Olivia (00:00:01):

Hello, everyone. And welcome. We're very pleased to have you for this webinar today. We are going to go ahead and get started. Welcome to the Finance Office Hour. We are going to be having a facilitated discussion on the No Surprise Billing Act, today. And now, without any further delay, I am going to go ahead and hand things over to Gervean Williams to get us started for today. Thank you so much.

Gervean Williams (00:00:24):

Thanks so much, Olivia, go ahead to the next slide. Well, thanks you guys so much for joining us. First, we have to have the disclaimer, all of this is new, with everything going on here lately. So with everything, this is for educational purposes and please make sure you consult with your legal counsel before you put anything into place for these new regulations. Next slide. So we have a action packed agenda today. So we have all our presenters here. These are the FQHC Allstars, so I'm really feel honored and privileged to be with everyone here today.

Gervean Williams (00:00:55):

We're going to kick off with Susannah, who's a partner at Feldesman Tucker, who is our go-to person on Medicare and all things CMS. Then we have our own Jeremy Crandall, who is our in-house director of Federal and State affairs, that's going to give us some things on what we're doing on the next run. I'm going to just throw in a couple things on implementation thoughts, and then we'll have Ray Jorgensen talk about flat rate sliding fee and prompt pay discount. And then we're going to wrap up the discussion with Scott Gold, who's with BKD and Rebecca, who's also the president Achieve Revenue Cycle Management, to talk about some of the workflow considerations. And with that, I'm going to go ahead and turn it over to Susan, to get us started.

Susannah Gopalan (00:01:33):

Thank you very much, Gervean and Olivia. So I'm going to kick off the discussion today by, giving an overview of a specific provision of the No Surprises Act and more importantly, how it's been implemented in regulations. So the No Surprises Act was part of the consolidated appropriations act of 2021, enacted at the end of December, last year. No Surprises, in general, it's a pretty wide ranging law that affects providers plans, a lot of duties by the federal agencies, but the main purposes of the law were to eliminate certain surprise billing events that occur for insured individuals, who accidentally access out of network services. That's one part of it. And then, there's a whole part of the law relating to transparency of information about the price of healthcare services. And it's that second part that this requirement we're going to talk about today, is located in. It's section 112, of the No Surprises Act.

Susannah Gopalan (00:02:44):

And it relates to providing a good faith estimate of the charges of services that are scheduled to occur in the future. So I'm going to tell you briefly about what the statute says, and then go somewhat, play by play as to how the regulation describes provider's obligations, to provide this good faith estimate. So what the law says is that, each healthcare provider and healthcare facility, effective for services as of January the first of next year, a couple weeks from now, is required to provide certain information to health plans, for privately insured patients and to patients, in the event that they are self pay or uninsured patients, about the estimated cost of services. So here's how it works. If a patient makes an appointment with the provider, at least three business days before the date the service is scheduled, then the provider must first inquire if the individual is enrolled in a group health plan, individual

insurance, or a federal health care program. And if they are so enrolled, if they're seeking to have a claim submitted. And next, the-

Gervean Williams (00:04:06):

Did we lose Susannah?

Susannah Gopalan (00:04:15):

Yes.

Gervean Williams (00:04:17):

Okay. I lost you for a second. Go ahead, sorry about that.

Susannah Gopalan (00:04:21):

You did? Okay, I'm sorry about that. So a notification of the expected charge for the item or service, with the expected billing and diagnostic codes for the item or service. Next slide, please. So what the law says is that, there are two parts of this good faith estimate requirement, as relates to privately insured individuals. The provider would give of this good faith estimate information to the private health insurance plans, which would turn around and generate, what the law refers to as, an advanced explanation of benefits for those individuals. This portion of the law has not been implemented by the federal agencies at this time. So this top bullet on this slide, look out for this to happen in the future. But as of right now, no good faith estimate information is being required for the privately insured individuals. And then, the next thing the law requires is in the case of an individual who is not enrolled in a private insurance plan, or a federal health benefit program, the provider sends to that individual, this good faith estimate.

Susannah Gopalan (00:05:35):

So that second bullet refers to the uninsured or self pay patients. And that's what we're talking about today. Next slide, please. So I want to tell you about how HHS and other federal agencies had implemented that requirement in the law, via regulation. The first thing I want to emphasize is, the implementing regulation that was issued this October 7th, is a final regulation. The agencies did see comment, it's called an interim final rule with comment period, but it's in final form. And to the extent that the agencies respond to the comments, including NACHCs, that would have to occur through amendments, to a regulation that's already out there on the books. So as I noted previously, these requirements in the red, at this time apply only to good faith estimates for the uninsured or self pay patients. Also important to know, the term healthcare facility for purposes of this requirement is defined, broadly.

Susannah Gopalan (00:06:40):

So the requirement does include facilities and providers, and it does include federally qualified health centers. And another important implementation note is that, this good faith estimate is require to include the charges for the service the patient asked for, and also any services provided in conjunction. So think, for example, of labs or radiology services that would be provided in conjunction with a scheduled appointment. The regulation creates this concept of convening providers, and that's the provider that's the point of first entry. And that provider is required to get the estimate to the patient,

as well as collecting information from what they call, co providers, which would be the referral providers of services such as, labs or radiology. Next slide.

Susannah Gopalan (00:07:41):

So, to go into this convening provider concept in a bit more detail, as I mentioned, the convening provider is the provider who receives the initial request for a good faith estimate. The triggering event for you to need to provide is estimate is that, either a patient schedules an appointment with you at least three days in advance of the date that the service is going to occur, or the patient requests a good faith estimate. So patients can basically shop, they can call and ask you for a good faith estimate, even if they're not scheduling the service.

Susannah Gopalan (00:08:19):

And also important to note, if they're scheduling the service less than three days in advance, you don't have to provide this estimate. The co provider or co facility is that provider of the connected or referral service. So in the case of a primary care provider, you're seeing a patient with a joint issue. You know you need a radiological service that wouldn't be provided in the health center. The radiology provider would be considered a co provider. So as I noted, and then as the reg has been drafted, the convening provider, which health centers would be, is under the obligation to get that estimate to the patient, including any information about the services the co provider might furnish. Next slide please.

Susannah Gopalan (00:09:11):

So this is the sequence of events. Once a patient schedules an appointment with you, at least three business days in advance, or asks you for the estimate, as described in the law as well, the provider has to ask the individual, if they're enrolled in a group health plan or individual health insurance coverage, or a federal health care program. And I'm going to stop briefly there and note that the term, federal healthcare program, definitely includes Medicare, Medicaid, Chip, WIC, the federal programs that directly finance services or in the case of Medicaid, federal state programs. But that term also, more broadly encompasses situations where the federal government financially supports services through a way that's not insurance.

Susannah Gopalan (00:10:07):

So for example, CMS is clarified that, patients in Indian health service facilities are beneficiaries of a federal healthcare program just by virtue of that IHS role, and those individuals, because they're federal healthcare program enrollees, are not considered uninsured for purposes of this regulation and would not need to get the good faith estimate. So if the person is enrolled in one of those programs or insurance, you ask them if they want to have a claim submitted, i.e., do they want to proceed through their insurance or do they want to proceed as self pay? And then, you have to inform the person that a good faith estimate is available and will be furnished to them. And then proceed, if they've scheduled services that entail associated services, to contact the co providers or the co facilities and commence to putting this estimate together. Next slide please.

