RHC Regulatory Updates & GFE Policy

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SPEAKERS

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Sarah Hohman 00:19

Hello, everyone. Thanks for joining us today. We'll give just a few minutes. I know we have pretty high registration numbers for this webinar. So we'll give folks just another minute to log on and then we will get started thanks for being here. All right, well welcome everyone. Good afternoon. My name is Sarah Holman. I'm the director of government affairs for the National Association of rural health clinics and the moderator also one of the presenters for today's call. Today we'll be talking about RHC regulatory updates going into 2023 Hard to believe, or almost at the New Year, as well as Good Faith Estimate policy. This webinar is done in conjunction with the Federal Office of Rural Health Policy and sponsored by hearses Federal Office of Rural Health Policy. We're supported by a cooperative agreement as you can see on your screen, and that allows you allows us to bring you these webinars free of charge. So we appreciate you being here. The purpose of this series, as always, is to provide our IT staff and other stakeholders with important technical assistance and RHC specific information. So we ask that you help us to spread the word about these free webinars by encouraging anyone who may benefit from this information to sign up to receive our announcements through our listserv. That includes dates, topics, and speakers. And you can do that through our website. We will have plenty of time for q&a today. So you can utilize the q&a box we ask that you hold your questions until we get to that point. In case we covered the information in the webinar previously. We're always happy to clarify once we get to that point. As with all webinars, we're at the mercy of good bandwidth for all parties. And we all know that connectivity can go up and down. So if you have audio or visual issues, we suggest leaving the webinar and coming back in. But don't worry if for some reason, you can't access the webinar live. A recording will be posted on our website with links to the slide and transcript. Just to ask or answer someone's question already, you are muted upon entry. There's quite a few of you here today. And so once we get to q&a, you're welcome to ask your question there, but you are muted upon entry. Okay, so with that, I'm not going to spend too much time introducing speakers. It's myself and Nathan BA, the executive director of NAR, HC, but we're happy that you're here with us. And with that, I'm going to turn it over to Nathan, who is going to start our agenda by covering regulatory updates headed into 2023.

Nathan Baugh 04:34

Thank you, Sarah. And the regulatory updates is a bit of a lightyear. I'm not gonna lie. So this will be quick and the vast majority of this will be on good faith estimate. You know, I'm stretching the imagination. a smidge. I'm stretching the imagination here by calling this stuff, regulatory updates. These are policy

updates. I think that's perhaps more accurate but we have a lot of payment changes. Of course at As many of you know, the upper payment limit or the RNC cap for our non grandfathered RFCs will be $126 beginning on January 1 2023. The payment for telehealth and medical telehealth visits for 2023 is actually going to go down from 9724 to $95.88 for 2023. And just a little bit of context on that we are paid the weighted average of the CPT codes are the the services that are billed on fee for service through telehealth. We don't have a lot of insight into exactly how they calculate this number. You know, but CMS did announce that it's going to go down to $95.88 for 2023. So that's, that's what's happening there. And for G 0071, which is our virtual care communications code. That is also going down. Similar to our telehealth code, this is the average of two CPT codes. So obviously, not a huge change there, but it is a slight reduction. Finally, the payments for our care management codes have not yet been published, both G 0511 and g 0512. We expect that they will be published, most likely on the CMS Rec Center website. That's where they are traditionally. Last I checked, I believe was yesterday. And it wasn't wasn't there yet. If anyone wants to learn more about what is a telehealth visit versus a virtual care communication versus chronic care management, versus a psychiatric collaborative care visit, you can go to that QR code. And you can see some of our resources that we that we have that where it kind of gives you some more context as to what exactly I'm talking about. But here again, I'm focusing just on the changes coming into 2023. Next slide, please. A couple of other things that was just clarified from the 2023 final rules. And this is only going to apply to some subset of our agencies. But those are agencies that were late grandfathered our ACS, that maybe had just opened in 2020 just got grandfathered in. Maybe they just had their application in by the end of 2020. But we're not even operating as an RHC. Yet. There are some question as to you know, if your first cost report is not a full 12 months, would that first cost report that you submit, be the the cost report that dictates your clinic specific cap? And the answer is no. If it's if it's less than a full 12 month cost report, so they want to give you a fair and, you know, representative, clinic specific upper payment limit. So to do that, they are going to base it off of your first full 12 month cost report that you submit. So hopefully that's clear, vast majority of you this does not apply either you were grandfathered in well before the changes to the payments and 2021 or your independent RHC. And this doesn't apply to you. But if you join the IHC program as a provider based RHC in late 2020 or early 2021. This is something to look at. Likewise, or not likewise. But another thing that I wanted to point out is that we have a new hospital facility type coming next year starting next year. I imagine not a whole lot of hospitals are going to jump immediately to RH status. But it has been very clear and explicit, both in the statute and now here again in the final rules that if you are owned by a hospital, and you're grandfathered and your hospital wants to convert to a rural emergency hospital status, they can do that and it will will not affect your grandfathered RHC status, or your grandfathered, RHC payment rate. And so we just really wanted to clarify that, in case your own, let's say buy a car that is considering this RH model, but it's wondering what it might do to your to the provider base or HIV status. Next slide, please. So there is a few new codes added to the chronic care management policy. And so what we tried to do here is show you some of the nuances between 2022 current policy and 2023. Again, this is this is advanced level stuff. So if you need a fundamental understanding of care management, go to our website and check out some of our resources. But for 2023, they're adding those codes that are in green at the bottom. We have general behavioral health and integration, and then something called chronic pain management, both the G 302 and g 3003. Code now. These are the descriptions of that are in the final rule, and we're not going to go into exactly what those are, but for us, how we build these is a bit tricky. So, G 3002, especially, is something that can be billed as an RHC encounter. And or at through G 0511. Okay, so, you will build G 3002. With modifiers CG as an encounter,

