



# Surprise Billing Laws Toolkit for the Indiana Hospital Association

UPDATED OCTOBER 2022

Contact:

Angela Smith (317) 977-1448 [asmith@hallrender.com](mailto:asmith@hallrender.com)

Matthew Reed (317) 429-3609 [mreed@hallrender.com](mailto:mreed@hallrender.com)



## **DEAR IHA MEMBER,**

As of January 1, 2022, hospitals and other healthcare providers are required to comply with a variety of new federal requirements designed to address “surprise” medical bills. These requirements differ in part from the state legislation that was originally passed by the Indiana General Assembly in 2020, and subsequently amended in 2021 and in 2022. Angela Smith and Matthew Reed are attorneys with Hall Render who helped IHA develop the following toolkit to assist IHA members in responding to the evolving legislative and regulatory landscape addressing out-of-network reimbursement, balance billing protections, and good faith estimates. This toolkit includes template documents that can be adapted by hospitals to assist in complying with current state and federal requirements. However, the information provided in this toolkit is not intended to be legal advice, and we strongly recommend that hospitals consult legal counsel to resolve any questions and ensure ongoing compliance.

Please note that the federal Departments of Labor, Health and Human Services (“HHS”), and the Treasury (collectively, the “Departments”) announced that they will defer enforcement of some requirements and issue additional rulemaking and guidance in the future. Therefore, we expect that the following analysis and recommendations will need to be amended as new rules and additional guidance are issued. IHA will continue to follow these issues and inform its members of substantive developments in this area.

### **Documents included in the toolkit:**

#### **Summer 2022 Updates**

Page 3: Requirements Related to Surprise Billing: Final Rule

Page 4: Updated Model Document

Page 4: Updated Guidance

#### **Spring 2022 Updates**

Page 6: Texas Medical Association v. HHS

Page 6: Indiana House Enrolled Act 1238

#### **Frequently Asked Questions:**

Page 8: FAQs Regarding Balance Billing Prohibitions

Page 12: FAQs Regarding Out-of-Network Reimbursement and the Independent Dispute Resolution Process

Page 18: FAQs Regarding Good Faith Estimates

Page 22: FAQs Regarding Patient-Provider Dispute Process for Uninsured and Self-Pay Patients

Page 24: Required Disclosures and Notices Chart

## SUMMER 2022 UPDATES

### **REQUIREMENTS RELATED TO SURPRISE BILLING: FINAL RULE**

On August 26, 2022, the Departments published their [first final rule](#) implementing certain requirements of the federal No Surprises Act (the “Final Rule”). This Final Rule is narrow in scope and responds to stakeholder comments related to the federal independent dispute resolution (“IDR”) process and the need for health plans to provide greater transparency into how they determine the qualifying payment amount (“QPA”). The Final Rule specifically creates the following new regulatory requirements:

- In light of the holding in *Texas Medical Association v. HHS* (see Spring 2022 Updates), the Departments revised the regulatory framework to be used by a Certified IDR Entity for determining the appropriate out-of-network rate by removing the presumption in favor of the QPA. Instead, the Certified IDR Entity must first consider the QPA for the applicable year for the same or similar item or service, and then must also consider all additional information submitted by a party related to each of the factors enumerated under the No Surprises Act to determine which of the two proposed rate offers best reflects the value of the item or service at issue. The Final Rule includes multiple examples to illustrate how the various factors should be considered by a Certified IDR Entity when making such a determination.
- When considering the information submitted by the parties, the Certified IDR Entity is to avoid double counting factors that are already accounted for by the QPA (such as patient acuity or the complexity of furnishing the item or service, unless there is a disagreement between the parties regarding whether such factor is appropriately represented in the QPA).
- Following the conclusion of the IDR process, the Certified IDR Entity must provide a written explanation of its determination, including the information the Certified IDR Entity determined demonstrated that the offer selected best represents the value of the out-of-network item or service, including the weight given to the QPA and any additional credible information submitted by the parties. Additionally, if the Certified IDR Entity relied on additional information when selecting the appropriate out-of-network rate, it must include an explanation as to why this information was not already reflected in the QPA.
- Plans and issuers are now required to disclose additional information with each initial payment or notice of denial of payment for out-of-network services if the plan or issuer “down-codes” the billed claim. Specifically, when a plan or issuer calculates the QPA based on a down-coded service code or modifier, the requisite explanation of payment or denial that must accompany an initial payment or notice of denial of payment is required to include: (i) a statement that the claim was down-coded; (ii) an explanation of why the claim was down-coded; (iii) a description of which service codes were altered and which modifiers were altered, added, or removed, as applicable; and (iv) the amount that would have been the QPA had the service code or modifier not been down-coded.

The foregoing requirements will go into effect on October 25, 2022.



The Departments acknowledged that the Final Rule was “purposefully narrow in scope” and therefore did not address comments related to other provisions of the No Surprises Act, such as the requirements related to the provision of good faith estimates to insured individuals and other provisions included in the previous No Surprises Act interim final rules.

## UPDATED MODEL DOCUMENTS

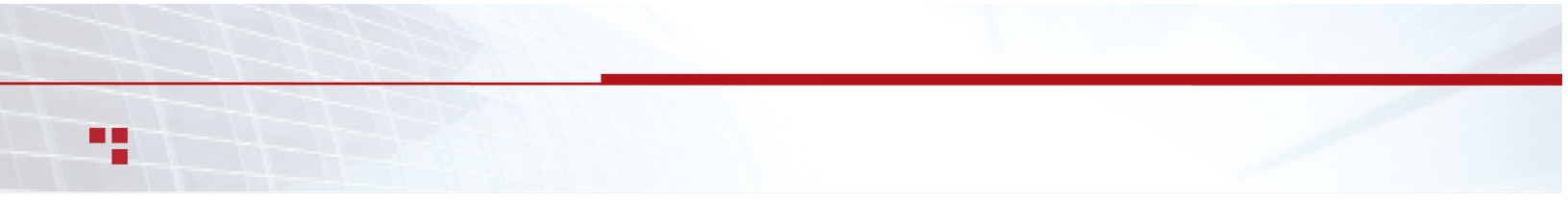
In response to comments from interested parties, the Departments updated the Model Disclosure Notice Regarding Patient Protections Against Surprise Billing (Attachment A), which providers and facilities may use to notify individuals of their protection against surprise medical bills in order to comply with the regulatory notice requirement under the No Surprises Act. Although providers and facilities are not required to use this model disclosure notice, so long as the notice they provide to patients complies with the requirements under the No Surprises Act, **HHS will consider providers’ and facilities’ use of the updated model disclosure notice to be good faith compliance with the No Surprises Act’s disclosure requirements beginning on or after January 1, 2023.**

Similarly, the Departments updated the Standard Notice and Consent Document (Attachment B) under the No Surprises Act, which providers and facilities must use when providing notice and seeking consent from individuals to waive their protections against surprise medical bills. **The revised version of the notice and consent document must be used starting January 1, 2023.**

## UPDATED GUIDANCE

On August 19, 2022, the Departments also published [“FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55.”](#) These FAQs attempt to respond to some commonly posed questions regarding the practical effect of the No Surprises Act in various situations. The FAQs include the following updated guidance:

- The prohibition on balance billing for out-of-network emergency services and air ambulance services under the No Surprises Act does apply to beneficiaries of group health plans and health insurers that do not have a network of providers (such as plans that use reference-based pricing). However, the limitation on cost-sharing for non-emergency services rendered by a non-participating provider at a participating facility does not apply if a plan doesn’t have a network of participating facilities.
- The No Surprises Act’s billing protections do apply to emergency services, non-emergency services furnished by a non-participating provider at a participating facility, and air-ambulance services if such services are otherwise covered by a health plan, even if the plan generally does not provide out-of-network coverage. Therefore, if a health plan covers any benefit for these services, it must cover the services even when rendered by a non-participating provider or facility (as applicable) in accordance with the cost-sharing, payment amounts, and IDR procedural requirements related to billing disputes set forth in the No Surprises Act, even if the health plan does not otherwise cover out-of-network services.

