No Surprises Act

Balance Billing & Good Faith Estimates

Who We Are

- Experienced Team of Revenue Cycle Professionals
- Committed to Helping Healthcare Organizations Thrive
- Passionate About Solving Even The Most Difficult of Revenue Cycle Challenges!

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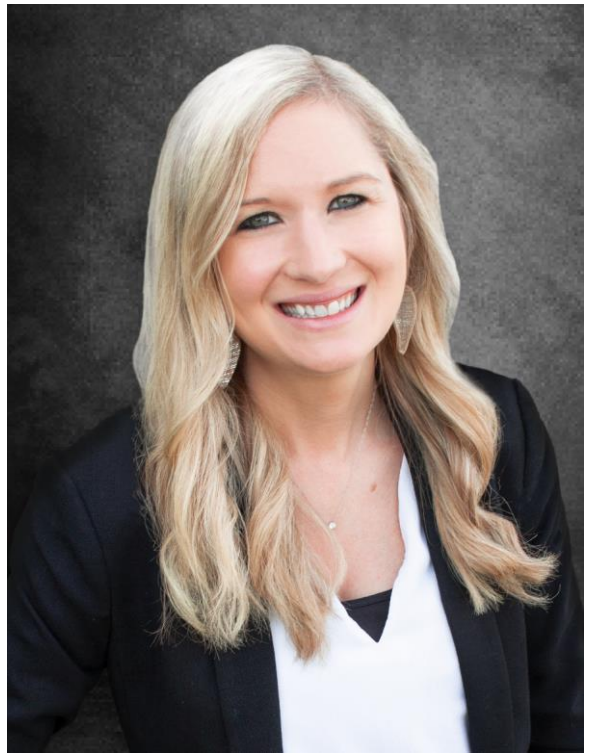
Introductions



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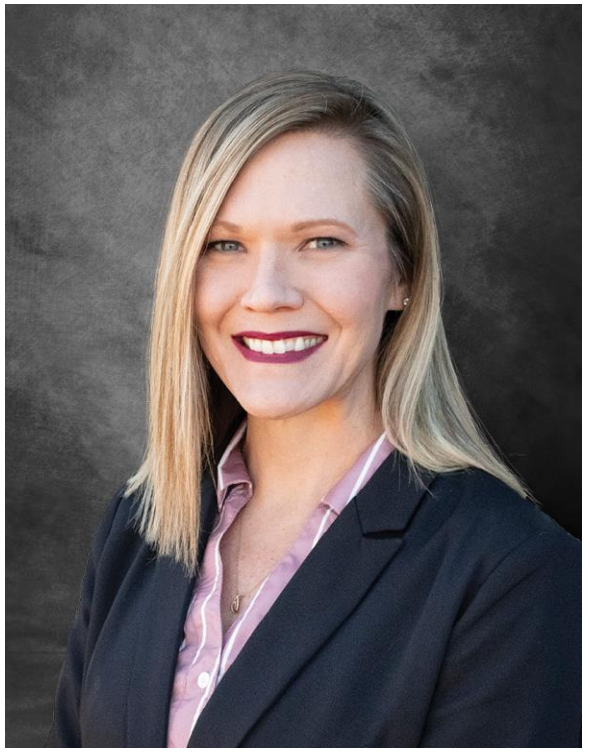

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Disclaimer

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No Surprises Act Packages

Webinar #1

- No Surprises Act Background
- Balance Billing
- Good Faith Estimates
- Additional NSA Regulations
- Q&A Session
- Recording sent out after session

Webinar #2

- Out-of-Network Reimbursement Methodology
- Nebraska State Law Interaction with NSA
- Independent Dispute Resolution Process
- Selected Dispute Resolution
- Q&A Session
- Recording sent out after session

Implementation Toolkit

- FAQ
- Workflows
- CMS NSA Documents & Forms
- Quick Start Implementation Checklist
- Crosswalk document with internal audit tools

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Acronyms

- DOS=Date of Service
- GFE=Good Faith Estimate
- HHS= Department of Health and Human Services
- IDR=Independent Dispute Resolution
- IFR=Interim Final Rule
- NSA=No Surprises Act
- OON=Out-of-Network
- QPA=Qualifying Payment Amount
- TOS=Time of Service
- SDR=Selected Dispute Resolution

Agenda

- No Surprises Act Background
- Balance Billing
- Good Faith Estimates
- Additional NSA Regulations
- Questions

No Surprises Act Background

Why Was NSA Put Into Place?

