Gervean (00:00):

Okay. Today we're going to talk about the No Surprise Billing Act: Developing Your Good Faith Estimate. Next slide. Of course, we're the National Association of Community Health Center, and our mission is to make sure that people have access to affordable quality healthcare, regardless of their ability to pay. Next slide. Welcome, everyone. A couple of housekeeping things before we get started. So, this meeting is being recorded and we will send a follow-up email after this is finished with all the handouts and the tools and templates we've created. A copy of those slides will be sent from trainings@nachc.org, so make sure you look for that in your email box. And then after this training, you will have an evaluation, please fill out that evaluation so you can give us valuable feedback so we can serve you guys better.

Gervean (00:55):

Next slide. So, today here is our agenda for today. The first thing we're going to do is we're going to go over a federal policy update about the No Surprise Billing Act, go through the regulatory requirements, and then just go do an overview on what really is the Good Faith Estimate, what is required. And we developed a template that we're going to review on a very high level, and then go through some comments to frequently asked questions. And then at the end, we are going to wrap up with a QA& for you guys. And with that next slide, I'll turn it over to my colleague Vacheria. And she's going to take it from here for a minute.

Vacheria Keys (01:34):

Thanks, Gervean. Hey, how is everyone doing? My name is Vacheria Keys. I'm the Director of Regulatory Affairs here at NACHC. Really nice to virtually meet you all. So, let's get started to talk about the Good Faith Estimate. How is implementation going? Please put it in the chatbox. Do you feel like our friend on the slide? Do you feel like you have a great handle on Good Faith Estimate? Do you have no clue what the Good Faith Estimate is? That is also an option as well. And honesty is the best policy. We know that it has been a trying time to implement Surprise Billing in the Good Faith Estimate in the middle of the pandemic, especially when the requirements started January 1st, 2022, which was also in the middle of the Omicron boom. And I don't think we've had any break since the pandemic. And so it was very unfortunate timing of the implementation of this.

Vacheria Keys (02:30):

So, I completely agree that it has been overwhelming, but that is why we have this webinar here today to give you guys some tools to implement the Good Faith Estimate, to give you an update on what NACHC has been doing. And then also hoping that we can land in a much better place and understand the tools that you need from NACHC to help you with the implementation. First, I do want to just give an update that NACHC has been coordinating with BIPOC, who has been really helpful in helping us think through how health centers can comply with the No Surprises Act, as well as Good Faith Estimate as well. We've had a listening session that was hosted by CMS, the agency CCIIO, that oversees the No Surprises Act. And we had several PCAs discuss the challenges that you all health centers are facing while trying to implement the No Surprises Act Good Faith Estimate. Health PCAs also talked about how we have different patient populations and we need different regulations to have flexibility to meet the needs of our patient population.

Vacheria Keys (03:34):

And so after that listening session, NACHC supplied CMS with a memo outlining how we have the sliding fee discount that majority of health center patients qualify for the sliding fee scale, which means that no

patient is receiving a bill that is super high or over $400. And supplying the agency with that information so they understand that health centers were created to provide affordable care, not to provide Surprise Billing, but how can we work on increasing transparency for our patients and making sure that we are capturing the essence of what the Good Faith Estimate is?

Vacheria Keys (04:11):

So, we believe there's an opportunity for CMS to issue another regulation, which would create more flexibility for FQHC specifically. We're hoping that there will be more flexibility around the requirement to mail the Good Faith Estimate, and really hoping that they will adjust the regulation so that health centers can meet the goals of transparency without the increased administrative burden that we know some of you all are facing.

Vacheria Keys (04:38):

Please let us know how we can be helpful after this webinar. But I'm going to just give a brief overview, next slide, of how we got here on the Surprise Billing timeline. So, it was a really long journey to get to the implementation of the Good Faith Estimate, but also just Surprise Billing. The No Surprises Act was introduced in 2019 after several congressional hearings. The first bill was introduced in July 2019, but before that, there was at least a year's worth of work and research by advocates on the ground. And so the idea behind pursuing the No Surprises Act was simply because of the growing medical debt that a lot of patients or Americans are facing. The fact that Americans can have insurance and still receive such large bills was very concerning, especially for the health policy community. However, the No Surprises Act was definitely more targeted towards hospitals, specialists like surgeons, or anesthesiologists, and so even though it was intended for bigger hospital systems, there are provisions that do apply to FQHCs, which we are going to get into today.

Vacheria Keys (05:48):

So, in December 2020, so also in the pandemic, the No Surprises Act was passed and it was included in the consolidated appropriations act. And so when it was passed, it was CMS was instructed, so the Centers for Medicare & Medicaid Services was instructed by Congress to issue regulations in 2021 for the No Surprises Act in their regulations to go into effect January 1st, 2022. In 2021 CMS, given that it was a pandemic did not immediately issue regulations. And so they issued interim final rules, which mean that when the regulation is issued it is final upon arrival. So, even though there was an opportunity to comment and NACHC did comment on behalf of health centers, the rules were already final when they were issued.

Vacheria Keys (06:42):

So, they issued the first one, July 2021. Surprise Billing one did not apply to health centers. Then there was 1.5, which came out in November, and then there's Surprise Billing two, which came out in September, which did include the Good Faith Estimate, which we are focusing on today. As of January 1st, 2022, all health centers should be complying with the Good Faith Estimate. And we know that compliance looks very different depending on where your health center is, depending on how COVID had hit your location or your town, and then also your technological capabilities, did your EHR have the ability to switch and adapt to a Good Faith Estimate? So, we know that these are all factors, and we are working towards compliance, and that's what we're discussing today.

