July 7, 2020

- **CMS price transparency rule might prompt simplification of hospital billing.**
  - CMS promulgated a hospital price transparency rule in November 2019 ("Transparency Rule") requiring hospitals to publish not just their gross chargemaster rates but also discounted cash prices, payer-specific negotiated charges and de-identified minimum and maximum negotiated charges for all items and services, as well as 300 "shoppable services," beginning in January 2021.
  - A D.C. federal judge recently rejected a challenge to the Transparency Rule brought by the American Hospital Association ("AHA"), but the ruling could be overturned.
    - The opinion noted it was a "close call" whether CMS reasonably interpreted "standard charges" to include negotiated rates and AHA has already appealed.
  - If the ruling stands, however, it will create significant administrative challenges that could prompt development of more simplified billing and payment systems.
    - AHA argues the Transparency Rule could force hospitals to publish 100,000 rows of data with millions of fields that would just confuse patients–a valid point that serves to highlight the complexity and unwieldiness of current payment systems where gross charges for items and services bear little resemblance to payer-specific negotiated charges and are incongruent with payment methodologies tied to inpatient DRGs and outpatient APCs rather than charges.
  - Billing and payment system complexity is a primary contributor to the U.S. health care delivery system's high administrative costs, accounting for as much as 25-30 percent of health care spending and over $250 billion in provider costs by some reports.
  - Is all this complexity really necessary? More simplified billing and payment systems could both enhance consumer decision-making and eliminate excess administrative costs, but heretofore there have been few efforts to overhaul current systems.
    - The continued investment of time and resources into these systems by providers and payors as they evolved over time has created inertia against wholescale changes.
    - The significant challenges presented by the Transparency Rule for both providers and payors may provide the force necessary to overcome this inertia, serving as the catalyst for development of more streamlined billing and payment structures.
  - **Key takeaway:** The price disclosure requirements under the Transparency Rule (if upheld on appeal) will present significant challenges for hospitals given the complexity of current billing and payment systems, but could serve as the catalyst for providers and payors to invest the time and resources to develop simplified billing and payment systems that provide transparency to consumers as well as significant administrative cost savings for providers.
- **Limitations on use of Provider Relief Fund payments may have unintended consequences for the economics of some hospital coverage arrangements.**
  - Hospitals often enter into coverage arrangements with independent physician groups for coverage of hospital departments or service lines.

- The economic terms of such arrangements vary widely, with hospitals commonly making fixed fee, net income guarantee, and/or fee-for-service payments to covering groups. Covering groups in turn may or may not assign the right to bill and collect for their professional services provided at the hospital.
- Many groups have been impacted by reduced collections for professional services during COVID-19, and some hospitals may have paid for such shortfalls coverage agreements, but Provider Relief Fund payments may not be available to cover such shortfalls in some instances.
  - For example, if a hospital guarantees aggregate physician collections for services at a pre-determined FMV amount, the risk of economic loss is on the hospital, and as between the hospital and the group the hospital ought to be the beneficiary of any Provider Relief Fund payment made in this context.
  - However, the hospital in this example likely is ineligible for a payment–there would be no ability for the hospital to claim lost revenue with respect to the physician services (billed and collected by the group), and a larger-than-normal guarantee payment likely would not qualify as a "healthcare related expense attributable to coronavirus."
    - Under the applicable FAQ (modified June 19, 2020), "healthcare related expense attributable to coronavirus" covers "a range of items and services purchased to prevent, prepare for, and respond to coronavirus," including supplies, equipment, training, staffing emergency operation centers, reporting expenses, and the like. None of the listed examples would appear to cover an increase in the cost of pre-existing coverage services.
  - Similarly, the group may be ineligible for a payment due to the hospital's revenue guarantee (which provides coverage of losses from another source), even if the hospital resists making the required payment.
  - To the extent that a coverage arrangement provides for the reassignment of collections for professional services to the hospital, the parties must also recognize that any Provider Relief Fund payments remitted to the group cannot be assigned to the hospital.
- **Key Takeaway:** Providers must review their coverage arrangements carefully in light of the principles governing payments from the Provider Relief Fund to determine eligibility for Provider Relief Fund payments and ensure that any payment received ultimately benefits the proper party in light of the overall economics of the arrangement.

- **Providers should anticipate rigorous False Claims Act ("FCA") enforcement activity by the U.S. Department of Justice ("DOJ") in the wake of COVID-19, tempered by a stated intention not to prosecute mistakes made in good faith.**
  - On June 26 the second-in-command of DOJ's Civil Division delivered extensive remarks to the U.S. Chamber of Commerce about DOJ's expected response to COVID-19 stimulus program fraud (transcript available here).
  - While voicing some reassurance that companies making "immaterial or inadvertent technical mistakes" or which "simply and honestly misunderstood the rules" will not be pursued, DOJ will vigorously pursue what it terms "actionable fraud." In distinguishing the former from the latter, DOJ shared several key observations–

- First, DOJ noted that while some whistleblower cases may be filed alleging deviations from non-binding guidance documents, DOJ's position is that "noncompliance with guidance documents cannot by itself form the basis of an FCA case."
- Second, DOJ signaled its intent to use its dismissal authority "to weed out cases that involve regulatory overreach" and to "consider moving to dismiss qui tams that are based on technical mistakes with paperwork or honest misunderstandings of the rules."
- Third, DOJ signaled it may use its dismissal authority in qui tam cases "that try to hold companies liable for doing what the government said was okay to do"–this latter statement seems very much aimed at not wanting FCA risk to chill private sector innovations in dealing with the pandemic. Notably, DOJ also signaled it will likely have more to say about making sure companies are not discouraged from addressing the pandemic by the risk of "unwarranted [FCA] liability."

- While these statements were, no doubt, intended to provide measured reassurance to providers acting in good faith, they by no means signal any relaxation of the measures by which "actionable fraud" will be challenged.
- **Key Takeaway:** Against the backdrop of an accelerating volume of private qui tam cases, the place no provider wants to be is pinning its hopes on the willingness of DOJ to use its dismissal authority to jettison a meritless case–a provider is far better off reducing the risk of such litigation on the front end whenever possible.

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