Illinois Health and Hospital Association

Frequently Asked Questions

September 2022

No Surprises Act

Below are frequently asked questions (FAQs) around hospital or provider requirements under the No Surprises Act (NSA). This is a living document, meaning it will be updated periodically as additional questions, guidance, or requirements arise. If you have questions or comments, please contact IHA.

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Federal NSA Resources

Providers may contact the Centers for Medicare & Medicaid Services (CMS) with questions about the NSA by emailing them at provider_enforcement@cms.hhs.gov. Providers may also call the NSA Help Desk at 1-800-985-3059 between 7 a.m. and 7 p.m. CT, 7 days per week. **CMS maintains a website where it posts updated policies and guidance here.**

Important CMS Guidance Documents (Updated 9.9.22)

- **FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation part 55 (August 2022)**
- **Federal IDR Portal Walkthrough Webinar and IDR System Demonstration Webinar (August 2022)**
- **Chart Determining Applicability of Federal IDR Process (August 2022)**
- **Chart Regarding Federal IDR Process in Bifurcated States (August 2022)**
- Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties (April 2022)
- Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities (April 2022)
- Frequently Asked Questions for Providers About the No Surprises Rules (April 6, 2022)
- FAQs about Consolidated Appropriations Act, 2021 Implementation – Good Faith Estimates (GFE) for Uninsured (or Self-Pay) Individuals Part 2 (April 5, 2022)
- Federal Independent Dispute Resolution (IDR) Process
- Uninsured and Self-Pay Good Faith Estimates (GFEs)

IHA Resources on the No Surprises Act

Where can I find IHA resources on the No Surprises Act? (Updated 9.9.22)

- **IHA NSA resources, including one-pagers and regulatory summaries, are posted here.**
- **Slides and a recording of IHA's Nov. 15 webinar are posted under the Price Transparency Resources tab.**

No Surprises Act and Patient Billing Protections

I have questions on the disclosure of balance billing protections from Part I of the NSA. My understanding is this: We must publicly post a disclosure explaining the protections provided in the NSA; we must post the same information on our website; and we must provide a one-page summary directly to the patient (all patients) at the time of billing. Can this be included with a patient statement? If not – can we give this information to each patient at the time of registration? Does this need to be documented somehow? (Updated 12.21.21)

- This summary of requirements is correct. Providers, including Hospitals, Hospital Outpatient Departments, Critical Access Hospitals, and Ambulatory Surgical Centers must make publicly available information on patients' rights regarding balance billing, including state-specific rights under IL Public Act 096-1523. Facilities/providers may use CMS' model form (CMS-10780 Appendix III), altered to reflect PA 096-1523.

The public notice must be on a searchable homepage of the facility's/provider's website. Facilities/providers must also prominently display a sign with the required disclosure information in a location of the facility/provider, such as where individuals schedule care, check-in for appointments, or pay bills, unless the provider does not have a publicly accessible location.

Facilities/providers must also give each insured patient a one-page notice of their rights under the No Surprises Act and IL Public Act 096-1523. Facilities/providers may again use CMS' model form (CMS-10780 Appendix III), altered to reflect PA 096-1523.

Facilities/providers must provide the notice in-person, by mail, or by email, as selected by the insured patient. Thus, if the patient agrees, it may be included with the patient statement. Similarly, if the patient agrees, it may be given in-person at the time of registration. IHA is unaware of any required documentation that the notice has been given to the insured patient at this time. However, it is never a bad idea to document compliance with federal and state requirements. We urge members to consult with their general counsel when planning compliance with the NSA.

When do surprise billing protections take effect?

- Regulations applicable to health care providers are effective Jan. 1, 2022. In other words, providers may not balance bill patients for out-of-network emergency services and certain scheduled services when provided at an in-network facility beginning Jan. 1, 2022.
- Regulations specific to health plans or issuers are generally applicable for plan years beginning on or after Jan. 1, 2022.

What protections and facilities/providers are applicable under the No Surprises Act? (Updated 4.8.22)

- Emergency services protections apply when a patient receives emergency care at in-network or out-of-network hospital emergency departments or independent freestanding emergency departments. Note that protections apply until the visit ends, even at out-of-network facilities. The protections end when the patient is discharged or notice and consent requirements are satisfied and the patient either consents to being balance billed or is transferred.
- Non-emergency service protections apply when an insured individual seeks covered services at in-network hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers. Any care rendered by any provider during such a visit is limited to in-network cost sharing unless the situation meets notice and consent criteria.
- Surprise billing protections for air ambulance services apply to all providers of air ambulance services, including both fixed-wing and rotary-wing air ambulances, when services are furnished to an insured individual with air ambulance coverage.

- CMS clarified in its 4.6.22 FAQ document that balance billing protections for non-emergency services by out-of-network providers during patient visits to in-network health care facilities do not apply at health care facilities such as urgent care centers. They apply at facilities that include hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers.

How do the NSA protections apply for inpatients that came in through the emergency room in 2021 and were discharged in 2022? (Updated 3.21.22)

- During a March 2022 call, CMS advised that prohibitions on balance billing apply for services that occur during plan years based on the date of service. If the date of service was in 2021, or in 2022 but before the new plan year started, then prohibitions on balance billing do not apply.

How do NSA protections apply for uninsured/self-pay patients that scheduled a service in 2021 that was ultimately furnished in 2022? (Updated 3.21.22)

- During a March 2022 call, CMS advised providers to pay attention to when the act of scheduling occurred. If the act of scheduling happened prior to Jan. 1, 2022, then the uninsured/self-pay good faith estimate (GFE) requirements do not apply. However, if the services are rescheduled, and the rescheduling occurs after Jan. 1, 2022, then GFE requirements under the NSA do apply.

Rural health clinics are not included in the out-of-network portion of the Act. However, if you have an urgent care/walk-in clinic within your rural health clinic, is that also excluded? (Updated 12.21.21)

- This depends on how the urgent care/walk-in clinic is licensed by the state. If the urgent care/walk-in clinic is licensed as a hospital outpatient department or emergency department, then the No Surprises Act requirements apply.

How can providers ensure plan network information is timely and accurate?

- Beginning Jan. 1, 2022, the NSA requires plans to establish a verification process to ensure accurate provider directories, a response protocol for individuals (including providers) inquiring about the network status of a provider, and a publicly accessible provider database. Health plans must verify and update provider directory information no less than every 90 days, or within two days of receiving notice of a change. When an individual inquires about the network status of a provider or a facility, the NSA requires plans to respond within one business day and retain records of the inquiry for two years.
- The required web-based provider database must include the provider and facility contact information, specialty information, direct or indirect contractual relationship with the plan, and digital contact information.
- The plan must also communicate the appropriate federal and state contact information for consumers to report any violations.
- While these requirements are effective Jan. 1, 2022, the Departments indicated they will exercise enforcement discretion pending further guidance.

