

# Finance Office Hour: Facilitated Discussion On the No Surprise Billing Act

Friday, December 17, 2021



# THE NACHC MISSION

## **America's Voice for Community Health Care**

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.



## MATERIAL COVERED TODAY

This presentation has been designed to provide education on the “No Surprise Billing Act” .

This presentation should not be relied upon as legal advice

# Today's Agenda

- Final Rule Overview
  - Jeremy Crandall, Director of Federal and State Policy, NACHC
  - Susannah Vance-Gopalan, Partner, Feldesman Tucker Leifer Fidell LLP
- Thoughts on Implementation
  - Gervean Williams, Director, Financial Training and Technical Assistance, NACHC
- Sliding Fee and Prompt Pay Considerations
  - Ray Jorgensen, Principal, Ray Jorgensen Consulting, LLC
- Workflow Considerations
  - Scott W. Gold, CPA, BKD
  - Rebekah Wallace Pardeck, CPC, CMPE, CPCO, Achieve Revenue Management, LLC

# Policy Overview

**Susannah Vance Gopalan**

Feldesman, Tucker, Leifer, Fidell, LLP

# The No Surprises Act: Overview of Good Faith Estimate Requirements

Susannah Vance Gopalan

December 17, 2021

# NO SURPRISES ACT § 112 – GOOD FAITH ESTIMATE

- Adds a new Section 2799B-6 to the Public Health Service Act
- Requires “each health care provider and health care facility,” beginning 1/1/2022, to provide certain information to plans and patients
- If the patient makes an appointment at least 3 business days before the date the service is scheduled, then the provider must
  - (1) inquire if the individual is enrolled in a group health plan, individual insurance, or federal health care program, and if so enrolled, if the individual is seeking to have a claim submitted for the relevant item or service; and
  - (2) provide a “notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service, and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item or service. . . .”

# NO SURPRISES ACT § 112 – GOOD FAITH ESTIMATE

- Recipient of the information
  - In the case of an individual who is enrolled in a group health plan or group or individual health insurance coverage offered by a private health insurance issuer, then the notification is required to be sent to the plan or coverage issuer (which, in turn, is required to issue an “advanced explanation of benefits,” per Section 111 of the No Surprises Act)
  - In the case of an individual who is not enrolled in a group health plan, group or individual health insurance coverage, or federal health benefit program, the notification is required to be sent to the individual

## PART II IFR: REQUIREMENTS FOR PROVISION OF GOOD FAITH ESTIMATES (GFE) OF EXPECTED CHARGES FOR UNINSURED (OR SELF-PAY) PATIENTS

- The [Part II Interim Final Rule](#), issued on October 7, 2021, was issued *in final*; the agencies *may* make changes through future rulemakings in response to comments, but are not required to
- Implements Section 112 of the No Surprises Act
- Scope of the regulation (45 C.F.R. § 149.610)
  - Under the No Surprises Act, the estimate requirements for both uninsured/self pay patients and privately insured patients were required to take effect January 1, 2022, but the agencies have delayed implementation of the portions applicable to plans / privately insured patients
  - The term “health care facility” is defined more broadly for purposes of this regulation than for the surprise billing component of the No Surprises Act; for purposes of 45 C.F.R. § 149.610, the definition includes FQHCs
  - The requirement to provide GFEs to uninsured or self-pay patients applies to “convening providers or facilities” – the provider or facility that “receives the initial request for a good faith estimate . . . and who is or . . . Would be responsible for scheduling the primary item or service”

## GFE – “CONVENING PROVIDER” AND “CO-PROVIDER”

- **“Convening health care provider or convening health care facility”** is defined in the regulation as “the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service” (45 C.F.R. § 149.610(a)(2)(ii).)
- **“Co-health care provider or co-health care facility”** is defined in the regulation as “a provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service” (45 C.F.R. § 149.610(a)(2)(iii).)
- **“Primary item or service”** is defined as the item or service to be furnished by the convening provider or convening facility that is the initial reason for the visit. (45 C.F.R. § 149.610(a)(2)(xi).)
- The convening provider is required to contact “all co-providers and co-facilities who are reasonably expected to provide items or services in conjunction with and in support of the primary item or service” within one business day of the patient scheduling an appointment or requesting an estimate, to request that the co-provider submit good faith estimate information to the convening provider (45 C.F.R. § 149.610(b)(1)(v)-(vi).)