Vacheria Keys (07:34):

Next slide. Surprise Billing part two; interim final rule, that is where the Good Faith Estimate is located and that's where that regulation lives in. That was issued September 30th in 2021. And it's a few departments that are issuing the regulations just based on the different types of health plans that the regulations oversee. The Center for Consumer Information and Insurance Oversight, CCIIO, is the CMS agency responsible for implementation and enforcement of the Good Faith Estimate, as well as the Surprise Billing regulation. So, the Surprise Billing part two interim final rule included establishing an independent dispute resolution process to determine out-of-network payment amounts between providers or facilities and health plans.

Vacheria Keys (08:24):

The purpose of that was to remove the patient from the patient having the responsibility of figuring out was it the facility that had to pay, or was it the health plan? So, that removes the onerous from the patient and requires the provider or facility and the health plan to determine the cost of those services. The regulation also required the Good Faith Estimate of medical items or services for uninsured or self-paying individuals. It also established a patient and provider dispute resolution process for uninsured or self-pay patients to determine the amount due to a provider or facility under certain circumstances. And this requirement kicks into effect for claims that are over $400. And then also it provided a way to appeal certain health plan decisions.

Vacheria Keys (09:12):

Next slide. This is a brief overview of the Good Faith Estimate, and then we're going to spend the rest of the webinar really breaking down all the different requirements, but just want to give a holistic overview of the Good Faith Estimate. It applies to uninsured or self-pay patients, and enforcement for uninsured patients delayed until the adoption of further rules beginning in 2023. We haven't heard about how this will apply to insured patients, so we will just focus on the uninsured and self-pay patients. So, the Good Faith Estimate needs to have in it expected costs for the care that they are considering or scheduling to receive from all the providers and the facilities responsible for providing the care to that patient. So, it needs to include expected costs for care.

Vacheria Keys (10:04):

Sorry, my lights turned off on me.

Vacheria Keys (10:08):

Those expected charges need to include any discounts or adjustments or the amount that would have been provided to the patient. And so this is really important because the Good Faith Estimate should reflect if that patient is eligible for the sliding fee program, the discount program. So, we want to make sure that there is a way that your health center can reflect in that Good Faith Estimate that the patient understands that they would be eligible for other discounts when they come in for services. I'm going to skip this next one because the convening healthcare provider piece does not go into effect until next year. And then there's timing requirements with the Good Faith Estimate, depending on when the patient schedules their appointment. We're going to get into that in a little bit too. And then as well as a single Good Faith Estimate can be issued for reoccurring primary items or services so long as the estimate does not exceed 12 months. So, if this is a service that the patient has to come in for twice a month, then you could give them a Good Faith Estimate based on that.

Vacheria Keys (11:19):

Next slide. So, who is required to generate a Good Faith Estimate, the Surprise Billing Act or No Surprises Act applies to all healthcare providers and facilities operating under the scope of state-issued licenses or certifications. So, it does not exempt any type of provider or facility. And the reason that's really important is because the idea is for just healthcare, in general, to be more transparent in America, and to make sure that patients understand what they are paying before they receive the service. So, even though health centers are founded on the mission of being transparent, providing affordable care, never turning away a patient based on their ability to pay, it's still very important that health centers comply with this regulation to the extent that is feasible. And that is what NACHC is working on with CMS to make sure the regulations fit the way the health center program functions. But health centers are required to generate a Good Faith Estimate.

Vacheria Keys (12:23):

Next slide. Which patients need a Good Faith Estimate? So, any patient who is uninsured or who is insured, but does not plan to use their insurance benefits for the services that they are receiving should be receiving a Good Faith Estimate. So, this includes self-pay patients that are responsible for charges or the portion of charges for their visit and patients that qualify for the sliding fee discount program and are also uninsured. So, the two main things you want to remember is just, it's an uninsured patient or someone who plans to pay out of pocket that day and not include their insurance coverage. Who does it not apply to? Patients that are on Medicaid, patients on Medicare, or other federal healthcare programs? So, we really are focusing on how we serve our uninsured patients and patients who are paying out of pocket who maybe are underinsured.

Vacheria Keys (13:19):

Next slide. So, what are the elements of a Good Faith Estimate? And I see there's a lot of good questions in the chat. We're going to end with Q&A, so please keep your questions coming, and we will make sure that we will get to them. But they might all also be addressed later in the back end. And no, you do not need a Good Faith Estimate for patients that have private insurance, only for the uninsured, and patients that are choosing to pay out of pocket, so you treat them like uninsured patients when they arrive. So, what's required under the Good Faith Estimate? You have to post the notice. So, inside of the health center, where it's easy for a patient to see, in the office, on your website, you need to post notices concerning an uninsured patient's right to obtain a Good Faith Estimate. So, patients need to know that they have the right to request a Good Faith Estimate, and that needs to be posted.

Vacheria Keys (14:11):

It could be printed out and put right there where someone checks in, and make sure it's in a visible place, as well as on the website. Second, before issuing a Good Faith Estimate, you need to determine whether that patient is going to pay out of pocket, so self-pay, or they're uninsured. Step three, you inform the self-pay patients orally as well as in writing that they have the right to obtain a Good Faith Estimate of charges upon request or when they schedule an appointment. That means that you are required to provide a Good Faith Estimate if someone requests a Good Faith Estimate, or when they are scheduling an appointment. And we'll talk about the timing of the scheduling on the next slide. And so the last piece is that you are required to provide a written Good Faith Estimate within the timeframe of the regulation.

