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LEGAL GUIDELINES FOR WAIVER OR REDUCTION OF MEDICARE AND COMMERCIAL COPAYMENTS

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INTRODUCTION

INTRODUCTION

- The HME industry is young.
- The industry grew up relatively unregulated.
- Another challenge is that few people with CMS and on Capitol Hill have ever set foot in an HME company.
- As the government is famous for doing, it overreacted.

INTRODUCTION

- The pendulum will eventually swing back towards the middle.
- Until that time, however, the HME industry will have to deal with intrusive government scrutiny.
- The demand for what the industry has to offer will only increase exponentially.

INTRODUCTION

- There is an increase in utilization of HME; this is to be expected in light of the "graying of America."
- Generally speaking, HME is expensive.
- Contractor auditors are becoming more sophisticated in reviewing HME claims.

INTRODUCTION

- It is a priority of CMS to uncover and prevent fraud in the Medicare fee-for-service program.
- Health care providers (not just HME providers) have become the new bogey man to the government.

INTRODUCTION

- Another large challenge for the HME provider are the inquiries and investigations being conducted by DME MACs, RACs, CERTs, ZPICs, UPICs, Supplemental Medicare Review Contractors (SMRC), the NSC, and accrediting organizations.
- Reimbursements from all payors have been cut drastically in recent years.

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FEDERAL LAW

FEDERAL LAW

- The HHS Office of the Inspector General ("OIG") issued a Special Fraud Alert directly to the health care community in 1991 regarding the routine waiver of copayments or deductibles under Medicare Part B. *See* 59 Fed. Reg. 242 (1994).

FEDERAL LAW

- In that Special Fraud Alert, the OIG stated that the routine waiver of Medicare cost-sharing amounts "is unlawful because it results in
  - False claims
    - Reasonable charge submitted may not exceed actual charge
    - Misstating actual charge
  - Violations of the anti-kickback statute and
  - Excessive utilization of items and services paid for by Medicare

FEDERAL LAW – FALSE CLAIMS

- An HME supplier that routinely waives cost-sharing amounts for Medicare beneficiaries, but bills Medicare for the full allowable amount, is guilty of submitting false claims.
- The OIG highlighted in its Special Fraud Alert that "A provider, practitioner or supplier who routinely waives Medicare copayments or deductibles is misstating its actual charge."

FEDERAL LAW – FALSE CLAIMS

- In addition to the federal false claims statute, state laws regulating insurance fraud and deceptive trade practices have been used by both state regulatory agencies and private parties to act against health care providers that routinely waive cost-sharing amounts.

FEDERAL LAW – ANTI-KICKBACK & BENEFICIARY STATUTES

- The AKS prohibits the offering or paying of anything of value to any person as an inducement to purchase, lease, or order an item or service covered by a federal health care program.

FEDERAL LAW – ANTI-KICKBACK & BENEFICIARY STATUTES

- The OIG state in its Special Fraud Alert that AKS violations may arise because "When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them."

FEDERAL LAW – ANTI-KICKBACK & BENEFICIARY STATUTES

- The Beneficiary Inducement Statute prohibits transferring anything of value to a Medicare beneficiary when it is likely to influence the beneficiary to order or receive a Medicare covered item or service from a particular provider, practitioner or supplier.

FEDERAL LAW – GUIDANCE FOR A SUPPLIER'S POLICIES & PROCEDURES

- Both CMS and the OIG have identified procedures which will reduce the risk that a supplier will violate a federal statute.
- The OIG recommends that suppliers adopt written policies and procedures that prohibit personnel from advertising discounts and waivers of cost-sharing obligations and from advising Medicare beneficiaries that they are not liable for their coinsurance and deductibles.

FEDERAL LAW – GUIDANCE FOR A SUPPLIER'S POLICIES & PROCEDURES

- CMS provides guidance on what constitutes good faith collection efforts.
- Suppliers may waive cost-sharing amounts as long as the following conditions are met
  - The supplier does not advertise or use waivers to solicit business;
  - The supplier does not routinely waive cost-sharing obligations;

FEDERAL LAW – GUIDANCE FOR A SUPPLIER'S POLICIES & PROCEDURES

- The supplier "waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; fails to collect coinsurance or deductible amounts after making reasonable collection efforts."

FEDERAL LAW

- Penalties
  - Whoever submits a false claim to the Medicare program may be subjected to criminal, civil or administrative liability for making a false statements and/or submitting false claims
  - Can include imprisonment, criminal fines, civil damages and forfeitures, civil monetary penalties and exclusion

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STATE LAW

STATE LAW

- State law is not consistent in regard to waiver of copayments for non-Medicare and non-Medicaid patients.
- Generally, the waiver of copayments is prohibited by provider contracts.
- However, in the case of non-contracted or out-of-network suppliers, there is less guidance.

