IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
CIVIL TRIAL DIVISION

TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA d/b/a UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM, et al.	:	August Term 2005
Plaintiffs,	:	No. 4392
v.	:	Commerce Program
AMERICHOICE OF PENNSYLVANIA, INC.	:	Control No. 061575
Defendant.	:	

ORDER and MEMORANDUM

AND NOW, this 23rd day of January, 2007, upon consideration of the parties' Motion to Determine Law of the case pursuant to the Quality Healthcare Accountability and Protection Act, 40 P.S. §§ 991.201, *et seq.*, ("Act 68") it hereby is ordered:

Act 68 requires the defendant to pay plaintiffs the "reasonably necessary costs" of all emergency medical services provided to participants enrolled in a private managed care plan. "Reasonable necessary costs" are neither the predetermined Medicaid rates nor the provider's full published rates.

The Quality Healthcare Accountability and Protection Act requires payment to medical emergency providers mandated by law to provide stabilization emergency services in such

amount as to ensure no financial loss. The actual costs "reasonably necessary" to provide all services provided, must be factually proven at trial.

A pretrial conference is scheduled for Friday, February 16, 2007, beginning at 9:30 a.m. in Room 530 City Hall, Philadelphia, Pennsylvania, for the purpose of determining how trial will proceed initially limited to medical services rendered under these three specific procedure codes.

BY THE COURT:

_____

MARK I. BERNSTEIN, J.

IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
CIVIL TRIAL DIVISION

TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA d/b/a UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM, et al.	:	August Term 2005
Plaintiffs,	:	No. 4392
v.	:	Commerce Program
AMERICHOICE OF PENNSYLVANIA, INC.	:	Control No. 061575
Defendant.	:	

MEMORANDUM OPINION

Plaintiffs are the Trustees of the University of Pennsylvania Health System, Pennsylvania Hospital and Presbyterian Medical Center (collectively "UPHS"), a medical provider obligated by Federal law[1] to provide emergency stabilization medical treatment to all persons, including Medical Assistance participants. Defendant Americhoice is a private managed care organization required by the Quality Healthcare Accountability and Protection Act, 40 P.S. §§ 991.2101 - 991.2193 ("Act 68") Act 68 to reimburse medical providers for emergency stabilization treatment.[2] Americhoice has contracted with DPW to pay for medical assistance medical care. UPHS has brought claims under Act 68 for unjust enrichment and as a third party beneficiary of both the Health Choices Agreement between Americhoice and DPW and the agreement between Americhoice and its enrollees.

In conference, the court requested the parties submit Cross-Motions to Determine the Law With Respect to Reimbursement Under Act 68. The question presented herein is the

1 The Emergency Medical Treatment and Active Labor Act 42 U.S.C. § 1395dd.
2. 40 P.S. § 991.2116.

discreet issue of the amount of reimbursement due out-of-network healthcare providers required to render emergency stabilization medical services to enrollees of a Medicaid Managed Care Plan.

In 1965 ,Title XIX of the Social Security Act[3] established the Medicaid Program as a Federal-state program providing healthcare services to the indigent including emergency and inpatient hospital care. The Federal government allocates funds to participating states "for the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish Medical Assistance to…[eligible] individuals."[4] Under Title XIX, a participating state must designate a "single state agency to administer or supervise the administration of the [state Medicaid] plan."[5] In Pennsylvania, that agency is the Department of Public Welfare ("DPW").

Pennsylvania's Medical Assistance ("MA") program is comprised of two systems: fee-for-service and managed care. Under the fee-for-service system, health care providers enrolled in the MA program provide necessary medical services to eligible recipients and receive payments directly from DPW according to an established fee schedule.[6] Under the managed care system, "Health Choices," DPW contracts with private managed care organizations ("MCOs")[7] to provide medical services on a "capitated basis." Flat rate payments are made based upon the

---

3. 42 U.S.C. §§1396-1396u.

4. 42 U.S.C. § 1396.

5. 42 U.S.C. § 1396a(a)(5).

6. 55 Pa. Code. §§ 1150, *et seq.*

7. In the healthcare industry, there are MCOs which are not affiliated with federal and state medical assistance plans, and MCOs which exist solely for the purpose of MA. For the purposes of this opinion reference to "MCO" refers to a MA MCO.

number of participating individuals.[8] MCOs retain providers which render services to members in accordance with rates established by negotiated contracts between MCO and the provider. Providers which have not entered into a contract with a specific MCO are “non-plan” or “out-of-network” providers.