Vacheria Keys (15:09):

Next slide. So, what are the requirements around mailing the Good Faith Estimate? One of the first is if the item or service is scheduled at least three business days before the services are furnished. So, they call to schedule an appointment three days before their appointment, then they need to receive a Good Faith Estimate, then no later than one business day after they have scheduled that appointment. Second, if the item or service is scheduled at least 10 business days before the service date, so before that appointment that's been scheduled, then they need to receive a Good Faith Estimate within three business days after scheduling that appointment. And then last, if the Good Faith Estimate is requested by a self-pay patient, and they're just making an inquiry, then they need to receive the Good Faith Estimate within three business days of that request.

Vacheria Keys (16:06):

Next slide. So, now I'm going to turn it over to Gervean, who's really going to walk us through some of the practical and operational pieces. And then I will follow up with you guys for some Q&A. Gervean.

Gervean (16:23):

Okay. Thanks so much, Vacheria. The first part in order to implement this Good Faith Estimate is that you have to have public notification. And I did a template for the public notification, this is the top part of it. And all the templates will be emailed to you with the slides after we finish today. But basically, you need to let the public know what No Surprise Billing is and their rights for billing. So have this posted on your website, have it posted in your own lobby. So, think about how you post for your sliding fee, wherever you post anything for your sliding fee, post the same thing for the No Surprise Billing Act, so your patients are aware of this. So if you don't have this on your website, you don't have this posted in your health center, that's your number one thing to do because this is a requirement.

Gervean (17:12):

Next slide. After you have the public notification, then you have to notify your patients. So, here is the top part of a patient notification. And one thing you want to communicate to your patients very clearly is this is not a bill. One of the challenges with the whole No Surprise Billing Act because health centers are different, we always try to communicate how much the cost of services are going to be for the patient before they receive services, but other healthcare providers they don't normally do that. So, informing the patients, it's like, we're not changing our model, the sliding fees discount is still available, but this is a new regulation, so we're just letting you know that we're giving you this Good Faith Estimate, and this is not a bill, because by law, we're required to give this to you.

Gervean (18:04):

Next slide. So, then this goes down to the individual items on the patient notification. So it's like, this is your right to have a Good Faith notification, the timing on when you need to get a notification. And if you get a Good Faith Estimate, if your actual charges are $400 or more, then the Good Faith Estimate, then you can dispute your bill. Now, the unique thing with community health centers is we work with the patients and we make sure that they're provided care regardless of their ability to pay. So, now I can see some of the comments in there, it's like, we're getting caught up in the regulations because this is more so for the hospital settings, when people go and get a surgery, and then they get a bill from the hospital, the anesthesiologist, and the surgeon, we don't have that problem but we still need to be compliant with this.

Gervean (18:56):

So, just let the patients know, this is bigger than our health center services, and explain to them why the Good Faith Estimate is out there because I hear a lot in the field that it's like, we give the patients a Good Faith Estimate and then they get afraid because it's a lot higher than our sliding fee and they don't understand, they think it's a bill.

Gervean (19:15):

So, having those conversations with your patients, having the financial counselors say, this is what we're going through, this is what we have to do in order to be compliant. And just make sure that they're totally aware of all these different things. And one thing I'm going to pause for a second, if you don't have a flat rate sliding fee program, this Good Faith Estimate, I think is going to send people over the edge in order to make sure they put in place a flat rate sliding fee because if you have your flat rate sliding fee, you're able to tell that patient before they have care exactly how much it's going to cost for them in order to receive services. And I think you can use a Good Faith Estimate in your sliding fee, in conjunction with each other so that they can complement each other so that you can be compliant, but then make sure your patients receive the care and not afraid of getting a huge bill after they receive services.

Gervean (20:12):

We've talked about the public notification, then we talked about the patient notification. Now, what do you need to include on the GFE? So, here are all the requirements that are required on the GFE; patient name, description of services, itemization of services, expected charges. And then these last ones on the right-hand side, the NPI, tax ID, office and location, disclaimers, those are pretty much boilerplate, so you can hard wire that in so it can just populate in your Good Faith Estimate. So, really the only one it's on the left-hand side, where we get into some challenges in developing this. So, CMS put out a form it's called Form 10791, I do believe, of a template of a Good Faith Estimate.

Gervean (20:57):

We go to the next slide and go over that. Oh, I'm sorry. So, on the Good Faith Estimate, you do need to have very clear disclaimers, so disclaimers to make sure that it's not a contract, you're not required to pay. And CMS has linked to disclaimers that you need to put on your Good Faith Estimate, but those can be standard disclaimers.

Gervean (21:20):

Next slide. So, here I just took a snippet of the Good Faith Estimate template. The first part of the Good Faith Estimate has the patient's name, then it has the patient diagnosis session, and at the bottom part it has just the provider, NPI, disclaimer, and all that information. So, I've highlighted this because this is the meat of the Good Faith Estimate, this is where all the conversations I'm hearing in the field is going on. Fortunately, when the rule first came out and it says, you have to have the CPT codes and the ICD 10 codes on the Good Faith Estimate. And when we had our listening session, it was a lot of feedback in saying, health centers are different, we're not a hospital, the ICD 10 codes do not determine the pay, and we don't know what the ICD 10 code is until we see the patient.