Numerous studies have shown that patients frequently receive substantial “surprise” medical bills

- Payments made by patients who got a surprise bill for emergency care were more than 10 times higher than those made by other patients for the same care
- In a period from 2010-2016:
  - 39% of ER visits to in-network hospitals resulted in an out-of-network bill
  - Average amount of a surprise medical bill increased from $220 to $628

NSA protects patients against “Surprise Bills” by putting into place:

- Balance Billing Provisions
- Good Faith Estimate Requirements

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NSA Structure

Three Departments:

- Department of Health and Human Services
- Department of Treasury
- Department of Labor

Operational Dates:

- Balance Billing Protections
  - Facilities/Providers: January 1st, 2022
  - Payors: Plan, policy, or contract years starting on OR after January 1st, 2022
- Good Faith Estimate
  - Uninsured/Self-Pay: January 1st, 2022
  - Group/Individual Health Insurance: July 1st, 2022 or beyond

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NSA Interim Final Rules

Released July 13, 2021:

- Interim Final Rule Requirements Related to Surprise Billing; Part I
  - Balance Billing Protections
  - Calculated OON Payment

Released October 7th, 2021:

- Interim Final Rule: Requirements Related to Surprise Billing; Part II
  - Good Faith Estimate
  - Independent Dispute Resolution Process

Comment period on both rules (60 days)

Additional Interim Final Rules are expected to be released

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Provider Definition?

- The term “Provider” is often used interchangeably for both a facility and physician
- In the NSA it is important to differentiate between what applies to a physician vs. facility
- Therefore, throughout this presentation the term “provider”, will be used for a physician, and the term “facility” will be used for a facility

Balance Billing

Balance Billing Outline

NSA protects patients from balance billing in certain situations and imposes duties on providers and facilities:

Two Duties:

- NSA Balance Billing Disclosure
- Balance Billing Prohibitions

What is Balance Billing?

"PFS world" defines balance billing is known as ANY amount billed to the patient (deductible, co-insurance, etc.)

NSA defines balance billing differently:

- "The practice of out-of-network providers billing patients for the difference between (1) the provider's billed charges, and (2) the amount collected from the plan or issuer plus the amount collected from the patient in the form of cost sharing (such as a copayment, coinsurance, or amounts paid toward a deductible)"

*Essentially balance billing is when the **OON provider/facility bills the patient for any amount above the allowed amount** (i.e. contractual adjustment)*

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Balance Billing Disclosure

What Is The Purpose & Who Must Provide?

Disclosure Purpose:

- To provide general, publicly available, information about patient protections from balance billing
- Think about it like the Notice of Privacy Practices Document

Who Must Provide Disclosure:

- ALL providers and facilities must post & provide **Regardless of network status**
- **EXCEPT** for providers who do **NOT** provide services at a facility or in connection with a visits at a facility
- Example: A cardiologist who performs visits at a facility would have to post in office & provide, but an audiologist who never goes to facility, would not.

Disclosure Content

Must comply with applicable language requirements and have statements regarding:

- Federal laws in relation to balance billing protections
- State laws in relation to balance billing protections
- Contact information for appropriate state and federal agencies that a patient may contact if provider/facility has violated a requirement

Providers/facilities may, but are not required to, use CMS model disclosure

Disclosure Content- Federal & State Language

Federal Law:

- CMS provided language for federal law in model disclosure

State Law:

- HHS is encouraging states to develop model language to assist providers/facilities in disclosure statement
  - Nebraska has not yet developed language
- Critical Access Hospitals are excluded from Nebraska state law
  - HOWEVER, if also disclosing on behalf of a provider, then add in statement about state law

Required to have BOTH federal and state law in the disclosure

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Disclosure Content- Nebraska State Law

How does Nebraska Law Prohibit balance billing?

- OON facilities/providers cannot bill patient over in-network allowable for emergent services

What is the law?

- Nebraska Out of Network Emergency Medical Care Act 44-6834 through 44-6850
- Operational as of January 1st, 2021

Who must comply with Nebraska State law?

- **Facilities:** General Acute Hospital, Satellite Emergency Department, Ambulatory Surgical Center
  - **Critical Access Hospitals DO NOT have to comply with this law**
- **Providers:** Health care professionals, who are individuals credentialed pursuant to the Uniform Credentialing Act (i.e.-physicians, etc.)

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CMS Disclosure

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

CMS-10780-Model Disclosure

Public Disclosure Requirement

Providers/facilities must post the disclosure prominently at:

- Emergency department
- Scheduling, check-in, financial services, etc.
- If provider does not have a publicly accessible location, then not applicable

Providers/facilities must post on public website:

- The disclosure or link to the disclosure must appear on a searchable homepage of the provider's/facility's public website
- If provider does not have a website, then not applicable

Must meet BOTH of these requirements

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Disclosure Delivery Requirements

- Provide to patients that have group/individual health insurance
- Provide by mail or e-mail, or in-person, as selected by the patient
- Must be one-page (double-sided) and 12-point font
- Providers are only required to provide the disclosure to patients whom they provide services to at a facility or in connection with a visit at a facility

Disclosure Timing

- Provide prior to ANY patient payment request (INCLUDES time of service payment requests)
- If no time-of-service payment request, then provide prior to claim submission date

