Impact on DMEPOS Providers - The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection

On April 11, 2022, the White House issued a press release to announce several new initiatives aimed at reducing the burden of medical debt and increasing consumer protections around medical debt (https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/). The release has generated some questions from the supplier community, which we will try to answer in this article.

These new initiatives outlined in the press release are designed to accomplish 4 main goals:

- Hold medical providers and debt collectors accountable for harmful practices
- Reduce the role that medical debt plays in determining whether Americans can access credit – creating more opportunities for people with medical debt to get a home or business loan
- Help low-income American veterans get their medical debt forgiven
- Inform consumers of their rights

Those 4 initiatives will be accomplished as follows:

1. **Holding Providers and Collectors Accountable** – HHS will be evaluating collection practices, financial assistance offerings, and 3rd party debt collection and debt buying/selling practices. They will be requesting data from over 2000 different providers regarding their processes around debt collection. The White House would like to see providers make it easier, for patients who qualify for it, to receive financial assistance. Any potential violations that are uncovered during this process by HHS will be shared with the appropriate enforcement agencies. In addition, the Consumer Financial Protection Bureau (CFPB) will investigate debt collectors that violate patient and family rights and hold violators accountable. Some examples of what the CFPB considers to be unscrupulous collection tactics can be found here:

https://www.consumerfinance.gov/about-us/newsroom/cfpb-issues-bulletin-to-prevent-unlawful-medical-debt-collection-and-credit-reporting/

2. **Improve Government Underwriting Practices –** Recent research has concluded that factoring paid-off medical debt causes lenders to underestimate the creditworthiness of applicants. The Federal Housing Administration (FHA) has removed medical debt from consideration when processing loan applications. The Administration is now issuing guidance to all agencies to eliminate medical debt as a factor for underwriting in credit programs. The Office of Management and Budget (OMB) will also be issuing guidance to agencies asking them to either eliminate or reduce the impact of medical debt when underwriting credit programs.

3. **Support Veterans in Financial Hardship –** Veterans Affairs (VA) will streamline their process that veterans use to get their VA medical debt forgiven. There will be a new, easier online option to apply for debt relief, and an income threshold for debt relief will be established. The VA will also stop reporting medical debt to consumer reporting agencies.

4. **Help Consumers Know Their Rights –** The CFPB will offer more education and resource tools to help individuals and families understand their medical bills and financial obligations as well as their rights surrounding debt collection and credit reporting.

As mentioned above, this memo, having just been released, has already generated some confusion and questions amongst our membership and provider community. And as you can see in the text above, there will be more guidance issued at a later date stemming from this memo. For now, below are some Q & As that might help some of you as you digest this memo and the associated guidance:

Q: With so much focus on debt collection practices and eliminating medical debt, are they suggesting that I should not be billing my patients for their deductible and/or co-insurance responsibility?

A: No, that is not what is being suggested. In fact, in many instances, and especially with federal programs (Medicare, Medicaid, CHIP, VA, etc.), you are legally required to continue attempting to collect applicable deductible and co-insurance responsibility from patients. This guidance is not in any way indicating that you should not collect, or that you are not entitled to, a patient's portion of the financial responsibility associated with the products and services that you provided to them.

Q: I outsource my patient collections; can I assume their collection efforts are in full compliance with this new guidance? Or is there something I should be doing to ensure that?

A: Additional guidance is likely forthcoming. You should communicate with your collection agency to make sure they are aware of this new endeavor and are following the topic to ensure they are compliant with any additional regulations or requirements that stem from this memo.

Q: As a DME supplier, what am I required to offer in terms of financial hardship assistance?

A: At the federal level, and at this time, there are no requirements placed on you as a supplier to offer financial assistance or any defined thresholds at which you must offer that. Depending on your state, however, there could be some requirements, or even with certain payers, funding sources, or programs with whom you participate that require that of you.

Q: If I do not have a financial hardship process spelled out and in place, but I would like to establish one (or am required to have one), where could I get one?

A: Upon request, VGM can provide you with some generic outlines or guidelines by which you could create your policy; however, we recommend you consult with an appropriate health care attorney to prepare a Policy suitable to your specific business needs and the requirements you are looking to satisfy.

