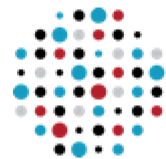

CAP Insights on the No Surprises Act's Good Faith Estimate Requirements

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Welcome

Jonathan L. Myles, MD, FCAP

- Chair, CAP Council on Government and Professional Affairs
- Vice-Chair of the CAP Council on Scientific Affairs

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Welcome

Theresa S. Emory, MD, FCAP

- Chair, CAP Payment Policy Subcommittee, Economic Affairs Committee

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Agenda

- Background on the No Surprises Act
- Overview of Good Faith Estimate Requirements and Patient-Provider Dispute Resolution Process
- CAP Advocacy – How Can Pathologists Comply?
- Questions

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CAP Advocacy on the No Surprises Act

- The CAP lobbied Congress for several years to hold patients financially harmless from bills for out-of-network services provided at in-network hospitals/facilities.
- Congressional leaders struck an agreement and passed legislation, the “No Surprises Act,” in December 2020.
- Key provisions advocated for by the CAP, include:
  - Independent dispute resolution (IDR) process with no minimum dollar amount threshold and an option to batch claims together.
  - Removal of Medicare and Medicaid rates from IDR process.
  - Insurers will make payments for out-of-network services that is determined through negotiation or IDR.
  - Require a study on network adequacy.

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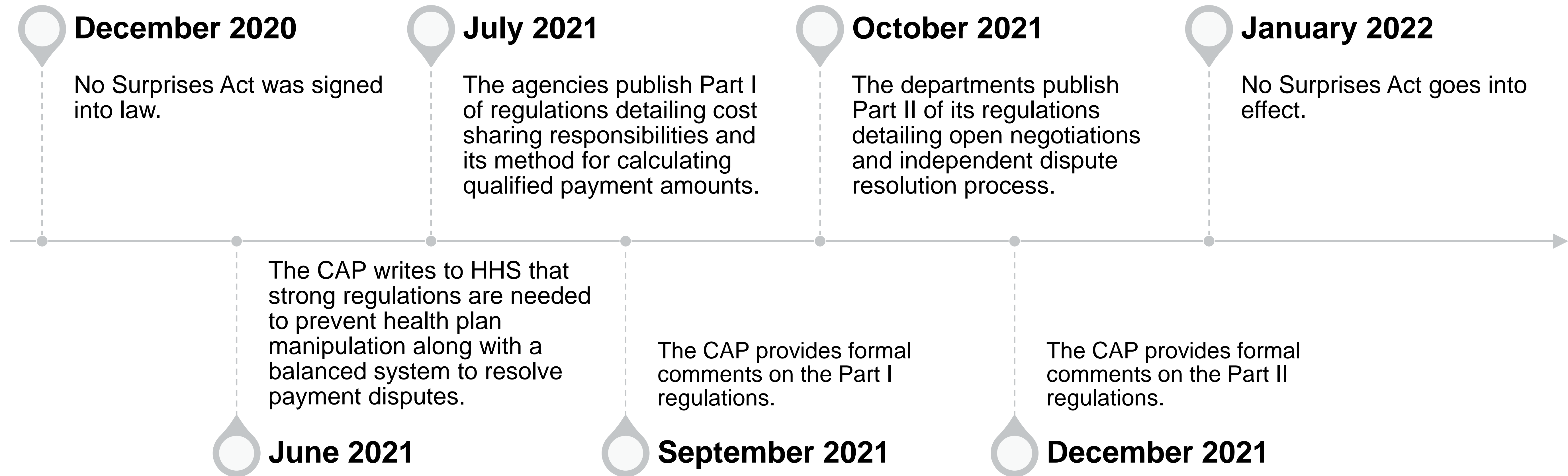
CAP Advocacy on the No Surprises Act



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Good Faith Estimate Requirements

- Health care providers and facilities must:
  - inquire about the individual’s health coverage status, and
  - provide a “good faith estimate” (or GFE)

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Good Faith Estimate Requirements

- For individuals who have health insurance (and will submit their claim), the statute requires *the good faith estimate to be provided to the health plan/issuer*.
- *NOTE: These requirements are* not *currently in effect – the HHS will release future rulemaking to implement.*

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Good Faith Estimate Requirements

- For individuals who do not have health insurance and are not enrolled in a federal health care program (Medicare, Medicaid, etc.), or who are not seeking to file a claim with their insurer (self-pay), *the good faith estimate is provided to the individual*.