Preventing Duplication of Disclosure

- All providers are required to provide independent disclosure, unless a written agreement with the facility is in place
- Facility can provide disclosure for their affiliated providers if written agreement is in place:
    - "Written Agreement" can be a new agreement or an amendment to an existing agreement
    - Facility disclosure must include information applicable to both the facility and the provider
    - If facility fails to provide full or timely disclosure information, then the facility, but not the provider, would violate the provider disclosure requirements
  - HOWEVER, each provider still must post the disclosure on a public website

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Provider Considerations

- Providers are going to be responsible for posting and providing disclosure, regardless of network status, unless they have an agreement in place with the facility
- Therefore, providers should have agreement in place with every facility they provide services at, REGARDLESS if their network status matches the facility!
- Example-General surgeon who has specialty clinics at multiple hospitals would need to have an agreement with each hospital

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Key Takeaways for Disclosure

Facilities are required to:

- Post disclosure on their website and in public areas, including ER
- Provide disclosure to every commercial patient prior to TOS payment request

Providers are required to:

- Post disclosure on their website and in public areas in their office
- Provide disclosure to commercial patients, who they are providing services to at a facility, prior to TOS payment request

Providers who have a written agreement in place with a facility are only required to:

- Post disclosure on their website

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Balance Billing Operationalizing

Balance Billing Decisions

- In some situations, Balance Billing is prohibited
- In other situation, facilities & providers have the option to balance bill:
  - **Decision Point #1** :

    Do you want to balance bill or accept the rate outlined by law?
    - If you want to balance bill, you must learn the Notice & Consent Rules
    - If you do not want to balance bill, Notice & Consent are not necessary
  - **Decision Point #2** :

    To what degree do you want to collaborate with providers to assist or facilitate compliance for their ability to balance bill?

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Where Does Balance Billing Apply?

Any service provided to patients that are within facilities:

- Hospitals (Statute specifies CAH, OP Hospital, Acute Hospital)
- Ambulatory Surgical Center
- Independent Freestanding Emergency Department

Does not apply services provided in:

- Independent Clinic
- Rural Health Clinics
- Urgent Care Clinics

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When Is Balance Billing Prohibited?

Strictly prohibited:

- Emergency services provided by ANY OON provider/facility
- Ancillary Services:
  - Anesthesiology, Pathology, Radiology, Laboratory, Neonatology, Assistant Surgeons, Hospitalists, Intensivists
  - Ancillary services provided by an OON provider when there is **NO** in-network provider who can furnish such a service at the in-network facility
- Services due to unforeseen, urgent medical needs (even if Notice and Consent was previously obtained)
- Air Ambulance

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What Is Considered an Emergency Service?

Emergency Department Services

Pre-Stabilization Services:

- Services related to an emergency medical condition, patient is still not stable, but moved out of the ER

Post-Stabilization Services:

- Services related to an emergency medical condition, patient is stable, and is receiving services to maintain or improve stability
- Considered emergent, unless certain circumstances are met

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When is Balance Billing Permitted?

Permitted with Notice & Consent:

- Non-Emergent services provided by an OON, non-ancillary, provider at an in-network facility
- Post-stabilization services:
  - Specific provider documentation required
  - Patient can travel using nonmedical or nonemergency medical transportation to a PPO facility within a reasonable distance and is documented in medical record
  - Only apply in limited circumstances

Always Permitted:

- Non-emergent services provided by:
  - OON provider at OON facility
  - OON facility
- Patients are subject to their OON insurance benefits/patient responsibility and have no protections under the NSA

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What Rate Do OON Providers/Facilities Receive If Notice & Consent is NOT Obtained?

Payment rate for OON providers/facilities, “OON Rate”, is determined:

- By state law
- If no state law, payor/provider agreed upon amount
- If parties cannot agree, then the IDR process

Patient responsibility for OON services is determined:

- By State law
- If no state law, then the lesser amount of the Qualifying Payment Amount (QPA) or billed charges

Nebraska State Law:

- Governs payment for emergency department services only (CAHs excluded)

Qualifying Payment Amount (QPA):

- Median of contracted rates for a specific service in the same geographic region within the same insurance market as of January 31, 2019

Discussed in depth in second webinar

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What Health Insurance Plans Are Subject To Balance Billing Protections?

- Group Health Plans:
  - Insured and self-insured group health plans
  - Private employment-based group health plans subject to ERISA
  - Governmental plans sponsored by states, counties, school districts, etc.
- Individual Health Insurance Coverage:
  - Coverage offered in the individual market
  - Through or outside of an Exchange
  - Student health insurance
- Grandfathered Plans & Grandmothered Plans
- Traditional Indemnity Plans
- Federal Employees Health Benefits Program (FEHBP) carriers subject to OPM regulation and contract provisions

What Health Coverage Is NOT Subject to Balance Billing Protections?

