Surprise Billing Laws Toolkit for Indiana Hospital Association

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Indiana Hospital Association

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DEAR IHA MEMBER,

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

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

Documents included in the toolkit:

FAQS REGARDING BALANCE BILLING PROHIBITIONS

1. **Is balance billing strictly prohibited for *all* out-of-network emergency services?**
   Yes. The federal No Surprises Act prohibits balance billing for any emergency service (including further examination and treatment to stabilize an emergency condition) provided in a hospital, off-campus hospital emergency department or freestanding emergency department.

2. **Can an out-of-network facility and/or out-of-network provider balance bill for services *after* an emergency condition is stabilized?**
   Sometimes. A provider is prohibited from balance billing for all services provided to a patient following the stabilization of an emergency medical condition ("post-stabilization services") unless *all* of the following conditions are satisfied:
   a. The treating physician determines that the patient is medically able to travel to a participating provider or facility within a reasonable distance, without requiring emergency medical transportation;
   b. The out-of-network facility (or out-of-network provider) satisfies all of the requisite notice and consent criteria described in question 8; and
   c. The patient is capable of understanding the notice and freely provides informed consent to waive the balance billing protections.

3. **Can an out-of-network facility balance bill for nonemergency services?**
   Yes. Current laws do not prohibit an out-of-network facility from balance billing for non-emergency services. However, as discussed in question 2, balance billing for post-stabilization services is conditional.

4. **Can an out-of-network provider balance bill for non-emergency services in a participating facility?**
   Sometimes. Out-of-network providers may balance bill for services provided in a participating hospital, hospital outpatient department, critical access hospital, ambulatory surgery center, abortion clinic, birthing center, urgent care facility, laboratory, imaging center or infusion center if the participant voluntarily waives his or her legal protections after full compliance with the requisite notice and consent process described in question 8. Notwithstanding the foregoing, out-of-network providers are never permitted to balance bill for "ancillary services" and certain other services described in questions 5 and 6. Additionally, an out-of-network provider may only bill for post-stabilization services if they satisfy each of the conditions described in question 2.

5. **Can an out-of-network provider balance bill for "ancillary services" provided in a participating facility?**
   No. Out-of-network providers who provide ancillary services in a participating facility may not balance bill a patient for any amount beyond the in-network cost sharing amount. "Ancillary services" include diagnostic services (such as radiology and laboratory), items and services related to Emergency Medicine, Anesthesiology, Pathology, Radiology, Neonatology; and items and services provided by assistant surgeons, hospitalists, or intensivists.

6. **Are there other circumstances where out-of-network providers are strictly prohibited from balance billing for nonemergency services?**
Yes. Out-of-network providers may not balance bill for items and services rendered in a participating facility if: (i) there is no in-network provider available to furnish those items and services at the participating facility, or (ii) the items or services are for unforeseen urgent medical needs.

7. **Do the balance billing restrictions apply to *all* non-emergency services, regardless of the location?**
No. The prohibition on balance billing for non-emergency services applies only when an out-of-network provider renders nonemergency services at a participating hospital, hospital outpatient department, critical access hospital or ambulatory surgery center.

8. **Are facilities and providers required to notify patients of the balance billing restrictions?**
Yes. Facilities and providers are required to provide a disclosure that includes the following information in clear and understandable language: (i) the restrictions on providers and facilities regarding balance billing in certain circumstances, (ii) any applicable state law protections against balance billing, and (iii) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

   We have adapted a model disclosure form developed by CMS to include Indiana's requirements that can be used to satisfy this requirement. (See **Attachment A**). The disclosure must be provided in three ways: (i) the disclosure or a link to the disclosure must be posted on the provider's or facility's public website, (ii) prominently displayed in a location where patients check in or scheduling typically occurs, and (iii) given to covered individuals in a health plan, who receive items or services furnished in a participating hospital, hospital outpatient department, critical access hospital or ambulatory surgery center, and provided in-person, by mail, or by email, as selected by the individual.

