Washington Update

Sarah Hohman, MPH
Director of Government Affairs
National Association of Rural Health Clinics

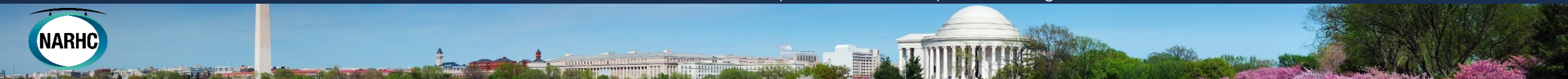
Agenda

- **Legislative Priorities / Updates**
  - Telehealth Policy Post PHE
  - Behavioral Health
  - RHC Modernization Act of 2022
  - Medicare Sequester
  - Good Faith Estimate / No Surprises Act
- **Federal COVID-19 Funding for RHCs**
- **Regulatory Updates**
  - 2022 Medicare Physician Fee Schedule
    - Mental Health via Telehealth
  - 2023 Medicare Physician Fee Schedule
- **Big Picture Considerations**

Legislative Updates – Telehealth Policy Post-PHE

Public Health Emergency Update

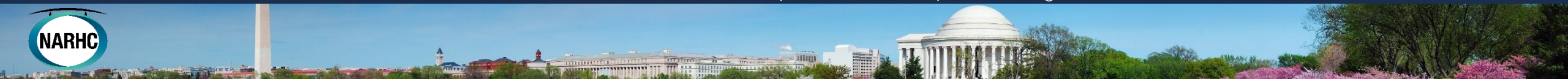
- Health and Human Services (HHS) Secretary Becerra renewed the PHE on October 13, 2022.
  - Renewals can be for UP TO 90 days at a time
  - States will receive minimum 60 days notice when the PHE is set to expire / not be renewed



Current Medicare Telehealth Billing Policies

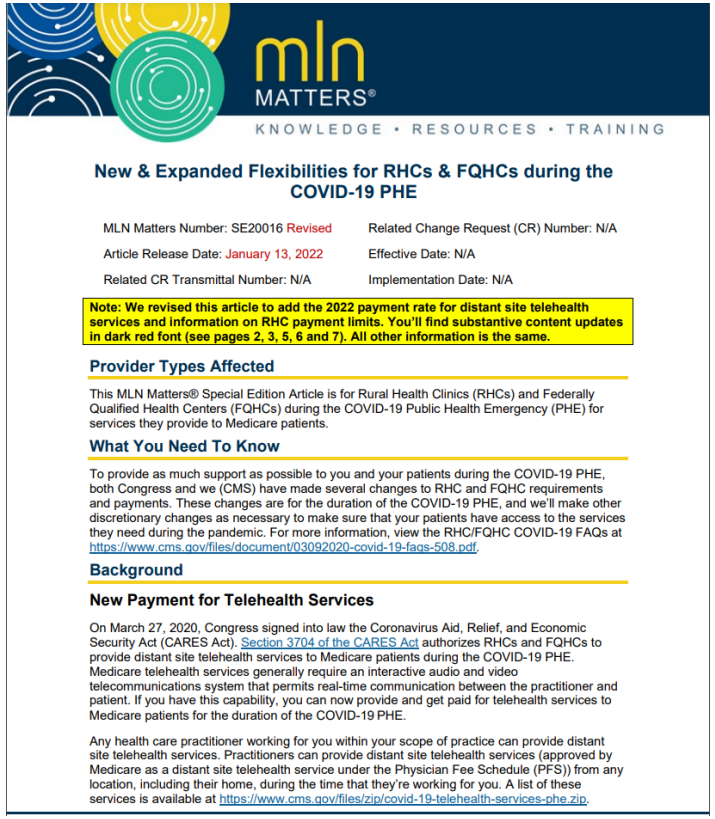
Name of Telehealth Service	Brief Description	How to Bill	Amount (2022)
Virtual Check-In or Virtual Care Communications	Remote evaluation – G2010 Brief communication with patient (5 min) – G2012	G0071 No modifier necessary Rev Code 052X	$23.88
Chronic Care Management	99484, 99487, 99490, 99491, 99424, and 99425 = G0511 99492, 99493 = G0512	G0511 – Care Management G0512 – Psychiatric Care Management	G0511 - $79.25 G0512 - $151.23
Digital e-visits	Online digital evaluation and management 99421-99423	G0071 No modifier Rev Code 052X	$23.88
Telehealth Visits	One to one substitutes for in-person services/visits List of allowable services maintained by CMS	**G2025** Modifier 95 optional Modifier CS (for services where cost sharing is waived) Rev Code 052X Costs and encounters carved out of cost report	$97.24
Mental Health Telehealth Visits	CPT Codes that can be billed with 0900 revenue code	Rev Code 0900 Use proper mental health CPT code Modifier CG always Modifier 95 if audio-video Modifier FQ if audio-only Count costs and encounters on cost report	All-Inclusive Rate

These codes are not new but fall within the telehealth umbrella!



G2025 Policy Established – April 17, 2020

- MLN Matters SE 20016
- Special Payment Rule from the CARES Act is interpreted by CMS to be one payment rate and code **for all telehealth services**
- RHCs to bill G2025 for any of 200+ CPT codes that FFS providers can bill as a telehealth visit listed here
- Costs and encounters associated with telehealth visits must be carved out of the cost report



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KNOWLEDGE • RESOURCES • TRAINING

New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

MLN Matters Number: SE20016 Revised | Related Change Request (CR) Number: N/A

Article Release Date: January 13, 2022 | Effective Date: N/A

Related CR Transmittal Number: N/A | Implementation Date: N/A

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

Provider Types Affected

This MLN Matters® Special Edition Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) during the COVID-19 Public Health Emergency (PHE) for services they provide to Medicare patients.