What should providers do if the health plan directory is not accurate?

- Providers and plans are asked to use their best judgment in implementing these provisions until additional guidance is provided to health plans on how to keep provider directories up-to-date.
- In cases where a provider directory is not accurate and the wrong cost sharing amount is assessed, the provider must return excess cost sharing collected with interest. It remains to be seen whether provider protections in such cases will be stipulated in future guidance.

What non-emergency or "scheduled services" are covered under the NSA?

- The NSA provides balance billing protections for non-emergency services. Non-emergency services include any non-emergency item or service furnished by an out-of-network provider during a visit <u>at an in-network facility</u>. Balance billing protections in these cases may be waived if the notice and consent requirements are met.

How do the Departments define post-stabilization care?

- The Departments expanded the definition of emergency services to include post-stabilization services. Post-stabilization services are also subject to surprise billing protections.
- Post-stabilization services are defined as any additional item and service covered under a plan/coverage and furnished by a nonparticipating provider or nonparticipating emergency facility after an individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which other emergency services are furnished.
- Post-stabilization services are covered regardless of the department of the hospital in which such items and services are furnished.
- Post-stabilization services are subject to surprise billing protections until the point of discharge, transfer, or consent by the patient to be balance billed.

What responsibilities does the patient have to find out who is OON?

- In emergency situations there is no patient responsibility regarding the network participation of a provider.
- Beyond emergencies, the purpose of the No Surprises Act is to protect patients from surprise or balance bills in situations when the patient would not expect a balance bill. Therefore, NSA protections for non-emergency services only apply to non-emergency scheduled services that occur at in-network facilities. In that respect, it is the insured patient's responsibility to ensure they seek scheduled, non-emergency services at in-network facilities. Beyond this, there are no patient responsibilities under the NSA regarding provider network participation.

In general, how should hospitals obtain patient signatures when communicating with a patient via a virtual or electronic platform? (Updated 3.21.22)

- It is IHA's current understanding that electronic signatures are sufficient. IHA suggests hospitals meet with their general counsel and/or compliance officers to discuss issues like obtaining a patient's electronic signature.

NSA Enforcement

How can providers submit a billing complaint? (Updated 9.9.22)

- **Providers and facilities should contact the Departments with concerns about plans' or issuers' compliance with NSA requirements.**
- **Providers and facilities may call the No Surprises Help Desk at 1-800-985-3059 or submit at complaint online here.**

Who is enforcing federal and state surprise/balance billing requirements? (Updated 4.15.22)

- On Feb. 10, 2022, the Illinois Department of Insurance published Company Bulletin 2022-03 Initial Implementation of the Federal No Surprises Act in Illinois, available here.
- The Bulletin outlines which governmental agencies enforce various balance billing situations based on the provider, payer, and item or service involved.
- IHA encourages all Illinois providers to review this Bulletin with their legal counsel to ensure understanding and compliance.
- CMS posted a letter on the CMS Center for Consumer Information and Insurance Oversight (CCIIO) website describing allocation of enforcement responsibility among various state and federal agencies.

What is CMS' turn-around time for addressing complaints, including billing complaints from providers? (Updated 3.21.22)

- On a March 2022 call, CMS indicates that the complaint portal went live on Jan. 1, 2022. CMS has actively received inquiries and complaints from consumers and providers, and efforts are underway to address those issues in the order they are received. However, many complaints received thus far are specific to NSA provisions that have not yet been finalized in regulations. In such instances, CMS suggested consumers and providers may need to wait until implementing regulations are issued, which CMS suggested would be around July 2022.
- CMS also indicated it will soon communicate what providers can expect when it comes to NSA enforcement, and additional guidance and FAQs are forthcoming.

Applicable Plan Types under the NSA

How do we know if a patient is subject to NSA Protections?

- Currently there is no formal mechanism or guidance from the federal government aiding providers in determining whether a particular patient is subject to balance billing protections. In comments to the Departments IHA urged the federal government to require health plans to inform the provider whether NSA protections apply in a given situation at the point an eligibility determination is completed. Until such requirements

are enforced, the AHA and IHA encourage providers to err on the side of caution when sending bills to patients for out-of-network care. This may mean waiting until the payer adjudicates the patient's claim before attempting to collect cost sharing.

What types of health care coverage are applicable under the NSA?

- Balance billing protections under the NSA are applicable to patients enrolled in the following types of health coverage with respect to plan years beginning on or after Jan. 1, 2022:
  - Federal Employees Health Benefits Program
  - Individual and small group market coverage, including:
    - Coverage offered in the individual market
    - Through or outside of an Exchange
    - Student health insurance coverage
  - Group health plans, including:
    - Insured and self-insured group health plans
    - Private employment-based group health plans subject to ERISA
    - Non-federal governmental plans (such as plans sponsored by states and local governments) subject to the PHS Act
    - Church plans subject to the Code
    - Grandfathered, grandmothered and transitional health plans
  - Traditional indemnity plans, with the caveat that indemnity plans may have unique benefit designs that cause certain provisions of the NSA not to be relevant (e.g., requirements specific to non-emergency services provided by nonparticipating providers at certain participating facilities would never be triggered if a plan does not have a network of participating facilities)
- NSA protections do not apply to:
  - Excepted benefits coverage (e.g., dental benefits)
  - Short-term limited duration health plans
  - Retiree-only plans
  - Health reimbursement arrangements or other account-based group health plans that make reimbursements subject to a maximum fixed dollar amount for a period

How do NSA protections apply to tiered network plans?

- In a tiered network scenario, the provider is still in-network. Therefore, it is our understanding that the NSA protections on balance billing and limits on cost sharing do not apply. The cost sharing applied to the patient would be that which is stipulated in the plan, even if the scenario involves a tier 2 provider with higher cost sharing than a tier 1 provider.

How do NSA protections apply to plans that do not have a network, such as reference-based pricing plans? (Updated 9.9.22)

- **If the insured individual is enrolled in a plan that does not have a network, then the NSA protections specific to emergency items and services, including post-stabilization services, and air ambulance services apply. However, it is unlikely that the protections specific to scheduled non-emergency items or services would apply as the NSA stipulates that such items or services must be furnished at an in-network facility.**

Do NSA protection apply if the patient has a group health plan or group or individual health insurance coverage that generally does not provide out-of-network coverage? (Updated 9.9.22)

- **Yes, the NSA's protections regarding emergency services, non-emergency services furnished by a non-participating provider at a participating facility, and air ambulance services apply if those services are otherwise covered under the plan or coverage.**

How do NSA protections apply to open access network plans?