Gervean (22:13):

So, when they updated the FAQ, they said that you don't have to put the ICD 10 codes on that Good Faith Estimate before times, you can add that in once you know that. In my opinion, that was a huge win. So, let's look at this example here. It's a couple of different ways you can do this Good Faith

Estimate, this is just an example, and this is for educational purposes only. I forgot to put out a disclaimer out there Vesheria. But you can maybe say that for your self-pay or your uninsured patients, you're going to charge them for a 99205 if they're a new patient, or 99215 if they're established patients. And in this office visit, this includes our standard panel of lab work. So if they come in, you can say, it's going to be a 99215, we're going to charge you $250 for this, it's going to include this panel of labs, and that's going to be your Good Faith Estimate for this visit. So this is one way of just simplifying this.

Gervean (23:14):

This is going to be a process, we're learning as we go because this is something new for healthcare all over the country. So, this is just one example I was thinking about that you can be compliant, you can have all the different elements in there, and then make sure you can give this to the patient. Another thing with a Good Faith Estimate, you can actually discount that based on your slide and fee if they qualify for the sliding fee. So that's a conversation you had to have with your patient and with your financial counselor or whoever's handling this Good Faith Estimate template.

Gervean (23:46):

Now, if you're doing this for dental visits, this comes up a lot. It's like, with dental visits, normally the patients come in, they have an office visit, then they do a treatment plan. So, what you can do for a dental visit, say for that initial visit, that's just going to be in order to develop your treatment plan, so you can work with your medical staff chief dental officer to say, what does that office visit look like to just assess a patient to see what is the best course of treatment for them? And then select that code for your Good Faith Estimate. And then for behavioral health, the same thing, getting with your behavioral health counselors and saying, what is that initial assessment? How much time does it take? Because those are mostly times-based visits, and say what would be the best thing to put on a Good Faith Estimate template for our patients?

Gervean (24:34):

So, those are a couple of different ways in order to make sure that you're compliant, get all the elements in there, but definitely talking with your clinical team to say, what's the best code to put in there? And what should we include in this code so we can make sure that we can assess the patient effectively when they come in for their visit?

Gervean (24:50):

Next slide. So, I'm going to turn it over to Vacheria, to cover this slide.

Vacheria Keys (24:59):

Yeah. Thanks, Gervean. And we're going to double back to some of these questions in the chatbox. We have some Q&A at the end that might already address it. And then we will definitely follow up to make sure everyone's clear on how to do a Good Faith Estimate. In our conversations with BIPOC and CMS, I think the goal behind the Good Faith Estimate is to increase transparency for uninsured and self-pay patients, so they know before they get to the visit and after they've already received the service, a surprise bill is what patients were not expecting to get. And so the goal behind the Good Faith Estimate, as we know the sliding fee scale, and the sliding fee discount program also works to make services affordable. It is not apples to apples as far as the sliding fee scale and the Good Faith Estimate. But there are ways that health centers within the health center program can increase transparency.

Vacheria Keys (25:52):

So first, can you post your schedule of charges visibly in the health center's waiting room or registration area? And no, it doesn't have to be every charge, but can it be your top 10 charges so that patients understand what services look like and what they cost without having to do digging themselves? That it's posted on the patient portal? How accessible is it on your website? And so these are also things that are just very important, so patients can be empowered, they can plan out their care, their visits, and how much it's going to cost. Additionally, just like Gervean said, transitioning to a nominal fee scale so it's established flat fees for services. Something that we've heard is the sliding fee discount, if it's a 20% off, 20% off of what? And so at least on a nominal fee scale there's set fees that they can look at and establish without having to do the math and the leg work behind it.

Vacheria Keys (26:46):

And then also I understand, I saw a few questions in the chat about how do you do a Good Faith Estimate that's going to include the sliding fee discount, which means that you need the financial information to do that? And so if it's feasible for your health center, can you move financial counseling up to the front of your process so you can gather that information from the patient so that you can give them that holistic estimate of what the cost would be for that service when they arrive that day? So, that is the goal of the Good Faith Estimate, is that the patient knows when they arrive at the health center, how much it exactly is going to cost.

Vacheria Keys (27:19):

We know that what the patient says on the phone might not align with what the provider says that patient needs or what they're actually seeing for that day, and that is completely fine if the services change because it is a little bit of a guesstimate. And we know that the person who is scheduling is not the provider, who is not the billing person, or the financial counselor person. So, we understand that information will have to flow differently throughout the health center, but how can we build that in to collect that information upfront so that the patient doesn't see a bill that says, you could be paying $400, but you know that they fall under the sliding fee discount and they're really going to be paying $30? So, how can we just build that into your health center's workflow so that patients are receiving accurate estimates and they're not scared off by seeing a very large number that once they get to the health center and that financial information is collected will be much, much less than that? And so that's definitely an important piece.

Vacheria Keys (28:15):

How can you increase transparency in your health center for patients to know how much that visit is going to cost, how it's going to impact them, and continue to come in for these different services. Next slide. So, here we go. We're going to get into some questions and then I hope these answer a lot of questions for you guys. Yes, you can post the Good Faith Estimate in the patient portal, that is acceptable under the regulation.

Vacheria Keys (28:42):

So next slide, and then Gervean, please feel free to hop in wherever you want to. Oh, actually Gervean, I'm going to ask you to hop in here. So, must say Good Faith Estimate include a diagnosis code such as for new patients? And this language comes directly from CMS, from the FAQ. So no, a provider or a facility is required to provide a diagnostic code only where one is required to calculate the Good Faith Estimate. For example, in situations where the facility has not determined diagnosis, such as for an

initial screening or visit, there is not a relevant diagnostic code for that item or service. That means, however, the provider must include the expected charges and service codes, for the items and services that will be furnishing that visit. And so Gervean, there was a lot of questions about the ICD code, and how do you do that? So, could you just elaborate on that piece a little bit?

