DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

December 21, 2021

The Honorable Asa Hutchinson
Governor of Arkansas
State Capitol Room 250
500 Woodlane Ave.
Little Rock, AR 72201

Commissioner Alan McClain
Arkansas Insurance Department
1 Commerce Way
Little Rock, AR 72202

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Dear Governor Hutchinson and Commissioner McClain:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) understands that Arkansas has authority and intends to enforce certain provisions of the Public Health Service Act (PHS Act) as extended or added by the Consolidated Appropriations Act, 2021 (CAA) with respect to issuers, and that CMS will directly enforce certain PHS Act provisions extended or added by the CAA in Arkansas with respect to issuers, providers, and facilities. This letter also explains that the federal independent dispute resolution and patient-provider dispute resolution processes will apply in Arkansas. Additionally, this letter reflects CMS's determination that the Arkansas external review process currently does not have the capability to address adverse determinations related to the surprise billing protections of the No Surprises Act under section 2719 of the PHS Act, as extended by Section 110 of the No Surprises Act, consistent with 45 CFR 147.136, as amended by the Requirements Related to Surprise Billing; Part II (86 FR 55980).

The CAA was enacted on December 27, 2020.[1] Title I (No Surprises Act) and Title II (Transparency) of Division BB of the CAA amended Title XXVII of the PHS Act by establishing new protections for consumers related to surprise billing and transparency in health care. The CAA contains new requirements for health insurance issuers in the individual and group markets, health care providers and facilities, and providers of air ambulance services. It amended section 2723 of the PHS Act and added a new section 2799B-4 of the PHS Act such

[1] Pub. L. 116-260 (Dec. 27, 2020).

that these new requirements are generally enforced in the same manner as the market-wide reforms in Part A of Title XXVII.[2] Therefore, states have primary enforcement authority over these new requirements under the CAA with respect to health insurance issuers, health care providers and facilities, and providers of air ambulance services.

CMS, on behalf of the Department of Health and Human Services (HHS), has an obligation under section 2723 of the PHS Act to directly enforce the applicable provisions in Parts A and D of Title XXVII of the PHS Act that a state fails to substantially enforce. Similarly, HHS has an obligation under section 2799B-4 of the PHS Act to directly enforce the applicable requirements under Part E of Title XXVII of the PHS Act that a state fails to substantially enforce. Therefore, in June 2021, CMS asked each state to complete a written survey providing its assessment of whether the state has the authority and intends to substantially enforce the new consumer protections extended or added to the PHS Act by the CAA beginning on the applicable effective date (generally January 1, 2022). In addition, CMS asked each state whether it has an All-Payer Model Agreement or specified state law in order to determine whether the federal independent dispute resolution (IDR) process would apply in the state beginning on January 1, 2022. CMS also asked whether the state has any state resolution process for payment disputes between providers and uninsured (or self-pay) patients in order to determine whether the federal patient-provider dispute resolution will apply in Arkansas. We have included a copy of this survey as an appendix to this letter. The survey includes descriptions of each applicable provision's requirements. Please note, these descriptions are not an exhaustive list of all the new requirements and should not be used as a substitute for the statutory provisions or implementing regulations.

Enforcement

Based on the survey response and CMS communications with the Arkansas Insurance Department staff, CMS understands that the Arkansas Insurance Department will enforce sections 2719 (as applied by section 110 of the No Surprises Act), 2799A-2(a), 2799A-3, 2799A-4, and 2799A-5 of the PHS Act with respect to health insurance issuers.

The Arkansas Insurance Department also communicated that Arkansas lacks authority to enforce certain PHS Act provisions. Specifically, the Arkansas Insurance Department stated it lacks authority to enforce 2746, 2799A-1, 2799A-2(b), and 2799A-9 of the PHS Act with respect to health insurance issuers; sections 2799B-1, 2799B-2, 2799B-3, 2799B-8, and 2799B-9 with respect to health care providers and facilities; section 2799B-5 with respect to providers of air ambulance services; and sections 2799B-6 and 2799B-7 with respect to health care providers, facilities, and providers of air ambulance services. However, the Arkansas Insurance Department expressed interest in entering into a collaborative enforcement agreement with CMS to enforce section 2799A-1(c) with respect to health insurance issuers.

Under a collaborative enforcement agreement, the state will perform the compliance functions of policy form review, investigations, market conduct examinations, and consumer assistance, as

[2] While the general enforcement framework is the same under sections 2723 and 2799B-4 of the PHS Act, there are differences in the federal civil money penalties that can be imposed for violations of provisions that fall under each statute. Compare, e.g., 42 U.S.C. 300gg-22(b)(2)(C) with 42 U.S.C. 300gg-134(b)(1).

applicable, with respect to the noted provisions of the PHS Act as extended or added by the CAA. Only in the event that Arkansas is unable to obtain voluntary compliance will CMS consider undertaking formal enforcement action against a health insurance issuer, to the extent warranted. CMS will provide a copy of the collaborative enforcement agreement directly to the Arkansas Department of Insurance for signature. Without such an agreement in place, CMS will perform these regulatory functions in Arkansas pursuant to sections 2723 and 2799B-4 of the PHS Act, as applicable.