9. **If allowed, how does an out-of-network facility (for post-stabilization services) or an out-of-network provider (for post-stabilization or non-emergency services in a participating facility) attain the patient's waiver of the balance billing protections?**
Facilities and providers must use the standard notice form developed by HHS, as adapted for Indiana-specific requirements. (See **Attachment B**.) This document may *not* be modified, except to delete the bracketed language and to add information identifying the provider, the patient, and a good faith estimate of the items and services expected to be provided by the out-of-network facility and/or provider(s). The completed form must be provided to the patient or the authorized representative at least 5 business days in advance of a scheduled service. The form must be a separate document and cannot be attached or incorporated into another document. The document must meet language access requirements and a representative must be available to explain it and answer any questions. The notice form includes a consent form, which a patient must sign and return to the provider, prior to the provision of the service, if the patient is to consent to be balance billed for the service. Finally, a copy of the signed consent must be provided to the patient in-person, by mail, or by email (as selected by the patient), and to the health plan of the patient, provided that notice to the health plan may be satisfied by attaching a copy of the signed consent form to the bill if the provider bills the patient directly. An incomplete consent form will be treated as a lack of consent and balance billing protections will still apply to the patient.

10. **How will the participant's cost-sharing responsibility be determined for services for which an out-of-network provider is prohibited from balance billing?**
To determine a participant's cost-share liability for services for which an out-of-network provider is prohibited from balance billing, the provider must apply the patient's in-network cost-share obligation to the "recognized amount." The "recognized amount" is equal to an amount determined by (1) an All-Payer Model Agreement, (2) a specified state law, or (3) the lesser of the amount billed by the out-of-network provider, or the "Qualified Payment Amount" ("QPA").

Currently, Indiana is not a part of an All-Payer Model Agreement, nor has Indiana enacted a specified law that otherwise determines the appropriate out-of-network rate for an item or service. Therefore, the "recognized amount" for services provided in Indiana by out-of-network providers will be based on the lesser of the billed charges or the QPA.

Generally, the QPA for a given item or service is determined by finding the median of the contracted rates recognized by the health plan on January 31, 2019, for: (i) the same or a similar item or service, (ii) that is provided by a provider in the same or similar specialty, (iii) is provided in the same geographic region in which the item or service is furnished, and (iv) increased annually for inflation. A participant's health plan is responsible for establishing the QPA and will state their calculated QPA in their initial payment or denial for an out-of-network item or service.

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

FAQS REGARDING OUT-OF-NETWORK REIMBURSEMENT AND THE INDEPENDENT DISPUTE RESOLUTION PROCESS

1. **How will out-of-network facilities (for emergency services) and out-of-network providers (for emergency services and, absent a waiver, for non-emergency services in a participating facility) be paid for these services?**
The federal No Surprises Act contemplates three ways of determining the out-of-network rate for services: (1) an amount provided in an All-Payer Model Agreement, (2) a specified state law that provides the amount to be paid for an out-of-network service (or a mechanism for determining the appropriate out-of-network rate), or (3) the amount determined through the federally mandated independent dispute resolution ("IDR") process.

Indiana does not have either an All-Payer Model Agreement or a specified state law that can be used to determine the appropriate out-of-network rate for services provided by out-of-network providers. Therefore, the appropriate out-of-network rate for items and services provided by out-of-network facilities (for emergency services) and out-of-network providers (for emergency services and, absent a waiver, for non-emergency services in a participating facility) will be determined through the federally mandated IDR process. The response to this Question 1 and to Question 2 briefly summarize

the independent dispute resolution process.

Under the IDR process, within 30 calendar days of receiving a bill from a nonparticipating provider or facility, a health plan is required to send an initial payment or notice of denial. If the provider is unwilling to accept the initial payment or denial, the provider may initiate an open negotiation period between the parties by sending the health plan an "open negotiation notice" within 30 business days from the date the provider receives the initial payment or notice of denial.