STATE LAW – CALIFORNIA

- In California, the only legal authority to express an opinion on this matter does not follow the majority of states.
- In 1981, the California Attorney General held that a dentist's practice of waiving Commercial Patients' copayments and advertising such waivers was not fraudulent.
- Since then, there has been little activity concerning routine copayment waivers in the courts of California.

STATE LAW – CALIFORNIA

- California has a number of broadly-written laws prohibiting kickback arrangements.
- On their face, none of these laws expressly prohibit inducements provided directly to commercial patients.
- However, it is possible that a court will consider waiver of copayment to be a kickback under the laws.

STATE LAW – TEXAS

- Texas Attorney General Opinion No. DM-215 (1993) addresses whether the Texas Insurance Code prohibits a health care provider from waiving a copayment in instances where there is an assignment of benefits.

STATE LAW – TEXAS

- The Texas Insurance Code states
  - The payment of benefits under an assignment does not relieve a covered person of a contractual obligation to pay a deductible or copayment.
  - A physician or other health care provider may not waive a deductible or copayment by the acceptance of an assignment.

STATE LAW – TEXAS

- It is likely that the Texas Insurance Code prohibits a DME supplier from waiving a copayment for commercial patients in instances where there is an assignment of benefits.

STATE LAW – FLORIDA

- The Florida Patient Brokering Statute provides, in relevant part, the following:

  (1) It is unlawful for any person, including any health care provider or health care facility, to:

  (a) Offer or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or to engage in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage to or from any health care provider or health care facility.

STATE LAW – FLORIDA

- A violation of the Florida Patient Brokering Statute is a third degree felony.
- This is a broadly-drafted statute and is similar to the federal statute, except that it is applicable to any patient, regardless of payor.

STATE LAW – FLORIDA

- The Florida Deceptive Insurance Practices Statute requires a health care facility, including home medical equipment providers, to disclose, on the claim form submitted to the insurer, any agreement between the health care facility and the patient to accept less for services rendered than is reflected on the claim form.

STATE LAW – FLORIDA

- Failure to do so is a false claim under the statute.
- If a supplier intends to waive copayments for commercial patients in Florida, it should inform the insurer upon the submission of its claim of the waiver.
- The insurer likely will take the position that the reimbursement amount paid to the supplier should be reduced by the amount of copayment waived by the supplier.

STATE LAW – FLORIDA

- The practice of waiving copayments may, however, be considered a violation of the Florida Patient Brokering Statute if the waiver is not made pursuant to the requirements of the federal safe harbors or in the case of documented financial hardship.

STATE LAW – COLORADO

- Colorado has a statute specifically addressing waiver of copayments in the Colorado Criminal Code:

  (3) Except as otherwise provided . . . , if the effect is to eliminate the need for payment by the patient of any required deductible or copayment applicable in the patient's health benefit plan, a person who provides health care commits abuse of health insurance if he knowingly:

STATE LAW – COLORADO

(a) Accepts from any third-party payor, as payment in full for services rendered, the amount the third-party payor covers; or

(b) Submits a fee to a third-party payor which is higher than the fee he has agreed to accept from the insured patient with the understanding of waiving the required deductible or copayment.

- The statute specifically exempts waivers made on a case-by-case basis when the health care provider determines that payment of the copayment would create significant financial hardship for the patient.

STATE LAW – COLORADO

- As with Texas and Florida, the Colorado statute is applicable to all payors and clearly prohibits waiving copayments without case-by-case consideration of financial hardship.
- Based on the analysis above, caution dictates that any reduction of commercial insurance copayment should be granted on a case-by-case basis, in consideration of the financial situation of the particular patient, and in accordance with the HME supplier's written policy.