# GFE – COLLECTING INFORMATION FROM PATIENT

- Convening providers / facilities are required to
  - Ask if an individual is enrolled in a group health plan, group or individual health insurance coverage, or Federal health care program
  - **If yes** – Ask whether the individual is seeking to have a claim submitted for the primary item or service with such plan or coverage (if not, the person is defined as “self-pay”)
  - Inform uninsured (or self-pay) individuals of the availability of a good faith estimate of expected charges upon scheduling an item or service or upon request
  - Contact all co-providers or co-facilities as described above

45 C.F.R. § 149.610(b)(1)

# GFE – INFORMING PATIENTS OF THE AVAILABILITY OF GFE

- Information regarding GFE availability must be provided both in writing and orally
- Convening provider must
  - provide written notice in a clear and understandable manner prominently displayed (and easily searchable from a public search engine) on the convening provider's/facility's website, in the office, and on-site where scheduling or questions about the cost of items or services occur
  - Orally inform uninsured and self-pay patients of the availability of the GFE when scheduling items and services, and when questions about the cost of items or services occur
- Information about the GFE must be made available in accessible formats and languages spoken by the patient population
- CMS has developed a standard notice regarding the availability of a GFE, available [here](#).

45 C.F.R. § 149.610(b)(1)(iii); 86 Fed. Reg. 56016

# GFE - TIMEFRAMES

Convening providers are required to provide a GFE within these timeframes:

- When a primary item or service is scheduled at least 3 business days in advance – within one business day after scheduling
- When a primary item or service is scheduled at least 10 business days in advance – within 3 business days after scheduling
- When a good faith estimate is requested by an uninsured (or self-pay) individual - not later than 3 business days after the date of the request

45 C.F.R. § 149.610(b)(1)(vi)

# CONTENTS OF A GFE

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- CMS has issued “Data Elements” guidance for the GFE, as well as a GFE template, available [here](#)
  - Appendix 2: Standard Form: “Good Faith Estimate for Health Care Items and Services” Under No Surprises Act
  - Appendix 11: Good Faith Estimates, Data Elements

# CONTENTS OF A GFE, CONT.

- Patient name and date of birth
- Description of the primary item or service requested
- Itemized list of items or services expected to be furnished for the primary item or service (including both by convening and co-providers and facilities)
  - “Items or services” defined as “all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees . . . provided or assessed in connection with the provision of health care” – **includes, as well a traditional medical services, “services such as those related to dental health, vision, substance use disorders and mental health”**
  - Note: For GFEs issued during CY2022, “HHS will issue its enforcement discretion in situations where a good faith estimate . . . Does not include expected charges from co-providers or co-facilities” (86 Fed. Reg. 56023)

As well as . . .

45 C.F.R. § 149.610(c); 86 Fed. Reg. 56015

# CONTENTS OF A GFE, CONT.

- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;
  - “Expected charge” defined as “for an item or service, the cash pay rate or rate established by a provider or facility for an uninsured (or self-pay) individual, *reflecting any discounts for such individuals*, where the good faith estimate is being provided to an uninsured (or self-pay) individual”
    - For health centers, this means that the estimate must take into account any applicable discounts under the Section 330-required Sliding Fee Discount Program
  - “Service code” means the code that identifies and describes an item or service using the CPT, HCPCS, DRG, or NDC code sets
  - “Diagnosis code” means the code that describes an individual’s disease, disorder, injury, or other related health conditions using the ICD code set

And also . . .

45 C.F.R. §§ 149.610, (a)(2), 149.610(c)

# CONTENTS OF A GFE, CONT.

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- Name, NPI and TIN of each provider or facility represented in the GFE
- State(s) and office or facility location(s) where services expected to be furnished
- List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service

45 C.F.R. § 149.610(c)

# REQUIRED GFE DISCLAIMERS

The convening provider/facility must include disclaimers on the GFE, as follows:

Separate good faith estimates will be issued regarding listed pre- or follow-up services

There may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the GFE

The information provided in the GFE is only an estimate, and actual items, services, or charges may differ

Individual has right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate ("substantially in excess" defined as \$400)

The good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate

# FORMAT FOR GFE

- Must be provided in written form either on paper or electronically, according to the individual's requested method of delivery
- Electronic GFEs
  - must be provided in a format that the patient can both save and print
  - Must be provided in a manner consistent with health information privacy and security protections (GFE will contain protected health information)
- GFE must be provided and written using clear and understandable language
- If patient requests to receive GFE information orally (on the phone or in person), the convening provider may convey the information orally, but must also issue the GFE in written form

