

FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION – GOOD FAITH ESTIMATES (GFEs) FOR UNINSURED (OR SELF-PAY) INDIVIDUALS – PART 1

December 1, 2021

Set out below are Frequently Asked Questions (FAQs) regarding implementation of Section 112 of Title I (the No Surprises Act (NSA)) of Division BB of the Consolidated Appropriations Act, 2021 (CAA 2021), and implementing regulations published in the Federal Register on October 7, 2021 as part of interim final rules with comment period, titled “Requirements Related to Surprise Billing; Part II.”

These FAQs have been prepared by the Department of Health and Human Services (HHS) to address the provision of GFEs for uninsured (or self-pay) individuals, as described in Public Health Service Act (PHS Act) section 2799B-6 and implementing regulations at 45 CFR 149.610. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

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Additional FAQs related to good faith estimates for uninsured (or self-pay) individuals are available at https://www.cms.gov/ccio/resources/regulations-and-guidance#Good_Faith_Estimates.

Q1: When do the GFE requirements for uninsured (or self-pay) individuals go into effect?

A1: Providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals in connection with items or services scheduled, or upon the request of the uninsured (or self-pay) individual, on or after January 1, 2022.

Q2: Which providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals?

A2: Generally, all providers and facilities that schedule items or services for an uninsured (or self-pay) individual or receive a request for a GFE from an uninsured (or self-pay) individual must

provide such individual with a GFE. No specific specialties, facility types, or sites of service are exempt from this requirement.

The terms “health care provider (provider)” and “health care facility (facility)” are defined in regulations for purposes of the GFE requirements for uninsured (or self-pay) individuals as:

- “Health care provider (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, including a provider of air ambulance services;
- “Health care facility (facility)” means an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.¹

There may be variations in practice patterns, such as whether a specific provider or facility furnishes services to uninsured (or self-pay) individuals, along with the types of items or services provided. There are some items or services that may not be included in a GFE because they are not typically scheduled in advance and not typically the subject of a requested GFE (such as urgent, emergent trauma, or emergency items or services); however, to the extent that such care is scheduled at least 3 days in advance, a provider or facility would be required to provide a GFE.

For example, individuals will likely not be able to obtain GFEs for emergency air ambulance services, as these are not generally scheduled in advance. However, making these requirements applicable to providers of air ambulance services helps to ensure that individuals can obtain a GFE upon request or at the time of scheduling non-emergency air ambulance services, for which coverage is often not provided by a plan or issuer and thus even individuals with coverage must self-pay.

Q3: What happens if more than one provider or facility is involved in providing a primary item or service to an uninsured (or self-pay) individual?

A3: In instances where multiple providers might be responsible for furnishing care in conjunction with a primary item or service, the “convening provider or facility” must provide a GFE to the uninsured (or self-pay) individual, which includes items or services reasonably expected to be furnished by the convening provider or facility, and items or services reasonably expected to be furnished by co-providers or co-facilities.

The convening provider or facility is the provider or facility that is responsible for scheduling the primary items or services. Other providers or facilities that furnish items or services in conjunction with the primary item or service furnished by the convening provider or facility are considered “co-providers” and “co-facilities.”

No later than one business day after scheduling the primary item or service or receiving a request for a GFE, the convening provider or facility must contact all co-providers and/or co-facilities that will provide items or services in conjunction with the primary items or services and request GFE

¹ 45 CFR 149.610(a)(2).

information including the expected charges for these items or services expected to be provided by the co-provider or co-facility.

We understand that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities. Therefore, for GFEs provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities.

We note that nothing prohibits a co-provider or co-facility from furnishing the GFE information to the convening provider or facility before December 31, 2022, and nothing would prevent the uninsured (or self-pay) individual from separately requesting a GFE directly from the co-provider or co-facility, in which case the co-provider or co-facility would be required to provide the GFE for such items or services. Otherwise, during this period (January 1, 2022 through December 31, 2022), we encourage convening providers and facilities to include a range of expected changes for items or services expected to be provided and billed by co-providers and co-facilities.

Q4: Do providers or facilities need to provide GFEs to all individuals, for instance, patients with Medicare or Medicaid?

