How does the No Surprises Act Impact RHCs?

Good Faith Estimate Information and Webinar Q&A Follow-Up

**Good Faith Estimate Summary**
- Starting January 1, 2022, RHCs (and most other health care providers/facilities) will be required to provide uninsured and self-pay patients with a Good Faith Estimate (GFE) of their expected out-of-pocket costs for services, if the individual schedules the service at least 3 business days in advance, or otherwise requests information about charges. This requirement is a component of the No Surprises Act passed in December 2020 and was released by CMS as an Interim Final Rule (IFR).
  - RHCs are not subject to other provisions of the No Surprises Act, including the disclosure requirements regarding patient protections against balance billing.
- The intent of the GFE provision is to allow uninsured or self-pay patients to have access to information about health care pricing before receiving care. This information will allow uninsured (or self-pay) individuals to evaluate options for receiving health care, make cost-conscious health care purchasing decisions, and reduce surprises in relation to their health care costs for items and services.
- The GFE must include charge information for the primary service that the RHC expects to provide to the patient, and for any items/services for which there is a separate charge that are “reasonably expected” to be provided “in conjunction with the primary service.”
- The Good Faith Estimate should be created based on the information know at the time of scheduling or other request of a GFE. Therefore, the individual scheduling the patient must thoroughly document the need for the visit as described by the patient and/or the services requested.
- Theoretically, the GFE must also include information for services that the patient will receive from non-RHC providers for the same “period of care”. The definition of a “period of care” is open to interpretation; however, CMS will not enforce the requirement to include cost data from other, outside providers until 2023.
- While the requirements will go into effect on January 1, 2022, CMS may choose to update the regulation based on comments from the provider community.
- A flow chart outlining an RHCs responsibilities can be found at the end of this document.

**Q: When and to whom are facilities/providers required to provide a Good Faith Estimate?**
**A: Every time** an individual requests charge information or is in the process of scheduling an appointment, the facility/provider must inquire whether the patient has insurance and if so, whether they plan to have a claim filed with their insurance for their visit. If the patient is uninsured or elects to be self-pay, they **must be provided** a Good Faith Estimate of charges following the timeframe below.
If an uninsured or self-pay patient: | Is a GFE required, and when?
---|---
Schedules an appointment: 10 or more business days in advance of appointment | Yes, within 3 business days of scheduling
Between 3 to 9 business days in advance of appointment | Yes, within 1 business day of scheduling
Less than 3 business days in advance of appointment or for walk-in patients | Not required at the time of scheduling, but patients may still request a GFE which must be provided within 3 business days.
Requests a GFE, or otherwise asks about the cost of a service, but does not schedule appointment | Yes, within 3 business days of the request
Schedule the same service on a recurring basis (e.g., multiple physical therapy appointments, lab infusions, etc.) | A single GFE can be issued for recurring services, **up to a maximum of 12 months.**

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

**A: 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.**
Q: Does a notice of the availability of a Good Faith Estimate need to be displayed in my facility?
A: Information regarding the availability of a “Good Faith Estimate” must be prominently displayed on the convening provider’s and convening facility’s website and in the office and on-site where scheduling or questions about the cost of health care occur. This may include other offices within your RHC where cost conversations may occur. The model notice, the second file available in this folder download, is not required to be used; however, it meets the requirements of compliance and some form of notice is required. There is no explicit requirement for this notice to be posted in all languages, but it must be made available in accessible formats and languages spoken by individuals considering or scheduling items or services.

Q: What services must be included in a Good Faith Estimate?
A: A GFE must list, and provide charge information for:

- The primary service that the RHC expects to provide to the patient during the “period of care.”

- The items and/or services that are “reasonably expected” to be provided “in conjunction with the primary service” for which the RHC or an outside provider has a separate charge.

For example, if a patient schedules an appointment for a suspected strep throat, the GFE might include an office visit, a lab test (if the RHC has a separate charge for that), and a generic medication.

Note that the services to be listed are to be based on the information that the RHC has at the time the GFE is requested. The GFE is not required to account for unanticipated care that is not reasonably expected or results from unforeseen events. For example, a patient that schedules an appointment for a sore throat but during their visit shares several other medical concerns.

Q: What is the “period of care”?
A: This is unclear. We would assume that this would typically be a single day. However, if a patient receives a single service that requires returning to the RHC on multiple days to receive the full service (e.g., the 2-dose HPV vaccine), then the period of care should encompass all those dates. (This is different from a recurring service -- such as weekly behavioral health visits - where the same service is provided multiple times. See the above table about GFEs for recurring visits.) Also, if the patient will have lab work or imaging done on a different day and those services are scheduled by the RHC, then the period of care must include those dates also.

