Grabbag, Including Minnesota's New Medical Debt Law

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Can A Hospital Take Steps To Facilitate Discharge?

- Absolutely! SNF bed agreements are very low risk.
- People worry about paying SNFs. The fear is the antikickback statute: Is this hospital paying the SNF for referrals?
- Ask yourself, do you know a hospital in the country that wants more SNF referrals?

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Two Midnight Rule Confusion

- No patient should be an outpatient for 3 nights.
- An inpatient is anyone who
  - Needs hospital care
  - Is expected to be there for 2 midnights.
- “Outpatient” isn’t a STATUS. It is a person who needs hospital care but isn’t expected to be in the hospital 2 midnights.
- If the patient doesn’t need hospital care, they shouldn’t be an inpatient OR outpatient. If they need hospital care, as the second midnight approaches, they absolutely should be admitted.

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Those Pesky MA Plans

- MA plans have often shirked legal obligations.
- SSA § 1852 requires MA plans to provide "benefits under the original Medicare fee for service program.“
- 42 CFR 422.101 implements it, and CMS recently amended it in large part to clarify that MA plans must follow the 2 midnight rule.
- Encourage folks to actually review contracts and manuals.
- Insurance commissioner is a possible ally.

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MAC Denials of Education Costs

- Seems to be quite common.
- Lots of issues about control/tuition collection etc.
- We have sought political assistance. Not had too much success.
- The cost of appeal/negotiating with the MAC is low.
- The track record at the PRRB is depressing. Remember nearly all PRRB wins are reversed by the administrator. Usually not worth a PRRB hearing unless you are willing to go to District Court.

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Tell Me About Tell-A-Health

- Absent Congressional action the old geographic limits will spring back on 1/1/25.
- That will greatly limit telehealth.
- Reason for hope for lame duck action on this.
- You do NOT need to use a physician's home address. CMS calls this a temporary reprieve, but what required it??

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Where Is A Service Provided?

- 2025 Medicare Physician Fee Schedule says that through the end of 2025 physicians providing telehealth from home can use their work address.
- This dispensation is unnecessary. No rule says where a service is.
- I would posit that it should be where the patient is. Otherwise arbitrage is easy.

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Direct Supervision Isn’t What It Once Was!

- No longer need to be “in the office suite.”
- Availability by smartphone (that is, audio AND visual capability) is sufficient.
- The smartphone needn’t be USED. It must just be an option.

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What Is All Of This Talk About Chevron?

- At least three big decisions last term.
- Loper involves deference to an agency. Chevron required deference. Loper permits courts to exercise independent judgment.
- Corner Post says the APA's six-year statute of limitations only runs once the injured party is affected.
- Jarkesy says juries, not ALJs must impose fines unless the case meets the "public rights" exception.

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Will Baylor Bring a New Focus on TPR?

- The Teaching Physician Rule (TPR) permits physicians working with residents to bill.
- Medicare pays hospitals for training residents. When there is Graduate Medical Education (GME) payment, pretend the resident didn’t exist.
- When the resident is “off” the GME clock, if they are licensed, they are just a physician.
- Most other payors don’t pay for GME, so there isn’t an equivalent limit on billing.
- For Medicare, there is a documentation requirement!

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A Very Important Lesson About Legal Counsel

- Even if an organization is wrong, the size of damages can vary.
- In Baylor, the government sought recoupment of the HOSPITAL payment.
- In some Stark cases, the government tries to recover on services PERFORMED by a physician with an improper compensation arrangement. Stark only bars REFERALS. (And the definition of "referral" is crazy!!)

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Is Intrasystem Free Transportation Allowed?

- Free transportation gets a bad rap.
- No one questions bringing a service to the patient.
- Why is bringing the patient to the service different?

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How Far Back Should a Refund Go?

- Forever.
- 10 Years.
- 6 years.
- 5 years after the year in which payment was made.
- 4 years.
- 3 years.
- 1 year.

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How Far Back Should a Refund Go?

- Forever.
- 10 Years.
- 6 years.
- 5 years after the year in which payment was made.
- **4 years.**
- 3 years.
- 1 year.