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

After the health plan receives the open negotiation notice, the health plan and the provider must attempt to mutually agree upon an appropriate out-of-network rate for the items or services in question for 30 business days (the "open negotiation period"). If the parties cannot reach an agreement within the open negotiation period, then the out-of-network rate will be determined through the federally mandated IDR process, as described in question 2.

2. **How will the IDR process work[1]?**

If there is no agreement on the out-of-network rate by the end of the open negotiation period, either party has 4 business days to initiate the IDR process by providing a "notice of IDR initiation" to the other party and to the Departments (through the federal IDR portal). The Departments have developed a standard Notice of IDR Initiation that the initiating party must complete and use to initiate the IDR process.

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

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

(a) Any information requested by the Certified IDR Entity relating to the offer or the items or services provided;

[1] On October 7, 2021, the Departments issued guidance regarding the independent dispute resolution process for determining the appropriate out-of-network reimbursement for covered individuals. HHS intends to provide additional guidance about this process, including information concerning how IDR entities are to conduct the evaluation of various factors submitted for consideration. Only a summary of the process is provided herein.

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

In coming to its determination regarding the appropriate out-of-network rate, the Certified IDR Entity must choose one of the two offers presented. The Certified IDR Entity must start with the presumption that the QPA is the appropriate payment amount and must select the offer closest to the QPA, unless "credible information" is submitted by the parties that clearly demonstrates that the QPA is "materially different" from the appropriate out-of-network rate. If the Certified IDR Entity determines that the QPA materially differs from the appropriate out-of-network rate, the Certified IDR Entity must select the offer it determines best represents the out-of-network rate for the items/services – which could be either party's offer.

Within 30 business days after being selected, the Certified IDR Entity must select an offer and provide a written decision, including detailed explanations of any additional considerations the Certified IDR Entity relied upon in making its determination. The decision is binding and non-appealable.

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

3. **What factors will the Certified IDR Entity consider when determining whether the appropriate out-of-network rate is materially different than the QPA?**

The Certified IDR Entity is to consider the following factors in determining whether the out-of-network rate is materially different from the QPA:

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

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

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

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

5. **Can multiple claims be consolidated and submitted through a single IDR process?**
Sometimes. The No Surprises Act allows a health plan or a provider to "batch" like items and services and consider them jointly in one single IDR process, if the items or services in question are:
   (a) Billed by the same provider;
   (b) Paid by the same health plan;
   (c) The same or similar items and services; and
   (d) Provided within the same 30 business day period (or 90 calendar day period if provided during the "cooling-off period" as described in question 6).

6. **What is the "cooling off period"?**
Once a Certified IDR Entity issues a determination, the No Surprises Act prohibits the party who initiated the IDR process from initiating a separate IDR process with that same opposing party for the same or a similar item or service for 90 calendar days. However, following the termination of this "cooling off period", the initiating party may batch together all claims for those same or similar items or services provided during the cooling off period and initiate another IDR process against the same opposing party.

7. **What are the relevant timeframes in which the different aspects of the IDR process must be completed?**
Please see chart on page 9.

FEDERAL IDR PROCESS TIMELINES		
Action	**Timeframe**	**Responsible Party**
Open Negotiation Notice	**30 Business Days** from the date of receipt of initial payment or denial	Provider (sent to Health Plan)
Open Negotiation Period	**30 Business Days** from the day provider sends the Open Negotiation Notice	N/A
Notice of IDR Initiation	**4 Business Days** from the end of the Open Negotiation Period	Either party (sent to the other party in writing; and submit to the Departments through the Federal IDR portal)
Selection of Certified IDR Entity (by parties)	**3 Business Days** from receipt of Notice of IDR Initiation Notice of selection to be sent to the Departments and the Certified IDR Entity on the **4th Business Day** from receipt of Notice of IDR Initiation	Both parties to mutually select the Certified IDR Entity. Initiating Party (to submit notice of selection through the Federal IDR Portal)
Selection of Certified IDR Entity (by Departments)	**6 Business Days** from receipt of the Notice of IDR Initiation, the Departments will select the Certified IDR Entity if the parties are unable to mutually select	Departments
Submission of Offer and Other Credible Information	**10 Business Days** from selection of the IDR Entity	Each party (submitted through the Federal IDR portal)
Payment of Certified IDR Entity Fee	At the time each party submits its offer to the IDR Entity	Each party to submit the entire fee, the prevailing party will have its fee remitted within **30 Business Days** from the date the IDR Entity issues its determination
Selection of Offer and Decision	**30 Business Days** from selection of the IDR Entity	IDR Entity (submitted through the Federal IDR portal)
Payment of Out-of-Network Rate	**30 Calendar Days** from the IDR Entity's determination	Health plan (if out-of-network rate is less than initial the payment) Provider (if out-of-network rate is more than the initial payment)
"Cooling Off Period"	**90 Calendar Days** from the date of the IDR Entity's determination	Neither party may initiate the IDR process for the same or similar item or service with the same opposing party