We are pleased that we will be able to accomplish our enforcement through the collaborative enforcement agreement with Arkansas. We ask for your cooperation in working with CMS to effectively enforce the new PHS Act consumer protections extended or added by the CAA in Arkansas. If, in the future, Arkansas should act to assume direct enforcement authority of any of the noted provisions, CMS will enter into discussions with Arkansas on the process for an effective transition to state enforcement under 45 CFR 150.221. We look forward to working with Arkansas to ensure that your residents are afforded all of the protections in title XXVII of the PHS Act that were extended or added by the CAA.

In the September 16, 2021 Notice of Proposed Rulemaking (NPRM) entitled, *Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement* (86 FR 51730), HHS proposed to have direct enforcement authority for new CAA provisions that require issuers to submit information to HHS regarding agent and broker compensation, air ambulance services, pharmacy benefits and drug costs, and compliance with the prohibition on gag clauses on price and quality information, unless the state notifies CMS of its intent to enforce. Therefore, if the September 16, 2021 NPRM is finalized as proposed, CMS expects to directly enforce sections 2746(c), 2799A-8, 2799A-9(a)(4), and 2799A-10 of the PHS Act with respect to issuers in Arkansas unless Arkansas notifies CMS of its intent to enforce.

We ask for your cooperation in working with CMS to effectively enforce the new PHS Act consumer protections extended or added by the CAA in Arkansas. If, in the future, Arkansas should act to assume enforcement authority of any of the provisions that CMS is currently responsible for enforcing, CMS will enter into discussions with Arkansas on the process for an effective transition to state enforcement under 45 CFR 150.221. We look forward to working with Arkansas to ensure that your residents are afforded all the protections in title XXVII of the PHS Act that were extended or added by the CAA.

I want to take this opportunity to thank the staff in the Arkansas Department of Insurance for the productive conversations and survey responses related to authority and enforcement of these new consumer protections. The existing PHS Act enforcement structure is very much a partnership between states and the federal government, and we recognize and support the fundamental role states play in protecting consumers. This letter does not change Arkansas's role as primary enforcer of the other market-wide reforms codified in Parts A, B, and C of Title XXVII of the PHS Act with respect to health insurance issuers that issue, sell, renew or offer health insurance coverage in the individual or group market in Arkansas.[3]

[3] This includes the patient protections regarding choice of health care professional from section 2719A(a), (c), and (d) of the PHS Act, recodified by the No Surprises Act as new section 2799A-7 of the PHS Act.

Independent Dispute Resolution

Section 2799A-1 of the PHS Act governs the out-of-network rate that plans and issuers are generally required to pay nonparticipating providers and facilities for emergency services, and nonparticipating providers for non-emergency services performed at certain participating facilities. Section 2799A-2 of the PHS Act governs the out-of-network rate that plans and issuers are generally required to pay nonparticipating providers of air ambulance services for covered air ambulance services. The out-of-network rate under these sections may be determined by an All-Payer Model Agreement under section 1115A of the Social Security Act, or if the state does not have an All-Payer Model Agreement, a "specified state law," as defined in section 2799A-1(a)(3)(I) of the PHS Act and 45 CFR 149.30. In order for an All-Payer Model Agreement or specified state law to determine the out-of-network rate, it must apply to the nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services; the plan, issuer, or coverage (including where a state law applies because the state has allowed a plan that is not otherwise subject to applicable state law an opportunity to opt in, subject to section 514 of the Employee Retirement Income Security Act); and the item or service involved.

If neither an All-Payer Model Agreement nor specified state law apply, the out-of-network rate is an amount agreed upon between the plan or issuer and the provider, facility, or provider of air ambulance services. If the plan or issuer and the provider, facility, or provider of air ambulance services do not agree upon an amount and therefore enter into the federal independent dispute resolution process, the out-of-network rate is the amount determined by a certified independent dispute resolution entity. Sections 2799A-1(c) and 2799A-2(b) of the PHS Act require the Departments of HHS, Labor, and the Treasury to establish a federal independent dispute resolution process. In order to determine whether this federal independent dispute resolution process will apply in Arkansas and in what circumstances, in its written survey, CMS solicited information regarding state All-Payer Model Agreements and state laws that may be consistent with the federal definition for a "specified state law."

Arkansas does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Arkansas did not identify in its survey response any state laws as governing the out-of-network rate. Therefore, the federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will apply for purposes of determining the out-of-network rate with respect to items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Arkansas by nonparticipating providers, nonparticipating emergency facilities, or nonparticipating providers of air ambulance services. The Arkansas Department of Insurance will enforce the outcome of the federal independent dispute resolution process for such cases in Arkansas.

Patient-Provider Dispute Resolution

Section 2799B-7 of the PHS Act requires HHS to establish a patient-provider dispute resolution process through which uninsured (or self-pay) individuals who, under section 2799B-6 of the

PHS Act, receive a good faith estimate of the cost of a scheduled service from a provider, facility, or provider of air ambulance services and are then billed charges substantially in excess of that estimate can seek a determination from a dispute resolution entity for the amount of charges to be paid. Under the regulations implementing this statute, uninsured (or self-pay) individuals have 120 calendar days from receiving the initial bill containing charges for the item or service that is substantially in excess of the expected charges in the good faith estimate to initiate the patient-provider dispute resolution process and obtain a binding payment amount determination from a selected dispute resolution entity.