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Patient-Provider Dispute Resolution (PPDR)

- The No Surprises Act established a process for uninsured (or self-pay) individuals to seek a determination from a selected dispute resolution entity for the amount to be paid by the uninsured (or self-pay) individual to the provider or facility for items or services.
- When the billed charges for any provider or facility are in excess of the GFE for that provider or facility by $400 or more, the item or service may be eligible for payment determination by a dispute resolution entity through the PPDR process.
- NOTE: This is a different dispute resolution process from the federal IDR process used by providers-insurers and is generally paid for by the HHS so as not to create a barrier to access to process, but it uses the same online portal.

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Patient-Provider Dispute Resolution (PPDR)

- For a billed item or service that was included on the GFE, if the billed charge is more than $400 than the expected charge in the GFE, and the dispute resolution entity determines the provider or facility has not provided credible information that the difference reflects the costs of a medically necessary item or service based on unforeseen circumstances, the amount to be paid by the uninsured (or self-pay) individual will be equal to the GFE amount.
  - If the provider or facility has provided credible information that the billed charges are justified, the amount to be paid by the uninsured (or self-pay) individual will be the lesser of: (1) the billed charge; or (2) the median payment amount.
- For billed items or services not listed on the good faith estimate and not justified, then the amount to be paid for the new item or service will be $0.

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Patient-Provider Dispute Resolution (PPDR)

Billed Charge	Credible Information Provided to Justify Charges	Amount to be Paid
Less than or equal to expected GFE charge	N/A	Billed charge (and not eligible for PPDR process)
Greater than expected GFE charge	No	Expected GFE charge
Greater than expected GFE charge	Yes	The lesser of: 1. Billed charge or 2. Median payment amount
Not included on GFE	No	$0
Not included on GFE	Yes	The lesser of: 1. Billed charge or 2. Median payment amount

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Applicable Health Care Providers and Facilities

- **For the purposes of the GFE, a 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.**
- **All health care institutions licensed under applicable state or local law are treated as health care facilities that must comply with the good faith estimate. Note that this is broader than the definition of facility for purposes of the balance billing requirements.**

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Convening Provider/Facility v. Co-Provider/Facility

- **Convening health care provider/facility** – the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) patient and who is or, in the case of a request, would be responsible for scheduling the primary item or service
  - The convening provider/facility is responsible for providing a single good faith estimate to an uninsured (or self-pay) patient and must contact all applicable co-providers/facilities (ie pathologists) and request their expected charges
- **Co-health care provider/facility** – a provider or facility other than a convening provider or a convening facility that furnishes items/services customarily provided in conjunction with a primary item or service

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Timeline

- Upon receiving a request or upon scheduling a primary item or service, the convening provider/facility must contact all co-providers and co-facilities who are reasonably expected to provide items or services in conjunction with, and in support of, the primary item or service.

- Co-providers and co-facilities must then provide, and the convening provider or convening facility must receive, the GFE information no later than 1 business day after the co-provider or co-facility receives the request from the convening provider/facility.

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Co-Provider/Facility Content Requirements

- Patient name and date of birth
- A list of items or services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service
- Name, National Provider Identifiers, and Tax Identification Numbers of the co-provider or co-facility, and the state(s) and office or facility location(s) where the items or services are expected to be furnished by the co-provider or co-facility
- A disclaimer that the GFE is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the co-providers or co-facilities identified in the GFE

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Co-Provider/Facility Content Requirements

[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	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
				Total Expected Charges from [Provider/Facility 1]	**$**
Additional Health Care Provider/Facility Notes					

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CAP Advocacy – How Can Pathologists Comply?

- On March 22, 2022, CAP staff and leadership met with the Centers for Medicare & Medicaid Services (CMS) staff to discuss the significant – and particular – difficulty in determining the cost of pathology services in advance
- On April 13, 2022, the CAP sent a letter to the CMS with additional examples so they could share them with more individuals and get us better clarification
- In July 2022, the CMS provided further details that they agreed the CAP could share with our members
- On October 12, 2022, the CMS invited CAP to discuss additional details around the requirements and provide more information

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CAP Advocacy – How Can Pathologists Comply?

- *"[W]e would expect that the convening provider or convening facility would include in their request sufficient information about the primary item or service (for instance, the anticipated pathology order) so that the co-provider or co-facility can determine what other related ("in conjunction with") items or services the co-provider or co-facility expects to furnish."*
- *"We recognize that there may be instances where providers or facilities such as laboratories or pathology professionals may not know the full extent of tests and interpretations that will be needed in advance of receiving an order for laboratory or pathology services from another provider or facility. While the interim final rules do not require the GFE to include charges for items or services that could not have been reasonably expected, we would expect that providers or facilities such as pathologists or laboratories would develop and submit GFE information based on the initial anticipated order and clinical circumstances known at the time of scheduling the primary item or service."*