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WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- DME suppliers are facing a common challenge: Commercial insurers are closing their provider panels, thereby not allowing the suppliers to bill the insurers as in-network suppliers.
- This relegates the out-of-network suppliers to one of two choices: (1) decline to serve the patient or (2) to serve the patient and bill the insurer as an out-of-network supplier.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- The challenge with billing as an out-of-network supplier is that the patient normally has to pay a higher copayment than if the DME supplier was an in-network supplier.
- This has led some out-of-network suppliers to offer to waive the patient's copayment if the patient purchases from the out-of-network supplier.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- The problem with waiving such copayments is that the out-of-network supplier may be setting itself up for liability.
- Private parties, including insurers and competitors, often file lawsuits against out-of-network health care providers that routinely waive copayments and deductibles.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- For example, Aetna has pursued an aggressive legal campaign against out-of-network providers that waive copayments and deductibles.
- Aetna has brought suits against providers in California, New Jersey, New York, and Texas.
- Similarly, other insurers have brought suit against out-of-network providers who waive copayments and deductibles.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- Many of these suits allege breach of contract claims and unjust enrichment.
- Allegations of fraud and deceptive trade practices are also common.
- Claims of statutory and common law fraud allege that providers that waive copayments submit claims that do not reflect the actual discounted charge and, therefore, materially misrepresent the transaction.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- As an example, such claims have succeeded in the federal and state courts of New Jersey.
- In other states, regulatory authorities have issued guidance indicating that routine waivers of patients' cost-sharing obligations constitute fraud.
- As evidenced by the suits brought by various private parties, a DME supplier will be at risk of having to defend a lawsuit for steering patients to an out-of-network supplier and waiving copayments.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- A number of state and federal courts have addressed cases involving out-of-network providers that routinely waived copayments and deductibles.
- A common claim in these cases is that the provider submits a false or fraudulent claim and overcharges the insurer when the provider bills the insurer the full amount but does not intend to collect the copayment.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- Upon reviewing case law, several legal scholars have concluded that the non-collection of the patient's copayment or deductible may be lawful in and of itself, **but the intentional or contractual waiver of the obligation to pay the deficiency prior to submitting a claim is, by contrast, unlawful.**

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- An example of a case ruling in favor of the insurer is *Kennedy v. Connecticut General Life Insurance Co.*, 924 F.2d 698 (7th Cir. 1991).
- In *Kennedy*, a chiropractor sued CIGNA because CIGNA refused to pay a claim submitted by the chiropractor who was an out-of-network provider.
- Under CIGNA's insurance policy, CIGNA covered 80 percent of medical expenses and the beneficiary was required to pay the remaining 20 percent.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- When the chiropractor submitted a claim of $1,727, CIGNA suspected that he did not collect the 20 percent copayment.
- Therefore, CIGNA requested proof that the $1,727 represented 80 percent of the full amount charged. In the process, CIGNA received information that the chiropractor waived the patient's copayment.
- As a result, CIGNA refused to pay the claim and the chiropractor sued.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- The court ruled in favor of CIGNA.
  - According to the court, if the chiropractor "wishes to receive payment under a plan that requires copayments, then he must collect those copayments – or at least leave the patient legally responsible for them."
- A number of state insurance agencies have weighed in on this issue.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- For example, the New York Department of Insurance has taken the position that the practice of waiving copayments may constitute fraud in the state
  - Depending on the circumstances, the waiver of otherwise applicable copayments could constitute insurance fraud.
  - If a health care provider, as a general business practice, waives otherwise required co-insurance requirements, that provider may be guilty of insurance fraud. See opinion of the Office of General Counsel dated March 27, 2008.

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- For example, if a health care provider indicates that the charge for a procedure is $100 and the insurer anticipates that the provider will collect a 20% copayment amount, the insurer will reimburse the insured $80.
- If, however, the provider waives the copayment, that provider's actual charge becomes $80, which then obligates the insurer, assuming payment at 80% of the usual charge, to reimburse the insured only $64.
- See *N.Y. Ins. Dep't, Position Statement, "Re: Health Insurance, Waiver of Deductibles and Co-Insurance"* (April 2, 2008).

WAIVING COPAYMENTS FOR OUT-OF-NETWORK PATIENTS

- In the event a DME supplier accepts the risks associated with waiving copayments for out-of-network patients, then it would be prudent for the out-of-network supplier to notify the insurer that the supplier waived the patient's cost-sharing responsibility.
- Such notice may serve as a credible defense against any claim of fraud and deceptive trade practices.
- However, such notice may cause the insurer to deny the claim.

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EXHIBITS

ACCREDITATION COMMISSION *for* HEALTH CARE

EXHIBIT A

- Template "Policy and Procedure for Waivers of Cost-Sharing Obligations"

FINANCIAL MANAGEMENT POLICY AND PROCEDURE		NUMBER FM 5.6
APPROVED BY:	ORIGINAL APPROVAL DATE:	MOST RECENT REVISION DATE:
TITLE: WAIVER AND COLLECTION OF DEDUCTIBLES AND CO-PAYMENTS		PAGE: 1 of 8

I. DEFINITION

Medicare Deductible - The amount the client must pay for health care services before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts may change every year.