45 C.F.R. § 149.610(e), (g); 86 Fed. Reg. 56023

# GFE COMPLIANCE

- The GFE is considered part of the patient's medical record
  - Must be maintained in the same manner as the medical record
  - Convening providers must be able to provide a copy of any GFE issued within the last 6 years to a patient
- Providers do not fail to comply with the regulation solely because they made an error or omission, despite acting in good faith to supply the GFE
- Where providers/facilities rely on co-providers/facilities to obtain GFE information, convening provider will not have violated the regulation if it relies on co-provider information, unless the convening provider/facility knew or reasonably should have known that the information was incomplete or inaccurate

45 C.F.R. § 149.610(f)

# ENFORCEMENT

- The agencies issued a [Notice of Proposed Rulemaking](#) on September 16, 2021, relating to the enforcement of the No Surprises Act and specific requirements on air ambulance services; no final rule has been issued yet
- States have the primary role in enforcing the provider-oriented rules in the No Surprises Act
- Section 104 of the Act allows HHS to enforce the provider-oriented requirements of No Surprises *if* HHS determines that a State has failed to substantially enforce the requirements
- HHS has [surveyed the States](#) as to whether / to what extent they intend to enforce the provisions, but no information is available yet (as to whether each State will enforce, and if so, which agency within the State will assume responsibility for enforcement)
- HHS may apply civil money penalties in an amount up to \$10,000 per violation
- HHS stated in the preamble to the NPRM its intention to conduct about 200 investigations each month of potential No Surprises violations by providers or facilities (86 Fed. Reg. 51766)

# ENFORCEMENT

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- Patients may file a complaint with HHS if the patient believes a health care provider or facility has failed to meet the requirements in the regulations concerning surprise billing (Part I IFR) or the transparency/GFE requirements (Part II IFR) (45 C.F.R. § 149.450)
- Additionally, HHS will operate a dispute resolution process enabling patients to contest billed charges that are “substantially in excess” (\$400 or more) of the expected charges outlined in the GFE (45 C.F.R. § 149.620)

# QUESTIONS?

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**Susannah V. Gopalan**

[SGopalan@ftlf.com](mailto:SGopalan@ftlf.com)

**Feldesman Tucker Leifer Fidell LLP**

(202) 466-8960 (Reception)

(855) 200-3822 (Training Team)

[www.ftlf.com](http://www.ftlf.com)

[Learning.ftlf.com](http://Learning.ftlf.com)

# Policy Update

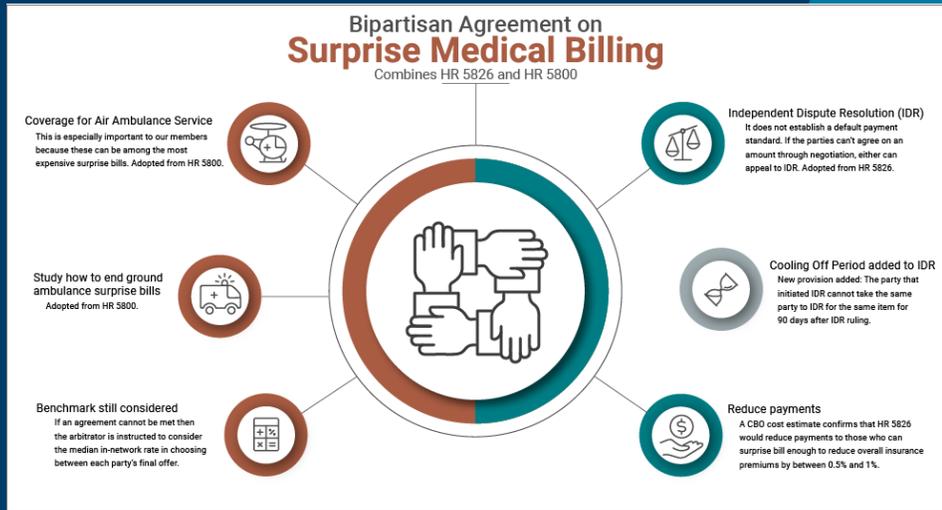
**Jeremy Crandall**

Director of Federal and State Policy,  
NACHC

# Surprise Billing Rule – Concerns for FQHCs



- No Surprises Act passed Congress in late 2020, seeks to eliminate surprise medical bills for patients
- Part 1 Interim Final Rule (IFR) creates Independent Dispute Resolution (IDR) between providers and payors; definition of “facility” did not apply to FQHCs
- Part 1.5 Proposed Rule outlines civil monetary penalties, hardship exemptions
- Part 2 IFR **requires providers to give uninsured or self-pay patients a good faith estimate of expected charges**
  - *Definition of “facility” includes FQHCs and RHCs*