- Similar to other plans with provider networks, if the patient with an open access network plan seeks covered emergency services at an in-network or out-of-network facility, or a covered service at an in-network facility, the NSA protections apply.

Do NSA protections apply to Union health plans?

- *Similar to other plans with provider networks, if the patient enrolled in a union health plan seeks covered emergency services* at an in-network or out-of-network facility, or a covered service at an in-network facility, the NSA protections apply.

How do NSA protections apply if the patient's plan does not cover emergency department (ED) visits?

- If a health plan or issuer includes any benefits with respect to services furnished in an ED or an independent freestanding ED, then the plan or issuer must cover emergency services as defined by the NSA implementing regulations.
- If a health plan or issuer does not include any benefits with respect to services furnished in an ED or an independent freestanding ED, then the patient does not have coverage for those items and services and protections under the NSA would not apply.

Will providers have to revise their Managed Care Payer Contracts to align with the NSA requirements?

- There are no requirements under the NSA that providers and payer revise their contracts to align with the NSA. Rather, there are process changes and requirements necessary on behalf of both parties in order to come into compliance with the NSA. As such, it may be advantageous for providers to revisit and make specific NSA-related changes to their contract with health plans. IHA encourages members to engage legal counsel in such matters.

What if the patient is part of a Healthsharing community (e.g., Liberty Healthshare), are they considered uninsured or insured from the perspective of the NSA?

- Health reimbursement plans are not subject to the NSA. As Healthsharing communities are no-network, self-pay health reimbursement arrangements, it is our interpretation that individuals enrolled in such plans would not be subject to NSA balance billing protections. However, IHA encourages members to consult with legal counsel before balance billing any patient, regardless of their plan.
- However, note that individuals enrolled in health reimbursement plans may request a good faith estimate similar to uninsured or self-pay patients.

Sometimes when we try to transfer a patient to an in-network facility, there are no beds available at that facility, forcing us to admit the patient as an inpatient at our facility. Do NSA protections still apply in such cases?

- The No Surprises Act expands the definition of emergency services to include post-stabilization services, which end upon discharge, transfer, or patient consent to being balance billed. The law and implementing regulations only permit patients to waive balance-billing protections in the emergency setting under very limited circumstances. Additionally, if there are no in-network providers available to furnish items or services, then the implementing regulations state that nonparticipating facilities may not balance bill.
- IHA will continue urging the departments to issue additional guidance on this and other matters under the NSA. In the interim, we suggest members exercise caution and solicit legal counsel in determining when they will attempt to balance bill patients.

Communicating with Other Facilities and Payers

How do we know if a patient is subject to NSA Protections?

- Currently there is no formal mechanism or guidance from the federal government aiding providers in determining whether a particular patient is subject to balance billing protections. In comments to the Departments IHA urged the federal government to require health plans to inform the provider whether NSA protections apply in a given situation at the point an eligibility determination is completed. Until such requirements are enforced, the AHA and IHA encourage providers to err on the side of caution when sending bills to patients for out-of-network care. This may mean waiting until the payer adjudicates the patient's claim before attempting to collect cost sharing.

How will our registration department know if a patient's coverage is out-of-network?

- Unfortunately, there is not specific guidance on which entity, the payer or provider, is responsible for determining whether a provider is in- or out-of-network for a specific patient. Similarly, there is not specific guidance on how one determines whether a provider is in- or out-of-network for a specific patient. IHA and AHA asked the Departments to require health plans and issuers to provide this information to the provider at the point an eligibility determination is made. Until the Departments address

this issue in guidance, IHA encourages providers to err on the side of caution when sending bills to patients for out-of-network care.

How will we communicate patient information regarding out-of-network care, good faith estimates, etc. to health plans and issuers?

- The lack of standards around provider-payer communication led the Departments to delay enforcement of the required good faith estimate and advanced explanation of benefits for insured patients. The Departments encourage both parties to make a good faith effort to comply with these NSA requirements, and we expect formal notice and comment rulemaking on these pieces of the NSA in the coming calendar year.

Qualifying Payment Amount (QPA)

How is the QPA calculated?

- The health plan/issuer calculates the QPA and communicates that amount to the provider, most likely with the initial payment or notice of denial within 30 days of receiving a clean claim.

- The QPA is the plan or issuer's median in-network rate for the:
    - Same or similar item or service;
    - Provided by a provider in the same or similar specialty;
    - In the same insurance market;
    - In the same geographic region; and
    - In 2019 (adjusted for inflation).
    - Note – if the plan is a self-insured group health plan, the administering entity is treated as the plan for purposes of calculating the QPA.

What do you mean by the same or similar insurance market?

- For the purposes of calculating the QPA, plans and issuers must use rates from plans within the same insurance market. The regulations define three markets: the individual market, small group market, or large group market. If a plan is self-insured, the regulations define "insurance market" as all self-insured group health plans of the plan sponsor or, at the option of the plan sponsor, all self-insured group health plans administered by the same entity.

What adjustments are made for different types of facilities?

- The only facilities differentiated in the regulations are hospital-based emergency departments and independent freestanding emergency departments. If a plan or issuer contracts at different rates for emergency services based on these two types of facilities, then the QPAs for those services must be calculated separately based on facility type.

- Other facility characteristics (e.g., academic medical centers, teaching hospitals, safety net hospitals, children's hospitals, etc.) are not considered when calculating the QPA.

What are the geographic regions in Illinois?

- For the purposes of calculating the QPA, geographic regions are determined by metropolitan statistical areas (MSAs). Each metropolitan statistical area (MSA) in a state is considered a geographic region, with one final region consisting of all other portions of the state. The U.S. Office of Management and Budget (OMB) determines MSAs, with current guidance found here.
- Illinois MSAs as of November 2021 are as follows:
  - Bloomington, IL (Code: 14010)
  - Cape Girardeau, MO-IL (part) (16020)
  - Carbondale-Marion, IL (16060)
  - Champaign-Urbana, IL (16580)
  - Chicago-Naperville-Elgin, IL-IN-WI (part) (16980)
  - Danville, IL (19180)
  - Davenport-Moline-Rock Island, IA-IL (part) (19340)
  - Decatur, IL (19500)
  - Elgin, IL (20994)
  - Kankakee, IL (28100)
  - Lake County-Kenosha County, IL-WI (part) (29404)
  - Peoria, IL (37900)
  - Rockford, IL (40420)
  - St. Louis, MO-IL (part) (41180)
  - Springfield, IL (44100)
- If there is not sufficient information to calculate the QPA (i.e., median) for an item or service provided in a particular MSA, the plan or issuer must consider all MSAs in the state to be a single region when calculating the QPA. In other words, all MSAs in the state will constitute one geographic region, and all other portions of the state will continue to constitute a different region.
- If there is still insufficient information to calculate the QPA after combining MSAs, geographic regions will be based on Census divisions, with one region consisting of all MSAs in the Census division, and one region consisting of all other portions of the Census division. There are nine Census divisions, with Illinois falling in the Midwest division. More information is here.