Susannah Gopalan (00:11:06):

So the No Surprises Act, in general, has a lot of requirements about informing patients about the protections available to them. And that's true of this good faith estimate. Not only do you have to provide the patients with the estimate in certain circumstances, but you have to let them know that they're entitled to it. So you're required, under the law, to include a notice, both on your website and in

your facility about the availability of this good faith estimate. CMS has a whole battery of different templates and form documents relating to No Surprises. And I've included on this slide, a hyperlink to the CMS folder, where you can access a model disclosure about the availability of the good faith estimate. So you're required to put it on your website, post it in your facility, and also orally inform patients at the time they make their appointment or ask for the estimate, that it's available.

Susannah Gopalan (00:12:11):

Next slide, please. Timeframes. Something that I've mentioned before, but at risk of belaboring the point, if a patient makes an appointment for a same day, sick service or the next day, that's not far enough in advance for them to be entitled to this estimate. So they have to be scheduling it at least three days out, for these rules to kick in. So when they schedule an appointment at least three business days in advance, but less than 10, then you have to get the estimate to them within one business day after they schedule it. If they schedule the item at least 10 days out, then you have to get the estimate to them within three business days. And if they're simply calling to ask about the cost, but not making an appointment, then you need to get the estimate to them within three business days, after the date of the request. Now, providing the estimate, that isn't defined in the regulation. But if you are mailing this estimate, my interpretation is that, posting the document would qualify as providing it. If you get that done within the timeframes required in the rules. Next slide please.

Susannah Gopalan (00:13:31):

So there's a not only a template notification of the availability of a good faith estimate, but there is also a model, good faith estimate in this folder that I referenced. There's a hyperlink here. And also, a document that gives all the data elements, the required components of a good faith estimate and tells you the details about them. And I'm going to go through them here. I think my co presenters who are billing and operational experts, will have important detail, to flesh this out. Next slide, please. I know so many of you on the line, who are operational experts at your health centers are scratching your heads about this, because in the primary care setting, when a patient calls, they may have a vague complaint about a headache or their child running recurrent fevers, and you don't know what service they're requesting, but these are the fields required in this regulation.

Susannah Gopalan (00:14:40):

So you're supposed to give the primary item or service the patient is requesting. And then you're supposed to itemize the items or services expected to be furnished, in response to that request. Items or services is defined as, all encounters, procedures, medical tests, supplies, prescription drugs, DME provided, in conjunction with the provision of healthcare. So it's broad. In my interpretation as to prescription drugs, the only situation where you would include those costs would be, if it's a drug that's being furnished in the context of the appointment, like a physician administered drug. And importantly, the agencies clarified in the preamble, that the items are services include, dental, vision, SUD and mental health services. So this is a broad concept of healthcare services.

Susannah Gopalan (00:15:40):

And then, I did want to note that, for the co providers, those referral providers, et cetera, the agencies did say in the preamble, that they intend to exercise enforcement discretion, during calendar year 2022. Layperson's reading of that is, you won't incur compliance consequences if you fail to include the co provider's information on your estimate, during calendar year 2022, HHS is acknowledging that, that's going to be a tough part of all this to implement. Next slide please. So the estimate also has to include

applicable diagnosis codes, expected service codes and expected charges associated with each item or service. As for the diagnosis codes, the red defines that as meaning that, a code in the ICD code set. As for service codes, that means, a code in the CPT, HCPC, DRG or NDC code set. So we're talking about specific items and services and their associated codes.

Susannah Gopalan (00:16:53):

As for the expected charge, if you're dealing with an uninsured or self-paid patient, who is not entitled to discounts. So in the health center situation, over 200%, that charge should be based on the health center's charge master, not on payers fees or any other standards. So it would be the charge in your charge master, associated with the CPTs and HCPCS you've listed for the services. The estimate is required to reflect any discounts the individual would receive. So if it's an individual who is already been determined, eligible for your sliding fee discount schedule, you would provide them with that charge, inclusive of whatever discount they're entitled to, in their sliding fee class. And if you have a flat fee, sliding fee policy, then what you would provide as the estimate would be their flat fee, based on their signing fee class. Next slide, please.

Susannah Gopalan (00:17:58):

The estimate is also required to include the name NPI and TIN of each provider or facility listed on the estimate and importantly, a list of items or services that the convening provider and anticipates, will require separate scheduling. So I think a frequently occurring example of this might be, a complex dental procedure, a patient calls with a dental catastrophe that has happened. And you know that they first are going to need an extraction. And then later they'll need restorative services. It's okay for your estimate to include, only the extraction. And you would list on the estimate, you will need to make a follow-up appointment for the restorative services. And the cost of those is not included here on the estimate. Next slide, please. Disclaimers. These estimates are required to include a lot of disclaimers. They're all listed in the regulation, and the disclaimers are also covered in the model good faith estimate, on the CMS website.

Susannah Gopalan (00:19:01):

So if you don't want to reinvent the wheel, interpreting the regulation and providing your disclaimers, you could use verbatim, the language from the CMS model. But one important thing about it to note is, you're telling the patient that this is only an estimate. It's not a guarantee that this GFE represents all that they'll have to pay. You're notifying them, that they can be eligible for an independent dispute resolution process, if they want to contest the ultimate charge, more on that later. And you're letting them know, there may be additional items or services that need to be provided in follow-up, that are not encompassed on this estimate. Next slide, please. Format for the estimate. The regulation states, the estimate has to be provided in the manner the patient requests, either by, on paper or electronically, as the patient prefers.

Susannah Gopalan (00:20:00):

If it's provided electronically, the reg says it must be in a format the patient can both, save and print. So an email could meet that, a patient portal communication could meet that, as long as the patient can save and print the information. And importantly, if it's done electronically, it must be in a manner with all health information, privacy and security protection. So there's going to be PHI in these estimates. And so you would need to use encryption and whatever policies you have to protect PHI and communicating

with patient. Patients might ask for the information to be provided orally. You can do that, but you do also have to provide it in writing, in order to make these requirements. Next slide please.

Susannah Gopalan (00:20:49):

So the regulation states that, this estimate is to be considered part of the patient's medical record. I'm aware that presents some interesting challenges, like a lot of this, for example, what if you have a person who's not an established patient, who's merely calling to shop for the price of services and you don't have a record set up for them, but the red does require it be treated as part of the medical record. Your EHR vendors may be coming to you with potential solutions about incorporating this functionality and the EHR or practice management system. And that's worth looking into you for sure. The reg specifies, that you have to keep a copy of this estimate for at least six years, so that you can provide a GFE from the last six years, to the patient. And that's true, even if the patient doesn't request a copy of it, you have to just make sure you have it on file.

Susannah Gopalan (00:21:49):

The red does have some safe harbors, to the extent a provider makes a good faith error, in furnishing an estimate. That's not an instance of non-compliance with these rules. I think in our view, that doesn't really go far enough, because there needs to be an acknowledgement that this estimate is inherently speculative, when the provider has not yet seen the patient in the room and visualize their condition and even reach a diagnosis. But the reg does at least, have this concept that if you make a good faith error or rely in faith, on information from your co providers, that doesn't constitute a failure to comply with the terms of this reg. Next slide, please. So as far as enforcement, the provider oriented rules in No Surprises, including this, and including some of the surprise billing related rules, the states have primary authority to enforce those provisions.

Susannah Gopalan (00:22:59):

The law provides that, if states are not substantially enforcing the requirements, and it's HHS that makes that determination, then HHS can take over enforcement. HHS has been surveying the states, as to what they intend to do on this. I don't think there's clear information out there as to which states have taken up the option to be the enforcing entity on these rules. If HHS does enforce, then it can apply civil money penalties in an amount up to $10,000 per violation. And HHS did state, in its proposed rule on enforcement of this law, that they intend to conduct a small number, like 200 investigations, all around the country each month of potential, No Surprises violations by providers or facilities. Next slide please.