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Hospitals Must Give Notice Before Curtailing Services

- 182 days' notice required if:

  (1) ceasing operations;

  (2) curtailing operations to the extent that patients must be relocated;

  (3) relocating the provision of health services to another hospital or another hospital campus; or

  (4) ceasing to offer maternity care and newborn care services, intensive care unit services, inpatient mental health services, or inpatient substance use disorder treatment services.

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MN Requires 60 Day Notice of Many Transactions

(j) "Transaction" means a single action, or a series of actions within a five-year period, which occurs in part within the state of Minnesota or involves a health care entity formed or licensed in Minnesota, that constitutes:

(1) a merger or exchange of a health care entity with another entity;

(2) the sale, lease, or transfer of 40 percent or more of the assets of a health care entity to another entity;

(3) the granting of a security interest of 40 percent or more of the property and assets of a health care entity to another entity;

(4) the transfer of 40 percent or more of the shares or other ownership of a health care entity to another entity;

(5) an addition, removal, withdrawal, substitution, or other modification of one or more members of the health care entity's governing body that transfers control, responsibility for, or governance of the health care entity to another entity;

(6) the creation of a new health care entity;

(7) an agreement or series of agreements that results in the sharing of 40 percent or more of the health care entity's revenues with another entity, including affiliates of such other entity;

(8) an addition, removal, withdrawal, substitution, or other modification of the members of a health care entity formed under chapter 317A that results in a change of 40 percent or more of the membership of the health care entity; or

(9) any other transfer of control of a health care entity to, or acquisition of control of a health care entity by, another entity.

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Exceptions To The Requirement

(k) A transaction as defined in paragraph (j) does not include:

(1) an action or series of actions that meets one or more of the criteria set forth in paragraph (j), clauses (1) to (9), if, immediately prior to all such actions, the health care entity directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, all other parties to the action or series of actions;

(2) a mortgage or other secured loan for business improvement purposes entered into by a health care entity that does not directly affect delivery of health care or governance of the health care entity;

(3) a clinical affiliation of health care entities formed solely for the purpose of collaborating on clinical trials or providing graduate medical education;

(4) the mere offer of employment to, or hiring of, a health care provider by a health care entity;

(5) contracts between a health care entity and a health care provider primarily for clinical services; or

(6) a single action or series of actions within a five-year period involving only entities that operate solely as a nursing home licensed under chapter 144A; a boarding care home licensed under sections 144.50 to 144.56; a supervised living facility licensed under sections 144.50 to 144.56; an assisted living facility licensed under chapter 144G; a foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, for a physical location that is not the primary residence of the license holder; a community residential setting as defined in section 245D.02, subdivision 4a; or a home care provider licensed under sections 144A.471 to 144A.483.