Are Medicare or Medicaid rates included in the QPA?

- No. Plans may not include fee-for-service or contracted Medicare or Medicaid rates (e.g., rates for Medicare Advantage plans or Medicaid Managed Care Organization contracts). Additionally, rates for short-term, limited duration, account-based plans, and other forms of limited coverage are not included in the definition of applicable insurance.

Can providers ask payers how the QPA amount was calculated? (Updated 9.9.22)

- Payers must share specific information regarding the QPA in writing, either paper or electronically, with out-of-network providers, emergency facilities, or air ambulance

service providers (as applicable). This information must be shared when the QPA serves as the "recognized amount." Required information includes:

- The QPA for each item or service involved;
- **If the QPA is based on a downcoded service code or modifier, a statement from the plan or issuer explaining that the service code or modifier billed by the provider, facility, or air ambulance provider was downcoded; an explanation of why the claim was downcoded, including a description of which service codes or modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded;**
- A statement certifying that: (1) the QPA applies for purposes of the recognized amount; and (2) each QPA shared with the provider or facility was determined in compliance with the methodology outlined in the July 2021 interim final rules;
- A statement that: (1) if the provider/facility wishes to initiate a 30-day open negotiation period for purposes of determining the total payment amount, the provider/facility may contact the appropriate person/office to initiate open negotiation, and (2) that if the 30-day open negotiation period does not result in a determination, the provider or facility may initiate the IDR process within 4 days after the end of the open negotiation period; and
- The plan or issuer must also provider contact information, including a telephone number and email address, for the appropriate office/person to initiate open negotiations for purposes of determining the total payment amount (including cost sharing) for an item or service.

- **Upon request** of the provider/facility, the plan or issuer must provide, in a timely manner, the following information:
  - Whether the QPA includes contracted rates that were not set on a fee-for-service basis for the specific items and services at issue;
  - Whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount;
  - If a related service code was used to determine the QPA for a new service code, information to identify which related service code was used;
  - If an eligible database was used to determine the QPA, a plan or issuer must provide information to identify which database was used to determine the QPA; and
  - A statement that the plan/issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive based or retrospective payments or payment adjustments for the items and services involved, which were excluded for purposes of calculating the QPA.

What actions should providers or facilities take if a plan or issuer fails to disclose required information on the QPA? (Updated 9.9.22)

- **Providers and facilities may still initiate the open negotiation process within 30 business days of receiving the initial payment or payment denial from a plan or issuer. However, a plan or issuer's failure to satisfy disclosure requirements may adversely affect a provider or facility's ability to meaningfully participate in negotiations during the open negotiation process.**
- **In cases in which a plan or issuer fails to comply with disclosure requirements, provider and facilities may request an extension to initiate the Federal IDR process (see more information here).**
- **To request an extension, providers and facilities must email a request for extension due to extenuating circumstances to FederalIDRQuestions@cms.hhs.gov, and include the time period(s) for which they are seeking an extension.**
- **Additionally, providers and facilities should notify the No Surprises Help Desk at 1-800-985-3059 or submit a complaint here if they are concerned about a plan or issuer's compliance with disclosure requirements.**

If we have no out-of-network providers practicing at our facility, do we need to determine the QPA?

- If an insured patient seeks items or services at an in-network facility where all providers are also in-network, then the health plan/issuer would not calculate and communicate a QPA. Rather, previously established contracts between the facility/providers and the payer establish the total payment amount.

Independent Dispute Resolution (IDR) Process

When will the IDR portal open? (Updated 4.15.22)

- The Federal IDR portal opened on April 15, 2022.
- An overview of the Federal IDR process is available on CMS' YouTube channel.
- Disputes for which the open negotiation period has expired have 15 business days from April 15 to submit a notice of initiation of the IDR process through the IDR portal.
- Questions on the IDR process or portal may be sent to federalIDRquestions@cms.hhs.gov.

Many payers do not have a provider network. Instead, these payers negotiate claim by claim. Should we expect all of these claims to go through the federal IDR process?

- If a plan does not have a provider network, and your hospital/facility is thus out-of-network, then our interpretation is that only emergency services and post-stabilization services are applicable to NSA protections. It is possible that such interactions require the use of the federal IDR process. However, the IDR process is preceded by a 30-business day open negotiation period, during which payment may be determined.

Notice and Consent

Where can I find the notice and consent forms? (Updated 9.9.22)

- The notice and consent forms are on CMS' website as part of the CMS Form Number CMS-10780 zip file download.
- CMS recently updated the instructions for these forms. A crosswalk of changes is available in the zip file download.
- **For items and services furnished on or after Jan. 1, 2023, providers and facilities must use the revised version of the standard notice and consent form (Appendix IV).**

When can we use the notice and consent process?

- In general, the notice and consent process may be used for post-stabilization services and certain scheduled services provided by an out-of-network provider at an in-network facility. However, balance billing is never permitted for some services furnished at **in-network facilities**. These include:
  - Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner;
  - Items and services provided by assistant surgeons, hospitalists and intensivists;
  - Diagnostic services, including radiology and laboratory services; and
  - Other items and services provided by a nonparticipating provider if there is no participating provider who can furnish such items or services at such facility.
- Additionally, if your **facility is out-of-network** for a specific patient and the radiology and laboratory services are considered post-stabilization services, you cannot balance bill the patient as radiology and laboratory items and services are considered ancillary services under the NSA for which balance billing protections always apply. While the patient may consent to certain out-of-network care, they cannot waive their balance billing protections for radiology and laboratory services and therefore the facility may not balance bill.

Do we have to translate the notice and consent documents into 15 languages, or for our area could we do only English and Spanish? (Updated 12.21.21)

- The No Surprises Act requires providers and facilities to make the notice and consent documents available in the top 15 languages in a state or geographic region in which the applicable facility is located. Providers and facilities will need to translate the notice and consent documents into the top 15 applicable languages. If an individual's preferred language is not among the 15 languages made available, then the provider or facility must furnish the individual with a qualified interpreter. IHA and the American Hospital Association have asked the Departments to make translations of these documents available; however, thus far the Departments have not responded to this request.

When using the notice and consent form, can we list the physician or provider group instead of an individual physician or provider's name? (Updated 4.8.22)

- No, the form must explicitly identify the individual provider who is expected to provide a given item or service.