if you do it in person, chronic pain management services 30 minutes in person, if you do that, you billet CG as an encounter, and the first one that you do have chronic pain management has to be an in person. Okay? Any you there at any months thereafter, you can do chronic pain management, either virtually or in person. If you continue to do that 30 minute service in person, Bill g 3002. With modifier CG get paid your IT encounter, if you're doing it electronically, then you're going to want to bill it as g 0511. So that's a weird nuance for us. Again, like I said, the payment amount for 2023 has not yet been announced. These three codes are not going to be baked into the average of that is used to set the G 0511 code, you'll see that second column to the right or the I guess it would be the 123 the fourth column right? Paid the average of the following CPT codes, you'll see those CPT codes are exactly the same from 2022 to 2023. Right. But that G 0511 code is now representing three additional services. So if you do any of those three services, with that notable exception of G 3002, which also can be an encounter, then you would build G 0511. And you're just gonna get paid the average of the other six codes. So that is this is obviously an advanced sort of just update on a nuanced and a very complicated topic. So just want to put that out there. Again, that's starting in 2023. Last thing I'll say and I'll turn it over to Sarah, is that CMS did indicate to us that they will be releasing guidance, I presume, most likely in mln matters. Or maybe they'll be updating an mln matters, specifically on these care management codes and the chronic pain management codes to help you know clarify this even further and make it easier to explain. So I'm going to stop there and turn it back over to Sarah.

Sarah Hohman 14:26

You actually have one more Oh, I have one more.

Nathan Baugh 14:30

Oh, not yet this, this is not yet locked into place. So there's a massive caveat on everything I'm about to say. But if I'm reading the tea leaves, at least what I'm seeing it with my inside the beltway perspective, is that Congress appears ready to add licensed professional counselors and Marriage and Family Therapists as Medicare for fighters and an end of year appropriation package. And if they do that, we're pretty confident that they would add them to the list of practitioners that can provide an RHC encounter. Should they do that, which is looking likely, at this time? I think that there would probably need to be a fair amount of regulations issued and guidance put out about exactly when and how you can get your an LPC or a marriage and family therapist, you know, enrols get them the proper numbers that they need to build for Medicare sort of on their own, and sort of any other implications that I'm not thinking of right now. So that could very well be coming. If Congress makes that decision. It might not start January one, Congress might, you know, say that this is coverage that beginning as of July 1, to give CMS some time to implement what they need to implement. I'll be frank, you know, since I've been working with the RHC program, that we I haven't lived through a time period where we've added profession, professions to the list of RFC clinicians. So I'm not really sure what this looks like and how difficult it is or how quickly CMS can get this up and running. But we'll certainly be tracking it over the course of the next year. Now. I'm done. Right. So Yep. Good. Okay. Thank you. Thanks, guys. I'm still here to help with the q&a. Okay,

Sarah Hohman 16:45

great. Thanks, Nathan. So we're going to jump into talking about price transparency and good faith estimates. Specifically, I want to start with my own caveat, that these are ta webinars. So we're here to provide technical assistance and education, and help walk you through the laws and regulations that that are currently out there for, for our HCS. We'll talk sort of about how gFV policy has, has evolved, since it was created and and looking towards the future what what may occur. But I do want to make the distinction between technical assistance webinars and advocacy opportunities or the advocacy that that we may do otherwise. So it's the TA webinars, just want to start with that. We're going to start to add more of a 30,000 foot level and talk about price transparency, kind of theoretically, and, and the timelines that have led us to where we are right now. Then we'll talk about current policy, and what's to come and what's required in your, in your RHC. Now changes just in the last week, so we'll cover those as well. So what is price transparency in in healthcare, the Association of American Medical Colleges defines it as readily readily available information on the price of health care services, that together with other information helps define the value of those services, and enables patients and other care purchasers to identify, compare and choose providers that offer the desired level of value. So over the last decade, plus, there has been increased pressure on the healthcare industry to participate more in price transparency to sort of identify a variety of ways to address the rising cost of health care, and those impacts on on patients. So you can see a variety of different statistics on the screen, but national health expenditures continues to grow broadly and per capita. And, you know, account for a significant amount of GDP 19.7% in 2020. This is a 9.7 increase alone from 2019. And what the data shows is that the increase in national health expenditures is not necessarily because patients are receiving more services, but for other reasons, the cost of health care continues to grow. And so they've looked towards price transparency as perhaps one of the options or one of the ways to reduce healthcare to identify why it's so expensive. They say price transparency exists in other industries. So why can it exist in healthcare, sort of what's the what's the difference there? And if it doesn't work, at least, at least we tried it And so there's the there's the pressure from national health expenditures continuing to grow, not necessarily translating to better outcomes in the United States, despite this significant expenditure. And also pressure because patient out of out of pocket costs continues to grow. So co pays and coinsurance to patients continues to grow. And that makes patients more attentive to the cost of services. And so they look towards options like price transparency provisions in order to address these. So this is a brief snapshot, I'm not going to walk through all the different pieces, because not all of these pieces apply to our HTS. But like I said, this has been an effort for over a decade, there were pieces of price transparency provisions in the Affordable Care Act back in 2010, that it led towards hospital price transparency provisions. So the disclosure rules that that went into effect, officially in 2015, but not really until an executive order under the Trump administration, the piece of legislation that more of you are probably familiar with. And that lead to good faith estimate provisions came from the no surprises Act, which was signed into law at the end of 2020. That included both hospital price transparency provisions, and also Good Faith Estimate pieces. This, this timeline is somewhat out of out of date now. So there are pieces expected to go into effect in 2023. We'll talk about that a little bit later, that are now delayed further. But this has been a bipartisan effort for over a decade, there's still a lot of interest in this. And so we're here to provide that education. And to look at where we're where we're going from here. I wanted to talk briefly about the theoretical impacts of price transparency provision. So the idea, again, this, this is theoretical in nature, perhaps what we're seeing now, and what we'll continue to see does not match

