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MANAGED CARE

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changing views about “usual charges”

AT A GLANCE

The OIG's new definition of “usual charges” could have a significant impact on payment rates for a hospital's services.

- Traditionally, “usual charges” has referred simply to nondiscounted rates maintained in a hospital's charge description master.
- The OIG's definition of the term includes discounted rates that a hospital negotiates with commercial payers.
- If the OIG's definition is adopted, payers may attempt to apply it, thereby complicating rate setting negotiations and monitoring of contract compliance.

The HHS Office of Inspector General (OIG) recently proposed a new definition of “usual charges” that—if implemented—will profoundly affect providers' payer relations and contracts with commercial managed care plans.^a The OIG has proposed including in the definition of a hospital's “usual charges” the discounted rates that the hospital offers commercial payers with which it contracts.

The OIG's proposal was prompted by government regulators' concern about high rates in hospitals' charge description masters (CDMs), which they claim may have been inflated to enable hospitals to obtain inappropriately high Medicare “outlier” payments.

The OIG's proposed definition of “usual charges” differs from the customary definition, which, in essence, equates such charges with a hospital's CDM rates. The proposed definition also differs from the Medicare definition of “customary charges,” which excludes from the charge calculation all claims for services to persons who are “represented by a plan or agent under contract or agreement to make payment directly to the provider on a basis other than full charges.”^b

Under the OIG's definition, a hospital's CDM rates would be distinguished from the current market standard of the reasonable value of hospital services. If the government adopts this definition, commercial payers are likely to follow suit.

Customary “Usual Charges”

When a hospital's managed care contract uses the term “covered billed charges,” or more simply “charges,” the contract traditionally is referring to charges made on the UB-92 at the hospital's normal nondiscounted rates maintained on its CDM. This defini-

a. Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, *Federal Register*, September 15, 2003 (Proposed amendment to 42 C.F.R. § 1001.701).

b. *Provider Reimbursement Manual* § 2604.3.

tion is so universally understood in the industry that contracts often do not include any further clarification. All payers are charged at the hospital's CDM rates—a practice that is required by law in some states. For example, California requires hospitals to comply with systems and procedures set forth in the *Accounting and Reporting Manual for California Hospitals*, which states that hospitals must bill at their CDM charges.

Of course, most hospital services are not paid at full charges. Accounting adjustments may be made for charity care or bad debt, and market circumstances may prompt hospitals and payers to negotiate contractual adjustments that provide for discounted rates.

Nevertheless, depending on the market, either the hospital or the payer may decide that it is to its advantage not to negotiate a contract for lower rates. Without a contract, payment will be expected at the hospital's full charges. Hospitals and payers often do not contract exclusively for trauma and emergency services because patients must be brought to the closest appropriate hospital, regardless of whether the patient's payer contracts with that hospital.

When hospitals and payers do negotiate contracts with discounted rates, however, the customary definition of "usual charges" often provides the basis for setting the rates. In its simplest form, the contract may identify a discount as a percentage of charges.

As markets evolved to use per diem rates, many hospitals were able to include stop-loss rates that substituted, or added, a percentage-of-charges rate for the most complex cases after the charges for the case exceeded a certain dollar threshold. In today's market, many hospital contracts still state some part of the negotiated rate as a percentage-of-charges rate, whether in the form of a stop-loss rate or a rate for a particular type of admission, such as trauma.

Contract rates are negotiated as a package. For example, the hospital agrees to accept a low per diem payment for a day in the intensive care unit only because it receives more for those higher-cost claims that exceed the stop-loss threshold and are paid on the basis of a percentage of charges. These rate packages are fully

modeled by the hospital and the payer using sophisticated techniques and the latest data on actual charges and payments during the preceding year of operations. Although these predictions are never perfect, both parties to the rate negotiation have a reasonable idea of the hospital's "yield" or the payer's "cost" of each proposed or agreed-upon rate package. Adoption of the OIG's definition of "usual costs" would significantly complicate the negotiation process and raise new challenges regarding contract compliance.

The OIG Proposal

In 2002, federal regulators began to investigate Medicare "outlier" payments—payments for treatments that are so expensive that they substantially exceed the DRG payment due under Medicare's inpatient PPS. The complex outlier payment formula applied a facility-specific cost-to-charge ratio to the hospital's current charges, the general concept being to connect the outlier payment to the hospital's additional cost of treating the outlier patient. Because the outlier payment ratio was based on historical charge data, and the outlier patient was billed at current charges, federal regulators claimed that some hospitals, by steeply increasing their charges, may have been "gaming" the system to receive outlier payments higher than warranted by the actual higher cost of additional treatment.