The regulation defines the “period of care” as “the day or multiple days during which the good faith estimate for a scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished... including the period of time
during which...telemedicine services, imaging services, laboratory services... that would not be scheduled separately by the individual, are furnished.”

Q: When must GFEs include information about charges for care provided by non-RHC providers?
A: This component will not be enforced until 2023. However, there are two levels to this question -- when it is appropriate to include such information in a GFE, and when CMS will require that this information be included.

1. **Appropriate**: This is another gray area. The regulations require that charges for outside providers be listed on the GFE when it is “reasonably expected” that the outside provider will provide the service “in conjunction with the primary service” -- given the information that the RHC had at the time the GFE was requested.

2. **Compliance/ Enforcement**: As discussed below, CMS has publicly acknowledged that providers will have difficulty getting charge information from outside providers to include in a GFE. Accordingly, while the requirement to include this information (when appropriate) officially goes into effect on Jan. 1, 2022, CMS has publicly stated that they will not enforce this requirement until Jan. 1, 2023.

Q: If charge information from an outside provider is needed for a GFE, what are the relevant timelines?
A: The RHC has one business day from the date of the patient scheduling the appointment or requesting the information to request GFE info from the outside provider; the outside provider has one business day to respond.

Q: Do Good Faith Estimates expire?
A: As written, there is no explicit expiration date for GFEs.

Q: What must be included in a GFE?
A: Below are the content requirements of a Good Faith Estimate for the convening (originating) provider/facility, per the regulation:

- Patient name and date of birth;
- Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled);
  - *An “item or service” is defined as “all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care.”*
- 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 those by the convening provider/facility and by the co-providers/facility;
  o *The regulation does not define care “reasonably expected to be furnished in conjunction with the primary item or service.” We anticipate future regulations will elaborate on this definition.

- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;
- Name, NPI, and TIN for each provider/facility listed on the GFE;
- List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service.
- Certain disclaimers as listed below.

Q: How can we include diagnosis codes on a GFE for patients we haven’t yet seen?
A: Both the law and regulation are clear that the GFE must include diagnosis codes; however, this isn’t typically reasonable for RHCs when scheduling patients or discussing services via phone. NARHC is seeking to lower this administrative burden for RHCs and recognizes the challenges of this component, but as of now, a “good faith” attempt at including the appropriate diagnosis code is required.

Q: What disclaimers must be included on GFEs?
A:
- The RHC may, as part of the course of care, recommend additional services that will need to be scheduled or requested separately and are not reflected in the GFE;
- The GFE is only an estimate of items or services reasonably expected to be furnished at the time it was issued, and that actual items, services, or charges may differ from the GFE;
- The GFE is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from the RHC or any other provider listed.
- The patient may initiate the patient-provider dispute resolution process if the actual billed charges are “substantially in excess of” (currently defined as more than $400 greater than) the expected charges included in the good faith estimate, as specified in 45 CFR 149.620; this disclaimer must:
  o include instructions for where the individual can find information about how to initiate this dispute resolution process and
  o state that initiating the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to the individual.
Additionally, co-providers/co-facilities must provide the following information to the convening provider/facility:

- Patient name and date of birth;
- An itemized list of items or services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care;
- Applicable diagnosis codes, expected service codes and expected charges associated with each listed item or service;
- Name, NPI and TIN 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; and
- A disclaimer that the GFE is not a contract and does not require the individual to obtain the items or services from any of the providers or facilities identified in the GFE.

*It is unclear at this time when the “burden” of providing a GFE changes to a different provider. However, if a patient whose care originated at the RHC is then referred to a specialty provider, for example, at the time of scheduling, it is our understanding that the specialty provider would then also need to issue a Good Faith Estimate for those services.

CMS states “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.”

A sample Good Faith Estimate form, including the required disclaimers can be found at the third file available in this folder download.

Q: In what formats do GFEs need to be provided to patients?
A: GFEs must be provided in written form, either on paper or electronically; the patient can elect how to receive it. Electronic versions can be shared either through the patient portal or email, and the patient must be able to both save and print it. Even if staff discuss the GFE verbally with the patient, the RHC is still required to provide it in electronic or paper form to meet the requirements.

Q: Where does the GFE documentation need to be maintained?
A: A good faith estimate issued to uninsured (or self-pay) individual is considered part of the patient’s medical record and must be maintained in the same manner as a patient’s medical record. Convening providers and convening facilities must provide a copy of any previously issued good faith estimate furnished within the last 6 years to an uninsured (or self-pay)
individual upon the request of the uninsured (or self-pay) individual. This will assist in tracking purposes of when the GFE was provided to patients.