Gervean (29:40):

Yes, thanks so much. So, we are not required to put the ICD 10 code on our Good Faith Estimate because this was basically Bill for hospitals, and hospitals ICD codes drive payment, for us it doesn't. So, all you need to do is make sure you put your CPT codes or your procedure codes on what you're doing with that patient on your Good Faith Estimate. So, that's one thing, because we don't know what the ICD 10 code is until we actually see the patient, so that was like you're putting the carpet for the horse.

Vacheria Keys (30:12):

Exactly. I guess, so I saw a lot of chats about that, and this was a new change as well. So, CCIIO issued the new FAQ to clarify this about a new patient on April 6th, so this is a new change it's not like this has been there from the beginning. But that's to show that the agency is taking feedback and making changes along the way because several providers question this piece specifically a lot to say, how are we going to have a code and we haven't even seen the patient? And also the idea that the person scheduling is not the person who makes the call about what service they're coming in for, and then also the reality of the patient probably doesn't know what they're coming in for. So, it's a lot of question marks around it. Hopefully, it is easier for you guys when you can just use a service code and focus on the expected charges.

Vacheria Keys (31:02):

Next slide. Are providers required to provide expected charges for future visits in the initial Good Faith Estimate? No. Providers in facilities are not required to include in the Good Faith Estimate for an initial visit, any expected charges for items or services that will be furnished in the future day after the initial visit, and not for items or services briefly expected to be furnished in conjunction with that primary care service. That means that you do not need to think past that initial visit unless it's a reoccurring service, but if they're in, you base the Good Faith Estimate for that visit, that they are coming in within that timeframe. So, just remembering the timeframe, if the patient makes the appointment within three business days of the day they're coming in, they need a Good Faith Estimate. But following an initial visit with an uninsured patient upon requests or upon scheduling additional items, then the provider must provide a new Good Faith Estimate to include those expected charges.

Vacheria Keys (32:05):

However, I will just leave that at there because I already said that part. So, there is a way if a patient requests saying, Hey, I think I got added different services, can I get a new Good Faith Estimate because I'm going to have to be coming back in? That is required, but at the time a scheduling, you do not need to think about what is this visit going to lead to, and does a Good Faith Estimate need to require those things?

Vacheria Keys (32:32):

Next slide. How do providers and facilities address where unforeseen items or services that were not otherwise scheduled in advance are furnished during the visit? The interim final rule does not require the Good Faith Estimate to include charges for items or services that could not have been reasonably

expected. And so I think want to just stop there because I know the Good Faith Estimate feels really heavy. But Gervean, can you just speak to that part about what's reasonable to expect?

Gervean (33:08):

Yeah. Actually, Vacheria and I were on email conversation with our legal counsel MR. Feldesman Tucker, and I was like, so say for instance, if they gave a patient a Good Faith Estimate to come in for a dental visit to do a treatment plan, but then the dentist goes, we need to pull this tooth right now, but they gave them a Good Faith Estimate just for an office visit, what would be the requirements since they had to do an extraction? It's like, well, since they didn't know what they was going to do, it's not reasonable for them to know that they needed to price out doing an extraction. So, there is some wiggle room. So, if something comes up during that office visit that you had no idea of knowing and it's not on a Good Faith Estimate, that's okay, because that happens in healthcare, we all know that. So, is that what you want me to hit on Vacheria?

Vacheria Keys (33:56):

Yes. And then I'll just say if a provider or facility expects or is notified of any changes to the scope of the Good Faith Estimate that was provided at the time of scheduling, then the provider must provide a new Good Faith Estimate, no later than one business day before. So, that's in a case scenario where the patient called, they said they were coming for one thing, and then they called back and say, actually my leg is broke too with my ankle, what are you all going to do about it? Then you need to add the broken leg, with the ankle and make sure the Good Faith Estimate is given back to them within one business day before the services are furnished.

Vacheria Keys (34:37):

And I know the timelines might feel very stringent. And I think that there has been grace periods for enforcement, so aim to be compliant, but if you can't get it out in these timelines, that is okay. You have to figure out what's your workflow and how your system is going to work, so I think be paying attention to if every Good Faith Estimate is missing the mark, then that might need that you need to work something out in your workflow. But if some patients just fall through the cracks or you have workforce reasons where you are understaffed, and that is why Good Faith Estimates aren't meeting these timelines. And that is just the reality of the fact that we have been in a pandemic for over two years and people are doing the best they can. And that is the reality that I think every provider in America, besides just health centers is also facing as well.

Vacheria Keys (35:29):

Next slide. Is a provider or facility required to provide a Good Faith Estimate to uninsured individuals upon scheduling same-day or walk-in items? No. The requirement to provide a Good Faith Estimate to an uninsured patient is not triggered upon scheduling or items if it's been less than three business days. For example, if an uninsured patient arrives to schedule a same-day lab test, the lab test provider is not required to give the individual a Good Faith Estimate. And we know definitely a lot of the patients that attend health centers might come in the day before and ask for an appointment or might try to come in that day, so those patients do not need to receive a Good Faith Estimate. And that is not something that you need to worry about, it's more so the patients that are scheduling out at least three days before the appointment that they want.

