NATIONAL COUNCIL for Mental Wellbeing

An Overview for Community Behavioral Health Organizations of "Good Faith Estimates" and Other Relevant Requirements of the No Surprises Act*

The No Surprises Act (NSA) (Title I, Div. BB, of the Consolidated Appropriations Act 2021 (CAA 2021)) was part of a law providing funding for the federal government for fiscal year 2021, including COVID-19 relief provisions. The NSA imposed new requirements, most of which took effect on January 1, 2022, on both health insurers and various types of health care providers, with an overall goal of reducing the prevalence of surprise medical bills and making patients' out-of-pocket expenditures on health care services more transparent and predictable.

Most provisions of the NSA contain protections for privately insured patients, but some apply to uninsured and self-pay patients. The aspect of the law most likely to impact the operations of community behavioral health providers is the requirement, in Section 112 of the NSA, to provide a "good faith estimate" of the expected charges for furnishing scheduled services to certain uninsured or self-pay patients.

This Overview will provide detailed information about the good faith estimate requirement, and a brief summary of other potentially relevant provisions of the NSA.

I. Section 112 of the NSA: Requirement To Provide a "Good Faith Estimate"

Below, we will discuss the requirements for providers and facilities both to provide good faith estimates (GFE) in relevant situations, and also, to provide notice to the public about the availability of a GFE.

A. The Good Faith Estimate

Section 112 of the NSA requires a provider or facility to supply a GFE for certain services, effective January 1, 2022. Specifically, the law requires providers and facilities to take certain steps if a patient schedules health care services at least three (3) days in advance.

First, the provider or facility must determine if an individual is defined as an "uninsured (or self-pay)" individual. If the individual meets this definition, then the provider/facility is required to furnish a GFE listing relevant information about the services expected to be provided, and their associated charges. Under the law, uninsured or self-pay patients may initiate a dispute resolution process if their billed charges are substantially in excess of the GFE amount.

Implementing regulations that were issued in October 2021 clarified applicable definitions and expanded upon the requirements of the statute. For example, the regulations added a requirement that prospective patients who are uninsured or self-pay may request a GFE, even if they are not scheduling a service. The regulations are located at 45 C.F.R. Part 149, Subpart G (Protection of Uninsured or Self-Pay Individuals). For additional information on the GFE requirement, please also consult Ending Surprise Medical Bills, on the CMS website, where NSA policies and resources are aggregated.

Below, we have provided information, arranged in a question-and-answer format, about the most important aspects of the GFE requirement.

Q: Who are the "providers and facilities" required to furnish the GFE to uninsured and self-pay patients?

A: For purposes of the GFE requirement, the regulations use a very broad definition of "health care facility," including any institution that is licensed as an institution in its State or is approved by the agency of such State or

locality as meeting the standards for licensing. "Health care provider" is defined as any physician or other health care provider acting within the scope of the provider's license under State law.[1]

Because of the breadth of the "facility" definition, the requirement to furnish GFEs would most likely apply to any community behavioral health organization.

Please note that if a community behavioral health organization (as a **facility**) provides a GFE in connection with a service to be furnished by a clinician, the clinician is not required to provide a separate GFE.

Q: What services are subject to the requirement?

A: The GFE requirement is intended to include "all encounters, procedures, medical tests, supplies, durable medical equipment, and fees," and HHS specifically noted that it includes "services such as those related to dental health, vision, substance use disorders and mental health."[2]

Q: Which patients are entitled to receive a GFE?

A: There are two sets of criteria in determining whether a GFE needs to be furnished.

First, providers/facilities are required to furnish a GFE only to those patients/consumers who either (1) schedule an appointment at least 3 business days in advance, or (2) request a GFE.[3] (Any inquiry of discussion by the patient about the cost of services is considered a "request" for a GFE.)

Please note that if patients do schedule an appointment within the qualifying timeframe, and they qualify as uninsured or self-pay, then the GFE **must be provided**; it is not sufficient for the provider/facility to offer the GFE at the patient's option.

Second, within the set of patients who meet those timing criteria, the provider or facility is required to furnish the GFE only to patients who qualify as **"uninsured"** or **"self-pay."** Upon a patient's advance scheduling of a service or upon the individual's request for a good-faith estimate, the provider or facility must ask the patient questions to determine if the patient meets either category.

