PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2001-D19

PROVIDER -
St. Mary=s Hospital and Medical Center
San Francisco, CA

Provider No. 05-0457

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

DATE OF HEARING-
March 23, 2001

Cost Reporting Period Ended -
June 26, 1988

CASE NO. 91-1844

INDEX

ISSUE:

Did the Intermediary properly adjust outpatient surgery, anesthesia and supply charges?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary=s Hospital and Medical Center (AProvider≅) is a short-term, general service, acute care hospital located in San Francisco, California. On its fiscal year ended (AFYE≅) June 26, 1988 cost report, the Provider grossed-up its charges for its Medicare outpatient surgery, anesthesia, and supplies and used the grossed-up figure for apportionment purposes. Blue Cross and Blue Shield of California (AIntermediary A) adjusted the Provider=s charges to agree with the summary of paid claims report (APS&R report≅). The Provider filed a timely appeal with the Provider Reimbursement Review Board (ABoard≅) pursuant to 42 C.F.R. ээ 405.1835-.1841. The Medicare reimbursement at issue is approximately $100,000.

The Provider renders inpatient and outpatient surgery in the same surgical suites using the same staff, equipment, and supplies. Due to competition in the area, the Provider established charges for its outpatient surgical services, including those related to anesthesia and supplies, at a lower rate than the corresponding inpatient charges. Although the charges are less for outpatients, the costs for both inpatient and outpatients is the same. The surgical procedure charges are based upon time and staffing levels. The minimum staffing level is used for both inpatient and outpatient procedures. The Provider grossed-up its outpatient charges to the comparable level of its inpatient charges in order to provide for proper cost apportionment to outpatient services and the Medicare program.

The Intermediary adjusted the charges to agree with the PS&R report, which reflected the Provider=s billed charges for outpatient services.

The Provider was represented by Thomas P. Knight, President of Toyon Associates, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate general counsel of the Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Provider notes that the Board has previously ruled on this issue for this Provider for another fiscal year. See St. Mary=s Hospital and Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Case No. 98-D45, April 24, 1998, Medicare and Medicaid Guide (CCH) & 46,271, HCFA Administrator declined review, June 1, 1998 (ASt. Mary=s≅). The Provider indicates that it believes that the Board reached the correct decision in St. Mary=s and should make a similar finding in the instant case.

The Provider contends that the Intermediary is responsible for evaluating the Provider=s

charging practices to ascertain whether they may serve as an equitable basis for apportioning costs. In order for a Provider=s charges to be acceptable for apportioning costs, the charge structure must be applied uniformly to each patient, whether inpatient or outpatient, and the charges must be reasonable and consistently related to the cost of the services. Since the Provider=s charging practice for outpatient surgery is different from its charging practice for inpatient surgery, the Provider asserts that its surgery, anesthesia, and supply charges must be adjusted in order to promote proper and equitable cost apportionment. The Provider contends that the regulations at 42 C.F.R. ээ 413.5, 413.50, 413.53 and manual provisions at HCFA Pub. 15-1 ээ 2204, 2203 and 2302.6 support its position that charges used for cost apportionment must be adjusted.

The Provider proposes that the charges for its outpatient surgical services be increased or grossed-up to the level of equivalent inpatient charges. This charge gross-up includes all surgical outpatients including Medicare patients. The proposed gross-up involves increasing the total charges reflected on Worksheet C of the cost report as well as increasing the Medicare outpatient charges.

