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IN THE SUPREME COURT OF TEXAS
AUSTIN, TEXAS

*In re* NORTH CYPRESS MEDICAL CENTER OPERATING CO., LTD.,

Relator

CRYSTAL ANN ROBERTS,

Real Party In Interest.

Original Proceeding from Cause No. 2016-17517
234th Judicial District Court of Harris County, Texas
Hon. Wesley Ward, Presiding

# BRIEF OF AMICUS CURIAE TEXAS HOSPITAL ASSOCIATION IN SUPPORT OF THE MOTION FOR REHEARING OF RELATOR North Cypress MEDICAL CENTER OPERATING CO., LTD.

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## TABLE OF CONTENTS

IDENTITY OF PARTIES AND COUNSEL ..... ii

TABLE OF CONTENTS.....iii, iv

TABLE OF AUTHORITIES .....v, vi

STATEMENT OF INTEREST AND CONCERN .....vii, viii

STATEMENT OF JURISDICTION.....ix

STATEMENT OF FACTS.....x

ARGUMENT.....1

I. THIS DISCOVERY DISPUTE AFFECTS MORE THAN THE IMMEDIATE PARTIES TO THE LITIGATION .....1

A. Disclosure of negotiated rates will likely violate contractual confidentiality provisions and privacy rights.....1

II. THE BURDEN CAUSED BY THE COURT'S DECISION UNDERMINES THE PUBLIC POLICY UNDERLYING THE TEXAS HOSPITAL LIEN LAW ..... 4

A. The Texas Hospital Lien Law ensures that individuals injured by the actions of third parties have access to necessary treatment in hospitals ..... 4

III. THIS COURT FAILED TO CONSIDER THE FULL PURPOSE OF THE CHARGE DESCRIPTION MASTERANDERRONEOUSLY CONCLUDED THAT HOSPITAL CHARGES ARE ARBITRARILY SET..... 8

A. Hospitals must comply with applicable law ..... 8

B. The CDM is not arbitrarily set, and may or may not affect the amount the hospital is paid for a service ..... 9

C. The full CDM rates can apply to insured patients ..... 11

CONCLUSION AND PRAYER ..... 13

CERTIFICATE OF SERVICE..... 14, 15

# TABLE OF AUTHORITIES

## CASES

*Baylor Univ. Med. Ctr. v. Borders,*
581 S.W.2d 731 (Tex. App. – Dallas, 1979) ..... 4

*In re CI Host, Inc.,*
92 S.W.3d 514 (Tex. 2002) .....1, 2

*In re N. Cypress Med. Ctr. Operating Co., Ltd.,*
2018 WL 1974376, (Tex. Apr. 27, 2018) .....9, 10

## STATUTES

42 U.S.C. §1395dd (2016) .....5

Tex. Civ. Prac. & Rem Code Ann. §18.001 (West 2018) .....7

Tex. Health & Safety Code Ann. §311.022 (West 2018).....5

Tex. Ins. Code Ann. §552.003 (West 2018)..... 8

Tex. Prop. Code Ann. Chapter 55 (West 2018) .....vii, 4

Tex. Prop. Code Ann. §55.003(a) (West 2018) ..... 6

Tex. Prop. Code Ann. § 55.003(b)(2) (West 2018) .....4, 5

## OTHER AUTHORITY

Federal Register: *Medicare-Participating Hospitals Treating Individuals with Emergency Medical Conditions (Sept. 9, 2003)* .....5

Federal Register: *Hospital Emergency Services Under EMTALA (Aug. 19, 2008)*.....5

Texas Health and Human Services Commission: *Hospital Uncompensated Care Report (2015)* ..... 6

The Centers for Medicare and Medicaid Services: *Medicare Secondary Payer* (Jan. 30, 2014)..... 11

## STATEMENT OF INTEREST AND CONCERN

The Texas Hospital Association ("THA"), as a representative of over 465 member hospitals in Texas, is vitally interested in and concerned about the matters before this court, which will affect the delivery of care and treatment to individuals, and the operations and financial viability of Texas hospitals. There are 647 general and special hospitals within that provide a wide array of healthcare services to the communities they serve. Approximately 2.85 million patients are admitted as inpatients into Texas hospitals each year, and hospital emergency room admissions total over 11.6 million per year. The issue before this court, relating to a statutory hospital lien filed under Chapter 55 of the Texas Property Code (the "Texas Hospital Lien Law"), and the reasonableness of the charges secured by such liens, is of great interest and concern to THA and its member hospitals.