- Health Shares
- Plans or Coverage Consisting Solely On Expected Benefits:
  - Liability Insurance
  - Accident Insurance
  - Workers Compensation
  - Auto Insurance Medical Pay
- Short Term, Limited-Duration Insurance
- Retiree-Only Plans

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What Are The Insurance Company Responsibilities?

Emergency Services:

- Cannot require prior authorization
- Cannot limit coverage or automatically deny ER services based solely on final DX code
- Payor must ALWAYS:
  - Pay provider/facility the “OON Rate”
  - Process patient responsibility as determined by QPA
  - Apply patient responsibility toward in-network deductible & out-of-pocket maximum

Non-Emergent Services:

- UNLESS Notice & Consent is obtained, payor must:
  - Pay OON provider at an in-network facility the “OON rate”
  - Process patient responsibility as determined by QPA
  - Apply patient responsibility toward in-network deductible & out-of-pocket maximum

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Key Takeaways for Operationalizing Balance Billing

- **Facilities and providers must determine if they want to balance bill**
  - **If yes, understand when it's permitted and when it's prohibited**

- **Insurance Companies must follow applicable regulations**

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Balance Billing Notice & Consent

When Does Notice & Consent Need to Be Obtained?

Provider/facilities ONLY need to get notice and consent **IF** they want to balance bill in situations eligible for Notice & Consent

- Provider Eligible Situations:
  - OON, non-ancillary, provider performing non-emergent services at in-network facility
  - OON provider performing post stabilization services
- Facility Eligible Situations:
  - OON facility providing post stabilization services

Key Phrase-"If they want to balance bill"

- If the provider/facility does not wish to balance bill, then Notice & Consent **DOES NOT APPLY**

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Notice & Consent Packet

- Notice & Consent standard document packet contains:
  - Page 1-2: Provider Instructions (Do not include in patient packet)
  - Page 3: Notice
  - Page 4: Good Faith Estimate for OON services/items
  - Page 5: Consent
  - Page 6: Details about estimate
- Documents in packet **MUST** be provided together to the patient

CMS-10780
Notice & Consent

Notice Requirements

- Purpose:
  - To notify the patient they are not required to sign consent and provide patient with information about balance billing protections
- Requirements:
  - Must utilize CMS Standard Notice
  - Must be provided with NSA Consent
  - Physically separate from
  - Written and provided on paper or electronically, as selected by the patient

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CMS Notice

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

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Estimate Requirements

ONLY include services for the OON provider/facility

Multiple OON providers may provide a single notice that includes:

- Each provider's name listed on the notice document
- Notice and a GFE for each service that each provider is furnishing
- Which services are being furnished by which providers
- A statement that the patient has the option to consent to each provider separately

Prior Authorization/Care Management Information

- General information can be provided to satisfy this requirement
- The departments encourage providers to contact plan about any such limitations

List of In-Network Providers

- For post stabilization services ONLY, an OON provider at an in-network facility, must provide a list of in-network providers at facility who are able to furnish the items/services involved

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CMS Estimate

Estimate of what you could pay

Patient name:_____

Out-of-network provider(s) or facility name:_____

_____

Total cost estimate of what you may be asked to pay:	

► **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

► **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Call [*Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]*

► **Questions about your rights?** Contact [*contact information for appropriate federal or state agency]*

Prior authorization or other care management limitations

[*Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:*

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[*In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]*

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit [*website*] for more information about your rights under federal law.

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Consent Requirements

- Purpose:
  - Patient consent to be balance billed by OON provider/facility
- Requirements:
  - Provided voluntarily and take into consideration:
    - Patient's emotional and mental state at time of consent (undue stress)
    - Cultural and contextual factors that may affect decision-making (mistrust based on historical inequities, language barriers, etc.)
  - Acknowledgement statements
  - Date patient received the notice
  - Date and time that the patient signed
- Patient may revoke consent by notifying provider in writing prior to care

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CMS Consent

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

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Timing

Appointment scheduled more than 72 hours prior to DOS?

- Provide 72 hours prior to service

Appointment scheduled within 72 hours of DOS?

- Provide on the day that the appointment is made

Appointment scheduled same day?

- Provide notice at least 3 hours prior to service

Language Requirements

Documents must be made available in the 15 most common languages in the state

- Can instead choose the 15 most common languages spoken in the geographic region rather than the state

Notice & Consent is not valid if the patient cannot understand

- Example-Limited English proficiency, disability, language other than the 15 most common

Must also continue to comply with other state/federal laws regarding language access

Signed Consent & Retention

- Signed Notice & Consent
  - The OON provider or the in-network facility (on behalf of the OON provider) must provide the patient with a copy of the signed notice and consent.
  - Provide by mail or e-mail, or in-person, as selected by the patient

- Retention
  - Retain written notice & consent for 7 years
  - Provider must retain **OR** may coordinate with facility

Reminder!