What You Need To Know

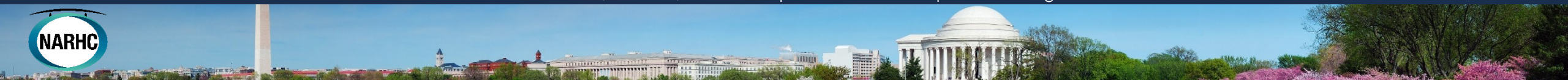
To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and we (CMS) have made several changes to RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we'll make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, view the RHC/FQHC COVID-19 FAQs at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

Background

New Payment for Telehealth Services

On March 27, 2020, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Section 3704 of the CARES Act authorizes RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and patient. If you have this capability, you can now provide and get paid for telehealth services to Medicare patients for the duration of the COVID-19 PHE.

Any health care practitioner working for you within your scope of practice can provide distant site telehealth services. Practitioners can provide distant site telehealth services (approved by Medicare as a distant site telehealth service under the Physician Fee Schedule (PFS)) from any location, including their home, during the time that they're working for you. A list of these services is available at https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip.



Concerns with G2025 System

- Payment of $97.24 is less than AIR for vast majority of RHCs
  - May disincentive RHCs from providing telehealth as a replacement for in-person encounters
- Disguises the actual service provided causing a number of downstream problems such as:
  - Hard (Impossible?) to identify AWV done via telehealth
  - G2025 is not eligible for risk adjustment for ACOs or Medicare Advantage
  - Without descriptions of the services provided, there are challenges in gathering good data

March 11th "Omnibus" bill

- De-links Medicare telehealth waivers from PHE
- Telehealth waivers (coverage) extended for 151 days (5-months) post PHE
  - Mental health via telehealth is permanently covered; in-person requirements waived for PHE + 151 days

H.R. 4040

- Passed the House in July
- Extends G2025 and other telehealth payment policies through 2024
- NARHC and NRHA got letters entered into the record by Rep. Adrian Smith thanking Congress for continuing telehealth policies but expressing disappointment with the continuation of the special payment rule

NARHC NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

July 26, 2022

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Republican Leader
United States House of Representatives
Washington, DC 20515

Dear Speaker Pelosi and Leader McCarthy:

The National Association of Rural Health Clinics (NARHC) is grateful that the House of Representatives is considering extending Medicare coverage of telehealth through 2024 but we are concerned that the current language in H.R. 4040 will perpetuate inequitable payment policies for safety-net providers.

Presently, our peers in traditional office settings are able to bill for telehealth services as if the service was provided physically in the office. In other words, they have coding and reimbursement parity between telehealth services and in-person services.

On the other hand, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) do not use their normal coding and reimbursement rules for telehealth. RHCs and FQHCs instead have a "special payment rule" that requires them to bill a single code, G2025, for all telehealth services which is then reimbursed at a single nationwide rate (currently $97.24).

We are concerned with this "special payment rule" methodology for a whole host of reasons. First and foremost, the payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth. Second, the current rules require RHCs and FQHCs to "carve-out" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process. Third, the use of a single telehealth code, G2025, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth severely hindering their ability to properly participate in ACOs and other quality programs.

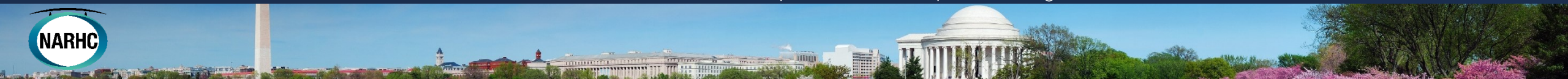
Complicating matters is the fact that for mental health services provided via telehealth, RHCs and FQHCs do use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that it should work this way for all services, not just mental health services.

NARHC strongly believes that the best way to encourage telehealth usage in underserved communities is to create parity between in-person and telehealth policies. We strongly encourage Congress to amend H.R. 4040 to include the payment policy enumerated in Section 9 of H.R. 7876, the Connecting Rural Telehealth to the Future Act introduced by Representative Adrian Smith and Representative Terri Sewell.

Please feel free to contact me if you would like to discuss this issue further.

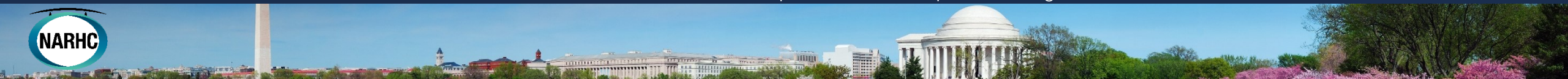
Sincerely,

Nathan Baugh
Executive Director
National Association of Rural Health Clinics
(202) 543-0348



What does Medicare telehealth coverage look like in the future?

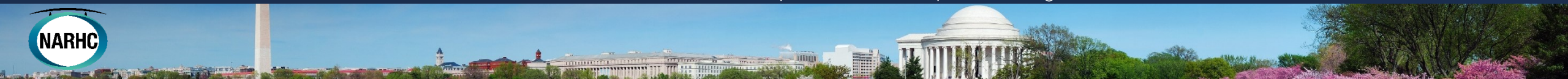
- It is evident that telehealth is here to stay, but the details remain undecided
  - What telehealth waivers will be rescinded, modified, and kept?
    - Ex. Will HIPAA compliant platforms be required again?
    - Ex. Will providers need to be in specified distant site locations?
    - Ex. Will Medicare pay parity with in-person visits?
    - Ex. Will audio-only telehealth be allowed? What services can be done audio-only?
    - Ex. Will there be in-person requirements for all telehealth?