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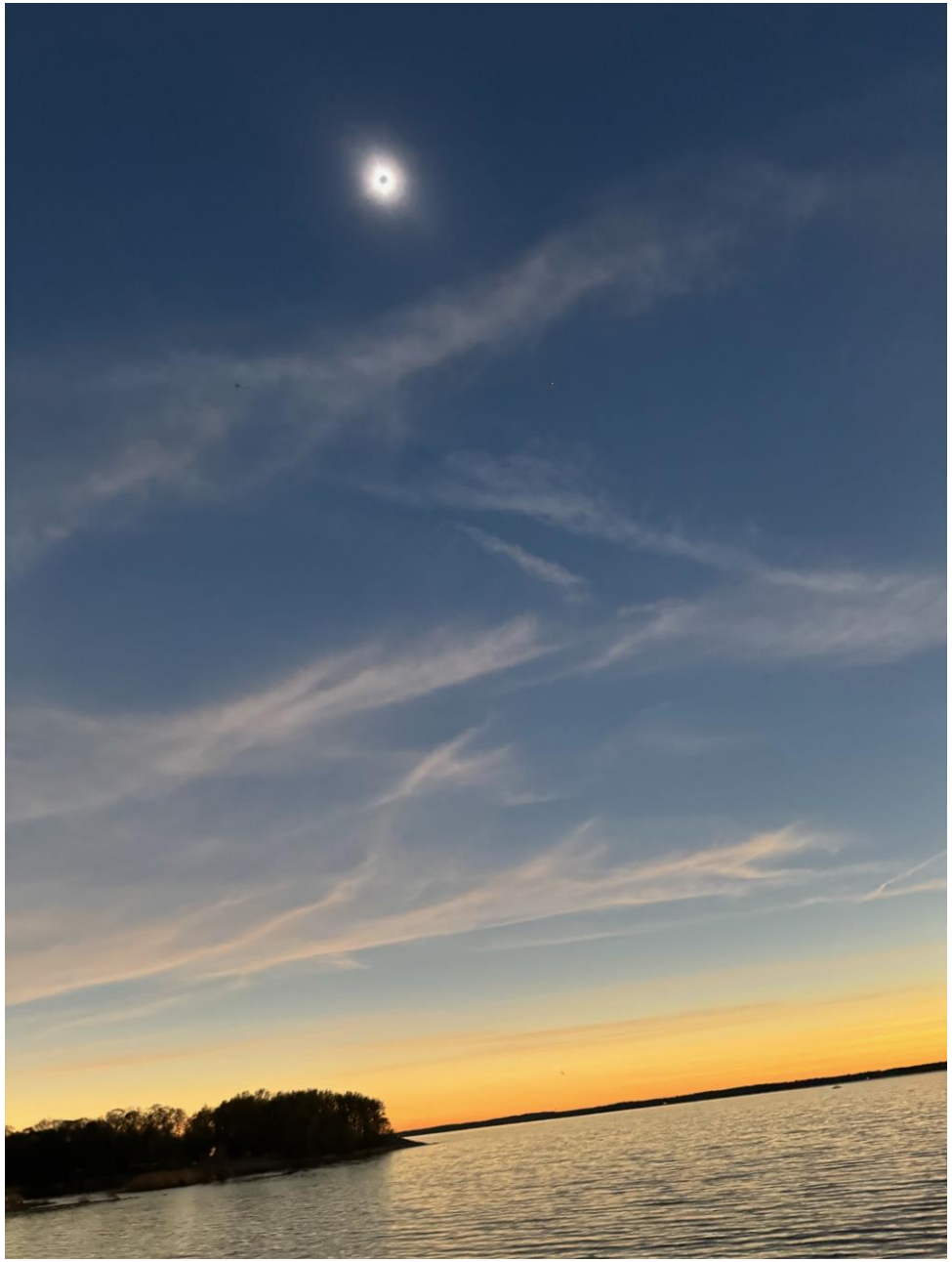

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Quick Thoughts on NSA and Price Transparency

- People conflate them.
- Price Transparency requires hospitals to list every payment amount that they have agreed to. Some still think it only requires highest and lowest; that is wrong.
- Price Transparency is a data windfall for clinics and insurers.
- Good Faith Estimate issues still arise.
- Will we have to deal with them for insurance??

The New Debt Law: Big Picture

- Effective October 1, 2024 new limits on debt collection, refusing to provide treatment because of outstanding debt, and addressing coding errors and credit balances take effect.
- The law is poorly written, inconsistent with most current practices and, I would argue, contrary to common sense.

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Policies and Posting

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62J.806 Policy for Collection of Medical Debt

(1) Requirement.

A health care provider must make available to the public the health care provider's policy for collecting medical debt from patients. The policy must be made available by:

(1) clearly posting the policy on the health care provider's website or, for health professionals, on the website of the health clinic, group practice, or hospital at which the health professional is employed or under contract; and

(2) providing a copy of the policy to any individual who requests the policy.

(2) Content.

A policy made available under this section must at least specify the procedures followed by the health care provider to:

(1) communicate with patients about the medical debt owed and collecting medical debt;

(2) refer medical debt to a collection agency or law firm for collection; and

(3) identify medical debt as uncollectible or satisfied, and ending collection activities.

EFFECTIVE DATE.

This section is effective October 1, 2024.

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Key Definition: Health Care Provider

(1) a health professional who is licensed or registered by the state to provide health treatment and services within the professional's scope of practice and in accordance with state law;

(2) a group practice; or

(3) a hospital.

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62J.807 Denial of Health Treatment or Services Due to Outstanding Medical Debt

(a) A health care provider must not deny medically necessary health treatment or services to a patient or any member of the patient's family or household because of current or previous outstanding medical debt owed by the patient or any member of the patient's family or household to the health care provider, regardless of whether the health treatment or service may be available from another health care provider.