The Provider contends that the gross-up principle is well established and has been the subject of a number of Board and court decisions. In general, these cases find that grossing-up of charges is required for proper apportionment. In Madison Avenue Hospital v. The Travelers Insurance Company, PRRB Dec. No. 79-D10, March 5, 1981, Medicare and Medicaid Guide (CCH) & 29,654, declined rev. HCFA Administrator, December 9, 1981, a hospital charged a lower rate for use of the operating room for abortion patients than for other patients. The Board found that grossing-up abortion patient charges to the level of other patients was necessary under HCFA Pub. 15-1 э 2302.[1] In St. Mary=s Hospital Medical Center v. Heckler, 753 F.2d 1362 (7th Cir. 1985), a hospital charged a lower rate for laboratory services to outside patients than it charged for its hospital patients. The court concluded that the outside patient laboratory services must be grossed-up because the hospital could not document that the cost of the outside laboratory services were any different than the cost of its other laboratory services.[2] In Tri-County Hospital v. Heckler, Civ. No. 83-2638, (D.D.C. April 18, 1985), Medicare and Medicaid Guide (CCH) & 34,604, a hospital charged a lower rate for pharmacy services to its outpatients, nursing home residents and over-the-counter patients, than it charged its inpatients. The court held that the lower rate for pharmacy services had to be grossed-up to the level charged to the hospital patients in order to establish a uniform charge structure for cost apportionment purposes, because the hospital could not document that the cost of the lower rate services were any different from the cost of the same services for inpatients.[3] In Glencoe Municipal Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 89-D4,

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[1] See Provider Exhibit 2.

[2] See Provider Exhibit 8.

[3] See Provider Exhibit 9.

November 22, 1988, Medicare and Medicaid Guide (CCH) & 37,530, declined rev. HCFA Administrator, December 23, 1988, a hospital charged a lower rate for laboratory services to non-provider patients than what it charged its own patients. The Board concluded that the charges for laboratory services furnished to the non-provider patients had to be grossed-up to the same level as those of the provider=s patients.[4]

In the instant case, the Provider established a lower charge for outpatients than inpatients and acknowledges that the costs for both were the same. Therefore, for proper apportionment of cost, the outpatient costs must be grossed-up to the level of inpatients. The Provider presented the method it used to gross-up.[5]

The Provider notes that the Intermediary in St. Mary=s suggested that if the Provider was permitted to gross-up its outpatient Medicare charges then there would also have to be a gross-up of the 20 percent coinsurance amount which applies to outpatient Part B services. The Provider indicates that the Part B coinsurance is to be reported based upon the actual amount billed to the patient and should not be changed. The Provider states that there is no rule directing the gross-up of the coinsurance amount and the charge gross-up requested by the Provider was solely for the purpose of correcting the cost apportionment process and should have no impact on the coinsurance amount.

In addition, the Provider claims that the Intermediary has not challenged its facts about its charge structure or its gross up calculation. The Provider claims that the Intermediary is responsible for evaluating the charging practices and should allow adjustments where it is shown that it would be equitable to do so.

INTERMEDIARY'S CONTENTIONS:

The Intermediary indicates that it reconciled the settlement data in the Provider=s as-filed cost report to the PS & R report. The Intermediary contends that the Provider did not demonstrate with compelling evidence that the PS&R report used by the Intermediary was inaccurate, erroneous or unacceptable for cost reporting purposes, pursuant to HCFA Pub 13-2 ээ 2241-2243. The Intermediary asserts that the PS&R report serves as the best source of settlement data for purposes of apportioning allowable costs of services to beneficiaries, pursuant to 42 C.F.R. э 413.50 and 413.53, and determining Program payments, pursuant to 42 U.S.C. ээ 1395f(b) and 1395g, 42 C.F.R. ээ 413.60 and 413.64 and HCFA Pub. 15-1, Chapter 24.

The Provider did not demonstrate with compelling evidence that certain fiscal year 1988 claims were not included in the PS&R report. It is the Provider=s responsibility to prove that such claims have not been processed for payment by the intermediary. The Intermediary indicates

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[4] See Provider Exhibit 10.

[5] See Provider Exhibit 11.

that the Provider has not reconciled its records, logs or remittance advice to the PS&R report or furnished any supporting documentation.