The court's April 27, 2018 decision in the instant case ignores the full effect of the underlying discovery dispute on third parties, and discourages the use of proper liens by hospitals. The court's decision frustrates the purpose of the Texas Hospital Lien Law – to secure payment for necessary treatment rendered by hospitals to persons injured by other persons –

because a hospital's burden to defend its charges as reasonable will become unsustainable.[1]

THA has paid all fees associated with the submission of this amicus brief.

[1] The brief submitted by *Amicus* Americans for Patient Access contains examples of the discovery requests propounded on healthcare providers, as a direct result of this Court's April 27, 2018 decision. Several members have advised THA that their hospitals have received similar extensive and abusive discovery requests – and in cases that do not involve a hospital lien but where charges are in dispute.

## STATEMENT OF JURISDICTION

The court has jurisdiction of this case pursuant to TEX. GOV'T CODE ANN. § 22.001. This is an appeal from the 234th District Court, Houston, Texas.

## STATEMENT OF FACTS

Crystal Ann Roberts sought and received treatment at North Cypress Medical Center following an automobile accident. Roberts did not have health insurance, and North Cyprus sent Roberts a bill for the care and services provided. North Cypress also filed a hospital lien notice for those same services, as permitted by the Texas Hospital Lien Law.

In settlement negotiations with the at-fault driver's liability insurer, Roberts ostensibly presented North Cypress's full charges as a basis for damages. Roberts also sought to reduce the amount billed by North Cypress. North Cypress complied with this request and presented at least one reduced bill. However, Roberts unilaterally deemed the reduction to be inadequate and filed suit against North Cypress, claiming, among other things, that the billed and reduced charges were unreasonable.

Before the trial court, Roberts sought the production of North Cypress's negotiated rates with Medicare, Medicaid, and commercial insurers, as somehow related to the care, treatment, and services received by Roberts. Despite objections that Roberts was uninsured, North Cypress was ordered to produce the reimbursement rates – many of which were negotiated with individual insurers and subject to confidentiality provisions. The relevance of these negotiated rates, which are contractually inapplicable to Roberts, is the issue now before this court.

## ARGUMENT

### I. THIS DISCOVERY DISPUTE AFFECTS MORE THAN THE IMMEDIATE PARTIES TO THE LITIGATION

#### A. Disclosure of negotiated rates will likely violate contractual confidentiality provisions and privacy rights.

This court previously considered the serious potential for discovery requests to infringe on third parties' privacy rights. *See In re CI Host, Inc.*, 92 S.W.3d 514 (Tex. 2002). There, the court weighed a similar request where the trial court ordered discovery over objections that the "request was overbroad and demanded confidential information, trade secrets, and information beyond the scope of discovery." *Id.* at 515. Although the party subject to the discovery request did not meet its burden to support its objection before the trial court, at argument before this court, both parties acknowledged that the information sought contained protected and confidential information belonging to third parties. *Id.* at 517. In recognizing that "others may be detrimentally affected or even abrogated by disclosure of some information" and that "discovery rules do not require notice to third parties so that they might have an opportunity to be heard on their own objections," the court stated that it is "loath to allow [a party] to unilaterally waive [other's] privacy rights by its failing to adhere to the discovery rules." *Id.* (citing *Cf. Eli Lilly & Co. v. Marshall*, 850 S.W.2d 155, 160 (Tex. 1993)

(taking into account compelling public interests in determining scope of discovery in products-liability suit)).

The instant case presents similar facts.[2] A hospital's reimbursement rates are negotiated between a hospital and each individual insurer, are contractually defined, and are usually subject to strict confidentiality provisions. Requiring North Cypress, or any hospital, to disclose mutually agreed-upon terms would render negotiations between the hospital and each insurer meaningless because: (1) those negotiated terms and reimbursement rates will be subject to third-party disclosures, which would force hospitals and insurers to surrender total control of the information and documents, and (2) non-beneficiaries, who do not pay premiums in exchange for health insurance coverage, would be entitled to the benefits of those negotiations by virtue of simply being injured by a negligent party, who also does not pay premiums for health insurance and should not benefit from negotiations between the hospitals and insurers. The disclosure of contractually-defined confidential information would force a violation of applicable confidentially provisions, and would not be adequately protected through the use of a protective order due to the breadth and amount of litigation involving hospital charges, as discussed by other *Amici*.

[2] Relator and several *Amici* argue that the discovery sought by Roberts is irrelevant, overbroad, and seeks information that is confidential and not reasonably calculated to lead to admissible evidence. THA agrees.