If a patient presents to the emergency department that is out-of-network, do we provide that patient with the notice and consent up front?

- No. The No Surprises Act protects patients from balance bills for emergency care regardless of whether the facility is in-network or out-of-network. Once the patient is stable, the facility may consider presenting the notice and consent to the patient. This may only happen if the patient meets certain criteria, including the ability to travel to an in-network facility using non-medical or non-emergency medical transportation. The patient's attending physician or treating provider must make this determination, and it is just one of several criteria that must be met in order for the facility to utilize the notice and consent with a patient in the post-stabilization portion of a facility inpatient or outpatient stay.

Would we ever use the notice and consent process for uninsured or self-pay patients?

- No. The Notice and Consent process is specific to insured patients.

My understanding is that this applies to situations where our hospital may be in-network, but a provider (independent general surgeon as example) may not be in-network. Does the facility (hospital) have any obligation to provide the notice and consent that the provider (general surgeon) is out-of-network, or is the burden on the provider? (Updated 12.21.21)

- Facility responsibilities for the notice and consent process depend on whether the services are post-stabilization or scheduled non-emergency services. For post-stabilization services, the facility must manage the notice and consent process for all out-of-network providers engaged in the patient's care. For scheduled, non-emergency out-of-network professional services furnished at an in-network facility, the facility has the option, but not the obligation, to complete the process on behalf of the out-of-network provider.

  Additionally, out-of-network providers have the option to coordinate and use a single notice and consent document, or complete separate documents. If multiple out-of-network providers use the same notice and consent document, the patient may choose to waive their balance billing rights for certain services within the document and are not required to waive their balance billing rights for all services.

The notice and consent process cannot be used for diagnostic services, including radiology and laboratory services. Does this mean that hospitals must accept plans that do not have network arrangements?

- If the patient comes to the hospital for emergency services, then you must treat the patient regardless of the patient's plan or ability to pay. Both the NSA and EMTALA

apply. The NSA expands the definition of "emergency" to include post-stabilization services. See more information below.

- If the patient is seeking non-emergency, scheduled services and your facility is out-of-network, then the NSA balance billing protections do not apply.

If a patient declines consent to be balance billed, what happens next? Can we decline to treat the patient?

- The answer to this question depends on the items and services the patient needs.
- Post-Stabilization Services
    - The following conditions must be met for out-of-network providers and out-of-network facilities to use the notice and consent process for post-stabilization patients:
        - The emergency treating physician/provider must determine the patient is stable enough for transfer to an in-network facility using non-medical/non-emergency transportation while considering distance, affordability and travel conditions.
        - The out-of-network providers and out-of-network facilities providing post-stabilization services must satisfy all of the notice and consent requirements stipulated in the No Surprises Act and implementing regulations (see IHA summary and webinar slides).
        - The treating emergency provider must determine that the patient or the patient's representative is able to provide informed consent. The provider must consider factors such as the patient's mental or emotional state, mental or behavioral conditions, substance use, language access, literacy levels, cultural or other contextual factors, and historical inequities for underserved communities.
        - The out-of-network provider or out-of-network facility must also satisfy other conditions laid out by the federal government and comply with any relevant state law.
    - Even if all of the above conditions are met, if the patient does not give consent to be balance billed or to transfer, then the balance billing protections continue to apply.
    - We expect additional guidance on post-stabilization services and the notice and consent process, but it is unlikely such guidance will be made available before Jan. 1, 2022.
    - If the patient does consent to be balance billed by the out-of-network facility, ancillary services still fall under balance billing protections. For example, if the patient require anesthesiology services after consenting to being balance billed by the facility, and the anesthesiologist is out-of-network, the balance billing

protections are still in place and the anesthesiologist may not balance bill the patient.

- Scheduled Non-Emergency Services
    - Balance billing protections are in place when non-emergency items or services are scheduled at in-network facilities.
    - Each out-of-network provider at an in-network facility is responsible for their own notice and consent process unless the provider and facility agree that the facility will take on the notice and consent process. However, there is no requirement for the facility to agree to coordinate the notice and consent process for out-of-network providers.
    - If the patient seeks non-emergency care from an out-of-network provider at an out-of-network facility, the notice and consent process is not required. The patient is willingly going out-of-network and balance-billing protections do not apply.
        - In such cases, providers may want to notify the patient that all services are out-of-network.

If a post-stabilization patient consents to treatment at the out-of-network facility and one of the out-of-network providers is for anesthesiology services, can the out-of-network anesthesiologist balance bill the post stabilization patient receiving care at the out-of-network facility to which the patient consented?

- No. Anesthesiology is an ancillary service for which balance billing protections always apply. In this scenario, while the patient may consent to certain out-of-network care, they cannot waive their balance billing protections for anesthesiology services and therefore the anesthesiologist could not balance bill the patient.

Our hospital does not directly employ many of the providers furnishing ancillary services, such as anesthesiology, pathology and radiology services. These doctors bill for their services independent of the hospital. For the Notice and Consent, do we need to retain the notice and consent form and provide it to these outside providers upon request?

- Out-of-network emergency facilities, in-network health care facilities, and out-of-network providers are required to retain written notice and consent documents for at least 7 years after the date on which the item or service was furnished. The regulations specifically state that this retention requirement applies to out-of-network providers at in-network facilities.
- Providers and facilities may coordinate so that only the facility retains such documentation, but that is not a requirement under the regulations.

Is there any reason a facility should provide the "notice" to all emergency department patients, and the "consent form" only when it applies? Or should providers think about "notice & consent" as one concept that only applies in specific and rare situations?

- It is our understanding that the notice and consent documents should be given to the patient at the same time. Therefore, it probably would not be advantageous to supply all emergency department patients with the notice, as it is our interpretation that the facility would have to supply the notice again at the time the patient is presented with the consent form.
- Additionally, emergency services are always subject to NSA protections; therefore, the Notice and Consent process will rarely be used in the emergency department.
- IHA suggests each facility consult with its legal counsel to determine the best course of action.

How will HHS oversee patient information sharing requirements, such as the notice and consent?

- Enforcement of NSA requirements is based on complaints, required health plan and arbitrator entity reports, and audits.
- Complaints of NSA violations may come from consumers, state insurance departments, the National Association of Insurance Commissioners (NAIC), other federal/state agencies, providers, or health plans/issuers.