The Intermediary indicates that it has not previously determined if the gross-up of outpatient charges is necessary. In this regard, however, the Provider has not furnished information or documentation to the Intermediary to support the grossing up of charges, pursuant to 42 C.F.R. ə 413.53 and HCFA Pub. 15-1 əə 2202.4 and 2302.6. The Intermediary states that since the Provider has not furnished adequate information or documentation to support its contentions, its determination was in accordance with 42 C.F.R. əə 413.20 and 413.24 and HCFA Pub. 15-1 əə 2300 and 2304 and should be affirmed.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS

1. Laws - 42 U.S.C.:

ə 1395f(b)	-	Amount Paid to Providers
ə 1395g	-	Payment to Providers of Services

2. Regulations - 42 C.F.R.:

əə 405.1835-.1841	-	Board Jurisdiction
ə 413.5	-	Cost Reimbursement: General
ə 413.20	-	Financial Data and Reports
ə 413.24	-	Adequate Cost Data and Cost Finding
ə 413.50	-	Apportionment of Allowable Costs
ə 413.53 et seq.	-	Determination of Cost of Services to Beneficiaries
ə 413.60	-	Payments to Providers: General
ə 413.64	-	Payments to Providers: Special Rules

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

ə 2202.4	-	Charges
ə 2203	-	Provider Charge Structure as a Basis for Apportionment
ə 2204	-	Medicare Charges
ə 2300	-	Adequacy of Cost Data and Cost Finding
ə 2302 et seq.	-	Charges
ə 2304	-	Adequacy of Cost Information
Chapter 24	-	Payments to Providers

4. Medicare Part A Intermediary Manual, Part 2 (HCFA Pub. 13-2):

ə 2241	-	Provider Statistical and Reimbursement System
ə 2242	-	Intermediary Use of PS&R System Report In Cost Settlement Process
ə 2243	-	Description of Reports Available From Standard PS&R System

5. Cases:

Glencoe Municipal Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 89-D4, November 22, 1988, Medicare and Medicaid Guide (CCH) & 37,530, declined rev. HCFA Administrator, December 23, 1988.

Madison Avenue Hospital v. The Travelers Insurance Company, PRRB Dec. No. 79-D10, March 5, 1981, Medicare and Medicaid Guide (CCH) &29,654, declined rev. HCFA Administrator, December 9, 1981.

Oregon 90 Coinsurance Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, PRRB Case No. 96-D29, April 26, 1996, Medicare and Medicaid Guide (CCH) & 44,168, rev=d HCFA Administrator, June 24, 1996, Medicare and Medicaid Guide (CCH) & 44,591.

St. Mary=s Hospital Medical Center v. Heckler, 753 F.2d 1362 (7th Cir. 1985).

St. Mary=s Hospital and Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Case No. 98-D45, April 24, 1998, Medicare and Medicaid Guide (CCH) & 46,271, HCFA Administrator declined review, June 1, 1998.

Tri-County Hospital v. Heckler, Civ. No. 83-2638, (D.D.C. April 18, 1985), Medicare and Medicaid Guide (CCH) & 34,604.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, finds and concludes as follows:

The Board after considering the facts, parties= contentions and documentary evidence presented, finds and concludes that it was proper for the Provider to gross-up its outpatient surgery charges to match those of its inpatient surgery charges and utilize these grossed-up charges to apportion inpatient and outpatient costs.

The Board has previously noted that the amount the Medicare program will reimburse a provider is determined by a four step process. See Oregon 90 Coinsurance Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, PRRB Case No. 96-D29, April 26, 1996, Medicare and Medicaid Guide (CCH) & 44,168, rev=d HCFA Administrator, June 24, 1996, Medicare and Medicaid Guide (CCH) & 44,591. The first step is the identification of allowable costs. The second step is the allocation of overhead costs. The third step is the apportionment of allowable costs between Medicare and non-Medicare patients. The fourth step involves settlement of the Medicare program=s liability by subtracting the applicable beneficiary coinsurance and deductibility amounts from the provider=s Medicare allowable costs.

