

## RT115 Negotiating a Part A Contract

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*The goal of this roundtable is to provide background, strategies and lines of reasoning for pathology groups negotiating with a hospital for Part A payment for clinical pathology services.*

*The implications to the pathologist of lumping Medicare Part A payment and payment for similar services to other patients under a broadened definition of "Part A" is examined.*

*The status and significance of the OIG's June 2004 "Draft Supplemental Compliance Program Guidance for Hospitals" will be discussed.*

### Discussion Topics:

1. Is the "Reasonable Compensation Equivalent" a useful benchmark in the negotiation process?
2. What are the best points for the pathologist to emphasize in negotiations?
3. Is it wise to acquiesce and accept a grossly low final offer of payment? Or is it best to politely reject such an offer?
4. What is the appropriate course of action if the hospital will not even consider payment?
5. If the June 2004 Draft Compliance Program Guidance for Hospitals were to be finalized with its original language, what could constitute a situation in which the pathologist performs administrative and clinical duties yet the hospital/pathologist relationship does not "run afoul" of the anti-kickback statutes?

**"Part A"** in Federal nomenclature is "Hospital Insurance" as defined by the Medicare Act of 1965. It pays for inpatient hospital stays, care in a skilled nursing facility hospice care and some home health care. Most Medicare beneficiaries do not have to pay a monthly payment for Part A, because they or their spouse paid Medicare taxes while they were working. Part A is roughly equivalent to the **"technical component"** of the non-Federal world. After TEFRA became law in 1982 "Part A" has come to include a **"management portion"** for pathologist services in the clinical laboratory, built into the DRG. The government pays this money to the healthcare facility. The "management portion" is built in to the "Part A" fee paid to the facility, which is then supposed to pay the pathologist an agreed amount for these services.

**"Part B"** in Federal nomenclature is "Medical Insurance" as defined by the Medicare Act of 1965. This insurance helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A. Medicare beneficiaries have the option of enrolling in Part B and most beneficiaries pay a monthly premium (set at \$66.60/month in 2004, usually structured as a deduction from their Social Security payment). Part B is roughly equivalent to the **"professional component"** of the non-Federal world.

The terms “Part A” and “Part B” have come to be used as informal synonyms for the technical component and professional components of the non-Federal world, but it is important for pathologists to understand the differences.

**REASONABLE COMPENSATION EQUIVALENT (RCE)** - For Medicare and where applicable, some other Federally-funded programs, this is determined by CMS to be the reasonable amount of money a health care facility could claim as its cost per FTE to obtain pathologist services under “Part A”. The RCE for “Part A” pathology services to Medicare patients was established by HCFA most recently as \$208,000-\$219,500/year/FTE adjusted for geography, with small yearly updates allowed. The RCE provides an important tool in negotiations between pathologists and hospitals to establish Medicare Part A compensation for managing clinical laboratory services.

### **HISTORICAL PERSPECTIVE – PART A PAYMENT FOR PATHOLOGY SERVICES**

With the coming of the Federally Medicare and Medicaid programs in the 1960s, methods of paying pathologists for their clinical pathology services quickly evolved. In areas administered by certain HCFA regional offices the percentage contract and salary arrangements common in the era began to be replaced. By the late 1960s, some HCFA regional offices, at their own discretion, began to pay pathologists a professional component for their clinical pathology services. Professional Component Billing emerged as a valid method of billing for the professional services of pathologists in the clinical laboratory.

Regulators in the central offices of HCFA in Baltimore were not proponents of component billing. But it was not certain that HCFA had the regulatory authority to extinguish the practice under the original Medicare Act of 1965. In 1976, with tacit support from HCFA, Senator Herman Talmadge of Georgia sponsored a bill that would have abolished component billing for laboratory testing. Thanks to strong efforts by pathologists, the “Talmadge Bill” died.

In 1980 HCFA went ahead anyway, and published a regulation in the Federal Register that purported to make component billing of Medicare beneficiaries unlawful. The College of American Pathologists sued Medicare, claiming among other things, that the proposed regulation was unlawful because it was contrary to the Medicare Act. The case was brought in Federal Court in Little Rock, with the CAP and the Arkansas Society of Pathologists as plaintiffs. A preliminary injunction was issued, blocking the proposal. The Court went further, seeming to suggest that the Medicare Act did envision component billing.

But in 1982 the Tax Equity and Fiscal Responsibility Act (TEFRA) amended the Medicare Act. Under TEFRA, federally-funded health care programs began the transition to the DRG (Diagnosis Related Groups) system for Part A payment to hospitals, based on ICD-9. As a part of this change the Professional Component Billing system for Clinical Pathology in Medicare was significantly altered. Under this new plan, healthcare facilities received the pathologist’s payment for most of the pathologist’s services as a part of the DRG payment.

In TEFRA, Congress divided payment to pathologists into two categories:

(A) Activities "which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility..."

AND

(B) Those services for Medicare patients "which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient."

Those falling into the first category were now to be covered by "Part A" of Medicare. Those falling in the second category were to remain as physician services under "Part B" of Medicare.

