TRAINING
HANDOUTS

Head Off Massive Financial Penalties for Innocent Self-Pay Billing Errors

Presented by:
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Inconvenience

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Prior to joining Brennan, Manna & Diamond, Daphne served as Senior Advisor for a health care consulting company; held policy positions in the Ohio Department of Medicaid, including leading Ohio Medicaid's interaction with the Centers for Medicare & Medicaid Services and overseeing various components of Ohio Medicaid policy. She also served as director of state and local government relations for Nationwide Children's Hospital in Columbus, OH. Daphne graduated cum laude from Capital University Law School and Indiana University, and is licensed to practice law in Ohio.

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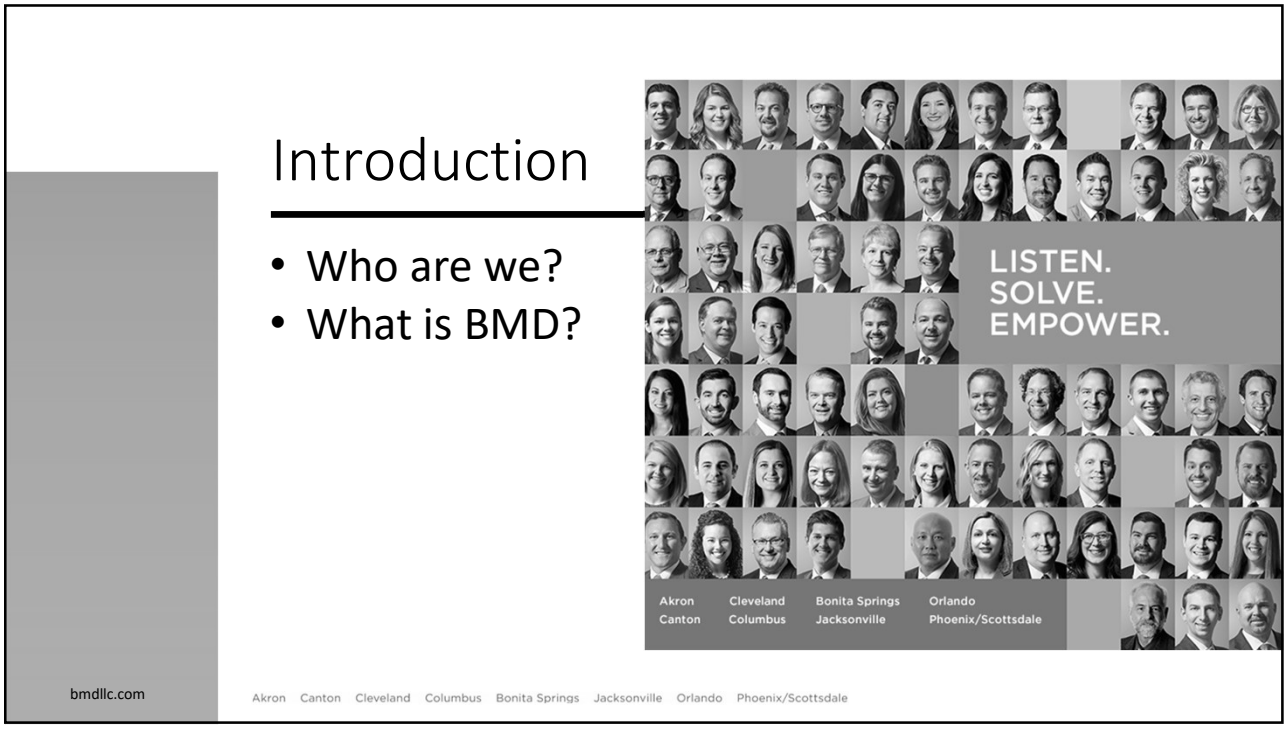

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•AGENDA

- **When and Why Do Patients Self-Pay?**
- Self-pay and Payors
- Discounts and Fraud & Abuse Laws
- Case Studies/Scenarios
- Consequences
- Recommendations

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When and Why Do Patients Self-Pay?

- An increasing amount of patients are opting to self-pay or pay in cash for a variety of reasons:
  - High deductible insurance plans
  - Lack of trust with insurers
  - Market competition and high cost of medical care
  - No insurance coverage
- A recent Healthcare Financial Management Association study found that hospitals have seen a 10% increase in revenue from self-pay patients in the past 5 years
- The AARP projects that 16% of doctors' practices and hospitals will move to a cash-only model in the coming years.