Medicare program regulations at 42 C.F.R. ə 413.53(A) provide for the apportionment of reasonable costs and state that A[t]otal allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based on actual services received by program beneficiaries.≅ The regulations further state that A>[a]pportionment= means an allocation or distribution of allowable cost between the beneficiaries of the health insurance program and other patients.≅ 42 C.F.R. ə 413.53(b). A provider=s ancillary costs are apportioned based upon the charges incurred by Medicare beneficiaries to total charges incurred by all hospital patients for each ancillary department.

In the instant case, the Board finds that the Provider=s inpatient and outpatient surgical patients utilized the same staff, equipment and supplies for a number of surgical procedures and incurred similar costs. The Board also finds that, due to competition, the Provider established a lower

charge for its outpatients. The Board notes the manual instructions dealing with utilization of a provider=s charge structure as a basis of apportionment provides, in part, that A[w]hile the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not charges are allowable in apportioning costs under the program.≅ HCFA Pub. 15-1 ə 2203. It is not appropriate to utilize the ratio of charges to cost used for apportionment purposes, where charges have not been uniformly applied to all patients. When differences in charges exist, providers are required to record all charges used for apportionment at their gross value. HCFA Pub. 15-1 ə 2202.4. The purpose of grossing-up charges is to insure proper apportionment of costs between Medicare and non-Medicare patients. The Board also notes that grossing-up of charges for apportionment is consistent with generally accepted accounting principles. Therefore, the Board finds that it was proper for the Provider to gross-up its outpatient surgery charges to match those of its inpatient surgery charges and utilize these grossed-up charges to apportion inpatient and outpatient costs.

DECISION AND ORDER:

The Intermediary adjustments disallowing the Provider=s grossing up of its outpatient surgery charges for apportionment purposes was improper. The Intermediary=s adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire (Dissenting Opinion)
Martin W. Hoover, Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: April 25, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman, Esquire

St Mary=s Hospital and Medical Center

I respectfully dissent. I continue to hold the view that both sides of the apportionment equation - charges and co-pay, must either be uniformly Agrossed up≅ in order to accurately reflect the appropriate relationship of charges to co-pay, or both need to be left unmanipulated. Documentation in the instant case leaves me unclear as to what manipulation, if any, was applied to the Aco-pay≅ side of the equation. Lacking such evidence of an equalizing manipulation of the apportionment equation, I dissent.

As I stated in my dissent in St.Mary=s Hospital and Medical Center v. Blue Cross and Blue shield Association/Blue Cross of California, PRRB Case No. 98-D45, April 24, 1998, Medicare and Medicaid Guide (CCH) & 46,271 (ASt. Mary=s≅), my logic is rooted in the concept of Areasonable cost≅ and Afair share≅ as codified at 42 USC 1395x(v)(1)(A). This statute is intended to assure comparability of payment for efficiently delivered health care services between Medicare and non-Medicare recipients.

The question of Agrossing up≅ charges to meet the comparability requirements of 42 U.S.C. 1395x(v)(1)(A), the issue in this case, presents a well-marked analytical trail. Beginning in 1979, the PRRB upheld the Intermediary=s Agrossing up≅ of a Provider=s non-uniform charges to effectuate comparability. Madison Avenue Hospital v. The Travelers Insurance Company, PRRB Dec. No. 79-D10, March 5, 1979. In 1985, the U.S. Court of Appeals, Seventh Circuit (St. Mary=s Hospital Medical Center v. Heckler, 753 F.2d 1362 (7th Cir. 1985)) and the U.S. District Court for the District of Columbia (Tri-County Hospital v. Heckler, Civ. No. 83-2638, (D.D.C. April 18, 1985)) both upheld Intermediary Agrossing up≅ of

Provider charges to equalize cost apportionment for Medicare payment calculation. In 1988, the PRRB reaffirmed the Agrossing up≅ methodology implemented by the Intermediary. Glencoe Municipal Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 89-D4, November 28, 1988. To this point, then, the Agross up≅ analytical trail has been notched by the Intermediary, the PRRB, the HCFA Administrator (by declining review), and the Courts - all recognizing the necessity to Agross up≅ lower charges for comparability in determining the ratio for cost allocation between Medicare and non-Medicare recipients.