State/Federal Surprise Billing Law Interaction

Do we have any updates on how the State plans to enforce NSA requirements? (Update 7.5.22)

- **Illinois and CMS came to an enforcement agreement effective Aril 27, 2022. It is posted on CMS' Consolidated Appropriations Act, 2021 website.**
- **An IHA summary of the agreement is here.**
- **Information on the state's arbitration process is here (Company Bulletin 2011-07).**

What state contact information should I put on the public and patient notices regarding surprise billing protections? (Updated 7.5.22)

- **Consumer complaints should be filed online with the Illinois Department of Insurance.**
- **Complaints must be made in writing.**
- **Consumers may also call the Office of Consumer Health Insurance (OCHI) with questions at (877) 527-9437.**

Does Illinois' surprise billing law supersede the No Surprises Act?

- It depends. Illinois' law supersedes the No Surprises Act when:
  - The health plan or issuer involved is overseen by the state;
  - The item or service is provided at an in-network facility; and
  - The item or service falls under one of the five categories covered under Illinois' law: anesthesiology, emergency, laboratory, pathology, or radiology.

Where can I find more information about Illinois' surprise billing law? (Updated 7.5.22)

- **During the Spring 2022 Legislative Session, Rep. Bob Morgan sponsored House Bill 4703 which amended Illinois' surprise billing protections (Public Act 096-1523) to better align with the federal No Surprises Act.**
- **Effective July 1, 2022, Public Act 102-0901 amends the Illinois Insurance Code to mirror No Surprises protections that ban balance or surprise billing in certain situations. These protections are specific to insured individuals and fall into two categories: emergency services, and non-emergency services at participating health care facilities.**
- **An IHA summary of Public Act 102-0901 is here.**

Uninsured/Self-Pay Good Faith Estimate (GFE)

Aren't there GFE requirements for insured patients? What are the requirements, and when are they effective? (Updated 4.8.22)

- Yes, there are GFE requirements for insured patients as well. Specifically, if a facility is out-of-network, the patient is enrolled in a plan or coverage, and the patient intends to have a claim submitted for scheduled items or services, the provider or facility must submit a good faith estimate to the plan or issuer. The plan or issuer must, in turn, send an advance explanation of benefits to the patient.
- Enforcement of this requirement is delayed until rulemaking is issued. We currently expect such rulemaking to occur this summer.

Which physician types must furnish GFEs to uninsured or self-pay patients? (Updated 1.14.22)

- In general, all providers and facilities that schedule items or services for an uninsured or self-pay individual or receive a request for a GFE from an uninsured or self-pay individual must provide one. No specific specialties, facility types, or sites of service are exempt from this requirement.
- The term "health care provider" is defined as a physician or other health care provider who is acting with the scope of practice of that provider's license or certification under applicable State law, including air ambulance service providers.
- The term "health care facility" means an institution licensed as such under State or applicable local law and meeting the standards of that license. This includes, but may not be limited to, hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgical centers, rural health centers, federally qualified health centers, laboratories, and imaging centers.

Are GFEs required for all services provided to uninsured/self-pay patients or only for hospital related services?

- The good faith estimate for uninsured/self-pay patients must include all expected charges across all providers and facilities involved in the anticipated course of care for an item or service, including any items or services reasonably expected to be provided in conjunction with the primary item or service.

- This includes 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 for the primary item or service.

What is the definition of a "convening provider?" Is the convening provider always the facility?

- The convening provider is the entity responsible for scheduling the primary item or service. This will often be the hospital or facility. The convening provider is responsible for notifying the uninsured or self-pay patient about the availability of good faith estimates, as well as coordinating the estimates from all providers and delivering the combined good faith estimate to the patient.
    - Primary item or service: the item or service that is the initial reason for the visit and is provided by the convening provider or facility.
- If there is a situation where an out-of-network physician schedules the primary service at an in-network facility themselves, then the physician would be the convening provider.

If a hospital contracts with an outside provider group, say radiology, it will not necessarily know which radiologist reads and interprets the submitted films, and therefore will not know which physician to list on the GFE. What NPI should be listed on the GFE? (Updated 3.21.22)

- During a March 2022 call, CMS said the group NPI may be used on the GFE.

What is the GFE timeline for an uninsured/self-pay patient that wants to schedule a same-day item or service?

- An individual may still request a good faith estimate for an item or service that is scheduled in less than three business days. However, there is no estimate requirement triggered upon scheduling of an item or service in less than three business days before the appointment.

How can a provider comply with the timeline to provide a GFE when hospital financial assistance policies first require a patient to complete a financial assistance application to determine their discount?

- IHA is working with the American Hospital Association and others to communicate with the Departments and demonstrate why the current regulations are unaligned with the typical financial assistance policies employed by many hospitals across the country. In the interim, we suggest reviewing current policies and determining whether any patient financial discounts might be determined upfront.
- (Updated 3.21.22) On a March 2022 call, CMS indicated it is aware that this is burdensome and they are reviewing current requirements. Guidance is forthcoming. In the interim, CMS reminded providers that GFEs should be updated as more information on a patient's financial status is revealed.

Does the GFE need to be in writing or can it be given by phone? (Updated 1.14.22)

- The GFE for uninsured/self-pay patients must be in writing. The GFE may be transmitted either via paper or electronically (e.g., through a patient portal) based on the patient's preference. If transferred electronically, the patient must be able to save and print the GFE.
- If the patient requests the GFE be delivered orally or in-person, the provider may furnish the GFE in that way as well, but must follow up with a written paper or electronic GFE. A written paper or electronic GFE is required because patients must furnish the GFE if they want to initiate the patient-provider dispute resolution process.

Can a patient decline receiving a GFE? (Updated 1.14.22)

- No; uninsured and self-pay patients must receive a GFE under the NSA if a service is scheduled at least three days in advance.

On the GFE, what phone number do we enter for questions or more information? (Updated 12.6)

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

- An Oct. 25, 2021 memo from the Center for Consumer Information and Insurance Oversight (CCIIO) includes the URL for the No Surprises Act website where consumers and other entities may submit complaints. The memo also includes the phone number that providers should include in the GFE and other documents describing patient protections under the NSA.
- Neither the website nor the phone line will be operational until Jan. 1, 2022.
- The website is: https://www.cms.gov/nosurprises/consumers
- The phone number for information and complaints is: 1-800-985-3059

Do we have to use the GFE template produced by the Departments?

- No, you may use your own GFE form. However, the Departments did specify information that must be on the GFE. For convening providers/facilities, the following information must be on the GFE:
    - Patient name and date of birth.
    - Description of the primary item or service in clear and understandable language (and date of service, if applicable).
    - Itemized list of items or services, grouped by each provider/facility, reasonably expected to be furnished for the primary item or service and items or services reasonably expected to be furnished in conjunction with the primary item or service for that period of care, including those provided by the convening provider/facility and any co-providers / co-facilities.
    - Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service.

