Hospital Pricing – Emerging Compliance Issues

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Hospital Pricing Compliance Issues: A Legal Overview

- Definition of “Charges”
- Federal Anti-Kickback, CMPL and Transparency Laws
- Federal Tax Exemption Laws
- State Laws
- Litigation Involving Health Care Pricing
- Compliance Considerations
I. Definition of “Charges”

- Medicare Cost Apportionment Regulation

Charges are defined as--

“the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as a 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)(ii)
Medicare Provider Reimbursement Manual

“. . . . Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All 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.”

PRM, Part I, §2202.4

- “Usual Charges” are defined as the average amounts that a provider agrees to accept as payment in full for all classes of patients except non-managed care government (Medicare, Medicaid) patients, capitated patients and uninsured patients provided services free of charge or at a substantially reduced rate.
- “Usual charges” are computed on the basis of the preceding calendar year or a rolling 12-month period.
In the current environment, who are expected to pay full hospital “charges” as reflected on the hospital chargemaster:

- Uninsured patients who do not qualify for financial assistance under the hospital’s financial assistance plan
- Out-Of-Network patients
- Indemnity insurers without a contract
- Liability insurers (e.g., auto insurers)
II. Federal Laws Impacting Hospital Pricing

A. The Anti-Kickback Statute, 42 U.S.C. 1320a-7b(b) and Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a(a)(5)

Define “Remuneration” (i.e., a potentially prohibited payment) to include “Discounts” and Free Services.

- Both statutes prohibit the offer or payment of any remuneration directly or indirectly to beneficiaries of federal health plans in an effort to influence the beneficiary’s selection of a health care provider.
The Anti-Kickback Statute, 42 U.S.C. 1320a-7b(b)
Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a(a)(5), cont’d

- The AKS applies to discounts offered to both patients and all other possible referral sources (e.g. physicians, hospitals, other providers)
- The CMPL applies only to discounts and free services offered to patients
- The AKS and CMPL do not apply to discounts to uninsured and others who are not covered by federal health plans (Query: Are QHPs considered federal health plans as the result of premium subsidies provided under the ACA)
CMPL “Safe Harbors” for Discounts

Pricing discounts and free services that are excepted from the CMPL definition of “remuneration”

- Incentives given to patients to promote preventive care
- Coupons or rewards for free or discounted health care items or services offered on equal terms to the general public and not tied to other billable items or services
- Free or discounted health care items offered to patients after determining financial need and not offered by advertisement or tied to other billable items or services

42 USC 1320a-7a(i)(6)(D), (G), (H)
OIG Guidance on Hospital Discounts to Patients Under the AKS and CMPL

AKS and CMPL do not apply to discounts or waivers of copayments and deductibles for Medicare and other federal health plan beneficiaries, in the following situations:

- A bad debt write-off after reasonable collection effort
- Waiver of Part A deductible on inpatient admissions reimbursed under the DRGs in accordance with AKS safe harbor
- In individual cases of “reasonably verified financial need,” *OIG Document on Hospital Discounts, Feb. 19, 2004*
OIG Guidance on Hospital Discounts to Patients Under the AKS and CMPL, cont’d – Non-Covered Services

- Discounts offered to federal health plan beneficiaries on non-covered goods and services potentially raise a concern under the Anti-Kickback Statute.
- Hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a federal health care program.
- Waivers of copayments and deductibles cannot be offered as part of an advertisement.
Anti-Kickback Discount Safe Harbor, 42 U.S.C. 1001.952(h)

The AKS Discount safe harbor protects certain discounts and reductions in price from prosecution under the Anti-Kickback Statute

- Does not apply to:
  - Discounts to patients
  - A reduction in price to one payer but not to Medicare and Medicaid
  - “Swapping” discounts for Medicare/Medicaid referrals may violate the Anti-Kickback Statute
“Swapping” often occurs in relation to referral sources subject to “bundled” payments or lab billing rules

- See OIG Advisory Opinions 99-2 (discounts to SNFs on Part A ambulance services); 99-13 (discounts to physicians on non-federal lab tests); 04-16 (discounts on ESRD composite rate lab testing); 15-04 (lab agreement not to bill patients for out of network “Exclusive Plan” tests).