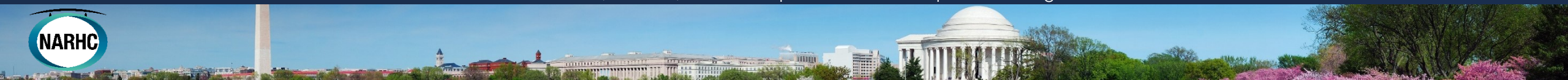
Moving Forward

- Likely to be a series of temporary extensions of Medicare telehealth policy as questions are answered
- Each extension provides Congress with an opportunity to tweak aspects of the telehealth policy

- **There is bipartisan agreement and industry wide expectations that Medicare telehealth policy will not revert to the very limited pre-COVID rules.**



Behavioral Health



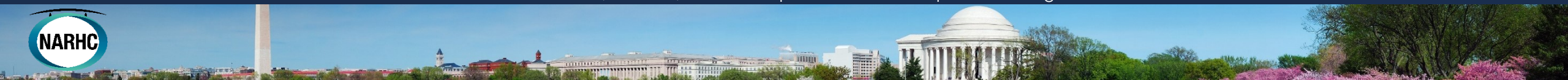
RHC Provisions in President Biden's FY 2023 Budget Proposal

RHC Behavioral Health Initiative

- $10 million for a RHC grant program – funding RHCs where there is no behavioral health provider *("fund the salary of a behavioral health provider, address provider burnout, and expand the availability of services such as mental health screenings, counseling, and therapy.")*

Modernize Medicare Mental Health Benefits

- Allow payment to RHCs/FQHCs for Licensed Professional Counselors and Marriage and Family Therapists providing mental health services



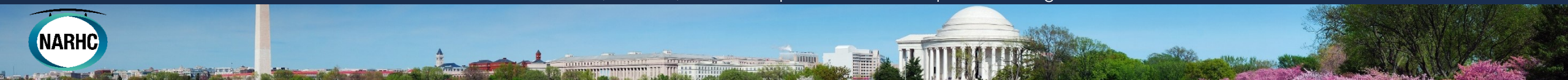
RHC Behavioral Health Initiative Update

Outreach to Committees of Jurisdiction

- Letters to House HHS/Labor Appropriations Subcommittee, House Ways & Means, House Energy and Commerce, Senate Committee on Finance
- Joint meetings with NRHA and NOSORH

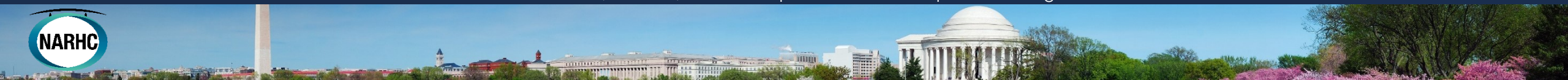
House and Senate Appropriations Report Included $5 million for RHC BHI

- First, but very important steps in establishing a grant program for RHCs
- Next steps: Final appropriations package



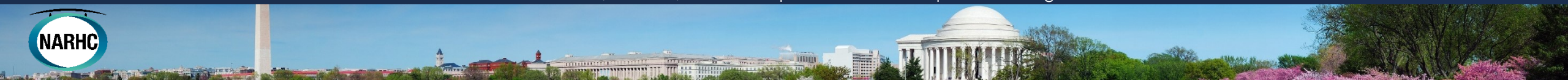
Other Mental Health Legislation

- Recent House committee markup advanced mental health bills to the full House of Representatives for consideration
  - H.R. 432 would add mental health counselors and marriage and family therapists as covered Medicare providers, including in the RHC setting
  - H.R. 8878 would create a "special payment rule" for Medicare coverage of intensive outpatient programs in RHCs and FQHCs, supporting a care delivery model for patients that need services beyond the scope of traditional outpatient care but do not rise to the level of inpatient or partial hospitalization care



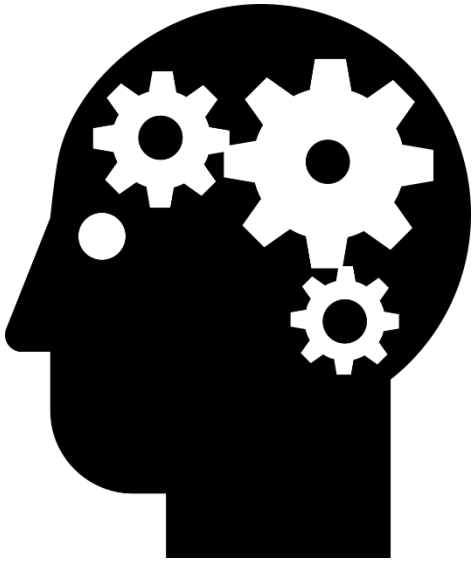
Mental Health via Telehealth

- In December of 2020, Congress made *permanent* Medicare coverage of telehealth for mental health services but made no mention of how this might extend to safety net providers.
- CMS finalized a regulatory change to the definition of an RHC (and FQHC) mental health encounter to include telehealth encounters:
  - (3) Visit - Mental health. A mental health visit is a face-to-face encounter **or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology** for the purposes of diagnosis, evaluation or treatment of a mental health disorder between an RHC or FQHC patient and one of the following…
- NARHC welcomed this policy change by CMS allowing RHCs to use normal coding, normal reimbursement, and normal cost reporting rules for mental health telehealth visits.

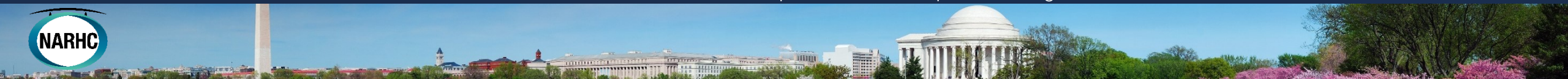


Mental Health via Telehealth In-Person Requirements

- In-person requirements are waived during PHE *and for 151 days after PHE ends*
- **After this period, beneficiaries must have an in-person visit within 6 months of furnishing mental health via telehealth service and an in-person service must be provided at least every 12 months thereafter.**
  - Some exceptions may be made based on patient need
  - Some of the details are unclear –
    - Does the telehealth provider need to be the provider that sees the patient for their in-person visit?



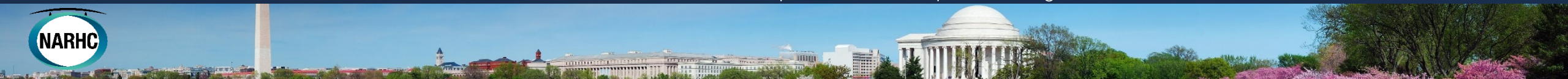
RHC Modernization Act of 2022



New Legislation to Modernize Various Provisions of RHC Statute

- Align federal RHC scope of practice rules with state scope of practice rules
- Remove the requirement for RHCs to provide certain lab services onsite
- Give RHCs the ability to contract (instead of formally employ) with PAs and NPs
- Fixes the RHC reference to the term "urbanized area" which is no longer being defined by the census bureau
- Allows RHCs to provide a majority of behavioral health services if they are located in a mental health HPSA

…intended to be cost-free legislation to fix "low hanging fruit" issues in the RHC statute.