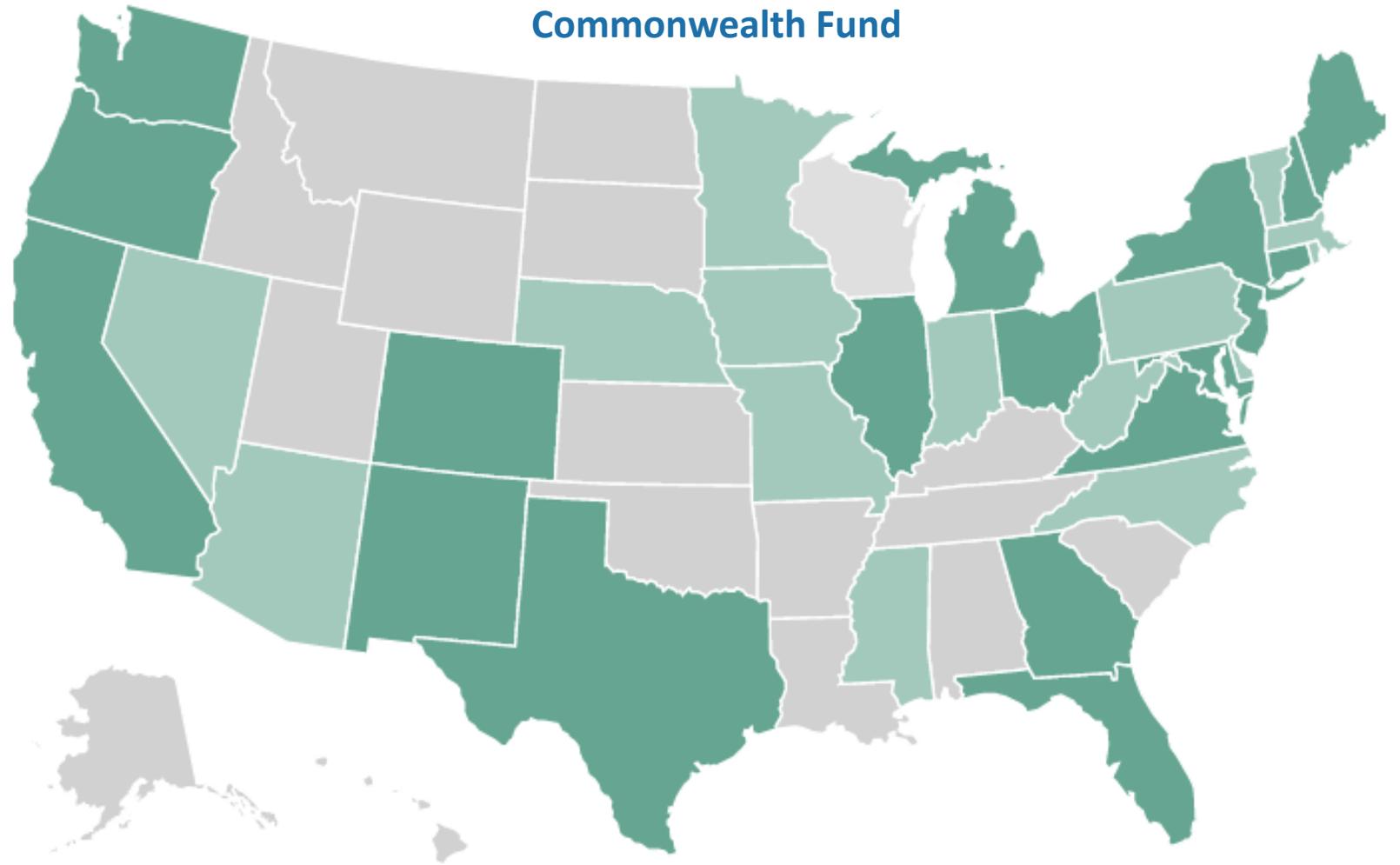
# More background

- *The politics...*
  - Key priority for House, Senate leaders
  - Long-running battle between insurers and large-scale providers (hospitals, air ambo)
- *NACHC Outreach*
  - Meetings w/ Congressional staff – “Intention was to apply to FQHCs”
  - Reopening statute remote
  - HHS/HRSA/CCIIO – Ongoing...
- *Process Gathering*
  - Considerable range of feedback in how health centers handle SFDS (35 FQHCs across 10 states)
- *Next steps*
  - Track rollout in early 2022