- Key finding in Swapping Arrangements: “Company A's profit margin for the non-Federal health care program business under the Proposed Arrangement would be less than the profit margin on the services that it bills directly to Federal health care programs.”

Any discount given to referral sources that is not given to Medicare and Medicaid must reflect actual cost savings.
B. Social Security Act Exclusionary Statute, 42 U.S.C. 1320a-7(b)(6)

Permits, but does not require, the OIG to exclude from participation in federal health care programs any provider or supplier that submits bills to Medicare or Medicaid for amounts that are substantially more than the provider’s usual charges in the absence of good cause for the substantial difference.
OIG Proposed Rule (Sept. 15, 2003) defines “usual charges”

- Defines “usual charges” in terms of average payment amounts accepted from non-governmental payers
- Defines “substantially more than usual charges” as 120% of usual charges
- Usual charge limitations under the Exclusionary Statute have thus far not been enforced
- Final rule was expected in April 2005 but was never published
C. False Claims Act, 31 U.S.C. 3729
False Statement Act, 18 U.S.C. 1035

The False Claims Act, 31 U.S.C. 3729, prohibits the knowing submission of false claims for payment to the federal government. The HIPAA criminal provisions, 18 U.S.C. 1035, impose criminal penalties for knowing false statements submitted to any health care plan (e.g., commercial insurance).
OIG Analysis in Fraud Alert on Routine Waiver of Copayments and Deductibles as the Misstatement of Charges:

A provider who routinely waives Medicare copayments or deductibles is misstating its actual charge. For example, if a provider claims that its charge is $100, but routinely waives the Medicare 20% copayment, the actual charge is $80. Medicare should be paying 80% of $80 (or $64) rather than 80% of $100 (or $80).
Waivers or reductions of deductibles and copayments for Medicare patients should be given only in the case of verifiable need or available safe harbor.

False Claims Act issues may arise with insured patients under qualified health plans for which federal subsidies are received under the ACA.

Waivers or reductions of deductibles and copayments for commercial insurance patients should be given only--
  - as allowed by commercial contract, or
  - in the case of verifiable need, or
  - with notice to commercial payer.

False Claims issues should not arise with uninsured.
D. Medicare Cost Reporting Rules

1. Medicare Cost Apportionment
   42 C.F.R. 413.53(b)(2)(ii)

   ▪ Charges are used as a statistic for Medicare cost apportionment.
   ▪ The Medicare cost apportionment definitions have been interpreted to require a uniform charge structure, even though Medicare regulations do not impose a uniform charge structure.
   ▪ Providers using non-uniform charge structures are required to obtain MAC approval to “gross up” charges for Medicare cost apportionment purposes.
2. Medicare Outlier Formula, 42 C.F.R. 412.84

- Uses the cost-to-charge ratio (CCR) from the most recently filed cost report with retrospective reconciliation to the actual CCR for a cost reporting period if the current CCR varies by more than 10% from the CCR used during the period to pay outliers.

- OIG November, 2013 Report: “[T]he routine receipt of outlier payments for certain MS-DRGs at high-outlier hospitals raises concerns about why charges and estimated costs for similar patient-care cases vary substantially across hospitals.” OEI-06-10-00520

- OIG recommended Medicare contractors to increase monitoring of outlier payments.
3. Medicare Bad Debt Rule, 42 C.F.R. 413.80

- Requires that providers make a reasonable collection effort on Medicare copayments and deductibles as a condition for reimbursement of Medicare bad debts.
- The collection effort on Medicare accounts must be similar to that of non-Medicare accounts.

PRM §310

- Write-offs resulting from routine waivers of Medicare copayments and deductibles should not be claimed as Medicare bad debts.
4. Medicare Provider-Based Status, 42 C.F.R. 413.65

CMS Region V: Non-uniform pricing structures will disqualify a hospital department/location from receiving and/or maintaining hospital-based status.
E. Hospital Charge Transparency Statute

Section 10101 of the Affordable Care Act, amended Section 2718(e) of the PHSA (42 USC 300gg-18): “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.”

