

Ratesetting 101 for Medicare Providers, or “How Much is Too Little?”

A discussion of Medicare’s “Substantially In Excess” rule.

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Pursuant to section 1128(b)(6)(A) of the Social Security Act, a participating Medicare provider may not charge Medicare an amount “substantially in excess” of the supplier's “usual charges.” Thus, engaging in a practice of discounting the provider’s usual charges to levels below their Medicare charge may subject the provider to exclusion from Federal Healthcare programs.²

The term “substantially in excess” is not well defined in the law. However, on April 20, 2000, the OIG did publish a letter issued by D. McCarty Thornton, Esq., Chief Counsel to the Inspector General on April 20, 2000, regarding this issue (the “AML Discount Letter”). The AML Discount Letter provides that “a provider need not even

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² The HHS “exclusion authority” has been called the “Medicare Death Penalty”, as exclusion from the Medicare Program, which carries with it the effect of exclusion from ALL federal healthcare programs, can be the death blow to a physician practice. Pursuant to the exclusion authority, the Secretary of HHS “may exclude the following individuals and entities from participation in any Federal health care program Any individual or entity that the Secretary determines—

(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs; (Emphasis added).

Furthermore, 42 CFR §1001.701, entitled “Excessive claims or furnishing of unnecessary or substandard items and services” provides that “[t]he OIG may exclude an individual or entity that has—

- (1) Submitted, or caused to be submitted, bills or requests for payments under Medicare or any of the State health care programs containing charges or costs for items or services furnished that are substantially in excess of such individual’s or entity’s usual charges or costs for such items or services; or

worry about section 1128(b)(6)(A), unless it is discounting close to half its non-Medicare/Medicaid business within these parameters, providers are free to negotiate discounts so long as the discounts are not tied to unlawful referrals of Federal health care program business.”

Advisory Opinion 99-2

On March 4, 1999, the Government published an advisory opinion³ indicating that substantial contractual discounts offered by ambulance service suppliers to hospitals and/or nursing facilities that bear risk for such services under the Medicare PPS payment system raise issues under the Anti-Kickback Statute (AKS).⁴ In Advisory Opinion 99-2, OIG disapproved a proposed reimbursement arrangement between a participating ambulance supplier and a participating nursing home.⁵ The OIG felt that the reimbursement rates offered by the nursing home, which were significantly discounted from the ambulance service’s Medicare rates, were too low to be permissible, and especially so since the ambulance service supplier proposed to charge Medicare the supplier’s full rate for services provided to Part B beneficiaries.⁶ The OIG observed that “[t]he circumstances surrounding the Arrangement suggest that a nexus may exist between the discount to the SNFs for PPS-covered transports and referrals of other

³ Advisory Opinions are only binding on the entities that request them. However, they are substantial indicators of the Government’s position with respect to similar fact patterns, and it is generally thought wise to avoid arrangements identical or similar to those that have been disapproved by published opinions. The principles announced in published advisory opinions are generally applicable to all similarly situated providers. Thus, the guidance contained in A.O. 99-2, directed to a requesting ambulance service, is likely beneficial to physician practices, healthcare facilities, etc.

⁴ The Anti-Kickback Statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. See section 1128B(b) of the Social Security Act. Violation of the statute constitutes a felony punishable by a maximum fine of \$25,000, imprisonment up to five years or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid.

⁵ “Pursuant to the Agreement, Ambulance Company X [proposed to] charge the Nursing Home fixed per-transport rates for basic life support (“BLS”), advanced life support (“ALS”), and chair car services. The contractual rates for BLS and ALS services represent[ed] discounts of up to 50% of the “reasonable charge” established by Medicare for Ambulance Company X’s services in the [Ambulance Company’s] area. Ambulance Company [further proposed to] charge Medicare its full usual and customary amount for transporting Nursing Home residents for whom ambulance services are covered under Medicare Part B.”

⁶ “With respect to the amount of the discount, Ambulance Company X ... represented that part of the proposed discount would be directly attributable to cost savings Ambulance Company X [could] achieve when providing services for PPS residents. For example, Ambulance Company X ... certified that its billing costs should be substantially less for services for PPS-covered residents because Ambulance Company X will submit a single, consolidated bill to each SNF at the end of each month and because Ambulance Company X will not need to bill residents for copayments or deductibles. Ambulance Company X also believe[d] its collection rate w[ould] generally be higher for PPS residents. Ambulance Company X estimate[d] that these factors can reasonably be expected to result in savings equal to **approximately 10% of the Medicare reasonable charge** for each transport rendered to a PPS resident, depending on the circumstances. Nonetheless, in light of the competitive market, Ambulance Company X [proposed to offer] discounts in excess of anticipated savings attributable substantially to SNF PPS.” (Emphasis added).