Medicare Co-Payment - The portion of the cost of an item or service that the Medicare client is responsible to pay. The Medicare Part B co-payment is generally 20 percent of the Medicare allowed amount for the item or service.

Upon taking the action described above, the Billing Supervisor may if in the best interest of Company write off past due amounts.

Any responsibility assigned to an officer of Company under this policy may be delegated by that officer to an appropriate designee, unless delegation is expressly prohibited under this policy.

II. PURPOSE

A supplier who routinely waives the Medicare co-payment amount is misrepresenting the actual charge. Routine waiver of deductibles and co-payments by a supplier is unlawful because it encourages false claims and excessive utilization of items and services. Routine waiver of deductibles and co-payments may also violate the Medicare-Medicaid anti-kickback statute. Company may forgive co-payment amounts only after considering a particular client's financial hardship. Exceptions to this policy must be well documented and show that good faith effort has been made to collect the deductibles and co-payments.

III. SCOPE

This policy applies to all employees of the ABC Company ("Company"). All employees will be educated in this policy at orientation and annually thereafter during Corporate Compliance training.

IV. ADMINISTRATION

This policy will be reviewed, approved and administered by the:

- Chief Financial Officer ("CFO").
- Chief Operating Officer ("COO").
- Corporate Compliance Officer ("CCO").
- Billing Supervisor.

V. POLICY

It is the policy of Company that co-payment and deductible amounts that are the client's responsibility under the rules of the Medicare or Medicaid program or any other governmental or commercial third-party payor may not be waived, except on a case-by-case basis upon a determination of financial need. Prior to or at the time of delivery, client will be provided with an estimate of any amounts the client will be responsible for paying. Routine waiver of co-payment and deductible amounts is a violation of federal law and Company policy.

Exhibit A

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VI. PROCEDURE

Application: A client or representative of a client who requests waiver of a co-payment or deductible will be asked to complete an Application for Waiver of Co-payment form ("Application") (sample attached). The Billing Supervisor has the option to review the Application in accordance with this policy and procedure. The Billing Supervisor has the authority to approve waiver of a co-payment or deductible. Any determination will be placed in the client's billing file immediately by the Billing Supervisor. Applications must be renewed annually by the client or the client's representative. A letter will be issued to the client or client's representative informing the parties whether the Application was granted or denied.

Income Guidelines: If the client does not have secondary insurance and the client's family income is less than 150% of the federal poverty guidelines (as shown in the table below), the client may be considered eligible for waiver of co-payment unless the Billing Supervisor has reason to believe that the client or the client's family has sufficient available assets (not including primary residence, primary automobiles or retirement accounts) to pay the co-payment amount without financial hardship.

If the client has secondary coverage through the Medicaid program of a state where Company is not eligible to receive Medicaid reimbursement, the client is considered not to have secondary insurance for purposes of this policy.

If the client's family income is more than 150% of the federal poverty guidelines, the client should be presumed not to be eligible for waiver of co-payment unless the family has unreimbursed medical expenses exceeding 20% of annual family income. If there are other unusual circumstances that, in the judgment of the Billing Supervisor, cause genuine financial hardship, the Billing Supervisor may consider such circumstances in making the waiver determination when requested by the client or the client's representative. The Billing Supervisor will document the basis of the determination.

All waivers are valid for a period not to exceed twelve months, unless stated otherwise. It is the responsibility of the client or the client's representative to inform Company of a positive change in the client's financial situation that would nullify his or her qualification for the waiver.

Documentation of Financial Hardship: It is not necessary to request documentary evidence of income and expenses in every case. However, if the Billing Supervisor has any doubt about the accuracy of the information provided, the information should be verified before approving the waiver. In some cases, it may be advisable to request copies of pay stubs, medical bills, tax returns, or other documents. The Billing Supervisor should document the verification process.

Communications with Beneficiaries. Company will not advertise an intent to waive deductibles or coinsurance for Medicare beneficiaries, or advertise an intent to discount services for Medicare beneficiaries. No Company employee may tell a client or family member that he or she does not have to pay the co-payment amount unless the Billing Supervisor has made a determination of financial need.

Extended Collection Policy. Company will issue individual letters of collection to all accounts past due at 90 days. These collection letters will be followed up by a phone call from Company's Billing Department, or other designated Company representatives, within ten business days of estimated receipt of the letter by the client or client's representative. Phone calls will be made by the designated Company representative until affirmative contact is made with the client or the client's representative. The purpose of the follow-up phone call is to collect detailed information from the client or the client's representative as to the reason for non-payment on the past due amount of Company's

Exhibit A

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account. The designated Company representative will solicit either an agreement to a specific payment plan, or the submission of an initial or new waiver Application if appropriate.