IPPS 2014 Final Rule: Hospitals must either make public a list of their standard charges (whether the chargemaster or another form), or their policies for allowing the public to view a list of those charges in response to an inquiry.
III. Federal Tax Exemption Limitation on Charges

The Affordable Care Act enacted Section 501(r) of the Internal Revenue Code, which among other things imposes the following new requirements on charitable tax-exempt hospitals:

- The obligation to establish written financial assistance policies ("FAP") and emergency care, and
- The imposition of certain limitations on charges (IRC 501(r)(5))

A tax-exempt hospital organization is required to limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the FAP to not more than the *amounts generally billed* ("AGB") to individuals who have insurance covering such care.
Federal Tax Exemption Limitations on Charges, cont’d

Methods for calculating Amounts Generally Billed: Hospital facilities may base AGB on one of two methods -

- "Prospective Method" – Current Medicare or Medicaid fee for service rates
- "Look Back Method" – Medicare or Medicaid rates alone, or a combination of Medicare, Medicaid and private insurer rates over the prior 12 months (no commercial insurance rates only methodology allowed)

- AGB is determined on an individual hospital basis as defined by Medicare provider number.
- A Hospital facility may change the method it uses to determine AGB at any time, so long as its FAP is first updated to describe the new method.
- A Hospital system may select various AGB calculation methods among its facilities.
- Final rule, Treas. Reg. 1-501(r)-5(b) is effective for tax years beginning after 12/29/2015.
IV. State Laws Governing Hospital Charges

A. Price Information List, O.R.C. §3727.42

Hospitals must compile and make available to the public a price information list containing:

- Usual and customary room and board charges
- Usual and customary charges for -
  - 30 most common radiology procedures
  - 30 most common lab procedures
  - ER services
  - OR services
  - Delivery room services
  - PT, OT and pulmonary therapy services
  - Any other services designated as high volume
O.R.C. §3742.27, cont’d

- The hospital must provide its billing policies, including the policy for assessing interest.
- The hospital must indicate whether the charges listed include the fees for services of hospital-based physicians, and if not, how fee information for such services can be obtained.
Ohio Tax Exemption Laws

B. Ohio’s tax-exemption statute for property used for charitable or public purposes, O.R.C. §5709.12(B)

“Real or tangible personal property belonging to institutions that is used exclusively for charitable purposes shall be exempt from taxation.”

“The property is made available under the direction or control of the [charitable] institution… for use in furtherance of or incident to its charitable…, purposes and not with the view to profit.” O.R.C. 5709.121(B)
Vick v. Cleveland Memorial Medical Foundation, 2 Ohio St. 2130 (1965)
A nonprofit hospital that operates for the primary purpose of providing services to those in need regardless of ability to pay does not lose its essentially charitable nature by charging patients who are able to pay and creating surplus in the hospital trust fund.

Crestview of Ohio v. Donahue, 14 Ohio St. 2d 121, (1968)
Convalescent hospital is not exempt from taxation because it did not have as a primary objective the care of the poor or needy who were unable to pay for its services.

Tax-exempt, hospital-affiliated organization sought tax-exemption for fitness center. The Court found that the organization's offering of charity memberships to slightly over one-tenth of one percent of total memberships insufficient to meet the charitable use standard.

Cleveland Clinic sought tax-exemption for the Beachwood Family Health & Surgery Center. Only 1.4% of the patients treated in the Center were treated without regard to ability to pay.

Tax Department Examiner: “Property is not used for charitable purposes where only about one or two percent of persons who could not pay and considered charity cases were provided services while the remainder of the patients paid fees for services.”

Tax Commissioner denied tax exempt status.

On appeal the Ohio Board of Tax Appeals reversed:

“As established through the evidence and testimony presented, as set forth herein, we find that CCF uses the subject property "in furtherance of or incidental to its charitable * * * purposes and not with the view to profit. CCF has demonstrated that it operated and used the subject property, adhering to its stated mission of providing healthcare to all, regardless of a patient’s race, creed or ability to pay for services.”
C. Ohio’s Medicaid Regulations, Ohio Adm. Code 5160-1-02(B)(1); 5160-1-17.2(A); 5160-1-29(C)(5)

- Requires Medicaid providers to charge Medicaid no more than the provider’s usual and customary rates to others.
- “Fraud, waste and abuse” defined to include “differing charges for the same services to Medicaid and non-Medicaid consumers.”
- Ohio Auditor’s Office and the Medicaid Surveillance and Utilization Review Section apply these Medicaid rules as a Most Favored Rate provision. See Omnicare Respiratory Services v. ODJFS, 2010-Ohio-625 (10th App. Dist. 2/23/10); HCMC, Inc. v. ODJFS, 179 Ohio App.3d 707 (10th App. Dist. 12/2/08)
- In audits, the Auditor and SURS treat the difference between the Medicaid rate and the lower rate offered other payers as a Medicaid overpayment.

