Required Compliance Components (and updates) of the No Surprises Act

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Disclaimer

The information provided in this training is intended only to be a summary of legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance. This tutorial presents current policy and operations as of the date it was presented. We encourage all attendees and/or library members to refer to the applicable statutes, regulations, and appropriate interpretive materials for complete and current information. This resource is to provide clarity but is not to be considered as legal interpretation of the law.

Disclaimer

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The Focus of the No Surprises Act

3

A Closer Look

- Hidden Charges
- Excessive Balance Billing
- Medical Debt despite efforts to confirm network status

4

Consumer Empowerment

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What is Surprise Billing?

Surprise billing occurs when an individual receives an unexpected medical bill from a health care provider or facility after receiving medical services from a provider or facility that, usually unknown to the participant, beneficiary, or enrollee, is a nonparticipating provider or facility with respect to the individual's coverage.

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Summary of the Rule

- No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
- No balance billing for out-of-network emergency services (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for **non-emergency services by nonparticipating providers at certain participating health care facilities**, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)

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What is a Facility?

Health care facilities include:

hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers

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Does the Balance Billing Protection Rule Apply to Me in My Chiropractic Office?

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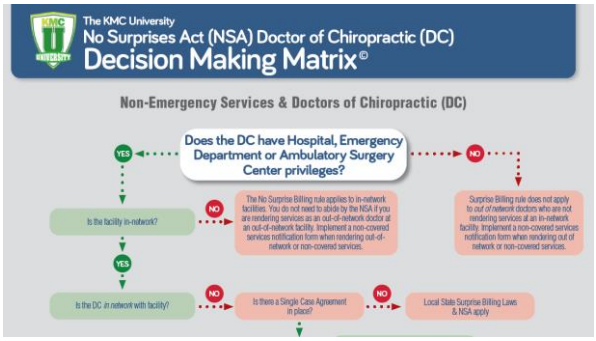

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Single Case Agreement

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Cost Sharing Amounts- For the 1%

- Amount determined by an applicable **All Payer Model Agreement (PMA)** under the Social Security Act Section 1115A

If no PMA

- Amount determined by **State Law** or
- The lesser of the billed charge or the plan's or issuer's median contracted rate which is referred to as **Qualifying Payment Amount (QPA)**

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Overview

- The qualifying payment amount (QPA) is the basis for determining individual cost sharing for items and services covered by the balance-billing protections in the No Surprises Act (NSA), under certain circumstances.
  - Cost-sharing for emergency items and services and non-emergency items and services furnished by an out-of-network provider in an in-network facility must be based on the lesser of billed charges or the QPA, where an All-Payer Model Agreement under section 1115A of the Soc. Sec. Act or a specified state law does not apply.
  - Cost-sharing for air ambulances services must be based on the lesser of billed charges or the QPA
- Certified Independent Dispute Resolution (IDR) entities are required to consider the QPA when selecting between the offer submitted by a plan or issuer and the offer submitted by a facility or provider or provider of air ambulance services when determining the total out-of-network payment rate for items and services subject to the federal IDR process.

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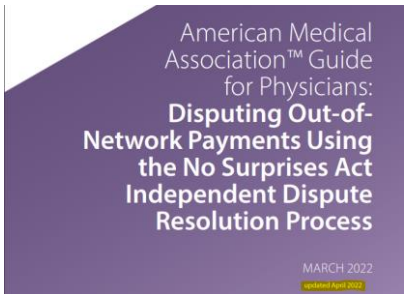

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CMS IDR Update in August 2022

High Volume of Disputes

Between April 15th and August 11th, disputing parties initiated over **46,000** disputes through the federal IDR portal, which is substantially more than the Departments initially estimated would be submitted for a full year. Of the disputes initiated between April 15th and August 11th, certified IDR entities rendered a payment determination in over **1,200** disputes. Between April 15th and August 11th, non-initiating parties challenged over **21,000** disputes' eligibility for the federal IDR process, which constitutes nearly half of all disputes initiated. This does not necessarily mean that these disputes are ineligible, only that a party has challenged the eligibility of a dispute and that additional review by the certified IDR entities is necessary to determine eligibility. As a result of eligibility challenges, preliminary data suggests that certified IDR entities have already found over **7,000** disputes ineligible for the federal IDR process. Certified IDR entities have also determined a number of disputes to be eligible for the federal IDR process despite eligibility challenges made by non-initiating parties.

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David's Slingshot!