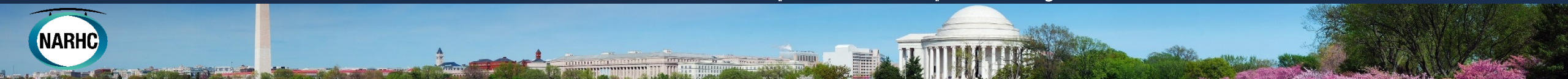


Medicare Sequester

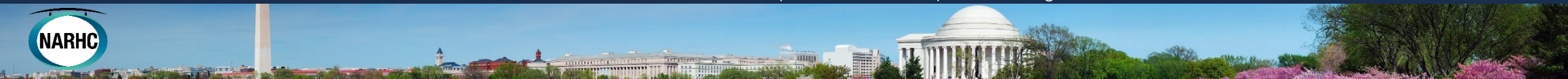
2% Medicare Sequester Back in Effect

- Beginning July 1, 2022 Medicare sequester policy was fully re-implemented
  - RHCs, and all of healthcare, should now expect to receive 78.4% of the allowable
- A similar, 4% "pay as you go" or "PAYGO" Medicare reduction is currently scheduled to kick in on January 1, 2023
  - There is industry wide expectation that Congress will again waive this payment reduction

The use of the sequester has long since been part of the games of political/budget chicken with significant impacts on things like Medicare reimbursement! For a more in-depth history, visit NARHC.org.



Federal COVID-19 Funding and Supply Programs for RHCs



RHC COVID-19 Funding Programs

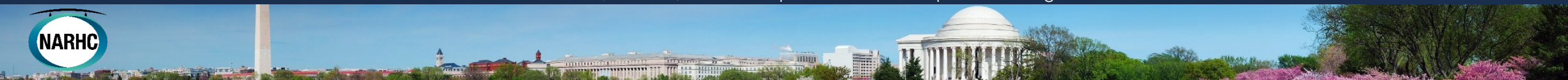
- **Provider Relief Fund Payments (various amounts)**
- **RHC COVID-19 Testing ($49,461.42 per RHC)**
- **RHC COVID-19 Testing and Mitigation ($100,000 per RHC)**
  - Project period ends December 31, 2022
  - Final closeout reporting on RHCcovidreporting.com in January 2023

- **Allowable Expenses**
  - Testing and testing-related
  - Mitigation and mitigation-related
  - Otherwise unreimbursed

Retention payments!

Expanding digital technologies!

Facility retrofitting!



RHC COVID-19 Supply Programs

- **RHC COVID-19 Vaccine Distribution Program**
  - Free, direct supply of COVID vaccines, including bivalent boosters
- **RHC COVID-19 Testing Supply Program**
  - Free, direct supply of at-home test kits and point-of-care testing supplies
- **RHC COVID-19 Therapeutics Program**
  - Free, direct supply of COVID therapeutics

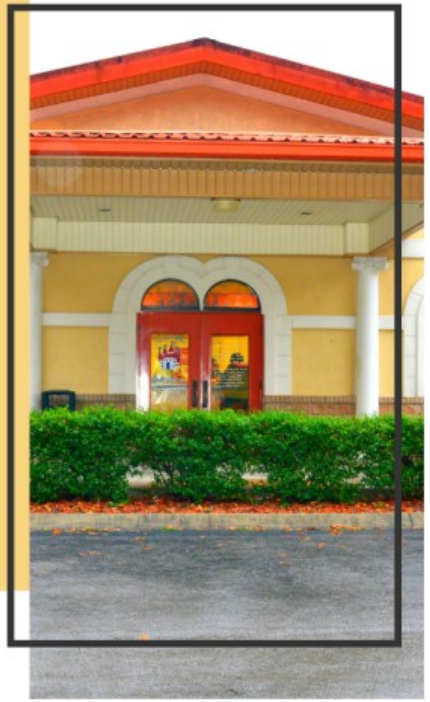
https://www.narhc.org/narhc/COVID-19__RHCs.asp

Share Your Story

COVID-19 Supply Program - Tullahoma Pediatrics

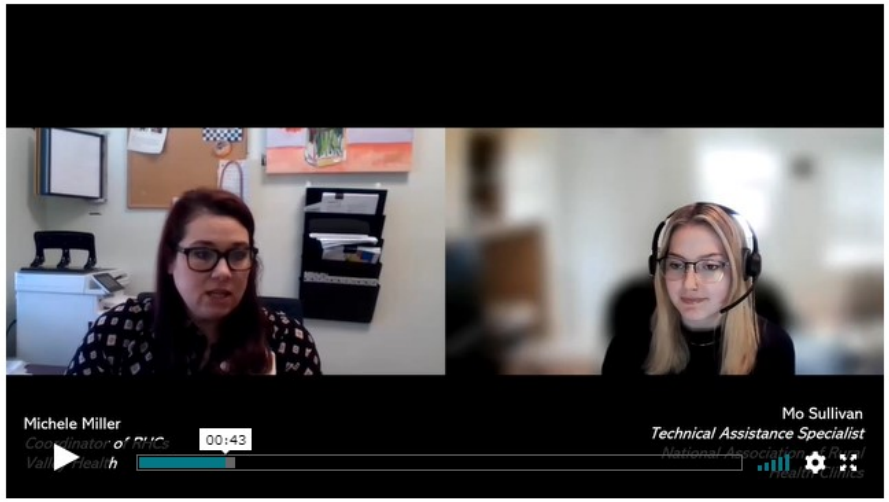
I called around to the local factories and small businesses that might have employees that did not have access to covid testing. In talking with several people I found that a good percentage of the folks that thought they might have Covid 19 were not able to get tested in a timely manner. The HRSA RHC Covid-19 Testing Supply program along with partnering with the church allowed us to get 2 pallets of tests out to our community in basically a few hours. I think it's a great program and I was happy to be a part of getting these tests to the people in the community that really needed them.