- 
- Health plans are required to calculate separate median contracted rates (and consequently separate QPAs) by provider specialty in instances where their contracting process sets or otherwise results in different rates for different specialties.
  - A provider or facility may not initiate the open negotiation period of the IDR process prior to receiving an initial payment or notice of denial of payment from the applicable health plan. If the provider or facility is concerned about a health plan's failure to timely issue an initial payment or provide notice of a denial of payment for services, it can submit a billing complaint through the No Surprises Act website.
  - The initial payment issued by a health plan for services covered under the No Surprises Act does not have to equal the QPA. When there is no specified state law or All-Payer Model Agreement, the initial payment issued by the health plan is required only to be an amount that the health plan reasonably intends to be payment in full based on relevant facts and circumstances and as required under the terms of the plan or coverage.
  - If a health plan intends to deny coverage for a service provided by a nonparticipating provider or facility that is subject to the requirements of the No Surprises Act, the health plan must provide written notice to the provider or facility stating that payment for the item or service will not be made and explaining the reason for such denial. If it wishes to dispute the amount of an initial payment or a denial of payment for services subject to the No Surprises Act, a nonparticipating provider or facility may do so by initiating the IDR process. A notice of denial of payment for services subject to the No Surprises Act differs from an "adverse benefit determination," which may be disputed through a plan's or issuer's claims and appeals process.
  - If a health plan fails to provide the information it is required to provide when making an initial payment or notice of denial of payment for services covered by the No Surprises Act, the nonparticipating provider or facility can either: (1) initiate the IDR process without first receiving that information; or (2) request an extension to initiate the IDR process until the information is provided. Importantly, the guidance provides that failure by either party to supply information required to be submitted under the No Surprises Act may lead to the Certified IDR Entity either not taking the absent information into consideration when making its findings or inferring that the absent information is adverse to the party who failed to produce it.

## **SPRING 2022 UPDATES**

### **TEXAS MEDICAL ASSOCIATION V. HHS**

On February 23, 2022, the U.S. District Court for the Eastern District of Texas (the “Court”) vacated key portions of the interim final rule implementing the IDR process under the No Surprises Act. Specifically, the Court found that, in the interim final rule, HHS exceeded its authority when it generally required the Certified IDR Entity to determine the appropriate rate for out-of-network services by choosing the offer of either the health plan or the provider that is closest to the health plan’s median contracted rate, otherwise known as the QPA, unless the Certified IDR Entity determines, based on credible information submitted by the parties, that the QPA is materially different from the appropriate out-of-network rate. The Court found that this HHS’ presumption in favor of the QPA is inconsistent with the language of the No Surprises Act and “rewrites clear statutory terms.” Therefore, the Court vacated all provisions within the interim final rule that require the Certified IDR Entity to presume that the offer closest to the QPA is the appropriate out-of-network rate.



Consequently, in determining whether the health plan’s offer or the provider’s offer is to be the appropriate rate for items or services provided by an out-of-network provider to a covered individual, a Certified IDR Entity must *equally consider* all factors listed within the text of the No Surprises Act in light of any credible information provided by the provider and the health plan, including:

1. The QPA;
2. The level of training, experience and quality and outcomes measurements of the provider or facility;
3. The market share held by the out-of-network provider, facility or health plan;
4. The acuity of the individual receiving such out-of-network item or service;
5. The teaching status case mix and scope of services of the out-of-network facility;
6. Evidence of efforts of the out-of-network provider and insurer to enter into a network agreement during the previous 4 years; and
7. Any other credible information related to the offer which the party wishes the Certified IDR Entity to consider in making their determination.

On February 28, 2022, the Departments issued a memorandum regarding the Court’s ruling and indicated their intent to withdraw guidance documents that were based on or referred to the portions of the interim final rule that the Court invalidated, effectively immediately. The Departments also announced their intent to provide training on the revised guidance for certified IDR entities. This Surprise Billing Laws Toolkit has been updated accordingly, and references to the presumption that the QPA is the appropriate out-of-network rate have been removed.

### **INDIANA HOUSE ENROLLED ACT 1238**

On March 18, 2022, Governor Holcomb signed into law House Enrolled Act 1238 (“HEA 1238”). In part, HEA 1238 amended relevant Indiana code provisions to state that health care practitioners and facilities can satisfy the Indiana-specific balance billing and good faith estimate requirements by complying with the requirements of the federal No Surprises Act, effective July 1, 2022.



There are certain discrepancies between the state and federal laws that could result in differing interpretations and potentially, legal challenges in the future.<sup>1</sup> However, it is not unreasonable to interpret the amended law to state that, so long as each provider and facility is in compliance with the federal No Surprises Act requirements, they will not need to comply with the Indiana-specific laws concerning balance billing and good faith estimates.

Consequently, with the understanding that Indiana providers and facilities will be in compliance with the federal No Surprises Act, this Surprise Billing Laws Toolkit, including the model forms, have been amended to remove references to those Indiana specific requirements, based on our current interpretation of the amendments made by HEA 1238. **Due to the delayed effective date of HEA 1238, members should begin using the updated model forms on July 1, 2022.**

