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overview

DIFFERENTIAL CHARGING TO MEDICARE AND SELF-PAY AND COMMERCIAL PAYORS

Institute on Medicare and Medicaid Payment Issues

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Background

- Chargemasters (or charge description masters, or “CDM”) are lengthy documents sometimes containing tens of thousands of lines of all of a hospital’s charges.
- Broken down by:
  - Procedure;
  - Item or service; or
  - Hybrid
- Every hospital has, and indeed is required to have, a chargemaster.

Background *(cont.)*

- Recent attention due to:
  - Steven Brill *Bitter Pill* article in Time. Claims:
    - Hospitals use extremely high charge mark-ups to price gouge the uninsured and the underinsured.
    - Drugs in particular are highly over-priced, and even Medicare does not pay fairly for them.
    - Hospitals charges are not subject to market forces.
    - Hospitals use this outsized return to pay oversized paychecks to hospital executives.
    - Medicare discounts off of charges are appropriate, and everyone should be allowed to be insured under Medicare.
    - Hospitals should discontinue the practice of using CDMs.

Background *(cont.)*

- Recent attention due to: *(cont.)*
  - Number of uninsured increased to all-time high in 2010 of 49.9 million individuals, but then dipped slightly in 2011 to 48.6 million.
    - Still 4.5 million more uninsured than in 2007.
  - Recent case in SDNY (United States Of America, et al. v. Huron Consulting Group, Inc) argued that increasing charges faster than costs was the basis for False Claims Act liability. Court determined that, while not a good practice, it is not unlawful.

Background *(cont.)*

- Why are charges high?
  - Generally irrelevant for payment
  - Need to increase charges more than cost to keep up with customers only paying a percent of charges
  - Some self-paying customers (generally wealthy foreigners) expect to be paying high prices for care

Background *(cont.)*

- In any event, charges are not as high as they have been depicted.
  - Charge compression
  - Charges have stabilized
    - Outlier threshold has decreased from $33,560 in 2003 to $21,821 in 2013
  - Hospitals generally have a lower margin on self-pay patients than any other payer, including Medicaid
  - With the ACA, insurers will no longer be able to place annual and lifetime limits

Impact of Charges on Payment

- Outliers
- New technology payments (both inpatient and outpatient)
- Transplant costs
- Fee schedule Part B payments
- Medicaid (sometimes)
- Charge-based payers, including some MA Plans and Medicaid MCOs
- Uninsured and underinsured.

Rules Pertaining to Charge Structures

- Cost Apportionment Context. Charges are used as a statistic for allocating costs to Medicare and non-Medicare patients alike.
  - "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."
  - 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.

Rules Pertaining to Charge Structures *(cont.)*

- Cost Apportionment Context *(cont.).*
  - Not very relevant in a prospective pay environment, but still on the books.
  - Acknowledgement in Manual that cannot dictate charges.

Rules Pertaining to Charge Structures *(cont.)*

- 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."
  - "Customary charges are those uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement. Where a provider does not have an established charge schedule in effect and applied to most patients, the determined "customary charges" are the most frequent or typical charges imposed uniformly for given items or services. However, in either case, in order to be considered customary charges, they must actually be imposed uniformly on most patients and actually be collected from a substantial percentage of 'patients liable for payment on a charge basis.'"

Rules Pertaining to Charge Structures *(cont.)*

- Substantially in Excess Rule.
  - 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."
  - OIG has tried to publish rulemaking – twice – unsuccessfully
  - Many State law equivalents, some of which impose an MFN responsibility on providers

Rules Pertaining to Charge Structures *(cont.)*

- State Limits on Charges to the Uninsured or Underinsured.
  - Varies from state to state. Includes large states, such as California, New York, New Jersey, and Illinois.
  - Usually involves:
    - Income level threshold
    - Benchmark amount to be charged
    - Procedural requirements associated with collections

Outliers

- Subject to much scrutiny in the wake of Tenet scandal.
- Formula revised in 2003.
  - Updating RCC
    - RCC is from the most recent tentative settled cost report, if more recent than the most recent settled cost report.
    - CMS can require Contractor to use an even more recent one if evidence of rapid increase in charges.

Outliers *(cont.)*

- Statewide averages
  - No longer used for extraordinarily low RCC.
  - But could be used for high RCCs or new hospitals.
- 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.

Outliers *(cont.)*

- OIG Outlier Report (June, 2012)
  - CMS has not performed reconciliations for 292 of the 305 cost reports furnished to it.
  - Delayed settlement of these cost reports.

Bifurcated Billing in Provider-Based Space

- Concern with creating disincentives for patients with private insurance to receive services in provider-based space, due to coinsurance.
- CMS has stated that it can't dictate to private insurers how they pay for services.