FAQS REGARDING GOOD FAITH ESTIMATES

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

2. **What are the federal GFE requirements that will be subject to enforcement beginning on January 1, 2022?**
   As of January 1, 2022, providers and facilities will be required to provide GFEs to ***uninsured and self-pay individuals*** for all scheduled services *and* upon request.

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

3. **Are there state GFE requirements that still need to be addressed after the federal GFE requirements go into effect?**
   Yes. Until the Departments fully implement the federal GFE and advance explanation of benefits requirements for Covered Individuals, Indiana providers and facilities should continue to follow the Indiana law requirement to provide a GFE to *Covered Individuals* (excluding Medicaid recipients) for ordered, scheduled or referred non-emergency services within 5 business days of receiving a request for the GFE (or within 5 business days of receiving relevant information from the covered individual).

   Indiana requires providers to make diligent attempts to ensure that individuals are aware of their right to request a good faith estimate by at least three of the following means of communication:
   1. Notice on the provider and facility's website;
   2. On-hold messaging;
   3. Waiting room notification;
   4. Pre-appointment reminders (including email or text messaging);
   5. During appointment check-in and/or check-out;

6. During patient financial services or billing department inquiries; and/or
7. Through an electronic and patient communication portal.

This communication must state words to the effect that: "A patient may ask for an estimate of the amount he/she will be charged for a non-emergency health care service provided in our facility. The law requires an estimate be provided within 5 business days."

4. **What type of facilities and providers must comply with the GFE requirements?**

The GFE requirements apply to a much broader set of healthcare facilities and providers than the balance billing provisions of the No Surprises Act and do not distinguish between in-network and out-of-network providers.

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

A "healthcare facility" or "facility" which includes an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) licensed by the State or approved by the State agency responsible for licensing such institution as meeting the established standards for licensing.

A "health care provider" or "provider" which means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services.

For purposes of the Indiana GFE requirements for **covered individuals**, the following must comply:

A "practitioner" which means an individual (excluding dentists and optometrists) who holds:

a. an unlimited license, certificate, or registration;
b. a limited or probationary license, certificate, or registration;
c. a temporary license, certificate, registration, or permit;
d. an intern permit; or
e. a provisional license;
   issued by the board regulating the profession in question; or
f. an entity that is owned by, employs, or performs billing for professional health care services rendered by an individual described above.

A "provider facility" which includes:

a. A hospital licensed under IC 16-21-2.
b. An ambulatory outpatient surgery center licensed under IC 16-21-2.
c. An abortion clinic licensed under IC 16-21-2.
d. A birthing center licensed under IC 16-21-2.
e. Except for an urgent care facility, a facility that provides diagnostic services to the medical profession or the general public, including outpatient facilities.
f. A laboratory where clinical pathology tests are carried out on specimens to obtain information about the health of a patient.
g. A facility where radiologic and electromagnetic images are made to obtain information about the health of a patient.
h. An infusion center that administers intravenous medications.

The term does *not* include private mental health institutions and Medicare certified, freestanding rehabilitation hospitals.