Circumstances Strictly prohibited from Notice & Consent:

- Emergency services provided by ANY OON provider/facility
- Ancillary Services:
  - Anesthesiology, Pathology, Radiology, Laboratory, Neonatology, Assistant Surgeons, Hospitalists, Intensivists
  - Ancillary services provided by an OON provider when there is **NO** in-network provider who can furnish such a service at the in-network facility
- Services due to unforeseen, urgent medical needs (even if Notice and Consent was previously obtained)
- Air Ambulance

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Facility Considerations

What providers come to your facility (excluding ancillary service providers) that don’t match your network participation?

Do those providers intend to balance bill?

- If not, Notice & Consent does not apply
- If yes, do those providers require assistance in obtaining Notice & Consent?

Provider Considerations

Do you intend to balance bill?

If no, then Notice & Consent does not apply

If yes, then:

- Ensure you are not an ancillary provider
- Review facility network statuses compared to your network statuses
- Coordinate with facility to ensure proper and timely Notice & Consent

Key Takeaways for Notice & Consent

- When an OON provider/facility wants to balance bill patients for services that are **eligible for Notice and Consent**:
  - Develop workflow to ensure timely notification
  - Utilize CMS Notice & Consent packet (Notice, Consent, Estimate)
  - Make available in the 15 most common languages for the state
  - Coordinate retainment of documents

Balance Billing Claim Submission

What To Provide The Payor?

- **IF** Notice/Consent was obtained, OON provider/facility must provide timely notification:
  - Non-Emergent Services:
    - Notify the plan that the service was provided during a visit at an in-network facility
    - Provide copy of signed notice and consent
    - If provider does not submit claim, then notification requirement is met by including notice/consent with the bill sent to the patient
  - Post-Stabilization Services:
    - Notify the plan as to whether all conditions were met that allow notice & consent
    - Provide copy of signed notice and consent
- Absent receiving information from the facility/provider, the plan can assume patient has not waived protections!

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How To Submit Claim?

- Provide notice when transmitting the claim, either on the claim itself or in a separate document
  - HHS is encouraging providers/facilities to provide directly on claim form
- How to provide notice on claim form?
  - No Guidance
  - HHS is seeking recommendations on how standard transactions to submit claims can be modified to accommodate the submission of:
    - Whether surprise billing protections apply to the services on the claim
    - Whether the service was furnished during a visit at a in-networking facility by an OON provider
    - Whether the requirements for notice and consent have been met
- How to provide copy of notice and consent?
  - No Guidance
  - HHS is “particularly interested” in comments regarding the requirement to provide the payor with a copy of the signed notice/consent

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What is Considered “Timely Notification”?

- No Guidance
  - HHS is seeking comments on whether additional rulemaking would be helpful regarding the process and timing for notification to the payor
  - Including a definition for “timely”

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Key Takeaways For Claim Submission

- Facility/provider responsible for notifying plan if notice & consent was obtained
  - No current guidance
- Unanswered questions:
  - Will there be a unform way to notify insurers on claim form?
  - How will signed notice/consent be provided electronically?

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Good Faith Estimate (GFE)

Who Must Comply with GFE?

What Entities Must Comply with GFE?

- **Health Care Facilities**-Under this section of the IFR, “health care facility” is defined more broadly than the balance billing section
  - **Definition:** “An institution in any state in which state or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such state or locality responsible for licensing such institution as meeting the standards established for such licensing.”
- **Health Care Providers**-Under this section of the IFR, “provider” is defined as:
  - **Definition:** “A physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services”

What Does This Mean?

- ALL providers licensed within the state must provide GFEs, including
  - **Facilities**-hospital, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center

    AND
  - **Providers-**such as independent physician clinics, stand alone physical therapy centers, dental clinics, optometrists, behavioral health providers, etc.

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When Is a GFE Required?

When Is a GFE Required?

- Scheduled Care
  - Uninsured or self-pay patients only
- Upon Patient Request
  - Any patient, regardless of insurance status or type

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Scheduled Care

- Provide GFE to Uninsured or Self-Pay Patients
  - **Self-pay** is a patient who is electing to not use their commercial insurance
  - **Uninsured** is when a patient does not have a qualifying health insurance OR the patient's benefits do not cover the service/item
  - Health shares, short term limited duration insurance, work comp, and liability insurance are NOT health insurance, and therefore are considered uninsured
  - EFFECTIVE Jan 1st, 2022
- Provider GFE to Commercial Insurance-**Delayed Implementation**
  - Provider to send GFE to plan
  - Plan to provide patient with advanced EOB
  - DELAYED to at least, if not beyond, July 1st, 2022

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What About Urgent Care?