what theoretical impacts were intended to be. But the idea is that by putting increased pressure on insurers, and providers to publish lists of their, you know, most frequent services and charges or to create good faith estimates, the idea is that this pressure helps patients because patients become more informed consumers, it empowers them to shop around for health care services, if they know what X facility charges for a certain procedure, versus what y facility charges, they can perhaps compare those and go to whatever they feel is the best value. And so, in theory, price conscious consumers will go for lower cost and higher quality care. Again, this is this is theoretical and may not play out in the real world. But this is why price transparency is one of the one at one of the avenues being pursued to to address rising healthcare costs. The idea is that if consumers are educated and more price conscious, and seeking that lower cost that there will be greater competition among health plans among providers to address their costs and in more of a value based perspective. So these are the theoretical impacts. And so far, what we've learned from this is really on the hospital price transparency side. So some of these provisions that have been in effect for for a little bit longer. The majority of these went into effect and really started started being more paid attention to in early 2021. But the hospitals that were in compliance with the price disclosure requirements, and again, compliance is is not not perfect when you're creating new regulation and things like that, but from what they were seeing, there were significant differences or variations between the publicly available data that hospitals had disclosed their prices. And there are reasons for that in in many ways that we know different, different bundles accounting for different things at different facilities. But from the kind of the stipulations placed around what hospital price lists were supposed to look like. They were seeing significant discrepancies between facility subtypes and in the same city, up until up until this year, the maximum penalty was just over $100,000. Some facilities were paying this cost and not disclosing their prices. And so that was a challenge and in compliance and standardizing a lot of these things, but because these disparities started to be shown, and insurers and hospitals were struggling to justify these differences, at least on a large scale, especially because, you know, compliance wasn't perfect. It continued to keep the industry in the spotlight, it continues to be a bipartisan focus that they're, they're still focusing on, they're still implementing additional pieces of, of price transit, price transparency provisions, including the requirements in in the RHC, which pertained to Good Faith Estimate requirements. Be the provisions like I said, surrounding Good Faith Estimate come from the no surprises act. So since that piece of legislation passed in late 2020, the majority of the no surprises Act was related to balance billing provisions for very specific facility types. For this part of of the no surprises act, RH C's are not classified as qualified facilities. And so these balance billing provisions don't apply to Archie's us facilities. But the additional piece that was included in this piece of legislation was the good faith estimate. So the good faith estimate provision applies to all providers, this is not an RHC specific issue. This is this is all providers and hospitals in an outpatient facilities and things like that, especially practices, all providers. But we're going to talk about sort of some of the complexities and an RHC what it may look like for you. So providers are required to first provide notice. So I want to have this in the beginning, we'll talk about what a good faith estimate is, if you're not already familiar. Next, but the first piece that's required is a notice of the availability of a good faith estimate in your facility. So the regulation says that this should be on the provider's website, in the office. And in additional locations, perhaps within the facility, where scheduling or cost of services, conversations may occur. And there is not a specific list of the languages for example, that this notice needs to be provided in but they do say it should be in accessible formats and languages spoken by by your patients that maybe scheduling items or services. A good faith estimate, if you're not already familiar is an estimate of the charges associated with items and services

expected to be furnished to both uninsured patients and self pay patients. So your uninsured patient population may be a bit more self explanatory, but your self pay patients are those patients who do have health insurance coverage. But for whatever reason, do not wish to have a claim submitted to their insurer for the specific item or service that they're inquiring about the cost for or that they're scheduling an appointment for. And that's why, though, the way that the regulation is written is that every patient when they request a good faith estimate, or they schedule an appointment three or more days in advance is asked if they have health insurance coverage. If not, you're triggered to create a good faith estimate. And if they do have health insurance coverage, the facility is supposed to ask the individual scheduling the appointment, if they want to have a claim submitted to their insurer for that specific item or service. And so this question perhaps will be out of the blue for a lot of your patients. And they may say, of course, of course I do. That question may surprise them. But that is sort of the flow that's intended to be asked so that you're capturing both the uninsured patient population, and also those interested in being self pay kind of goes back to the theoretical impacts of price transparency. If those patients are educated and price conscious consumers, they could perhaps get a good faith estimate from your facility or another facility and sort of compare that. I am well aware and saying that that in rural perhaps they don't have the ability to kind of shop around But as much for services, but again, this is not an RHC specific requirement, but an all provider requirement. So these provisions went into effect January 1 of 2022. providers are required to issue a gap to uninsured or self pay patients, I said both upon request, and when a patient schedules an appointment, and they meet those other criteria, three or more days in advance. And the the very quick turnaround and schedule is, is here on your screen as well. An important thing to note is that this does not apply to beneficiaries in Medicare and Medicaid, other federal health insurance programs. CMS believes that there are price transparency provisions that already are in effect for for these patients. So it doesn't apply to them. But it will apply to your commercial pay patients and your uninsured. Good Faith estimates are are not optional. So if a patient that's uninsured, or self pay, schedules an appointment three or more days in advance, it needs to trigger the creation of a good faith estimate, which needs to be issued either on paper or electronically. That scheduling of a visit three or more days in advance does not trigger you to ask the patient if they would like a good faith estimate. But it just needs to trigger the creation of one. It is not not optional, as as written in the regulation. I do recognize that I'm going through some of these a little bit faster. We've been talking about good faith estimate, you know, since December of last year. And so perhaps for many of you this is the first time you've heard about it. But for those of you that are kind of waiting for the updates and and some additional conversation, we'll get there I'm going through a little bit quicker, but definitely happy to happy to answer questions or chat with you one on one if if you need to review some of these a little bit more. A good faith estimate is intended to include the primary service that the RHC expects to provide to the patient. So the initial reason for the visit, and the services and charge information reasonably expected to be provided in conjunction with the primary service during a period of care. I'm doing a lot of quoting here from from the statute and from the regulation that has come since. And separate good faith estimates would be provided when other items or services beyond the period of care are scheduled. So there's a variety of things in here that are a little bit subjective, right. So reasonably expected for, for example. This is based on the information that the RHC has, when the appointment was scheduled, or the good faith estimate was requested. The good faith estimate is not required. And truly can't account for unanticipated care that you wouldn't reasonably expect our that comes from unforeseen events. So there are there are still challenges with with this, certainly, especially because oftentimes, it's your non clinical scheduling staff having that initial conversation with the