Susannah Gopalan (00:23:56):

So there are two enforcement mechanisms that can be initiated by patients that are important to know about. A patient can file a complaint with HHS, if the patient believes that a provider or facility has failed to meet the requirements in the regs, and HHS can then in turn, turn that over to the state, if it's enforcing, or turn it over to this independent dispute resolution process, if it were relates to dispute about billed charges.

Susannah Gopalan (00:24:28):

And that brings me to the second mechanism. The law requires HHS to operate an independent dispute resolution process, enabling patients to contest, where the final billed charges from one provider are substantially in access, which has been interpreted as $400 or more of the expected charges. If that threshold is met, then a patient can initiate this IDR process, where an HHS designated dispute

resolution entity conducts a whole process, to determine what the appropriate amount is, to collect from the patient. And that the feds can also delegate that to the state, if the state is enforcing these provisions and the state has chosen to operate its own IDR process. So I think that culminates the material I had, and I'm going to turn it right over to Jeremy Crandall, now.

Jeremy Crandall (00:25:29):

Thanks Susannah. And good afternoon, everybody. I have just a few, if you will, slides. I'm going to try to whip through them without talking incredibly fast. I'm also going to hold, if everybody could bear with me. I work at NACHC, I'm the Director of Federal and State Policy, but I see that my background is really being funky right now. So I'm going to change that really quickly. So if we go to the next slide, please. So really, the main piece that I want to talk about, you obviously just heard from Susannah about a lot of the particulars of this good faith estimate requirement. I just want to give you all a little bit of a policy meets politics, if you will, process background so that you all have the latest information about what we are doing to try to influence this.

Jeremy Crandall (00:26:16):

First of all, you heard all the particulars about this Part 2, interim final rule. It is important for everybody to know and understand. I did see a question very early on, it wasn't, where did this come from? It was basically, a little bit of background about what this is all about. And really, this effort to address surprise billing as it impacts patients, but specifically the relationship between the provider and the insurer has been a long running issue at the federal level, and at the state level as well. And so, unfortunately, frankly, this good faith estimate piece is one small item in a much larger issue, that affects a lot of very influential and significant players in the healthcare system. And so, this good faith estimate is in this Part 2, as it relates to health centers, but there's an entire other Part 1, that relates to the relationship between providers and ensures. That Part 1, the definition of facility does not include FQHCs, which was a very good outcome of something that we strongly advocated for.

Jeremy Crandall (00:27:26):

So there is some good news, if you will, that there's a lot more related to this, that ultimately does not apply to health centers. Can we go to the next slide please? So what I wanted to do in this slide is, give you all a quick snapshot about what is going on here. So, as I mentioned, this is a long running battle between significant players in the healthcare industry.

Jeremy Crandall (00:27:47):

Really, one of our biggest challenges, long running on this is that, this is a top priority for key leaders on both sides of the aisle, in the House and in the Senate. And so in many ways, it has dramatically limited our options, in terms of being able to influence this. But really, throughout the year, what we have been doing is, directly engaging with the Hill, with policy staff and really, the biggest piece of feedback that is important for you all to know is, we did hear directly from some of the most senior level folks that influenced the legislation, that the intention was to include FQHCs and all other providers, as it relates to this good faith estimate. And so, in the short term, our ability to be able to influence the statutory requirements, is limited, if non nonexistent.

Jeremy Crandall (00:28:32):

And so it's going to be a challenge. But what we have been doing is, directly engaging with the Health and Human Services Department, the secretary there, Secretary Becerra. We've been directly engaging

with the Bureau of Primary Healthcare and HRSA, and other agencies to really emphasize, how drastic of a requirement this is. But also, the very close connection between the sliding fee discount program approach, and what this good faith estimate requires. And so, we've engaged in a very robust information gathering process over the last several months. Big hat tip to many of you that have responded to those inquiries, to really talk through what the siding fee discount program looks like. And the last piece that I will say is, what is to come, separate from actually implementing this, which you are going to hear from my colleagues about, in a minute. Really, we are not going away on this issue, is what I want to convey to you all. This is an interim final rule, as Susannah said.

Jeremy Crandall (00:29:33):

We have to act accordingly, that this is going into effect, in approximately two weeks, but that does not end our ability to be able to influence this. And so, what we are going to be doing in the coming months is, continue to engage with you all. And I would highly encourage you, as you work to implement this, gather any anecdotal or quantitative information you can, as it relates to implementation of this. If it is not as big of a deal as, as we think, great. But ultimately, if it is as big of a challenge as we expect, the more information you can provide us, so that we can continue to engage with policy makers, the better. And so when that comes, I just can't report on that yet. We want to get through the next couple of weeks and then, reassess what our next move is going to be.

Jeremy Crandall (00:30:20):

But I want to really emphasize with you all that, we are going to continue to find ways that we can influence implementation of this policy. The last thing I will say, and then I'll stop Gervean, I saw you come on camera, is that we did submit an extremely robust comment letter, as a relates to this good faith estimate or requirement. We outlined a number of avenues that we are hopeful that the bureau, not the bureau, excuse me, that HHS will take, whether a full-on exemption for health centers or some other process, where the bureau and HRSA can work with other agencies to come up with an approach that makes sense for health centers, because of the unique way that we engage with our patients. We are operating under no illusion that there will be anything different between now and January one, but we are going to continue to advocate in the months to come, to try to seek the best outcome for you all.

Jeremy Crandall (00:31:13):

So I'm going to stop there, Gervean I know we got a lot more to cover. Oh, thank you. I did want to plug... Hold on. Can we go to the last slide? I do want to plug, that there are many states that are taking action on surprise billing as well. And one question that we are getting consistently from the federal government is, are there any requirements, as it relates to surprise billing at large, but specifically this good faith estimate requirement, where the health center has to physically provide information to the patient, requirements under state law?

Jeremy Crandall (00:31:44):

Is there any sort of requirement or state law, where a health center has to provide something? What the feds are asking is, do any of those types of state requirements exist, and are there exemptions for federally qualified health centers, where we could use that as an indication that, look, there are other examples where states have taken action and they've recognized that health centers are unique. So I'll put my email in the chat and you can all find me at NACHC, but if anybody has anything on this, we are going to continue to look for it. Gervean, I'll stop there.

Gervean Williams (00:32:15):

Thanks so much, Jeremy. So I'll just go jump through these slides. So a couple of implementation thoughts, first of all, you need to have someone who's going to be your good faith estimate ambassador, and this cannot be someone at the front desk or scheduling. And probably, since you're the one that signed up for the webinar, you might be that good faith estimate ambassador for your health center. What I mean by that is that, whenever a patient comes, this is a person that's going to trigger that process. So someone has to own that process.

Gervean Williams (00:32:42):

Secondly, you want to make sure you post it on your website and your lobby and your patient packet. You need to make sure you communicate to your patient, that they can request a GSE. And then after that, have a meeting that includes clinical finance and front office and IT staff to discuss, how are you going to pull together the GFE, using the CMS template as a guideline. And Rebecca's going to go over some more detail on that. But have a team together to have that discussion in your health center, on what it's going to look like. Next slide. So CMS put a lot of templates out there and my colleague, Olivia is going to email those out to you, but here is a sample of their public posting of the ability to request a good faith estimate. Next slide.