As in the *CI Host* case, the court should fully consider the interests of third parties affected by the instant discovery dispute. Failure to seriously consider the effect of forcing the production of confidential, negotiated contract terms would upend longstanding business practices between hospitals and insurers, and alter the manner in which healthcare is reimbursed and delivered. The potential fallout from such disclosure would be immeasurable. At a very basic level, North Cypress would be forced to choose between three inadequate options:

1. In an attempt to obtain *some* to-be-determined reimbursement (likely less than both the billed and reduced charges), disclose reimbursement rates subject to confidentiality provisions, thus breaching contractual confidentiality provisions;
2. Accept an amount arbitrarily set by Roberts as reimbursement; or
3. Release the underlying lien, likely foregoing payment altogether, to avoid a forced breach of confidentiality provisions.

Each of these options would discourage a hospital from continuing the provision of care subject to a hospital lien, and perhaps care to uninsured patients altogether. Because of this, the court should require the trial court to fully consider the issues and third-party rights involved in the instant dispute prior to a final decision.

## II. THE BURDEN CAUSED BY THE COURT'S DECISION UNDERMINES THE PUBLIC POLICY UNDERLYING THE TEXAS HOSPITAL LIEN LAW.

### A. The Texas Hospital Lien Law ensures that individuals injured by the actions of third parties have access to necessary treatment in hospitals.

The Texas Hospital Lien Law serves the narrow but important public policy of maintaining access to necessary services and treatment for injured persons, and securing payment for those services when the injuries are caused by a third party found liable for the injuries by way of settlement or judgment. As one court noted, the Texas Legislature's intent in enacting Chapter 55 of the Texas Property Code "was to provide for payment to the hospital in situations [where an individual is injured by a third party]." *Baylor Univ. Med. Ctr. v. Borders*, 581 S.W. 2d 731, 733 (Tex. App.—Dallas, 1979). "Giving the hospital a separate cause of action to satisfy its lien insures that an accident victim will receive aid and that the hospital will be reimbursed for its services, thus reducing hospital costs." *Id.* The legislature recognized that accident victims treated by hospitals for their injuries will have varying degrees of ability to pay for those services, and that "hospitals needed a means of reimbursement without instituting suits against indigents, where recovery was unlikely." *Id.*

Moreover, a hospital's lien may <u>not</u> attach to "the proceeds of an insurance policy in favor of the injured individual . . . ." *See* Tex. Prop. Code

Ann. §55.003(b)(2) (West 2018). This exclusion furthers the Legislature's intent that a hospital's lien exists for the benefit of providing aid and services to uninsured accident victims, as a lien may be the only mechanism for a hospital to be reimbursed.

In addition, under federal and state law, hospitals must provide emergency care, treatment, or services to any person who arrives at the hospital, regardless of the person's financial status or ability to pay. *See* Tex. Health & Safety Code §311.022 (West 2018); and the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. §1395dd (2016). These obligations cease once a patient's emergency medical condition has stabilized or the patient is admitted as an inpatient;[3] however, accident victims may require continued hospitalization or care. A hospital's lien allows for the continued provision of care beyond the stabilization of the emergency condition, with the understanding that the lien will secure payment for the hospital's continued services.[4] It is important to note that a hospital's lien may only attach to the injured party's cause of action for damages against the at-fault party, a judgment in favor of the injured party,

[3] *See* Medicare-Participating Hospitals Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,221 (Sept. 9, 2003), and Hospital Emergency Services Under EMTALA, 73 Fed. Reg. 48,654 (Aug. 19, 2008).

[4] The Brief submitted by *Amicus* Americans for Patient Access contains an explanation of the larger billing and reimbursement matrix, and the potential effects and scope of the court's majority opinion.

or the proceeds of a settlement for the injured party. *See* Tex. Prop. Code Ann. §55.003(a). The lien cannot attach to the injured person's personal property, real property, or anything else other than the injured person's tort action. *Id*. In plain terms, the hospital's lien is only as good as the injured party's recovery.