The AMA and the American Hospital Association (AHA) filed a complaint (PDF) and motion for a stay or for summary judgment (PDF) on Dec. 9, 2021, in the U.S. District Court for the District of Columbia arguing that the IFR conflicts with the statute by establishing a presumption in favor of the QPA. The text, context, purpose and history of the NSA make clear that the statutory IDR procedure Congress created leaves no room for the agencies to require the arbitrator to put a thumb on the scale in favor of health insurers over providers. The Physicians Advocacy Institute, nine national medical specialty societies and sixteen state medical associations filed an amicus brief (PDF) in support of the AMA-AHA's lawsuit.

The Texas Medical Association (TMA) brought a similar suit in the U.S. Federal District Court for the Eastern District of Texas. In February, that court found in favor of TMA and vacated the provisions in the IFR that weighted the IDR process in favor of health plans. In April, the administration filed a notice of appeal to the U.S. Court of Appeals for the Fifth Circuit challenging the ruling but asked the court to hold its appeal pending the release of Final Rules. The court granted the administration's request and Final Rules were issued on August 19.

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Texas Medical Association

On July 26, 2022, the U.S. District Court for the Eastern District of Texas issued a judgment and order in LifeNet, Inc v. United States Department of Health and Human Services (LifeNet), vacating the final sentences of 45 CFR 149.520(b)(2), 26 CFR 54.9817–2T(b)(2), and 29 CFR 2590.717–2(b)(2), which are parallel provisions governing the Federal Independent Dispute Resolution (IDR) process applicable to air ambulance payment disputes. The sentence the court vacated states, "This [additional] information must also clearly demonstrate that the qualifying payment amount is materially different from the appropriate out-of-network rate."

As a result of the LifeNet decision, effective July 26, 2022, certified IDR entities may not apply the vacated standard in reaching a payment determination in any payment dispute related to air ambulance services. The Departments are in the process of identifying revisions and updates to Federal IDR program guidance and related documents that are necessary to make them consistent with the LifeNet decision, and will issue these updates in the near future.

This court's order *did not* affect any of the Departments' other rulemaking under the No Surprises Act. **Thus, consumers continue to be protected from surprise bills for out-of-network emergency services, out-of-network air ambulance services, and certain out-of-network services received at in-network facilities.** To learn more about these protections, visit www.cms.gov/nosurprises.

The Departments are reviewing the court's decision and considering next steps. This announcement serves as a notification to health care providers, emergency facilities, providers of air ambulance services, group health plans, health insurance issuers, Federal Employees Health Benefits (FEHB) Carriers ("Disputing Parties"), and certified IDR entities of steps the Departments are taking to conform to the court's order.

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Recent Updates for IDR

On **Tuesday, October 18, 2022**, the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (collectively, the Departments), in partnership with the Office of Personnel Management (OPM) launched an updated **Notice of Offer web form for providers**, facilities, providers of air ambulance services, plans and issuers (disputing parties). The new Notice of Offer web form in the **Federal Independent Dispute Resolution (IDR) portal** will replace all existing methods for submitting a Notice of Offer to certified IDR entities.

Click here to view a demo of the Notice of Offer web form

This updated Notice of Offer web form is intended to make submitting final offers for payments and other required information easier and less burdensome for disputing parties and certified IDR entities. With this improvement, disputing parties will now have access to a semi-customized Notice of Offer web form within the Federal IDR portal. **Beginning October 19, 2022, all disputes that are not currently within the 10-business day notice of offer phase of the Federal IDR process and that have not already received Notice of Offer forms from their certified IDR entity will receive a web link from their selected certified IDR entity to submit the Notice of Offer form through the Federal IDR portal once the certified IDR entity confirms eligibility for the Federal IDR process. Parties who received a Notice of Offer form in another format, such as an Excel form, before October 19, 2022 and are currently within the 10-business day deadline to submit an offer should submit your Notice of Offer directly to the selected certified IDR entity in the form and manner specified by your selected certified IDR entity by the Notice of Offer deadline.**

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Interesting but Not Applicable

- IDR is for out of network providers who are rendering services in a in-network facility.
- IDR updates will apply to only a small percentage of DCs.
- DCs who are part of the 1% should work closely with their state associations on any movements towards 'defining' the Qualified Payment Amount for out of network services.

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Disclosure Requirements- Misinformation

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing

Instructions for Providers and Facilities
(For use beginning January 1, 2022)

Section 2799B-3 of the Public Health Service Act (PHS Act) requires health care providers and facilities to make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes information in clear and understandable language on:

(1) the restrictions on providers and facilities regarding balance billing in certain circumstances,
(2) any applicable state law protections against balance billing, and
(3) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Health care providers and facilities may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the provider or facility should review and complete it in a manner consistent with applicable state and federal law. HHS considers use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 2799B-3 of the PHS Act and 45 CFR 149.430, if all other applicable PHS Act requirements are met.

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Do You Need a Billing Protection Disclosure?