Gervean Williams (00:33:28):

So now I'm going to turn it over to Ray. He's going to talk about some implementing the flat rate, sliding fee, and a prompt pay discount. These are a couple of different tools, it's not the silver bullet, but it's tools you can use in order to get beyond this good faith estimate. And we have a lot of questions, we're probably going to run over. So just hold on, you guys, and we're going to ask questions at the end, but we have a lot of content and I'll go ahead and turn it over to Ray.

Ray Jorgensen (00:33:52):

Thanks, tine. And thanks everybody for being here and for the folks who are participating on this panel, there was a great discussion and lots to learn. And I've seen all the frustration in the messaging that's happening here in this chat, and also before, and just know that like everything else in healthcare, the one thing you can expect, is constant change. So let's jump ahead here. Next slide please, and the one after. All right. So real quickly, when we look at HRSA, if you haven't read their compliance manual, which many of you may have not, but actually it's one of the most easy to read, easy to consume documents. And chapter nine specifically talks about the sliding fee discount program, and you'll see sliding fee discount program and sliding fee discount scale, those terms used interchangeably. So when we look at charges in general, in healthcare, one of our obligations around charges, is to make certain that we always charge more than what we expect to get paid.

Ray Jorgensen (00:34:43):

And the simple message around that is, especially when we came up with the new PPSG codes... Gosh, that almost 10 years ago now, that the PPSG codes, it used to be our all inclusive rate. They'd pay us that full rate, whether our charges were high enough or not. But the rest of the healthcare world, you got paid your charge or the payer's fee schedule, whichever was less. So, our objective in healthcare in general, and even as health centers is, we want to make sure our charges are above our highest paying payer, but because we are health centers, because we are receiving additional federal funding, we have to make sure, as it says here, that those charges, despite trying to keep them elevated to maximize

reimbursement, are consistent with local prevailing rates, that they are designed to cover reasonable costs, that they are posted and the board is approving them regularly.

Ray Jorgensen (00:35:33):

So that's pretty common. Although I will say I visit health centers and I'll meet a new CFO or a CFO has been there for a year or two and say, "Eh, we haven't updated our fee schedule in two years, three years, five years." And this is a board responsibility as much as it is a finance team, and certainly a CFO responsibility. So getting this regularly updated is important, not just for function, but also so that you're not all of a sudden fixing your are charges and getting those fees going up. And it's a 10, 15% hike, instead of it being a very gradual, 2% hike, that's frankly, much more palatable to your community. As it says in that second bullet, must take all reasonable efforts to obtain payment from third party payers. We can't just default everybody to Medicaid, a payer of last resort, obligates anyone who's receiving money from third party payers, to make sure all third party payers are billed.

Ray Jorgensen (00:36:22):

There are some exceptions to that, around privacy and people who feel endangered, if someone were to find they were there. And as Gervean said, and I want to emphasize, I'm not a lawyer, any of these decisions, any of these conversations, we encourage you to have them with legal counsel and get that approved. I'm more than happy to have a conversation with anybody on this call or with a health center CFO about this stuff. Please reach out to me if there's interest and it certainly can be very complex, but doesn't always need to be. But again, glad to talk about some of this, especially the sliding fee program we're going to talk about here in a second. The schedule of discounts, this is critical, must be applied based on ability to pay. So that's typically based on the federal poverty level.

Ray Jorgensen (00:37:05):

In some instances, when people don't have any income, we're going to talk about what types of... You have to have predetermined items that you will accept, whether it's a pay stub, whether it's a checking account, whether it's some other sort of financial support letter that you're willing to accept. And as it says here, it's available for those with family income, up to 200% of poverty. And I'm going to talk about something called, prompt payment, giving discounts with people over 200%, but we want to make sure that, we're complying with the law, which says that the sliding fee discount program can only work with people, up to 200% of federal poverty. Next slide, please.

Ray Jorgensen (00:37:44):

As I already indicated, we need these to be written. I'm encouraging you to have this on your website. I'm encouraging you to also have it in your lobbies, if you have people who are checking in with iPads, to be something they can see electronically. As we already mentioned, when you board approval. There is a very specified structure, eligibility requirements have to be clear about proof of documentation. What are you willing to accept? And it needs to be consistent across all your sites. And that's just to make sure that everybody's being treated fairly, that we're not subjectively determining who's eligible and who is not. Self declaration is fine, but what does that mean? What do you have to accept? Someone can't just show up and say, "I don't make any money." And yet, somehow they got there, they look like they've been eating and they're wearing clothing.

Ray Jorgensen (00:38:29):

We have to have some idea about that, what you're willing to accept around self declaration. And nominal charge, what does that mean? It can be different from literally, health center to health center. But if you're one health center with 15 clinics, you need to have some assurance that, that's going to be consistently done. Meaning nominal charges collected, the same way, at all 15 locations. And then billing and collection policies. How are you going to charge the patient and how are you going to be certain that they're not overcharged. And HRSA did add some language around refusal pay. And this is hard for health centers to hear, because of many health centers started out as free clinics. But if you determine that someone's eligible to pay a certain amount of money and they refuse to pay that money or make any effort towards it, which could even be a dollar a month, a dollar week, whatever it is, you do have the right to say, "We're not going to see you anymore because you're refusing to pay." Not a common theme, not one I'm recommending.

Ray Jorgensen (00:39:23):

And certainly we're all in this health center marketplace to help those in need, but it is part of the HR policy. And again, if you haven't read it, I encourages to do that. Next slide, please. This was interesting too. I've had folks say to me, "Well, our commercial insurance contracts, are not legally", and I'll say the term legal, "Allowed to waive co-pays." HRSA made it very clear that the sliding fee discount program and those discounts, apply to copays co-insurance deductibles, and frankly, anything that you're going to be providing. You can have more than one slide. You can have one for dental, then one for medical, if you're getting Title 10 money, you could have a separate slide for Title 10. In fact, that would be different, because those benefits go up to 250% of poverty. So you have to have some idea what rules exist and how you could lay those out. And you want to make it as clear as possible to your clientele, so it's easy for them to understand. If you're going to waive fees, when might you do that?

Ray Jorgensen (00:40:15):

Some people have decided to do it during a public health emergency. That would be really, a big deal around this pandemic. Some folks have done that at some level, I've worked with some healthcare for the homeless places, that determined that they were going to waive copays consistently. They had to get special permission from CMS, because certainly, those are Medicare eligible. Medicare says you can't just blanketly waive co insurance. But there are things you can do. Again, I'm recommending, check with legal counsel. And again, I'm glad to have a conversation with you, if that's of interest. Next slide please. So I already mentioned this briefly in charges, you're going to get paid the lesser of your charge, or the payer fee schedule. You always want to try and charge more than what you expect to get paid, but in a health center in particular, you have to make that it's consistent.

Ray Jorgensen (00:40:59):

As we said with local prevailing rates, typically we'd recommend looking at the Medicare fee schedule, literally, the professional fee schedule. And I would expect rates to be 150 to 250%, meaning you're going to multiply a hundred dollars Medicare fee, and that charge would be $150 to $250, depending on where you are. You can get very involved into an RV, RVS, or resource based, relative value scale study, but what some health centers do, frankly, they just call around and they check what other people are charging. That's local prevailing rates, and they determine schedules that way. There are some very sophisticated, some very unsophisticated way to do this. There's no right way to do it, but that underpayment management says, someone has to be monitoring, to make sure that your charges are consistently outpacing what you're getting paid from third party payers. And if that's not happening, then you're probably leaving money on the table, which you'd like to avoid doing. Next slide, please.