Vacheria Keys (36:27):

Next slide. In what forms must the Good Faith Estimate be provided? So, the Good Faith Estimate must be provided in writing and written form either on paper or electronically. This includes provider-patient portals or electronic mails, so email. Pursuant to the uninsured patient's requested delivery method. The Good Faith Estimate provided to uninsured patients that are transmitted electronically must be provided in a manner where the patient can both save that Good Faith Estimate as well as print it, and it must be provided in clear and understandable language in a way that individual can understand it. That's really speaking to making sure the patient can understand what they're reading. If a patient requests that the Good Faith Estimate information is provided in a format that is not paper electronic, like orally over the phone, the provider may provide that information orally but is required to follow up on written paper or electronic copy in order to meet the regulatory requirement.

Vacheria Keys (37:34):

So, this is a very important piece because this is our piece that we are working with CCIIO, CMS to provide more flexibility to health centers. It's really important thinking about the different patient populations that health centers serve, that a health center is able to make the call for that patient of, what is the best way to communicate this information to them? The reason the written portion is so important is because there is a dispute process where a patient can dispute a bill that's over $400. We know that majority of health center services are not over $400. So, even though that is the reasoning behind, it still does not apply to the majority of health center services.

Vacheria Keys (38:16):

And we also know that health centers are not going to send a patient to collections that health centers write off millions of dollars of debt a year. However, the regulations do fit us right now, and this is somewhere we are asking for more regulatory flexibility. But there is flexibility in that it can be delivered electronically in the patient portal, it can be delivered orally, but that oral Good Faith Estimate has to be followed up in writing. And Gervean, I don't know if you have anything to add?

Gervean (38:48):

Yeah. So, this is a situation where it's like, okay, who mails anything anymore? But anyway, so I was at a meeting with Rebekah Pardeck, she's the CEO of Achieve and Revenue Recycle Management Company, and she was coaching her clients to say, have your default to go to the patient portal. So, what they're doing, their financial counselors, they go through the Good Faith Estimate and they tell the patients we're required to give this, and a lot of the patients, they don't even want it. And it was like, well, you can select the default for it to go to your patient portal, so then you can just upload your Good Faith Estimates to the patient portal, so you're compliant. Your patient's aware of that, and then you don't have to worry about mailing. I was like, I think if there's any best practices with the Good Faith Estimate that I've seen so far, having that Good Faith Estimate in the patient portal is definitely one of those.

Gervean (39:41):

Because mailing it out, and how many of you guys send out statements and you get tons of return mail because their addresses are bad. So, if you communicate with the patient and say, is it okay if we can put your Good Faith Estimate in the patient portal? It's definitely an advantage. And then just communicate to them, and making sure that they take a picture of it, or being able to actually print it out as Vacheria said because there is a dispute process and they'll need to have that documentation if it ever comes to that point.

Vacheria Keys (40:16):

And then I do want to add, I saw a few questions that asked what if the patient refuses a Good Faith Estimate? It still needs to be attached to their medical records. So, that good faith needs to be generated, and if the patient portal is the medical record, so that is attached to their file, you just want to make sure that if the patient changes their mind and comes back and says, I want my Good Faith Estimate for when I came to visit two days ago, you want to be able to provide that to them. And so if they refuse it, then you don't have to meet that timeframe, but you do need to generate it and make sure that it is in that patient's file. That is required under the regulation. But this is an area that we know is a really big sticking point.

Vacheria Keys (40:59):

And I'm actually seen in the chatbox some people have to do mail because their patient population does not have internet access. And those are the things that we flag for CMS to say that different health centers have different patient populations and have different needs. And the health center needs to have the flexibility to decide what's best for their patient population to make sure they get the Good Faith Estimate, but that the health center's not engaging in burdensome activities that are not yielding what should happen. Next slide.

Gervean (41:29):

Oh, I see a question on a comment that a lot of patients don't sign up for the patient portal, which I know that's a challenge because the uptick and patients actually accessing the patient portal is somewhat limited, but we are supposed to be patient-center medical home so that's something you might want to look at. But if you communicate to the patients, and let them know that this is where that Good Faith Estimate is, and if your filling fee program is working, they're not going to use a Good Faith Estimate, but you need to have documentation. And having that in the portal and tied into medical records will definitely be as an advantage.

Vacheria Keys (42:05):

Yeah. And I don't think there's an issue with emailing it. I think documentation is the biggest takeaway, whatever your health center is deciding is the best to meet that patient's need you as a health center just need to have documentation that you have generated that Good Faith Estimate, and in some way you have provided it to the patient. That is the main goal in trying to stay compliant until there are different regulations and we move forward. However you want to store that Good Faith Estimate for your health center to make sure if there's any complaints or audits that you could say, no, Hey, we gave this to the patient on this day, that's the approach you want to take.

Vacheria Keys (42:44):

Next, do providers or facilities need to provide a Good Faith Estimate to uninsured individuals who have zero financial responsibility? And I thought this was a very important question for health centers. Yes, so even if the patient's going to pay $0, that's probably the best bill they're going to get, so of course, they will want to know that. All uninsured individuals who schedule items or services or request a good estimate must be provided that Good Faith Estimate. A Good Faith Estimate is required even if the uninsured individual has an estimated no financial responsibility because the actual bill charges for those items or services is not guaranteed to be zero. The Good Faith Estimate is required to initiate the patient-provider dispute resolution if the bill's charges are actually greater than $400.