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Who Must Comply

- Hospitals (including critical access hospitals)
- Hospital outpatient departments
- Ambulatory surgical centers
- Emergency departments of hospitals
- Independent freestanding emergency departments

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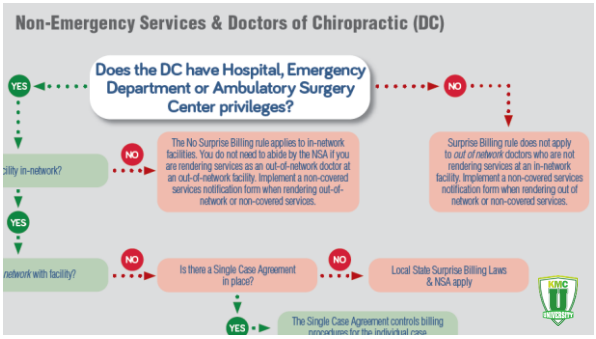

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1% of Providers

To Do List

- Locate the Balance Billing Protection Resources
- Obtain a Balance Billing Protection Form from CMS or from KMC University
- Obtain a Model Disclosure Notice from CMS or KMC University
- Review the AMA Resources (available online)

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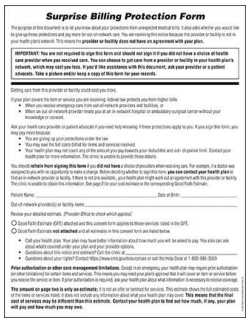
Billing Protection Form for the 1%



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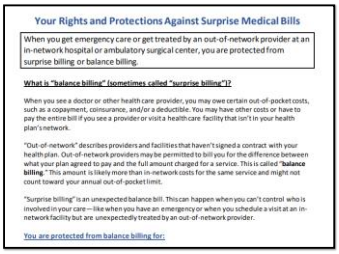
The Model Disclosure for the 1%



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Summary of the Balance Billing Protection NSA Rule

- No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
- No balance billing for out-of-network emergency services (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for **non-emergency services by nonparticipating providers at certain participating health care facilities**, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)
- **Disclose patient protections** against balance billing (PHSA 2799B-3; 45 CFR 149.430)

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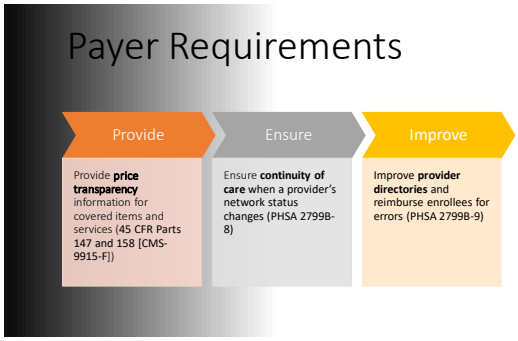

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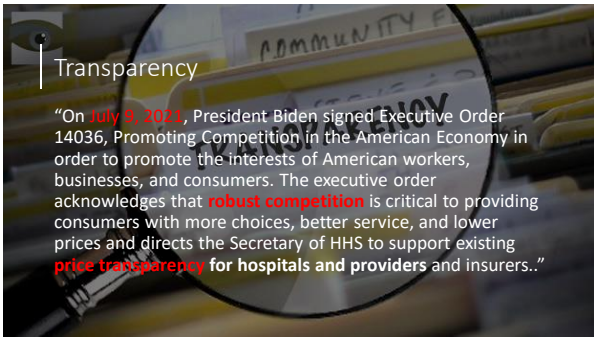

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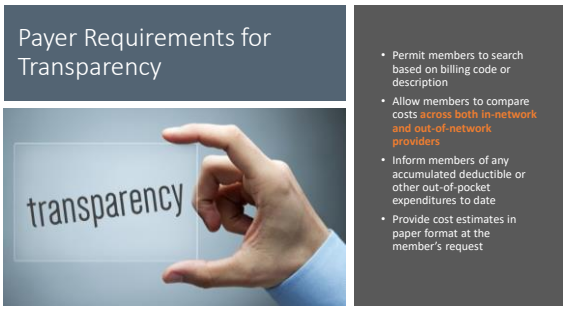

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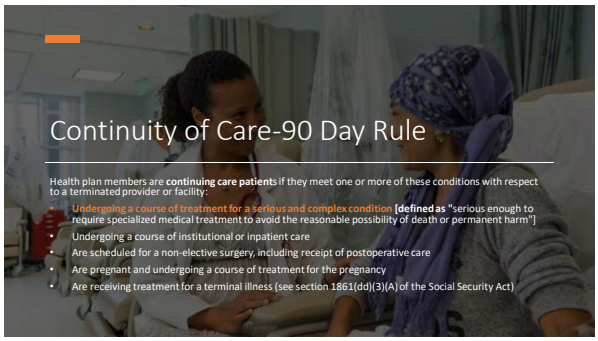