**Q: Does this apply to just RHCs or hospitals and other facilities as well?**

**A:** Other health care facilities and the providers who practice in these facilities are subject to the GFE provision. This is not an RHC specific issue.

**Q: Would posting all of our charges on our website or referring patients to MD Save meet the requirement?**

**A:** No, this is a specific requirement for providing each eligible patient with a GFE. All GFEs issued must meet all the Federal requirements, even if the Federal requirements are more extensive than its existing state requirements.

**Q: Do changes need to be made to the GFE if the RHC anticipates them in advance of a scheduled appointment after the GFE has been issued?**

**A:** If an RHC anticipates or becomes aware of any changes to the GFE, a revised GFE must be issued no later than 1 business day in advance of the service.

**Q: What is the enforcement process for the Good Faith Estimate provision?**

**A:** This is not clear. We do know that the patient-provider dispute resolution process will only be available for patients when their actual costs are more than $400 above the GFE. Additionally, The GFE requirements for uninsured or self-pay individuals will go into effect for services scheduled on or after **January 1, 2022**. HHS has acknowledged that it will take time for providers and facilities to develop processes for the exchange of required information between convening providers/facilities and co-providers/co-facilities. Prior to January 1, 2023, HHS will exercise its enforcement discretion in situations where a GFE provided by a convening provider to an uninsured or self-pay individual does not include the expected charges of co-providers or co-facilities. During this period, an uninsured or self-pay may not initiate the dispute resolution process against a co-provider or co-facility as long as the items and services to be provided by the co-provider/facility appear on the GFE, even if they do not include an estimate of charges or a range of expected charges. However, a co-provider or co-facility is required to provide a GFE directly to an uninsured or self-pay individual who requests one.

What does this mean? Patients can only initiate the dispute resolution process in 2022 against initial charges at the convening provider/facility, not the co-provider/co-facility, so long as the expected items and services are listed on the GFE even if they do not include expected charges.

**Q: What is the Patient-Provider Dispute Resolution Process for the Good Faith Estimate provision?**
A patient must initiate the dispute resolution process within 120 days from the date on the bill. Additional details about this process and sample forms can be found at the fifth file available in this folder download.

Q: What if an RHC makes a mistake on a GFE?
A: CMS states that a provider shall not be considered to be out of compliance if a mistake occurs on a GFE as long as the provider:
   ● Was “acting in good faith” when the mistake was made, and
   ● Corrects the error as soon as possible.

Q: What if a patient’s actual charges are different from what it indicated on the GFE?
A: The GFE form must state, in the disclaimer language, that it is an estimate and the patient’s actual charges may differ. So there are no official legal consequences if there are small differences in the charges, as long as the RHC was acting “in good faith.”

Additional Useful Q&A Published By CMS on Dec. 21
To note:

Q: 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?
A: 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.

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

If you have any additional questions please contact Sarah Hohman, Deputy Director of Government Affairs at Sarah.Hohman@narhc.org.
Good Faith Estimate Flow Chart

Start Here

Did the patient:
- Request a GFE OR
- Inquire about cost of a service?

GFE Required

Yes

Did the patient schedule an appointment (at least 3 business days in advance)? RHC must ASK: Does the patient have insurance? Will the use it to pay for this service?

No

Patient is uninsured or self-pay.

Yes

GFE Required

No

RHC must ASK: Does the patient wish for the claim to be submitted to their insurer? *Typically does not apply to Medicare and Medicaid patients.*

Yes

No GFE Required

No

Scheduled

Did the patient schedule an appointment in advance, or only request info about charges? *RHC staff must collect and document information to properly prepare GFE for each patient.*

Request Only

GFE must be provided within 3 business days of request OR scheduling

10+ business days in advance

GFE must be provided to patient in written form (electronic or on paper)

GFE must list and provide charges for:
- Primary service to be provided
- Items/services “reasonably expected” in conjunction with primary service that have separate charges

GFE must be included in patient’s medical record and available upon request for a minimum of 6 years

How far in advance?

Less than 3 business days in advance

GFE required within 1 day

No GFE Required

Between 3 and 9 business days in advance

GFE must be provided within 3 business days of request OR scheduling

10+ business days in advance

GFE must list and provide charges for:
- Primary service to be provided
- Items/services “reasonably expected” in conjunction with primary service that have separate charges

GFE must be included in patient’s medical record and available upon request for a minimum of 6 years