Vacheria Keys (43:36):

That's also where that piece comes in about the $400. As much it is also about the patient and making sure they're aware of how much the visit is and transparency, you as a health center need to do your due diligence too to make sure you are protected on the back end because this is a regulation that all providers and facilities are required to comply with. Enforcement might not be happening this year, but until this regulation and law is repealed, the Good Faith Estimate does need to be baked into your workflow, and how you're communicating with uninsured and self-pay patients. So, even if the bill is zero, even if it's $5, you do need to print that out and provide it to the patients.

Vacheria Keys (44:20):

Next slide. And so we are here at resources, so we're going to stop. And Gervean, I've seen a few questions on here that I wanted to go over. And you might be able to break this one down a little bit better, I saw a few people were confused about what is the number, the cost on the Good Faith Estimate? Should it be how much that bill is going to cost? Should it be what it's going to cost after the sliding fee discount? How do they get to that number?

Gervean (44:50):

Okay. That's a great question. And it all depends on the services, so with a Good Faith Estimate, first, you start with your charges. So, say for instance, a patient calls and it's like, I have a cough, I'm sick, and I want to come in to see a medical provider. Well, that's most likely going to be an office visit because you have to assess them. So then you'll go to your CPT codes. And this is Gervean's opinion, I'm not an attorney, but check with your legal counsel, but if you have an office visit for a patient to come in to be assessed, that could be a 99215 or 99214, whatever you and your clinical staff see fit, and then whatever charge you have associated with, that's going to be the charge for that Good Faith Estimate.

Gervean (45:34):

Now, and I should have pulled that FAQ, once you have that gross charge, you can have the Good Faith Estimate reflect your slide and fee discount, and say then what the actual patient is going to pay. That does make it a little bit more complicated, but that is a possibility that you can discount that like that. But really, I mean, you and your clinical team have to figure out if a patient comes in an uninsured or self-pay patient coming in for medical behavior health or a dental visit, what's the rate we're going to charge them? And if you look at the compliance manual and the billing and collection chapter, they do have...

Gervean (46:18):

I wonder if they still talk about the Prompt Pay discount. So, the Prompt Pay discount it's a policy where if someone doesn't have insurance, they come in and for a medical visit, a Prompt Pay discount, this is all we're going to charge you. You can use that for your Good Faith Estimate. It's different ways to work around trying to get to those codes. But definitely sitting down with your clinical team, your legal counsel to say, for those different service lines, what's going to be the code for your Good Faith Estimate?

Vacheria Keys (46:50):

Thanks, Gervean. And can we go back a slide, Alyssa, please? I saw someone ask about the $400 piece, so I just want to make sure. So, the threshold for if a patient can dispute a charge or claim to say that

this was higher than I was told, it's $400. Any charge that's under $400 that patient does not have the right to the dispute resolution process. The reason $400 is so important is because the chances of a patient getting a bill for over $400 at a health center is unlikely. And even if a health center does charge for a service over $400, majority of the time, the patient is offered a payment plan, they fall on the sliding fee scale, or the health center finds a way to make it work for the patient because we do not allow cost to be a barrier for the patient to come back in for care.

Vacheria Keys (47:46):

And so this is also an advocacy point that NACHC has used while we've been working with CMS to say that, Hey, this charge for a regular office visit annual wellness visit might be 295, but if 90% of our patients fall on the sliding fee discount, they're not paying 295. And so this is really important and we are working on this aspect of it to relax the regulations, but until then, the Good Faith Estimate is required for all uninsured patients visits that are scheduled within three business days or further out. So, it's not just based on requests. It is required for every uninsured patient.

Vacheria Keys (48:26):

And I know that is very annoying, but I do want to be clear that it's not just based on request. So here, saying that even if the patient has zero financial responsibility and you're literally just printing out a Good Faith Estimate to have a big zero on it, that is what is required under the regulation. And there was another question about how would you document it if you mailed it, then you would have that letter printed out and put it in the patient's file. And there should be a date on the letter that would show that you completed the good fake estimate in the required timeframe, and then that is incorporated into the patient's record. I saw someone say about scanning it to the portal, that's fine too, whatever your processes are.

Vacheria Keys (49:11):

And so I saw another question about referrals. So, you do not need to provide a Good Faith Estimate at this time in 2022 for a referral service. There is a piece in the regulation that talks about a convening provider. The health center would be a convening provider that referred a patient to a specialist. Further down the road, next year at some point, you might be required to provide a Good Faith Estimate for that referred service, but at the current time of today, and in 2022, you do not have to worry about a Good Faith Estimate for that referral, only focus on the services that your health center is providing. Let's just get it right for our own services, and we could worry about that referral piece and the specialty piece later down the line. But right now, we just focus on the services that health centers are providing to uninsured patient.

Gervean (50:05):

Vacheria, there's another question that's related to that, is like, does the Good Faith Estimate need to include charge for lab work if they will be billed by an outside provider? So, with lab services and health centers for uninsured patients, I typically see a lot of times they have contracts with the lab services to have a discounted fee for uninsured or self-pay patients, so depending on how your contract is with that lab service would depend on how you do the Good Faith Estimate. But I know a lot of health centers just include some basic lab services in the individual office visit because it's good quality care, and they can just go ahead and give the services. So, it depends on how you're set up with your contract or your lab services and how you include that on your Good Faith Estimate. Okay, go ahead Vacheria.

Vacheria Keys (50:52):

Thanks, Gervean. And then I also see some folks dropping in what they're doing, so please help your colleagues and tell us what you are doing with a Good Faith Estimate. Someone said we keep a Good Faith Estimate tracker for all mailed out Good Faith Estimates. We also note in the patient's chart of when the Good Faith Estimate was mailed out. We also key, log, and track all the Good Faith Estimates that were returned in the mail. And then I saw another good one. I got to find it, sorry.