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Types of Self-Pay Patients

There are two main types of self-pay patients:

1. Patients with no insurance
   - This could mean that the patient is uninsured, or they chose not to disclose their status

2. Patients with insurance who still want to pay cash
   - This could be for patients with high-deductible plans or for services that are not covered under insurance

Reminder: Make sure you are still asking patients for insurance information even if you have a mostly self-pay business. Not doing so could violate payor contracts and federal/state laws.

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Benefits of Self-Pay

There are many benefits to allowing patients to self-pay:

- Avoid administrative burdens of dealing with insurance and collections on the back end
- Guaranteed payment directly from patient
- Happier patients who feel that they are getting good treatment for a good price
- Savings for the patient and for the practice

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Self-pay and Payors

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Medicare and Self-Pay

- Medicare providers need to be very cognizant of when they accept cash from patients. Their ability to do so, and to give discounts, may depend on their status.
- Medicare providers can be:
  - Participating – Participating providers agree to accept assignment. In this case, the beneficiary/assignee's bill for the services is paid in full when the approved charge is paid, and the coinsurance and deductible are collected from the patient.
  - Non-Participating – Non-participating providers elected not to accept assignment and may collect cash payment directly from the Medicare beneficiary but are nonetheless limited in the amount that they can charge for Medicare-covered services.
  - Opt-Out – A provider who opts out of Medicare can treat Medicare-eligible patients and charge their own rates and accept cash pay but neither the provider nor the patient will be reimbursed for the service. No claims need, or can, be submitted to Medicare. Opt-out status lasts for two years.

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Medicare and Self-Pay

- Accepting cash payments for Covered Services
  - Participating providers may not accept payment directly from Medicare beneficiaries for services that Medicare covers (although they may still collect standard deductibles and copays). Cash may only be collected for the deductibles and copays
  - Non-participating providers may accept cash for covered services, but you also must submit claims to Medicare, so that Medicare may reimburse the patient directly. Non-participating providers are able to bill the beneficiary up to the limiting charge amount, which is 115 percent of the Allowed Amount for participating providers.
  - Providers who have opted out may not bill Medicare.

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Medicare and Advanced Beneficiary Notices

- When a Medicare provider performs a service that is not covered by Medicare, they must issue an Advanced Beneficiary Notice prior to billing the patient directly. ABNs must:
  - Include the reason for predicting the denial.
  - Not be given to all patients on a routine basis, but only when a denial can be expected for a particular reason.
  - Be completed before being given to the patient for signature.
  - Be hand delivered to the patient.
  - Completed and delivered before a procedure/service is initiated.
  - Providers may obtain an ABN each time a patient presents for a treatment which may be determined not to be medically necessary. However, CMS will allow a single ABN covering an extended course of treatment, provided it identifies all items or services for which the provider believes Medicare will not pay.
- Balance billing a Medicare patient outside of the ABN is not allowed.

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HIPAA Protections for Disclosure

- HIPAA does allow patients to restrict disclosure for payment purposes
- 42 C.F.R. § 164.522(a)(1)(vi) A covered entity must agree to the request of an individual to restrict disclosure of protected health information about the individual to a health plan if:
  - (A) The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
  - (B) The protected health information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.
- Wait! This is not a catch all or a way to avoid billing Medicare or other payors.

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HIPAA Protections for Disclosure

- Ensure your HIPAA procedure includes a policy for this type of restriction:
  - Include in Notice of Privacy Practices
  - Define the time frame that you will give the patient to make the payment in full
  - Establish the process for how dishonored payments are handled (if the patient does not make the agreed upon payments, HHS does expect the CE to make reasonable attempts prior to disclosing PHI)
- It is the patient's responsibility to make this request not to disclose
  - The intention is not to justify not billing
- Communicate with staff to ensure that it is clear that a restriction is in place when appropriate
- The policy will need to include information for how the restriction to disclose to a payor will affect return visits, electronic prescriptions, and referrals to other healthcare providers

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HIPAA Protections for Disclosure

- Covered Entities may disregard individual requests only in certain instances: Medicare/Medicaid audits or other reasons required by law
- The following are examples of scenarios where a request may not be able to be fully accommodated:
  - The request was made after the service occurred and information has already been released to the health plan.
  - The encounter cannot be unbundled and the patient refuses to pay out-of-pocket for the entire encounter. Note that if the encounter can be unbundled, you must do so in order to fulfill the restriction request. Unbundling services may result in a higher cost to the patient, which they should be made aware of.
  - You made a reasonable effort to secure payment and did not obtain payment in full.
  - The encounter date is related to a worker's compensation injury or a claim for life insurance or disability insurance benefits.
  - Disclosures that are required by law (i.e., disclosures for audits to Medicare or Medicaid, state or federal reporting requirements, or disclosures to comply with a legal mandate, court order, etc).
  - You are part of a health maintenance organization and therefore is both provider and health plan.