Regulations promulgated by HCFA to address cost equitableness are found primarily in HCFA Pub. 15-1 Section 2203 - - Provider Charge Structure as Basis for Apportionment. Basically, this Section requires that A . . each facility should have an established charge structure which is applied uniformly . . and . . consistently related to the cost . .≅ Further, in HCFA Pub. 15-1 Section 2314.B - - Limitation of Allocation of Indirect Costs Where Ancillary Services Are Furnished Under Arrangements, one method of equalizing charges is that of Agrossing up≅ the

charges of lower non-Medicare clients to meet Medicare. Ostensibly, the Manual states that such Agrossing up≅ can be used Aif the intermediary determines that a provider is able to≅; but upon condition that A . . the provider must receive the intermediary=s written approval within 90 days after the beginning of the cost reporting period.≅ Id.

In the 1998 ASt. Mary=s≅, the Intermediary offered two basic contentions. One was that it is the Intermediary=s call, not the Provider=s, to employ the Agrossing up≅ methodology of comparability. Referring to the third sentence of HCFA Pub. 15-1, Section 2203, the Intermediary notes that A . .whether to adjust the charges or lower the provider=s actual charges is clearly within the Intermediary=s discretion. The key word is Amay≅, not Amust≅...≅. Intermediary Response to Provider=s Position Paper at 3 (ASt. Mary=s≅) This contention does not fare well in light of at least four PRRB decisions. Florida Life Care, Inc. Group AGross-Up≅ v. Aetna Life Insurance Co., PRRB Dec. No. 90-D25, May 9, 1990 (AFlorida≅); St. Mary=s Hospital and Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 90-D34, June 18, 1990 (ASt. Mary=s≅); Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Co., PRRB Dec. No. 97-D13, December 3, 1996 (ASunbelt≅); Pinnacle Care Drug AGross Up≅ Group Appeal v. Aetna Life Insurance Co., PRRB Dec. No. 97-D41, March 26, 1997 (APinnacle≅). In AFlorida≅, the PRRB stated:

> Clearly, the Agross-up≅ method results in a more accurate cost-finding approach. As such, it is consistent with the Medicare law and regulations. The Board does give great weight to, but is not bound by, the PRM. In this case, it finds that the 90-day PRM limit for granting permission to use the Agross-up≅ technique is unreasonable because missing the 90-day deadline results in less accurate cost findings. This results in an improper underpayment of the Providers= costs and conflicts with 42 U.S.C. Sec. 1395x(v) and 42 C.F.R. Sec. 405.402 . . . The Board finds that a PRM timing requirement should not prohibit the Providers from using a more accurate cost finding methodology. Moreover, an intermediary approval to Agross up≅ charges should not be necessary because this methodology is the correct, most accurate method of determining costs in such a situation.

AFlorida≅ at 5.

Similarly, in ASt. Mary=s≅, the Board noted that A . . the prior approval requirement . . . should not prohibit the provider from effecting a more accurate allocation of costs≅. ASt. Mary=s≅ at 5. At this point along the analytical trail, all effected parties appear to embrace the Agross up≅ methodology of equalizing cost allocation.

The second contention of the Intermediary in the 1998 ASt. Mary=s≅ case was that all parts of the non-Medicare side of the apportionment formula, including the 20% co-insurance/co-pay,

must be Agrossed up≅ in order to reflect true uniformity of charges. This, I believe, is an accurate statement, and serves as the basis for my continuing dissent in this progeny of cases. It is this final Anotch≅ that pretty well takes the analytical trail out of the Acomparability v. business opportunity/loss leader≅ woods. As noted by the Intermediary in the 1998 ASt. Mary=s≅ case A . .PRM Sec. 2203 does not license a Provider to have a dual charge structure. (One to maximize its Medicare reimbursement and the other to maximize its business opportunities.) In the Medicare outpatient settlement, cost payments are reduced by a 20% charge-driven co-payment factor. The Provider should not have its costs determined at full retail pricing, but have its co-payment based on a substantial discount.≅ Intermediary=s Response to Provider=s Position Paper at 3. (1998 ASt. Mary=s≅)