Now armed with the statutory authority it lacked in the original Medicare legislation, HCFA issued regulations that placed severe restrictions on billing Medicare patients for ANY Clinical Pathology service. The CAP sued once again, claiming that the regulations violated the mandate of the law. This lawsuit resulted in significant modifications of the final regulations. For example, Blood Banking services and certain Hematology procedures were re-classified, the list of 18 tests that can be billed as a professional service was constructed and the rules for Clinical Pathology consultations were developed. The practice of Clinical Pathology under Medicare was substantially restricted, leading to the system that we practice under today.

For 2 transitional years hospitals paid pathologists under a formula known as the "Reasonable Compensation Equivalent" ("RCE"). In the mid-1980s, the RCE was valued at about \$120,000 per FTE for a pathologist practicing clinical pathology, adjusted for geographic region. After that initial period, when the DRG system became fully operational, pathologists and the hospital were asked to negotiate with each other for the fee payable under Part A. The healthcare facility was under no obligation to "pass-through" a specific amount. The pathologist could still bill for a limited list of Clinical Pathology services that met specific criteria and for properly documented consultations under Part B.

But TEFRA only applied to the Medicare system.

Pathologists who always received payment from the hospital prior to TEFRA pretty much went on with their previous arrangements, perhaps having to modify the language and structure of their agreement with the hospital to comply with Federal regulations.

Pathologists on a component billing system prior to TEFRA were faced with the option of

- 1) Attempting to work out a Medicare-like arrangement with their hospital AND the health plans of their patients or
- 2) Continue with a dual system – Part A payment for Medicare (if the hospital cooperated) and then continue to component bill for the non-Medicare portion of their practice.

Most pathology groups opted for choice #2.

For non-Medicare situations, pathologists who use Professional Component Billing sometimes encounter misinterpretation of the Federal method of reimbursement. Insurance companies and health plans may take the position that their payment to the healthcare facility includes a portion of funds that is somehow designated for the pathologist, akin to the Medicare program. But in most cases, the hospital has no such understanding, and still expects the pathologist to use the Professional Component Billing system.

This fragmented system has somehow worked well in some situations. On the other hand, for the many pathology groups who have encountered difficulty in their negotiations with their hospital, the Part A payment system has been a source of disappointment and frustration.

Despite the clear intent of Congress that pathologists would be paid by healthcare facilities for their "Part A" services to Medicare inpatients, many facilities have refused to pay for such services, sometimes using faulty justification for their failure to comply with the law. To be sure, the Office of Inspector General of HHS, which is responsible for criminal and civil investigations for HHS with power to levy sanctions, has expressed the opinion in at least 2 documents that payment by the hospital of no or token compensation to the pathologist may constitute fraud and abuse, a serious violation of the Social Security/Medicare Acts.

- In 1991, in an OIG Management Advisory Report entitled "Financial Arrangements Between Hospital and Hospital-Based Physicians" (OEI-09-89-00330) it was stated that agreements that compensate pathologists for less than the fair market value of the goods and services that they provide to hospitals or require pathologists to pay more than the fair market value for goods and services provided to the hospital is a potential violation of anti-kickback statutes of the Social Security Act.
- In 1997, in the OIG Compliance Program Guidance for Hospitals, the OIG reaffirmed and strengthened the language by stating that token or no payment for Part A management services may violate the anti-kickback statutes.

However, neither OIG nor CMS have taken action against hospitals that have failed to pay pathologists for their Part A services to Medicare patients. Keep in mind that in theory, action against a hospital accused of entering into a contract that violates the anti-kickback statute could also be taken against the hapless pathology group that agreed to participate in the illegal arrangement.

Dilemmas defining "fair market value" for a given situation, the issue of whether or not a pathology group receives goods and services of value to the pathology group that "offset" little or no monetary compensation under Part A and customs that differ from one region of the nation to another have contributed to pathology's inability to satisfactorily resolve this problem.

Thus, hospitals that have chosen not to pay pathologists for their Part A services have succeeded in doing so - even though the refusal to pay is contrary to the expectation of Congress.

On June 8, 2004 (shortly before this handout was prepared) the OIG published a "Draft Supplemental Compliance Program Guidance for Hospitals." The new proposed guidance, if it is finalized by the OIG without modification or clarification, will weaken the negotiating position of pathologists. The most disturbing language follows:

***"In an appropriate context, an arrangement that requires a hospital-based physician or physician group to perform reasonable administrative or clinical duties related to their hospital-based professional services at no charge to the hospital or its patients would not violate the anti-kickback statute. Whether a particular arrangement with hospital-based physicians runs afoul of the anti-kickback statute would depend on the specific facts and circumstances, including the intent of the parties."***

The CAP asked pathologists to write to the OIG, expressing opposition to the proposed language. Those letters had to be received by the OIG before July 23, which was end of the comment period. Other strategies may also be used to induce the OIG to change the final language. We expect to have more information by September 20.