  - Name, NPI, and TIN of each provider/facility represented in the good faith estimate and the states and office or facility locations where the items or services are expected to be furnished.
  - List of items or services that the convening provider/facility anticipates will require separate scheduling and that are expected to occur before or after the expected period of care for the primary item or service.
  - Disclaimers regarding additional items or services that are recommended that must be scheduled or requested separately, that the good faith estimate is only an estimate and that actual charges may differ, that the patient has the right to initiate the patient–provider dispute resolution process if the actual billed charges substantially exceed the expected charges in the good faith estimate, and that the good faith estimate is not a contract and does not obligate the patient to obtain the items or services from any of the providers identified in the good faith estimate.
- For co-providers/co-facilities, the following information must be on the GFE:
  - Patient name and date of birth.
  - Itemized list of items or services expected to be provided by the co-provider / co-facility that are reasonably expected to be furnished in conjunction with the primary item or service for the period of care.
  - Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service.
  - Name, NPI, and TIN of the co-provider / co-facility and the states and office or facility locations where the items or services are expected to be furnished.
  - List of items or services that the convening provider/facility anticipates will require separate scheduling and that are expected to occur before or after the expected period of care for the primary item or service.
  - A disclaimer that the good faith estimate is not a contract and does not obligate the patient to obtain the items or services from any of the co-providers / co-facilities identified in the good faith estimate.

What if I don't know what diagnosis code to include on the GFE? For example, what if we are scheduling an initial screening visit or check-up? (Updated 4.8.22)

- Providers or facilities are only required to provide a diagnosis code where one is required for the calculation of the GFE. In situations where the provider or facility has not determined a diagnosis, such as for initial screening visits or evaluation and management visits, or if there is not a relevant diagnosis code for an item or service, provider and facilities are not required to include a diagnosis code on the GFE. However, all expected charges and services codes for the items and services that are reasonably expected to be furnished during the visit must be included on the GFE.

How should providers store GFEs? (Updated 1.14.22)

- Providers should consider and treat GFEs as part of the patient's medical record. The same storage requirements and principals that apply to medical records apply to GFEs.

Can a provider produce a single GFE for a series of services or visits? (Updated 1.14.22)

- Yes, providers may produce a single GFE for recurring items or services. The GFE must clearly identify the scope of the estimate, including timeframe, frequency, and total number of visits included in the estimate. The GFE must also be updated annually and/or whenever there is a change to the estimated charges or scope of services.

Are patients enrolled in reference-based pricing plans considered uninsured? Should providers furnish GFEs for such patients? (Updated 1.14.22)

- ERISA-regulated reference-based pricing plans are subject to NSA requirements. Therefore, patients with such plans would be considered insured, and providers do not need to provide GFEs for such patients unless the patient indicates it plans to pay for the items or services being scheduled out-of-pocket.

If a patient is insured, but the item or service being scheduled is not covered by their insurance plan, does the provider need to furnish a GFE for that item or service? (Updated 1.14.22)

- Yes. If a schedule item or service is not covered by a patient's health plan, then the patient is considered uninsured under the NSA. We understand that providers may not know how to determine whether a patient's health plan covers a particular item or service, and we await clarification from HHS on this question.

My facility has a set price for services. Do I still need to furnish a GFE for uninsured or self-pay patients? (Updated 1.14.22)

- Yes. Even at facilities that operate under set prices, a GFE must be furnished. This is required under the NSA because the patient must provide the written paper or electronic GFE if they wish to initiate the patient-provider dispute resolution process.

The $400 threshold triggering the patient-provider dispute resolution process for uninsured/self-pay patients is a low bar. Legitimate, unexpected and expensive complications are common, particularly if the patient requires surgery or pharmaceuticals. How should we prepare for this?

- IHA is working with the American Hospital Association and others to communicate with the Departments and demonstrate why the current threshold of $400 in excess of the GFE is overly restrictive and burdensome. Please note that one of the required disclaimers for the GFE is a statement indicating that the GFE is only an estimate and that actual charges may differ.

Many of our ancillary providers are not employed by the hospital/facility. These providers do their own billing. Do we need to include these providers on the GFE?

- Yes, such providers would be considered co-providers on the GFE and the convening provider (in this case, the hospital) would need to include good faith estimate charges for co-providers on the GFE.
- The Departments are exercising enforcement discretion on the inclusion of estimates for co-providers until Jan. 1, 2023.

If the convening provider does not reach out or direct the patient to the co-provider, can the co-provider bill and expect payment?

- The convening provider is responsible for coordinating and producing a good faith estimate that includes all expected charges across all providers and facilities involved in the anticipated course of care. While HHS plans to exercise enforcement discretion through Dec. 31, 2022 concerning the incorporation of good faith estimates from outside providers or facilities, it encourages convening providers to give as much information as possible regarding additional items and services that may be included in the course of care.
- If the co-provider changes between the initial good faith estimate and provision of a scheduled item or service, the convening provider or facility is responsible for reissuing the good faith estimate no later than one business day before the item or service is scheduled to be provided. If a change in staffing occurs less than one business day in advance of delivering the item or service, the replacement provider or facility must accept the initial good faith estimate that was provided by the original provider or facility.
- Beginning Jan. 1, 2023, if the convening provider does not include co-provider estimates in the good faith estimate, then the convening provider would be out of compliance with the NSA.

If a provider orders radiology and laboratory services, but the services are provided on different days, do we provide the patient with one or two GFEs? In this scenario, all of the labs are ordered and billed by the same provider.

- If the radiology and laboratory services are part of the same anticipated course of care, then both should be on the same GFE. If they are billed by the same provider or facility, they can be displayed together. However, if they are billed by two different providers or facilities, you will want to break the estimated charges out by billing provider.

For inpatient admissions priced per diem, is that in itself the GFE or do you have to make a length of stay estimate which would nearly always be off by more than $400? (Updated 12.6.21)

- Our interpretation of the regulation is that a hospital should estimate the length of stay in the GFE. However, this is just our interpretation of the regulations and should not be considered legal advice. We recommend hospitals consult with their own counsel for their individual organization's needs.

If items or services are priced by DRG and there are outlier payments for length of stay, then the admitting DRG could be different than the discharge DRG. How should hospitals account for this on the GFE for uninsured/self-pay or even insured patients? (Updated 12.6.21)

- Length of stay (LOS) outliers and DRG payments are typically a Medicare FFS concept, and these concepts may not be generally applicable outside of that context. However, regardless of whether LOS outliers are implicated or not, there is inevitably going to be greater cost for longer stays than are expected. In this sense, hospitals will need to estimate how long they expect a patient to be in the hospital on the GFE and to the

extent that the GFE is off (which we recognize may be frequent), these matters may be subject to patient dispute processes. Please consult with your legal counsel to ensure your organization's needs in this area are met.