Actually, while endorsing Agross up≅ for the 80% factor of outpatient charges to meet inpatient charges, the PRRB, in Oregon 90 Coinsurance Group Appeal (Ore.) V. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, PRRB Dec. No. 96-D29, April 26, 1996, rev=d, HCFA Administrator, June 24, 1996 (AOregon≅) denied the Intermediary=s Agross up≅ adjustment of the 20% co-pay, because the Provider Adid not offer patients discounts from their regular charges≅. AOregon≅ at 9. The operant word is Adiscount≅; while the Provider clearly recouped less on outpatient charges (the business Aloss leader≅), the Board could not bring itself to call it what it is - a lesser (discounted) price.

AOregon≅, in fact, is a study in semantics. The HCFA Administrator, in reversing the Board, relied on PRM - 1, Sections 2202.4 and 2604.3. Section 2202.4 provides that charges be related consistently to the cost of services and uniformly applied to all patients, whether inpatient or outpatient. AAll patient charges used in the development of apportionment ratios should be recorded at the gross value.≅ Administrator=s Decision Letter, PRRB Dec. No. 96-D29, June 26, 1996, at 4. Section 2604.3 defines Acustomary≅ charges as those uniform charges listed in a provider=s established charge schedule A. . . applied consistently to most patients and recognized for program reimbursement.≅ Administrator=s Decision Letter, PRRB Dec. No. 96-D29, June 26, 1996, at 4. The Administrator further states,

> Accordingly, in order for charges to be Acustomary≅ for Medicare payment purposes, charges must be uniformly applied and recognized for program reimbursement. As customary charges are the proper charges upon which to base the determination of the Medicare payment, customary charges are the proper charges upon which to base the determination of the coinsurance amount for Part B outpatient services.

Id.

Applying the logic of the above to Medicare payment, the calculation of which is based on the apportionment ratio, one must include consideration of PRM - 2, Section 2418.2, which requires that Part B Medicare coinsurance be based on 20% of a providers= full charges, i.e. customary,

not discounted charges.

When a provider purports to offer identical services to two different customers, and bases the Acharge≅ on cost of the service, but Acharges≅ one customer more, and the other less - either there is an inflated charge to one, or a discounted charge to the other. Business logic tells me that, in the instant case, it is the latter. And that being the case, the 20% co-pay must be Agrossed up≅ to make the apportionment ratio/formula equitable.

This point can be deduced from the Provider=s Post Hearing Brief (1998 ASt. Mary=s≅) at 4:

> If the Provider had taken the approach of reducing inpatient charges to make them equivalent to the charging practice for outpatient surgery services rather than grossing-up outpatient charges, it is unlikely the Intermediary would insist on inpatient deductibles or coinsurance amounts to be reduced. Further, if inpatient charges were reduced, there would be no adjustment to Medicare outpatient charges and, therefore, no issue with respect to adjusting the outpatient coinsurance.

That is exactly the point. A Anetting down≅ of the ratio/equation would place outpatient co-pay at its actual amount. But as long as Agrossing up≅ is the method of choice for equalization of the apportionment ratio to business decision reality, both sides of the apportionment ratio must be based on the same Acustomary≅ (Afull≅, Auniform≅) and, I might add, non-reduced (Adiscounted≅) charge; be equal; and be comparable.

In the instant case, as in the 1998 ASt. Mary=s≅, (PRRB Case No. 98-D45, April 24, 1998) I reject any contention that the Provider can not unilaterally Agross up≅ lower outpatient charges to reach
Auniformity≅ and Acomparability≅with those charged to the inpatient. Of course it can, and someone must. But they must also Agross up≅ all factors making up the apportionment ratio, including a basing of the 20% co-pay on those same Auniform≅ grossed-up charges purported to be based on cost, so that both sides of the equation are accurate.

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Henry C. Wessman, Esquire