If Company has not received any payment or an initial or new waiver Application from the client or the client's representative within 60 days of the phone contact noted above, then the Billing Supervisor will take action consistent with the best interest of Company, including picking up the equipment, turning the account over to a collection agency, bringing a collection lawsuit, or refusing to provide products and services to the client in the future.

If the client or client's representative submits an initial or new waiver Application within 60 days of the phone contact noted above and that Application is denied, the client or client's representative will be informed of such denial by letter and by phone call within ten business days of the official denial. The purpose of the phone call is to inform the client or client's representative of the denial of the Application, and to solicit an agreement to a specific payment plan. At this point, if the client or client's representative does not submit any payment within 60 days of the phone contact noted above or the estimated receipt of the denial letter, whichever is earlier, then the Billing Supervisor will take action consistent with the best interest of Company including picking up the equipment, turning the client over to a collection agency, brining a collection lawsuit, or refusing to provide products and services to the client in the future.

Upon taking the action described above, the Billing Supervisor may if in the best interest of Company write off past due amounts.

Any responsibility assigned to an officer of Company under this policy may be delegated by that officer to an appropriate designee, unless delegation is expressly prohibited under this policy.

EXHIBIT B

- Template "Application for Waiver of Copayment or Deductible"

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[ABC COMPANY]
Application for Waiver of Co-payment or Deductible
(to be completed by the person with financial responsibility for service or item)

Please provide the information requested below to help us determine whether you are eligible for waiver of co-payment or deductible amounts. Waivers are generally valid for twelve months and then must be renewed.

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Insurance:_____

Policy Number:_____

Secondary Insurance:_____

Policy Number:_____

How many persons reside in your household?_____

Please list them with their names, ages and relationships:_____

_____

How many persons in your household are employed?_____ Please list their names and employers:

_____

_____

Estimated amount of annual un-reimbursed medical costs for household:_____

Monthly Household Income:

Salary/Wages	$_____
Pension	$_____
Social Security	$_____
Other:_____	$_____

Amount you presently have in savings: $_____

Do you receive assistance from any federal, state, county or local agencies, such as AFDC or public assistance?
Yes _____ No _____ If yes, please list each organization and the amount of assistance you receive monthly.

_____

_____

Exhibit B

FINANCIAL MANAGEMENT POLICY AND PROCEDURE	NUMBER: FM 5.6
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This form ( ) was read BY me or ( ) was read TO me. I have been offered the opportunity to ask questions about this form and I fully understand its contents.

I certify that all of the information above is true and correct. I also agree that, should this information change, I will promptly notify [insert Company name].

Signed:_____Date:_____

Interpreter's Statement (if interpreter assisted):

I have orally translated the information presented to the client by (Company representative's name):

_____

I have also read the hardship application form to (client's name):

_____

in (language):

Signature of Interpreter

Date

Exhibit B

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INCOME THRESHOLD TABLE - STANDARD (ALL 48 CONTIGUOUS STATES AND D.C.) Published by the U. S. Department of Health and Human Services in the Federal Register, Vol. 79, No. 14, January 22, 2014, pp. 3593-3594	
Size of Family Unit	**150% of 2014 Federal Poverty Guidelines**
1	$17,505

2	$23,595
3	$29,685
4	$35,775
5	$41,865
6	$47,955
7	$54,045
8	$60,135
For each extra person, add	$6,090

Exhibit B

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INCOME THRESHOLD TABLE – ALASKA Published by the U. S. Department of Health and Human Services in the Federal Register, Vol. 79, No. 14, January 22, 2014, pp. 3593-3594	
Size of Family Unit	**150% of 2014 Federal Poverty Guidelines**
1	$21,870
2	$29,490

3	$37,110
4	$44,730
5	$52,350
6	$59,970
7	$67,590
8	$75,210
For each extra person, add	$7,620

Exhibit B

FINANCIAL MANAGEMENT POLICY AND PROCEDURE	NUMBER: FM 5.6
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INCOME THRESHOLD TABLE – HAWAII Published by the U. S. Department of Health and Human Services in the Federal Register, Vol. 79, No. 14, January 22, 2014, pp. 3593-3594	
Size of Family Unit	**150% of 2014 Federal Poverty Guidelines**
1	$20,130
2	$27,135

3	$34,140
4	$41,145
5	$48,150
6	$55,155
7	$62,100
8	$69,165
For each extra person, add	$7,005

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QUESTIONS?

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THANK YOU

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