The provider or facility must first inquire if the patient has coverage for benefits under

- A group health plan;
- Group or individual health insurance coverage offered by a health insurance issuer;
- A Federal health care program[4], or
- A health benefits plan under a Federal Employees Health Benefits (FEHB) Program.

If the answer is "no," then the patient is **uninsured**.[5]

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[1] 45 CFR 149.610(a)(2)(vii)-(viii).
[2] 45 CFR 149.610(c); 86 Fed. Reg. 56015.
[3] 45 CFR 149.610(b)(1)(iv).
[4] Please note that a "federal health care program" is defined as a plan or program that provides health benefits (whether directly, through insurance, or otherwise) that is funded directly, in whole or part, by the U.S. government; examples include Medicare, Medicaid, Indian Health Service programs, Veterans Affairs Health Care, and TRICARE. Social Security Act § 1128B(f); CMS Fact Sheet, Requirements Related to Surprise Billing (n. 8).
[5] 45 CFR 149.610(a)(2)(xiii)(A).

If the patient does have coverage under one of the four forms listed above, then the provider/facility is required to ask if the patient intends to have a claim submitted to the plan or coverage. A **self-pay patient** is defined in the GFE regulations as a patient who has benefits for one of the types of coverage listed above, but who does not seek to have a claim for such item or service submitted to the plan.[6]

Please note that if *insured* patients request a GFE or schedule an appointment, providers and facilities are not at this time required to provide a GFE. NSA § 111 required private health plans to furnish an "advanced explanation of benefits" to enrollees, effective January 1, 2022, based on information furnished by the provider to the plan. However, HHS has not yet implemented that requirement in regulation.

Q: What must the GFE contain?

A: Per the law and regulations, a good faith estimate must contain the following information in clear and understandable language:

- The patient's name and date of birth;
- A description of the primary service (e.g., E/M, psychotherapy) being furnished to the patient (and if applicable, the date (or date range if recurring) the primary service is scheduled);
- An itemized list of services that are "reasonably expected" to be furnished (this could be what is captured in your standard fee schedule depending on patient need);
- Applicable diagnosis codes;
    - **Please note:** HHS clarified in guidance that diagnosis codes are required "only where one is required for the calculation of the GFE." If a provider/facility has not yet determined a diagnosis, or if there is no relevant diagnosis code for the item/service (such as for screenings), there is no requirement to include diagnosis codes on the GFE.[7]
- Expected service codes;
- Expected charges associated with each listed item or service (charges should correspond to amounts reflected in your organization's fee schedule for the listed service codes);
    - **Please note:** The "expected charges" *should reflect any discount available* your organization expects to provide for the care of the uninsured/self-pay consumer.[8]
- The name, National Provider Identifier (NPI), and Tax Identification Number (TIN) of each provider or facility represented in the good faith estimate, and the state(s) and office or facility location(s) where the items or services are expected to be furnished. (Solo psychiatrists would list their name, NPI/TIN and address; APA recommends using a business TIN rather than your SSN); and
- A list of services that the provider or convening facility[9] 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 (this may be less applicable in psychiatry; for services that fall outside the routine care).[10]

[6] 45 CFR 149.610(a)(2)(xiii)(B).
[7] CMS, FAQs About Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates, Part 2 (Apr. 5, 2022), Q/A 1.
[8] CMS, FAQs about CAA 2021 Implementation - Good Faith Estimates (Dec. 21, 2021), p. 4; see 45 C.F.R. § 149.610(a)(2)(vi).
[9] The "convening provider or facility" is the provider or facility that handles the scheduling of the primary service included in the GFE or receives the patient's request for the GFE. 45 CFR 149.610(a)(2)(ii).
[10] 45 CFR 149.610(c)(1).

Additionally, facilities and providers are required to include various "disclaimers" on the GFE. These are to help the individual understand what the GFE is, and importantly, to understand what the GFE is **not.** The GFE is not an invoice or a price guarantee—i.e., ultimate billed charges may exceed or be less than the amounts on the GFE. Further, as to anticipated service codes and diagnoses, the GFE is only that – an estimate – and actual services rendered may differ from the services listed on the document.[11]

Available resources: Please note that HHS has provided a GFE template, as well as a "data elements" guidance for the GFE, available here. (From the linked Zip drive, access **Appendix 2**: Standard Form: "Good Faith Estimate for Health Care Items and Services" Under No Surprises Act; and **Appendix 11**: Good Faith Estimates, Data Elements.) While there is no requirement to use these templates, the templates may be useful, for example, in providing text for the various required disclaimers.