Gervean (51:25):

No. That was really good with the return mail, that was a really good one because if you're doing a Good Faith Estimate and you're going to return mail, you can say we sent it out, and then you can suppress it, so you don't send them out again, so that will save you time and money. And if you're auditing, you can say we sent it out, but we had to return mail, so that's why we didn't send it out again. So, I like that return mail, that was great.

Vacheria Keys (51:47):

Yeah. And then we have another one, we check each appointment for self-pay or insured status and we make it a rule in our office to set out a Good Faith Estimate to every new appointment that does not have insurance listed. There are ways, but also take this as a best practice, it does not mean your health center has to do exactly what another one does, but just see how people are getting creative to meet the requirements in the least burdensome way for your health center. And I think Gervean, that's our main thing, we've been saying is every health center's going to have a different approach. So, you really do have to look at, like Gervean, keeps saying, talk to your clinical team, talk to your admin team, talk to your financial counseling team, Surprise Billing Good Faith Estimate might just need be an hour powwow where everybody takes the time to get on the same page. So, Gervean, do you have any feedback on how someone can navigate that of just trying to get everybody on board?

Gervean (52:42):

Basically, so I'm a huge thing on you should have a revenue cycle cross-division team, clinical, operations, IT, finance, you guys should be meeting regularly and having conversations about this Good Faith Estimate, and saying, how can we implement this? And who should be the one having the conversations with the patients? Having the conversation at the front desk might be a challenge, so you might have to change your patient flow process and pulling in the financial counselors more on the upfront process, or in the scheduling process. That was one thing I was thinking about. And it was something else, oh gosh, I just lost my train of thought. Sorry.

Vacheria Keys (53:22):

No, you're fine.

Gervean (53:23):

Oh, so I was thinking about this. This is a tangent, but think about you guys Form 5A on your grant, column three, I'm referring out to provider, this is in the future so health centers won't have to be a convenience provider, but any of those services that you refer out, you need to have conversation with those providers and say, what is your Good Faith Estimate process? Because when you send your patients out to them, you need to make sure that they're being in compliant with the rules because you

don't want them to refer them out to someone and they get a bill from them, they come back to you and it's like, oh, I was surprised by this.

Gervean (53:58):

So, getting agreements with those providers in column three on Form 5A has been a challenge. But this is one good thing about the Good Faith Estimate, so now they have to be transparent about their fees. So you can use that in order to support your OSV visit, and everything's like, oh, they have to do a Good Faith Estimate, so column three is good, just go to their resources. That's what I was thinking to add on to that, I went of on the [inaudible 00:54:25] sorry about that.

Vacheria Keys (54:25):

Thank you for defining tha silver lining is something that is not feeling silver, okay? We have another good best practice, we have the Good Faith Estimate built into our EHR letter template and completed upon the appointment verification calls in advance. Once completed, the Good Faith Estimate is delivered to the patient via portal, mail, or hand. The Good Faith Estimate is completed by any team member that may schedule an appointment for the patient. It works really well because the Good Faith Estimate auto stays in the chart with the date, timestamp, and how it was delivered to the patient. You get a gold star, that's great.

Gervean (55:03):

Okay. Okay. So whoever put that in, could you tell us what system you're on so that everyone can go to their vendor like, if this person's on NextGen, they can do this, do that for me. So whoever put that in, definitely put the chat, what you're on practice management...

Vacheria Keys (55:20):

Janita Taylor, you get a gold star for Good Faith Estimate. So, thank you guys for all these great things. So OCHIN Epic, I see that wasn't from Janita, we use Epic, we do that through Epic. And so we are also working with OCHIN and sharing our templates. So, we have three minutes, so we'll just wrap up here and give you guys a few of our next steps. So, we do have a template that we will share with you guys. There are these resources from CMS FAQs. Please reach out to us if you have great success stories, because we would love to highlight that for your health center community. If you feel like you're getting it right, we would love to hear from you. And if you still are lost after this webinar, we would also love to hear from you. All feedback is welcome.

Vacheria Keys (56:08):

Takeaways. Please start implementing the Good Faith Estimate. If you are starting from zero, that is okay, as long as you start complying after today, we're on a fresh start. But Good Faith Estimate is required for all uninsured patients. If they schedule within three business days or further out. We are also going to be trying to work with some EHR vendors to make sure the EHRs are incorporating the templates, so if you are working with a vendor that feels like they're not compliant or not helping you integrate, please let us know that as well. However, NACHC can be helpful for you guys, we really want to help you with this compliance. And we will also keep you guys updated as we work with CMS. And if there is a new regulation that comes out, we will need your support in submitting template comments, if we're supportive of the regulation or if we're not. Gervean, I don't know if you have any final words or wisdom to share?

Gervean (57:04):

My thing is, hang in there, they're not enforcing it right now, so this is a year for you to make the bumps and figure it out so that in January 2023, we're all compliant and we're good to go. But thanks so much for joining us. We really appreciate you. And we're here for your support.

Vacheria Keys (57:20):

Yes. And no, the Good Faith Estimate is not in the OSV, that is a BIPOC review, your Operational Site Visit is under BIPOC. These are CMS requirements and they are separate and BIPOC systems are separate. So, I wanted to just clear that up. But thank you guys so much for joining us today. Please feel free to reach out if you have any questions. And I hope you guys have a lovely day. Thank you.

Gervean (57:46):

Thank you. Enjoy.