The OIG's proposed rule would give the agency the discretion to exclude providers from federal healthcare programs for, among other things, submitting bills containing charges for items or services "that are substantially in excess of such individual's or entity's usual charges or costs for such items or services."

Significantly, the OIG's proposed definition of "usual charges" includes contractual fee-for-service rates negotiated with managed care plans:

We propose to define the term "usual charges" to include the amounts billed to cash paying patients covered by indemnity insurers with which the provider has no contractual arrangement; and any fee-for-service rates it contractually agrees to accept from any payor, including any discounted fee-for-service rates negotiated with managed care plans. Given the changes in the health care marketplace, negotiated rates have become a

substantial portion of many health care providers' revenues. To the extent a provider agrees to discount its rates, the discounted contract rate is its "charge" to those patients.

The OIG's proposed definition and the customary definition of "usual charges" clearly play different roles. As a rationale for its proposal, the OIG states, "In many cases, payments from Medicare and other Federal health care programs—even when capped by a fee schedule—may be substantially more than the payments that providers have agreed to accept from most or all of their other third party payors." The OIG's proposed definition is intended to correct this situation by limiting the amount that federal payment for services exceeds the rates hospitals negotiate with commercial payers. In this sense, the OIG's proposed definition may be viewed as a proposed contract-rate amendment for federal health program provider agreements.

By contrast, the purpose of the customary definition of "usual charges" is to communicate the reasonable value of services to payers with which the hospital has not negotiated contracts for discounted rates. It is also intended to define a benchmark for measuring commercial contract rates based on charges.

Despite these clear differences in definition, hospitals should not be surprised when their payers attempt to confuse the two and argue that a commercial contract rate of "65 percent of charges" means 65 percent of the negotiated discount rates that other hospitals have with their other contracting payers. Indeed, a payer in California is currently claiming the right to unilaterally reduce CDM rates of contracting hospitals that the payer regards as "too high" to rates that it regards as "reasonable."

California's Position

In 2001, California amended its prompt-payment statutes to define "unfair payment patterns" by health plans. Pursuant to these statutes, California's Department of Managed Health Care (DMHC) promulgated regulations addressing claims settlement practices and dispute resolution. The regulations, which became effective on January 1, allow payers to adjudicate the claims of noncontracted providers by:

... the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case.

The DMHC says that this rate "is designed to reiterate current California law as embodied in *Gould v. Worker's Compensation Appeals Board, City of Los Angeles*." *Gould* addressed whether a psychiatrist who treated disabled police officers could charge \$125 per hour instead of the \$98.40 per hour listed on the worker's compensation fee schedule. Hospital services were not addressed in the case.

The DMHC's position does not recognize that the value of the complex array of services hospitals furnish during a single admission cannot be assessed by the same methods used to assess the value of discrete physician services. Hospital charges are set at levels that generate a reasonable rate of return in the aggregate, in the context of the hospital's unique market position and costs.

Many state legislatures have declined to control hospital charges by rate setting, leaving financing of hospital care to the marketplace. Courts, too, generally recognize the right of hospitals to make decisions based on business justifications. As for costs, Medicare recognizes the uniqueness of hospital costs by refusing to consider a hospital's costs as unreasonable unless they are substantially higher than those of a comparable hospital (e.g., similar size, scope of services, case mix) in the same geographic area.

California's DMHC says that its intent is not to dictate a rate, but to define a method for determining whether health plans are paying fair rates. Hospitals may always sue the plan if they are unhappy with the plan's payment

levels. However, giving payers a regulatory basis to challenge the marketplace value of a hospital's CDM charges undermines the hospital's position in resolving payment disputes and gives payers a tool for delaying payment.

What You Should Do

As regulators redefine the concept of "usual charges," you should prepare for the potential impact such a regulatory development could have on your contract negotiations with payers, as well as payer compliance with contract terms.

As part of your preparations, you should:

- > Take care to more precisely define what you intend the term "charges" to mean in your contracts.
- > Be specific in identifying your contract rates and prepare to defend against payer attempts to unilaterally

reduce current charge-based contract rates.

- > Be prepared to challenge any attempts by payers to justify a unilateral reduction of contractual rates by using a definition of "usual charges" that differs from the one agreed to at the time of contracting.

Finally, the importance of monitoring such regulatory developments cannot be overemphasized. Only when you are aware that the ground is about to shift can you make the necessary moves to keep from stumbling. ■

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