If a patient uses a hospital's consumer friendly file posted on the website to estimate the cost of care, can the patient use that estimate to enter into the patient-provider dispute process?

- No. The patient-provider dispute process is specific to GFEs furnished by the convening provider.

What if we do not intend to bill the patient, do we still need to provide them with a GFE?

- Yes. GFEs must be created and furnished to uninsured/self-pay patients for any scheduled item or service.

Would patients who qualify for 100% charity care be required to receive an estimate even though they do not owe anything for the service?

- If the patient is uninsured or self-pay, the convening provider must create and provide a GFE to that patient for scheduled items or services. It is IHA's interpretation that this is true even for patients that qualify for and have 100% of their costs covered by charity care.
- Note that even if the hospital plans to provide 100% charity, a co-provider may not; and as the convening provider, the hospital needs to supply the co-provider's estimate. Also, a GFE displaying a $0 cost estimate may be helpful documentation should a patient initiate the patient-provider dispute resolution process. Documenting the GFE may protect the convening provider if a co-provider estimates charges of $0 but then changes the total bill to an amount in excess of $400 after the item or service is rendered. If the convening provider never supplied the GFE displaying a $0 estimate, then the patient may enter into a patient-provider dispute with the co-provider while also reporting the convening provider for noncompliance because it did not supply the initial GFE.

Are the Notice and Consent documents required for uninsured or self-pay patients?

- No. The Notice and Consent documents are specifically for insured patients. See Notice and Consent section above for more information.

Public Disclosure of Surprise Billing Protections

What providers must furnish patient protection disclosures? (Updated 4.8.22)

- A provider furnishing an item or service at a health care facility at which balance billing protections apply, or in connection with a visit to such a health care facility, must make balance billing protection disclosures to patients.
- A provider is not required to make the disclosure to individual to whom the provider furnish items or services if such items or services are not furnished in connection with a visit at a health care facility.
- A provider is not required to make the disclosure to individuals if there is a written agreement where the facility agrees to make the disclosure instead of the provider.

How often do you need to give patients this public disclosure? (Updated 9.9.22)

- Providers and facilities must publicly disclose patient protections under the NSA on their public websites.
- The regulations also encourage providers and facilities to display the notice in publicly accessible locations (e.g., patient check-in, scheduling desk, billing locations, etc.).
- Providers and facilities must also provide a one-page notice to patients when the provider/facility asks for payment or submits a claim.
- **Providers/facilities may use the model public disclosure form available from CMS to fulfill federal requirements. There are two versions of this form, Appendix I and Appendix III. Both are available here. Providers must use Appendix III (Version 2) beginning Jan. 1, 2023 to be considered in good faith compliance with disclosure requirements.**
- Note that the public disclosure document must include state-level protections as well. IHA is in communication with IDOI on potential model language that all Illinois providers might use to fulfill this requirement.
- (Updated 12.6.21) CMS recently updated the instructions for this forms. A crosswalk of changes is available in the zip file download.

Who should receive this disclosure? (Updated 12.6.21)

- Providers/facilities must give the disclosure notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer.
- This includes individuals in a health benefits plan under the Federal Employees Health Benefits Program.
- This only applies to the above individuals that receive items or services, and only if those items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

When should the provider give the disclosure to the patient? (Updated 12.6.21)

- Providers/facilities must issue the disclosure notice by the date and time when they request payment from the patient. If the provider/facility requests a copayment or coinsurance at the time of the visit, then the disclosure must also be given to the patient at that time.
- If the provider/facility does not request payment from the individual, the notice must be provided when the provider/facility submits a claim for payment to the plan or issuer.

Do patients need to sign an acknowledgement that they received the disclosure notice on patient protections against surprise billing? (Updated 4.8.22)

- No.

Should hospitals document that the Model Disclosure Notice (1) was given to patients, and (2) when it was given? (Updated 12.6.21)

- There is no required documentation for providing notice to uninsured/self-pay patients of their good faith estimate rights.

On the last page of the Model Disclosure notice, who should be listed in the statement below? (Updated 12.6.21)

If you believe you've been wrongly billed, you may contact [*applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws*].

- Our interpretation is that this should be the state or federal enforcement agency, and that the CMS website/number would apply here since CMS notes in the enforcement regulations that it will channel complaints to the appropriate enforcement agency.
- The website is: https://www.cms.gov/nosurprises/consumers
- The phone number for information and complaints is: 1-800-985-3059

How should hospitals summarize Illinois' surprise billing law in the disclosure document? (Updated 7.5.22)

- **The Illinois Department of Insurance is not aware of an Illinois-specific model notice for providers, suggesting that Illinois agencies will not make standard language available to providers for these notices.**
- **IHA suggests providers work with their general counsels to summarize patient protections under the state law (Public Act 102-0901).**
- **The main protections include:**
  - **When a beneficiary, insured, or enrollee utilizes a participating network hospital or a participating network ambulatory surgery center and, due to any reason, in-network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating physician or provider for covered services.**
- **Several other states with state-specific surprise billing laws have created model language summarizing their state-specific protections. These are available at the below websites:**
  - **California Hospital Association (linked within article): https://calhospital.org/cha-provides-state-specific-language-for-model-no-surprises-act-forms/**

- **New York Department of Financial Services (linked within letter): https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_10**
- **Washington Office of the Insurance Commissioner: https://www.insurance.wa.gov/federal-no-surprises-act**

- **For state complaints, the Illinois Department of Insurance confirmed that complaints against health insurance issuers should be made in writing and submitted here: https://www2.illinois.gov/sites/Insurance/Consumers/Pages/File-a-complaint.aspx. The Office of Consumer Health Insurance (OCHI) is also available by phone for questions at (877) 527-9431.**

Provider Directory Requirements

What entity is responsible for keeping provider directories up-to-date? (Updated 4.8.22)

- Both the health care provider or facility and the health plan or issuer are responsible for ensuring provider directory information is up-to-date.

What are the specific provider responsibilities? (Updated 4.8.22)

- Any health care provider or facility that has or has had a contractual relationship with a plan or issuer to provide items or services under the coverage must submit provider directory information to the plan or issuer.
- This information must be communicated, at minimum, at the beginning of the network agreements with the plan/issuer, at termination of the network agreement with the plan/issuer, when there are material changes to the content of the provider directory information of the provider or facility, upon request by the plan/issuer, and at any other time determined appropriate by the provider/facility/HHS.
- If plan/issuer participants, beneficiaries, or enrollees relied on incorrect provider directory information when making medical decisions, the health care provider or facility must reimburse the patient for the full amount paid in excess of the in-network cost-sharing amount, plus interest.