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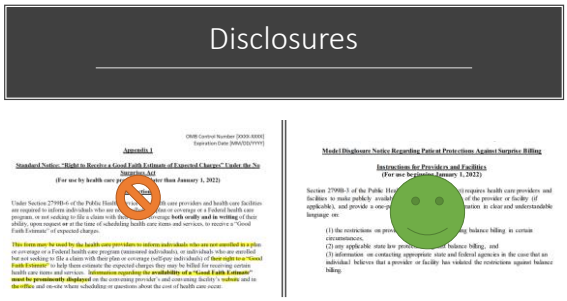

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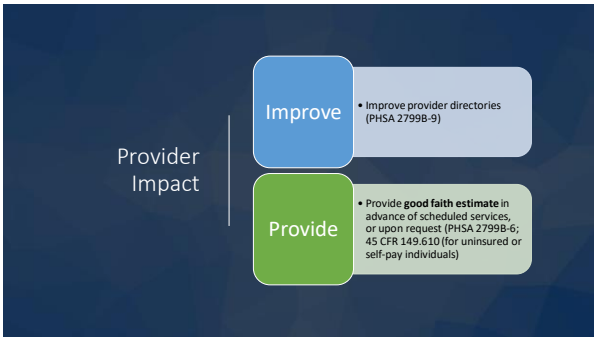

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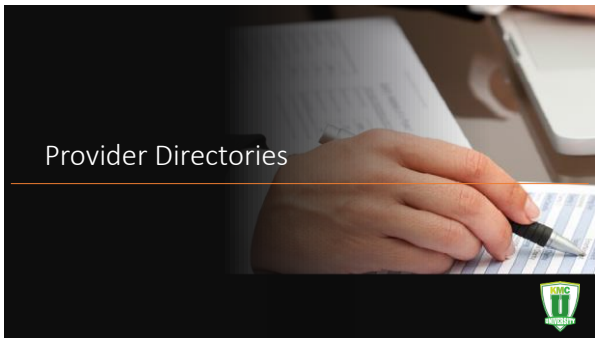

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Provider Requirements

Must submit provider directory information to a plan or issuer:

- at the beginning of a network agreement with a plan or issuer
- if the provider terminates a network agreement with a plan or issuer
- when there are material changes to the content of provider directory information of the provider
- at any other time (including upon the request of plan or issuer) determined appropriate by the provider, health care facility, or the Secretary of Health and Human Services (HHS)

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CMS Scenario..

- A doctor of chiropractic recently began a network agreement with a new health plan. **Is the DC required to submit provider directory information to the plan?**
  Yes, under the No Surprises Act, the DC is required to submit provider directory information (i.e. the provider's name, address(es), specialty, telephone number(s), and digital contact information) to a plan or issuer when they begin a network agreement with a plan or issuer with respect to certain coverage.

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Keep Information Up to Date

- Names, addresses, specialty, telephone numbers, and digital contact information of **individual health care providers**; and
- Names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or health care facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

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Providers Urged to Update Information

Hi Jill,

Your patients (and people who want to be your patients) rely on insurance companies' provider directories to find physicians that are right for them.

Under the No Surprises Act, your payers are **required** to have processes in place to remove providers who have not verified their directory information. Our records show that **as of September 16, at least one of your providers' information has not been verified** in more than 90 days.

It's essential that you complete this critical task today. Log in to the Availity Portal (now known as Availity Essentials) and check your providers' information.

Remember, even if nothing has changed, **the No Surprises Act requires verification of your directory information every 90 days.**

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What About Good Faith Estimates?

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The No Surprises Act Complexity

- Independent Dispute Resolution (IDR) Process
- Requires Good Faith Estimates
- Advance Explanation of Benefits
- Patient Provider Dispute Resolution
- Transparency & Balance Billing Protections

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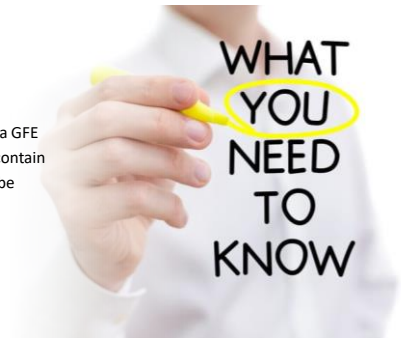
- **Who** should receive a GFE
- **What** a GFE should contain
- **When** should a GFE be provided
- **How** can a clinic be compliant



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"Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a **notification of the good faith estimate of expected charges to an uninsured (or self-pay) individual** who schedules an item or service…"

Good Faith Estimate

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Providers are defined as..

" physicians or other health care providers acting within the scope of their state licenses"

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Self-Pay Patients

Uninsured

Does not plan to use their insurance benefits to pay for the services provided by the physician—OON!