Under 45 CFR 149.620(h), HHS will defer to a state's patient-provider dispute resolution process if the state has a state law that meets the following minimum requirements with respect to the item or service for which payment is in dispute:

- Payment determinations made through the state process are binding, unless the provider, facility, or provider of air ambulance services offers for the uninsured (or self-pay) individual to pay a lower payment amount than the determination amount;
- The dispute resolution process takes into consideration a good faith estimate, that meets the minimum standards established in 45 CFR 149.610, provided by the provider, facility, or provider of air ambulance services to the uninsured (or self-pay) individual;
- If the state charges a fee to uninsured (or self-pay) individuals to participate in the patient-provider dispute resolution process, the fee must be equal to or less than the federal administrative fee; and
- The state must have in place a conflict-of-interest standard that, at a minimum, meets the requirements at 45 CFR 149.620(d) and (e).

CMS will review changes to the state process on an annual basis (or at other times if CMS receives information from the state that would indicate the state process no longer meets the minimum federal requirements) to ensure the state process continues to meet or exceed the minimum federal standards.

In the event that the state process is terminated, or CMS determines that it no longer meets the minimum federal requirements described in 45 CFR 149.620(h)(2), CMS will make the federal process available to uninsured (or self-pay) individuals in that state to ensure that the state's residents have access to a patient-provider dispute resolution process that meets the minimum federal requirements.

In order to determine whether this federal patient-provider dispute resolution will apply in Arkansas and in what circumstances, CMS solicited information regarding any state resolution process for payment disputes between providers, facilities, or providers of air ambulance services and uninsured (or self-pay) patients as part of CMS's written survey.

Arkansas did not indicate that any applicable state resolution process for payment disputes between providers and patients currently exists. Therefore, the federal patient-provider dispute resolution process under section 2799B-7 of the PHS Act and 45 CFR 149.620 will apply for purposes of determining the amount an uninsured (or self-pay) individual must pay a provider, facility, or provider of air ambulance services for an item or service for which the billed charges

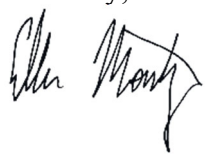
are substantially in excess of the good faith estimate of the expected charges that the applicable provider, facility, or provider of air ambulance services provided the individual prior to furnishing such item or service. CMS will enforce the outcome of the federal patient-provider dispute resolution process in Arkansas.

Please notify your CMS state engagement coordinator, Kathy Forno, at Kathy.Forno@cms.hhs.gov of any changes with respect to Arkansas's authority or intent to enforce any of the specified PHS Act provisions, and any changes with respect to the specified state law and state dispute resolution process.

If you have any questions or would like additional information regarding this letter, please do not hesitate to contact Kathy Forno at Kathy.Forno@cms.hhs.gov, or Mary Nugent at 301-503-9718 or Mary.Nugent@cms.hhs.gov.

Thank you for your cooperation as we prepare, together, to make sure health care consumers across the country receive the full protections of the law.

Sincerely,



Ellen Montz
Director
Center for Consumer Information and Insurance Oversight

Appendix

Background and Purpose Statement

This written survey is intended to capture the state's authority and intention to enforce specified provisions in Title XXVII of the Public Health Service Act (PHS Act), as amended by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021, which establish new protections for consumers related to surprise billing and transparency in health care.

With respect to health insurance issuers, facilities, and providers (including air ambulance services providers), states have primary enforcement authority over these new requirements. The Centers for Medicare & Medicaid Services (CMS) has a statutory obligation under sections 2723 and 2799B-4 of the PHS Act to directly enforce any provision (or provisions) that a state fails to substantially enforce. If the applicable state authority lacks the authority but wants to participate in the enforcement of a provision (or provisions), the applicable state authority may enter into a collaborative enforcement agreement (CEA) with CMS. Under a CEA, the applicable state authority agrees to seek voluntary compliance from health insurance issuers, providers, facilities, and/or air ambulance service providers, and refer to CMS for possible enforcement action any potential violation for which the state is not able to obtain voluntary compliance.

CMS will use the state's responses to this survey to determine, for each applicable provision and regulated entity, whether the applicable state authority will enforce the requirements directly or through a CEA, or whether CMS will be responsible for enforcement. To aid in the assessment of the state's authority and intention to enforce each applicable provision, a description of the requirements is included. Please note this description is not an exhaustive list of all the new requirements and should not be used as a substitute for the statutory provisions. The state should independently review each provision in the statute to determine whether it has sufficient authority to enforce the requirements with respect to each of the different regulated entities.

The Consolidated Appropriations Act, 2021 is available at: https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.

Title XXVII of the Public Health Service Act, as amended by the Consolidated Appropriations Act, 2021, is available at: https://www.govinfo.gov/content/pkg/COMPS-8798/pdf/COMPS-8798.pdf.

This survey also requests information regarding applicable state laws and regulations. To the extent that the state enacts legislation or issues a regulation that impacts the state's authority to enforce any of the specified provisions with respect to any of the regulated entities after submission of this survey, please notify your CMS state engagement coordinators.

Survey

PHS Act Sec. 2719 Appeals Process, as extended by Section 110 of the No Surprises Act
Applicability Date: This provision is applicable with respect to adverse benefit determinations related to surprise billing in plan years beginning on or after January 1, 2022.

Provision Description
Health plan participants and beneficiaries and health insurance policy enrollees must be permitted to request an external review as described under section 2719(b) of the PHS Act for adverse benefit

determinations by a plan or issuer under sections 2799A-1 and 2799A-2 of the PHS Act, including decisions related to whether an item or service for which the adverse benefit determination was made is subject to the requirements under those sections.