Medicare – Cash for Prescriptions

- There is a loophole to allow pharmacies to accept cash for Medicare patients
- However, many pharmacy contracts used to have "gag orders" that prevented pharmacists from disclosing this loophole.
- Medicare officials warned in a May 17, 2020 letter that gag orders are "unacceptable and contrary" to the government's effort to promote price transparency.
- As a result, many of these gag orders have been released.

When Can Patients Pay in Cash?

Commercial Payors

- Check your contracts!
- Private insurance providers may mandate in their contract that you directly bill the insurance company for any covered services regardless of whether the patient wishes to self-pay
- There may also be prohibitions against discounts or charging a patient less than their full copayment
- Most Favored Nation (MFN) Clause in the Healthcare Context
  - Insurance companies may require a promise that the providers not give equal or more favorable prices to any other plan
  - In the context of Self-Pay or Prompt-Pay discounts where the insurance company mandates direct billing, providers may have to bill the discount to insurance
  - MFN clauses are highly contested and have been investigated by state and federal governments and are banned in at least 18 states

Usual and Customary Charge

- Also look for "usual and customary charge" clauses in contracts
- If a discount is routinely and widely offered, the provider's usual charge may become the discounted rate.
- Could significantly affect provider's bottom line.
- Medicare generally prohibits providers from charging Medicare "substantially in excess" of the provider's usual charges. *See* 42 CFR § 1001.701.
- A discount program probably will not trigger the "usual charge" concerns unless it is offered to a significant portion of the provider's patients.

Discounts and Fraud & Abuse Laws

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Offering Discounts – State Law

Laws vary state by state – sometimes in opposite directions

- California
  - "Health care providers are hereby expressly authorized to grant discounts for health or medical care to any patient the [provider believes] is not eligible for insurance reimbursement, coverage under Medi-Cal," or the like.
- New York
  - Both in 2000 and 2007, the New York Dept. of Financial Services Office of General Counsel stated that waivers, lower rates, cash rates, and flat fee payments may violate N.Y. Penal Law § 176.05.
- Idaho
  - "It is unlawful for a service provider to engage in a regular practice of waiving, rebating, giving, paying, or offering [the following] of a claimant's deductible or claim for casualty, disability insurance, worker's compensation insurance, health insurance, or property insurance."

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Fraud & Abuse Laws

The Stark Law (42 USC 1395nn)

- Stark prevents physicians from referring patients for designated healthcare services payable by Medicare or Medicaid to an entity that has a financial relationship with the physician or their immediate family member.

Anti-Kickback Statute (42 U.S.C. § 1370a-7b)

- The AKS prohibits individuals from giving/taking anything of value in exchange for referrals in business payable by a Federal Health Care Program.

Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a(a)(5); 42 C.F.R. § 1003.102 and .103(b)(13))

- The CMPL prohibits knowingly offering anything of value to Medicare or Medicaid beneficiaries that is likely to influence the beneficiary's selection of a particular provider of services payable by Medicare or Medicaid, including waivers or discounts of coinsurance or deductible amounts.

Fraud & Abuse Laws

Comparison	Stark Law (42 USC § 1395nn)	Anti-Kickback Law (42 USC § 1320a-7b(b)
Prohibition	Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family) has a financial relationship, unless an exception applies Prohibits the designated health services entity from submitting claims to Medicare for those services from a prohibited referral	Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal healthcare program business
Referrals	Referrals from a physician	Referrals from anyone
Items/Services	Designated Health Services	Any items or services
Intent	No Intent standard for overpayment (strict liability) Intent required for civil monetary penalties for *knowing* violations	Intent must be proven (knowing and willful

Fraud & Abuse Laws

Comparison	STARK Law (42 USC § 1395nn)	Anti-Kickback Law (42 USC § 1320a-7b(b)
Penalties	Civil: • Overpayment/refund obligation • False Claims Act Liability • Civil monetary penalties and program exclusion for *knowing* violations • Potential $15K CMP for each service • Civil assessment of up to 3x the amount claimed	Criminal: • Fines up to $25K per violation • Ip to 5 years prison term per violation Civil: • False Claims Act Liability • Civil Monetary Penalties and Program Exclusion • Potential $50K CMP per violation • Civil assessment of up to 3x amount of kickback
Exceptions	Mandatory Exceptions	Voluntary Safe Harbors
Federal Health Care Programs	Medicare/Medicaid	All