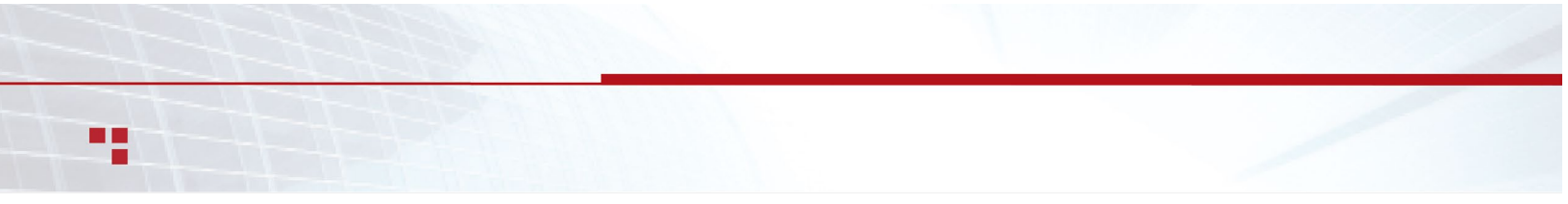
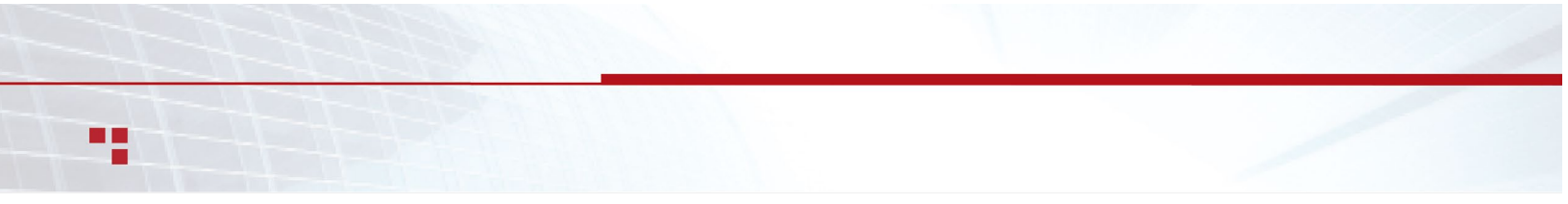
---

<sup>1</sup> For instance, HEA 1238 states that practitioners and facilities can satisfy Indiana law requirements related to both good faith estimates and balance billing for out-of-network services by complying with the requirements set forth in Section 2799B-6 of the Public Health Service Act (a section of the federal law that addresses only the provision of good faith estimates upon request and for scheduled appointments). Additionally, the new provisions do not expressly exempt providers and facilities who comply with the federal law from also complying with certain, more restrictive, requirements in Indiana law. The definitions of “practitioner,” “provider,” “facility,” and “provider facility” also differ between the federal and state laws.

## FAQS REGARDING BALANCE BILLING PROHIBITIONS (UPDATED OCTOBER 2022)


1. **Is balance billing strictly prohibited for *all* out-of-network emergency services?** Yes. The No Surprises Act prohibits balance billing for any emergency service (including further examination and treatment to stabilize an emergency condition) provided in a hospital, off-campus hospital emergency department, or freestanding emergency department.
2. **Can an out-of-network facility and/or out-of-network provider balance bill for services *after* an emergency condition is stabilized?** Sometimes. A provider is prohibited from balance billing for all services provided to a patient following the stabilization of an emergency medical condition (“post-stabilization services”) unless *all* of the following conditions are satisfied:
  - a. The treating physician determines that the patient is medically able to travel to a participating provider or facility within a reasonable distance, without requiring emergency medical transportation;
  - b. The out-of-network facility (or out-of-network provider) satisfies all of the requisite notice and consent criteria described in question 9; and
  - c. The patient is capable of understanding the notice and freely provides informed consent to waive the balance billing protections.
3. **Can an out-of-network facility balance bill for non-emergency services?** Yes. Current laws do not prohibit an out-of-network facility from balance billing for non-emergency services. However, as discussed in question 2, balance billing for post-stabilization services is conditional.
4. **Can an out-of-network provider balance bill for non-emergency services in a participating facility?** Sometimes. Under the No Surprises Act, out-of-network providers are prohibited from balance billing for services provided in a participating hospital, hospital outpatient department, critical access hospital, and ambulatory surgery center (each a participating “Facility”). However, an out-of-network provider may balance bill for services provided in a participating Facility *if* the participant voluntarily waives his or her legal protections after full compliance with the requisite notice and consent process described in question 9. Notwithstanding the foregoing, out-of-network providers are never permitted to balance bill for “ancillary services” and certain other services described in questions 5 and 6. Additionally, an out-of-network provider may only bill for post-stabilization services if they satisfy each of the conditions described in question 2.
5. **Can an out-of-network provider balance bill for “ancillary services” provided in a participating Facility?** No. Out-of-network providers who provide ancillary services in a participating Facility may not balance bill a patient for any amount beyond the in-network cost sharing amount for such services. “Ancillary services” include diagnostic services (such as radiology and laboratory); items and services related to Emergency Medicine, Anesthesiology, Pathology, Radiology, Neonatology; and items and services provided by assistant surgeons, hospitalists, or intensivists.



- 
- 
6. **Are there other circumstances where out-of-network providers are strictly prohibited from balance billing for nonemergency services?** Yes. Out-of-network providers may not balance bill for items and services rendered in a participating Facility if: (i) there is no in-network provider available to furnish those items and services at the participating Facility, or (ii) the items or services are for unforeseen urgent medical needs.
  7. **Do the balance billing restrictions apply to all non-emergency services, regardless of the location?** No. The prohibition on balance billing for non-emergency services applies only when an out-of-network provider renders nonemergency services at a participating facility (i.e., hospital, hospital outpatient department, critical access hospital, or ambulatory surgery center).
  8. **Are facilities and providers required to notify patients of the balance billing restrictions?** Yes. Hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgery centers, and out-of-network providers who provide services in those Facilities , or in connection with visits to such Facilities, are required to provide a disclosure that includes the following information in clear and understandable language: (i) the restrictions on providers and facilities regarding balance billing in certain circumstances, (ii) any applicable state law protections against balance billing, and (iii) 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.

We have adapted a model disclosure form developed by CMS that can be used to satisfy this requirement. (See **Attachment A**). **Note: Attachment A was updated on October 12, 2022, to reflect the updated model disclosure form developed by CMS. Although providers and facilities are not required to use this model disclosure notice so long as the notice they provide to patients complies with the requirements under the No Surprises Act, HHS will consider providers' and facilities' use of the updated model disclosure notice to be good faith compliance with the No Surprises Act's disclosure requirements beginning on or after January 1, 2023.**

The disclosure must be provided in three ways: (i) the disclosure or a link to the disclosure must be posted on the provider's or facility's public website, (ii) prominently displayed in a location where patients check in or scheduling typically occurs, and (iii) given to covered individuals in a health plan, who receive items or services furnished in a participating hospital, hospital outpatient department, critical access hospital, or ambulatory surgery center, and provided in-person, by mail, or by email, as selected by the individual.