A4: Effective January 1, 2022, providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals who schedule items or services or request an estimate. An uninsured individual is one who is not enrolled in a group health plan, or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan. A self-pay individual is one who is enrolled in but is not seeking to have a claim submitted to their group health plan, health insurance coverage, or FEHB program health benefits plan for the item or service being scheduled or for which a GFE is requested. Under the No Surprises Act statute, providers and facilities are generally not required to provide GFEs to individuals insured under Medicare, Medicaid, or other federal health care programs.

Q5: Do providers or facilities need to provide GFEs to individuals who have insurance but do not seek to have a claim for such item or service submitted to such plan or coverage?

A5: An uninsured individual is one who is not enrolled in a group health plan, or group or individual health insurance coverage, or a Federal health care program, or a FEHB program health benefits plan. A self-pay individual is one who is enrolled in but is not seeking to have a claim submitted to their group health plan, health insurance coverage, or FEHB program health benefits plan for the item or service being scheduled or for which a GFE is requested. Providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals. When inquiring about whether an individual is enrolled in a plan or coverage, providers and facilities may wish to consider discussing with the individual whether there are situations where the individual expects that the plan or coverage may not provide coverage for certain items or services.

Q6: Do providers or facilities need to provide GFEs to individuals who have insurance and are seeking to have a claim submitted to their insurance?

A6: HHS has not yet issued rulemaking related to the provision of GFEs for individuals who are enrolled in a plan or coverage and are seeking to have a claim submitted to their plan or

coverage. Until rulemaking to fully implement this requirement to provide such GFE to a plan or coverage is adopted and applicable, HHS will defer enforcement of the requirement that providers and facilities provide GFE information for individuals enrolled in a plan or coverage and who are seeking to submit a claim for scheduled items or services to their plan or coverage.

Q7: In what forms must the GFE be provided?

A7: The GFE must be provided in written form either on paper or electronically (for example, electronic transmission of the GFE through the convening provider's patient portal or electronic mail), pursuant to the uninsured (or self-pay) individual's requested method of delivery. GFEs provided to uninsured (or self-pay) individuals that are transmitted electronically must be provided in a manner that the uninsured (or self-pay) individual can both save and print, and must be provided and written using clear and understandable language and in a manner calculated to be understood by the average uninsured (or self-pay) individual. If a patient requests that the GFE information is provided in a format that is not paper or electronic delivery, like orally over the phone or in person, the provider/facility may provide the GFE information orally but must follow-up with a written paper or electronic copy in order to meet the regulatory requirements.

Q8: How do uninsured (or self-pay) individuals without internet access or a permanent address receive a GFE?

A8: For uninsured (or self-pay) individuals without internet access, a paper copy of the GFE can be provided in person or mailed to an address specified by the uninsured (or self-pay) individual. For uninsured (or self-pay) individuals without a permanent address, the GFE can be provided electronically or in person. For uninsured (or self-pay) individuals who may be housing insecure and have limited or no internet access, a paper GFE can be provided in person.

Q9: Why must a GFE be provided in writing to an uninsured (or self-pay) individual?

A9: A paper or printable electronic copy of the GFE is integral as it is a required input for the patient-provider dispute resolution (PPDR) process that the uninsured (or self-pay) individual can use if the actual billed charges exceed the GFE by at least \$400. When initiating the PPDR, the uninsured (or self-pay) individual must submit a copy of the GFE.

Q10: Do providers or facilities need to factor in financial assistance an uninsured (or self-pay) individual may receive when calculating the expected charges for items or services included in the GFE?

A10: Yes. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an uninsured (or self-pay) individual's actual billed charges. For example, certain tax-exempt hospital organizations are required to meet certain Financial Assistance Policy (FAP) requirements; for purposes of this example, any adjustments expected to be applied under the FAP would be factored in and reflected in the amount reported in the GFE. For more information, see *Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates (GFE) for Uninsured (or Self-pay) Individuals – Part 4*, available at https://www.cms.gov/ccio/resources/regulations-and-guidance#Good_Faith_Estimates.

Q11: Do providers or facilities need to provide a GFE to uninsured (or self-pay) individuals who have zero financial responsibility?