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Fraud & Abuse Laws

How Courts Apply the Anti-Kickback Law

- *United States v. Shaw*
- Under the Anti-Kickback Law, it is illegal for hospitals or providers to (1) knowingly or willfully offer to pay (2) renumerations to induce referrals, purchases, or arrangements for or recommendations either directly or indirectly, overly or covertly
- In *Shaw*, the defendant was charged with a count for writing off laboratory services for indigent and HMO patients, but this was to induce external dialysis facilities to order from them (LIFECHEM).
- The court reasoned that such an intention did not fall under any categorical exception or safe harbor (like a genuine discount offered to patients)

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AKS/CMPL Exception – Waiver of Co-Payments

Waivers of Co-Payments or Cost Sharing Amounts.

- The CMPL expressly defines "remuneration" to include "the waiver of copayment, coinsurance and deductible amounts (or any part thereof)", but it excepts the waiver of coinsurance and deductible amounts by a person, if:
  - the waiver is not offered as part of any advertisement or solicitation;
  - the person does not routinely waive coinsurance or deductible amounts; and
  - the person waives coinsurance and deductible amounts after determining in good faith that the individual is in financial need or failure by the person to collect coinsurance or deductible amounts after making reasonable collection efforts.
- The AKS contains a similar exception for the waiver of copays or cost-sharing payments for certain hospital services (42 C.F.R. § 1001.952(k)).
- Unless the provider can fit within the regulatory exception or otherwise prove the patient's inability to pay, the routine waiver of copays and deductibles associated with screening exams or other services almost certainly violates the AKS and/or CMPL.

CMPL Exception – Nominal Value

Gifts of Nominal Value

- The OIG has issued a policy statement to allow gifts of items or services of "nominal value," which the OIG interprets as no more than $15 per item or $75 in the aggregate per patient per year.
- There is not a similar explicit rule for the AKS, but the OIG has indicated that gifts of nominal value will not trigger the AKS.
- Therefore, gifts under the $15/$75 threshold will be low risk under the AKS.
- A provider hoping to use this exception needs to keep track of the gifts, services, discounts, or items provided to each patient under this exception.

CMPL Exception – Financial Need

Financial-Need-Based Exception.

- Protects the offer or transfer of items (other than cash or cash equivalents) or services for free or less than fair market value after a good-faith determination that the recipient is in financial need, and provided that the items or services:
  - (i) are not offered as part of any advertisement or solicitation;
  - (ii) are not tied to the provision of other reimbursable items or services; and
  - (iii) are "reasonably connected to the medical care of the individual."
- The OIG gave an example of remuneration protected under this exception: a physician's offer to a financially needy patient of a tool or service to assist a patient in remembering when to take medication upon the physician's learning that the patient lives alone and has trouble remembering which medication to take at what time.
- In another example, the OIG recognized that the exception would apply to a pharmacist's provision of a free extra package of diabetic test strips to a financially needy diabetic patient who had run out of test strips and needed an immediate supply before a refill could be authorized.

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CMPL Exception – Financial Need

- A good faith determination of "financial need" may vary depending on the individual patient's circumstances. These factors may include, for example:
  - the local cost of living;
  - a patient's income, assets, and expenses;
  - a patient's family size; and
  - the scope and extent of a patient's medical bills.
- Providers should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality.
  - Could include patient financial or employment documents, a patient questionnaire, or patient interviews
  - Retain this documentation and reassess periodically
- The guidelines should be applied uniformly in all cases.
- This exception may not be used as a blanket safe harbor but must be assessed on a case-by-case basis

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CMPL Exception – Promotes Access/Low Risk

Promotes Access with Low Risk of Harm.

- Exempts items or services that "improve a particular beneficiary's ability to obtain items and services that are payable by Medicare or a State health care program" and pose a low risk of harm to patients and Federal health care programs.
- Remuneration is considered to pose a "low risk of harm" if the remuneration:
  - (i) is unlikely to interfere with, or skew, clinical decision-making;
  - (ii) is unlikely to increase costs to federal health care programs or beneficiaries through overutilization or inappropriate utilization; and
  - (iii) does not raise patient-safety or quality-of-care concerns.
- Such incentives may not include:
  - Cash or instruments convertible to cash; or
  - An incentive the value of which is disproportionally large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care).

