

more than their other customers. This proposed rule would clarify that providers are not required to give Medicare and Medicaid their best price. Rather, this proposed rule only addresses the narrow situation in which the providers are charging Medicare or Medicaid substantially more than they regularly charge a majority of their other customers for the same items or services.

In an effort to more clearly define the scope of section 1128(b)(6)(A) of the Act, we are proposing to revise § 1001.701 to define specifically the terms “usual charges” and “substantially in excess,” and to clarify the “good cause” exception.

A. Definition of “Usual Charges”

We propose to define the term “usual charges” to include the amounts billed to cash paying patients; the amounts billed to patients covered by indemnity insurers with which the provider has no contractual arrangement; and any fee-for-service rates it contractually agrees to accept from any payor, including any discounted fee-for-service rates negotiated with managed care plans. Given the changes in the health care marketplace, negotiated rates have become a substantial portion of many health care providers’ revenues. To the extent a provider agrees to discount its rates, the discounted contract rate is its “charge” to those patients.

Specifically, when a provider contractually agrees to accept a fixed amount for an item or service or an amount based upon a payor’s fee schedule, such amount is the provider’s charge for that item or service to patients covered by the contract.

We also propose that the following charges should *not* be included when determining the usual charge:

- Charges for services provided to uninsured patients free of charge or at a substantially reduced rate;
- Capitated payments;
- Rates offered under hybrid fee-for-service arrangements whereby more than 10 percent of the individual’s or entity’s maximum potential compensation could be paid in the form of a bonus and/or withhold payment; and
- Fees set by Medicare, State health care programs, and other Federal health care programs, subject to the limitations described below.

1. Determining the “Usual” Charge

To determine the “usual” charge, we are considering two alternative approaches. First, in order to determine the “usual” charge, we are considering using the provider’s average charge. To

determine the average charge, one would list all of the provider’s charges for a particular item or service for the most recent 1-year period (this 1-year period can be the calendar year or a rolling 12-month period ending with the most recent month for which data are available), and then divide the sum of the charges by the number of charges. As noted above, Medicare fee-for-service charges and certain other charges would not be included.

Alternatively, we are considering using the “fiftieth percentile” method (*i.e.*, the median). To determine the median, one would take the following steps:

- List the provider’s charges for a particular item or service for the most recent one-year period. (This one-year period can be the calendar year or a rolling 12-month period ending with the most recent month for which data are available.)
- Arrange the charges from the lowest to the highest. (If the same rate is charged more than once, it must be listed each time that it is charged.)
- Select the median, which is a charge (or charge range) at which exactly half the provider’s charges are below and half are above.

This can be done in the following manner:

- Count the total number of charges and divide that number by 2.
- If the result is a whole number (*n*), begin at the lowest charge and count to the *n*th charge. The median is a number that is between the *n*th charge and the *n*th+1 charge.
- If the result is a fraction (*e.g.*, *n*.5), then begin at the lowest charge and count to the *n*th+1 charge. This is the median charge.

Set forth below are 3 examples that demonstrate how the median should be calculated.

Example A: Even number of charges (*i.e.*, the result is a whole number).

Charges: \$100, \$100, \$150, \$175, \$200, \$250, \$300 and \$500.

Median: Any number between \$175 and \$200.

There are 8 charges. The result of 8 divided by 2 is 4 (*i.e.*, a whole number) and, therefore, *n* equals 4. Since the result (*i.e.*, 4) is a whole number, the median is a number that is between the *n*th charge (*i.e.*, the 4th charge) and the *n*th+1 charge (*i.e.*, 4th+1 charge or the 5th charge). The 4th charge is \$175 and the 5th charge is \$200. Therefore, the median is any number between \$175 and \$200.

Example B: Odd number of charges (*i.e.*, the result is a fraction).

Charges: \$100, \$100, \$150, \$175, \$200, \$300 and \$500.

Median: \$175.

There are 7 charges. The result of 7 divided by 2 is 3.5 (*i.e.*, a fraction) and, therefore, *n*

equals 3. Since the result (*i.e.*, 3.5) is a fraction, the median is the *n*th+1 charge (*i.e.*, the 3rd +1 charge or the 4th charge). Therefore, the median is the 4th charge or \$175.

Example C: Many duplicate charges.

Charges: \$250, \$250, \$250, \$250, \$250, \$300, \$350 and \$350.

Median: \$250.

There are 8 charges. The result of 8 divided by 2 is 4 (*i.e.*, a whole number) and, therefore, *n* equals 4. Since the result (*i.e.*, 4) is a whole number, the median is a number that is between the *n*th charge (*i.e.*, the 4th charge) and the *n*th+1 charge (*i.e.*, 4th+1 charge or the 5th charge). The 4th charge is \$250 and the 5th charge is \$250. Therefore, the median is \$250.

We are soliciting public comments about these and other methodologies as a means of determining the “usual” charge.

2. Principles To Be Considered in Determining What Charges To Include

When determining what charges should be included in calculating a provider’s usual charges, the following principles should be considered:

a. Charges Billed Directly to Patients

The entire charge billed directly to patients can be included in determining usual charges as long as the provider makes a good faith effort to collect the full amount. However, if, for example, the provider charges \$100, but routinely accepts \$80 without trying to recoup the \$20 copayment balance, then the \$80 charge should be used in determining the usual charge. As noted above, charges for services provided to uninsured patients free of charge or at a substantially reduced rate are not included when determining the usual charge.

b. Charges Negotiated With a Third Party Payor

If the provider has a contract with a third party payor to accept an amount other than the provider’s actual charge, then for each service or item provided at the negotiated rate, this negotiated rate, together with the applicable copayment, if any, should be included when determining the usual charge.² This negotiated rate should be used even if the bill submitted to the payor lists a higher charge, because the higher charge is never collected.

² The lower negotiated rate may be based upon a predetermined fixed amount, a payor’s fee schedule, a fixed discount (such as a percentage discount) or some other payment methodology.