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# Combating healthcare fraud in New Jersey

## an interview with Paul J. Fishman

**United States Attorney for the District of New Jersey**

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by Joseph V. Geraci

# Out-of-network discounts: The disputes continue

» Discounts should be disclosed to payers.
» Discounts should be in return for prompt payment.
» As a best practice, the amount of the discount should correspond to cost savings associated with easier collections, time value of money, etc.
» Payers routinely challenge such discounts under fraud theories or through benefit plan language that "permits" denials in the event the patient responsibility portion is discounted.
» The Fifth Circuit Court of Appeals recently allowed a hospital that used out-of-network prompt payment discounts to sue Cigna for underpayments.

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Prompt-payment discount programs create a variety of compliance problems for out-of-network providers. And those compliance risks are exacerbated by aggressive investigations and legal positions taken by payers. This article explores some of those risks and suggests best practices to mitigate the risks, especially in light of the recent case in the Fifth Circuit Court of Appeals, *North Cypress Medical Center Operating Co. v. Cigna Healthcare*.

Geraci

## Why discounts and why the push back from payers

Payers use copayments and coinsurance as a means of controlling their network. And from the payer's perspective, copayments and coinsurance requirements are critical, because they are the main tools by which patients are driven to "lower" cost, in-network providers. On the other hand, providers need some method to survive in an out-of-network environment. Without that ability, many providers would lose any negotiation leverage they have. Consequently, out-of-network discounts are important to both sides. Given their importance, it is not surprising that out-of-network discounts carry a number of risks for providers.

## Complying with the Anti-Kickback Statute

The federal Anti-Kickback Statue (AKS) makes it a criminal offense to knowingly and willfully offer to pay, solicit, or to receive any remuneration to induce referrals or purchases of items or services reimbursable by federal healthcare programs.[1] Because discounts are a type of remuneration that benefits the patient, they are generally prohibited except in certain cases.

Notwithstanding, the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) has acknowledged that discounts for prompt payment may be permissible if they are not designed to induce purchases of services. Consequently, prompt payment discounts solely in return for the benefit of lower collection costs and the time value of money should be compliant.

Although the application of the federal Anti-Kickback Statute in the out-of-network model is currently limited to, mainly, Medicare

Advantage or Medicaid-managed care plans (which can be carved out of a prompt-payment discount program), that may be changing. With the advent of the healthcare Exchanges under the Affordable Care Act, federal healthcare subsidies have entered the private market. And, those subsidies could draw down federal Anti-Kickback Statute liability. Specifically, the AKS applies to all federal healthcare programs, which include any healthcare programs that are paid for directly, in whole or in part, by the federal government.[2] Whether the AKS applies to subsidized exchange products was addressed in 2013 when former HHS Secretary Kathleen Sebelius said, "[HHS] does not consider the plans or subsidies paid by the federal government for these plans to be federal health care programs" for purposes of the False Claims Act and AKS enforcement.[3] But whether a judge in a *qui tam* lawsuit would agree with former Secretary Sebelius is less certain. Further, many states have promulgated their own anti-kickback statutes that may have broader application than the federal AKS. That said, in our experience, most of these State Statutes generally follow the AKS.

Accordingly, the best practice is to design a discount to comply with the federal AKS (and any state kickback law)—meaning it should be offered solely in return for prompt payment, and the discount should correspond to the time value of being paid promptly and lower overall collection and billing costs.

### Payer allegations of fraud and unjust enrichment or violations of a plan's terms

An out-of-network discount designed to comply with the federal and state anti-kickback laws will still have legal risks. The recent case *North Cypress Medical Center Operating Co. v. Cigna Healthcare* illustrates these risks.[4] In that case, North Cypress Medical Center, a Houston-area hospital, operated out-of-network to Cigna, because it was unable to negotiate an acceptable in-network contract. North Cypress then notified Cigna that it was implementing a "prompt pay discount" where out-of-network patients would receive a discount on their coinsurance obligation if they paid upfront or within a short time period. North Cypress ultimately sued Cigna for underpayments after Cigna began delaying payment of claims and reimbursing North Cypress at drastically reduced rates.[5] Cigna then countersued North Cypress.

Cigna's arguments, as they relate to the discounting issues, boil down to a couple of main points. First, under the various plans' language, Cigna has no obligation to pay for items or services that the patient is not obligated to pay for or for which the patient is not billed. Consequently, Cigna asked the court to dismiss North Cypress' case, because Cigna had no obligation to pay North Cypress due to the prompt payment discount. Second, Cigna raised a variety of Employee Retirement Income Security Act (ERISA) counterclaims, alleging that North Cypress was overpaid, because it over-reported its charges and did not collect or attempt to collect the entire patient responsibility portion.

Regarding the first argument—that the case should be dismissed because of the various plans' language—the Fifth Circuit determined that North Cypress' case could continue, because there are thousands of plans at issue and each has unique language describing when claims should be paid. Accordingly, it is inappropriate to dismiss the entire case on summary judgment prior to a factual and legal analysis of each plan.

Next, the Fifth Circuit addressed Cigna's ERISA counterclaims. Here, Cigna asked the court to extend the statute of limitation on raising ERISA counterclaims in order to increase the number of potential counterclaims it has against North Cypress.

Earlier in the case, a lower court barred some of those counterclaims, because it held that Cigna's ERISA counterclaims were more akin to unjust enrichment counterclaims (which have a two-year statute of limitations) than fraud claims (which have a four-year statute of limitations). What is important for providers that are drafting discount policies are the Fifth Circuit's comments in determining that Cigna's counterclaims were more akin to unjust enrichment than fraud. Specifically, the Fifth Circuit recited the elements of fraud and then, *in dicta*, stated: "Indeed, given that North Cypress expressly informed Cigna of its discounts prior to any representations about charges, fraud seems particularly inapt."[6]

As mentioned, this comment was *in dicta* (i.e., the individual views of the author of the court's opinion and not binding in subsequent cases as legal precedent) and is therefore not compelling—but it is informative. The entire case is currently back at the district court.

## Conclusion

When drafting an out-of-network discount policy, providers need to be particularly mindful of the issues in this case. First, is it possible to determine what the various plans say with respect to their obligations to pay for healthcare if the patient responsibility portion is discounted? Alternatively, is it possible to identify the largest plans in the given region and review them? For instance, if in a smaller market, there may be a handful of large employers, and their plans may be accessible.

Second, any discount program should mandate that each payer be notified in writing of the prompt payment discount. In addition, if it is possible, that disclosure should be made on each CMS-1500 or UB04 form.

Finally, although this seems like common sense, providers need to train personnel to follow the discount policy closely. This includes training central business office personnel and others on the need to collect the amounts due in accordance to with the policy. But even with these safeguards, there will be payers, such as Cigna, that freeze payments and allege fraud.

1. *See* 42 U.S.C. §1320a-7b(b). Criminal penalties for acts involving Federal healthcare programs. Available at http://bit.ly/1Pk4dGB
2. Id. at §1320a-7b(f).
3. Jim McDermott: Letter to Kathleen Sebelius. Will qualified health plans represent federal health care programs? Aug. 6, 2013. Available at http://bit.ly/1h1PErjh
4. *North Cypress Medical Center Operating Co., Ltd. v. Cigna Healthcare.* 781 F.3d 182 (2015)781 F.3d 182, 197, Fifth Circuit Court of Appeals, March 10, 2015. Available at http://bit.ly/1NhkGGG
5. Id.
6. Id. at 205.