- HHS states: “Some items or services may not be included in a GFE because they are not typically scheduled in advance and are not typically the subject of a requested GFE, such as urgent, emergent trauma, or emergency items or services”
- “However, HHS clarifies that to the extent an urgent care appointment is scheduled at least 3 days in advance, these interim final rules require a provider or facility to provide a GFE”

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Upon Patient Request

- Does not have to be a scheduled service
- Patients may request a GFE to:
  - Compare costs
  - Decide if they want to file a claim to their health insurance
  - Where to seek care
- **ANY** discussion regarding the potential cost of items or services is a request for GFE
- **Request is considered "self-pay" for purposes of the requirement on the provider/facility to provide a GFE**
  - Request could come from any patient, regardless of insurance status or payor

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What Does the Patient GFE Need to Contain?

CMS GFE Template

- CMS has provided a model template providers/facilities may use:
  - Page 1-2: Provider instructions
  - Page 3-4: Summary
    - Patient Information
    - DX Codes
    - Date of Scheduled Service
    - Date of GFE Estimate
    - Summary of Provider Names/Charges
  - Pages 5-9: Detailed Provider Pages
    - Detailed Provider Information & Charges
  - Page 10: Disclaimer
    - Disclosure statements
    - HOWEVER, this model appears to possibly be missing a couple of disclosure statements

CMS 10791-GFE Template

GFE Content

- Must Include:
  - Patient name and DOB
  - Description of primary item/service and date primary services are scheduled
  - Itemized list of services, grouped by provider or facility, reasonably expected to be provided including those in conjunction with the primary services for that period of care (for both the convening provider and co-providers)
  - Applicable diagnosis codes, service codes, and charges associated with each service
  - Name, NPI, and TIN of each provider and states and facility location where care will be provided;
  - List of items/services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service
  - Several disclaimer statements

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GFE Content-Subsequent Services

- If subsequent service is NOT scheduled separately, then include in GFE
- If subsequent service is related, but IS scheduled separately, must list within GFE, but do not have to list specific charges
  - For example, list pre-surgery appointments or physical therapy in the weeks after the surgery
- The GFE must include a disclaimer that is directly above the list of separately scheduled services and must state:
    - Separate GFEs will be issued upon scheduling or upon request of the listed services
    - For the services included in the list, information such as DX codes, service codes, expected charges and provider/facility identifiers do not need to be included as that information will be provided in separate GFE upon scheduling or upon request
    - Instructions for how an uninsured or self-pay individual can obtain GFEs for these services

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Subsequent Services Example

- Knee Surgery w/ Hospital Stay:
  - A GFE would include an itemized list of items/services in conjunction with and including the actual knee surgery (such as physician professional fees, assistant surgeon professional fees, anesthesiologist professional fees, facility fees, prescription drugs, and durable medical equipment fees) that occur during the period of care
  - Hospital stay would not be scheduled separately, and therefore all the items/services that are reasonably expected to be provided from admission through discharge as part of that scheduled knee surgery, from all physicians, facilities, or providers be included in the GFE
  - When scheduling separate services, such as post discharge PT, then a separate GFE would be provided

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GFE Content-Itemized List of Services

- For surgeries and other items with multiple charges, do providers/facilities have to list out each charge?
  - HHS states “When a single service code is available that captures reporting and billing for the component parts of an item or service, the single service code and expected charge for that single service code would be reported in the good faith estimate to capture the most comprehensive coding level; the component parts would not be included in the good faith estimate as they would not be separately reported or billed.”
  - HHS provides example of a lab panel code (ie-general health panel), that only the panel code must be listed, not each code within the panel (ie-CBC, CMP)

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GFE Content-Expected Charge Amount

- Expected Charge Definition:
  - “For an item or service, the cash pay rate or rate established by a provider or facility for an uninsured (or self-pay) individual, reflecting any discounts for such individuals, where the good faith estimate is being provided to an uninsured (or self-pay) individual; or the amount the provider or facility would expect to charge if the provider or facility intended to bill a plan or issuer directly for such item or service when the good faith estimate is being furnished to a plan or issuer.”
- Essentially, charges on GFE must account for any self-pay discounts
- If financial assistance is
- Do NOT have to list both the full charge and expected charge

Content-Disclaimers

- Disclaimer that there may be additional services that convening provider/facility recommends as part of the course of care that must be scheduled separately and not reflected in GFE
- Disclaimer that information is only an estimate
- Disclaimer that informs patient about the right to initiate the patient-provider dispute resolution process
  - Must include instructions for where patient can find information about how to initiate dispute process
- Disclaimer that GFE is not a contract

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What are the Provider/Facility Responsibilities in Providing GFE?

Definitions

- Convening Provider/Facility:
  - The provider/facility who receives the initial request for GFE and is responsible for scheduling the primary service (typically the facility)
- Co-Providers/Facilities:
  - The provider or facility, other than a convening provider/facility, that furnishes items/services customarily provided in conjunction with a primary item/service.

