Frequently Asked Questions

What is the new requirement?

Beginning January 1, 2022, all CHCs (as well as most other health care providers) must provide all uninsured or self-pay patients with a Good Faith Estimate (GFE) of their total out-of-pocket costs before they receive care, as long as the patient schedules the appointment at least 3 days in advance or otherwise requests a GFE.

Where did these requirements come from?

The Good Faith Estimates (GFE) requirements came from the surprise billing legislation (called the "No Surprises Act"), which was enacted in December 2020. While most of that law's provisions – and the regulations issued to date – do not apply to CHCs, the GFE rules do. They were outlined in an Interim Final Rule published by CMS on September 30, 2021.

Which patients must be provided with a GFE starting January 1, 2022?

All uninsured and self-pay patients must be provided a GFE for a service/ visit, as long as they:

- Schedule an appointment for that service at least 3 business days in advance, OR
- Request a GFE (or otherwise ask about the costs of the service) even without scheduling an appointment.

How are "uninsured" and "self-pay" patients defined?

For GFE purposes, a person is considered uninsured or self-pay -- and therefore is eligible to receive a GFE -- if they meet any of the following:

- They have no insurance.
- They have insurance, but it does not include coverage for the service they are seeking. (E.g., they have medical coverage only and are inquiring about a dental service.)
- They have a short-term, limited duration plan.
- They are "self-pay", meaning that they have insurance, but plan to pay for the service entirely out-of-pocket and not submit the claim to their insurance company.

Are insured patients eligible to receive GFEs?

Starting on January 1, 2022, insured patients will be eligible to receive GFEs only if they meet the definition of "self-pay" (meaning they indicate that they do not plan to submit a claim to their insurer.)

Eventually, patients who use their insurance to help pay for a service will be eligible to request GFEs from their insurance company, and to facilitate this, providers such as CHCs will be required to send data to the insurance company. However, due to technical issues, this requirement is being delayed indefinitely, and it is unclear when it will go into effect.

When, and how quickly, must a GFE be provided to uninsured patients?

Here is a summary of if and when a GFE must be provided. Also, the attached flow chart addresses these requirements.

If an uninsured patient		Is a GFE required, and when?
Schedules an appointment:	10 or more business days in advance	Yes, within 3 business days of scheduling
	Between 3 to 9 business days in advance	Yes, within 1 business day of scheduling
	Less than 3 business days in advance	No
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 recurrent basis (e.g., multiple physical therapy appointments)		A single GFE can be issued for recurring services, up to a max of 12 months.

In what format must the GFE be provided to patients?

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 CHC is still required to provide it in written form also.

What are the record-keeping requirements around GFEs?

- A GFE issued to an uninsured individual is considered part of the patient's medical record and must be maintained in the same manner as a patient's medical record.

CHCs must provide a copy of any GFE furnished within the last 6 years to an uninsured individual upon their request