should be taken as the physician's or other person's “customary” charge. Use of relative value scales will help in arriving at a decision in such instances.

42 CFR § 405.503(b)

I Have To Give Medicaid My Lowest Price, Right?

- Maybe. Depends on state law.
- In some states the “usual and customary” charge is defined as the charge that you charge most often. (Mode).
- Some states follow Medicare. (Median).
- Some states require Medicaid to be the lowest. (Minimum).

Can Our Group Have Different Rates For Different Physicians?

- You CAN, the question is what it will mean.
- Unclear if U&C is by code or practitioner.
- If you bill as a group, probably best to assume it is by code.

Do I Have To Post My Price?

- Historically no, but now…
  - *COVID-19 testing.*
  - *Price transparency for hospitals.*
  - *State law.*
- No Surprises Act Good Faith Estimates.
- If not required, helps to avoid the (potentially dangerous) element of surprise.

Can I Require Patients To Pay More Than Their Insurer Reimburses?

- Do you have a contract with the insurer?
- If yes, then you will need to review the contract.
- If no, then you can charge the patient what you want.
- Remember concepts of implied contract.

Can I Require Patients To Pay More Than Their Insurer Reimburses?

- What if the payer is Medicare?
  - *If participating, then you must accept Medicare.*
  - *If nonparticipating, then limited by Medicare Limiting Charge (15% over Medicare's approved amount). (Beware of state limits! MN has one.)*
  - *If opted out, physicians do what you want.*
- Medicaid – state by state.

Can I Set Up A Cash Only Telehealth Service?

- Medicare's Mandatory Claim Submission is a potential problem.
- HIPAA allows patients to not bill insurers but:

  "A covered entity must agree to the request of an individual to restrict disclosure of protected health information about the individual to a health plan if:

  - (A) The disclosure is for the purpose of carrying out payment or health care operations
  - and is not otherwise required by law;":

- Do they really want to prohibit Medicare patients from the cash only telehealth??

Opting Out

- Done by professional, not entity.
- Out for 2 years. Other than 90-day recanting window, must stay out the WHOLE time. Even if the professional changes jobs.

Can I Charge A Patient For “Extras” Like Phone Calls? Faster Service? More In-person Time?

- Each payer has different rules.
- Medicare prohibits charging patients for covered services. What is covered?
- Most insurers include similar prohibitions in their contracts.
- Absent a contract, almost anything goes.

Can I Adjust My Fees To Out-of-Network Patients To Mirror The Network?

- Extremely controversial issue.
- Insurers want the network to mean something.
- There may be no contract between you and the insurer, but there is a contract between the patient and the insurer.

Can I Adjust My Fees To Out-of-Network Patients To Mirror The Network?

- How the insurer reimburses out of network services may affect the analysis.
  - *Fee schedule.*
  - *Percentage of charges.*
  - *Percentage of fee schedule.*

Can I Adjust My Fees To Out-of-Network Patients To Mirror The Network?

- New Jersey court ruled against Health Net and for the physicians in an ASC dispute where ASC waived co-insurance. State law forbid dentists from waving co-insurance. Garcia v. Health Net of New Jersey, Inc., No. A-2430-07T3, 2009 BL 295398, 2009 WL 3849685 (N.J. Super. Ct. App. Div. Nov. 17, 2009.)

Can I Adjust My Fees To Out-of-Network Patients To Mirror The Network?

- Compare this with North Cypress Medical Center Operating Co., Ltd. v. Cigna Healthcare, 781 F.3d 182 (2015)781 F.3d 182, 197, (5th. Cir. 2015), holding that limiting the patient's liability, limited the plan's liability in the same fashion.

Are There Limits On How Much I Can Raise My Prices?

- Federally, no.
- State law or contract may apply.
- Antitrust analysis considers a 5% price increase as suggestive of monopoly.

Antitrust

- Policy: Competition is good.
- Note: Health policy is a bundle of contradictions. How do you reconcile CONs and a desire for competition?
- Biased heavily in favor of buyers.
- Policy is almost as important as law.
- Antitrust is a broad term covering many behaviors.

Can You Know A Competitor's Charge?

Can You Know A Competitor's Charge?