Ray Jorgensen (00:41:52):

So prompt payment discount. I want to speak to this for a moment. And when we talked actually, in our pre group, there was some assumption that I'm applying this prompt payment discount to, only those over 200% of poverty. And I want to emphasize in the different examples I'm going to show you in a moment, some of which may be some of the folks on the phone. I just went out and grabbed some health center website detail and copied it and paste it in here so y'all can see it. And credit's given in the URLs down here. A prompt payment discount says that, there's time value to money, that I'm willing to let someone pay less money today, because at this moment in time, I don't have to bill them. I'm guaranteed to get money in-house, and it's not part of the sliding fee discount scale, or the sliding fee discount program.

Ray Jorgensen (00:42:33):

I have a separate payment policy and that's essential, if a hearer auditor comes in, and we're to see you having a discount program for people over 200%. And that was part of your sliding fee discount program, that would be problematic because the regs very, very clearly state, that the sliding fee discount program, your sliding fee discount scale, could only go up to 200%. But you could have a separate, standalone policy that says, anybody over 200%, they're going to get this discount. Now, I'm encouraging a flat rate program. And by that I'm saying that, people at a hundred percent of federal poverty, they pay, let's say... I'm making this up, I'm not telling you to do this, $20. If they're up to 125%, they pay $30, %126 to %150, they pay $40, all the way up. And let's say, when I got above 200%, my prompt pay discount might be, if you pay us today, then your discount's going to be, what we'll call the cafeteria.

Ray Jorgensen (00:43:25):

It's an all inclusive, you pay me $80 and then you're fine, everything's covered. We can have some carve outs. We can do some other stuff, but we're essentially saying that we want to come up with a very transparent schedule, that even those who are over 200% of poverty, would have some sort of benefit by doing this. So it's a matter of thinking about, how could we do this. Now, that fourth bullet, if they're going to make a prompt payment discount, pay at time of service or with a very fixed, defined period of time, you're going to afford this discount to any entity. And that means, not just a person, but even a third party payer, because all of you will have third party payer contracts that talk about, on best buy favor nation that they want to make sure they're getting the best price.

Ray Jorgensen (00:44:08):

And so, what I've seen happen over time is people say, "Well, gosh, this payer got mad because we discounted what the person paid at the time of service." This is critical to understand, the charge has to remain constant. If I have $100 charge and I'm going to bill that charge to Aetna, United, Blue Cross, everybody else, and they might pay me $60, $80, $50, whatever the number is. And you say, "Look, my prompt payment discount is going to go down to", again, I'm making this up, "$40." Those plans might say, "Hey, you're paying us less. Someone's getting a better deal. We want that deal." The reason we're giving that person, this deal is because, they're making that payment faster than those other third party payers. So Hey Aetna, Medicare, Blue Cross, Cigna, if you want this discount, then you pay us on this day of service, or within a week or whatever the deal is.

Ray Jorgensen (00:44:53):

And the payers don't pay that quickly. So again, this is a larger, more broad conversation I'd love to have, but the point is, we're giving any entity, not just an individual, the opportunity to take advantage of this more prompt payment discount. And as it says in that third indented bullet, it's not a reduced charge, but an adjustment down from the charge. The charges are constant, everybody gets charged the same. We're affording discounts. Financial hardship, that is very subjective. Someone's home might have burned down. Someone could have a spouse who just passed and we say, "You know what? On us today." It's subjective, only really, one person at each health center allowed to make that sort of call, but it is one we recommend. And the other thing I want to emphasize about the prompt pay discount, the legality of it, again, not a lawyer, but I'm looking... One, two three, the fifth indented bullet, legal because of pervasive application.

Ray Jorgensen (00:45:43):

It has to be consistently applied, across all locations, for all clients. And we're affording that, regardless of ability to pay, we can do a discount. And I'll show you how I tie this into those, into even the sliding fee discount program, in a moment. Professional courtesy, some health centers say, "Hey, there's no co-insurance for our staff. Not just for the staff we like, but for everybody." Everyone who meets the criteria of being that VIP, they don't pay for that. Some people do it for local medical providers, other doctors. They don't do that. Whatever your policy is, it should be written down. It needs to be consistently applied. And again, as long as it's unilaterally applied, consistently applied, there should not be a legal issue. Next slide, please.

Ray Jorgensen (00:46:28):

So this is an example of setting charges, based on what the provider codes. So down, the far left hand column, you've got your office visit codes, 99201 to 215. And I recognize, I probably should have got rid of 99201, because it's no longer a valid code, in 2021. But for the sake of throwing this together quickly, I apologize. I didn't delete that line, but you'll notice that the fees gradually increase as I go from, in this case, category one through five, and then in category six, that's my prompt payment discount that's greater than 200%. And then the last three columns to the right, are just proposed charges that I might put. This was something we put together years ago, for a client just to say, "Hey, what will we charge for services?" Now, you'll notice that $10 is a minimum and nominal fee. And that's why you won't see anything less than that, anywhere on this chart.

Ray Jorgensen (00:47:14):

The challenge with doing this is, let's say I did an office visit, I did a surgery. I did a diagnostic test. I did, maybe some sort of imaging. I'm going to have 4, 5, 6 different codes that somehow, I've got to add up, figure out what schedule they're in. And by the way, I'm assuming that the provider's going to actually get the visit coded at the time of service. My experience, visiting hundreds of health centers is, providers are still not getting their codes done for... If they're doing really well, a few days, in some cases, it's seven to 10 days. So I can't get providers to give me coding and then expect me to be able to send a bill, which is why this whole legislation and, raise humble opinion, it is ridiculous that we're supposed to give them an ICD and a CPT code ahead of time.

Ray Jorgensen (00:47:52):

And we can't even get our providers to code the stuff, on the date of service. I'm going down a whole bad rabbit hole there. But where I'm proposing here is that, instead of doing this individually, by individual HCPCS codes, we're going to instead just, go with one flat rate. Next slide please. So the flat

rate sliding fee, follows the sliding fee discount policies, but it's essentially a per diam rate, one flat rate, instead of me giving a price to each individual service that's done. We have seen anecdotally, payment go way up, self pay numbers increase, because patients know what to pay, they know what's expected. Front desk knows what to collect and it saves everybody the hassle of trying to figure all this stuff out. It's certainly easier to comply with No Surprise Billing, because I know upfront, what patients are going to pay for the work that you're going to provide.

Ray Jorgensen (00:48:42):

There's no, "Gosh, what's this bill going to be?" I'm not going to be surprised. Look, based on the sliding fee, there's only one rate you're going to pay, this much money if you're at this level. And even if you're over 200%, if you pay us at the time of service, or let's say, within two weeks, three weeks or 30 days, it's this flat rate, we're telling you upfront, this is what it would be. But again, the more readily published rates, easier for folks to follow. It's really difficult to explain all the different charges. And if the coding is not done on time, I can't have it happen, consistently. And I do see staff, even well trained staff, interpret different things just, differently because this is complex. Healthcare is hard, and trying to explain to people how it works and why should we set charges, and it's nuts. So this flat rate is just easier to understand for everybody and much easier from a compliance perspective. Next slide, please.

Ray Jorgensen (00:49:34):

So this is an example of a medical slide. It's a few years old. You can see it's back from, gosh, it's a decade old now, back to 2011. But notice we took the income, and this is obviously older because it's 2011 income guidelines. And I didn't again, have time to create this for this current income guideline, but across the top, category zero, up to 50%, you don't pay us anything, 50 to %100, let's say that's their nominal fee, it's $15. 100 to 149.9 is $30, 150, $50. This is our payment policy. Anything over 200%, they pay $75. And notice at the very bottom, and I don't know if we've got a cursor that we could use, to indicate where it says, 20% discount for same day payment, and then to the right, 10% discount for payment within 30 days.