Federal health care program business. First, the SNFs are in a position to direct a significant amount of business to Ambulance Company X that is not covered by the PPS payment. Second, both parties have obvious motives for agreeing to trade discounts on PPS business for referrals of non-PPS business: the SNFs to minimize risk of losses under the PPS system and Ambulance Company X to secure business in a highly competitive market [the arrangement] gives rise to an inference that the supplier and the SNF may be "swapping" discounts on Part A business in exchange for profitable non-discounted Part B business, from which the supplier can recoup losses incurred on the discounted business, potentially through overutilization or abusive billing practices. In connection with items or services provided to PPS SNFs, the presence of either of these discount arrangements is particularly suspect under the anti-kickback statute."

Furthermore, the Opinion goes on to note that "[p]rice reductions offered to SNFs that are not offered to Medicare or Medicaid patients residing in the same facility raise additional issues under section 1128(b)(6)(A) of the Act, which provides for permissive exclusion from the Federal health care programs of individuals or entities that submit or cause to be submitted bills or requests for payment (based on charges or costs) under Medicare or Medicaid that are **substantially in excess** of such individual's or entity's usual charges or costs, unless the Secretary finds good cause for such bills or requests. In determining an individual's or entity's "usual" charges, we will look at the amounts charged to non-Federal payers, including SNFs. If the charge to Medicare substantially exceeds the amount the supplier most frequently expects to receive from non-Federal payers, the supplier may be subject to exclusion under section 1128(b)(6)(A) of the Act." (Emphasis added.) Thus, according to OIG, substantial discounts offered by ambulance service suppliers to Medicare PPS facilities (including acute-care hospitals and nursing facilities) raise two substantial fraud and abuse concerns; AKS liability and substantially in excess of liability.

The Proposed Rule

On September 15, 2003, OIG published a notice of proposed rulemaking regarding the substantially in excess of provision.⁷ The notice proposed specifically to define the OIG's authority to exclude suppliers from Federal Health Care programs, when those suppliers bill to such programs charges "substantially in excess" of the supplier's "usual charges." The notice indicates that the OIG believes that providers must "charge Medicare and Medicaid approximately the same amount as they usually charge their other purchasers . . . or risk exclusion from all Federal health care programs." The OIG sets forth several proposed methodologies which the Government may choose to use to determine whether a supplier's Medicare charges are "substantially in excess" of the supplier's usual charges. Comments on the proposed rule were due on or before November 14, 2003, and the final rule has not yet been proposed for publication.

⁷ 68 FR 53939.

How To Stay Compliant?

As discussed above, given the state of flux that this area of the law is undergoing, it is important that every physician practice maintain a current chargemaster. Further, that chargemaster should reflect that the physician's charge is set at or above the current Medicare charge for each procedure/service. Of course, it may be possible to construct a good faith analysis that gives support to acceptance of a managed care organization's ("MCO") proposed rate schedule at 90% or more of the provider's Medicare charges as in compliance with the AKS and with the substantially in excess of provision. It is even more important to be aware of these issues when the MCO contracts for both Medicare AND non-medicare business, given the warnings seen in Advisory Opinion 99-2 concerning "swapping" big discounts on non-medicare business for more lucrative Medicare business.

Another approach could involve an analysis of a practice's rate structure and payer mix in accordance with the guidance contained in the AML Discount, to determine if the actual effect of implementation of a particular MCO fee proposal would cause a discount in fifty percent or more of non-federal health care program cases to fee levels substantially below a practice's Medicare rates. Alternatively, it would be possible to examine Guardian Angel's billing experience in other ways, and perform statistically valid analyses to obtain mode and median billing numbers to compare against the MCO's proposed rates. However, taking this approach necessarily involves reworking the entire analysis each time an MCO contract is considered. Thus, it is seen as a very expensive, time consuming, and, ultimately, undesirable approach for most physician practices.

In general, the recommended approach is to formulate a legally defensible response to the MCO, counter-proposing rates that the practice feels are appropriate given the need to be competitive in the marketplace, and the need to be compliant with Federal Health Care program billing requirements. It is strongly recommended that these rates be set at or above **100% of the provider's Medicare charge**, and in almost no event at a point less than 90% of the provider's Medicare charge.⁸ In any event, it is important to generate and maintain the appropriate documentation supporting whatever decision is made by the practice with respect to the MCO's proposal; especially with respect to any review performed by the practice's Federal Health Care program compliance officer/committee.

⁸ Of course, Medicaid, managed care Medicaid, State Charity Care, and other forms of indigent care "payers of last resort" are not expected to reimburse at Medicare levels, and, for purposes of this analysis, are disregarded.