# State Laws

## 33 States Have Enacted Surprise Billing Legislation

- 18 states have laws with comprehensive protections
- Comprehensive protections include dispute resolution, “hold harmless” provisions, and other criteria



- No Balance Billing Protections
- Partial Balance Billing Protections
- Comprehensive Balance Billing Protections

# Implementation Thoughts

**Gervean Williams**, Director of Financial Training and Technical Assistance, NACHC

[gwilliams@nachc.org](mailto:gwilliams@nachc.org)

# What to do now

- Assign the role of GFE Ambassador – not front desk or scheduling!
- Post on your website, in lobby and in your patient packets the option to request a GFE
- Have a Team meeting including clinical, finance, front office and IT staff to discuss GFE

# Public Posting from CMS

- OMB Control Number [XXXX-XXXX]  
Expiration Date [MM/DD/YYYY]
- **You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost**
  - Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an estimate of the bill for medical items and services.
- Excerpt from the CMS template

# Sliding Fee & Prompt Pay Considerations

**Ray Jorgensen, Principal**  
Ray Jorgensen Consulting, LLC

# NACHC Surprise Billing Sliding Fee & Prompt Pay Considerations



# Agenda

- Introduction
- HRSA Requirements
- Prompt Payment Overview
- FFS vs. Flat Rate
- Flat Rate Examples
- Summary

# HRSA Requirements (1 of 3)

- Charges MUST be....
  - Consistent with local prevailing (market) rates
  - Designed to cover reasonable costs
  - Posted
  - Board approved with “regular” review/update
- CHCs MUST make “all” reasonable efforts to obtain payment from third parties & governmental payers
  - Charges at “full amount” (no discount)
- Schedule of discounts MUST be...
  - Applied to patient payment based on “ability to pay”
  - Available for those with family income < 200% FPL
- Nominal fees collectible for patients < OR = 100% FPL

Source: <https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html>

# HRSA Requirements (2 of 3)

SFDS program must include:

- Written policies
- Governing board approval
- Specified structure
- Patient eligibility requirements
- Requisite/acceptable “proof” documentation
- Including self-declaration
- Nominal charge collection
- Billing and collections policies
- Including policies around refusal to pay

Source: <https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html>

# HRSA Requirements (3 of 3)

- Applicability to:
  - Co-insurance, and/or co-payments
  - Supplies, equipment or other patient costs
- Multiple SFDS utilization (e.g., 330 & Family Planning)
- Provision & Policy for waiving fees

Source: <https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html>

# Charge Setting

- Paid lesser of clinic/practice charge or payer fee schedule
- Always charge more than anticipated payment
- Charge floor .....Medicare fees (RVU based) 150%-250%+
- Underpayment Management
  - Posting payments within 10% of charge, raise charge(s) (e.g., \$100 charge results in payment (insurance + co-pay) of \$90+)

# Prompt Payment Discount

- NOT part of SFDS/SFDP but separate payment policy
- Applicable for 200%+ FPL
- AND, applicable to predetermined SFDS/SFDP
- Considerations:
  - Pay at time of service or within fixed period
  - Afford to any entity settling account at time of service
  - Not a reduced charge but adjustment (language is critical)
  - Time value to money
- Financial Hardship: Entirely subjective... case by case
- Legal because of pervasive application
- Afforded REGARDLESS of ability to pay
  - Maintain elevated full charge without disenfranchising
- Professional Courtesy (VIP)... anyone meeting criteria
- Prompt Pay & VIP: Non-discriminatory, unilaterally applied

# Flat Rate Sliding Fee (1 of 3)

- Must follow SFDS policies
- Per diem rate vs. unique fee per service
- Anecdotal evidence... dramatic increased \$\$
- EASIER compliance with No Surprise Billing
- Rationale for behavior delta:
  - Patients will more readily pay published rates
  - SFDS is challenging
  - Hard to understand... PM not helpful/seamless
  - Interpreted differently staff to staff & site to site
  - Easy to understand by patients and clinic staff
  - Patients know fee and arrive ready to pay
  - Clinic staff understand flat rate

# Flat Rate Examples

- NO MORE “SURPRISE” CHARGES AT HEART CITY CHECKOUT.
- NO MORE PERCENTAGE DISCOUNTS.
- ONE FLAT FEE: INCLUDES THE FOLLOWING TESTS;