Ray Jorgensen (00:50:19):

So one of the challenges around the prompt pay, and some of our lawyers here have made the statement, look, you can't do a prompt pay discount and not apply it to those on the sliding fee. They're saying, anybody over 200% of poverty, there's one flat rate, $75. But if you pay us today, all these rates above, we'll give you 20% discount. And if you pay us within 30 days, we'll do a 10% discount. The challenge, in Ray's mind, around the sliding fee is, that $30 in category two, let's say, whether a patient pays you today or a year from now, the most you can charge them is $30, because that's where they fall in the schedule. The over 200% of poverty, because it's not part of the sliding fee discount program, all bets are off if they don't pay you, according to this deal, within 30 days, that it's going to be 20% on same date of service, 10% off that if you pay us within 30 days, but you could write a program for anybody over 200%.

Ray Jorgensen (00:51:11):

That payment policy could say, if you don't pay us within 30 days, then it goes back up to full rate and we're going to charge you like we would, anybody else. That's up to you and your team to figure out what that looks like. What I'm suggesting though is, how simple this is to post this on your website and say, "Find out where your income level is. Here's how much it's going to cost you to come. And if you're not sure, the most you're going to pay out of pocket is $75." And it's essentially, an all inclusive price.

Now notice also, at the very bottom, the excludes. We're going to exclude lab services, there are some procedures, maybe some supplies, that makes sense. And it should, because we don't know what all of these things are. Maybe that will put us at too much financial risk.

Ray Jorgensen (00:51:51):

So we want to carve those out. Next slide, please. Now, this is a dental slide that we're going to go over here, real quickly. And you'll notice that it's a little more expensive, because dental is a little more expensive. You'll see the same discounts at the bottom 20% for same day, 10% for the next. And then, you'll see some different carve outs at the bottom, because dental's pretty expensive. So when we're looking at, trying to make this transparent, we are giving this to the patients on the website, then we'd be putting it in the lobby so it's able to be seen. Great to have a financial counselor that could explain this. And even as Gervean was talking about having your ambassador, this is a much more simple thing to be able to provide to folks, than trying to figure out what an estimate's going to be before they've been seen, before we know what's going to happen.

Ray Jorgensen (00:52:37):

I don't know how you'd pick the HCPCS codes. That's all one issue with their legislation. ICD wise, maybe you could grab that if they're historic patients, but for new patients, I don't see how simple that would be to do. I don't think it's simple at all. I'm just going to walk through these next examples just a little bit. This comes from Heart City Health and this was on their site.

Gervean Williams (00:52:58):

We're running close on time. So if you could wrap it up pretty quick, that'd be great.

Ray Jorgensen (00:53:02):

You got it. So what you can do, just flip through these different, next slides. You all can look at these later on. They're just examples of sliding fees from some other folks. And I just did this to show, people are already doing this, these schedules already exist. Look at some of these. See which ones you like. And again, I'm glad to have a conversation. These last few are all from the same health center. This is one of three. So you can go through all of them, but this is how they break it down and hopefully make it easy for folks to see. I'll pause there. Gervean, I apologize to the length, and thank you everybody for listening.

Gervean Williams (00:53:33):

Thanks so much, Ray. We'll turn it over to Rebecca and Scott, to wrap up things.

Scott Gold (00:53:42):

All right, real quick, just a couple of high level thoughts on financial considerations. I know Ray did a good job of highlighting a lot of the impact related to sliding fee, but really for the CFOs on the call, I know I'm fielding a lot of questions related to, what do we really need to be thinking from the financial side of the house? Is this going to have some impact on our financial statement audit per se? How's this flow through the cost report? Some of those types of things that are on our minds. And I think at the end of the day, any change that we make in the organization, relative to implementation of this, is likely going to have a financial impact. Think about the staffing additions that you may need to be in compliance.

Scott Gold (00:54:36):

Those costs are going to roll up and have an impact on the bottom line. So we just need to think about, how this is going to impact the organization and how that flows through. Now, as far as the compliance goes on the audit, I have not caught wind that there's going to be specific audit considerations that would maybe, roll under the uniform guidance, as of yet. But compliance in general, is something that in the audit environment, if there's no, non-compliance related to laws and regulations and things of that nature, that can become a reportable item on an audit. So I think we just want to take it seriously and make sure we do the best we can, but the practical side of it is, we're going to have to navigate a lot of the things that are there. Rebekah, thoughts on that, as you roll forward with a lot of your conversations?

Rebekah Wallace Parde (00:55:38):

Yeah. So thank you, Scott. And I know that we are getting close to the end of our time and Scott mentioned a couple things, and in the Q&A, we have seen some comments about additional staffing. And so I do think as we consider the operational impact of health centers, that can also be something that we have to think about from a financial standpoint. Is there an additional cost to the health center in terms of staffing, to be able to implement the regulations and the requirements for this particular regulation? So if we can go ahead and move on to the next slide, I appreciate you all allowing us a few extra moments. I know we are right to time, but I do hope to be able to offer up some practical takeaways, as we get to the conclusion of our time.

Rebekah Wallace Parde (00:56:24):

And then the ability to be able to address some of your questions that have come through, either in advance or since we have been on the webinar together. So in the working, the conversations that I have had with health centers of most recent on this topic, certainly is not surprising that the implementation of this requirement feels overwhelming. And I can appreciate that. So really, where I have been focusing it with health centers, is just getting started. So breaking the requirements down, even considering the templates that we are going to be reviewing and that Susannah and Gervean already mentioned, but then really moving forward, in terms of being compliant with this requirement, instead of being, I think, somewhat paralyzed by what seems to be the overwhelming expansiveness of it and the impact that it has on our day to day operations. One of the first places to start, is with the patient awareness.

Rebekah Wallace Parde (00:57:18):

So we've talked about that briefly already. And so I will mention it again, there is a requirement for us to make patients aware of their right to a good faith estimate. So for providers and facilities, we are required to inform our uninsured or self-pay patients, of their right for a GFE, or a good faith estimate. It does need to be on the organization's website, also displayed near your scheduling or similar areas. So, that may be your financial counseling areas, maybe it's your checkout stations, but in areas where patients are likely to be having conversations about their services and the potential cost of those services, or potentially scheduling appointments. Awareness of the patient right, or their eligibility, if you will, to receive a GFE, I think is important also for staff to understand, because of the fact that we know that, for uninsured patients or patients who are scheduling appointments three days in advance, that they have the option, or we need to provide, excuse me, the GFE to them. Individual can also inquire about the cost of services.

Rebekah Wallace Parde (00:58:29):

So there does need to be awareness when patients are asking about how much they owe, even though they may not formally ask for a GFE, that still should be treated as if the patient was requesting an estimate. So let me just repeat that. So a patient may not formally have the exact language in terms of, "I want to request a good faith estimate", but if the patient is having communications with members within the health centers, and they are asking about the cost of potential services or items that, that should be viewed and treated by the organization as the request of a good faith estimate, even if they are not scheduling an appointment at that time. There are templates that will be provided to you. This is on your screen, a screenshot of the notification for the patient awareness. So the patients do have the right to receive the good faith estimate.

Rebekah Wallace Parde (00:59:23):

You'll note at the bottom of that slide, that it does refer patients to the specific portion of the CMS website for the No Surprises rule. And so there is a dedicated portion of the CMS website. I feel it's pretty limited, right now. So if you are to go out there, I think the information that's there is limited, but anticipate as we continue to move forward, there'll be additional guidance for patients and for providers on that dedicated portion of CMS's website. If we could move to the next slide. The good faith estimate content. So Susannah reviewed the data elements to you with you and the data elements were actually outlined pretty specifically for us. In addition to that, there is a good faith estimate template that you could use from CMS. The template, as it stands with disclaimers, is eight pages long. So it is very lengthy.

