Pricing and Discounting:
Law and Strategy Behind Setting Rates

presented by
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Steve Wirth is a founding member, along with Doug Wolfberg and the late Jim Page, of the law firm of Page, Wolfberg & Wirth, LLC. The firm represents ambulance services, municipalities, fire departments, hospitals, and other organizations across the country in a wide range of medical transportation, reimbursement, compliance, labor and employment, and corporate law issues. Steve has 30 years of experience as an EMT, paramedic, flight paramedic, EMS instructor, fire officer, and EMS administrator. He is currently one of the three Commissioners for the Commission on Accreditation of Ambulance Services (CAAS), the national ambulance service accrediting body.

Steve is a frequently sought after speaker at regional, state and national conferences on a variety of EMS, fire service and public safety subjects. He has authored numerous articles on a variety of EMS management, risk management, corporate compliance and workplace law topics. He is a contributing writer for *Journal of Emergency Medical Services (JEMS)*, and *EMS Insider*. Steve co-authored the highly acclaimed *Ambulance Service Guide to HIPAA Compliance* (now in its Third Edition); *The Ambulance Service HIPAA Privacy and Security Video; Better Billing: The Ambulance Service Model Compliance Plan*; and *The Ambulance Service Model Personnel Handbook* --- all produced by PWW.

Steve graduated *cum laude* from Duquesne University School of Law and was a member of the school’s national trial advocacy competition team. In addition to his law degree, Steve has a Masters Degree in Health Services Administration from Gannon University in Erie. He remains in touch with patients and field provider issues as an active EMT and nationally certified firefighter with the Hampden Township Volunteer Fire Company where he serves as the medical officer.

Steve is also a life member of the Nippenose Valley Vol. Fire Co. near Jersey Shore, PA where he started his public safety career as a junior firefighter and later served as Lieutenant and then Deputy Fire Chief. He also serves on the Executive Boards of the Pennsylvania Fire and Emergency Services Institute, and the national AED Instructor Foundation.
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Today’s Agenda
• Legal Overview: What Laws Apply Here
• Kickbacks Take Many Forms
• Problems Unique to “Discounting”
• Establishing “Fair Market Value”
• Pricing Strategies to Consider

Legal Considerations
• Pricing
• Discounts
• Inducements
• The Economics of Compliance

Pricing Considerations
• Local
• State
• Federal

Local Pricing Considerations
• Local ordinances or regulations establishing maximum rates
• Contractual provisions
  – 911 contracts
  – Franchise agreements

State Pricing Considerations
• Rate regulated jurisdictions
  – CT, UT, AZ
Federal Pricing Considerations

• Antitrust law
• Medicare issues
• Fraud and abuse issues

Antitrust Issues

Antitrust Law

• Conspiracy or combinations in restraint of trade prohibited

Anti-Trust Examples

• Providers negotiating with managed care network or other payers
• Establishing rates in municipal procurements
• Facility pricing
• Two or more providers discussing their rates and charges

Antitrust Law

• "Messenger Model"
  – Permitted under the antitrust laws
  – Where multiple, competing providers use a common negotiator ("messenger")
  – Messenger can take the individual provider rate information to the purchaser of the services

Antitrust Law

• Messenger Model
  – Messenger can take specific offers back to individual providers
  – But messenger cannot share price or rate information between the competing providers
Medicare Issues

“Substantially in Excess”
- Providers can be excluded from Medicare if they charge Medicare an amount that is “substantially in excess” of their “usual charge”
  - Note: this is different than the discounting issues that can arise under the federal anti-kickback statute, which will be discussed in a few moments

What Do These Terms Mean?
- “Substantially in excess”?
- “Usual charges”?
- No definitive guidance exists!
- The closest we’ve come is a proposed rule from the OIG published in the Federal Register, September 15, 2003
  - Final rule was never issued

Definitions From Proposed Rule
- Substantially in Excess
  - More than 120% of the provider’s “usual charge”
- Usual Charge
  - The amount the provider most often charges or expects to receive for its services
  - Put another way – the median

Fraud and Abuse Issues
The Anti-Kickback Statute

- Prohibits knowing and willful solicitation or receipt of any remuneration, either directly or indirectly, in cash or in kind, to induce referrals of items or services reimbursable by the Federal health care programs.
  - 42 U.S.C.A. Section 1320a-7b

AKS Penalties

- Criminal
  - Up to 5 years in prison
  - $25,000 fine

AKS Penalties

- Civil
  - Civil Monetary Penalties of up to $50,000
  - Exclusion from Medicare
  - Other damages

The Anti-Kickback Statute

- Applies to both sides of an impermissible transaction or arrangement

Knowledge

- Make sure your facilities KNOW the “retail rates” for your services!
- Helps them understand significance of the discount you can offer
- If no knowledge of retail rates, how can facility know it’s a problem?

Why the AKS?

