Wyoming Health Council

FAMILY PLANNING PROGRAM POLICY AND PROCEDURES

No Surprises Act (NSA) rules and Good Faith Estimate (GFE) Effective Jan. 1, 2022, the No Surprises Act aims to help patients understand health care costs in advance of care and minimize unforeseen/surprise medical bills. For uninsured (patients who request confidential billing and do not want to use insurance benefits) and self-pay patient (not patients who are covered by public or private insurance), it requires giving a good faith estimate (GFE) ahead of scheduled, non-emergency, health care services.	
Effective Date	Implementation of this Act went into effect on January 1, 2022
Written	June 2022
Revision Dates	
Next Scheduled Review	June 2023
References and Resources	https://www.federalregister.gov/d/2021-21441/p-22 https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills Information (in part) for this document was taken directly from a summary email received from the WHC OPA Project Officer as part of the June 2022 Wyoming Title X Monthly Check-in.

No Surprises Act does apply to Title X and aims to protect the very client populations that we serve. Some health insurance coverage programs already have protections against high medical bills. You're already protected against surprise medical billing if you have coverage through Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These new rules don't apply to these programs.

The primary relevant requirement for Title X is to provide a verbal, electronic/printed version of a GFE to uninsured and self-pay clients. The GFE can reflect the appropriate Title X schedule of discounts for services provided based on income and can be a range rather than a specific dollar amount. No diagnostic codes are necessary. Anticipated services* can be based on chief complaint(s), primary symptom(s). See table on Surprise/Good Faith Estimate Billing Protection Form below

CMS recognizes that safety-providers, like Title X, have a different set of circumstances and already have protective program regulations that make services affordable for their patients, so they are looking at ways to make compliance for safety providers less onerous. For example, it may be compliant to hand out a non-tailored sheet based on the schedule of discounts and income that detail the full range of services that a health center provides, rather than having to tailor specifically for the expected services a client will receive in a particular visit.

Since the NSA requirements for insured folks are limited to Emergency Services, Post-emergency stabilization services, and non-emergency services provided at in-network facilities, these requirements will most likely not apply to Title X sites.

For insured patients who receive Emergency Services, Post-emergency stabilization services, and Non-emergency services provided at in-network facilities (as defined by the NSA): The NSA requires that health care providers and facilities give patients an easy-to-understand notice explaining the applicable billing protections, who to contact if they have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., patient must receive notice of and consent to being balance billed by an out-of-network provider).

The right of a GFE is patient driven; if a patient refuses to provide the information or context for a GFE to be provided, they have forfeited the entitlement of a GFE, and one does not have to be provided.

GFE expectations related to diagnosis code include but are not limited to; chief complaint(s), primary symptom(s).

Subrecipient agencies must inform clients of their rights under the NSA to include:

1. A GFE in verbal and electronic/printed version, if applicable.
2. To address questions, payment options or dispute resolution process with the clinic/program director.

The WHC does not provide direct patient care/services and does not have internal GFE procedures.

Agency specific Policy and Procedures (P&P) must be developed based on client population and clinic operations and to ensure compliance. Agency procedures should address:

1. Determining requirement for a GFE. See example flowchart
2. How patients are advised of this right.
    a. Compliance suggestions include posting Disclosures & Notices, Financial Policies, and on Intake or New Patient forms.
    b. Posted on agency website
3. Process of and staff responsible for:
    a. Training the biller/billing department
    b. Determining the patient's need for a GFE. See example flowchart
    c. Creating and delivering the GFE (e.g., use of templates and mail, email)
    d. Authority to resolve a dispute for both the patient and the agency and ensuring equitable implementation and for all patients. *(Usually the Program/Clinic Director)*

Here are some examples of a template and language to include on your website and/or financial intake forms:

Surprise Billing/Good Faith Estimate Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills.

Patient name: _____

Clinic name: _____

Program/Clinic Director: _____

You have indicated to the clinic that you are uninsured or self-pay.

The amount below is only an estimate; it is not a bill or contract for services. This table shows the full estimated costs of the items or service description based on the information you provided to the clinic. You could be charged more than the estimate if you get additional items or services during your visit that the clinic did not anticipate but are determined necessary by your provider. This means that **the final cost of services may be different than this estimate**.

By statute, this clinic provides Title X services on a sliding fee scale based on your individual/household income and size and the 2022 Federal Poverty Guidelines (FPG). The clinic may provide other services that may not qualify for a discount.

[*Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services.*].