Survey Questions
With respect to this provision (Sec. 2719 of the PHS Act, as extended by Section 110 of the No Surprises Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Does the state intend to enforce this provision against issuers?
3. Does the state currently have an external review process that applies to adverse benefit determinations under sections 2799A-1 and 2799A-2 of the PHS Act?
    a. If yes, please provide the applicable citation(s) to state law or regulations.
        i. Does the state believe the state's current standards are at least as consumer protective as the federal standards?
    b. If no, will the state codify or promulgate such standards by the applicability date of this section (January 1, 2022)?

PHS Act Sec. 2746. Disclosure to Enrollees of Individual Market Coverage, as enacted by Section 202 of Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021
Applicability Date: This provision is applicable one year after the date of enactment except contracts executed prior to the applicability date of this provision are exempt from reporting and disclosure.

Provision Description
Issuers of individual health insurance coverage and short-term, limited-duration insurance coverage are required to disclose to enrollees prior to plan selection the amount of any direct or indirect compensation that the plan will pay to the agent or broker associated with that enrollment. This disclosure must also be included on any documentation confirming the enrollment. Additionally, issuers must annually report to the Secretary of Health and Human Services (HHS), prior to open enrollment, any direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

Survey Questions
With respect to this provision (Sec. 2746 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by December 27, 2021?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority (such as whether state authority is limited to issuers of individual health insurance coverage or short-term, limited-duration insurance).

2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-1 (a), (b), (d), (e) and (f). Preventing Surprise Medical Bills, as enacted by Sections 102, 107, and 111 of the No Surprises Act

Applicability Date: These requirements are applicable to all group health plans and health insurance coverage, including grandfathered health plans, for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Provision Description

Limitations on Out-of-Pocket Costs for Out-of-Network Emergency Services

- If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to emergency services in the emergency department of a hospital or in an independent freestanding emergency department, the plan or issuer must cover emergency services without regard to whether the provider is a participating provider or facility and without prior authorization or any other limitation on coverage that is more restrictive than that applied for in-network emergency services.
- The cost sharing for out-of-network emergency services must count toward any in-network deductible or out-of-pocket maximums.

Cost-Sharing and Out-of-Network Payment Amounts

- The cost sharing is calculated as if the total amount that would have been charged for the emergency services by the out-of-network provider or facility were equal to the "recognized amount." If the state has an All-Payer Model Agreement, the recognized amount is the amount the state approves under that system. If not, it is an amount determined under a "specified state law;" or if no such state law exists, it is the "qualifying payment amount."
    - The term `specified state law' means, with respect to a state, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a state law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such state law applies to such plan, coverage, or issuer, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.
    - The "qualifying payment amount" is an amount calculated using a methodology to be specified in rulemaking by CMS and the Departments of Labor and the Treasury (the Departments).
- The out-of-network rate that plans and issuers are required to pay may be the amount the state approves under an All-Payer Model Agreement or an amount determined under a specified state law. If neither of these two rates apply, providers are paid an amount agreed upon through a 30-day open negotiation period between the plan and the provider or the amount determined by an independent dispute resolution entity.
- Within 30 calendar days of receiving a claim subject to the surprise billing protections, plans and issuers must make an initial payment or send a notice of denial of payment.

Emergency Services Definition and Non-Emergency Services Provided by an Out-of-Network Provider at an In-Network Facility

- The definition of "emergency services" is expanded to include:

  - Such services provided by an independent freestanding emergency department, which is defined as a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable state law, and provides emergency services.
  - Certain post-stabilization and observation services unless the provider determines the patient is able to travel using non-medical or non-emergency medical transport, satisfies consumer notice and consent requirements, and meets any other conditions specified by the Departments. The patient must be in a condition to receive the provider notice and provide informed consent in accordance with applicable state law.
- The consumer protections that apply to emergency services also apply to non-emergency services provided by an out-of-network provider at an in-network facility, unless, for some services, the provider satisfies certain notice and consent requirements.

Consumer Protections related to Price Transparency and Other Information

- Plans and issuers are required to include information about deductibles and out-of-pocket maximums and a customer service phone number and internet website on consumers' insurance ID cards.
- Plans and issuers are required to provide an Advance Explanation of Benefits notice prior to scheduled services. This notice must include whether or not the provider or facility is in-network; a good faith estimate of the cost of the service, including the estimated amount the plan or coverage would be responsible for paying and the estimated cost-sharing amount the patient would be responsible for paying; information about what the enrollee has accrued toward meeting deductibles or out-of-pocket limitations; and whether the item or service is subject to medical management. If the provider or facility is in-network, the Advance Explanation of Benefits must include the contracted rate for the service. If the provider or facility is out-of-network, the Advance Explanation of Benefits must describe how the patient may obtain information on participating providers and facilities.