patient, that would trigger the good faith estimate. There are certain things that we know a patient will or will not share on the phone in in that initial visit. Or that initial conversation, perhaps a patient on the phone and scheduling an appointment. scheduled it for headaches that they've been having recently. A good faith estimate is is created based on that. And then the patient shows up to their visit with your provider and in that conversation with your provider has a laundry list of of complaints or things that they would like addressed during the visit. We know that this happens. That Good Faith Estimate could not have reasonably included what I would say is that unanticipated care are those additional things that the patient patient brings up when they when they actually show up for their appointment. I have links to all of these at the end of the presentation as well. And they're linked in the individual slides. But this is a provided by CMS This is a sample Good Faith Estimate form. So the things that that should be should be included. I will note that on On this sample, it lists patient primary and secondary diagnosis and diagnosis code. This was initially basically said that the diagnosis code was a required component of of the good faith estimates. CMS later came out with additional FAQs that said the diagnosis code is not necessarily required. It's only required if necessary to create a good faith estimate. That's a piece that is especially challenging to to determine a diagnosis code before before the patient has even seen so that the diagnosis codes are not not required on on good faith estimates. Additional sample there are a list of disclaimers that need to be included on the good faith estimate that you issued to a patient. It's not a contract. Patients have the right to to dispute the bill. We'll talk about what enforcement looks like in just a minute. And a variety of other disclaimers. It says on here the estimate is based on information known at the time the estimate was created. There's a list of the disclaimers that are required, this is just a sample so you can create your own with with additional information as well. Right enforcement of the good faith estimate provisions, our patient initiated what's called a dispute resolution process. So if your patient is eligible for a good faith estimate, you issue one, they are later billed for their visit. And their bill is $400 or more than what was included on the good faith estimate. They can initiate what's called a dispute resolution process. When that happens, they they go online, they click the green button here. They pay a $25 non refundable fee, they need to have their good faith estimate and meet a variety of other criteria to start that dispute. And then an independent third party called a dispute resolution entity will review all the documentation in the in the case and determine the amount that that should be paid. So whether that's the amount on your good faith estimate, the build charge or some other amount between the two, determine what that patient should be paid. During this dis formal dispute process. The patient and the provider can what's called settle or determine a charge outside of this process at any point. And this process can sort of go away. But this is the formal dispute resolution process. Good Faith estimates are required to be included in the patient's medical record for a minimum of six years after they are after they are issued. Just on a slide titled documentation, I do want to, again highlight the importance of documentation in the creation of a good faith estimate in what your process for issuing good faith estimates. And all of that is if you know a patient takes you through this independent dispute resolution process. The third party will review all of the documentation and information available. So with the example that I gave earlier about a patient that comes in and has a laundry list of things they'd like to discuss with your provider. What they said in that initial conversation is what that good faith estimate is created based upon. And so your documentation that is taken at the time of that initial conversation. That is what the gFV has created based on is what is really critical that you that you have and that you continue to maintain the documentation for in the event, you would be in a dispute resolution process and and need to, to provide that to to the third party entity. I'm gonna launch a quick poll to ask about the dispute resolution process. So this asks, Have any of your patients initiated a

dispute following a bill that was $400 or more higher than the good faith estimate they received? Curious to know what your experience has been so far, far. There's a not sure option. If perhaps you're not the you're not the individual that would be it'll just give it just just another 30 seconds. But um, I, I see about 2% of you have definitely had had this situation. I'm not going to, you know, this polls anonymous, though, I'm not going to call out any of you. But I would definitely be interested in sort of having a further conversation if you're interested in talking more about what this process looked like. And whether, you know, this was resolved separately. Certainly, we don't have to chat further. But that additional insight is, is helpful as we learn about UEFI. So, so looking at about 2% of you. I'm going to end the poll now. But about 2% of you have have had this have had a patient initiate this process? 69% say no, and 29% say? Not sure. So that's really helpful. Thank you, everyone, for your participation. Okay, so there were additional, what's what we refer to as phase two provisions of good faith estimate policy that were intended to go into effect January 1 of 2023. So they were included in in the no surprises act. And then CMS delayed enforcement of these what we call phase two or part two provisions, until January 1 2023. They issued an FAQ just last week, that delayed this piece, further pending future rulemaking. So we can say, indefinitely for now. I just want to just want to say thank you to all our agencies that submitted feedback on this policy for us that allowed us to share important perspectives from the providers and the patients to CMS. And I just want to highlight, you know, we've talked about the impacts of these policies quite a bit, and some of the challenges that they've presented. But it really goes to show the impact and the importance of those of you in office manager roles and provider roles that submit that feedback, and allow CMS to kind of revisit what's what's feasible in implementation, what's presenting other burden and things like that. So I've linked the FAQs here. But this is, again, not not advocacy, just just an educational webinar. But really wanted to thank you all for for submission of your feedback as to these policies. CMS will have to issue future rulemaking. And kind of to identify the ways that a policy like this would work. So the intent was that good faith estimates, in addition to providing those services and charge information for the services provided within your facility, so within the RHC, for example, the good faith estimate would need to include co provider and CO facility services and charges on that same good faith estimate. If they were reasonably expected to be within that same period of care. There were a lot of questions still surrounding what that expansion would look like. And so they delayed it further, until they can issue future rulemaking. There's not a there's not a date right now set for that. And they have said that they would provide, you know, significant lead time, so that Archie's and other providers could could implement what they needed to, but just wanted to let you know that that piece that was supposed to kick in the first of 2023 has been delayed. Further FAQs are here for your reference. And I also wanted to say that this doesn't change current Good Faith Estimate policy. So the convening provider requirement that's been in effect for the last year is maintained, but this is just delaying that additional CO provider co facility piece. I'm gonna just talk about like, the impacts of price transparency, policy and sort of where it's headed. So I talked about what we've heard from what we've seen in the data from hospitals. So far, but wanted to say that this continues to be a bipartisan focus, despite, you know, some of these delays we've seen from CMS, these requirements were passed in, in law. And so there and, you know, if you if you listen to those in Congress talk, this continues to be something that that they're interested in so they continue to seek what those are what those options for addressing the rising cost of health care look like. One of them for right now is price transparency provisions. You know, the Congressional Budget Office, other entities are studying the impacts of price transparency policy. A recent CBO report said that first transparency poly policies could reduce prices by point one to 1%. If if fully implemented, so those aren't large impacts. But that doesn't