In Pennsylvania, the Quality Healthcare Accountability and Protection Act, 40 P.S. §§ 991.2101 - 991.2193 (“Act 68”) regulates the activities of “managed care plans" including services provided by MCOs to Health Choices enrollees.[9] Act 68 mandates reimbursement to medical providers for “out-of-network” emergency services provided to Health Choices enrollees. MCOs must reimburse out-of-network providers for all emergency services and pay "all reasonably necessary costs associated with the emergency services provided during the period of the emergency."[10] Act 68 does not set forth any process for determining “reasonably necessary costs.”

UPHS claims compensation for emergency medical stabilization services provided to Americhoice enrollees subsequent to December 2003, when the prior contract between the parties ended. UPHS has billed Americhoice for services rendered at the rate UPHS refers to as its “usual and customary charges.” UPHS is actually seeking reimbursement at its full published rates, a rate infrequently charged. Americhoice asserts it is required to pay and has already paid the “Medicaid Rate,” the rate used by DPW permanent to the non-managed care Medicaid

---

8. In 1996, DPW introduced mandatory managed MA program pursuant to a waiver under Section 1915(b) of the Social Security Act. 42 U.S.C. § 1396n(b). This section allowed flexibility to develop managed care programs to provide medical care to indigent people.

9. Act 68 was approved on June 17, 1998 and became effective January 1, 1999.

10. 40 P.S. § 991.2116.

Program.

Act 68 addresses the issue of what an MCO must pay a provider for non-contract emergency services. Section § 91.2116 of Act 68 requires Americhoice to pay UPHS "all reasonably necessary costs associated with emergency services provided…"[11] It further provides that in determining this amount "…a managed care plan shall consider both the presenting symptoms and the services provided."

This is a case of first impression statutory interpretation controlled by the Statutory Construction Act.[12] When legislative language is clear, the words of the statute are to be enforced without grafting any interpretation based upon presumed intent. "When the words of a statute are clear and free from all ambiguity, the letter is not to be disregarded under the pretext of pursuing its spirit."[13] In determining the meaning of a statute "Words and phrases shall be construed according to rules of grammar and according to their common and approved usage; but technical words and phrases and such others as have acquired a peculiar and appropriate meaning or are defined in this part, shall be construed according to such peculiar and appropriate meaning or definition."[14]

The plain language of Act 68 demonstrates that neither rate advocated by the parties has been legislatively mandated. The legislature clearly chose not to impose any specific default rate for reimbursement. "Reasonably necessary costs" vary by service rendered, by region of the

---

11 Beginning January 1, 2007, the Federal Deficit Reduction Act of 2005 will establish the Medicaid Rate as the default payment rate for non-contracted emergency services provided to MCO enrollees nationwide. (Deficit Reduction Act of 2005, § 1932, amending 42 U.S.C. § 1396u-2(b)(2)). This Act is inapplicable to the present action.

12. 1 Pa. C.S. § 1921 *et seq.*

13. 1 Pa. C.S. § 1921(b); *see also* Cherry v. Pennsylvania Higher Education Assistance Agency, 537 Pa. 186, 642 A.2d 463 (1994).

state and by institution. The act appreciates this fact by specifically referencing symptoms and services provided. The actual costs of providing a service is a known economic concept. Costs are those fixed and variable expenses incurred in providing a service without affording any excess or profit. The "reasonably necessary costs" of providing medical care is a matter for factual determination based upon evidence presented.

Medical providers, including UPHS, are paid for services at many different rates, including rates negotiated with commercial insurers, Medicare and Medicaid fee scheduled rates, and, in a very small percentage of cases, at the providers' full published charges. None of these negotiated or statutorily determined rates are the "cost" of treatment. Cost is a standard quantifiable and readily calculable economic concept determined in every business endeavor. The Legislature understood the difference between the phrases "necessary cost" and "billed charges" or "negotiated charges." The Legislature chose to require reimbursement on the basis of "cost."[15]

Since Act 68 does not provide any default rate it cannot be held as a matter of law that the provider's full published charges are "the reasonably necessary costs" of providing emergency services. The vast majority of services are billed at much lower governmentally mandated rates or negotiated contract rates with health insurance carriers. A hospital's full published charges are necessarily established at a level which accounts for patients from whom no payment will ever be received. These charges are often artificially inflated to afford a basis

---

14. 1 Pa. C.S. § 2903 (a).

15 When the operative words in a statute are not specifically defined, courts should consider other statutes dealing with the same or similar subjects in discerning legislative meaning. 1 Pa. Cons. Stat. § 531(10). The Pennsylvania Workers' Compensation Act provides that the payment for trauma care "shall be the usual and customary charge." 77 Pa.C.S. 531(10). These words have been in the law since at least 1997. Clearly, the legislature was familiar with the term "usual and customary charge" and rejected those terms and concept when enacting Act 68.

for negotiating increased third party or governmental payments.