Bifurcated Billing in Provider-Based Space
(cont.)

- Advantages of bifurcated billing:
  - Continued ability to use 340B drugs.
  - Less stringent GME rules.
  - Possible Medicaid advantage.
  - Enhanced Medicare reimbursement.
    - Higher rates.
    - Compensation for bad debt, uncompensated costs.

Bifurcated Billing in Provider-Based Space
(cont.)

- Precautions:
  - Need to “gross up”.
  - Notify payers of arrangement.
  - Treat all *Medicare* patients alike.
  - Address issues of Medicare managed care and MSP, etc.
  - Identify and address any Stark/Anti-Kickback issues.

Bifurcated Billing for Clinical Laboratory Services

- Hospital clinical labs are at a disadvantage when competing with commercial labs because hospital charges are higher than most commercial rates for stand-alone labs.
- Hospitals may find it beneficial to reduce their charges to commercial payers.
- Question of impact on “actual charge” that serves as a cap for Medicare, which may be viewed as similar to “customary charge”.
  - Similarly, Quest Diagnostics settled a case by Medi-Cal for differential charging for $241 million.
- Consequences could be both concerns about the veracity of charges to Medicare, as well as the possibility that the provider has been charging Medicare “substantially in excess” of its “usual charges”.

Bifurcated Billing for Clinical Laboratory Services (cont.)

- Relevant facts include:
  - Will the discounted charges apply to just self-pay patients, or to all non-Medicare patients?
  - If including commercially insured patients, will charges apply to all such patients, or only to a subset of the commercially insured?
  - What is permitted under commercial payer agreements?
  - Is any value being transferred to community physicians in the arrangement?

Discounts to Self-Paying Patients

- CMS
  - Must gross-up to full charges on the cost report
  - Collection efforts to Medicare must be no *less* than to other beneficiaries
  - Substantial discounting to the uninsured, including the non-indigent, does not render a hospital's charge structure entirely fictitious

Discounts to Self-Pying Patients *(cont.)*

- OIG
  - Cannot have copay waivers serve as an inducement to Medicare beneficiaries to use services.
    - Can result in criminal or CMP liability.
  - Allowable if:
    - There is an individualized determination of financial need;
    - The determination is based on uniformly applied criteria;
    - The financial need criteria are reasonable; and
    - The policy is not advertised.

Discounts to Self-Paying Patients *(cont.)*

- To determine whether financial need criteria are reasonable, OIG suggests considering the following:
  - local cost of living;
  - patient's income, assets, and expenses;
  - patient's family size; and
  - scope and extent of a patient's medical bills.

Implications of Write-offs and Write-Downs to Self-Paying Patients on Reimbursement

- Meaningful Use

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

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

Medicare Share = *Medicare/(Total*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.

- S-10 is the source of charity care charges.
- Providers disagreeing with calculation have appeal rights.

Implications of Write-offs and Write-Downs to Self-Paying Patients on Reimbursement *(cont.)*

- Revised DSH calculation
  - DSH payments to be reduced by 75%.
  - 75% reduction to be included in a national pool, reduced in proportion to reduction in uninsured population.
  - Allocated to hospitals in proportion to the amount of uncompensated care they furnish, as compared with total uncompensated care nationwide.

Implications of Write-offs and Write-Downs to Self-Paying Patients on Reimbursement *(cont.)*

- Unclear which of the following will be included:
  - Charity care.
  - Bad debt.
  - Payer shortfalls.
- S-10 to be source of data.

Implications of Write-offs and Write-Downs to Self-Paying Patients on Reimbursement *(cont.)*

- S-10
  - Data points include:
    - Charity care charges
    - Charity care costs (charges multiplied by RCC)
    - Non-Medicare uncompensated costs – charges for all bad debt and charity care, reduced to cost, with payment subtracted out.

Implications of Write-offs and Write-Downs to Self-Paying Patients on Reimbursement *(cont.)*

- S-10 issues
  - RCC does not include GME costs.
  - Data is based on date of service.
  - Charity care does not include payer short-falls, no matter how insignificant the payer's payments are.
  - Unclear if just inpatient acute care or broader – if narrowed to inpatient acute care, then difficult to implement for other payers.

Implications of Write-offs and Write-Downs to Self-Paying Patients on Reimbursement *(cont.)*

- S-10 Tips
  - Make sure your charity care policy is comprehensive and consistently applied.
  - Make sure that all charges for uninsureds and underinsureds are grossed up to full charges.
  - Determine how to revise charity care policy so as to be able to determine who qualifies for a charity care write-off prior to the deadline for filing the cost report.
  - Make sure bad debt policy is consistently applied.

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