- Of course. Target knows what Walmart charges.
- The problem is AGREEMENT about prices, not knowledge.
- But that agreement can be implied.

Antitrust

- For many antitrust issues, a violation is possible only if you have “market power.” The definition of the market is key.
  - *Product Market: what other good/service can a buyer get instead?*
  - *Geographic Market: where could the buyer reasonably go for an alternative?*

Antitrust

- Price Fixing: competitors agree to sell at a price or establish a minimum price. (You don’t need market power!!)
- Boycott: competitors agree not to deal with a particular party.

"Psst…Quit taking insurance. Pass it on."

Antitrust

- Monopolization: One party controls enough of the market to be able to fix price. Market share and barriers to entry are both relevant.
- Tying arrangements: One party requires buyers to purchase an unrelated item to receive the item sought by the purchaser. (Seller must have “market power.”)

Antitrust

- Most of the antitrust laws (with the exception of monopolization) require agreement between competitors.
- Airline pricing/conscious parallelism.


C7
C8
C10
C11
C9

When Antitrust Matters

- Negotiations with insurers.
- Relations with hospitals.
- Peer review.
- Joint ventures.
- Pricing.
- Mergers.

How Can You Get Negotiating Clout?

- Apparent options:
  - *Just say no.*
  - *Unionize.*
  - *Agree not to sign a contract.*
  - *Get big.*
- Which of these are legal?

Can We Jointly Negotiate?

- You can form a network, but if it increases your reimbursement, watch out.
- The safest approach for clinics may be a divisional merger.
- If the payor objects, joint negotiation is perilous.

Can I Collect My Fees Upfront?

- Nothing prohibits it (if your “fee” means only the patient liability. Collecting the whole fee from an insured patient is likely to be trouble.)
- It creates some practical issues.

Do I Have To Refund All Credit Balances?

- In many states the purely legal answer is yes.
- The practical answer is consistency; WWYW?

Can I Charge Patients Who No-Show?

- Depends who the payer is.
  - *Private payer: Check your contract.*
  - *Medicare: Yes, as long as you don't discriminate.*
    - Charge is for the missed business opportunity.
  - *Medicaid: Depends on the state. MN is a no.*

Can I Waive Co-Payments?

- Laws to consider:
  - *Federal Antikickback Statute.*
  - *Civil Monetary Penalties Provision.*
  - *State laws.*
    - Case to read: Kennedy v. Connecticut General Life Insurance, 924 F.2d 698 (7th Cir. 1991).

Can I Waive Co-Payments?

- Antikickback Statute: illegal to offer, give, solicit, or receive any remuneration if the purpose of the remuneration is to induce or reward referrals for services reimbursed under Medicare/Medicaid.
- Intent based.
- One-purpose test.

Can I Waive Co-Payments?

- Civil Monetary Penalties Provision: it is illegal to provide anything of value that the provider "knows or should know" is likely to influence the beneficiary's selection of a particular provider.
- Intent could be irrelevant, given the "knows or should know" language.

Can I Waive Co-Payments?

- Beware of state antikickback statutes, which extend the federal statute to private payers.
- State statutes may not necessarily mirror federal statute.
- Most contracts prevent it.
- What about for the poor? The angry?

Can I Give Free Care To Employees?

- Sort of…
- Beware of benefit plan issues.
- Who does it benefit, the employee or the insurance company?
- When treating your employees, remember the risks.

Can I Give Free Care To Doctors?

- Antikickback analysis: What is the intent?
- If only your best referral sources get free care, that's a problem.
- Stark law might apply, too.

Can I Give Free Care To Doctors?

- Stark: a physician may not make a referral to an entity for the furnishing of designated health services if the physician (or an immediate family member) has a financial relationship with the entity.
- Entity may not bill for DHS furnished under a prohibited referral.
- Intent is irrelevant.

Can I Give Free Care To Doctors?

- Designated Health Services.
  - *Clinical laboratory.*
  - *Physical therapy.*
  - *Occupational therapy.*
  - *Radiology services.*
  - *Radiation therapy services and supplies.*
  - *Durable medical equipment and supplies.*
  - *Parenteral and enteral nutrition.*
  - *Prosthetics and orthotics.*
  - *Home health services.*
  - *Outpatient prescription drugs.*
  - *Inpatient and outpatient hospital services.*

Can I Give Free Care To Doctors?