Below is additional information regarding the statutes and penalties around routine waiving of deductibles/co-insurance, as well as some additional information about financial hardship assistance for patients.

While it is acceptable for a DME supplier to waive a copayment when a patient establishes an inability to pay, the supplier can be subjected to liability if it routinely waives copayments.

There are two important federal statutes prohibiting routine waivers of copayments for beneficiaries of federal and state health plans. The law that most specifically addresses waiver of copayments is 42 U.S.C. 1320a-7a, sometimes called the beneficiary inducement statute. That statute prohibits the offer or payment of “remuneration” to a beneficiary by any person/entity if the person/entity knows (or should know) that the remuneration is likely to influence the beneficiary to obtain items or services from a

particular supplier. The definition of “remuneration” specifically includes waivers or reductions of copayment amounts, except when (1) the waiver is not advertised, (2) the supplier does not routinely waive copayments, and either (a) the supplier in good faith determines that the beneficiary is in financial need, or (b) the supplier fails to collect the copayment after making reasonable collection efforts.

The other relevant federal statute is the federal anti-kickback statute, 42 U.S.C. 1320a-7b(b). The anti-kickback statute prohibits, among other things, the offer or payment of remuneration to induce a person to purchase a Medicare or Medicaid-covered item or service. Unlike the inducement statute, the anti-kickback statute does not include a definition of “remuneration.” However, it is generally accepted that the term includes transferring “anything of value.”

The Office of Inspector General (“OIG”) has long taken the position that routine waivers of copayments violate the anti-kickback statute. In 1991, the OIG issued a Special Fraud Alert on the topic. Although the anti-kickback statute and the related regulations do not contain an explicit exception for financial hardship as the inducement statute does, the OIG stated: “One important exception to the prohibition against waiving copayments and deductibles is that providers, practitioners or suppliers may forgive the copayment in consideration of a particular patient’s financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and copayments must be made.”

Violation of either the beneficiary inducement statute or the anti-kickback statute can lead to substantial monetary penalties as well as possible exclusion from the Medicare and Medicaid programs. It is important, therefore, for a DME supplier to adopt and enforce a policy of waiving copayments only in individual cases where the supplier determines that the patient is financially needy. In all other cases, the supplier should pursue normal collection efforts. In addition, the supplier should avoid advertising that could be taken to imply that the supplier will routinely waive copayments.

The following sets out provisions that can be included in a formal Policy for Collections and Patient Assistance. The following provisions are only illustrations. The supplier should consult with its health care attorney to prepare a Policy suitable to the supplier’s specific needs.

Policy Statement

ABC Medical Equipment, Inc. ("ABC") is committed to complying with federal and state laws concerning accurate billing. At the same time, ABC is committed to providing access to high quality health care to all patients. ABC has encountered situations in which patients are unable to pay cost-sharing obligations because of financial hardships. In some situations, patients fail to pay cost-sharing obligations despite ABC's good faith collection efforts. To address these situations, ABC will implement this Policy and Procedure for Patient Assistance.

Purpose

Except under certain circumstances, waivers of deductibles and copayments are not permitted because such waivers misrepresent ABC's actual charge and may result in false claims. Also, the Office of Inspector General has indicated that such waivers may violate the Federal Anti-Kickback Statute. Accordingly, this policy sets forth procedures that ABC and all ABC employees will follow before any cost-sharing obligation is waived. Under this policy, ABC may waive a patient's cost-sharing obligation only after the patient demonstrates a financial hardship. Otherwise, ABC will employ good faith efforts to collect copayments and deductibles.

Definitions

Application – The form entitled, "Economic Assistance Request," that a patient must complete to request a financial hardship waiver. The application is attached as Attachment A.

Cost-Sharing Obligations – Payment obligations, including copayments, deductibles, and coinsurance, required under a patient's arrangement with the patient's third-party payor.

Family – All persons residing in a patient's home who are related to the patient by birth, marriage, or adoption.

Federal Poverty Guidelines (FPGs) – Often referred to as the "federal poverty level," FPGs are measures of poverty issued yearly by the Department of Health and Human Services in the Federal Register. The current FPGs are listed in Attachment B.