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62J.807 Denial of Health Treatment or Services Due to Outstanding Medical Debt

(b) As a condition of providing medically necessary health treatment or services in the circumstances described in paragraph (a), a health care provider may require the patient to enroll in a payment plan for the outstanding medical debt owed to the health care provider. The payment plan must be reasonable and must take into account any information disclosed by the patient regarding the patient's ability to pay. Before entering into the payment plan, a health care provider must notify the patient that if the patient is unable to make all or part of the agreed-upon installment payments, the patient must communicate the patient's situation to the health care provider and must pay an amount the patient can afford.

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Key Definition: Medically Necessary

(1) safe and effective;

(2) not experimental or investigational, except as provided in Code of Federal Regulations, title 42, section 411.15(o);

(3) furnished in accordance with acceptable medical standards of medical practice to diagnose or treat the patient's condition, or to improve the function of a malformed body member;

(4) furnished in a setting appropriate to the patient's medical need and condition;

(5) ordered and furnished by qualified personnel;

(6) meets, but does not exceed, the patient's medical need; and

(7) is at least as beneficial as an existing and available medically appropriate alternative.

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62J.808 Billing Errors

Subd. 1. Billing and acceptance of payment.

(a) If a health care provider or health plan company determines or receives notice from a patient or other person that a bill from the health care provider to a patient for health treatment or services ***may*** contain one or more billing errors, the health care provider or health plan company must review the bill and correct any billing errors found. While the review is being conducted, the health care provider must not bill the patient for any health treatment or service subject to review for potential billing errors. A health care provider may bill the patient for the health treatment and services that were reviewed for potential billing errors under this subdivision only after the review is complete, any billing errors are corrected, **and a notice of completed review required under subdivision 3 is transmitted to the patient.**

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62J.808 Billing Errors

Billing and acceptance of payment.

(b) If, after completing the review under paragraph (a) and correcting any billing errors, a health care provider or health plan company determines the patient overpaid the health care provider under the bill, the health care provider must, within 30 days after completing the review, refund to the patient the amount the patient overpaid under the bill.

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62J.808 Billing Errors

Subd. 2. Notice to patient of potential billing error.

(a) If a health care provider or health plan company determines or receives notice from a patient or other person that a bill from the health care provider to a patient for health treatment or services ***may*** contain one or more billing errors, the health care provider or health plan company must notify the patient:

(1) of the potential billing error;

(2) that the health care provider or health plan company must review the bill and correct any billing errors found; and

(3) that while the review is being conducted, the health care provider must not bill the patient for any health treatment or service subject to review for potential billing errors.

(b) The notice required under this subdivision must be transmitted to the patient within 30 days after the date the health care provider or health plan company determines or receives notice that the patient's bill may contain one or more billing errors.

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62J.808 Billing Errors

Subd. 3. Notice to patient of completed review.

When a health care provider or health plan company completes a review of a bill for potential billing errors, the health care provider or health plan company must (1) notify the patient that the review is complete, (2) explain in detail how any identified billing errors were corrected or explain in detail why the health care provider or health plan company did not modify the bill as requested by the patient or other person, and (3) include applicable coding guidelines, references to health records, and other relevant information. This notice must be transmitted to the patient within 30 days after the date the health care provider or health plan company completes the review.

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Key Definition: Billing Error

An error in a bill from a health care provider to a patient for health treatment or services that affects the amount owed by the patient according to that bill. Billing error includes but is not limited to (1) miscoding a health treatment or service, (2) an error in determining whether a health treatment or service is covered under the patient's health plan, or (3) an error in determining the cost-sharing owed by the patient.

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Key Definition: Medical Debt

(a) Debt incurred primarily for medically necessary health treatment or services. Medical debt includes debt charged to a credit card or other credit instrument, on or after October 1, 2024, under an open-end or closed-end credit plan offered specifically to pay for health treatment or services.

(b) Medical debt does not include:

(1) debt charged to a credit card or other credit instrument, under an open-end or closed-end credit plan, that is not offered specifically to pay for health treatment or services;

(2) services provided by a veterinarian;

(3) services provided by a dentist; or

(4) debt charged to a home equity line of credit.