mean that these are necessarily going away anytime soon. So still, still something we'll continue to track and provide education on. But this is what we've, what we're hearing so far. And, you know, the hope is that, as we learn more about this, you know, providers are included in these conversations to see what's reasonable price transparency policies, what we've seen so far implemented, they've been responsive to stakeholder feedback, and and how they how they continue to, to address these policies. It's interesting to look at the differences between what the impacts are to patients. And do they care about the availability of this? Are patients interested in being what they call price conscious consumers are shopping around for their health care, like we do, perhaps in in other parts of parts of our life? On one side, you see, yes, patients care. There's a variety of advocates and movements out there that talk about, it's our right to have these policies, it's our right to shop around. One survey says that 87% of patients would shop around if they could see posted prices that we support, price, transparency and health care, broadly 91%, according to this survey. But then on the flip side, we see Kaiser Family Foundation poll data that says that only one person, one out of 10 individuals are aware of hospital disclosure requirements, and that 85% of respondents don't shop around for best priced care. Again, these are just pull pull data. But it's interesting to see kind of the differences that from the from the patient perspective, and many of you have shared with us what your patient kind of response to price transparency provisions and good faith estimate have looked like something that we'll continue to pay attention to as well. Here's just an overview of all the resources. So from the regulation, to the templates to the now three FAQs that CMS has released. The last link here to NROTC resources is a page on our website that will continue to update with good faith estimate policy what's in effect right now. We did have the 2023 piece on there. It's still there. But it shows that enforcement discretion has has been continued through next year. And we'll continue to provide these resources, but I have not looked at them. But I see the number of them in the q&a box continued to grow. So Nathan, and I'll tackle those now.

Nathan Baugh 48:20

All right. Great job, Sarah. We're gonna get into FAQs here. Sir, do we have any other polls? That's it. That's just the one. There's the one that you do,

Sarah Hohman 48:34

actually. Okay. Um, yeah. So I'm going to launch this now. This asks, using the current process your RFC or system has in place? How long does it take to create a single good faith estimate? Give some time ranges for you here. Again, perhaps some of you have automated this process a little bit more than others. Perhaps some of you on this call are not the not the ones creating these but interested in seeing this data as well.

Nathan Baugh 49:03

Great. Yeah, we had we had a lot, some some are. So I think some were answered throughout. So I'm actually going to just kind of start at the bottom and ask the questions that are coming in now as opposed to ones that I think you may have answered. First I'm going to start with is totally out of order. So sorry, folks. But Jennifer roll asks if a patient schedules online but lists their insurance, are we to assume that they intend to use their insurance for us to Bill and then a GFP wouldn't be required?

Sarah Hohman 49:45

I mean, this hasn't been addressed explicitly in any in any guidance that I've seen. You know, some may make that assumption others others may not the Some of the guidance that has been issued pretty much says that the patient should be asked that question if they intend to intend to use their insurance. So, so I would say,

Nathan Baugh 50:16

your online portal should ask that explicitly. If you're whoever creates your scheduling online portal, it should ask do you intend to have this service submitted? It should, it should ask explicitly during that online scheduling process, in my opinion, that would be the best. But yeah, I think I agree with Sarah, if it doesn't, it's not explicitly said right now. Whether we can assume that they're going to use that insurance man. Yeah. Okay, again, I'm going to be skipping around a little bit here. So apologies if I miss your question, but the question from Katherine Fisher are GIA fees required for office visits with a primary care provider?

Sarah Hohman 51:10

If they the questions that need to be asked her, Are they are they requesting a good faith estimate, or if they schedule a visit, it doesn't matter what the visit is, who it's with, or what it's for, if they request or schedule that appointment three or more days in advance. And they are either uninsured or self pay patients that triggers the creation of a good faith estimate. It doesn't matter who they're who they're meeting with, or what the service is really. But that request and scheduling three or more days out, plus uninsured or self pay is what triggers that. And if

Nathan Baugh 51:50

you think about the filters that Sara just talked about, uninsured plus insured patients who don't want to use their insurance, I mean, theoretically, this is going to be a pretty small number of your patients. I mean, not not, you will have those right, especially probably more than the uninsured camp. But that those are the filters, it doesn't really matter who it's with. If they're scheduling it with you, the filters are more about the patient. Are they uninsured? Do they want to use their insurance? And then how fast are they scheduling care? I mean, I know that this question was asked earlier, but for Watkins, Sarah, essentially, you don't have to worry about it for Watkins. Right.

Sarah Hohman 52:39

Correct. Yeah. So that when they will, if they're not scheduling three or more days in advance, or they don't otherwise request, so they could still request? If they're, if they're a walk in? Walk in patient, but they sorry. But they do not. It doesn't like automatically trigger the creation of one like it does if they schedule three or four days in advance.