KAREN REAVES
TULLAHOMA PEDIATRICS, PLLC

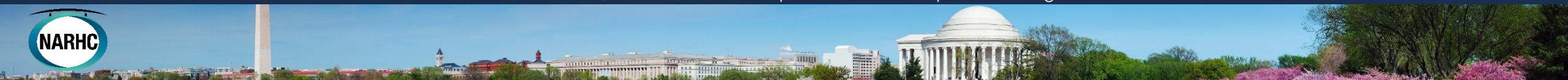


RHC Spotlights

COVID-19 Supply Program - Valley Health



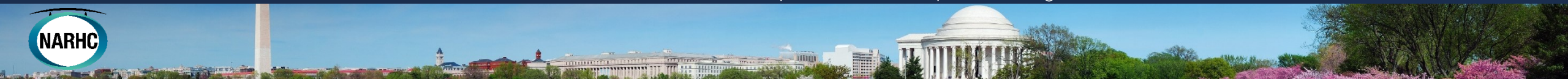
Email RHCcovidreporting@narhc.org



Regulatory Updates

2022 Medicare Physician Fee Schedule
RHC Provisions
Beginning January 1, 2022

- **Hospice**: RHC clinicians can provide hospice related care to a Medicare beneficiary enrolled in hospice and receive the all-inclusive rate payment for attending physician services.
- **Vaccine Administration:** RHCs should bill Medicare Advantage directly for COVID-19 vaccine administration.
- **CCM/TCM:** RHCs can bill for Transitional Care Management (TCM) and other care management services like CCM provided to the same beneficiary in the same time period, so long as all billing requirements for each code are followed.
- **Mental Health via Telehealth:** Permanent coverage



2023 MPFS Relevant Provisions

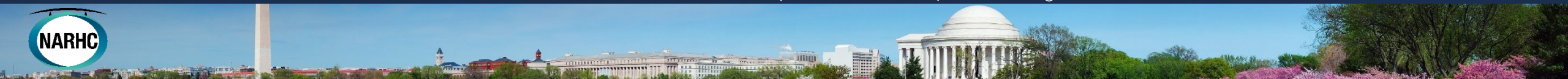
Beginning January 1, 2023 if included in final rule

New Care Management Codes Billable in RHCs

- Chronic Pain Management (CPM)
- General Behavioral Health Integration (GBHI)

Billed under G0511 which is currently a consolidated fee schedule rate of 6 codes ($79.25 in 2022)

- The addition of these codes will not change the average used to calculate the G0511 rate but it will continue to be updated annually



2023 MPFS Relevant Provisions

Medicare Economic Index (MEI) Rebasing

- Proposal to use new methodology to calculate MEI using 2017 publicly available data sources instead of 2006-based inputs
- NARHC is appreciative of the efforts to acknowledge issues with the outdated formula but 2017 data remains behind the impacts of current inflation

2023 MPFS Relevant Provisions

RHC Payment Methodology

- CMS proposes that MACs use the cost report ending in 2020 (or 2021 for RHCs that don't have an AIR established for 2020 services furnished) that reports costs for **12 consecutive months**

NARHC submitted comments on all of these provisions and will publish a full summary of the final rule in November.
https://www.narhc.org/narhc/NARHC_ADVOCACY.asp

Big Picture Issues for the RHC Program

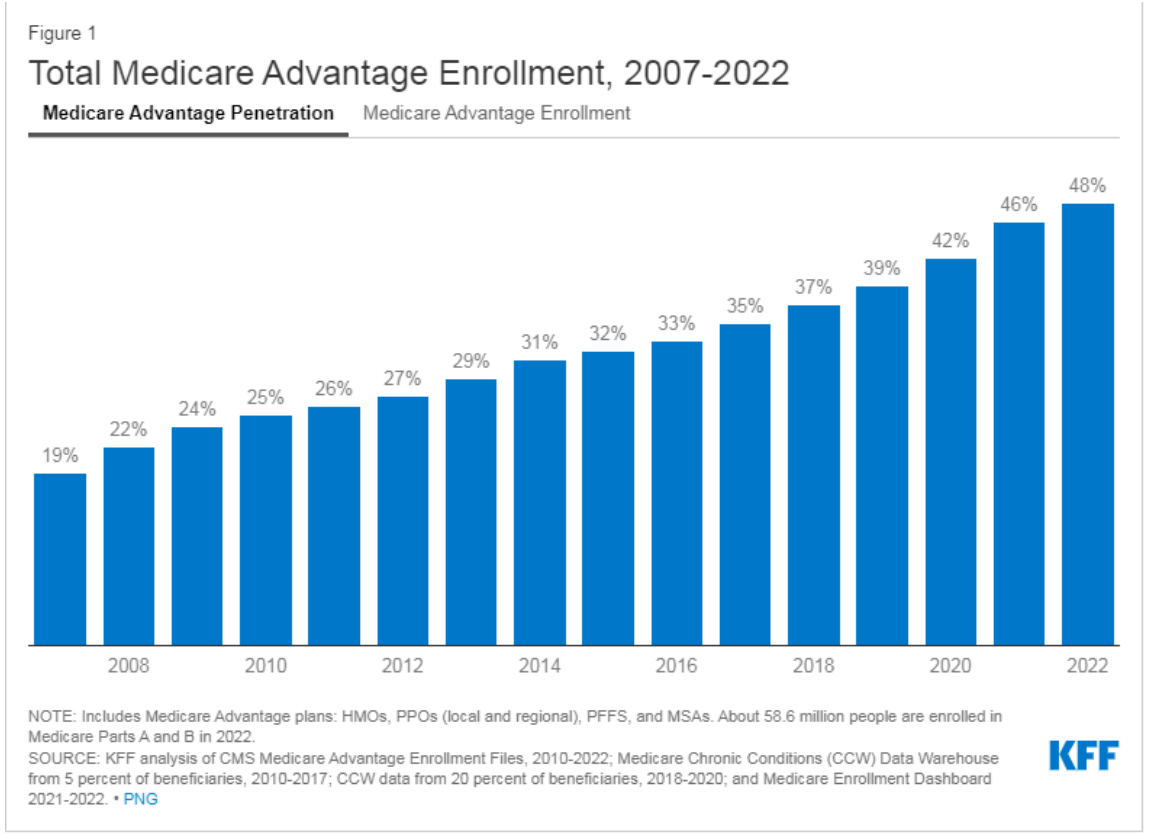
- Quality Reporting for RHCs
- Medicare Advantage Growth