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332C.02 Prohibited Practices

A collecting party must not:

(1) in a collection letter, publication, invoice, or any oral or written communication, threaten wage garnishment or legal suit by a particular lawyer, unless the collecting party has actually retained the lawyer to do so;

(2) use or employ sheriffs or any other officer authorized to serve legal papers in connection with collecting a claim, except when performing the sheriff's or other officer's legally authorized duties;

(3) use or threaten to use methods of collection that violate Minnesota law;

(4) furnish legal advice to debtors or represent that the collecting party is competent or able to furnish legal advice to debtors;

(5) communicate with debtors in a misleading or deceptive manner by falsely using the stationery of a lawyer, forms or instruments which only lawyers are authorized to prepare, or instruments which simulate the form and appearance of judicial process;

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332C.02 Prohibited Practices

(6) publish or cause to be published any list of debtors, use shame cards or shame automobiles, advertise or threaten to advertise for sale any claim as a means of forcing payment of the claim, or use similar devices or methods of intimidation;

(7) operate under a name or in a manner which falsely implies the collecting party is a branch of or associated with any department of federal, state, county, or local government or an agency thereof;

(8) transact business or hold the collecting party out as a debt settlement company, debt management company, debt adjuster, or any person who settles, adjusts, prorates, pools, liquidates, or pays the indebtedness of a debtor, unless there is no charge to the debtor, or the pooling or liquidation is done pursuant to court order or under the supervision of a creditor's committee;

(9) unless an exemption in the law exists, violate Code of Federal Regulations, title 12, part 1006, while attempting to collect on any account, bill, or other indebtedness. For purposes of this section, Public Law 95-109 and Code of Federal Regulations, title 12, part 1006, apply to collecting parties other than health care providers collecting medical debt in the health care provider's own name;

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332C.02 Prohibited Practices

(10) communicate with a debtor about medical debt by use of an automatic telephone dialing system or an artificial or prerecorded voice after the debtor expressly informs the collecting party to cease communication utilizing an automatic telephone dialing system or an artificial or prerecorded voice. For purposes of this clause, an automatic telephone dialing system or an artificial or prerecorded voice includes but is not limited to (i) artificial intelligence chat bots, and (ii) the usage of the term under the Telephone Consumer Protection Act, United States Code, title 47, section 227(b)(1)(A);

(11) in collection letters or publications, or in any oral or written communication, imply or suggest that medically necessary health treatment or services are denied as a result of a medical debt;

(12) when a debtor has a listed telephone number, enlist the aid of a neighbor or third party to request that the debtor contact the collecting party, except a person who resides with the debtor or a third party with whom the debtor has authorized with the collecting party to place the request. This clause does not apply to a call-back message left at the debtor's place of employment which is limited solely to the collecting party's telephone number and name;

(13) when attempting to collect a medical debt, fail to provide the debtor with the full name of the collecting party, as registered with the secretary of state;

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332C.02 Prohibited Practices

(14) fail to return any amount of overpayment from a debtor to the debtor or to the state of Minnesota pursuant to the requirements of chapter 345;

(15) accept currency or coin as payment for a medical debt without issuing an original receipt to the debtor and maintaining a duplicate receipt in the debtor's payment records;

(16) except for court costs for filing a civil action with the court and service of process, attempt to collect any interest, fee, charge, or expense incidental to the charge-off obligation from a debtor unless the amount is expressly authorized by the agreement creating the medical debt or is otherwise permitted by law;

(17) falsify any documents with the intent to deceive;

(18) when initially contacting a Minnesota debtor by mail to collect a medical debt, fail to include a disclosure on the contact notice, in a type size or font which is equal to or larger than the largest other type of type size or font used in the text of the notice, that includes and identifies the Office of the Minnesota Attorney General's general telephone number, and states: "You have the right to hire your own attorney to represent you in this matter.";

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332C.02 Prohibited Practices

(19) commence legal action to collect a medical debt outside the limitations period set forth in section 541.053;

(20) report to a credit reporting agency any medical debt that the collecting party knows or should know is or was originally owed to a health care provider, as defined in section 62J.805, subdivision 4; or

(21) challenge a debtor's claim of exemption to garnishment or levy in a manner that is baseless, frivolous, or otherwise in bad faith.