UPHS own conduct belies its claim that its full published rate is its costs. UPHS does not routinely collect these charges even from non-participating MCOs. None UPHS's contracts with insurers and MCOs provides for payment of full published rate. Marc LaPergola, Director of Operation Reimbursement and Managed Care Analysis for UPHS, testified that these charges can be 500% over costs:

> "Q: So for the year ending 2004, that would mean that the hospital's stated charges were approximately five times its costs?
> A: Yes."[16]

According to Michael Dandorph, Senior Vice President of Business Development for UPHS, UPHS routinely negotiates rates well below its full billed charges.

> "Q: Now you said earlier that, absent a delay in payment, none of your managed care contracts provide for the payment of full billed charges. Do you recall that testimony?
> A: Yes, I recall it." [17]

Roy Schwarz, Associate Vice President of Managed Care for UPHS, testified that UPHS receives its full billed charges less than 10% of the time.

> "Q: Okay, it sounds to me that on a percentage of revenue basis in your business, you're getting billed charges a very small percentage of the time. Is that a fair statement?
> A: …I would agree that it's probably less than ten or eight percent of the time…"[18]

If full published rate was in fact true cost, all contract payments would be dramatically below

---

16 . Deposition of Marc LaPergola, Director of Operation Reimbursement and Managed Care Analysis for UPHS, at 65-7.

17. Deposition of Michael Dandorph, Senior Vice President of Business Development for UPHS, at 56-7

18. Deposition of Roy Schwarz, Associate Vice President of Managed Care for UPHS, at 41-2.

cost. No business not even for profit eleemosynary institution, can continue operating when its routine charges are below cost. [19]

Neither is the Medicaid Rate the mandated reimbursement under Act 68. In Temple University Hospital, Inc. v. Healthcare Management Alternatives,[20] the Superior Court addressed the issue of the "reasonable value" of services provided to MCO enrollees in the absence of a contract between a hospital and an MCO. The Temple decision involved the predecessor to Act 68. That court was not faced with statutory interpretation. That case involved the application of common law unjust enrichment. That court found in favor of Temple University hospital determining that it was entitled to recover the "reasonable value of the benefit conferred," [21] the traditional measure of damages for an unjust enrichment claim under Pennsylvania law. [22]

The Temple court rejected the argument that Medicaid Rates established the "reasonable value of the benefit conferred," noting that the MCOs' own expert testified that those rates were significantly lower than the actual costs of providing the services. The Superior court held that "reasonable value" in the context of an unjust enrichment claim was "the value actually paid by the relevant community [of] hospital patients who are covered by insurance policies and Federal programs."[23]

---

19. This basic fact of economics is exemplified in the old joke: "we lose money on every sale but we make it up in volume."

20. 2003 Pa. Super. 332, 832 A.2d 501 (2003).

21. Temple, 832 A.2d 508 quoting Mitchell v. Moore, 1999 Pa. Super. 77, 729 A.2d 1200 (1999).

22. A claim for unjust enrichment requires that plaintiff demonstrate the following elements: 1) benefits conferred on defendant by plaintiff; 2) appreciation of such benefits by defendant; and 3) acceptance and retention of such benefits under circumstances in which it would be inequitable for defendant to retain the benefit without payment of value. Schneck v. K.E. David Ltd., 446 Pa. Super. 94, 97-8, 666 A.2d 327, 328-9 (1995). This Court notes that the language "reasonable value" is not the statutory language involved herein, which is "reasonably necessary costs."

23. The court ultimately concluded that the hospital should be awarded the average charge for the services contained

In Hosp. & Healthsystem Ass'n of Pa. v. Dep't of Pub. Welfare, 585 Pa. 106, 888 A.2d 601 (2005)("HAP"), the Pennsylvania Supreme Court did interpret Act 68. HAP involved a dispute between DPW and a hospital trade association representing 250 acute care hospitals in Pennsylvania. A provision requiring non-participating providers to accept Medicaid rates for emergency services rendered to Medicaid enrollees had been inserted into the 2002-2003 General Appropriations Act ("GAA") before passage.[24] The Pennsylvania Supreme Court held that including this substantive change in a General Appropriations Act was unconstitutional. While procedurally determining unconstitutionality, the Supreme Court interpreted Act 68 to contain an implicit right of the parties to negotiate "reasonably necessary costs." The Supreme Court said:

> We view the legislature's attempt to impose [Medicaid Rates] as the rate non-plan providers such as [HAP] *must* accept for emergency services as an effort by the legislature to suspend Act 68's requirement that providers be paid "all reasonably necessary costs" for the period of time covered by the 2002 GAA. As asserted by [HAP], prior to the 2002 GAA, out-of-network providers could negotiate with MA MCOs for "reasonably necessary costs" associated with emergency services pursuant to Act 68 as the legislature failed to impose specific reimbursement rates for these services. After the passage of the 2002 GAA, these costs were capped at [Medicaid Rates]. Thus, unquestionably, the amount [HAP] could receive for out-of-network services to MA MCO members was subject to change because prior to the passage of the 2002 GAA out-of-network providers were not limited in negotiating for these services. In other words, out-of-network providers could receive *all* reasonably necessary costs for a given service, even if such cost exceeded [Medicaid Rates]. After the passage of the 2002 GAA, they could not.

---

in contracts with governmental agencies and insurance companies.

24. The exact language of the GAA provision is as follows:

> Whenever medical assistance recipients enrolled in the Department of Public Welfare's prepaid capitation program receive medically necessary emergency services, including, but not limited to, emergency transportation services and post-stabilization inpatient hospital services, provided by non-contracting service providers, such services shall be paid for by the contractor at the payment rates adopted by the department for equivalent services provided under the department's fee-for-service program. (Hosp. & Healthsystem Ass'n of Pa., 888 A.2d at 604 (*quoting* 2002 GAA at 123-124).

The Supreme Court specifically noted that the Legislature had not imposed any specific rates by Act 68. The Supreme Court correctly concluded that this evidenced a "reasoned policy of the Legislature that the parties, the MCOs and the providers, are in the best position to determine reasonably necessary costs on a case by case basis."[25] The Supreme Court discussed the Temple case:

> Although Temple did not specifically involve application of Act 68, we find significant the court's rejection of the assertion that [Medicaid Rates] necessarily equal reasonable costs for the provision of hospital services in the absence of a specific directive. As in this case, the provider in Temple was obligated to provide services to…MCO enrollees and, in the absence of a contracted-for rate for these services, the court concluded that equity required that the provider be paid the average actual cost for the services. These costs, the court concluded, were neither represented by [Medicaid Rates] or the provider's published rates, but fell somewhere in between the two.[26]

The Supreme Court recognized that Act 68 did not impose any default rate but allowed the parties to negotiate what the "reasonably necessary costs" were. When negotiations fail, litigation and proof to a finder of fact are required to determine the "reasonably necessary costs."

No default rate for "reasonably necessary costs" has been mandated by Act 68. Proper charges cannot be determined as a matter of law.[27] The legislation is clear and the act's words must be interpreted in their commonly understood non-technical meanings. The "reasonably necessary costs" for medical treatment are factual questions to be determined based upon presenting symptoms and services rendered at trial. The Supreme Court has confirmed this interpretation.

---

25. Notably, no further change in this requirement was ever enacted into law reflecting the legislature's acquiescence in this interpretation.

26. Hosp. & Healthsystem Ass'n of Pa., 888 A.2d at 615.

27. Indeed "reasonably necessary costs" necessarily differ by region and by institution. Salaries in Philadelphia may be higher than those in Crawford County. The UPHS may be more or less efficient than Hahnemann Hospital. A teaching and research hospital may necessarily pay higher salaries and may be financing state of the art equipment as

Trial of this case can be conducted by proof of reasonably necessary costs by procedure code. The burden of proof rests with plaintiff, UPHS, to demonstrate that the actual costs incurred are in excess of what has already been paid by Americhoice.[28]

Medical charges are routinely determined by procedure code. Based upon information provided by the parties the most frequent medical services included herein are "Vaginal delivery without complicating diagnosis"[29] "Normal Newborn"[30] and vaginal delivery with complicating diagnosis.[31]

Accordingly, a pretrial conference is scheduled for Friday, February 16, 2007, beginning at 9:30 a.m. in Room 530 City Hall, Philadelphia, Pennsylvania, for the purpose of determining how trial will proceed initially limited to medical services rendered under these three specific procedure codes.

BY THE COURT

_____

MARK I. BERNSTEIN, J

---

compared to a community hospital.

28. In their Memorandum, Americhoice concedes that whether the Medicaid Rate is sufficient to cover UPHS's reasonably necessary costs is a factual question: "Whether payment at the [Medicaid Rate] is sufficient to cover UPHS's 'reasonably necessary costs" has not yet been determined and will be the subject of expert testimony. Americhoice recognizes that UPHS's "reasonably necessary costs" may ultimately be found to be greater that [Medicaid] rate levels, in which case Americhoice will have to make some further payment to UPHS."

29. 198 incidents.

30. 145 incidents.

31. 52 incidents.