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Who Also Gets One?

"…to an individual **who has not yet scheduled an item** or service, but requests a good faith estimate"

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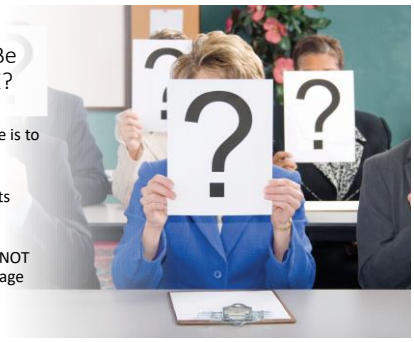
Who Should Be Offered a GFE?

Good Faith Estimate is to be offered to the following:

- Uninsured patients (self-pay)
- Patients who are insured but elect NOT to use their coverage



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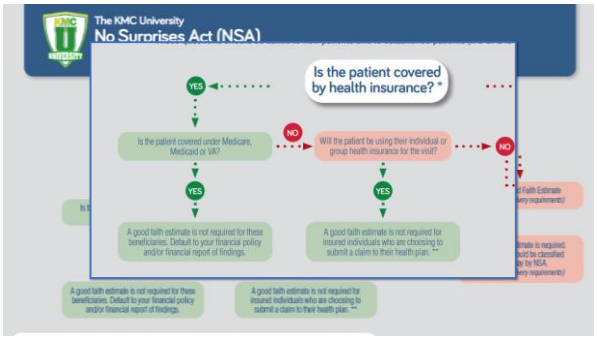

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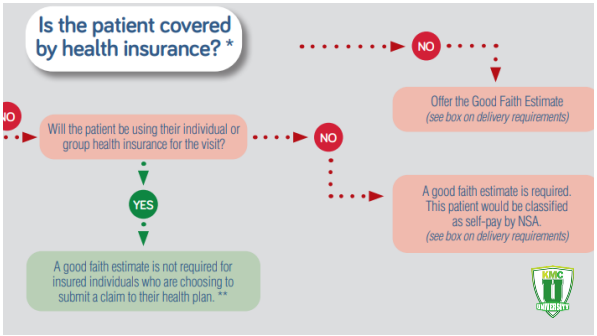

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Timeline for Good Faith Estimate

"PHS Act section 2799B-6 requires providers and facilities to furnish a good faith estimate to an uninsured (or self-pay) individual who schedules an item or service **at least 3 business days before the date such item or service is to be so furnished…"**

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Delivery Times

- **10 business days** in advance, the GFE must be provided **within three business days**
- **3-9 business days** in advance, the GFE must be provided **within one business day**
- **less than 3 days** in advance you ARE NOT required to provide a GFE in writing. Notify orally upon scheduling, provide estimate of initial evaluation

HEADS UP!

If patients request a GFE on their own, you need to **provide one within three days of the date requested**

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Delivery

In Writing

If electronic, in a format the patient can save and print

Can be verbal if followed up with written estimate

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Must Contain

- Patient name
- Patient date of birth
- Description of the services that will be provided, in understandable language
- Itemized list of goods or services reasonably expected to be provided in connection with the scheduled services
- Diagnostic codes, service codes, and expected charges associated with each of those goods or services
- Provider name, NPI and/or tax ID number
- Office location where services will be provided

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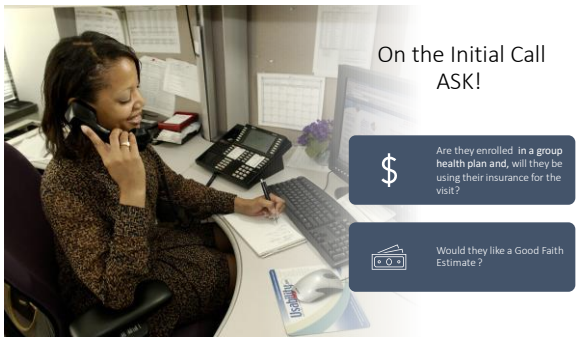

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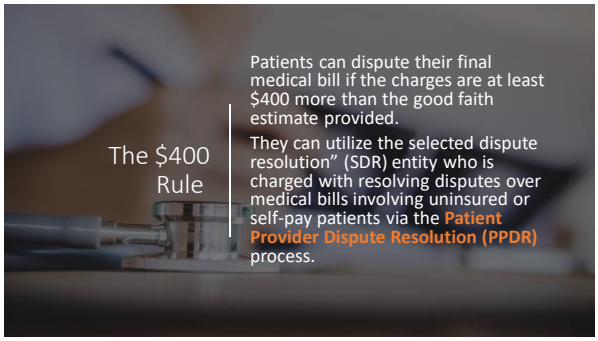