- Lipid Panel
- Blood Glucose
- Lead
- Quick Strep
- Neb Initial

- Urinalysis
- HGB A1C
- Hemoglobin
- Spirometry
- Pulse Ox
- Blood Draw

Source: <https://www.heartcityhealth.org/wp-content/uploads/2016/01/Sliding-Fee-Scale-Information.pdf>

(Additional costs may apply for tests not listed above or if referred elsewhere)

Slide	Fee (\$)
A	\$30
B	\$45
C	\$75
D	\$100

# Flat Rate Examples

% of Poverty Level	100%		Over 100% to 150%		Over 150% to 175%		Over 175% to 200%		FQHC. Over 200%
Program Code	P-0		P-1		P-2		P-3		P-4
Family Size	Above	At or below	Above	At or below	Above	At or below	Above	At or below	Above
1	0	\$ 12,880	\$ 12,880	\$ 19,320	\$ 19,320	\$ 22,540	\$ 22,540	\$ 25,760	\$ 25,760
2	0	\$ 17,420	\$ 17,420	\$ 26,130	\$ 26,130	\$ 30,485	\$ 30,485	\$ 34,840	\$ 34,840
3	0	\$ 21,960	\$ 21,960	\$ 32,940	\$ 32,940	\$ 38,430	\$ 38,430	\$ 43,920	\$ 43,920
4	0	\$ 26,500	\$ 26,500	\$ 39,750	\$ 39,750	\$ 46,375	\$ 46,375	\$ 53,000	\$ 53,000
5	0	\$ 31,040	\$ 31,040	\$ 46,560	\$ 46,560	\$ 54,320	\$ 54,320	\$ 62,080	\$ 62,080
6	0	\$ 35,580	\$ 35,580	\$ 53,370	\$ 53,370	\$ 62,265	\$ 62,265	\$ 71,160	\$ 71,160
7	0	\$ 40,120	\$ 40,120	\$ 60,180	\$ 60,180	\$ 70,210	\$ 70,210	\$ 80,240	\$ 80,240
8	0	\$ 44,660	\$ 44,660	\$ 66,990	\$ 66,990	\$ 78,155	\$ 78,155	\$ 89,320	\$ 89,320
Proposed	Nominal	\$20		\$ 35		\$ 45		\$ 55	Full charges
Lab		included		cost		cost		cost	

Source: <https://media.southernnevadahealthdistrict.org/download/boh21/20210325-boh/20210325-Item-VII-1-SF-Fee-Schedule.pdf>