Rebekah Wallace Parde (01:00:23):

So one of the things I want to note, while the information in the template may all be good information, that if you compare that to what's actually required, you may be able to reduce some of the data elements. So the template's a good place to start, but there are certain elements that are on the template, that are actually required in the data element appendix that was provided to us. So we do have the patient name and birth. The description of primary services and the CPT and ICD-10 codes, I want to talk about that for a moment. The description of the primary services or items that are being rendered does need to be in clear and understandable language for the patient. So we have to give them both the description and the narrative, the service that's being provided, in addition to the CPT, and the ICD-10 codes.

Rebekah Wallace Parde (01:01:18):

And I'll talk about that here in just a moment, too. So thinking of about the good faith estimate and the elements that need to be listed, we are required to provide the patient name and date of birth, the description, the CPT, the ICD-10 codes, the expected charges and the names of the providers and facilities, along with their NPIs and tax ID number. So there is quite a bit of information that is required and there is not a differentiating factor in terms of, is certain information only required for sliding fee scale discount patient, or uninsured patients. So the elements that are listed in the good faith estimate are required for all patients, for which we have to provide a good faith estimate for. In addition to that, on the next slide, we have another example of the good faith estimate disclaimers.

Rebekah Wallace Parde (01:02:14):

So we do know that there are several disclaimers that we need to include. So making sure that the patient is aware that this is an estimate and not their final total charges for services, and that it's not a contract. So there are various disclaimers that are outlined for us and included, as we have reviewed

already. But also, in addition to the disclaimers, I do want to note, and I know that we have touched on it briefly, but that there is, as Susannah mentioned, the opportunity for the patient to actually engage in a dispute resolution process. And you will see at the bottom of this template, that it tells patients to keep a copy of their good faith estimate in a safe place, or to take pictures of it, because if they want to engage in the dispute resolution process, they actually will need their estimate to be able to do so.

Rebekah Wallace Parde (01:03:17):

So there is, a as part of those disclaimers, as you see there, the instruction for patients to make sure that they have their good faith estimate and they'll need that, if for some reason, they dispute the total charges that they are billed, in comparison to the estimate that was provided. And then on the last slide that I have here, a few thoughts about workflow implementation, and I wish we had more time to really think through this, because I think the brevity of this slide is really deceiving. And part of the role that I provide with health centers and healthcare providers, I think is trying to figure out how do we take regulation and align it or meet it with reality. So here's the regulation, it's going to meet reality. Now, how do we actually operationalize this? And I think a lot of the questions surround scheduling, they surround estimates and actually producing the GFE.

Rebekah Wallace Parde (01:04:08):

So obviously, understanding the requirements, whether we like them or not, to develop a policy for the health center, is the first place to start. So let's start thinking about, how are we going for operational? I know that there have been some request for some sample operating procedures or standard operation operating procedures. And I think that Gervean is going to address those, but starting to think through what our policy is and making sure that we have our arms wrapped around what the requirements are, so that we can include those. And then, begin to document and procedure format. Educating our staff is going to be key to your compliance with this regulation. We likely are going to need to have distinct procedures that are step by step. So as I'm working with health centers now, we're evaluating the processes that we already have in place, that may be helpful, in relation to the GFE requirements and trying to determine if we can administer the GFE procedures, parallel with our current processes.

Rebekah Wallace Parde (01:05:09):

So for example, one of the questions that I probably have received most frequently, and I've seen it a lot in the Q&A today is, how do we know the ICD-10 or the CPT code? The knee jerk reaction I think I've heard is, "Well, we don't. It's impossible to know." And while I think that the certainty of any of the data elements requested can really, only be assured to some extent after the visit, most of you as health centers, are already gathering some of that information, prior to the visit. So think about a patient who's scheduling for a follow-up appointment, you likely know what their expected diagnosis is going to be, for new or acute patient visits. There's a concept in coding, that in lieu of a definitive diagnosis, that we can code signs or symptoms. And I'm not suggesting that the regulation directs the same, but while we're waiting for clarification on various operational aspects of this rule, I think we can really begin to try to comply, because I really think the intent of is clear, that it's forced to be as accurate as possible in providing that information to the patient.

Rebekah Wallace Parde (01:06:23):

The same with CPT codes. A lot of you are gathering appointment types, so you're looking at appointment types. New patients might get longer appointments than established patients, who might have preventive visits. So I think we can start to look at appointment type, to then help us further down

the road, of trying to ascertain CPT codes for the patient or associated out of pocket expense, or for their estimate. So what I'm suggesting in the health centers I'm working with is, okay, let's step away from what feels very overwhelming, look at what we're doing currently. And then, how can we again, bring those processes, parallel to what we're doing in conjunction with the GFE regulations. The last thing, and I have more I wanted to offer, but I know we're to time, excuse me, and we want to be able to take some questions for you, but Susannah mentioned this and I certainly had this in my thoughts too, but work with your EHR and your practice management systems.

Rebekah Wallace Parde (01:07:22):

So a lot of this can be documented through those processes, and this is a regulation that is applicable to widespread providers. So our systems that we utilize, are going to have to develop ways to help support us in these processes. So reaching out and we've already done this already, when I say we, some health centers that I am working with to say, "Okay, what is happening with our systems and how can they support us in capturing the information?" So with that, again, I'm going to limit my comments. I wish we had more time to share, but we'll have more time certainly, as we move forward with the implementation of this rule. I'll turn it back to Gervean.

Rebekah Wallace Parde (01:08:03):

The last thing, before I do that, though, is I do want to mention that, as your organization is working through, how do we operationalize the requirements, is also considering some sort of verification or quality control process. So once we have our procedures in place for issuing good faith estimates, making sure that we have the ability or a mechanism in place, to look at patient bills or statements that are going to be rendered in conjunction with the GFE, to try to ensure that we're being as compliant as possible, as we begin to send patients statements who have also received estimates from us. So with that, thank you for allowing me to share a few thoughts with you and Gervean, I'll turn it back over to you.

Gervean Williams (01:08:50):

Okay. Thanks so much, Rebekah. And I'm going to ask you to come back and present, after we're in this for like a month or so, and give some of the experiences that you're having with some of the health center clients that you work with in the field, on actually implementing this and making this operational. But I have a couple of questions. We still have over 500 people on the call. So I'm going to just throw out a couple of questions to the panel, and ask maybe three or four questions before we close out for today. Okay, so, and you answered this one Rebekah, seems like we have to query the provider for the diagnosis and the CPT code, each time we have a GFE request. Based on a recent visit. So I guess you need to do that for every visit.

Rebekah Wallace Parde (01:09:39):

So I don't think there's anything in the requirements, that says we have to query the providers. I think how we get to the ICD-10 and the CPT codes is an open question. So as we wait for further clarification, as I mentioned anything for follow up appointments, we have an expected ICD-10 code. And I think that we can word it as such in our GFE, that this is what is expected. And then for those acute patients or new patients, if we don't have a definitive diagnosis, if I pull from coding rules, that we can use signs or symptoms, I think that we have the ability to do our best to try to get to an anticipated diagnosis code for the patient.

Rebekah Wallace Parde (01:10:20):

I will say, there may be times when we just don't, but until we get further clarification, I think, instead of dismissing that element, that we do have ways that we can try to address both the ICD-10 and the CPT codes. And just making sure that the patient is clear in our conversations, that nothing is fine until they've actually seen the provider. So we're not diagnosing, we're not trying to do any of those things for the patient, but trying to give them some additional information for a financial transaction.