- 
9. **If allowed, how does an out-of-network Facility (for post-stabilization services) or an out-of-network provider (for post-stabilization or non-emergency services in a participating Facility) attain the patient’s waiver of the balance billing protections?** Facilities and providers must use the standard notice form developed by HHS. (See **Attachment B**). **Note: Attachment B was updated on October 12, 2022, to reflect the updated standard notice form developed by HHS. The updated form must be utilized starting January 1, 2023.** This document may *not* be modified, except to delete the bracketed language and to add information identifying the provider, the patient, and a good faith estimate of the items and services expected to be provided by the out-of-network Facility and/or provider(s). The document must meet language access requirements, and a representative must be available to explain it and answer any questions. The notice form includes a consent form, which a patient must sign and return to the provider, prior to the provision of the service, if the patient is to consent to be balance billed for the service. The completed form must be provided to the patient or their authorized representative at least 72 hours prior to the patient’s scheduled appointment. If there are fewer than 72 hours between the scheduling of the service and the service itself, consent must be obtained on the day the services are scheduled, but at least 3 hours prior to services being rendered. Finally, a copy of the signed consent must be provided to the patient in-person, by mail, or by email (as selected by the patient), and to the health plan of the patient, provided that notice to the health plan may be satisfied by attaching a copy of the signed consent form to the bill if the provider bills the patient directly. An incomplete consent form will be treated as a lack of consent, and balance billing protections will still apply to the patient.
10. **How will the participant’s cost-sharing responsibility be determined for services for which an out-of-network provider is prohibited from balance billing?** To determine a participant’s cost-share liability for services for which an out-of-network provider is prohibited from balance billing, the provider must apply the patient’s in-network cost-share obligation to the “recognized amount.” The “recognized amount” is equal to an amount determined by (1) an All-Payer Model Agreement, (2) a specified state law, or (3) the lesser of the amount billed by the out-of-network provider, or the QPA.

Currently, Indiana is not a part of an All-Payer Model Agreement, nor has Indiana enacted a specified state law that otherwise determines the appropriate out-of-network rate for an item or service. Therefore, the “recognized amount” for services provided in Indiana by out-of-network providers will be based on the lesser of the billed charges or the QPA. Generally, the QPA for a given item or service is determined by finding the median of the contracted rates recognized by the health plan on January 31, 2019, for: (i) the same or a similar item or service, (ii) that is provided by a provider in the same or similar specialty, (iii) is provided in the same geographic region in which the item or service is furnished, and (iv) increased annually for inflation. A participant’s health plan is responsible for establishing the QPA and will state their calculated QPA in their initial payment or denial for an out-of-network item or service. Importantly, a health plan is required to calculate separate QPAs for different provider specialties in instances where the health plan either specifically sets different rates for the same services based on a provider’s specialty, or in instances where the health plan’s contracting process otherwise results in different rates for the same item or service based on a provider’s specialty.

Finally, in order to determine the participant's cost-share responsibility, the patient's in-network cost-share obligation will be applied to the QPA for the item or service. For example, if a patient has an in-network 10% coinsurance obligation, and the QPA is determined by the health plan to be \$100, the patient's cost-share responsibility for the service will be \$10.

11. **(New October 2022) Do the balance billing protections apply to patients who are members of reference-based pricing plans which do not have a network of providers or facilities?** It depends on the nature of the services. Nonparticipating providers and facilities are prohibited from balance billing patients who are members of a health plan that does not have a network of providers for the receipt of emergency services. However, the provisions that prohibit nonparticipating providers from balance billing patients for non-emergency services at a participating facility do not apply when a health plan has no network of participating facilities.
12. **(New October 2022) How is the QPA established for reference-based pricing plans which do not have a network of providers?** Non-network plans will establish the QPA based on the in-network amounts paid by other group health plans for the relevant items and services furnished in the applicable geographic region. Specifically, the referenced based pricing plan will utilize an eligible database to identify the median of the in-network rate paid by group health plans for the same or similar item or service, provided in the same geographic region, in the year immediately preceding the year in which the item or service is furnished to the non-network plan member, and then increase that median rate by the percentage increase of the consumer price index for all urban consumers for the preceding year.
13. **(New October 2022) Do the balance billing provisions of the No Surprises Act apply in cases where a health plan generally does not provide out-of-network coverage?** Yes, so long as the service is a covered service under the health plan when provided by an in-network provider or facility. The No Surprises Act's billing protections apply to emergency services, non-emergency services furnished by a non-participating provider at a participating facility, and air-ambulance services, if such services are otherwise covered by a health plan, even if the plan generally does not provide out-of-network coverage. Therefore, if a health plan covers these services when rendered by a participating provider or facility, it must also cover the services even when rendered by a non-participating provider or facility, in accordance with the cost-sharing, payment amounts and IDR procedural requirements related to billing disputes set forth in the No Surprises Act, even if the health plan does not otherwise cover out-of-network services. In such a scenario, the health plan will be required to issue an initial payment which the health plan reasonably intends to be payment in full based on relevant facts and circumstances or a notice of denial of payment. If a health plan fails to provide either an initial payment or a notice of denial of payment in accordance with the requirements of the No Surprises Act, the provider or facility can issue a complaint by calling the No Surprises Help Desk at 1-800-985-3059 or by submitting the complaint online at <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint>.

## FAQS REGARDING OUT-OF-NETWORK REIMBURSEMENT AND THE INDEPENDENT DISPUTE RESOLUTION PROCESS (UPDATED OCTOBER 2022)

1. **What is the timeframe for health plans to provide payment for those services protected by the No Surprises Act?** A health plan is required to send an initial payment or notice of denial within 30 calendar days of receiving a bill from a nonparticipating provider or facility.
2. **Is the initial payment required to be equal to the QPA?** No. The initial payment is to be either: (1) an amount provided in an All-Payer Model Agreement, (2) an amount determined by a specified state law, or (3) the amount determined through the federally mandated independent dispute resolution (“IDR”) process. Indiana does not have either an All-Payer Model Agreement or a specified state law that can be used to determine the appropriate out-of-network rate for services provided by out-of-network providers. Therefore, the appropriate out-of-network rate for items and services provided by out-of-network facilities (for emergency services) and out-of-network providers (for emergency services and, absent a waiver, for non-emergency services in a participating Facility) will be determined through the federally mandated IDR process. Importantly, in such a situation, the initial payment is only required to be an amount that the health plan reasonably intends to be payment in full for the out-of-network item or service based on relevant facts and circumstances and as required under the terms of their plan or coverage. The initial payment is not required to equal the QPA.
3. **Is a health plan required to justify a denial of payment for services protected under the No Surprises Act?** Yes, if a health plan denies coverage for a service that is subject to the requirements of the No Surprises Act, the health plan must provide written notice to the provider or facility stating that payment for the item or service will not be made and explaining the health plan’s reasoning for the denial of payment. A provider or facility that receives such a denial of payment is permitted to initiate the federal IDR process to determine the appropriate out-of-network rate.

Please note, a notice of denial of payment does not include a notice of an “adverse benefit determination,” which may be disputed through a plan’s or issuer’s claims and appeals process.

4. **What information must the health plan include on an initial payment or notice of denial of payment?** A health plan must include the following information within the initial payment or notice of denial of payment:
  - a. The QPA for each item or service involved;
  - b. A statement certifying that the QPA applies for purposes of determining the patient’s cost-share liability;
  - c. A statement certifying that each QPA was determined in compliance with the No Surprises Act;
  - d. If the QPA is based on a down-coded service code or modifier;
    - i. a statement that the service code or modifier billed by the provider or facility was down-coded;



- ii. an explanation as to why the claim was down-coded, which must include a description of which service codes or modifiers were altered; and
  - iii. the amount that would have been the QPA had the service code or modifier not been down-coded; and
- e. A statement that if the provider or facility wishes to initiate the 30-day open negotiation period of the IDR process (see question 6 below), the provider or facility may contact the appropriate health plan employee or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a resolution, the provider or facility may initiate the federal IDR process within 4 business days after the end of the open negotiation period (see Question 7 below).