Medicare Quality Reporting Program for RHCs with AIR as the foundation

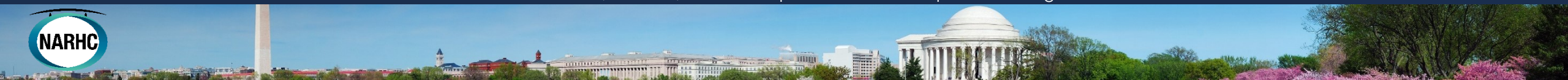
- Legislation introduced to create a quality reporting program for RHCs in exchange for going back to uncapped rates ~ but only for Provider-based RHCs.
- NARHC supports the creation of a Medicare quality reporting program, but it must be available to ALL RHCs.
- Likely that the financial incentive will need to be revised if we want this legislation to pass
  - We believe a simple upward adjustment to AIR as a reward for quality reporting

Medicare Advantage Growth

- RHCs have no formal reimbursement benefit from Medicare Advantage plans
- FQHCs (since 2003) have a "wrap-around" payment that ensures that they receive no less than what they would make from traditional Medicare
- There is some old and relatively unclear policies that provide protections for RHCs that are Out-of-Network providers
- But if an RHC agrees to a contract with the MA plan, then the RHC must bill (and be paid) according to the terms of that contract



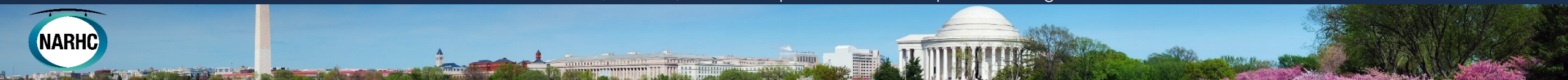
Good Faith Estimate / No Surprises Act



No Surprises Act – Balance Billing

- Federal legislation passed in December 2020 establishing policies for balanced billing for services provided by an out-of-network provider in:
  - Out-of-network Emergency Department, or
  - In-network facility
- A "facility" is:
  - Hospital
  - Hospital outpatient department
  - Critical Access Hospital (CAH)
  - Ambulatory surgical center

RHCs are NOT classified as qualified facilities for purposes of these provisions.



No Surprises Act – Good Faith Estimate

- The price transparency provision that DOES apply to **providers** (including those that work in RHCs) is the Good Faith Estimate (GFE)
  - "health care provider means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law…"

What is a GFE?

- An **estimate** of the charges associated with items and services **expected** to be furnished to:
  - Uninsured patients
  - Self-pay patients (patients with health insurance who do not wish to have a claim submitted to their insurer for these specific items/services)

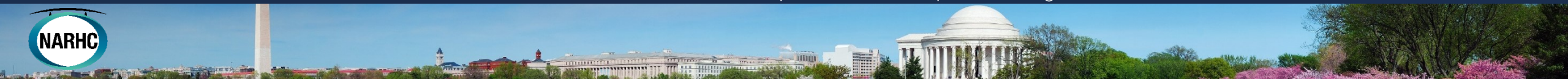
When do GFEs need to be issued?

- Beginning January 1, 2022, providers must issue a GFE to uninsured or self-pay patients that:
  - Request a GFE, OR
  - Schedule an appointment 3+ days in advance

- Does not apply to beneficiaries in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.

Appointment Scheduled:	GFE Required:
10+ business days in advance	Within 3 business days of scheduling
3-9 business days in advance	Within 1 business day of scheduling
Less than 3 business days in advance	No GFE required

When a patient requests a GFE, it must be issued within 3 business days of the request.

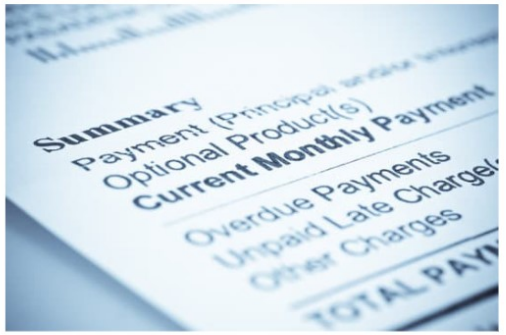


Are GFEs optional?

- No, when a patient schedules an appointment within the timeframe where they're eligible for a GFE, **they must be provided with a GFE**
  - In writing, either on paper or electronically
  - Orally, if the patient requests it in this method

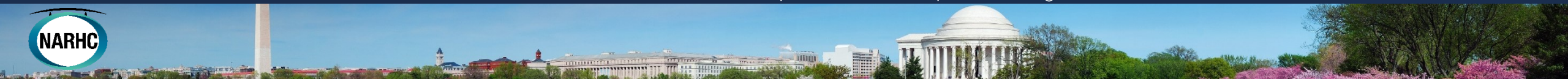
What must be included in the GFE?