Gervean Williams (01:10:51):

Thank you so much. Okay, for the panel, as a FQHC, if a patient is enrolled in our sliding fee discount program, is that considered a federal healthcare program?

Susannah Gopalan (01:11:06):

Jeremy, I'll take this one. And Jeremy add, as you like. So the definition of federal healthcare program, it's in the Social Security Act. As I mentioned, it definitely includes those federal and federal/state programs that function as insurance, like Medicare, Medicaid, Chip, but it also includes federal programs that directly or indirectly financially support the provision of services. So it's broader than just those programs that function as insurance. CMS, in a fact sheet on this rule, stated that they consider that programs such as the Indian Health Service Program constitute FHCP, such that if you're an IHS patient, you're considered a federal care program enrollee, and you don't need to get this good faith estimate as an uninsured self-pay patient. The Federal Health Center Program for the grantees under Section 330, similarly provides federal financial support that health centers can expend, both through using their sliding fee discount program for those under 200% of poverty, but also generally, to make services available in medically underserved areas.

Susannah Gopalan (01:12:19):

We did try to argue, pretty forcefully and NACHC's comments on this interim final rule, that the Section 330 program should be considered a federal healthcare program for this purpose. And so therefore, health center patients, whether or not you're receiving discounts under the sliding fee discount program, are enrollees in a federal healthcare program. That doesn't seem to be an issue that was on the radar of the agencies so far. So I think it's fair to say that, as of January one, you need to be going ahead and providing this estimate to uninsured and self-pay patients, regardless of whether they're entitled to discounts under the SFDP, and then perhaps, policy advocacy might result in a revision. But at this time, even though there's a good argument that Section 330 is a federal healthcare program, we don't have any evidence that the agencies view it that way.

Gervean Williams (01:13:20):

Okay. And Brian made a comment in her, I want to go ahead and address it. He said that the presentation today has been very frustration, because we're just saying to hire more consultants and spend more money. And Brian, I don't think we're saying that. I think we're thinking you need to look at your whole process, figure out what you have in place already, and what you can use that you have in place already in order to respond to this good faith estimate. And let's be clear, this is not your whole patient population. These are uninsured or self-pay patients that request a good faith estimate. So I think we should all just be calm right now. And then wait until January one, educate our patients and our employees on this new ruling, and then see what the volumes we're receiving. Because if a patient comes to you and say, "I want a good faith estimate", but then you say, but then we have our sliding fee discount, or we have our prompt paid discount.

Gervean Williams (01:14:11):

And we can also give you a good faith estimate. If you have a sliding fee and the patient is eligible, you have the resources and you can go ahead and take them down that road. So you don't have to do this for every patient, every time. So I appreciate your comment. And I know this is very frustrating. One of the questions we had ahead pf time was, who thinks this is a good idea? And I think no one does. They have the patients at heart, and that's what they're trying to do, to protect the patients.

Gervean Williams (01:14:39):

But this is a situation where, people put into regulation, who aren't used to actually providing healthcare. So that's the nuances from going from regulations, to operations. So we're trying to help you and give you some tools and resources and things to think about, in order to get this going. We have a lot of questions we're going to do a follow-up, definitely pull Rebekah back, to do some real life, situations on what she's experiencing and go through some of these Q&A's. I'm sorry we ran out of time today, but thank you so much for your comments, and I will follow up-

Jeremy Crandall (01:15:10):

Hey, Gervean?

Gervean Williams (01:15:11):

Yes.

Jeremy Crandall (01:15:12):

Gervean, can I answer one question that's process related? Is that okay? That's that's policy process.

Gervean Williams (01:15:17):

Absolutely.

Jeremy Crandall (01:15:17):

All right. There was a question about, sorry, just everybody bear with me for seven seconds... When, how will we know if our submitted comments will have an impact on the IFR? That's the interim final rule itself. Or, if there will be amendment for clarity of the IFR itself. So Susannah, weigh in here as well. The best answer I have is, I don't know, in the sense that, there were, I think somewhere between, when we submitted our comments, I think I saw about 4,000 comments that were submitted in response to this. It's all in the comments. And I think we all know what time of the year it is on the calendar. And so whether there will be any sort of concrete response between now and January one, we are operating and we are recommending all of you to operate under a scenario where we will not have any new clarity.

Jeremy Crandall (01:16:08):

What they have put out, is what they've put out and we have to act accordingly. So that's my answer to that question, but really, it wasn't a platitude when I said earlier on the call. We don't view January one of 2022, as the end of it. If we don't get new feedback on this in the next 14 days, it's not like we're just going to close up shop and then say, okay, it is what it is. We are still going to continue to push for clarity or some sort of relief. Whether that happening though, we don't know. Susannah, would you add anything to that?

Susannah Gopalan (01:16:38):

No, I think that's accurate. And so it's a paradox, an interim final rule with comment, it's issued in final, and they're asking you what you think about it. So it's not an notice. It's not a proposed rule, where they have to publish it, get the public's feedback and then finalize it. They shoot it in final and ask for comment. But any changes they make would need to be made through a new regulation. So as Jeremy said, there's no requirement that they address the comments or any particular timetable for it.

Jeremy Crandall (01:17:08):

And Gervean, if I could plug one other thing, I'm seeing all the questions in here, there's a lot of really, really good questions. This is not a solution to many of them, but the reg itself that lays out this good faith estimate requirement, is actually pretty descriptive. Now I get that when you start to unpack it, it just leads to 10 other questions and that I get it, I really do get it. And I couldn't imagine being in the shoes of many of you that are hearing this, but I would encourage many of you, as you figure out how to deal with this, look through that reg and Susannah, would you add anything to that? It does lay out a fairly decent roadmap as regs go, as to how to comply with this.

Susannah Gopalan (01:17:51):

I agree that it is very detailed, and then you can link directly from the reg, to the materials that CMS has provided, in model form. So there is a lot of detail there to follow.

Jeremy Crandall (01:18:03):

Thanks, Gervean. I know everybody would love to jump off, so I appreciate everybody listened to us for another minute or two.

Gervean Williams (01:18:09):

So I do have one clarification. So Susannah, you can help me on this. So when do you provide a GSE?

Susannah Gopalan (01:18:17):

Okay. Yes. And I did want to clarify that a bit. I think you said it was Brian, who expressed frustration about the fact that this requirement is being saddled on for the uninsured and self-pay patients. So it's true, this is a new requirement associated with serving these patients, and your Section 330 grand is in most cases, the main vehicle through which you're financing your care of this population. So I understand your frustration. As for when it has to be provided, there are two triggers. A, a patient who's uninsured or self-pay, makes appointment three or more business days in advance, for services. Or B, a patient who is uninsured or self-pay, requests a good faith estimate. Either one of those two, you have to go ahead and provide it and provide it in writing. So the exception would be the uninsured or self-pay who makes an appointment that's less than three days in advance.

Gervean Williams (01:19:17):

Thank you so much, Susannah, for that clarification, because I saw a couple of questions in there. And with that, so this is just the beginning. There's still a lot more out there and we will definitely give you as many resources possible. I did see a comment in there, if the CMS forms are available in Spanish, and I can work to see if we can have NACHC translate those into Spanish. So I think that would be a great resource for all of you guys. So I'll take ownership of that. And with that, I will end it today and I'll will look forward to, I'm sure I'll be pulling this panel back in 2022, to get more on this. But if you guys have

any questions, any concerns or any recommendations, please fell free to reach out to us and thank you so much. Happy Holidays and have a great weekend.