<u>Survey Questions</u>

With respect to these provisions (Sec. 2799A-1(a), (b), (d), (e) and (f) of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision(s).
3. Please provide information about any "specified state law(s)" as defined above. Please describe the items, services, providers, facilities, and payers to which the specified state law applies.
4. Does the state have an All-Payer Model Agreement, and if so, please describe the items, services, providers, facilities, and payers to which the Agreement applies.
5. Please provide any applicable state law or regulation that determines an individual's ability to provide informed consent.
6. Please provide any state laws or regulations governing authorized representatives.
7. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-1(c). Preventing Surprise Medical Bills, Independent Dispute Resolution (IDR) Process, as enacted by Section 103 of the No Surprises Act

Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description

- The out-of-network rate that plans and issuers are required to pay providers for claims subject to surprise billing protections under PHS Act section 2799A-1 subsection (a)(1) or (b)(1), regarding coverage of emergency services and coverage of non-emergency services performed by nonparticipating providers at certain participating facilities, respectively, is (1) an amount determined by an applicable All-Payer Model Agreement under Social Security Act section 1115A, (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law, or (3) if there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by plan or issuer and the provider or facility, or (4), if none of those three conditions apply, an amount determined by an IDR entity.
- During the 30-day period beginning on the day the provider receives an initial payment or notice of denial of payment from the plan or coverage, the plan or issuer or provider may initiate open negotiations. After 30 days, if there is no agreement, the parties may choose to enter an IDR process.
- Initiation of IDR process: A provider or plan or issuer may, during the 4-day period beginning on the day after the open negotiation period, initiate the IDR process by submitting a notification to the other party and the applicable Department.
- Certification of IDR entities: the Departments shall establish a process to certify (and recertify) every five years, and can revoke certifications, to ensure entities:
  1) have sufficient expertise and staffing to make payment determinations;
  2) are not a group health plan or health insurance issuer, or provider, or facility, or an affiliate or subsidiary of such, or an affiliate or subsidiary of a professional or trade association of such;
  3) carry out the required responsibilities;
  4) meet appropriate indicators of fiscal integrity;
  5) maintain confidentiality of individually identifiable health information;
  6) do not carry out any determinations for which they are not eligible for selection under the method specified by the Departments; and
  7) meet such other requirements as determined appropriate by the Departments.
- Selection of certified IDR entities: Under the IDR process, the plan or issuer and provider can jointly select an IDR entity, not later than the last day of the 3-business day period following the date of the initiation of the process. If there is no agreement on an IDR entity by the two parties, the applicable Department will select an entity not later than the 6 business days after initiation. IDR entities are required to make a decision on a payment amount within 30 days of being selected.
- Submission of offers and IDR determination: Not later than 10 days after the date of selection of the IDR entity, the parties are required to submit to the IDR entity an offer for a payment amount for the item or service. The IDR entity is required to select one offer to be the amount of payment for the item or service. In evaluating the offers, the IDR entity is required to consider:
  1) the qualifying payment amount for the item or service; and
  2) other additional information such as the level of training of the provider, quality and outcomes measurements, the market share held by the plan or provider, the acuity of the patient or complexity of providing the item or service to the patient, the teaching status and case mix of the facility, and demonstrations of good faith efforts made by the plan or provider to enter into a contract with the other party during the prior 4 years.

- In evaluating the offers, the IDR entity is prohibited from considering:
  1) the plan's usual and customary charges;
  2) the amount that would apply if surprise billing protections did not apply to the service; and
  3) the payment rate to that provider for the service from public payers including Medicare, Medicaid, CHIP, Tricare and VA coverage.
- Determinations by the IDR entity are binding and not subject to judicial review, except in cases of a fraudulent claim or evidence of misrepresentation of the facts presented to the IDR entity. The party that submitted the notification of initiation of the IDR process may not submit another notification to the same other party initiating the IDR process for an item or service that was the subject of the initial notification for 90 days. The party may submit such a notification by the 30th day following the 90-day period.
- Costs of the IDR process: The party whose offer is not chosen must pay all fees charged by the IDR entity. In cases where a settlement is reached, IDR entity fees would be split between the parties, unless they agree otherwise. Both parties also must pay an administrative fee for participating in the IDR process set by the applicable Department based on the estimated expenditures made by the applicable Department for the year to carry out the IDR process.
- The provision also allows parties to batch claims brought to the IDR process to promote administrative efficiency.

Survey Questions

With respect to this provision (Sec. 2799A-1(c) of the PHS Act), please provide responses to each of the below questions.

1. Does the state have a state law or regulation that provides for a method for determining total out-of-network payment amounts?
   a. If yes, please provide the applicable citation(s) to state law or regulations and describe the items, services, providers, facilities, and payers to which the specified state law or regulation applies. Is the state law or regulation binding on the parties?
2. Does the state currently have an IDR process for payment disputes between plans or issuers and providers?
   a. If yes, please provide the applicable citation(s) to state law or regulations.
      i. Please describe the items, services, providers, facilities, and payers to which the state law or regulation applies. Is the state law or regulation binding on the parties?
      ii. Does the state have an IDR opt-in option for self-insured plans and/or enrollees of self-insured plans?
      iii. Does the state intend on continuing to provide for IDR for plans, issuers and providers once the Federal process is in place?
3. If the state does not have an All-Payer Model Agreement under section 1115A of the Social Security Act or a state law or regulation that provides for a method for determining total out-of-network payment amounts (such as an IDR process), does the state plan to codify or promulgate such standards and make available to plans, issuers and providers?
   a. If yes, will the state be able to do so by the applicability date of this section?
      i. If not, when does the state anticipate establishing such standards for plans, issuers and providers?
   b. If no, does the state have the authority to enforce Federal IDR process standards against issuers, providers, and facilities?
      ii. If yes,
         1. provide the applicable citation(s) with respect to each regulated entity.
         2. Please note any limitations or relevant information on authority.

3. Does the state intend to enforce this provision against issuers, providers, and facilities?

iii. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
   1. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?

PHS Act Sec. 2799A-2(a). Ending Surprise Air Ambulance Bills, as enacted by Section 105 of the No Surprises Act

Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description

Group health plans and health insurance issuers are generally required to apply the same surprise billing requirements that apply to out-of-network emergency services to out-of-network air ambulance services, if the plan or issuer provides coverage of air ambulance services provided by an in-network provider.