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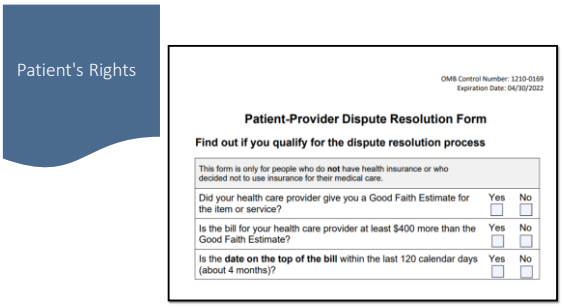

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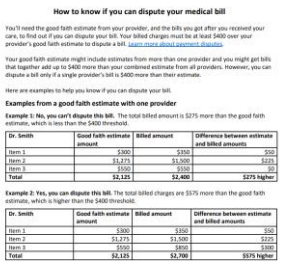
Consumer Empowerment

- Online resources for patients to dispute the Good Faith Estimate that was provided by the treating physician.

THIS PART OF THE RULE APPLIES TO ALL DCs



How to know if you can dispute your medical bill

You'll need the good faith estimate from your provider, and the bills you got after you received your care, to find out if you can dispute your bill. Your billed charges must be at least $400 over your provider's good faith estimate to dispute a bill. Learn more about payment disputes.

Your good faith estimate might include estimates from more than one provider and you might get bills that together add up to $400 more than your combined estimate from all providers. However, you can dispute a bill only if a single provider's bill is $400 more than their estimate.

Here are examples to help you know if you can dispute your bill.

Examples from a good faith estimate with one provider

Example 1: No, you can't dispute this bill. The total billed amount is $275 more than the good faith estimate, which is less than the $400 threshold.

Dr. Smith	Good faith estimate amount	Billed amount	Difference between estimate and billed amounts
Item 1	$300	$350	$50
Item 2	$1,275	$1,500	$225
Item 3	$550	$550	$0
Total	$2,125	$2,400	$275 higher

Example 2: Yes, you can dispute this bill. The total billed charges are $575 more than the good faith estimate, which is higher than the $400 threshold.

Dr. Smith	Good faith estimate amount	Billed amount	Difference between estimate and billed amounts
Item 1	$300	$350	$50
Item 2	$1,275	$1,500	$225
Item 3	$550	$850	$300
Total	$2,125	$2,700	$575 higher

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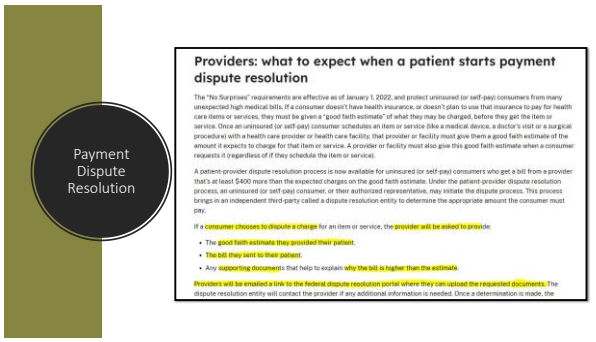

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Stop the Payment Dispute Resolution

- Patient and Provider come to an agreement
- Provider notifies the SDR
- Settlement agreement finalized

Health Care Provider or Facility Notice of Payment Settlement to Selected Dispute Resolution Entity

A health care provider or facility must complete this form when they, in partnership with the uninsured (or self-pay) individual or the individual's authorized representative have resolved a payment dispute outside of the dispute resolution process.

Federal standards require health care providers and facilities notify the Selected Dispute Resolution (SDR) entity, no later than 3 business days after the date of the settlement.

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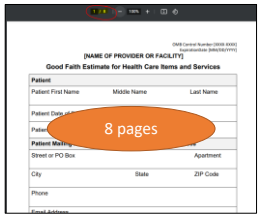
Government Form vs. KMC University



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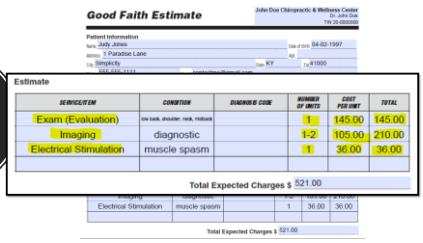
Initial Visit GFE Customization



Good Faith Estimate

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)			1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges $ 521.00

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New Patient Visit Customization

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	Pain		1	145-230.00	230.00
Imaging	diagnostic		1-2	65-105	215.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges $ 481.00

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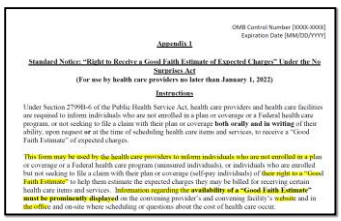
Must Notify Patient of Availability of GFE



Appendix 1

Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

(For use by health care providers no later than January 1, 2022)

Instructions

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage **both orally and in writing** of their ability, upon request **or** at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

This form may be used by the health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of their right to a "Good Faith Estimate" to help them estimate the expected charges they may be billed for receiving certain health care items and services. 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.