5. **What can a provider or facility do if a health plan fails to provide the information required on the initial payment or notice of denial of payment?** If a health plan fails to provide the information it is required to provide when making an initial payment or notice of denial of payment, the provider or facility can either: (1) initiate the IDR process without first receiving that information; or (2) request an extension to initiate the IDR process until such information is provided.

Importantly, if a party fails to supply information that is required to be submitted, the Certified IDR Entity may either exclude the absent information from consideration or infer that the absent information is adverse to the party who failed to produce that information.

Additionally, a provider can issue a complaint against the health plan for failure to provide the correct information on the initial payment or notice of denial as required by the No Surprises Act by calling the No Surprises Help Desk at 1-800-985-3059 or by submitting the complaint online at <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint>.

6. **In the event an out-of-network facility (for emergency services) or an out-of-network provider (for emergency services and, absent a waiver, for non-emergency services in a participating Facility) does not find the initial payment (or denial of payment) or services subject to the No Surprises Act to be acceptable, how would the out-of-network facility or out-of-network provider initiate the federal IDR process?** If the provider is unwilling to accept the initial payment or denial, the provider can initiate the federal IDR process by initiating a mandated open negotiation period between the parties by sending the health plan an “open negotiation notice” within 30 business days from the date the provider receives the initial payment or notice of denial.

The Departments have developed an [“open negotiation notice”](#) which providers must complete and utilize to initiate negotiation between the parties. The open negotiation notice must include: (1) information to identify the items or services subject to negotiation, including the day the item or service was furnished and the service code; (2) the initial payment amount or the notice of denial of payment; (3) the provider’s offer for the appropriate out-of-network rate; and (4) contact information of the provider.

After the health plan receives the open negotiation notice, the health plan and the provider must attempt to mutually agree upon an appropriate out-of-network rate for the items or services in

question for 30 business days (the “open negotiation period”). If the parties cannot reach an agreement within the open negotiation period, then the out-of-network rate will be determined through the federally mandated IDR process, as described in question 2.

7. **How will the IDR process work<sup>2</sup>?** If there is no agreement on the out-of-network rate by the end of the open negotiation period, either party has 4 business days to initiate the IDR process by providing a “notice of IDR initiation” to the other party and to the Departments (through the [federal IDR portal](#)). The Departments have developed a standard [Notice of IDR Initiation](#) that the initiating party must complete and use to initiate the IDR process.

Upon receipt of the Notice of IDR Initiation, the parties will have 3 business days to mutually select a Certified IDR Entity from a list of IDR entities on the federal IDR portal. If the parties do not mutually select a Certified IDR Entity, the Departments will randomly select one for them. Upon selection, each party will have 10 business days to submit an offer to the Certified IDR Entity for the amount that the party believes is the appropriate out-of-network rate for the item or service. The offer must be in the form of a dollar amount and the corresponding percentage of the QPA.

In addition to the offer, the parties must submit the following information for consideration by the Certified IDR Entity:

- (a) Any information requested by the Certified IDR Entity relating to the offer or the items or services provided;
- (b) The size of the provider’s practice;
- (c) The coverage area of the health plan;
- (d) Whether the health plan is fully-insured, or partially or fully self-insured;
- (e) The relevant geographic region for purposes of the QPA; and
- (f) Any other credible information related to the offer which the party wishes the Certified IDR Entity to consider in making their determination.

In coming to its determination as to which of the two offers is the appropriate out-of-network rate, the Certified IDR Entity must weigh the factors, described below in question 8, in light of the credible information submitted by the parties.

Within 30 business days after being selected, the Certified IDR Entity must select an offer and provide a written decision, including detailed explanations of:

- (1) what information the Certified IDR Entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the item or service;

---

<sup>2</sup> On October 7, 2021, the Departments issued an interim final rule outlining the requirements for the independent dispute resolution process for determining the appropriate out-of-network reimbursement for covered individuals. HHS intends to provide additional guidance about this process, including information concerning how IDR entities are to conduct the evaluation of various factors submitted for consideration. Only a summary of the process is provided herein.

- (2) the weight given to the QPA and any other credible information in selecting the appropriate out-of-network rate; and
- (3) if the Certified IDR Entity relied on information that is not the QPA in selecting the appropriate offer, why the Certified IDR Entity concluded that the information relied upon was not already reflected in the QPA.

If the Certified IDR Entity determines the appropriate out-of-network rate is greater than the health plan's initial payment, the health plan will have 30 calendar days to issue any additional payment to the provider. Conversely, if the Certified IDR Entity determines the appropriate out-of-network rate is less than the initial payment issued by the health plan, the provider will have 30 days to return any overpayment to the health plan.

8. **What factors will the Certified IDR Entity consider when determining which offer to choose as the appropriate out-of-network reimbursement for the item/service provided by the out-of-network provider?** The Certified IDR Entity is to consider the following factors in determining the appropriate out-of-network rate for items or services provided by out-of-network providers in participating facilities to covered individuals:

- (a) The QPA;
- (b) The training, experience, quality, and outcome measurements of the provider;
- (c) The market share held by the nonparticipating provider or health plan;
- (d) The specific patient acuity and complexity;
- (e) The teaching status, case mix, and scope of services;
- (f) Good faith efforts of the parties to enter into network agreements and contracted rates during the previous 4 years; and
- (g) Any additional information submitted by a party, so long as it is credible and relates to the offer.

Please note, in order to avoid double counting information that has already been accounted for by the QPA (such as patient acuity or the complexity of furnishing an item or service), when considering the information submitted by each the parties in relation to the above factors, the Certified IDR Entity is not to consider information that has already been accounted for by the QPA. However, the Certified IDR Entity will consider any information necessary if there is a disagreement between the parties regarding whether such information has been appropriately represented in the QPA.

The Certified IDR Entity may *not* consider the following factors in this determination:

- (a) Usual and customary charges for the item or service;
- (b) The amount the provider would have billed for the items or services absent the surprise billing prohibition; and
- (c) Public payer reimbursement rates for the item or service.

9. **Who pays for the IDR process?** The party whose offer is not chosen by the Certified IDR Entity bears the full cost of the IDR process. In the event that the parties come to a mutual agreement regarding the appropriate out-of-network rate prior to the determination by the Certified IDR Entity, the

parties will equally bear all costs associated with the IDR process.

10. **Can multiple claims be consolidated and submitted through a single IDR process?** Sometimes. The No Surprises Act allows a health plan or a provider to “batch” like items and services and consider them jointly in one single IDR process, if the items or services in question are:
  - (a) Billed by the same provider;
  - (b) Paid by the same health plan;
  - (c) The same or similar items and services; and
  - (d) Provided within the same 30 business day period (or 90 calendar day period if provided during the “cooling-off period” as described in question 6).
  