- Stark Professional Courtesy Exception:
  - *Must have medical staff;*
  - *Offered to all physicians on medical staff or in local community without regard to volume/value of referrals or other business generated by physician;*
  - *Items/services are routinely provided by the entity;*
  - *In writing and approved by governing body;*
  - *Recipient is not a Federal health care program beneficiary, unless there is financial need; and*
  - *Does not violate antikickback statute/other law.*

Can We Give Discounts To The Poor?

- Absolutely.
- At times, people take unusual positions.

Do I Have To Provide Charity Care? If So, How Much?

- Distinction: may v. must/hospital v. clinic.
- Federal tax-exemption requirement – must be organized for an exempt purpose.
  - *"Charitable" can include relief to poor and underprivileged, but also advancement of education and science.*
  - *Form 990 Schedule H.*
  - *No specific percentage of revenue is required.*

Do I Have To Provide Charity Care? If So, How Much?

- State tax-exemption rules vary.
- Medicare.
  - *Hospital may determine its own indigence criteria.*
  - *Provider Reimbursement Manual (PRM) sets forth guidance for charity care policies.*

Do I Have To Provide Charity Care? If So, How Much?

- PRM Guidance:
  - *May deem dual eligible as qualified to receive charity care.*
  - *Patient's indigence must be determined by hospital, not patient.*
  - *Consider patient's "total resources," including an analysis of assets, liabilities, income and expenses.*

Do I Have To Provide Charity Care? If So, How Much?

- PRM Guidance:
  - *Determine that no other source is legally responsible for medical bill (e.g., Medicaid, local welfare agencies).*
  - *Retain documentation of method by which indigence was determined, as well as back-up documentation to substantiate determination.*

Must I Put A Patient Into Collections?

- Different answer for clinics and hospitals.
- To claim bad debt on cost report, you must make "reasonable" collection efforts.
- The only issue for clinics is whether your fee is "real." Generally, collection isn't a factor in that analysis.

When Can I Claim Bad Debt?

- The debt must be related to covered services and derived from deductible and coinsurance amounts.
- The provider must be able to establish that reasonable collection efforts were made.
- The debt was actually uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

42 CFR 413.89(e)

Can I Charge Interest On Debts?

- Consider both federal and state law.
- Federal Truth in Lending Act.
  - *Applies if you extend credit to patients.*
  - *Must make periodic disclosures.*
- State usury laws.
- Medicare Policy.
- Medicaid.

Can I Charge Interest On Balances?

- WPS, CIGNA, MACs (and even CMS) assert that physicians cannot charge Medicare patients interest. They cite 42 CFR 424.55 (b)(2)(ii) which says a supplier agrees:

42 CFR 424.55 (b)(2)(ii)

"To collect only the difference between the Medicare approved amount and the Medicare Part B payment (for example, the amount of any reduction in incurred expenses under Sec. 410.155(c), any applicable deductible amount, and any applicable coinsurance amount) for services for which Medicare pays less than 100% of the approved amount."

The Flaw

“The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.”

MLN MM5613

The Flaw

- A charge for interest is not a service.
- The MACs have created a policy that is inconsistent with other Medicare guidance.

Can I Charge Interest On Debts?

- Minnesota:
  - *No written agreement: ≤ 6%.*
  - *Written agreement: ≤ 8%.*
  - *In most cases, need special license for > 8%.*
- Georgia:
  - *No written agreement: ≤ 7%.*
  - *Might need special license for > 8%.*
  - *Also depends on principal balance.*

What Collection Issues Must I Be Worried About?

- Fair Debt Collection Practices Act.
  - *Cannot call during "inconvenient" time.*
    - 8 a.m. – 9 p.m. is presumed convenient.
  - *If patient is being represented by an attorney, then must contact attorney.*
  - *Cannot call at work if patient/employer says not to.*
  - *Must cease communications if receive written notice from patient of refusal to pay.*

Presenter

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Thank you!

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