Survey Questions

With respect to this provision (Sec. 2799A-2(a) of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
   a. With respect to each regulated entity, if yes, provide the applicable citation(s).
   b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
   c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
   d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-2(b). Ending Surprise Air Ambulance Bills Independent Dispute Resolution Process, as enacted by Section 105 of the No Surprises Act

Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description

The Secretaries of HHS, Labor, and the Treasury are required to establish an IDR process similar to that for emergency services for determining out-of-network rates to be paid by plans and issuers to out-of-network air ambulance service providers.

Survey Questions

With respect to this provision (Sec. 2799A-2(b) of the PHS Act), please provide responses to each of the below questions.

1. If the state has an applicable All-Payer Model Agreement under section 1115A of the Social Security Act for payments for air ambulance providers, please provide the applicable citation(s) to state law or regulations and describe the items, services, providers, facilities, and payers to which the specified state law or regulation applies.

2. Does the state have a state law or regulation for air ambulance providers that provides for a method for determining total out-of-network payment amounts for air ambulance provider services?
    a. If yes, please provide the applicable citation(s) to state law or regulations and describe the items, services, providers, facilities, and payers to which the specified state law or regulation applies. Is the state law or regulation binding on the parties?
3. Does the state currently have an IDR process for payment disputes between plans or issuers and air ambulance providers?
    a. If yes, please provide the applicable citation(s) to state law or regulations.
        i. Please describe the items, services, providers, facilities, and payers to which the state law or regulation applies. Is the state law or regulation binding on the parties?
        ii. Does the state have an IDR opt-in option for self-insured plans and/or enrollees of self-insured plans?
        iii. Does the state intend on continuing to provide for IDR for plans, issuers and air ambulance providers once the Federal process is in place?
4. If the state does not have an All-Payer Model Agreement under section 1115A of the Social Security Act or a state law or regulation that provides for a method for determining total out-of-network payment amounts (such as an IDR process), does the state plan to codify or promulgate such standards and make available to plans, issuers and air ambulance providers?
    a. If yes, will the state be able to do so by the applicability date of this section?
        i. If not, when does the state anticipate establishing such standards for plans, issuers and air ambulance providers?
    b. If no, does the state have the authority to enforce Federal IDR process standards against issuers and air ambulance providers?
        ii. If yes,
            1. Provide the applicable citation(s) with respect to each regulated entity.
            2. Please note any limitations or relevant information on authority.
            3. Does the state intend to enforce this provision against issuers and air ambulance providers?
        iii. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
            1. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?

PHS Act Sec. 2799A-3. Continuity of Care, as enacted by Section 113 of the No Surprises Act
Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description
If an enrollee is a continuing care patient, and the contractual relationship between the plan or issuer and the provider is terminated, benefits with respect to the provider or facility are terminated because of a change in terms of participation of the provider or facility, or a contract between a plan and an issuer is terminated – resulting in a loss of benefits with respect to a provider or facility, then the plan or issuer must, within a timely manner, notify the enrollee of the contract or benefit termination and his or her right to receive transitional care from that provider under the same terms and conditions that would have otherwise applied for the shorter of 90 days or when the enrollee is no longer a continuing care patient.

Survey Questions

With respect to this provision (Sec. 2799A-3 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-4. Maintenance of Price Comparison Tool, as enacted by Section 114 of the No Surprises Act
Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description
Plans and issuers must offer price comparison guidance, by phone and on their website, to allow enrollees to compare the cost sharing for items and services furnished by any participating provider in a geographic region for the applicable plan year.

Survey Questions
With respect to this provision (Sec. 2799A-4 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-5. Protecting Patients and Improving the Accuracy of Provider Directory Information, as enacted by Section 116 of the No Surprises Act
Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description
- Plans and issuers are required to establish a database on their public website that includes a list of participating providers and facilities and their provider directory information (name, address, specialty, telephone number and digital contact information). Plans and issuers must also establish a process to verify the provider directory information at least every 90 days.

- Plans and issuers are required to establish a process to confirm a provider's network status for enrollees upon request. If the request is made via telephone, plans and issuers must respond in writing within one business day and retain the communication in the enrollee's file for at least two years.
- Any directory that contains provider directory information, other than the required database, must include a notification that the information contained in the directory was accurate as of the date of publication and refer enrollees to the database for the most current provider directory information.
- Nothing in this section shall be construed to preempt any provision of state law relating to health care provider directories.
- If an enrollee is furnished, by a nonparticipating provider or a nonparticipating facility, an item or service that would otherwise be covered if provided by a participating provider or facility, and the enrollee relied on the provider directory information or information regarding the provider's network status provided by the plan or issuer which incorrectly indicated that the provider is in-network, the enrollee is only responsible for the in-network cost sharing amount, and the deductible and out-of-pocket maximum must apply as if the item or service was provided in-network.
- Plans and issuers must include on each Explanation of Benefits for an item or service subject to the surprise billing protections under section 2799A-1, information on the requirements and prohibitions under 2799B-1 and 2799B-2, and information on how to report potential provider or facility violations to the appropriate state and federal agencies. The Explanation of Benefits must also include any other requirements under state law regarding the amounts providers and facilities may charge for an item or service provided out-of-network after receiving payment from the plan or coverage and any cost sharing from the enrollee.

