Report on Medicare Compliance Volume 31, Number 18. May 16, 2022 Good-Faith Cost Estimates Have Twists and Turns; 'The Definition of Self-Pay Is Inexact'

By Nina Youngstrom

Hospitals may hit a wall with the part of the No Surprises Act that requires them to give uninsured and self-pay patients a good-faith cost estimate of all services provided in connection with an episode of care within a margin of error of $400 after Jan. 1, 2023. Co-providers are supposed to produce cost information about scheduled office visits, diagnostic tests and procedures within one day at the request of hospitals (and other "convening" providers), but it's unclear, in the absence of CMS guidance, what leverage they have.

"What if other providers won't cooperate with the convening provider? There's no guidance on what people will do," said Martie Ross, a consulting principal at PYA. "If a co-provider does not respond with its charges, is the convening provider required to provide some estimate of those charges as part of its good-faith estimate? If so, is the convening provider potentially liable if such estimate proves inaccurate?" Conversely, there's the question of what happens if the convening provider fails to contact a co-provider and therefore doesn't include its charges in the good-faith estimate. "Is the convening provider then potentially liable for those charges?"

Hospitals and other facilities are already required to come up with good-faith estimates of their own services, but the convening provider part adds another dimension and, along with other aspects of the good-faith estimate requirement, including how to decide on charges for patients who have high-deductible insurance, that raises questions without satisfying answers yet, Ross said.

Hospitals are awaiting more guidance on the good-faith requirement, which is "one of two distinct regulatory schemes living under" the No Surprises Act, Ross said May 11 at a webinar sponsored by PYA.[1] The other is the ban on surprise billing. They're both complex and challenging, but Ross said "there are far more questions on the good-faith requirement than on surprise billing."

Good-Faith Estimates Have Twists

The No Surprises Act protects patients from large or unexpected bills from out-of-network providers when they're treated at hospitals, ambulatory surgery centers and other facilities, depending on the circumstances. The law limits patient liability for out-of-network services to no more than in-network cost sharing and deductibles. In other words, balance billing isn't allowed when patients receive emergency services at out-of-network hospitals or nonemergency services from out-of-network providers at certain in-network hospitals and other facilities. It applies to commercial payers, not Medicare and Medicaid. To ensure hospitals and physicians are protected as well, health plans and insurers must reimburse them directly for out-of-network care. There's a dispute resolution process for providers and payers to settle payment disputes about out-of-network services.