A11: Yes. All uninsured (or self-pay) individuals who schedule items or services or request an estimate must be provided a GFE. A GFE is required even if the uninsured (or self-pay) individual has no estimated financial responsibility because the actual billed charges for the items or services is not guaranteed to be \$0 and a GFE is required to initiate the patient-provider dispute resolution process if actual billed charges are at least \$400 greater than the estimate. For more information, see *Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates (GFE) for Uninsured (or Self-pay) Individuals – Part 4*, available at https://www.cms.gov/ccio/resources/regulations-and-guidance#Good_Faith_Estimates.

Q12: What are the GFE requirements for co-providers or co-facilities when co-providers or co-facilities may not have complete information from other providers or facilities involved during the period of care?

A12: Co-providers and co-facilities are required to submit GFE information to the requesting convening provider or facility, which must include, among other things, the expected charges for items or services that are reasonably expected to be provided in conjunction with the primary item or service. These expected charges must be sent to the convening provider or facility no later than 1 business day after receiving the request. In addition, co-providers and co-facilities must notify and provide new GFE information to a convening provider or convening facility if the co-provider or co-facility anticipates any changes to the scope of GFE information previously submitted to a convening provider or convening facility (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities).

In the event that an uninsured (or self-pay) individual separately schedules or requests a GFE from a provider or facility that would otherwise be a co-provider or co-facility, that provider or facility is considered a convening provider or convening facility for such item or service and must meet all requirements of convening providers and facilities for issuing a GFE to an uninsured (or self-pay) individual.

HHS understands that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities. Therefore, for GFEs provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities.

HHS notes that nothing prohibits a co-provider or co-facility from furnishing the GFE information to the convening provider or facility before December 31, 2022, and nothing would prevent the uninsured (or self-pay) individual from separately requesting a GFE directly from the co-provider or co-facility, in which case the co-provider or co-facility would be required to provide the GFE for such items or services. Otherwise, during this period (January 1, 2022 through December 31, 2022), HHS encourages convening providers and facilities to include a range of expected changes anticipated to be provided and billed by co-providers and co-facilities.

Q13: How can providers or facilities provide a GFE to an uninsured (or self-pay) individual when the underlying complexity of an individual's condition is not yet known?

A13: A GFE provided to uninsured (or self-pay) individuals must include, among other things, an itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care, and items or services reasonably expected to be furnished by co-providers or co-facilities. As discussed in the preamble,² the interim final rules do not require the good faith estimate to include charges for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events.

However, HHS notes that the convening provider or facility is required to provide an uninsured (or self-pay) individual a new GFE if the convening provider or facility or co-provider or co-facility anticipates or is notified of any changes to the scope of a GFE (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities) previously furnished at the time of scheduling; a new GFE must be issued to the uninsured (or self-pay) individual no later than 1 business day before the items or services are scheduled to be furnished. In addition, co-providers and co-facilities must notify and provide new GFE information to a convening provider or convening facility if the co-provider or co-facility anticipates any changes to the scope of GFE information previously submitted to a convening provider or convening facility (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities).

Providers and facilities are encouraged to review any previously issued GFE related to the primary item or service and make all applicable changes when providing the new GFE. Providers and facilities are also encouraged to communicate these changes upon delivery of the new GFE to help patients understand what has changed between the initial GFE and the new GFE.

Q14: Do hospitals offering a set price for services have to offer a GFE?

A14: Yes. A GFE must be provided to all uninsured (or self-pay) individuals who schedule items or services or request a GFE. A GFE is required even if there is a set price for the service because the actual billed charges may not reflect the anticipated set price for the service at the time of estimate. A GFE is required to initiate the PPDR in situations where the actual billed charges are at least \$400 greater than the estimate.

Q15: What is the projected administrative burden to provide GFEs to uninsured (or self-pay) individuals?

A15: The administrative burden of furnishing GFEs to uninsured (or self-pay) individuals is likely to vary based on the number of uninsured (or self-pay) individuals served by a particular provider or facility, and variations in practice patterns, such as the types of items or services provided.

² 86 FR 55980, 56020 (Oct 7, 2021).