- A GFE must list, and provide charge information for:
  - The primary service that the RHC expects to provide to the patient (the initial reason for the visit)
  - The items and/or services that are "reasonably expected" to be provided "in conjunction with the primary service" during a "period of care"
    - Encounters, procedures, tests, supplies, prescription drugs, other fees associated with providing care, etc.
- Separate GFEs would be provided when other items or services beyond the period of care are scheduled



"Reasonably Expected"

- The services to included on the GFE are to be based on the information the RHC has *at the time the appointment was scheduled or the GFE requested.*
  - The GFE is not required to account for unanticipated care that is not reasonably expected or results from unforeseen events.
- Highlights importance of **documentation** but also the significant flaws with this policy -
  - Non-clinical scheduling staff are expected to gather the information necessary to generate a GFE



Sample GFE

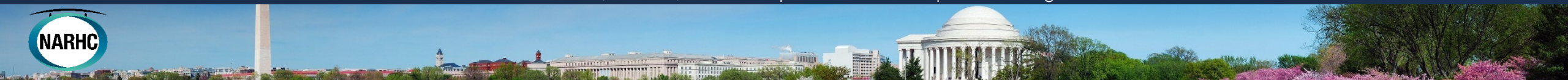
[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Account Number (last four digits) (optional):		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email [ ] By phone		
Patient Diagnosis (if determined)		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	
If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] Check this box if this service or item is not yet scheduled		

Date of Good Faith Estimate: _____/_____/_____	
Summary of Expected Charges (See the itemized estimate attached for more detail.)	
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Total Estimated Cost: $	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE[S] OF SERVICE, IF SCHEDULED] [[ADD IF ADDITIONAL ITEMS/SERVICES ARE BEING INCLUDED], as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [Include if items or services are reoccurring, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]



Sample GFE

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 1]				**$**	
Additional Health Care Provider/Facility Notes					

4

Health Care Items/Services Expected to Be Separately Scheduled with Another Provider or Facility

DISCLAIMER: For health care items/services listed below, separate good faith estimates will be issued upon scheduling or upon request. Specific information such as the names and identifiers for the providers or facilities that may furnish the services, diagnosis codes (if required for the calculation of the GFE), service codes, and expected charges will be provided in separate good faith estimates once these items or services are scheduled (or upon request).

Service/Item	Provider/Facility [Instructions for obtaining a good faith estimate for the service/item, such as provider/facility name, address, phone number, and email]

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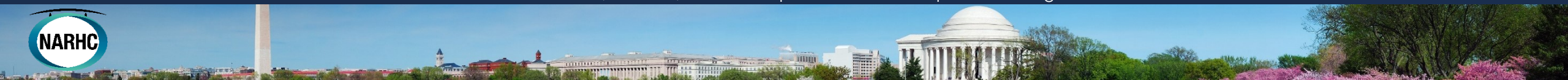


e Good Faith Estimate does not include any unknown or unexpected costs that may arise during
atment. You could be charged more if complications or special circumstances occur. If this happens,
d your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider
facility, federal law allows you to dispute the bill.

e Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to
tain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

you are billed for more than this Good Faith Estimate, you
spute the bill.

u may contact the health care provider or facility listed to let them know
an the Good Faith Estimate. You can ask them to update the bill to mat
k to negotiate the bill, or ask if there is financial assistance available.

u may also start a dispute resolution process with the U.S. Department
rvices (HHS). If you choose to use the dispute resolution process, you
hin 120 calendar days (about 4 months) of the date on the original bill.

ou dispute your bill, the provider or facility cannot move the bill for the
llection or threaten to do so, or if the bill has already moved into collecti
cease collection efforts. The provider or facility must also suspend the
paid bill amounts until after the dispute resolution process has conclud
nnot take or threaten to take any retributive action against you for dispu

ere is a $25 fee to use the dispute process. If the Selected Dispute Re
ur dispute agrees with you, you will have to pay the price on this Good
5 fee. If the SDR entity disagrees with you and agrees with the health
ve to pay the higher amount.

learn more and get a form to start the process, go to www.cms.gov/no
0-985-3059.

r questions or more information about your right to a Good Faith Es
it www.cms.gov/nosurprises/consumers, email FederalPPDRQuestion
5-3059.

eep a copy of this Good Faith Estimate in a safe place or take
ed it if you are billed a higher amount.

IVACY ACT STATEMENT: CMS is authorized to collect the information on this for
der section 2799B-7 of the Public Health Service Act, as added by section 112 of t
of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the inf
uest to initiate a payment dispute, verify the eligibility of your dispute for the PPD
conflict of interest exists with the independent dispute resolution entity selected to
also be used to: (1) support a decision on your dispute; (2) support the ongoing
gram; (3) evaluate selected IDR entity's compliance with program rules. Providing t
failing to provide it may delay or prevent processing of your dispute, or it could cau
he provider or facility.

gimers Required

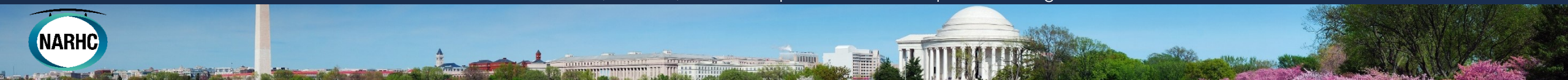
[Provider/Facility 2] Estimate [Delete if not needed]

Provider/Facility Name		Provider/Facility Type	
Street Address			
City		State	ZIP Code
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

Details of Services and Items for [Provider/Facility 2]

Service/Item	Address where service/item will be provided	Diagnosis Code (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		
Total Expected Charges from [Provider/Facility 2]				**$**	
Additional Health Care Provider/Facility Notes					

5



Required Notice

- RHCs are required to display information regarding the availability of GFEs:
  - On the provider's website
  - In the office
  - Where scheduling/cost of services conversations occur

In accessible formats and languages spoken by individuals considering or scheduling items or services

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

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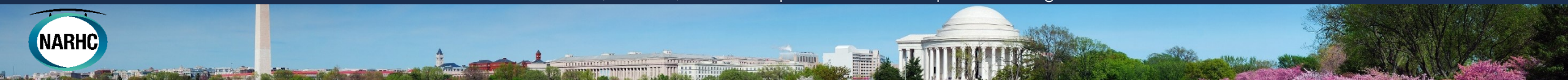
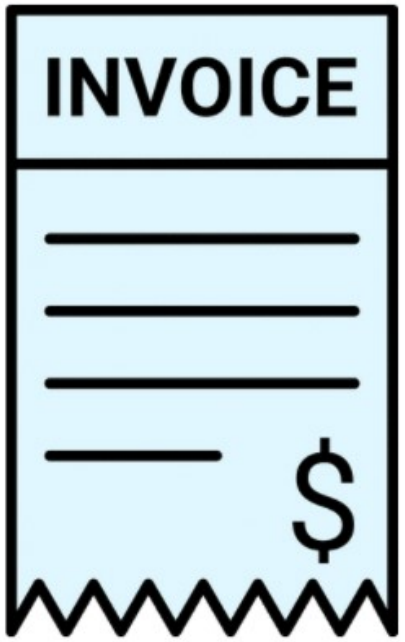


GFE Enforcement



- Patient initiated "dispute resolution process"
  - If after getting a bill the patient realizes they've been billed for an amount that's $400 or more than what was included or GFE, they can request that an independent third-party, called a dispute resolution entity, review the case and determine an appropriate payment.

