

The Price is Right? Updates on the No Surprises Act, Price Transparency and Other Pricing Issues

Health Law Webinar

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Agenda

- Checking in on the NSA.
- Overview of price transparency for hospitals.
- General principles on pricing that apply in all settings.
- Exploration of Medicare specific rules.
- Overview of some antitrust issues, and what you can and can't do.
- How inconsistent pricing/discounts can create trouble.



Lingo Matters

- No Surprises Act (NSA).
 - Applies to a wide range of licensed entities/professionals.
 - Addresses out of network care.
 - Has notice requirements, and much, much more.
- Price Transparency.
 - Only applies to hospitals.
 - Requires making information available on your website.
 - Requires tons of machine readable data.

NSA

- The No Surprises Act, Public Law 116-260, passed December 27, 2020.
- A variety of state laws.
- Like HIPAA, more restrictive state laws generally control.

The Problem

- Patient goes to an in-network hospital for a surgery by an in-network surgeon. Unbeknownst to the patient, the anesthesiologist is out of network.
- The anesthesiologist bills more than the plan allows, leaving the patient on the hook.

The Regulatory Framework

- Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872 (July 13, 2021).
- Requirements Related to Surprise Billing; Part II, 86 FR 55980 (October 7, 2021).

Overview: Two Rules In One?

- Portions apply only to services provided in air ambulances, hospitals (including CAH) ambulatory surgical centers, or freestanding emergency rooms. The rule calls them “facilities.”
- Applies to both the facility’s bill and the bills by medical professionals for services to patients at the facility.
- This portion generally does NOT apply to services at a SNF or free-standing clinic.*

Overview: Two Rules In One?

- Professionals/organizations that take patients to hospitals or ASCs have a notice requirement.
- The second part of the rule requires a “Good Faith Estimates” of charges. While it also applies to “Facilities” the term is defined differently for this provision.

Key Definition: “Facilities” That Must Provide a GFE

- Facility: Health care facility (facility) means an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.

Overview

- Some provisions apply to health plans, others apply to “facilities” and professionals.
- Unfortunately, the law uses the term “provider” to refer to “professionals.”

Overview

- Emergency Services: applies to services at out-of-network hospitals and the professionals providing services there.
- Non-emergency Services: applies to services by professionals at a participating hospital/ASC.

Emergency Services

- For EMTALA services, the patient should be treated as if in-network. Co-pays/deductibles are the same as if it was an in-network service.
- Co-pay calculated at the lower of median rate/ billed charge.
- Plans can't use diagnosis code to determine coverage.

Emergency Services

- The “emergency” continues post-stabilization until the patient can reasonably transfer considering distance, patient’s condition, etc.
- The treating physician is the sole arbiter of when/how far the patient may go/when “emergency” ends.

Non-Emergency Services

- For some non-emergency services, the facility/professional can condition treatment on the patient agreeing to permit balance billing.
- Patient consent is required.
- There is a HUGE exception. Can't seek consent for "ancillary services."

“Ancillary Services”

- Items and services “related to” emergency medicine, anesthesiology, pathology, radiology and neonatology. (Mentions physicians and non-physician practitioners.)
- Items and services “provided by” assistants at surgery, hospitalists and intensivists.
- “Diagnostic services” such as radiology and laboratory.
- Any item or service provided by a non-participating professional if there is no participating professional who could provide the service.

Four Patient-facing “Forms”



Standard Disclosure

- 42 CFR § 149.430
- Model form (CMS Form No. 10780)



“Universal” Good Faith Estimate

- 42 CFR § 149.610
- Model form (CMS Form No. 10791)



Standard Notice & Consent OON Non-Emergency Services

- 42 CFR § 149.430
- Model form (CMS Form No. 10780)



Standard Notice & Consent OON Post Stabilization Emergency Services

- 42 CFR § 149.10
- Mandatory form (CMS Form No. 10780)

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TYPO??



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NO!!



Standard Notice & Consent OON Post Stabilization Emergency Services

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Model Disclosure: CMS Form No. 10780

- Hospitals, ASCs, Freestanding EDs and “physician or health care providers” must:
 - Post on website.
 - Have a sign posted prominently at the location of facility or provider.
 - 2 sided, 12-point font form provided to insured patients.

Must SNFs Post The Sign?

- Not a “facility” for this part of the rule.
- A “physician or health care provider” is a “physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law, but does not include a provider of air ambulance services.”
- “Physician or health care provider” would seem to be people. But why the underlined phrase?

How Many Signs Do We Need?

- 149.430:

disclosure under this paragraph (c)(1)
(2) With respect to the required disclosure to the public, a provider or facility must make public the information described in paragraph (b) of this section on a sign posted prominently at the location of the provider or facility. A provider that does not have a publicly accessible location is not required to make a disclosure under this paragraph (c)(2).

Do We Have To Give The Notice Every Visit? Annually?

- 149.430 requires you to “provide to any individual” a copy of the notice.
- Can notice ever be “unprovided?”

When Is the Estimate Required?

- Estimate is required if appointment is scheduled for 3 or more business days in advance:
 - When the appointment is scheduled 3-9 business days out, the notice must be provided within 1 business day of the date the appointment was scheduled.
 - If scheduled for 10 or more business days out, the estimate must be provided within 3 business days of the date the appointment was scheduled.
- Patient can also request an estimate without scheduling an appointment, in which case the estimate must be provided within 3 business days.

Independent Dispute Resolution (IDR)

- Determines payment rate for items and services when the facility or professional and plan can't agree.
- Baseball-arbitration.
- Presumption that QPA is the appropriate amount. (The focus of almost all NSA litigation.)

Who Is The Convenor?

- The “convening” professional or facility is the party that receives the initial estimate request and who is or, in the case of a request, would be responsible for scheduling the primary item or service.

42 CFR 149.610(a)(2)(ii)



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42 CFR 149.610(a)(2)(ii)

What's New?

- Litigation continues. The TMA keeps winning in the 5th Circuit. Their recent loss is now being reviewed.
- Most of the challenges involve the IDR process and how much deference the QPA receives.
- We await new rules require GFEs for all patients.

Price Transparency



Price 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.
- <https://www.cms.gov/files/document/steps-making-public-standard-charges-shoppable-services.pdf>.

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



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BP logo and text at the bottom of the sign.

“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.
- Name another situation where people pay a percentage of billed charges...

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!)
 - If opted out, then do what you want.
- Medicaid – state by state.

Can I Set Up A Cash Only Telehealth Service?

- Medicare's Mandatory Claim Submission (SSA §1848(g)) is a potential problem.
- HIPAA allows patients to refuse to bill insurers but there is a carveout:
 - *“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??

If Medicare has a covered service and the same service is covered by some commercial payers but not all and reimbursement differs by payor – some pay on the line item, some bundle the service into another service on the same day, some do not pay at all – can a healthcare organization choose to NOT bill any payer, including Medicare, for the covered Medicare service?

- Generally, doing something for free is fine. The main exception: when it is tied to another service in a way that may be a kickback.

When we share pricing with patients, should we share the rates we are paid by the insurer or the rates that the patient would pay if they pay directly (cash)?

- Hopefully the two numbers are essentially the same?

Must we issue ABNs for non-Medicare beneficiaries when the service/item is anticipated to not meet the Medical Necessity rules for the commercial payers?

- “Must” and “should” are different.
- May be a contractual question.
- More notice to patients is always wise.
- It may not technically be an “ABN.”

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.



When Antitrust Matters

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

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 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.

Presenter



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