Nathan Baugh 53:08

Sure. Some folks have asked for the sample documents. To go back to that. Okay, you're you're there. But those are also you can find those online if you download the slides. Let's see here. Someone says cool, all patients are now walking patients. Because that way is you're sure that you don't have to do it. That is a bit of a way to get around it. I would say. But that could always change. So I would not ignore Good Faith Estimate forever, certainly track it. And, you know, unless you want to convert to a fully walk in clinic, you know, you're still gonna have to deal with this. Let's see, is a good faith estimate required if at the time of scheduling it is found that the patient has 100% financial assistance?

Sarah Hohman 54:09

So CMS has said that if even if the the expected charge would be $0, that a good faith estimate needs to be issued? I will say that was in in an FAQ, specifically.

Nathan Baugh 54:29

Can we just list all the self pay pricing on site, like on a website with a top lab and imaging that patients would get as well as the office visit pricing?

Sarah Hohman 54:41

Yeah. So this doesn't meet your requirement of issuing good faith estimates. Certainly. I've heard of some clinics having that list. In addition to or that helps to generate your good faith estimates quickly or perhaps in a more automated fashion. If you have that list. Just kind of pull from it based on that conversation, but just having the list of services and associated charges does not meet the GFP requirement.

Nathan Baugh 55:15

Briana asked, I may have missed this, but the GS does the GFP gets scanned to the images after it's done. I presume She means the medical record.

Sarah Hohman 55:23

Yeah, that's a good place to keep it. So it doesn't need to be does need to be maintained for six years. So keeping it in the, in the medical record would be my recommendation.

Nathan Baugh 55:38

Okay. Michael asked to clarify if a patient does not have insurance or does not plan on using insurance, is a GFP done automatically? Or is the patient asked if they would like one? If one is done automatically, this would likely take time to explain? Or if the patient denies needing one, is that documented just thinking of potential workflow issues, in addition to the time period needed to create a GFP?

Sarah Hohman 56:04

Sure, I may need you to repeat that. But so definitely some workflow issues here. And from what we heard from from a lot of clinics, patients are sometimes confused when they receive a good faith estimate. Because it's not a, you ask the patient if they would like one, if they are uninsured, or self pay self pay, it's a little bit a little bit more nuanced, but they're uninsured, let's just say and they schedule an appointment three or more days in advance, you create a good faith estimate for them. They don't get asked at that point, if if they would like a good faith estimate. And so some, you know, may be confused about why they're receiving it, or, or something like that. But it needs to be it does need to be created and and issued to them.

Nathan Baugh 56:59

Yeah, there's not a lot of allowance for patients to deny it if they if they otherwise hit that category of needing one. Right? Yeah. Although that's one of the things that, you know, could potentially change going forward. Because just looking at some of the feedback that had been provided to CMS, that issue specifically was like when your patients don't want it or say, Don't give this to me, and then we're forced to give a good faith estimate to them. That was highlighted as one of the points of confusion, especially for the patients. So it's, it's potentially one of the things that CMS will revisit. Okay. Chris asked, What about patients who scheduled their follow up appointment, six months out had insurance, but don't in the future. And we aren't aware of this until time of registration.

Sarah Hohman 58:04

So the good faith estimates don't inherently expire. If Well, the part of the disclaimer does say like, it's listed here, that they're valid for 12 months from the date of the good faith estimate, that's more like a protection for you. But if you issue this. So this is a little bit confusing, because if they schedule an appointment, six months out, you go based on the information you have at the time, you know, unless the patient calls you back sometime in that six month period and says that they don't have insurance, you couldn't reasonably reasonably have that information. And so, you know, it's there's a date on a good faith estimate. And it's valid based on the information that you reasonably know. But you wouldn't need to, like recreate that good faith estimate if they would call you back and and let you know, but based on the information you have at the time the the visit was scheduled.

Nathan Baugh 59:10

Pamela asks, How will this work with ER visits? It's it's like walk in, essentially, you don't have to do it right. Let's see. Next slide. Or next one says one of the sides indicated that we are to include the price for prescription drugs on our gFV. How would we go about doing that when we don't know what medications would or could be ordered?

Sarah Hohman 59:38

So this would again, I would say go back to you know what's reasonably expected, based at the based on when that initial conversation was had. Again, if this is with your non clinical scheduling staff, which is

oftentimes those that have that initial conversation, that document you know what That conversation is like. And we've heard that, you know, oftentimes this requires a conversation with additional folks in the office to create a good faith estimate. But it's what is reasonably expected based on that initial conversation. So, you know, all of what they're going to disclose all that results from that, including medications can't always be expected on to be included on a good faith estimate. They list you know, those medications and labs and other tests and things that may be included, if those are reasonably expected. So for example, if a patient's scheduling their appointment, and perhaps you are aware, for for whatever reason, about medications or other tests, those would be included. But that reasonably expected piece does carry a lot of weight. But also, like I said earlier, highlights the the importance of documentation from that first conversation. And if, you know, patients are scheduling on line, there's some additional things that perhaps your your EMR has the availability to automate some of these things we have have heard of, of clinics and systems, having those conversations with their their HR provider to see where can pieces be automated and specific prompts and questions asked. So I encourage you to pursue that as well.

Nathan Baugh 1:01:31

Next question is from Magen support, widow. Maybe Meghan, but she asked, How are we supposed to know what to put on the good faith estimate when the provider does not know what they plan on doing until they see the patient?

Sarah Hohman 1:01:49

You Yeah, I mean, you're highlighting one of the challenges that individuals have have posed to CMS about about this policy. And why price transparency in health care is a bit more challenging than price transparency. And in other industries, perhaps you only have the information that you have, from from one initial conversation, not the conversation between a provider and a patient. And so, you know, I have seen some unknowns listed on the good faith estimate. That's that makes it very challenging to create, you know, charge information associated with it. I don't have a great answer for you here. This is a challenge of this of this policy, I'll just say,

Nathan Baugh 1:02:40

Why would there not be a place for the patient to sign on this form?

