

**c. Charges Billed to Third Party Payors With Whom the Provider Does Not Have a Contractual Arrangement**

A provider often bills third party payors with whom the provider does not have a contractual relationship. In such cases, the patient is usually responsible for the difference between the full charge that is billed to the third party payor and the amount received from it. The usual charge includes cost-sharing amounts that should be collected.

**d. Contractual Rates Offered, Directly or Indirectly, to Managed Care Plans**

In determining usual charges, providers should include any contractual per-service rate offered, directly or indirectly, to commercial managed care plans, Medicare+Choice plans, State managed care plans and other Federal managed care plans. In addition, providers should include contractual per-service rates that vary depending on conditions (i.e., bonuses or withholds), provided the total variance is less than or equal to 10 percent. We have selected the 10 percent benchmark because we believe it is a small enough number that we can be confident that the charge will be reasonably ascertainable. We believe that a larger percent would increase the uncertainty as to the actual amount of payment for the item or service. In determining usual charges, we propose that providers handle contractual per-service rates in the following manner:

- Include contractual per-service rates offered, directly or indirectly, to managed care plans only if 10 percent or less of the provider's maximum potential compensation could be paid in the form of a bonus and/or a return of certain funds previously deducted from the provider's compensation (i.e., a "withhold payment").
- In determining usual charges, the rate to be used for such contractual per-service rates would be the base contractual per-service rate (without the bonus and/or withhold payment), plus one-half the potential bonus and/or withhold payment, regardless of whether the bonus or withhold payments are actually paid.

We recognize that, in many cases, the aggregate rate paid for a particular item or service cannot be determined until a decision is made regarding the contingent, additional compensation. Notwithstanding, we believe that, in cases where the additional compensation is less than or equal to 10 percent of the provider's maximum potential compensation, the contractual per-service rate (adjusted in the manner

set forth above) can be included in a provider's usual charges without significantly distorting the accuracy of those charges.

We are soliciting comments on the foregoing, including comments on whether 10 percent is the appropriate range or whether a larger range would be appropriate in situations where the fee paid for the item or service could otherwise be ascertained. In addition, we are seeking comments about the difficulties, if any, that may arise in assessing the rates paid for items and services provided under managed care plans, and how those difficulties might be resolved.

**e. Rates Offered to TriCare (Including TriCare Standard, Formerly Known as CHAMPUS)**

Rates offered to the Department of Defense (DoD) for its various health care plans should be included in determining usual charges, regardless of whether they are offered in connection with a managed care plan, unless the rates are based upon (1) capitated payments or (2) hybrid fee-for-service arrangements employing bonuses or withhold payments that exceed the proposed 10 percent threshold established above in section II.A.2.d. of this preamble discussion. Providers often offer the DoD's health care programs rates that are significantly lower than those offered to other Federal health care programs.

**f. Charges of Affiliated Entities**

Some companies create separate legal entities for their Medicare and non-Medicare business. By segregating the Medicare business, such companies often have substantially different charges for Medicare and non-Medicare business. However, in determining the usual charge, the provider should include all charges of any affiliated entities providing substantially the same items or services in the same or substantially the same markets. An "affiliated entity" is any entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the provider.

**B. Definition of "Substantially in Excess"**

Section 1128(b)(6)(A) of the Act is a permissive exclusion statute. That is, the OIG may, but is not required to, exclude a provider for violation of the statute. In exercising its discretionary authority, the OIG is proposing that, for purposes of section 1128(b)(6)(A) of the Act, only those charges or costs that are more than 120 percent of a provider's

usual charges or costs will be deemed to be "substantially in excess." Having considered various options, we believe this 120 percent measure is a reasonable interpretation of "substantially in excess" and is high enough to permit reasonable variation. Based on anecdotal evidence and our review of particular factual situations in the advisory opinion context and elsewhere, we believe that a 20 percent differential is high enough that most people would agree that the charges to Medicare are substantially in excess.

For purposes of the regulation, where the actual charge submitted exceeds an applicable fee schedule, we would consider the fee schedule amount as the actual charge. As a result, providers submitting charges (as capped by any applicable fee schedule) or costs that are equal to or less than 120 percent of their usual charges or costs will not be subject to sanction under section 1128(b)(6)(A) of the Act. Moreover, for providers submitting charges or costs that are more than 120 percent of the provider's usual charges or costs, exclusion is not mandatory. That is, the authority regarding whether to exclude such a provider from Federal health care programs remains within the discretion of the OIG, notwithstanding the 120 percent benchmark.

We are specifically seeking comments on both this proposed definition of "substantially in excess" and the 120 percent benchmark. We are also interested in comments as to whether the numeric benchmark for "substantially in excess" should vary based upon certain factors (e.g., whether the benchmark should be lower for some providers than others based on the type or location of a provider or the reimbursement methodology applicable to the provider or whether the benchmark should take into account certain market considerations) and, if so, how and why. We will continue to consider data on charging practices and are interested in suggestions on potential sources of data. We are also interested in comments on whether and in what circumstances it might be appropriate to define "substantially in excess" on a case-by-case basis when below the threshold.

**C. Clarification of the "Good Cause" Exception**

Section 1128(b)(6)(A) of the Act grants the Secretary the authority to permit providers to charge Medicare or Medicaid substantially in excess of their usual costs or charges if the Secretary determines there is good cause for the higher charges or costs. The Secretary's decision regarding whether good cause