Survey Questions

With respect to this provision (Sec. 2799A-5 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Please provide any state law or regulation regarding health care provider directories.
4. Please provide any state law or regulation regarding the amounts providers and facilities may charge for an item or service provided out-of-network after receiving payment from the plan or coverage and any cost sharing from the enrollee.
5. Does the state intend to enforce this provision against issuers?

PHS Act Sec. 2799A-9. Increasing Transparency by Removing Gag Clauses on Price and Quality Information, as enacted by Section 201 of Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021

Applicability Date: This provision was applicable upon enactment (December 27, 2020).

Provision Description

- Group health plans and issuers offering group health insurance coverage are prohibited from

entering into agreements with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that restrict the plan or issuer from sharing provider-specific cost or quality of care information to referring providers, the plan sponsor, enrollees, or prospective enrollees; electronically accessing de-identified claims and encounter information for each enrollee in compliance with federal privacy laws; or sharing such information or directing that it be shared with a business associate.

- Issuers offering individual health insurance coverage are prohibited from entering into agreements with a health care provider, network or association of providers, or other service provider offering access to a network of providers that restrict the issuer from sharing provider-specific price or quality of care information to referring providers, the plan sponsor, enrollees, or prospective enrollees; or sharing such information for plan design, plan administration, and plan, financial, legal, and quality improvement activities with a business associate in compliance with federal privacy laws.

Survey Questions
With respect to this provision (Sec. 2799A-9 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against issuers?
    a. If yes, provide the applicable citation(s).
    b. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    c. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce against issuers?
    a. If so, as of when, given that the provision is already applicable?

PHS Act Sec. 2799B-1. Balance Billing in Cases of Emergency Services, as enacted by Section 104 of the No Surprises Act
Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description
Nonparticipating providers and facilities that provide emergency services are prohibited from billing and holding patients liable for amounts greater than the in-network cost sharing that is based on the "recognized amount."

Survey Questions
With respect to this provision (Sec. 2799B-1 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
    a. With respect to each regulated entity, if yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.

2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers and facilities?

PHS Act Sec. 2799B-2. Balance Billing in Cases of Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities, as enacted by Section 104 of the No Surprises Act

Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description

- Nonparticipating providers who, in a participating facility, provide non-emergency items and services for which benefits are covered under the patient's plan or coverage are prohibited from billing and holding patients liable for amounts greater than the in-network cost sharing that is based on the "recognized amount," unless the provider satisfies certain notice and consent requirements. This exception does not apply to ancillary services, as defined in statute and rulemaking, or when there is no participating provider who can furnish the item or service at the facility.
- A nonparticipating provider or nonparticipating facility satisfies the notice and consent requirements in the following circumstances:
    - If the patient makes an appointment to receive items and services at least 72 hours in advance, the provider or facility provides the patient a written or electronic notice not later than 72 hours in advance of the appointment. If the patient makes an appointment within 72 hours of the appointment date, the provider or facility provides the notice on the date the appointment is made. The notice must:
        - Inform the patient that the provider or facility is a nonparticipating provider or facility;
        - Provide a good faith estimate of the charges for the scheduled items and services;
        - State that the provision of such estimate or consent to be treated does not constitute a contract with respect to the estimated charges;
        - In the case of a nonparticipating provider in a participating facility, include a list of and notice of the option for the patient to be referred to any participating providers at the facility who are able to provide the items and services;
        - Include information about whether prior authorization or other medical management may be required in advance of receiving the items and services;
        - Clearly state that consent to receive the items and services from the nonparticipating provider or nonparticipating facility is optional, and the patient may seek care from a participating provider or at a participating facility, in which case the charges to the patient would not exceed the applicable in-network cost sharing; and
        - Be available in the 15 most common languages in the geographic region.
- Nonparticipating providers and facilities are required to obtain written consent from and provide a signed copy of such consent to the patient. The nonparticipating provider or facility must retain a copy of the consent for at least seven years. The Secretary of HHS, in consultation with the Secretary of Labor, is directed to specify through guidance a document that constitutes such consent.

Survey Questions

With respect to this provision (Sec. 2799B-2 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
    a. With respect to each regulated entity, if yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers and facilities?

PHS Act Sec. 2799B-3. Provider Requirements with Respect to Disclosure on Patient Protections against Balance Billing, as enacted by Section 104 of the No Surprises Act
Applicability Date: These requirements are applicable January 1, 2022.

Provision Description
Each health care provider and facility must make publicly available, post on their website, and provide consumers a one-page notice. The notice must contain information on the applicable balance billing requirements and prohibitions under sections 2799B–1 and 2799B–2, any other applicable state law requirements regarding how much the provider or facility can charge a patient for out-of-network services, and how to contact the appropriate federal agencies if the consumer believes that the provider or facility has violated the balance billing requirements and prohibitions.

Survey Questions
With respect to this provision (Sec. 2799B-3 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
    a. With respect to each regulated entity, if yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Please note any applicable state legislation or regulation regarding cost-sharing limitations for out-of-network services.
4. Does the state intend to enforce this provision against providers and facilities?

PHS Act Sec. 2799B-5. Air Ambulance Services, as enacted by Section 105 of the No Surprises Act
Applicability Date: These requirements are applicable for services furnished during plan years that begin on or after January 1, 2022.

Provision Description
Air ambulance services providers are prohibited from billing or holding consumers liable for amounts greater than the in-network cost-sharing amount.

Survey Questions

With respect to this provision (Sec. 2799B-5 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against air ambulance services providers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against air ambulance services providers?