Advice: In the absence of verifiable financial need, providers should not agree to accept payment in amounts below the Medicaid payment rates.
D. Ohio’s Consumer Sales Practices Act, O.R.C. §1345.01, et seq.

OCSPA prohibits deceptive or unconscionable consumer sales practices

- OCSPA exempts consumer-physician transactions but does not exempt consumer-hospital transactions


“A transaction between a service provider such as a hospital and a consumer is not clearly exempted” from the OCSPA.
Under the OCSPA, the following circumstances are taken into consideration in determining whether an act or practice is unconscionable:

- Whether the supplier has knowingly taken advantage of the inability of the consumer to protect his interests because of physical or mental infirmities.

- Whether the supplier knew that its price was substantially in excess of the price at which similar services were obtainable in similar consumer transactions by like consumers.

_O.R.C. §1345.03(B)_
Penalties for violations of OCSPA include three times the amount of actual damages plus attorney fees.

Ohio Adm. Code 109:4-3-05 requires a supplier of a consumer transaction service to provide the consumer with the option of receiving a written or oral estimation of the cost of the services.

Supplier must conspicuously post this notice or provide written notice to each consumer.


Patient filed a counterclaim in a collection suit alleging violation of the OCSPA. The court found that hospital silence does not constitute a misrepresentation or fraud and that the hospital’s failure to disclose lower negotiated prices was not unconscionable.
E. Ohio Case Law - “Reasonable Charges”

St. Vincent Medical Center v. Sader, 100 Ohio App. 3d 379 (1995)

– In the absence of an express agreement to pay customary charges, a patient will be obligated to pay the reasonable value for services rendered.
– The Hospital is entitled to the presumption of reasonable value.
– On a Motion for Summary Judgment, if the patient or insurer presents evidence rebutting the reasonable value of services rendered, the Hospital has the burden of submitting evidence demonstrating the reasonableness of its charges.
V. Litigation Related to Hospital Charges


- Non-contracting third party payer sues Florida hospitals and hospital association alleging collusive pricing, inequitable pricing, and group boycott.

- Alleges hospitals’ refusal to accept checks paying reasonable amount (e.g., Medicare plus 26%) constitutes a concerted refusal to deal.

Footnote: Florida District Court dismissed all claims on June 24, 2005.
B. Consumer-Based Class Action Lawsuits against Non-Profit Hospitals

- Richard Scruggs' firm and local counsel have filed close to 70 lawsuits against more than 400 hospitals and the American Hospital Association in over 26 states
- First lawsuits filed on June 15, 2004
- Named plaintiffs are uninsured patients of defendant hospitals
- Defendants may be targeted based upon above-average charge-to-cost ratios and aggressive collection practices
Claims of class action lawsuit
- Breach of duty owed to third party beneficiaries under Hospital’s “agreement” with government taxing authorities to provide free care in exchange for tax-exempt status under §501(c)(3) of the Internal Revenue Code
- Breach of contract between Hospital and plaintiff/patient for implied obligation to charge patients no more than fair and reasonable amount for services
- Breach of good faith and fair dealing
- Violation of state consumer protection laws
- Unjust enrichment/constructive trust seeking to disgorge tax-exempt savings and profits on uninsured from overbilling uninsured despite hospital tax-exempt status
Most federal courts (OH, AL, MI, CA, MS, NY, PA, CO, VA) dismissed federal claims in class action suits.