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Home | Policies & Resources | Consumers | Resolving out-of-network payment disputes

Medical bill disagreements if you're uninsured

Resolving billing disagreements between consumers and providers

Starting in January 2022, if you're uninsured or self-pay (insured but not planning to use your insurance to pay for your care), health care providers and facilities must give you a good faith estimate before you get care. If after getting your bill you realize that any of your providers or facilities billed you for an amount that's $400 or more than what's on your good faith estimate, you can use a new dispute resolution process to request that an independent third-party, called a dispute resolution entity, review your case and determine an appropriate payment. This process is referred to as "patient-provider dispute resolution." The dispute resolution entity will review the good faith estimate, your bill, and information submitted by your provider or facility to determine if you should pay the amount on your good faith estimate, the billed charge, or an amount in between the two. There's a $25 non-refundable administrative fee to start this process.

You'll be eligible to use this process if:

- You're uninsured or self-pay (you have insurance but didn't use it to pay for your health care item or service).
- You scheduled and received the medical items or services on or after January 1, 2022.
- You have a good faith estimate from your provider.
- You have a bill dated within the last 120 calendar days (about 4 months).
- The difference between the good faith estimate and the bill from any single provider or facility is at least $400.

Note: The good faith estimate may have expected costs from more than one provider. You're eligible for the patient-provider dispute resolution process only if your bill from an individual provider or facility is at least $400 more than the total expected costs on the good faith estimate from that provider or facility. View an example of what a good faith estimate (PDF) may include.

How to start the billing dispute process

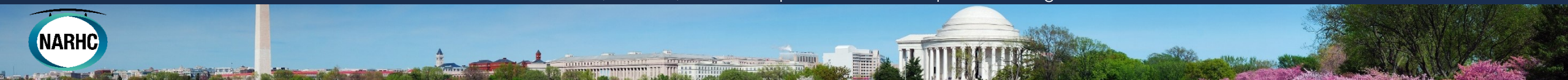
If you meet all of the conditions above, you're eligible for the dispute resolution process. You'll need a copy of your good faith estimate and a copy of your bill to begin the process. We'll ask you to provide copies of these documents and to pay an administrative fee.

A $25 non-refundable administrative fee is required to start the patient-provider dispute resolution process. If the dispute resolution entity decides in your favor, this amount will be deducted from the amount you owe your provider. You can pay this fee online, or you can mail a money order or cashier's check when you submit your dispute form through the mail. Personal checks aren't accepted. If you mail your dispute form but pay online, you'll get an email with information on how to complete your payment online once we get your dispute form.

Start a dispute online

Start a dispute by mail or fax (PDF)

Your protections during the patient-provider dispute resolution process

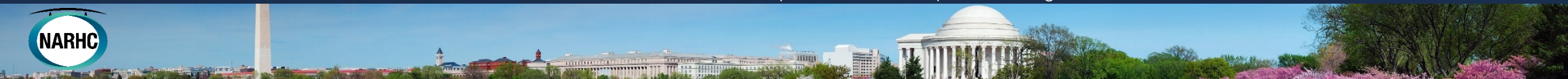


Documentation

- GFEs must be included in the patient's medical record and available upon request for a minimum of 6 years

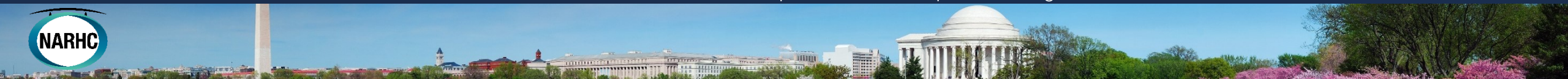
Phase 2

- The good faith estimate will also include items or services reasonably expected to be provided along with the primary item(s) or service(s), even if the individual will receive the items and services from another provider or another facility (co-providers)
- Enforcement of this GFE requirement is expected to begin January 1, 2023
- The "Convening Provider" is responsible for determining which other services will be necessary. Correspondence between Convening Providers and "Co-Providers" may be necessary to provide the patient a full picture of the cost of a particular medical event. Ultimately, GFEs must account for the mix of in-house providers, consultations, and follow-up care relevant to a given course of treatment.



Phase 2

- The way this is presented by CMS is that all reasonably likely charges must be assembled and presented to the patient in a single GFE document, including from the convening facility and any involved co-providers.
- Biggest challenge lies in determining what is included in a "period of care" versus what would trigger the other provider to issue their own GFE.
- All providers should consider what systems need to be in place to generate accurate estimates for co-provider treatments.

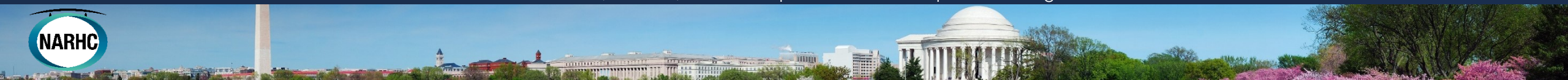


Phase 3

- Effective date to be determined
- GFEs including provider and co-provider estimates must be provided to all patients regardless of their insurance status

Request for Information

- Gathering "information and recommendations on transferring data from providers and facilities to plans, issuers, and carriers; other policy approaches; and the economic impacts of implementing these requirements."
- Please email Sarah.Hohman@narhc.org as soon as possible.



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Questions?

Sarah Hohman, MPH
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