Sarah Hohman 1:02:50

CMS created this I did not. This is just a sample Good Faith Estimate if you want to take this and revamp it and create a signature place for your patient so that there can be an acknowledgement that they received it on such and such a date. That is certainly certainly something you can do.

Nathan Baugh 1:03:16

Timeline question, if a patient schedules and appointments for months in advance, are we still required to give them a good faith estimate within three days? Or if it's September, and they scheduled for January? Is a GFP required?

Sarah Hohman 1:03:30

Yes, and, yes. That the timelines are based upon when the appointment is scheduled, not when the appointment is going to occur. occur. Yep, yep.

Nathan Baugh 1:03:46

Lexis as so we don't have to ask upfront if the patient wants a good faith estimate, they have to ask for one before we create one for them. Question mark?

Sarah Hohman 1:03:55

No. So there are two ways that a patient can be eligible to receive a good faith estimate. If they ask for one, or if they schedule an appointment three or more days in advance, so if they so requesting is pretty self explanatory, but if they schedule an appointment three or more days in advance, you ask if they are insured? And if they are you ask if they would like to? Or if they are interested in having a claim submitted to their insurer for that item or service. If they say no, then you would also be triggered to create one so there's both the request side of things and the when it's automatically generated.

Nathan Baugh 1:04:47

I just lost my question. I had one prep.

Sarah Hohman 1:04:50

I do want to just just say that everyone I know that it's after. After an hour we still have a bunch of questions we tend Go a bit longer to to address what we can and get through as many as we can. So thanks to everyone that has that has stuck through, obviously, the whole recording will be available if you if you can't stick around for the whole time, but we'll keep going for a little bit longer.

Nathan Baugh 1:05:17

Are we required to send good faith estimates to out of network patients who are out of their network benefits? And several folks had that question. You want me to tackle this?

Sarah Hohman 1:05:35

Sure.

Nathan Baugh 1:05:36

So out of network or in network doesn't totally matter. The it's irrelevant to the filter that you have to ask, in this scenario, it's does this patient when it's submitted to their insurance or not? Right? So it's not really your problem? If it's at a network or a network? It's It's It's, do they want you to submit it to the their insurance full stop or not? Would you agree, sir?

Sarah Hohman 1:06:08

Yeah, I would the the self pay piece of like, Good Faith Estimate is more self pay kind of by choice versus self pay in terms of a in network out of network situation. So

Nathan Baugh 1:06:23

Catherine, I think we should just clarify this again. Can you please clarify who is required to get a good faith us matching slides that say, everyone? That's definitely not the case. But I've also heard is only for patients who are uninsured self pay? Again, it's that that it's not? It's definitely not everyone? Right? Medicare and Medicaid, government insurance? They're out, right? It's, it's specifically for uninsured patients, right. And patients who are opting not to use their commercial insurance. Okay. So, or self pay? Right. So that is that is who needs to get it. And even in that case, if they are doing urgent care, you're not required to give them a good faith estimate. Right? If they're if they're Watkins, right. So Kelly asked, Can we complete with a range of codes? I think you answered that already. No, it has to be specific to the patient, right? So you can't just give up, you just can't You can't give all your patients like, well, here are our charges, here's our charge master, that's not gonna cut it. Are all private providers required to give good faith as men or just RFCs?

Sarah Hohman 1:07:49

All providers?

Nathan Baugh 1:07:55

If a patient doesn't want to have insurance build, and then they don't pay the good faith estimate, can we bill the insurance? That's a good question.

Sarah Hohman 1:08:12

Interesting question. Yeah, and I will say that, you know, I've heard and I am not as familiar with this, but I've heard of some, some people pointing out that it may put you in like breach of contract with those insurers that you have contracts with, if you're not billing them. So that's a piece that that we need to dig a little bit more into. It's obviously very unique to your contract. But I would look into that, that as well to ensure that you're not out of contract if you're if you're not billing them. But I have heard that that concern from

Nathan Baugh 1:08:50

from folks or routine physicals etc would it be reasonably expected that the patient may need fasting lab work? We struggle if we are expected to know and include what lab charges might possibly be charged as each patient's history may be different

Sarah Hohman 1:09:08

very good points. I am not clinical neither of us are and I recognize that a lot of you creating good faith estimates are not clinical but I do not want to share what I think is is reasonable reasonably expected. Definitely shared that that's a subjective kind of phrase for them to use and when these are when different pieces of this are necessary but I do not want to say what I think would be reasonably expected on one

Nathan Baugh 1:09:38

Yeah, it's it's very subjective reasonably expected within the period of care I believe that's what it is. Can one good faith estimate be enough for uninsured patient for the year?

Sarah Hohman 1:09:54

Um I'm gonna stop sharing and and fine into this. There's a there's specific language on when a good faith estimate can. So if it's like recurring visits, for example, you know that a patient is going to come in for, you know, some something routine, I can't think of it off the top of my head on, you know, a 30 day rotation for first six months, for example. There is an allowance for that I believe it's for up to 12 months. That's when the gap would be valid for so if it's like some recurring service, you could include that on there. I think that that may help to answer your question.

Nathan Baugh 1:10:45

Kelly clarifies when I asked about a range of codes, and an example of follow up codes, like she wants to list all the end items 9212 through five, because we do not know what level will be provided.

Sarah Hohman 1:10:57

Oh, can you like a range of a range of charges? I've I've heard of, of that being something that some providers are, are doing because it is so unknown. That's technically not what I what I think they're looking for on this. But in some cases, you know, that's that still does provide some type of estimate to the patient. Even if it even if it is arrange.