# Flat Rate Examples

Centerstone Health Services, Inc.						
Sliding Fee Schedule 2021 - updated 3-10-21						
Slide Category		A	B	C	D	N/A
Poverty Level		0 - 100%	>100 - 150%	>150 - 175%	>175 - 200%	> 200%
	Fee per family member, per visit	Nominal Fee \$10	Patient Pays \$25	Patient Pays \$40	Patient Pays \$55	100% of Charges
Family Size	Income less than	Income less than	Income less than	Income less than	Income less than or equal to	Income <u>more</u> than
1	Annual(up to)	\$ 12,880.00	\$ 19,320.00	\$ 22,540.00	\$ 25,760.00	\$ 25,760.00
	Monthly	\$ 1,073.33	\$ 1,610.00	\$ 1,878.33	\$ 2,146.67	\$ 2,146.67
	Weekly	\$ 247.69	\$ 371.54	\$ 433.46	\$ 495.38	\$ 495.38
2	Annual(up to)	\$ 17,420.00	\$ 26,130.00	\$ 30,485.00	\$ 34,840.00	\$ 34,840.00
	Monthly	\$ 1,451.67	\$ 2,177.50	\$ 2,540.42	\$ 2,903.33	\$ 2,903.33
	Weekly	\$ 335.00	\$ 502.50	\$ 586.25	\$ 670.00	\$ 670.00
3	Annual(up to)	\$ 21,960.00	\$ 32,940.00	\$ 38,430.00	\$ 43,920.00	\$ 43,920.00
	Monthly	\$ 1,830.00	\$ 2,745.00	\$ 3,202.50	\$ 3,660.00	\$ 3,660.00
	Weekly	\$ 422.31	\$ 633.46	\$ 739.04	\$ 844.62	\$ 844.62
4	Annual(up to)	\$ 26,500.00	\$ 39,750.00	\$ 46,375.00	\$ 53,000.00	\$ 53,000.00
	Monthly	\$ 2,208.33	\$ 3,312.50	\$ 3,864.58	\$ 4,416.67	\$ 4,416.67
	Weekly	\$ 509.62	\$ 764.42	\$ 891.83	\$ 1,019.23	\$ 1,019.23
5	Annual(up to)	\$ 31,040.00	\$ 46,560.00	\$ 54,320.00	\$ 62,080.00	\$ 62,080.00
	Monthly	\$ 2,586.67	\$ 3,880.00	\$ 4,526.67	\$ 5,173.33	\$ 5,173.33
	Weekly	\$ 596.92	\$ 895.38	\$ 1,044.62	\$ 1,193.85	\$ 1,193.85
6	Annual(up to)	\$ 35,580.00	\$ 53,370.00	\$ 62,265.00	\$ 71,160.00	\$ 71,160.00
	Monthly	\$ 2,965.00	slidingfee-3-10-20v2	\$ 5,188.75	\$ 5,930.00	\$ 5,930.00
	Weekly	\$ 684.23	\$ 1,026.35	\$ 1,197.40	\$ 1,368.46	\$ 1,368.46
7	Annual(up to)	\$ 40,120.00	\$ 60,180.00	\$ 70,210.00	\$ 80,240.00	\$ 80,240.00
	Monthly	\$ 3,343.33	\$ 5,015.00	\$ 5,850.83	\$ 6,686.67	\$ 6,686.67
	Weekly	\$ 771.54	\$ 1,157.31	\$ 1,350.19	\$ 1,543.08	\$ 1,543.08
8	Annual(up to)	\$ 44,660.00	\$ 66,990.00	\$ 78,155.00	\$ 89,320.00	\$ 89,320.00
	Monthly	\$ 3,721.67	\$ 61.00	\$ 6,512.92	\$ 7,443.33	\$ 7,443.33
	Weekly	\$ 858.85	\$ 1,288.27	\$ 1,502.98	\$ 1,717.69	\$ 1,717.69
Each Additional Person	Annual(up to)	\$ 4,540.00	\$ 6,810.00	\$ 7,945.00	\$ 9,080.00	\$ 9,080.00
	Monthly	\$ 378.33	\$ 567.50	\$ 662.08	\$ 756.67	\$ 756.67
	Weekly	\$ 87.31	\$ 130.96	\$ 152.79	\$ 174.62	\$ 174.62

# Flat Rate Examples

Class A				Class B			
100% or Below of Federal Poverty level				101% to 150% of Federal Poverty level			
\$10 Nominal Fee, all inclusive including x-ray				\$15 Office Visit, all inclusive including x-ray			
100% Discount on labs performed by contracted labs				100% Discount on labs performed by contracted labs			
100% Discount on Dental Services performed by contracted dentist				100% Discount on Dental Services performed by contracted dentist			
Family Size	Annual	Monthly	Weekly	Family Size	Annual	Monthly	Weekly
1	\$ 12,880	\$ 1,073.33	\$ 247.69	1	\$ 19,320	\$ 1,610	\$ 372
2	17,420	\$ 1,451.67	\$ 335.00	2	\$ 26,130	\$ 2,178	\$ 503
3	21,960	\$ 1,830.00	\$ 422.31	3	\$ 32,940	\$ 2,745	\$ 633
4	26,500	\$ 2,208.33	\$ 509.62	4	\$ 39,750	\$ 3,313	\$ 764
5	31,040	\$ 2,586.67	\$ 596.92	5	\$ 46,560	\$ 3,880	\$ 895
6	35,580	\$ 2,965.00	\$ 684.23	6	\$ 53,370	\$ 4,448	\$ 1,026
7	40,120	\$ 3,343.33	\$ 771.54	7	\$ 60,180	\$ 5,015	\$ 1,157
8	44,660	\$ 3,721.67	\$ 858.85	8	\$ 66,990	\$ 5,583	\$ 1,288
Each Add'l	\$ 4,540	\$ 378.33	\$ 87.31	Each Add'l	\$ 6,810	\$ 567.50	\$ 131