Q: In what timeframe must we provide the GFE?

A: Convening providers are required to provide a GFE within the following timeframes:

- When a primary item or service is scheduled at least 3 business days in advance – within **one business day** after scheduling
- When a primary item or service is scheduled at least 10 business days in advance – within **3 business days** after scheduling
- When a good faith estimate is requested by an uninsured (or self-pay) individual - not later than **3 business days** after the date of the request[12]

If you are using the U.S. mail to send the GFE, then postmarking the document by the deadline constitutes compliance.

Q: In what format must we provide the GFE?

A: The GFE must be provided in **written form** either on paper or electronically, according to the individual's requested method of delivery.

If the GFE is provided electronically, it must be provided in a format that the patient can both save and print. Additionally, because the GFE contains protected individual health information, all applicable laws governing health information privacy and security (including the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. Part 2, as well as any relevant State requirements) must be followed. For example, if the GFE is transmitted via email, the message or attachment must be encrypted. A patient portal is typically a secure method of transmission.[13]

The GFE must be treated as part of patient's health record. Providers/facilities must be able to provide a copy of any previously furnished GFE to the patient for a period of 6 years.

Q: Is the GFE required to include information about services furnished by other providers?

A: The law does require the GFE to include information that the convening provider collects from "co-providers" or "co-facilities" – those that are expected to provide items or services "in conjunction with and in support of" the

[11] See 45 CFR 149.610(c)(1)(viii)-(xi) for a full list of the disclaimers required for the GFE.
[12] 45 CFR 149.610(b)(1)(vi).
[13] 45 C.F.R. § 149.610(e), (g); 86 Fed. Reg. 56023; CMS/CCIIO, Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution (Dec. 21, 2021), p. 9.

primary item or service that is the subject of the GFE. Examples of "co-providers" might include laboratories or radiological facilities that provide labs or imaging in conjunction with an appointment. HHS exercised enforcement discretion not to impose any penalties during 2022 relating to GFEs that do not include information relating to co-providers/facilities.[14]

Q: Is a new GFE required for every service/appointment?

A: Generally, a new GFE is required for every scheduled service. However, a convening provider or convening facility may issue a single good faith estimate for recurring primary items or services if the following are satisfied: (1) the GFE for recurring services includes the expected scope of the recurring services (i.e., timeframes, frequency, total number of recurring items or services); and (2) the scope of the GFE for the recurring services does not exceed 12 months.[15]

Q: How is the GFE requirement being enforced?

A: A patient-provider dispute resolution process is available for uninsured or self-pay individuals who get a bill for an item or service that is substantially in excess of the expected charges on the good faith estimate. The term "substantially in excess" is defined in the regulations as total billed charges that are **at least $400 more** than the amounts listed in the GFE. Under the PPDR process, the individual may seek a determination from a Selected Dispute Resolution (SDR) entity for the amount the individual has to pay. In the dispute resolution process, the SDR entity decides whether the difference between the billed charge and the GFE reflects costs of medically necessary items or services based on unforeseen circumstances.[16]

As to other enforcement mechanisms, States have the primary role in enforcing the provider-oriented rules in the No Surprises Act.[17] Section 104 of the Act allows HHS to enforce the provider-oriented requirements of No Surprises, including issuing money penalties for noncompliance, *if* HHS determines that a State has failed to substantially enforce the requirements. Additionally, patients may file a complaint with HHS if the patient believes a health care provider or facility has failed to meet the requirements in the regulations concerning surprise billing (Part I IFR) or the transparency/GFE requirements.[18]

The regulations do specify that providers/facilities do not fail to comply with federal good faith estimate requirements solely because, despite acting in good faith and with reasonable due diligence, they make an error or omission in a required GFE.[19]

B. Requirement To Provide a "Notice of Availability of GFE"

HHS used its rulemaking authority to require that providers and facilities provide public notice that GFEs are available upon scheduling an item or service or upon request. Information regarding GFE availability must be provided both in writing and orally.

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[14] No Surprises Act Interim Final Rule, preamble, 86 FR 56023.
[15] CMS/CCIIO, Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution, Dec. 21, 2021, p. 5; see 45 C.F.R. § 149.610(b)(1)(x).