Moreover, Texas leads the nation in the percentage of individuals who are uninsured, and many of these individuals do not have the financial resources to pay for the care they need and receive in hospitals.[5] In 2015 alone, Texas hospitals provided $23.4 billion in uncompensated care, with a $6.6 billion shortfall.[6] As set forth above, the court's decision will subject hospitals to onerous discovery requests and will leave hospitals with less incentive to provide services to uninsured accident victims beyond what is required by law. Roberts' attorney claims "there was no mechanism to dispute [a hospital's] bills."[7] This is not true: the current process for presenting, supporting and controverting the cost and necessity of services

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[5] Jenny Deam, *U.S. Census: Texas Uninsured Rate Dropped to 16.6 Percent Last Year*, The Houston Chronicle (Sept. 12, 2017), https://www.chron.com/business/medical/article/U-S-Census-Texas-uninsured-rate-dropped-to-16-12191505.php

[6] Texas Health and Human Services Commission, Hospital Uncompensated Care Report (2015); https://hhs.texas.gov/sites/default/files/rider35-hospital-uncompensated-care-report.pdf

[7] John Council, Lien On Me: Reimbursement Rates Ruling Seen as a Game-Changer For Medical Billing Litigation, Texas Lawyer (May 24, 2018), https://www.law.com/texaslawyer/2018/05/24/lien-on-me-reimbursement-rates-ruling-seen-as-game-changer-for-medical-billing-litigation/

allows providers and experts to debate a hospital's claims without onerous discovery requests for confidential information, and, in comparison to the process that will result from this court's decision, is minimally burdensome. *See* Tex. Civ. Prac. & Rem. Code Ann. §18.001 (West 2018).

The forced disclosure of a hospital's negotiated reimbursement rates, which are not applicable to uninsured patients (the very individuals intended to benefit from a hospital's lien), would devalue a hospital's lien and force a hospital to either reduce the services they provide to their community, or shift the additional unpaid amounts to other private payers or local taxpayers. A personal injury attorney who reviewed this court's holding for the Texas Trial Lawyers Association opined that the court's decision "has the potential to have far-reaching implications, not just for hospital lien disputes, but also for any contract or tort case where there is a debate about what are the reasonable medical expenses," and predicted that "medical providers will not want to endure the hassle [and] will be even less likely to accept personal injury patients" and that "the ultimate effect will be less access to quality medical care for injury victims, which is unfortunate."[8] Such a result is not in the best interest of patients, hospitals or the community served, nor is it consistent with the intent and purpose of the Texas Hospital

[8] *See* Council, *supra* note 7 (quoting attorney Dan Christensen).

Lien Law. This court's decision forces hospitals to choose between the Scylla of violating proprietary and confidential contractual arrangements or the Charybdis of accepting whatever payment the injured party offers, to avoid burdensome discovery.[9] The hospital could also forego a lien altogether, which means waiving a substantive right to payment underpinned by decades-old legislatively-enacted public policy that a hospital should be paid when it treats injured accident victims.

## III. THIS COURT FAILED TO CONSIDER THE FULL PURPOSE OF THE CHARGE DESCRIPTION MASTER AND ERRONEOUSLY CONCLUDED THAT HOSPITAL CHARGES ARE ARBITRARILY SET.

### A. Hospitals must comply with applicable law.

Texas law prohibits a hospital from knowingly or intentionally charging different prices for the same service. *See* Tex. Ins. Code Ann. §552.003 (West 2018). Considering the range of services provided by any one hospital and the potential number of patients any one hospital could treat, there must be a mechanism for each hospital to bill consistently for its

[9]*Amici* Parkland Health and Hospital System, Hunt Regional Medical Center, and Americans for Patient Access have provided the Court with examples of the types of discovery requests that have been received by Texas hospitals. As these requests become commonplace within and outside the context of lien cases, it is not hard to imagine how hospital business offices could become paralyzed by the burden of responding or objecting to the requests. At a minimum, time and resources will be diverted toward responding or objecting to the requests as required by law.

services. Simply put, the hospital's charge description master ("CDM," also known as the "chargemaster") is that mechanism.

The CDM is the central repository for potentially tens of thousands of charges, rates, modifiers and other information related to any particular service. It contains billing and revenue codes, including: Current Procedural Terminology ("CPT"), Healthcare Common Procedure Coding System ("HCPCS"), International Statistical Classification of Diseases and Related Health Problems ("ICD"), Diagnostic Related Groups ("DRG"), Ambulatory Payment Classifications ("APC"), and other codes. As a result, through the CDM *every* patient is billed the same amount for similar services, which includes a full itemized description and billing codes or other information required for reimbursement from payers. The CDM ensures a similar bill for similar services, and thereby a hospital's compliance with law.