PHS Act Sec. 2799B-6. Provision of Information Upon Request and for Scheduled Appointments, as enacted by Section 112 of the No Surprises Act
Applicability Date: These requirements are applicable January 1, 2022.

Provision Description
When an individual schedules an item or service at least three business days in advance, providers and facilities must, within one business day of the date of scheduling, ask about the individual's insurance coverage status and whether the individual is seeking to have a claim submitted to the individual's plan or coverage, and provide a good-faith estimate of the expected charges to the plan or issuer or to the individual if they are not insured or are not seeking to have a claim submitted to their plan or coverage. If the individual schedules the item or service at least 10 business days in advance, the provider or facility must meet these requirements within three business days of the date of scheduling.

Survey Questions
With respect to this provision (Sec. 2799B-6 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
    a. With respect to each regulated entity, if yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers and facilities?

PHS Act Sec. 2799B-7. Patient-Provider Dispute Resolution, as enacted by Section 112 of the No Surprises Act
Applicability Date: These requirements are applicable January 1, 2022.

Provision Description
- The Secretary is required to establish a patient-provider dispute resolution process where uninsured individuals who receive a good-faith estimate of the cost of a scheduled service from a

provider (pursuant to 2799B-6), but who are billed charges substantially in excess of the estimate can seek a determination from a dispute resolution entity for the amount of charges to be paid. The Secretary will certify such entities that meet at least the requirements under 2799A-1(c). The process must establish a method of selection of a dispute resolution entity that is not a party to a dispute (or an employee or agent of such party, or have a material, familial, financial, or professional relationship with such party, or other conflict of interest).

- Uninsured individuals are those who, with respect to an item or service, do not have coverage under a group health plan or group or individual health insurance policy or a federal health care program or the federal employee health benefit program, or those who do have such coverage but do not have coverage for such item or service, or those who do not wish to seek coverage for the claim from their health plan or health insurance issuer for such item or service. The Secretary shall establish a fee for use of the process that does not act as a barrier to the uninsured individual's participation.

Survey Questions
With respect to this provision (Sec. 2799B-7 of the PHS Act), please provide responses to each of the below questions.

1. Does the state currently have a dispute resolution process for payment disputes between providers and patients?
    a. If yes, please provide the applicable citation(s) to state law or regulations.
        a. Does the state believe the state's current standards are consistent with section 2799B-7 of the PHS Act?
    b. If no, can the state codify or promulgate such standards by the applicability date of this section?
    c. If no, does the state plan to codify or promulgate such standards and make available to plans, issuers and providers an IDR process as defined in the statute?
        a. If yes, will the state be able to do so by the applicability date of this section?
            1. If not, when does the state anticipate establishing an IDR process for providers and patients?
2. If the state does not have an IDR process for providers and patients and does not plan to establish one by the applicability date of this statute, does the state have the authority to enforce Federal IDR process standards against providers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
    e. Does the state intend to enforce this provision against providers?

PHS Act Sec. 2799B-8. Continuity of Care, as enacted by Section 113 of the No Surprises Act
Applicability Date: These requirements are applicable for plan years beginning on or after January 1, 2022.

Provision Description
In the case of services provided to a continuing care patient, providers are required to accept payment from plans and issuers and, if applicable, cost sharing from patients under their prior contract terms as payment in full, and must continue to adhere to all policies, procedures, and quality standards imposed under the prior contract.

Survey Questions
With respect to this provision (Sec. 2799B-8 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers?
    a. If yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.
3. Does the state intend to enforce this provision against providers?

PHS Act Sec. 2799B-9. Provider Requirements to Protect Patients and Improve the Accuracy of Provider Directory Information, as enacted by Section 116 of the No Surprises Act
Applicability Date: These requirements are applicable January 1, 2022.

Provision Description
- Providers and facilities are required to establish business processes to ensure the timely provision of provider directory information to plans and issuers. Such provider directory information must be provided when the provider or facility enters into or terminates a network agreement and when there are material changes to the provider directory information.
- If a nonparticipating provider or facility bills an enrollee an amount that exceeds the in-network cost sharing amount for an item or service that would otherwise be covered if provided by a participating provider or facility, in a manner that would be prohibited under § 2799A-5(b), the provider must refund the enrollee any amount he or she paid in excess of the in-network cost sharing amount, plus interest, at a rate determined by the Secretary.
- This section does not prohibit a provider from requiring in a contract or contract termination with a plan or issuer that the plan or issuer remove the provider from the provider directory upon termination of such contract or that the plan or issuer bear the financial responsibility for providing inaccurate network status information to an enrollee.
- Nothing in this section shall be construed to preempt any provision of state law relating to health care provider directories.

Survey Questions
With respect to this provision (Sec. 2799B-9 of the PHS Act), please provide responses to each of the below questions.

1. Does the state have the authority to enforce this provision against providers and facilities?
    a. With respect to each regulated entity, if yes, provide the applicable citation(s).
    b. If no, does the state expect to enact legislation or issue a regulation to obtain the requisite authority applicable by January 1, 2022?
    c. If no, is the state interested in entering into a collaborative enforcement agreement with CMS?
    d. Please note any limitations or relevant information on authority.
2. Please note any state legislation or regulation that codifies requirements that are at least as consumer protective as the federal provision.

3. Does the state intend to enforce this provision against providers and facilities?

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-0702. The time required to complete this information collection is estimated to average 2.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.