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Other Key Points

- You can’t report medical debt to a consumer reporting agency.
- Debtors who win must be awarded costs and reasonable attorneys’ fees.
- Strict liability to the debtor in the amount of actual damages and $1,000 per violation and reasonable attorneys’ fees.
- Willful violations permit triple damages/fines.
- The amount is increased by the CPI.

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Very Limited Protections

- A collecting party is not liable if they show by a preponderance of the evidence that the violation….
  - Was not intentional and resulted from a bona fide error made notwithstanding the maintenance of procedures reasonably adopted to avoid any bona fide error or
  - Was the result of inaccurate or incorrect information provided to the collecting party by a healthcare provider … (this really only protects collection agencies).

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Spouses No Longer Liable for Medical Debt

- The sentence in Minnesota Statute 519.05 that said when spouses live together, they're jointly liable for medically necessary services to either spouse and for household articles furnished and used by the family has been deleted. You are still permitted to collect from the decedent's estate.

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MN Stat. 144.587-589

- Effective for services on or after 11/1/23.
- Establishes requirements for
  - Screening for Coverage or Assistance.
  - Providing notice of charity care policies.
  - Making certifications before sending patients to collection or pursuing collection litigation.
- Creates a new cap on charges to uninsured patients.

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Key definitions:

- Hospital: a private, non-profit or municipal hospital licensed under Minnesota Statutes 144.50-56.
- Insurance affordability program, navigator, presumptive eligibility, revenue recapture are taken from other Minnesota laws.
- Uninsured service or treatment means any service or treatment that is not covered by a health plan, contract or policy that provides health coverage or any other insurance coverage. Seemingly includes cosmetic?? (Note at times they use “patient” rather than “service.”)
- “Unreasonable burden” includes requiring reapplication to anything denied w/in 12 months.

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Screening Requirements

- If the hospital participates in the presumptive eligibility program, it must determine whether a patient is eligible for the program.
- If patient uninsured, or insurance is unknown:
  - If certified application counselor organization (offer to?) schedule appointment with the counselor “to occur prior to discharge” unless it would delay discharge.
  - If not a certified application counselor organization, before discharge (offer to?) schedule an appointment with a MN Sure-certified navigator that will occur post-discharge, unless scheduling will delay discharge.
  - If discharge would be delayed, or pt declines appt., provide patient with contact information for MN Sure-certified navigator.

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Charity Care

- If patient is uninsured/insurance unknown, screen for charity care eligibility. Must attempt to complete screening in 30 days after services.
- Asset verification must be limited to:
    1. Information reasonably necessary and readily available to determine eligibility.
    2. Facts that are relevant to determine eligibility.
- Must not demand duplicate forms of verification of assets.
- Unless ineligible, must assist with applying for charity care. May not place an unreasonable burden on the patient, “taking into account the individual patient’s physical, mental, intellectual or sensory deficiencies or language barriers.”

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Pending Charity Care Decision HOSPITAL May Not

- Offer or enroll patient in a payment plan.
- Change terms of a payment plan.
- Offer, provide application materials or suggest assistance with applying for a loan or line of credit for medical debt payment.
- Refer to debt collection.
- Deny healthcare services to the patient or any member of the patient's household because of the outstanding medical debt.
- Accept a credit card payment of over $500 for medical debt owed to the hospital.

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Notice

- Post notice in all language spoken by more than 5% of the population in the hospital's service area about availability of charity care in admission/registration areas, emergency departments, and areas of hospital finance and billing accessible to patients.
- On website, provide current version of the hospital's charity care policy, a plain language summary of the policy, and the application form. Summary and application must be in all languages spoken by more than 5% of the population.

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“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.
- Can you name another situation where people typically pay a percentage of billed charge?

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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?

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Peril of the Percentage

- Your “standard charge” for a service is $5000. 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.

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Are Different Prices For Different Patients Allowed?

- 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.

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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.

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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?)

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Medicare Is Entitled To Our 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.

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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.”

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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)

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We Have To Give Medicaid My Lowest Price, Right?

- Maybe. Depends on state law.
- In some states (MN) 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).

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Can A 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.

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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 Set Up A Cash Only Telehealth Service?

- Medicare's Mandatory Claim Submission is a potential problem.
- HIPAA allows patients to not bill insurers but:

  "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??

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QUESTIONS

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