### B. The CDM is not arbitrarily set, and may or may not affect the amount the hospital is paid for a service.

This court's opinion contains assertions regarding the CDM that would benefit from additional explanation. For example, the court recognizes "that many considerations go into negotiated rates that may explain a discount applied to a particular insurer." *In re N. Cypress Med. Ctr. Operating Co., Ltd.*, 2018 WL 1974376, at *6 (Tex. Apr. 27, 2018). Nonetheless, the court also finds "that hospitals are pressured to set these charges as high as

possible because reimbursement rates typically increase along with them," leading to an "increasingly arbitrary nature of chargemaster prices" *Id.*, at *3. This is not necessarily true. The methodology used by hospitals to set their respective CDMs is not arbitrary, and prices may be developed by analyzing the cost and overhead involved in providing a service by basing a CDM on an analysis of the local market, by using a hybrid of both analyses, or by relying on other factors unique to the hospital's circumstances. Whatever method a hospital uses takes into account many considerations inherent to providing care and treatment to patients. These methods are complex and difficult to understand, but to characterize them as arbitrary would be inaccurate.

Further, while hospitals do negotiate rates with insurers, many times those reimbursement rates have no correlation to the CDM. An insurer's reimbursement rates may be charge-sensitive, which means the reimbursement is a pre-determined percentage of the CDM charge. However, another common reimbursement methodology involves a case rate – meaning that a hospital is paid a flat rate for a service or group of services related to a specific diagnosis. With case-rate reimbursement, an increase in the CDM charge does not correlate to increased reimbursement. In addition, in most cases hospitals are contractually restricted from increasing CDM rates. For example, insurers may prevent rate increases by limiting the

percentage that a CDM's rate can rise and may only allow for one increase every 12 months.

### C. **The full CDM rates can apply to insured patients.**

Where another party or insurer may have responsibility to pay for care provided to a patient, such as when a patient is insured but injured by a third party, the patient's healthcare insurer will usually decline to reimburse the hospital for services provided. The hospital and patient are left to secure primary payment from the responsible party or insurer.

The Centers for Medicare and Medicaid Services ("CMS") uses similar methodology under the Medicare Secondary Payer ("MSP") policy "when the Medicare program does not have primary payment responsibility – that is, when another entity has the responsibility for paying before Medicare."[10] The MSP program exists to "shift costs from Medicare to the appropriate private sources of payment," and ensures that "Medicare does not pay for items and services that certain health insurance or coverage is primarily responsible for paying."[11] Where there is another avenue to recoup costs expended for care or treatment provided to an individual, Medicare forces the responsible insurer to make primary payment. In such cases, whatever CMS would

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[10] The Centers for Medicare and Medicaid Services, "Medicare Secondary Payer" (Jan. 30, 2014) - https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

[11] *Id.*

reimburse the hospital is irrelevant – the hospital must bill the responsible insurer, and can only do so using the full CDM rates, with the parties free to negotiate what will actually be paid to the hospital.

In any situation where the hospital and insurer do not have a negotiated reimbursement structure in place, including where a patient's insurer has not contracted with the hospital (also known as being "out of network"), the hospital can only bill through the CDM, and at full rate. A liability insurer could certainly negotiate reimbursement rates with any given hospital, similar to healthcare insurers, as all insurers would benefit from those negotiations and avoid the issues presented in the instant case. However, in the absence of a contracted rate, such as in the instant case, a hospital is forced to bill the responsible party at the full CDM rate and offer to negotiate an amount for reimbursement that fairly compensates the hospital for care and services provided. In such cases, it would be arbitrary to *disregard* the CDM rate, and, contrary to the court's prior ruling, the amounts that would be paid to the hospital under its managed care contracts is wholly irrelevant to such disputes.

## CONCLUSION AND PRAYER

Based on the legal and policy arguments presented in this brief, *Amicus Curiae* respectfully requests that this court reconsider its holding, delivered on April 27, 2018, fully consider the effect of this dispute on third parties, and issue an order granting mandamus relief as requested by Relator.

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE WITH RULE 52.3(j)

I certify that I have reviewed this Amicus Curiae Brief on behalf of the Texas Hospital Association and that I have concluded that every factual statement herein is supported by competent evidence.

By: /s/ Cesar J. Lopez
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## CERTIFICATE OF COMPLIANCE WITH RULE 9.4(i)(3)

I hereby certify according to my word processor's word-count function, in the sections of this document covered by TRAP 9.4(i)(1), there are 2981 words

By: /s/ Cesar J. Lopez
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## CERTIFICATE OF SERVICE

I hereby certify that on this 29th day of June, 2018, a true and correct copy of the foregoing instrument was delivered electronically to:

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Signed this 29th day of June, 2018.

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