Financial Hardship Waiver – Waiver of a cost-sharing obligation provided to a patient because the patient demonstrated a financial need.

Gross Family Income – Gross family income refers to the total yearly value of the family's income from all sources prior to any tax deduction.

Manager – Under this policy, the Manager is responsible for reviewing applications and determining whether to grant a financial hardship waiver. _____ will serve as the Manager under this policy. S/he may delegate his/her responsibilities under this Policy to any employee of ABC.

ABC – In this policy, references to ABC include all employees and representatives authorized to act on behalf of ABC.

Procedure

Private Insurance Companies – ABC will comply with all contracts in place with insurance companies. In the event a contract conflicts with this Policy, the contract will take precedence over this policy. When ABC waives the cost-sharing obligation related to the patient's private insurance, ABC will notify the affected insurer.

Statements Regarding Waivers – ABC will not advertise or otherwise promote the waiver of deductibles or copayments. No ABC employee may tell the patient or the patient's representative that the patient does not need to pay the cost-sharing obligation unless the patient has submitted an application and the Manager has authorized a waiver. At the time ABC provides services to a patient, ABC representatives will provide to the patient an estimate of the patient's cost-sharing obligation. Only when the patient volunteers that he/she cannot pay the cost-sharing obligation may the ABC representatives may inform the patient of the availability of a financial hardship waiver and the application process. ABC will document any waiver provided to a patient on the patient's invoice or receipt for service.

Financial Hardship Waivers

Application Required – When a patient requests a financial hardship waiver, ABC will require the patient to complete and submit an application entitled, "Economic Assistance Request." If the patient requests an application for patient assistance, ABC representatives may email, fax, mail, or hand deliver the application to the patient. Alternatively, at the patient's request, ABC representatives may receive the information verbally and complete the application on behalf of the patient. Any application

completed in this manner will be mailed to the patient for the patient to sign and return. The patient will also be required to supplement an application completed verbally with evidence of financial hardship.

Up to Date Information – Upon receipt of the application, ABC will inform the patient of the patient's responsibility to notify ABC of any changes to the patient's situation. ABC may rely on the documentation submitted by the patient for 12 months, unless the patient notifies ABC of any changes to his or her situation. At the expiration of the 12-month period, ABC will request that the patient completes a new application.

Documentation Supplementing the Application – ABC need not request documentation to support the patient's statements on the application in every case. ABC will require supplemental documentation for applications completed verbally. Also, in the event the Manager has any doubts regarding the accuracy and validity of an application, ABC will require the patient to submit documentation evidencing a financial hardship. In such events, ABC will request a copy of the patient's tax return and/or other evidence of the patient's financial need, which may include evidence of (i) homelessness; (ii) enrollment in Women, Infants, and Children (WIC) programs; (iii) receipt of food stamps; (iv) participation in a subsidized school lunch program; (v) participation in an unfunded state or local assistance program; (vi) residence in low income, subsidized housing; and/or (vii) other evidence of financial need, such as pay stubs or medical bills.

Eligibility Criteria for Financial Hardship Waivers – The Manager will review the submitted documentation and determine whether the patient meets the criteria for a financial hardship waiver. The basis for any determination will be documented and kept in ABC's records. The eligibility criteria for financial hardship waivers are as follows:

Full Waiver – The patient is eligible for full waiver of the patient's cost-sharing obligation if the patient's gross family income is less than or equal to the applicable FPG. Under such circumstances, the patient may receive a full waiver. However, the Manager is not required to grant a full waiver; the Manager may determine that a partial waiver is appropriate.