11. **What is the “cooling off period”?** Once a Certified IDR Entity issues a determination, the No Surprises Act prohibits the party who initiated the IDR process from initiating a separate IDR process with that same opposing party for the same or a similar item or service for 90 calendar days. However, following the termination of this “cooling off period,” the initiating party may batch together all claims for those same or similar items or services provided during the cooling off period and initiate another IDR process against the same opposing party.



12. What are the relevant timeframes in which the different aspects of the IDR process must be completed?

FEDERAL IDR PROCESS TIMELINES		
Action	Timeframe	Responsible Party
Open Negotiation Notice	<b>30 Business Days</b> from the date of receipt of initial payment or denial	Provider (sent to Health Plan)
Open Negotiation Period	<b>30 Business Days</b> from the day provider sends the Open Negotiation Notice	N/A
Notice of IDR Initiation	<b>4 Business Days</b> from the end of the Open Negotiation Period	Either party (sent to the other party in writing; and submit to the Departments through the Federal IDR portal)
Selection of Certified IDR Entity (by parties)	<b>3 Business Days</b> from receipt of Notice of IDR Initiation  Notice of selection to be sent to the Departments and the Certified IDR Entity on the <b>4th Business Day</b> from receipt of Notice of IDR Initiation	Both parties to mutually select the Certified IDR Entity.  Initiating Party (to submit notice of selection through the Federal IDR Portal)
Selection of Certified IDR Entity (by Departments)	<b>6 Business Days</b> from receipt of the Notice of IDR Initiation, the Departments will select the Certified IDR Entity if the parties are unable to mutually select	Departments
Submission of Offer and Other Credible Information	<b>10 Business Days</b> from selection of the IDR Entity	Each party (submitted through the Federal IDR portal)
Payment of Certified IDR Entity Fee	At the time each party submits its offer to the IDR Entity	Each party to submit the entire fee, the prevailing party will have its fee remitted within <b>30 Business Days</b> from the date the IDR Entity issues its determination
Selection of Offer and Decision	<b>30 Business Days</b> from selection of the IDR Entity	IDR Entity (submitted through the Federal IDR portal)

Payment of Out-of-Network Rate	<b>30 Calendar Days</b> from the IDR Entity's determination	Health plan (if out-of-network rate is less than initial the payment)  Provider (if out-of-network rate is more than the initial payment)
"Cooling Off Period"	<b>90 Calendar Days</b> from the date of the IDR Entity's determination	Neither party may initiate the IDR process for the same or similar item or service with the same opposing party

## FAQS REGARDING GOOD FAITH ESTIMATES

1. **When do the federal good faith estimate requirements go into effect?** According to the No Surprises Act, on January 1, 2022, providers and facilities must comply with the good faith estimate ("GFE") requirements and advanced explanation of benefits that broadly require "providers" and "facilities" to provide a GFE of "expected charges" for all anticipated items and services to individuals both upon request *and* upon scheduling an item or service to be furnished. However, on August 20, 2021, the Departments stated in a set of frequently asked questions that they will defer enforcement of advanced explanation of benefits and GFE requirements related to participants of health plans ("Covered Individuals") until future rulemaking occurs.

2. **What federal GFE requirements will be subject to enforcement beginning on January 1, 2022?**

As of January 1, 2022, providers and facilities will be required to provide GFEs to ***uninsured and self-pay individuals*** for all scheduled services *and* upon request.

An "uninsured or self-pay individual" is:

- an individual who does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code; or
- an individual who has benefits for such item or service under a group health plan or individual or group health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code but who does not seek to have a claim for such item or service submitted to such plan or coverage; or
- An individual who is enrolled in short-term, limited duration insurance, but is not also enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program, or a health benefits plan under chapter 89 of title 5, United States Code.

3. **Are there state GFE requirements that still need to be addressed after the federal GFE requirements go into effect?** No. As further described on Page 3, although Indiana law contains its own good faith estimate requirements for certain providers and facilities, House Enrolled Act 1238 (2022) added provisions within the applicable chapters of the Indiana Code which state that a provider or facility may satisfy Indiana’s good faith estimate requirements by complying with the requirements of the federal No Surprises Act. Therefore, an Indiana provider or facility that is compliant with the federal good faith estimate requirements does not need to consider compliance with the Indiana-specific good faith estimate requirements.

4. **What type of facilities and providers must comply with the GFE requirements?** The GFE requirements apply to a much broader set of healthcare facilities and providers than the balance billing provisions of the federal No Surprises Act and do not distinguish between in-network and out-of-network providers.

For purposes of the federal GFE requirements for **uninsured and self-pay individuals**, the following must comply:

A "healthcare facility" or "facility" which includes 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) licensed by the State or approved by the State agency responsible for licensing such institution as meeting the established standards for licensing.

A "health care provider" or "provider" which 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.

5. **Do we have to change how we notify patients of their right to a GFE?** If the individual is uninsured or plans to self-pay for the items or services, the provider/facility must advise the individual, *both* verbally and in writing, that a GFE of expected charges will be provided upon scheduling and upon request.

In addition to informing all patients of their right to request a GFE both verbally and in writing, providers and facilities must also prominently display a written notice on their website and in the location where scheduling typically occurs. A slightly modified version of a CMS-developed model notice that can be utilized to satisfy this requirement is included as **Attachment C**.

6. **What triggers the need to actually provide a GFE to an uninsured/self-pay individual?** When scheduling a service, providers and facilities must determine whether a patient is a Covered Individual, and if so, whether he/she intends to submit a claim for the item or service at issue.

If the provider/facility determines that the individual is uninsured or intends to self-pay, the provider or facility is required to provide a GFE to the individual for all scheduled services **and** upon request. Importantly, providers/facilities must consider any discussion regarding the potential cost of

items/services to be a request for a GFE.

7. **What needs to be included in the GFE for the uninsured or self-pay individual?** The scope and specific content of the GFE will vary based on whether the provider or facility is considered to be a “convening provider/facility” or a “co-provider/facility.” A “convening provider/facility” receives the initial request for a GFE and is responsible for scheduling the primary item or service, while a “co-provider” furnishes items and services customarily provided in conjunction with the primary item or service. For example, if an uninsured patient requested a GFE from a hospital for a surgical procedure, the hospital would be the “convening facility” and the surgeon and anesthesiologist would be “co-providers.” Conversely, if an uninsured patient schedules a surgical procedure directly with their surgeon’s office, the surgeon would be considered the “convening provider,” the hospital or outpatient surgery center where the surgery would be conducted would be the “convening facility,” and the anesthesiologist and any other providers that would be billing separate from the surgeon would be “co-providers.”

Convening providers/facilities must determine whether the patient is a covered individual, and if so, whether the individual intends to submit a claim for the items or services at issue. If the individual is uninsured or plans to self-pay for the items or services, the convening provider/facility must advise the individual, both orally and in writing, that a GFE of expected charges will be provided upon scheduling and on request.