[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary.*]

Date of service	**Description of anticipated services*** (i.e., visit, labs, pharmacy items)	**Estimated amount based on full fee**	**Percent discount based on reported income**	**Estimated amount you may be asked to pay or may owe**
Total estimate of what you may be asked to pay or may owe:				

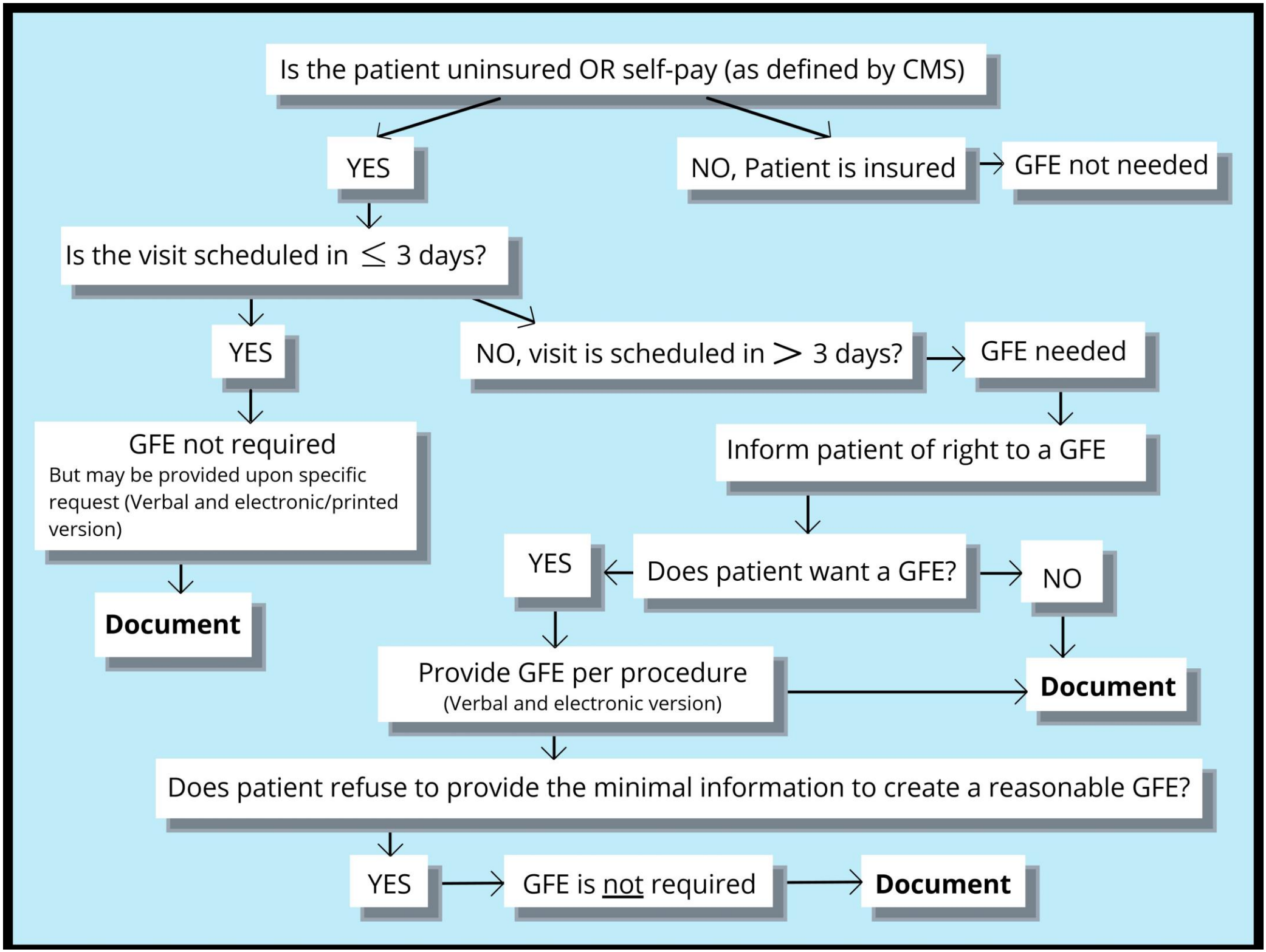
Other examples may be found on https://www.cms.gov/nosurprises/consumers/understanding-costs-in-advance

Patient Rights Disclaimer:

If you are billed at least $400 above this Good Faith Estimate, you have the right to dispute the bill. You may contact the Program/Clinic Director to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 non-refundable fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.
To learn more and get a form to start the process, go to www.cms.gov/nosurprises.
For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises.

An example of a flowchart to determine the need for a GFE is on the following page. This chart has been approved by the WHC OPA/HHS Project Officer. Additional information regarding insured clients, please see paragraph 2 on page 2.

All program staff can access this policy, updates, and training regarding this policy on the Wyoming Health Council website. Monitoring for compliance of this policy will be completed through required deliverables and program reviews during site visit.


Is the patient uninsured OR self-pay (as defined by CMS)
YES
NO, Patient is insured
GFE not needed
Is the visit scheduled in ≤ 3 days?
YES
NO, visit is scheduled in > 3 days?
GFE needed
GFE not required
But may be provided upon specific request (Verbal and electronic/printed version)
Inform patient of right to a GFE
Document
YES
Does patient want a GFE?
NO
Provide GFE per procedure
(Verbal and electronic version)
Document
Does patient refuse to provide the minimal information to create a reasonable GFE?
YES
GFE is not required
Document