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Convening Provider/Facility Responsibilities:

1. Inquire about the patient's health insurance status
2. Inquire if the patient is wanting to submit claim to their health insurance (commercial insurance only)
3. Inform uninsured or self-pay patient of the availability of a GFE

Convening providers/facilities shall consider ANY discussion or inquiry regarding the potential costs of items or services under consideration as a request for a GFE

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How To Inform Patients of GFE?

- Convening provider/facility information regarding the availability of GFEs must be:
    - Posted on website that is easily searchable from public search engine
    - Prominently displayed on website, in the office, and locations where patients schedule/check-in/ask financial questions
    - Provided orally when scheduling an item/service
    - Make available in accessible formats, and in the language spoken by the patient
- CMS created a model notice that can be utilized

CMS 10791-Right to Receive a GFE

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How To Provide The GFE?

- Must be provided in written form, either on paper or electronically, based upon patient's requested method of delivery
  - If provided electronically, must be in format that a patient can both save and print
- If patient requests GFE orally, the convening provider/facility may provide orally but MUST also issue a written GFE
- Must be kept in medical record for at least 6 years

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Timeframe for GFE Delivery to Patient

- Upon Patient Request:
  - Not later than 3 business days after the date of the request
- Self-Pay/Uninsured Scheduled Care:
  - When a primary item or service is scheduled ***at least*** 3 business days before the date the item or service is scheduled to be furnished: Not later than 1 business day after the date of scheduling
  - When a primary item or service is scheduled ***at least*** 10 business days before such item or service is scheduled to be furnished: Not later than 3 business days after the date of scheduling
- A single GFE can be issued for recurring care (12-month period)

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If Patient Has Previous GFE, Does a New One Need to Be Provided When Scheduling?

- If patient requested and obtained GFE prior to scheduling, then:
  - New GFE must be issued within specified timeframe
  - Per HHS, “the individual may not have been evaluated for underlying conditions that could impact the accuracy of the GFE”

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Co-Providers/Facilities Responsibilities

1. Convening provider/facility must contact co-provider/facility within 1 business of patient request or scheduling self-pay/uninsured patient
2. Co-provider/facility must provide convening provider with GFE within 1 business day of convening provider/facility request
3. The Co-provider/facility must notify the convening provider/facility of changes at least 1 business day prior to DOS
   - If changes occur less than 1 business day, must accept previous co-provider's expected charges

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Co-Provider/Facility GFE Content

- GFE information submitted to convening provider/facility must include:
  - Patient Name & DOB
  - Itemized list of items or services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care
  - Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service
  - Name, NPI, and Tax ID of the co-provider/facility, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by the co-provider/facility
  - A disclaimer that the good faith estimate is not a contract

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What If The GFE Is Off?

What If the GFE Is Off?

- If GFE is incomplete or inaccurate, provider/facility must provide corrected GFE to uninsured/self-pay patient “as soon as practicable”
- However, if services are furnished before an error in a GFE is addressed, the provider/facility may be subject to patient-provider dispute resolution if the actual billed charges are “substantially in excess” of the GFE
  - “Substantially in Excess”=More than $400 of GFE total charges per provider/facility
- Does the IFR require a corrected GFE to be provided if services have already been completed?
  - Not specifically, however we would recommend providing a corrected GFE as we believe it would hold better weight in the dispute process

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Unforeseen Circumstances

GFE does not have to include charges for unanticipated items/services that were not reasonably expected for that item/service and that could occur due to unforeseen circumstances

Selected Dispute Resolution (SDR)

- Patients have the right to file a dispute when charges are “substantially in excess” of the GFE
  - “Substantially in Excess”=More than $400 of GFE total charges (per provider/facility)
- Steps:
  1. Patient sends initiation notice within 120 calendar days of receiving initial bill
  2. If additional info is requested, patient has 21 calendar days to submit
  3. Parties have 10 business days to provide GFE, billed charges, and prove there were unforeseen circumstances resulting in the difference
  4. SDR entity will decide patient responsibility within 30 business days
- While process is pending, provider must stop collection efforts
- Will go into SDR process in more detail in Webinar #2

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Enforcement

Regulators are exercising enforcement discretion thorough December 2022 for situations where the GFE does not include co-providers and co-facilities

Key Takeaways

- ALL providers must comply with GFE requirements
- **Inform** of GFE:
  - Orally notify patient when scheduling uninsured/self-pay patient
  - Post on website and applicable locations
- **Provide** GFE to:
  - Uninsured & self-pay patients
  - Upon patient request (regardless of insurance status or if service has been scheduled)
- **Monitor** GFE to:
  - Provided corrected/updated GFE prior to services being performed
  - Ensure GFE is within $400 of billed charges

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Additional NSA Regulations

Insurance Cards

- Effective for plan years beginning on or after January 1st, 2022:
- Payment information must be provided on Insurance ID cards, including:
  - Applicable deductibles
  - Applicable out-of-pocket maximum limits
  - A telephone number and website where consumer assistance will be provided