The convening provider is responsible for providing the GFE that includes the GFE for the primary requested item or service and an itemized list of all “items and services” reasonably expected to be provided by the co-providers and co-facilities involved in the scheduled services, during the “period of care.” Within 1 business day of the event that triggers the need to provide a GFE, the convening provider/facility must ask any and all co-providers/facilities reasonably expected to provide items or services in conjunction with the primary service to provide their own GFE of “expected charges” to the convening provider. However, between January 1, 2022, through December 31, 2022, 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. In the meantime, HHS has encouraged convening providers to include a range of expected charges for these items and services. During this period, an uninsured or self-pay individual may not initiate the dispute resolution process against a co-provider or co-facility for items and services to be provided by the co-provider/facility to the uninsured/self-pay individual which appear on the GFE but do not include an estimate of expected 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.

The Departments issued an interim final rule which includes very specific requirements as to what information needs to be included in the GFEs, and CMS has developed a GFE template form that can be used to comply with these requirements. IHA has slightly modified this form to include clarifying information from the Department’s interim final rule to ensure Indiana providers are in compliance with the federal GFE requirements uninsured and self-pay individuals. (See **Attachment D.**)



“Items or services” include 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. This includes items or services such as those related to dental health, vision, substance use disorders, and mental health.

“Period of care” means the day or multiple days during which the good faith estimate for scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished, regardless of whether the convening provider, convening facility, co-providers, or co-facilities are furnishing such items or services, and also includes the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished.


8. **Does the good faith estimate have to be given in a specific manner (e.g., mailed)?** Yes. Although providers and facilities may provide a verbal GFE to the patient, in order to comply with the applicable regulatory requirements, they must also provide a completed GFE by hard copy, email, or mobile app, based on the patient’s preference. Any GFE provided electronically must be in a manner that allows the patient to both save and print it.
  
9. **How much time do we have to provide a GFE to an uninsured/self-pay patient?** Providers and facilities are to provide GFEs to uninsured and self-pay patients for all scheduled services and upon request, within the following timeframes:
  - Within 3 business days after scheduling a primary item or service to be furnished to an uninsured (or self-pay) patient at least 10 days later; or
  - The next business day after scheduling a primary item or service to be furnished to an uninsured (or self-pay) patient at least 3 but less than 10 days later; or
  - Within 3 business days of receiving a request for a GFE by an uninsured (or self-pay) individual.
  - No GFE is required for items and service scheduled within < 3 business days prior to the appointment. However, the uninsured /self-pay patient can still request one.
  
10. **Are we supposed to maintain copies of the GFE’s we provide to patients?** Yes. The GFE is considered part of the patient’s medical record, and as such, the convening provider and facility must maintain each patient’s GFE in the same manner as the provider/facility maintains the rest of the patient’s medical record. Additionally, upon the request of a patient, a convening provider/facility must provide a copy of any GFE previously issued by the to the patient within last 6 years.

## FAQS REGARDING PATIENT-PROVIDER DISPUTE PROCESS FOR UNINSURED AND SELF-PAY PATIENTS

- 1. What happens if the actual charges exceed the GFE amount?** The Departments have included a process for uninsured and self-pay patients to dispute charges that are “substantially in excess” of the GFE, even if the increase in charges are due to items and services that were not originally listed on the GFE. “Substantially in excess” is defined as total billed charges that exceed the GFE by \$400 or more.
- 2. What if a convening provider doesn’t have the capability to include all of the items and services reasonably expected to be provided by a co-provider or co-facility by January 1, 2022?** The Departments have acknowledged that providers and facilities may need additional time to develop the necessary communication channels to enable a convening provider to timely provide a GFE that includes all the expected charges for items and services anticipated to be furnished by co-providers/co-facilities in conjunction with the primary services during a period of care. Therefore, between January 1, 2022, and December 31, 2022, HHS announced it will exercise its enforcement discretion in situations where a GFE provided to an uninsured or self-pay individual doesn’t include the expected charges of co-providers or co-facilities. In the meantime, HHS has encouraged convening providers to include a range of expected charges for these items and services.
- 3. What is the general process for resolving a billing dispute with an uninsured or self-pay patient?** Within 120 calendar days of receiving an initial bill for charges that exceed a GFE by at least \$400, an uninsured/self-pay patient may initiate the dispute resolution process by filing a completed patient-provider dispute initiation form through the federal IDR portal and paying an administrative fee, expected to be no more than \$25. Upon receipt, HHS will appoint a “Selected Dispute Resolution” (“SDR”) entity to adjudicate the dispute.

After validating whether the item or service is eligible for the process, the SDR entity will request documentation from the billing provider or facility as to the GFE, the billed charges, and any documentation demonstrating the medical necessity of the item or service at issue and any unforeseen circumstances that could not have been reasonably anticipated at the time the GFE was provided that may have contributed to the actual billed charges being substantially in excess of the GFE. In cases where unforeseen circumstances during treatment would reasonably result in higher than expected charges, the SDR entity may consider additional information to support charges for medically necessary items or services. Therefore, providers/facilities should provide a detailed, written explanation as to any change in circumstances, how it resulted in higher billed charges, and why the billed charge reflects the cost of a medically necessary item or service.

Considering the foregoing, the SDR entity will make a determination as to the amount the uninsured/self-pay individual must pay within 30 days of receiving all requested information from the provider/facility.

- 
4. **How will the SDR determine the amount payable for the items and services in dispute?** The SDR entity will review each unique item or service in the bill provided to the patient, and all documentation submitted by the patient and the provider or facility to determine whether the difference between the billed charges and the GFE:
- (a) reflects the cost of medically necessary items and services, and
  - (b) is based on changes in circumstances that the provider/facility could not have reasonably anticipated when the GFE was provided.

Specifically, in determining the correct payment for items and services which were originally included on the GFE, the SDR entity must adhere to the following rules:

- (a) If the billed charge is equal to or less than the expected charge, the payment amount is the billed charge;
- (b) If the billed charge is greater than the expected charge and the difference is not based on the cost of unforeseen, but medically necessary items/services, the payment amount is the expected charge;
- (c) If the billed charge is greater than the expected charge and the difference is based on items/services determined to be medically necessary and unforeseen, the payment amount is the lesser of:
  - (i) The billed charge; or
  - (ii) The median payment amount for the same or similar item/service, by the same or similar provider in the geographic area where the item/service was provided according to an independent database. However, if the amount determined by an independent database is less than the expected charge for the item or service listed on the GFE, the amount payable will equal the expected charge.

Similarly, in determining the correct payment for items and service which were not originally include don the GFE, the SDR entity must adhere to the following rules:

- (a) If the SDR entity determines that the billed charge does not reflect the cost of medically necessary items or services that were provided based on changes in circumstances that the provider/facility could not have reasonably anticipated when the GFE was provided, the amount paid is \$0; and
- (b) If the billed charge does satisfy the criteria for medically necessary items and services that were provided based on unforeseen circumstances, the payment amount is the lesser of:
  - (i) The billed charge; or
  - (ii) The median payment amount for the same or similar item/service by a same or similar provider in the geographic area where the item/service was provided according to an independent database.