[16] 45 CFR 149.620.
[17] See Commonwealth Fund, Map: No Surprises Act Enforcement, for information on individual States' choices as of March 2022. Most States appear to have chosen a State-federal collaborative approach.
[18] 45 CFR 149.450.
[19] 45 CFR 149.610(f).

As to written notice, the provider must provide such notice (1) on the provider's/facility's website, (2) in the office, and (3) on-site where scheduling or questions about the cost of items or services occur. The information must be made available in accessible formats and languages spoken by the patient population.[20]

As to oral communication of information, providers/facilities must inform uninsured and self-pay patients about the availability of the GFE when the schedule or inquire about services.

Available resources: CMS has developed a standard notice regarding the availability of a GFE, available here. (From the zip drive available at this link, select **Appendix 1 –** Right to Receive a Good Faith Estimate.)

II. Other Relevant Aspects of the No Surprises Act

A. Sections 102-105 of the NSA: Surprise Billing Protections and Disclosures

The NSA includes protections, at Sections 102-105, against surprise medical bills that **privately insured** patients receive relating to:

- out-of-network emergency services;
- out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and
- out-of-network air ambulance services.

Note: These requirements do not apply to individuals who are covered under public programs, or to uninsured or self-pay patients.

These surprise billing restrictions and rules relating to non-emergency services generally prohibit plans from imposing out-of-network cost sharing in certain situations when insured patients access out-of-network services when receiving care at an in-network "facility." Providers are also prohibited from balance billing enrollees in those situations, and providers and facilities are required to disclose protections against balance billing.[21]

These rules will likely be of limited applicability to community behavioral health providers. The main reason for this is that the restriction on surprise billing for non-emergency services applies narrowly to services furnished in conjunction with care at an in-network "facility," with "facility" defined narrowly for this purpose as a **hospital, hospital outpatient department (OPD), critical access hospital (CAH), or ambulatory surgical center (ASC)**.[22] A typical example of a situation governed by these rules would be one where a privately insured patient schedules a joint replacement at an ASC participating in their insurance network, but receives a surprise bill because the anesthesiologist for the procedure was not in-network. Given that community behavioral health entities do not qualify as "facilities" for purposes of these rules, "surprise billing" as contemplated here could occur only if a CBHO or its clinician furnished care to a patient in conjunction with care in a hospital, OPD, CAH, or ASC.

Health care providers and facilities are required to provide public notice about the prohibitions on surprise billing. While providers are not required to make disclosures if they do not provide services in hospitals, OPDs, CAHs, or ASCs, or in connection with visits in those facilities, and most CBHOs' services would probably fall within that exception, it is nonetheless prudent to provide the public notice.

[20] 45 CFR 149.610(b)(1)(iii); 86 Fed. Reg. 56016.
[21] 45 CFR 149.420.
[22] 45 CFR 149.30, 149.120, 149.420.

The regulation requires providers/facilities to "make publicly available, post on a public website of such provider or facility (if applicable), and provide to any individual" who is an enrollee in a group or individual plan, information about the protections against surprise billing (45 C.F.R. § 149.430). The information is required to be made publicly available on the provider's website (if it has one) or on a sign in the provider's / facility's office. With respect to individual patients who are enrollees in group or individual health plans, the provider or facility is also required to provide the information in a one-page notice.

Available resources: CMS has issued a model notice of the NSA surprise billing protections. Find model disclosure documents here: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

B. Section 113 of the NSA: Continuity of Care Requirements

Under NSA Section 113, when the contractual relationship between a private insurance plan or issuer and a provider or facility ends and results in a change in the provider or facility's network status (i.e., the provider goes from an in-network to an out-of-network status), if the health care provider or facility has a **continuing care patient**, as defined below, the facility or provider must:

- Accept payment from the plan or issuer (and cost-sharing payments from the individual) for the course of treatment of a continuing care patient at the previously agreed-upon payment amount for up to 90 days after the date the patient was notified of the change in the provider's network status.
- Continue to adhere to all policies, procedures, and quality standards imposed by the plan or issuer for such items or services as if the contract were still in place.

A "continuing care patient" is defined in the law as an individual who is undergoing a course of treatment for a serious and complex condition; is undergoing institutional or inpatient care; is scheduled to undergo nonelective surgery; is pregnant and undergoing a course of related care; or who is determined to be terminally ill.

Please note: HHS has not yet issued implementing regulations on this provision.