Partial Waiver – If the patient's gross family income is greater than the applicable FPG, but less than or equal to two times the applicable FPG, ABC may reduce the patient's cost-sharing obligations. The amount waived will depend upon the particular patient's circumstances. If the patient's gross family income is greater than two times the applicable FPG, ABC will presume that the patient is not eligible

for patient assistance unless (i) the patient's family has unreimbursed medical expenses that exceed 20% of its gross family income or (ii) the patient demonstrates the existence of other extraordinary circumstances that justify a financial hardship waiver. Under such circumstances, the Manager may grant a partial waiver of the patient's cost-sharing obligation. The Manager has the authority to grant a full waiver in the event the Manager determines that such a waiver is justified by the patient's financial situation. The basis for any determination shall be thoroughly documented in ABC's records.
Provision of Financial Hardship Waivers – If the patient meets the eligibility criteria, ABC may provide a financial hardship waiver unless the Manager determines that a financial hardship waiver is unnecessary or inappropriate in a particular case. For example, the Manager may decide that a financial hardship waiver is inappropriate because the patient falsified documentation or because the evidence of financial need is unreliable. ABC will promptly notify the patient of the Manager's determination regarding the patient's application.

Documentation – ABC will maintain copies of all applications and supplemental documentation submitted by patients. ABC will document and maintain records concerning (i) the amount of a waiver provided to a patient and (ii) the basis for ABC's decision.

Yearly Review of Financial Hardship Waivers Granted – Each calendar year, the Manager will evaluate the number of patients receiving financial hardship waivers from ABC. If the number of such patients is approximately 10% or more of the patient population served by ABC in that year, then the Manager will take steps to ensure that ABC is not unnecessarily waiving cost-sharing obligations. For example, the Manager may retrain staff on this policy and require supplemental documentation for all applications before ABC grants a financial hardship waiver.

Waivers Following Good Faith Collection Efforts

ABC may write off the cost-sharing obligation of a patient who does not qualify for a financial hardship waiver only if (i) the patient's cost-sharing obligation remains unpaid after 120 days and (ii) ABC exercised and documented the following collection efforts:

Initial Invoice – After ABC provides services to a patient, ABC will issue to the patient an invoice detailing the amount of the patient's cost-sharing obligation.
Second Invoice – If the patient fails to pay the cost-sharing obligation within 30 days, ABC will send to the patient a subsequent statement detailing the patient's outstanding balance.

Telephone Contact and Third Invoice – If the cost-sharing obligation remains unpaid after 60 days, ABC will send a third billing statement. Within 10 days following the date of the letter, ABC will contact the patient by phone. Phone calls will be made until affirmative contact is established with the patient or the patient's representative. During the phone call, an ABC representative will (i) collect information concerning the reason for non-payment, (ii) solicit an agreement for a specific payment plan, and/or (iii) offer to provide an application for patient assistance. If the patient submits an application, ABC will promptly notify the patient of the Manager's determination. If the application is denied, or the patient does not submit an application, ABC will continue efforts to collect the patient's cost-sharing obligation. Fourth Invoice – If the patient's obligation remains unpaid after 90 days, ABC will send a fourth billing statement.

All invoices, telephone and in-person contacts regarding the patient's cost-sharing obligation will be documented in the patient's billing file. If a patient's cost-sharing obligation remains unpaid after 120 days, the Manager will review the documentation regarding ABC's collection efforts. The Manager may then direct an ABC representative to continue collection efforts, turn the account over to a collection agency, bring a collection lawsuit, refuse to provide products and services to the client in the future, or write off the obligation. The Manager may write off the obligation as long as the good faith collection efforts listed above are clearly documented in the patient's file.

Audits

The billing and waiver procedures of ABC will be audited from time to time. Findings from such audits shall be submitted in writing to ABC's officers and directors. ABC's officers and directors may also engage an outside party to conduct an audit of ABC.

Economic Assistance Request

On the Economic Assistance Request Form, the patient will be asked several questions, such as:

1. Are you married?
2. How many dependents do you have?
3. What is your current household size? (Include spouse, children, and legal dependents living in your home)
4. Are you receiving any type of assistance from local, county, state, or federal government agencies? If so, describe the assistance.

5. Is a guardian or anyone else legally responsible for your medical bills? If the answer is “yes,” provide the person’s name and contact information.
6. Do you own your house? If yes, is it paid for?
7. Do you or anyone in your household have any unpaid medical and/or other bills?
8. How much do you have in savings to which you have immediate access (not including qualified retirement)?
9. What is your monthly net income from the following: employment, Social Security, child support, retirement, investments, spouse, disability?
10. What are your monthly expenses for the following: rent/house payment, prescriptions/medical, insurance, food, car payment, other?

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