## **NEGOTIATING WITH THE HOSPITAL**

### **First, determine if the hospital will even entertain negotiations**

Some hospital systems, as a general policy, will not approve a Part A payment in their system. In those circumstances successful negotiation or any meaningful discussion that can be called "negotiation" may be futile.

On the other hand, even in such circumstances, an occasional pathology group in a specific local situation (strong tradition, other ties with the hospital) has successfully negotiated a payment.

And, if the administrator is friendly but has his/her hands tied by higher authorities, proceeding cautiously in a discussion could lead to other "make-up" opportunities.

### **Second, be ready to make your case for payment**

Understand the history of Part A payment, emphasizing that the government expects negotiations.

Talk about all parties having an interest in reaching agreement. Gently point out that no payment or token payment to the group may be a violation of the law.

Be ready to explain all that a pathologist does in a clinical laboratory:

- 1. Assuring that tests, examinations and procedures are properly performed, recorded and reported.*
- 2. Interacting with members of the medical staff regarding issues of laboratory operations, quality and test availability.*
- 3. Designing protocols and establishing parameters for performance of clinical testing.*
- 4. Recommending additional diagnostic or therapeutic tests, when appropriate.*

5. *Supervising laboratory technical personnel and advising them regarding aberrant results.*
6. *Selecting, evaluating and validating test methodologies.*
7. *Directing, performing and evaluating quality assurance control procedures.*
8. *Evaluating clinical laboratory data and establishing a process for review of tests prior to issuance of patient reports.*
9. *Assuring the healthcare facility's compliance with state licensure laws, Medicare conditions, JCAHO standards, the CAP Laboratory Accreditation Program and CLIA '88 and any other federal certification standards.*
10. *Pathologists are present or on call 24 hours a day to provide the above services.*

Make the point that as the responsible physician authority in the laboratory the pathology group is legally liability for events in the laboratory and is also liable in the event of an issue raised by an accrediting or licensing agency.

Other possible points, depending on the pathology group's involvement could include: Administrative duties over and above what would ordinarily be expected of a Medical Director: committee work, teaching, research, attending conferences.

### **Third, be prepared to face counter points**

The hospital may claim that it is faced with the seemingly incessant demand for payment by physicians in other specialties – for example, obstetrician/gynecologists or orthopedic surgeons asking for payment for taking ER call and physicians asking to be paid to serve on hospital committees.

***“Why is the pathology group's request different?”***

***“Well, we do pay you – we offset your Part A payment by providing you goods and services rather than giving you a check.”***

Since we have conceded to you the valuable right to bill patients for anatomic pathology and to bill non-Medicare patients for these exact same services, we really should be charging you for:

Rent for office space and rent for laboratory space

Housecleaning

Utilities

Patient demographic information that our business office organizes for you

Secretarial services

Technology services and phlebotomy services

Supplies

Telephone and fax capability

Computers

***“If we really started adding up these goods and services and credited that against the ‘fair market value’ of your Part A service to this institution, we may well***

***discover that the group should be writing a check to the hospital each month for the net amount you owe us.”***

***“And, to tell you the truth, while we see that there are certain times that we need to list you as medical directors, we are not all that sure that you do very much anyway on a daily basis.”***

***“We understand and appreciate that you are capable of performing these professional services that you are interested in ‘selling’ to us, but we do not wish to purchase all of those services. We’ll pay you for a few of those services that you list. We have technologists on the staff – they tell us that they can handle several of those items. Therefore, here is the amount that we are willing to pay the pathology group for the few services that we need right now.”***

***“There was a lawsuit, titled Parsa v. State of New York that determined that the pathologist is not entitled to any portion of the hospital’s Part A payment.”***

If faced with this well-known argument, explain that this lawsuit was decided before TEFRA and the findings of the court are completely obsolete.

**Fourth, be ready with a ballpark figure of payment that you feel is justified**

As a starting point for what may constitute fair market value, consider the RCE amount of \$208,000-\$219,500/FTE. Remember that the payment is for time spent full time for a practice that only does Medicare. A large laboratory may need more than one FTE to handle the percent of the clinical pathology practice that is Medicare; a smaller laboratory less than one FTE. The formula is:

***Add the percent of time each pathologist in the group spends on relevant clinical pathology services;***

***then multiply that number by***

***the percent of Medicare patients in the average daily census;***

***then multiply the product by the applicable RCE.***

***The result equals the appropriate payment based on the RCE.***

**Fifth, be ready to finalize the agreement or protect the pathology group if there is no agreement**

If the group will be billing non-Medicare patients for the professional component, be sure that the contract with the hospital explicitly states that the Part A payment is only for Medicare patients.

If the negotiations fail, attempt to somehow document that you pointed out that not paying the group fair market value under Part A of Medicare may represent fraud and abuse. This is important because the group, by not receiving payment, may be entering into an illegal contract. The issue has never been raised, but no one wants to be the test

case. This documentation may take the form of your own contemporaneous notes of your meeting.

***Additional reading:***

***CAP Today – March 2004 (available on the CAP web site)***

**Spirit of the law:**

***The little-known history of Part A payments—and why they belong to you***

***Author: Jack R. Bierig***