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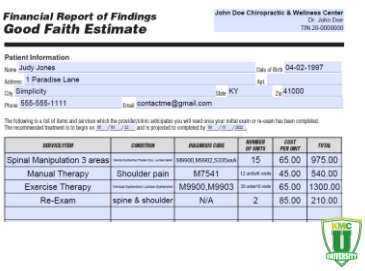
Second Step of the GFE Process



Financial Report of Findings
Good Faith Estimate

John Doe Chiropractic & Wellness Center
Dr. John Doe
TIN 20-0000000

Patient Information
Name Judy Jones Date of Birth 04-02-1997
Address 1 Paradise Lane Apt
City Simplicity State KY Zip 41000
Phone 555-555-1111 Email contactme@gmail.com

The following is a list of items and services which the provider/clinic anticipates you will need since your initial exam or re-exam has been completed. The recommended treatment is to begin on __/__/__ and is projected to completed by __/__/__.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas		M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy		M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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Treatment Plan from the DC

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 06 / 03 / 22 and is projected to completed by 08 / 15 / 2022

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Cervical Dysfunction Thoracic Dys., Lumbar Syndr	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy	Cervical Dysfunction' Lumbar Dysfunction	M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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Treatment Plan

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 04 / 19 / 2022 and is projected to completed by 06 / 19 / 2022

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment 2 Regions	Neck		20		
Re-Evaluation 99213	Neck		2		
Muscle Stim 97014	Neck		12		
Laser	Neck		12		
Exercises	Neck		4		

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Maintenance Plan

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 06 / 19 / 2022 and is projected to completed by 06 / 19 / 2023

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment S8990	Maintenance		24		

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Financial Hand Off

The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed.
The recommended treatment is to begin on 06 / 03 / 22 and is projected to completed by 08 / 15 / 2022

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Cervical Dysfunction Thoracic Dys., Lumbar Syndr	M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/6 visits	45.00	540.00
Exercise Therapy	Cervical Dysfunction' Lumbar Dysfunction	M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

Total Expected Charges $ 3025.00

Disclaimer

This Good Faith Estimate only provides an estimate of the charges for those items or services reasonably expected to be furnished to you by Dr. John Doe upon your receipt of the scheduled/requested primary item or service. There may be additional items or services which the provider recommends as part of your course of care that you will be required to schedule separately which may not be reflected in this Good Faith Estimate. An additional estimate may be required.

The estimate is only valid for 6 months from the following date of estimate 5 / 03 / 22. If the actual charge for these services exceeds our estimate by the greater of $1,000 or 15%, we will provide a revised estimate prior to any charges incurred by you. This Good Faith Estimate is not a contract

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What About Hardship Arrangements?

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.

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Document Delivery
It is part of the medical record

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Audit Your Current Process

Gather	Gather with your team and review your current intake process
Train	Train staff on the expectations of the newer regulations such as No Surprises Act
Make	Make note of areas that are lacking

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The Established Patient- Data Collection

- Confirm on each call the insurance status of the patient
- Blame federal law for the reason you must ask the question AGAIN
- Create an outgoing hold message

  Thank you for calling. We appreciate your patience as our office is implementing new regulations required for healthcare providers. Please be ready with your insurance information when making your appointment. If you do not have insurance, you can request a Good Faith Estimate for the services recommended by the treating physician.
- Say it with a smile :)

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Need to Know Data Collection Process

- First Name Last Name
- Type of Problem (area)
- Insurance or Self-Pay
- DOB
- Address
- Email & Phone
- Insurance Details [injury claim, Medicare, Medicaid, VA, individual health, group health, Medicare Part C (MA)]

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Data Equals Action

- If self-pay or uninsured, need to develop a GFE
- If insured but service or technique is not covered need to inform patient and offer alternatives or provide estimate
- If insured and wants to know cost, need to offer and provide GFE
- If it is an injury claim need to confirm status of claim and whether doctor can take the case (WC or Auto)
- If Medicare or Medicaid or Medicare Advantage –need to consider network status of provider and inform patient accordingly

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Collect the Data & Offer

- Ask the questions
- Offer the Good Faith Estimate (if required)
- Book the Appointment
- Consult the Timeline for Delivery of GFE
- Develop, Deliver & Document

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Non-Compliance Penalty

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What's Next?