- “Overutilization”
- Theory that a financial incentive to refer people for health care services that will ultimately be paid by the federal government will result in the creation of artificial demand
- Drives up health care costs
- Encourages unnecessary services
The Anti-Kickback Statute

- Penalties for Violation
  - Civil Monetary Penalties
    - Up to $25,000 in fines per violation
    - Plus up to $50,000 in civil monetary penalties (CMPs) per violation
    - Amount depends upon specific section violated
  - Exclusion from Medicare/Medicaid Programs (the Death Penalty; includes “blackballing”)
  - Criminal penalties
    - Up to five years imprisonment

Intent Requirement

- The statute requires proof of intent as an element of the offense
- But intent can be inferred from a variety of circumstances – there is usually not a “smoking gun” that proves intent

Remuneration

- Extremely broad concept
- Anything of value
  - Cash, services, supplies, space, etc.
  - Even “non-cash” transactions have “value!”
  - Such as: discounts, forgiving a debt
- Express, implied, in-kind, direct, covertly or overtly

AKS and False Claims Act

- You certify the claim is in compliance with all laws!
- Unlawful discount under AKS could be a “false claim” because you’ve certified compliance with all applicable laws
- “False Certification”

“NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under the law and may be subject to civil penalties”
Beware: “Kickbacks” Can Take Many Forms!

Kickback Examples

- **Leases**: ambulance service leases a garage bay and a crew room in a firehouse; total of 1200 sq ft of unfinished space and 300 sq feet of finished space, and pays $10,000 per month

Kickback Examples

- **Debt forgiveness**: municipality owes an ambulance service $100,000 in fees but ambulance service forgives the debt in exchange for being given an exclusive response area;

Kickback Examples

- **Waiver of copayments**: provider bills Medicare, accepts the 80% from Medicare as payment in full, and waives the patient cost-sharing portion (but, some exceptions permitted by OIG)

Kickback Examples

- **Supplies**: hospitals giving supplies to ambulance services in exchange for bringing patients to the facility (but, now there is an restocking “safe harbor” regulation

Kickback Examples

- **In-kind services**: ambulance service provides free training to a fire department or facility in exchange for access to patients; or ambulance service employees mop the floors or take vital signs at a nursing home in between calls
Kickback Examples

- Discounts: ambulance service charges a SNF $50 for an ambulance transport under Medicare Part A, when they receive Part referrals from the same facility and charge Medicare Part B $400 for the same trip

“Real Life” Examples

- 2003: New York rescue squad agreed to pay $10,000 to resolve liability under CMP provisions based on “deep discounts” to an area hospital which agreed to pay $25,000 to resolve the case

OIG Advisory Opinion 99-2

- Shift to PPS
  - Ambulance providers required to bill the SNF for some services Medicare used to pay directly (Part A transports)
  - Most services are still under Part B
  - Facility receives a Part A per diem prospective payment that includes ambulance service

“Real Life” Examples

- 2006: Large ambulance company settles for $9 million after alleged improperly discounted ambulance service to nursing homes

SNF and Facility Discounts

- Substantial PPS discounts being given
  - I.e., when facility has to pay, bill is $75
  - When Medicare pays, we bill $150
  - Discounts not passed on to Medicare or Medicaid
  - Provider may also have a First Call Arrangement for all calls in the facility
SNF and Facility Discounts

• Spot the Kickback?
  – When the SNF bears the financial risk, they get a “sweetheart deal”
  – In return, we get all of their more lucrative Part B transports that we can bill at full Medicare rates!
  – On the surface - we win (more “good” calls), the SNF wins (they get lower cost services), but
  – IT’S PROBABLY ILLEGAL!

OIG’s Conclusions

• Part B referrals cannot be given in exchange for PPS discounts
• Practice constitutes illegal remuneration under the statute
• If only one purpose is to induce referrals, other legitimate purposes don’t count
• 50% discounts on PPS services were not cost-justified

What are the differences between the “substantially in excess” issue and the anti-kickback issue?

Substantially in Excess

• Requires no inducement in exchange for referrals

Anti-Kickback Statute

• Applies when something of value is given as an inducement to refer federal health care services (like Medicare patients)

Substantially in Excess

• Example
  – Could apply if you have a large amount of discounted contracts or payment arrangements with managed care organizations

Anti-Kickback Statute

• Example
  – Could apply if you give a discount to a nursing facility or hospital on Part A trips where that facility also refers Medicare patients to you
Discounts in Disguise

• Ever since OIG Advisory Opinion 99-2, most ambulance services are aware of the prohibition against “swapping”
  – Discounts given to SNFs or hospitals on PPS transports while billing regular rates to Medicare Part B

Discounts in Disguise

• However, some ambulance services have found “back door” methods or more subtle ways of “encouraging” facilities to give them their business

Discounts in Disguise

• Examples
  – “Slow payment” (i.e., “net 180 days”)
  – Interest free financing on accrued debts
  – Debt forgiveness – especially at contract renewal time!

Discounts in Disguise

• Examples
  – “Sweet deals” on non-ambulance services (wheelchair van services, rides for shopping, personnel or staffing assistance, etc.)
  – Just because such services are not covered by Medicare, giving them away to a referral source is still something of value!