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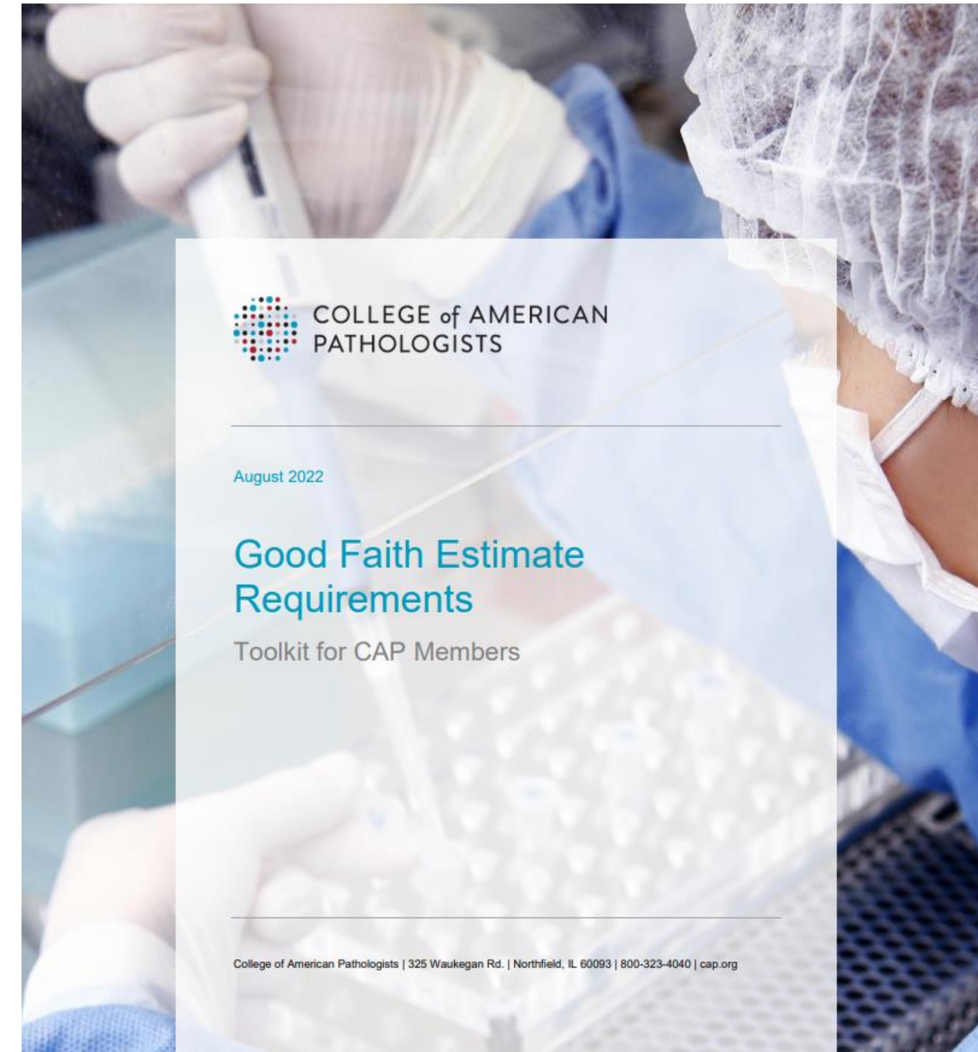
GFE Toolkit for Pathologists



https://www.cap.org/advocacy/lobbying-and-political-action/surprise-medical-bills

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CAP Advocacy Going Forward

- The CAP remains engaged with Congress and the administration to ensure regulators follow statute.
  - Working with stakeholder groups to oppose adverse regulatory positions.
  - Activate grassroots to urge Congress to oppose rules that are in the insurance industry's favor.
- The CAP will continue advocacy with CMS on the good faith estimate requirements to obtain guidance and ensure pathologists can appropriately and easily comply.

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Stay Informed Through the CAP

- **Good Faith Estimates Information and Toolkit**
  https://www.cap.org/advocacy/lobbying-and-political-action/surprise-medical-bills

- **Final 2023 Medicare Payment and Quality Regulations on Monday, December 5 at 3 PM ET/ 2 PM CT**

- **Follow CAP on social media**
  - **Twitter @CAPDCAdvocacy**
  - **Facebook.com/capathologists**

- **Visit CAP.org > advocacy**

- **Read *Advocacy Update***

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Questions

Convening Provider v. Co-Health Care Provider

- **Convening health care provider** – the provider is who receives the initial request for a good faith estimate from an uninsured (or self-pay) patient and who is or, in the case of a request, would be responsible for scheduling the primary item or service
- **Co-health care provider** – a provider other than a convening provider or a convening facility that furnishes items/services customarily provided in conjunction with a primary item or service

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