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OIG Advisory Opinion 08-03

- Advisory Opinion (No. 08-03) permitted a health care system to offer patients discounts for prompt payment of cost-sharing amounts and amounts owed for non-covered services regardless of the patient's financial status, payor, or ability to pay, for both inpatient and outpatient services.
- Inpatient Services: Falls within the safe harbor for waivers of beneficiary coinsurance and deductible amounts for hospital inpatient services:
  - Hospital would not claim the Prompt Pay Discount as debt or otherwise shift the burden to the Medicare/Medicaid programs, other third-party payors, or individuals
  - The Prompt Pay Discount would be offered without regard to the reason for the patient's admission, length of stay, diagnostic-related group, or ambulatory payment classification
  - The Prompt Pay Discount would not be part of a price-reduction agreement between the hospital and any third-party payor

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OIG Advisory Opinion 08-03

- Outpatient Services: Does not fall within a safe harbor. However, the arrangement would not be subject to sanctions because:
  - The hospital did not advertise the Prompt Pay Discount to patients. Instead, patients were notified of the Prompt Pay Discount during the course of the actual billing process.
  - Third-party payors would be notified of the Prompt Pay Discount.
  - All costs associated with the arrangement would be borne by the hospital and would not be passed on.
  - The Prompt Pay Discount would be reasonably related to the amount of collection cost that would be avoided.
- Based on this analysis, the OIG concluded that the Prompt Pay Discount was unlikely to be used to encourage referrals and would not result in overutilization of a federal healthcare program.

The Value-Based Trend

- 2020 CMS Rulemaking on Stark Law
  - New exception to self-referral restrictions allow physicians and healthcare providers to enter value-based compensation arrangements without fear of violation
- 2020 CMS Rulemaking on Anti-Kickback Law
  - The new rule creates several new Safe Harbors where value-based arrangements and patient engagement are encouraged. In the event of Self-Pay, the patients may only end up paying for the value received and reduce up-front costs.

Case Studies/Scenarios

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Case Studies

What Have Other Providers Done Right?

- Patient First
  - Patient First provides self-pay pricing for their offices in Maryland, New Jersey, Pennsylvania, and Virginia for an array of services
    - Program is limited to patients not covered by their partners in government or private health insurance programs
      - Limited by Medicaid/Medicare Restrictions in the Fraud and Abuse Laws
      - Limited by MFN Clause by private insurance partnership contract
- Baptist Health
  - In contrast to Patient First, Baptist Health in Florida provides individual quotes for Self-Pay Pricing and requires full payment up front.
  - Similar to Patient First, these self-pay prices are limited to those without healthcare insurance – federal and private insurance partners limit the options for self-pay

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Consequences

Penalties

- Federal Level Restrictions
  - Fraud and Abuse Laws are the first layer of consequences. Criminal penalties for acts involving federal health care programs involve fines of $100,000, imprisonment for 10 years, or both
- State level Restrictions
  - New York establishes a penal code for alleged insurance fraud
  - Idaho imposes civil monetary penalties for wrongful discounts/waivers
  - California may not have restrictions given their support for self-pay
  - Each state will undoubtedly vary
- Private Insurance Restrictions
  - Healthcare providers that violate contracts with insurance companies risk liability usually in the form of monetary damages
  - Unauthorized discounts could give rise to claims for breach of contract, tortious interference with contract, and statutory or common law fraud—particularly if there is no showing of the patient's financial need or the supplier's reasonable but unsuccessful collection efforts

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Recommendations

- When in doubt, do not provide discounts or waivers to patients to limit your practice's liability
- Hire an attorney well versed in both federal and (your) state healthcare law
- Differentiate between the obligations for federal and private payor policies
- Use due diligence in checking a patient's insurance – only provide self pay options when there is reasonable belief that they do not have insurance with a covered entity
- Properly notify patients of their rights and obligations
- A robust and accurate Self-Pay plan is beneficial for both the patient and the provider
- Be transparent about your prices with patients when possible.
- Providers in multiple states must look at each state to check for restrictions that may apply

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Recommended Tasks

- When identifying which patients can receive discounts:
  - Check the patient's eligibility to pay
  - Identify which patients are eligible by using the HHS "reasonable hardship" standard, which doesn't require indigence
  - Identify state restrictions on patients' eligibility to receive discounts/waivers based on financial hardship
  - Ensure there are no restrictions in the clinic policy
  - Ensure there are no restrictions in payor policy
  - Ensure the patient has not restricted reporting PHI to payors under HIPAA

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Questions?

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