Routine Waivers

• An Example of the Issue
  – Approved charge - $400
  – Provider receives 80% from Medicare ($320)
  – Provider waives the 20% copayment ($80)

Routine Waivers

• Why do some providers waive copayments?
  – To encourage pts to use their service instead of a competitor’s (that’s the potential kickback!)
  – In other cases, might be legitimate reasons, like financial hardship, or the services are tax-supported
  – Which reasons are legitimate and which may violate the AKS?
Why Routine Waivers Are A Problem?
• OIG: Waivers could be illegal remuneration designed to induce referrals to your service
• Copayments and deductibles provide important incentives for patients not to overutilize services
• If patient has to pay something, perhaps they’ll be a more careful health care consumer and keep Medicare costs down

General Rules: Collection of Copayments and Deductibles
• Provider must make “reasonable collection efforts” for copays
  – Similar to effort made to collect comparable amounts from non-Medicare patients
  – Must include billing the beneficiary or responsible party
  – May need to include subsequent billings, phone calls, etc. (beware Federal FDCPA)

General Rules: Collection of Copayments and Deductibles
• Additional Exceptions:
  – Particular patient’s indigency
    • No need to bill beneficiaries who are previously known to be indigent
  – Cost of collecting the amount exceeds or is disproportionate to the amount to be collected
  – Financial hardship (documented)

Advisory Opinion 01-10
• OIG approved the waiver of copayments and deductibles for city residents by a municipal ambulance provider (FD)
• “Insurance only” billing policy for residents
• The FD bills non-residents but waives all out-of-pocket expenses for residents
• FD treats their local tax revenues as payment of copayments and deductibles

Advisory Opinion 01-10
• “Insurance only” billing may implicate the AKS, but OIG allowed the program
• OIG deferred to a longstanding Medicare rule (Section 2309.4 of the Medicare Carriers Manual), which allowed municipal entities to charge patients only to the extent of their insurance
• OIG essentially said “since Medicare allows it, we will too”

See also . . .
• 01-11, 02-8 and 02-15: municipal fire district/ambulance district may waive copayments and deductibles for residents and treat property taxes as copayments and deductibles
• 03-09: municipal fire protection district may waive copayments and deductibles for residents and employees of tax-paying businesses while working on the premises
• 04-06: fire district permitted to implement a policy of billing residents only to the extent of their insurance
What About Non-Public Ambulance Services?

- 01-12: OIG disapproved an exclusive, 3-year contract under an RFP procurement where the ambulance service agreed to serve as the exclusive provider – at no cost to the city – and to waive copayments and deductibles for city residents
  - If the city wishes to require its contracted ambulance service to waive copayments and deductibles, the city must pay those amounts to the ambulance service

What About Non-Public Ambulance Services?

- 01-18: OIG approved an exclusive provider contract between an ambulance service and a municipality where the municipality is paying the provider a subsidy designed to cover the waived copayments and deductibles

Subscription Programs

- Related to waiver of copayment issue
- Also called “membership” programs
- Provider charges an annual fee and waives out-of-pocket expenses (typically for emergencies only) as an incentive to purchase the subscription

Subscription Programs

- 03-11: OIG approved a subscription program of a nonprofit, emergency-only ambulance service
  - Subscription fees basically cover the copayments and deductibles in the aggregate

Subscription Programs

- Two tests:
  - All subscription fees reasonably approximate the waived cost-sharing amounts for all subscribers during the subscription period; or
  - Subscription fees from Medicare beneficiaries reasonably approximate the waived cost-sharing amounts for Medicare beneficiaries during the subscription period

Discounting and Pricing Strategies
Key Point:

Keep All Discounts “Modest” and Tied to Cost and Efficiency Benefits

“Fair Market Value”

• NO discounts BELOW your FULLY LOADED COSTS

“Fully Loaded Costs”

• OIG: Total of ALL costs divided by the number of ambulance trips
• Include: Staffing, fuel, vehicle expense, overhead, ancillary costs

Comparison

• Look at rate given to a facility with potential Part B referrals to the rate given to a facility with little or no Part B referrals

Capitated Rate Agreements

• Facility pays a nominal rate for each Part A patient or bed per day regardless of whether all or any of the patients are transported

Capitated Rate Agreements

• Look at historical data to calculate rate: past utilization and predicted utilization
• Monitor annually
• Fee must relate to the actual cost of providing the service
Mileage “Discounts”

- Podunk Ambulance offers a facility discount of 20% below Medicare allowed amount for base rate, but gives first 30 miles for free. Closest hospital is 32 miles away.
- Is this a discounting problem?

Educate Facilities

- Letter and “Issue Brief” on the AKS and Discounting Dilemma
- Emphasize importance of compliance initiatives and the “two way” street of the AKS
- Emphasize your good track record and quality patient care!

Watch Your Contracts!

- Are they “exclusive”?
- Do they specifically mention referrals?
- Are there other provisions to protect you from an allegation of “illegal swapping”?

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