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Provider Directories

- Applicable to plan years beginning on or after January 1st, 2022
- Requires payors to establish processes for :
  - Updating and verifying the accuracy of provider directory information
  - Responding to patient requests about a provider's network status
- If a patient is furnished an item or service by an OON provider/facility, and the patient was provided inaccurate information from the provider directory or response protocol, the payor must process patient responsibility as in-network

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Provider Directories-Payor Responsibilities

- Establish a public-facing provider directory database
- Establish a process and timeline to remove providers from the directory who have not verified their information
- Develop a process to verify the provider directory database *at least* once every 90 days
- Payors have two business days to update the provider directory upon receiving a provider notification that their information has changed
- Payors must indicate whether a provider/facility is in-network to consumers who inquire about that provider or facility's network status within one business day

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Provider Directories-Provider/Facility Responsibilities

- Verify directory information every 90 days
- Update information when it changes, including network status

Where Do I Start for Balance Billing?

1. Matrix of your (facility's) network statuses
2. Inventory of providers that perform services within your facility
   - Ancillary vs. employed vs. non-employed
   - Network statuses
   - Merge into matrix to identify any providers performing services at your facility that do not match your network participation
   - Contact any non ancillary providers that don't match to understand their intention to balance bill
   - Develop workflow for Notice & Consent if provider wishes to balance bill
3. Prepare and post disclosure on website and required physical locations
4. Coordinate compliance for disclosure for non-employed providers
   - Contract or amendment to existing contract

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Where Do I Start for GFE?

1. Bring all key stakeholders together (scheduling, registration, UR, financial counseling, PFS, etc) for planning
2. Develop script for scheduling staff to ensure patients are informed at time of scheduling
3. Coordinate workflow for initiation and delivery of GFE within required timeframes
4. Review GFE estimates after service delivery for accuracy

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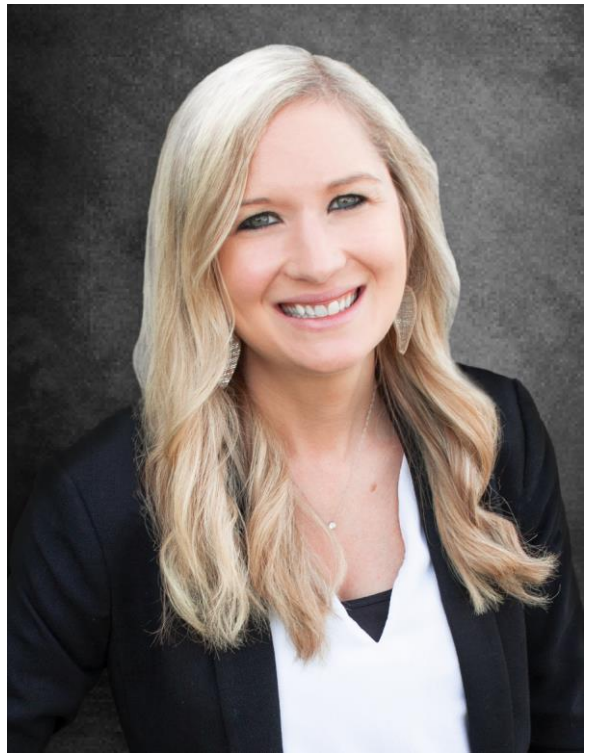
Contact Us



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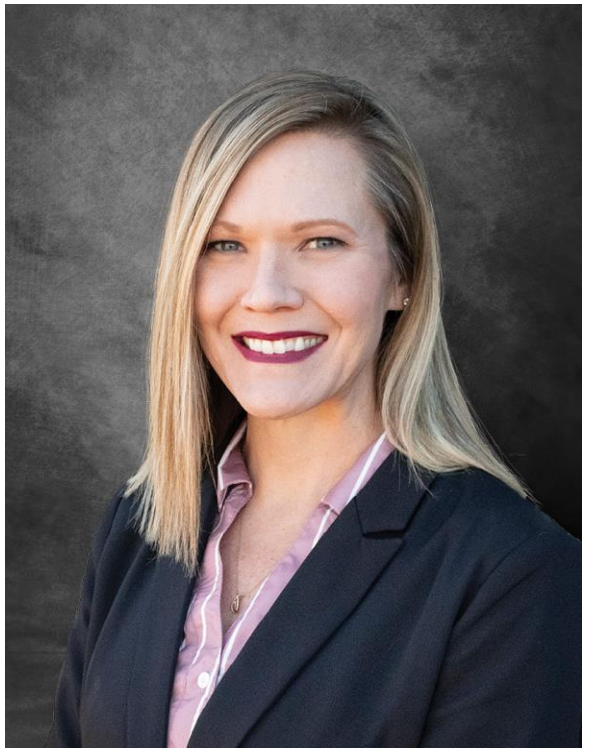

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Questions