Nathan Baugh 1:11:34

Yeah, so I some people are questioning I guess. Krisha asks, patients do not have to use their insurance if they have it. Question mark, that can be considered self pay question. And then Jennifer, I think response to that and says you have to build insurance if you are in network provider, that is law. Yeah, I'm not 100% sure if what law that is it very well, could be one that I'm just not familiar with. But certainly the

rules from CMS make it clear that even even if you have insurance, the like there is a question that is asked of the patient. Do you want this to be you know, billed to your insurance? So it seems odd to me that that would possibly be breaking a law? If the if the answer is we have to bill your insurance, right. So there might there might might be like thinking of something slightly more nuanced or different, Jennifer than what you're thinking of. But it's pretty clear in the in the regulations about that. But yeah, you can essentially say, Hey, I don't want to use my insurance for this. I want to pay out of pocket that to me that it seems like patients certainly have that option. And in that case, you would you would give that patient a good faith estimate. We'll go for a little bit longer. I mean, there's these questions are still rolling in a bit. I know it's long, but 450 of you are still with us. So we we appreciate your attention. And we we do hope that you find this this helpful and useful. But we will do a hard stop at 420 Eastern. In regards to our contracts, our local Blue Cross Blue Shield requires us to obtain a limited patient waiver that indicates the patient chose not to have their insurance billed if written documentation is not obtained. And the patient decides to submit their claim to their that I'm sorry, submit their claim. The provider may be liable for the charges, especially if it's outside timely filing limits. Interesting. Yeah. I mean, that notch not 100% sure about how this, you know, national policy impacts that specific local BCBS policy. But you know, thank you for sharing. Let's see, sir. Do you have any did you find that thing that you wanted to screenshare?

Sarah Hohman 1:14:34

I think that I like explained it as I was okay.

Nathan Baugh 1:14:38

Do you want to throw up? Do you want to throw up our slides again or something? If Jennifer asks if we are giving good faith estimates to patients with commercial insurance and it's off by more than 400 Are they still are they still allowed to dispute it? Or since it's not a requirement to give them one but they got one anyways. They don't qualify for a CMS dispute. So so it sounds like she's saying that they gave a good faith estimate anyways to a patient that was using their commercial insurance. And it was off.

Sarah Hohman 1:15:24

But they build the payer.

Nathan Baugh 1:15:33

Yeah. And maybe the like, you know, maybe the they have a high deductible. Right. So like, yeah, they want to use their insurance. But they have a high deductible, it was more than 400 off, right. Yeah, I mean, they be to kind of be disputed.

Sarah Hohman 1:16:00

I have not seen this, specifically come up anywhere. But I think that the patient makes the choice of whether they're self pay or having their insurance built. At the point of that conversation, so

Nathan Baugh 1:16:23

yeah, I mean, this, I would say don't give a good faith estimate. If, if, if you're not required to give one. So that that's my, like, don't be issuing good faith estimates to people who want to use their commercial insurance, I don't think it would be a good idea to to, because all you're doing is opening yourself off to potentially getting dragged into a dispute. You know, but that's what I would say there. Chelsea asked, How does providing a good faith assessment look like when we have a sliding fee schedule based on income? We don't receive their income information till they come in for the appointment?

Sarah Hohman 1:17:03

Yeah, so CMS has said that if if you have a sliding fee scale, that the Sliding Fee Scale should be included in your, their what they would be expected to pay, like the cash pay price. So, you know, I understand that your system is currently set up to get that information when they come in for the appointment. But if you need it, to schedule that visit, and, you know, to create the good faith estimate, then perhaps that that needs to change and timeline. Because that has the cache pay price based on your Sliding Fee Scale, if you have one of those in place, as what the GFC is supposed to be issued? Based upon? CMS had said that

Nathan Baugh 1:17:54

easy one, any update on the advanced EOB requirements timeline?

Sarah Hohman 1:18:01

No. So the advanced explanation of benefits, which is a OB was also part of the no surprises act in the good faith estimate section. When CMS issued regulation about good faith estimate, phase one, phase two, a EOB, they have not yet given an effective date for that, what you could kind of think of as phase three or part three of these provisions. So it didn't have an effective date previously, it still does not have an effective date. And a lot of the you know, the pieces kind of limiting phase two of good faith estimate are also limitations for that advanced explanation of benefits. P So no update there, but also no effective date. Still.

Nathan Baugh 1:18:57

All right, I see that we're at 419. And I think at this point, I we understand there's a lot of questions on this. We really thank you guys all for joining us. But I think we are losing our brainpower here. And so we should probably go ahead and end it. I believe we're gonna have a actually a poll when you exit out. And that will give you your code. Do you want to talk about that, sir?

Sarah Hohman 1:19:29

Sure. Yeah. So thank you to all 370 plus of you that have stuck with us till till the very end. The last thing that I just put in the chat is our specific webpage dedicated to DFE. And so I know some folks earlier were were asking about the different templates and that not working. We have CMS has all of their templates and disclaimers kind of in a zip file. On our website. The CMS templates and resources are bro

Going out by disclaimer and template and things like that. So hopefully that's helpful. We will continue to update this page. I will also review all of the q&a that perhaps, you know if there are any that we we didn't get to where this webinar doesn't answer. We'll also address those on this webpage as well. So thank you to everyone who attended today's webinar, as well as the Federal Office of Rural Health Policy as always, for sponsoring this RHC technical assistance webinar series. If you have any ideas for future webinars or additional content that you're looking for, please email Nathan or I with fat ra to webinar topic for CR HCP. The CEU code will be in the survey at the end of the survey that you will be prompted with at the completion of today's webinar, and also will be emailed in in your follow up email tomorrow. And when we scheduled our next webinar, a notice will be sent to all of those who have registered for or who have signed up for our listserv. Also, as always, we have office hours every other Wednesday, Nathan and I are there to answer your questions. So please don't hesitate to reach out to either of us with any follow ups. And thank you for all that you do. And thanks for being here and have a great rest of your day. Thank you guys