## REQUIRED DISCLOSURES AND NOTICES CHART

No Surprises Act Applicable Form/Disclosure	Description of the Applicable Form/Disclosure	Public Disclosure Requirements?	Language Access Requirements?
<b><i>Forms related to the Balance Billing and Patient Cost-Sharing Protection Protections</i></b>			
<p>Standard Notice and Consent</p> <p><a href="#">An updated version of this form is found in Attachment B to the IHA Toolkit.</a></p>	<p>HHS developed a standard notice and consent form which is to be utilized in scenarios where a non-participating provider (or non-participating emergency facility) is seeking to obtain consent from the patient to balance bill.</p> <p><b>NOTE:</b> in August 2022, HHS updated the notice and consent form. The updated notice and consent form must be used starting January 1, 2023.</p> <p>The form cannot be modified except to add information identifying the provider or facility (as applicable), the patient and the contemplated items and services, or as needed to address state law.</p> <p>The notice must also contain a GFE amount the non-participating provider or facility may charge the patient for the items and services involved (including any item or service the provider reasonably expects</p>	<p>No.</p>	<p>Yes. <b><u>Must be made available in the 15 most common languages in the geographic region in which the provide/facility is located.</u></b> See Fed. Reg. 36909 (July 13, 2021). If the individual's preferred language is not among the 15 most common languages made available or the individual cannot understand the language in which the notice and consent document are provided, the individual must be provided with a qualified interpreter.</p>



	<p>to provide in conjunction with such items and services).</p> <p>Additionally, the notice must be physically separate from, and not attached to or incorporated into, any other documents. A flawed consent document will be treated as a lack of consent, and balance billing protections will still apply to the patient.</p> <p>The notice and consent form must be presented to the patient at least 72 hours prior to the patient's scheduled appointment for out-of-network services. If there are fewer than 72 hours between the scheduling of the service and the service itself, consent must be obtained on the day the services are scheduled, but at least 3 hours prior to services being rendered. A participating health care facility may present the notice on behalf of the non-participating provider. This requirement is <b><u>effective January 1, 2022.</u></b></p>		
Model Disclosure Notice Regarding Patient Protections Against Surprise Billing	The model disclosure form available here was developed by HHS for providers/facilities to comply with section 2799B-3 of the PHS Act which requires providers	Yes. To satisfy the public disclosure requirements, <b><u>by January 1, 2022,</u></b> the disclosure must be:	Yes. While the Model disclosure does not necessarily need to be made available in other languages, the facility <b><u>must take reasonable steps to ensure</u></b>



<p><a href="#">An updated version of this form is found in Attachment A to the IHA Toolkit</a></p>	<p>and facilities to make publicly available, post on a public website of the provider/facility, and provide a one-page notice that includes information 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.</p> <p><b>NOTE:</b> in August 2022, HHS updated model disclosure form. HHS will consider providers' and facilities' use of the updated model disclosure notice to be good faith compliance with the No Surprises Act's disclosure requirements beginning on or after January 1, 2023.</p>	<ul style="list-style-type: none"> <li>• Posted to the public website</li> <li>• Posted prominently where patients check-in for appointments or pay bills <ul style="list-style-type: none"> <li>○ To this end, we recommend posting the disclosure in the ED, hospital registration areas, and any area where patients pay bills.</li> </ul> </li> <li>• Provided to patients in-person, by mail, or via email, as selected by the individual no later than the date and time on which they request payment from the individual (including requests for copayment or coinsurance made at the time of the visit to the provider or facility). If the provider or facility does not request payment from the individual, the notice must be provided no later than the date on which the provider or facility submits a claim for payment to the plan or issuer.</li> </ul>	<p><b><u>meaningful access to individuals with limited English proficiency, including offering language assistance services such as translating written content into other languages.</u></b> See 86 Fed. Reg. 3 6913 (July 13, 2021).</p>
--	---	--	--

**Forms Related to No Surprises Act Good Faith Estimate Requirements**

The forms and related requirements below are specific to all uninsured and self-pay patients. Generally speaking, **effective January 1, 2022**, providers and facilities are required to provide a GFE of expected charges to **uninsured and self-pay patients** upon scheduling an item/service or upon request. Note, HHS

has deferred enforcement of the GFE requirements for insured individuals who intend to submit a claim to the plan for scheduled items/services until future rulemaking is issued.

<p>Standard Notice Right to Receive a Good Faith Estimate</p> <p><a href="#">An updated version of this form is found in Attachment C to the IHA Toolkit</a></p>		<p>Yes. <b><u>This form must be displayed on the provider/facility’s website, in the office and on-site where scheduling or questions about health care occur.</u></b> Information regarding the availability of a GFE for uninsured and self-pay <b><u>must be provided in writing and verbally.</u></b> See 86 Fed. Reg. 56016</p>	<p>Yes. The form <b><u>must be available in accessible formats and languages spoken by individuals considering or scheduling items/services with the convening provider/facility.</u></b> See 86 Fed. Reg. 56016 (October 7, 2021).</p>
<p>Model Good Faith Estimate</p> <p><a href="#">An updated version of this form is found in Attachment D to the IHA Toolkit</a></p>	<p>This form is required for uninsured patients or insured individuals who are considered self-pay (i.e., the insured individual elects not to submit a claim to his/her health plan for the item/service and instead wishes to pay out of pocket).</p> <p>If the patient is insured and intends to submit a claim to the plan for the item/service, this form is NOT required at this time.</p> <p>HHS developed a model GFE form available <a href="#">here</a>. To use the model form, the provider/facility must fill in the blanks with the appropriate information. HHS considers use of the model form to be good faith compliance with the</p>	<p>No.</p>	<p>Yes.</p> <p>Providers and facilities make these efforts to provide GFE information in a manner understandable to the uninsured (or self-pay) individual to help achieve the goal of the statute and ensure that uninsured (or self-pay) individuals are aware of the GFE information and the options available to them.</p> <p>HHS is of the view that when providing a GFE, <b><u>providers or facilities should also take into account any vision, hearing, or language limitations; communication needs of underserved</u></b></p>



	<p>GFE requirement (to inform uninsured/self-pay patients of expected charges), though note that use of this exact model notice form is not required. Additionally, CMS has included an Appendix (included in the CMS zip file) which identifies data elements that providers/facilities are required to include in the GFE. Compliance with this requirement is <b><u>effective January 1, 2022.</u></b></p> <p>However, from January 1, 2022 – December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE does not include expected charges for items/services from a co-provider or co-facility. Those data elements must be included effective January 1, 2023.</p>		<p><b><u>populations; individuals with limited English proficiency; and persons with health literacy needs.</u></b> These factors meaningfully contribute to whether the uninsured (or self-pay) individual can understand and ask any questions about the total expected costs for items or services. Providers and facilities are also required to comply with other state and Federal laws regarding language access, to the extent applicable.</p> <p><b><u>Providers and facilities must take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include provision of language assistance services such as providing qualified interpreters, written or sight translation of written GFEs in paper or electronic form into languages other than English.</u></b> When language assistance services are provided, they must be provided free of charge and be accurate and timely.</p> <p>See 86 Fed. Reg. 56021 (October 7, 2021).</p>
--	--	--	--