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Changes on the Horizon

- **Current** -a GFE is required for uninsured/self-pay patients or insured patients who are not using their insurance and includes only the expected charges from the provider who is actually providing the estimate
- **Future**- the departments are going to enforce a requirement that it includes the expected charges of other providers and other facilities that may be involved in the service other than the one that's scheduling the service
- **Future**- GFE will be required for all patients- insured, uninsured, and those opting not to use their insurance

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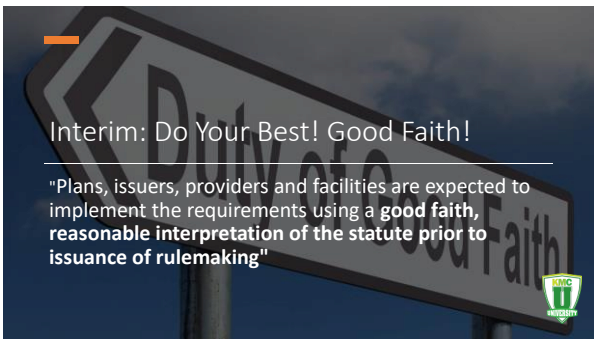

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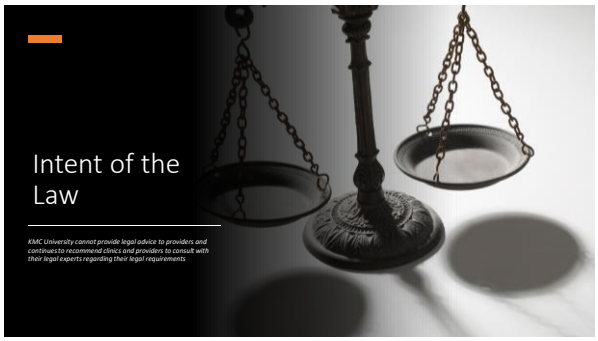

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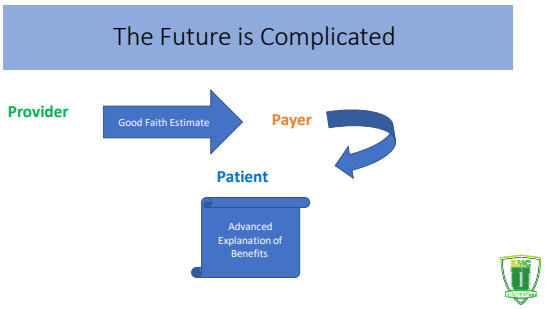

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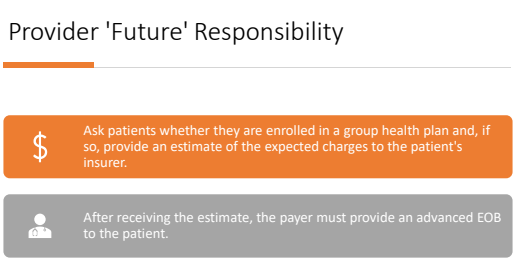

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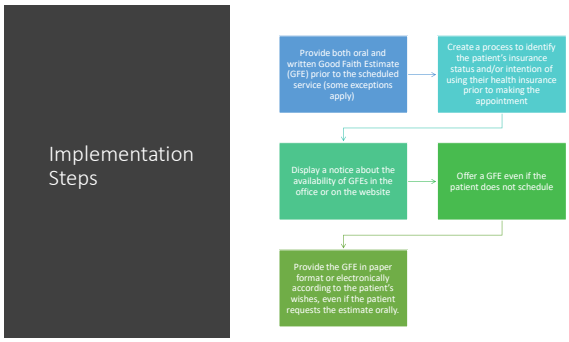

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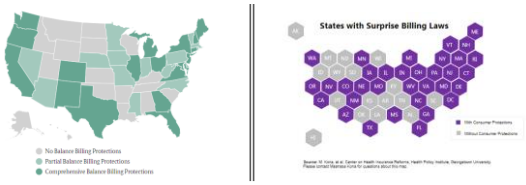
State Laws



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Resources

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Recommendations

Stay Alert to Educational Opportunities	Know Your Fees & Compliance Obligations	Build a Financial Report of Findings Process
Include a Good Faith Estimate in the Intake Process	Patient Rights Posted in the Clinic	Patient Rights on Surprises Act Posted on Your Website

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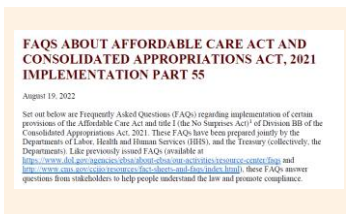
For Nerds Like Us



FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 55

August 19, 2022

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act and title I (the No Surprises Act)[1] of Division BB of the Consolidated Appropriations Act, 2021. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

Full FAQ of how the ACA blends with the NSA

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