- Federal tax law claims fail as a matter of law. Patients are not third party beneficiaries under 501(c)(3).
- All claims fail under the doctrine of res judicata for failure to raise claims in earlier state court collections suit.
- In most cases, state law claims were dismissed without prejudice, which allows plaintiffs to refile in state court.
Consumer Cases Challenging Hospital Charges Continue

Herrera v. JFK Med. Ctr, M.D. Fla, No. 8:14-cv-2327 (2/20/15)

- U.S. District Court denies hospital’s motion to dismiss claims for breach of contract and violation of Florida’s Deceptive and Unfair Trade Practice Act
- Claims resulted from motor vehicle accident in which charges exceeded auto insurance benefits. Disputed charges included $5,900 for CT/spine; $6,404 for CT/brain; $3,359 for CT/lumbar
- Charges alleged to be 65 times higher than prices paid by private and government-sponsored health insurance
- The Court did deny class certification because liability and damages assessments turned on too many factual questions
Consumer challenges to hospital charges in Ohio are surfacing in counterclaims to collection actions against patients insured under employer sponsored plans that refuse to pay Hospital charges or to negotiate plan-provider contracts with the Hospital but instead just unilaterally apply a discount based upon Medicare pricing.
C. False Claims Act Litigation Based on Health Care Pricing


- An excerpt from the *Virginia* case provides as follows:

  Commercial reference laboratories offer those discounts [below the Medicaid fee schedule] to induce their customers to use a single commercial reference laboratory for the majority or all of their clinical testing needs. The discounted fees can be so low that they do not cover the laboratory’s costs. Therefore, the laboratory relies on higher paying, “pull through” Medicaid and other referrals from those customers to operate at a profit. Despite Commonwealth regulations mandating that Medicaid receive the same rates charged to non-Medicaid clients, Defendants have treated Medicaid referrals in much the same way as other “pull through” business. (Paragraph 24)

- Lawsuits were brought by a whistleblower that was a competing lab
- Quest paid $241 million to settle the CA case
- LabCorp paid $49.5 million to settle the CA case
VI. Considerations for Discount Policies

A. Discounts to the Uninsured or Underinsured Indigent Patients

1. Develop and consistently apply financial assistance eligibility requirements.
2. Review patient intake procedures to determine eligibility; determine eligibility sooner rather than later.
3. Train patient accounting/billing staff on financial assistance policies.
4. Assist patients in applying for government assistance programs or third party coverage.
5. Communicate charity care availability to needy, use signs, statements in patient registration forms, and bills.
Discounts to the Uninsured Indigent, cont’d


7. Consider sliding scale discounts based on income/need level.

8. Do not advertise a copayment waiver policy in an attempt to induce Medicare patients to select your hospital.

9. Compare charge-to-cost ratio to statewide average in Ohio. Average CCR for urban hospital is .278 or 359% charge-to-cost ratio. Average CCR for rural hospital is .443 or 226% charge-to-cost ratio. (IPPS 2014 Final Rule)
B. Discounts to the Uninsured Who Are Not Indigent

1. Consider offering discounts consistent with the weighted average of discounts offered to commercial third party payers.

2. Avoid discounts that reduce charges below Medicare and Medicaid rates.

3. Apply discounts consistently.

4. CMPL and AKS should not apply because patients are not beneficiaries of federal health care programs.
C. Write-offs and Discounts of the Self-Pay Portion of Non-Indigent Insured Patients’ Bills

1. Avoid routine waiver of copayments and deductibles for federal health plan patients, unless eligible for:
   • AKS safe harbor (e.g. inpatient deductible)
   • CMPL safe harbors (e.g. incentives to promote preventive care)
2. Review third party payer agreements for provisions that may require collection of coinsurance and deductibles.
3. Notify third party payers of intention to make routine write-offs.
4. Do not advertise deductible and copayment waiver for federal health plan patients.
D. Discounts to Non-Patients (e.g. Referral Sources such as physicians)

1. Do not tie discounts to the volume or value of referrals or to an exclusive arrangement (i.e. avoid “swapping” discounts for referrals).
2. Do not price below the Medicaid fee schedule unless the differential may be supported as actual cost saving (i.e. do not take a larger profit on Medicare and Medicaid business).
3. Never price below total costs of the item or service being offered at a discount.
4. Non-uniform pricing will require gross up for Medicare cost report apportionment.