# Flat Rate Examples

Class C				Class D			
<b>151% to 175% of Federal Poverty level</b> <b>\$20 Office Visit, all inclusive including x-ray</b> <b>100% Discount on labs performed by contracted labs</b> <b>100% Discount on Dental Services performed by contracted dentist</b>				<b>176% to 200% of Federal Poverty level</b> <b>\$25 Office Visit, all inclusive including x-ray</b> <b>100% Discount on labs performed by contracted labs</b> <b>100% Discount on Dental Services performed by contracted dentist</b>			
Family Size	Annual	Monthly	Weekly	Family Size	Annual	Monthly	Weekly
1	\$ 22,540	\$ 1,878	\$ 433	1	\$ 25,760	\$ 2,146.67	\$ 495.38
2	30,485	2,540	586	2	34,840	2,903.33	670.00
3	38,430	3,203	739	3	43,920	3,660.00	844.62
4	46,375	3,865	892	4	53,000	4,416.67	1,019.23
5	54,320	4,527	1,045	5	62,080	5,173.33	1,193.85
6	62,265	5,189	1,197	6	71,160	5,930.00	1,368.46
7	70,210	5,851	1,350	7	80,240	6,686.67	1,543.08
8	78,155	6,513	1,503	8	89,320	7,443.33	1,717.69
Each Add'l	\$ 7,945	\$ 662	\$ 153	Each Add'l	\$ 9,080	\$ 756.67	\$ 174.62

# Flat Rate Examples

<b>Class E</b>			
<b>201% and above of Federal Poverty Level</b>			
<b>No Discount Provided</b>			
<b>Family Size</b>	<b>Annual</b>	<b>Monthly</b>	<b>Weekly</b>
1	\$ 25,761	\$ 2,146.75	\$ 495.40
2	\$ 34,841	2,903.42	670.02
3	\$ 43,921	3,660.08	844.63
4	\$ 53,001	4,416.75	1,019.25
5	\$ 62,081	5,173.42	1,193.87
6	\$ 71,161	5,930.08	1,368.48
7	\$ 80,241	6,686.75	1,543.10
8	\$ 89,321	7,443.42	1,717.71
Each Add'l	\$ 9,080	\$ 756.67	\$ 174.62

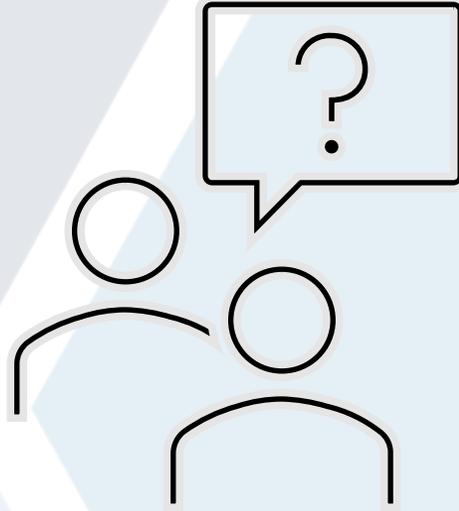
This is 3 of 3

Source: <https://healthfirstchc.net/patients/discount-programs/>

# Summary

- Read HRSA Compliance Manual, Chapter 9
- Equitable application of SFDS & Prompt Pay
- Stay informed & Analyze data
- Longitudinal Analysis
- Staff feedback & education
- Commit to educate (top down)

# Questions



Ray Jorgensen

[RJorgensen@AllianceChicago.org](mailto:RJorgensen@AllianceChicago.org)

LinkedIn: <https://www.linkedin.com/in/ray-jorgensen-a04368/>

# Workflow Considerations

**Scott W. Gold, CPA**  
BKD

**Rebekah Wallace Pardeck, CPC, CMPE, CPCO**  
Achieve Revenue Management, LLC

# Financial Considerations

- Is there a financial impact?
- Does this impact the financial statement audit?
- Are there cost report considerations
- Should we anticipate an impact on staffing expense?



# Patient Awareness

- Organization's website
- Displayed near scheduling/similar area
- Verbally disclosed to patients

## You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call [INSERT PHONE NUMBER].



# Good Faith Estimate Disclaimers

## Disclaimers

GFE is an estimate and subject to change

May be additional services

Patient's right to initiate dispute resolution process

GFE is not a contract

### Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

**If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.**

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call [HHS PHONE NUMBER].

**For questions or more information** about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call [HHS NUMBER].

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

# Workflow Implementation

- Develop well defined policy
  - Inclusive of required elements
- Document in procedure format
- Consider utilizing templates and tools
  - CMS -10791
  - <https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/practicing/cms-10791>
- Educate staff
- Document
- Include verification/quality control process

# Questions

**Scott Gold, CPA**  
Partner  
BKD, LLP  
[sgold@bkd.com](mailto:sgold@bkd.com)  
417.865.8701

**Rebekah Wallace Pardeck, CMPE,**  
**CPC®, CPCO™**  
President  
Achieve Revenue Management  
[rebekah@achieverev.com](mailto:rebekah@achieverev.com)  
417.840.3179

# Questions?

The webinar recording and slides will be emailed to all participants.

## Thank You!

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