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

In addition to informing all patients of their right to request a GFE both verbally and in writing, providers and facilities must also prominently display a written notice on its website and in the location where scheduling typically occurs. Indiana law requires the notice to be placed in a third location as well, as discussed in Question 3. A CMS-developed model notice, adapted to include Indiana state law requirements is included as **Attachment C**.

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

If an individual is uninsured or self-pay, providers and facilities are required to provide a GFE to the patient for all scheduled services ***and*** upon request. Importantly providers/facilities must consider any discussion regarding the potential cost of items/services under consideration to be a request for a GFE.

If the GFE is for a Covered Individual, a provider or facility is required to provide a GFE within 5 business days of receiving a request from the Covered Individual for a GFE for ordered, scheduled or referred non-emergency services. Currently, Indiana law does *not* require a GFE to be automatically provided to a Covered Individual upon the scheduling of an item or service.

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

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

The convening provider is responsible for providing the GFE that includes the GFE for the primary requested item or service and an itemized list of all "items and services" reasonably expected to be provided by the co-providers and co-facilities involved in the scheduled services, during the "period of care". Within 1 business day of the event that triggers the need to provide a GFE, the convening provider/facility must ask any and all co-providers/facilities reasonably expected to provide items or services in conjunction with the primary service to provide their own GFE of "expected charges" to the convening provider. However, between January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE provided by a convening provider to an uninsured or self-pay individual does not include the expected charges of co-providers or co-facilities. During this period, an uninsured or self-pay individual may not initiate the dispute resolution process against a co-provider or co-facility as long as the items and services to be provided by the co-provider/facility appear on the GFE, even if they do not include an estimate of charges or a range of expected charges. However, a co-provider or co-facility is required to provide a GFE directly to an uninsured or self-pay individual who requests one.

The Departments issued an interim final rule which includes very specific requirements as to what information needs to be included in the GFEs, and CMS has developed a GFE template form that can be used to comply with these requirements. IHA has adapted this form to include Indiana's GFE requirements so it can be used for insured, self-pay, and covered individuals alike. (See **Attachment D.**)

"Items or services" include all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care. This includes items or services such as those related to dental health, vision, substance use disorders and mental health.

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

8. **Does the good faith estimate have to be given in a specific manner (e.g. mailed)?** Yes. Although providers and facilities may provide a verbal GFE to the patient, in order to comply with the applicable regulatory requirements, they must also provide a completed GFE by hard copy, email or mobile app, based on the patient's preference. Any GFE provided electronically must be in a manner that allows the patient to both save and print it.

9. **How far in advance do we have to send the GFE for scheduled services?**

Providers and facilities are to provide GFEs to ***uninsured and self-pay patients*** for all scheduled services and upon request, within the following timeframes:

- Within 3 business days after scheduling a primary item or service to be furnished to an uninsured (or self-pay) patient at least 10 days later; or
- The next business day after scheduling a primary item or service to be furnished to an uninsured (or self-pay) patient at least 3 but less than 10 days later; or
- Within 3 business days of receiving a request for a GFE by an uninsured (or self-pay) individual.
- No GFE is required for items and service scheduled within < 3 business days prior to the appointment. (However, the uninsured /self-pay patient can still request one.)

Until the Departments fully implement the federal GFE and advance explanation of benefits requirements for Covered Individuals, Indiana providers and facilities should continue to follow the requirements in Ind. Code 27-1-46-11 and provide a GFE to ***Covered Individuals*** for ordered, scheduled or referred non-emergency services within 5 business days of receiving a request (or receiving relevant information from the covered individual).

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

1. **What happens if the actual charges exceed the GFE amount?**
   The Departments have included a process for uninsured and self-pay patients to dispute charges that are "substantially in excess" of the GFE, even if the increase in charges are due to items and services that were not originally listed on the GFE. "Substantially in excess" is defined as total billed charges that exceed the GFE by $400 or more.

2. **What if a convening provider doesn't have the capability to include all of the items and services reasonably expected to be provided by a co-provider or co-facility by January 1, 2022?**
   The Departments have acknowledged that providers and facilities may need additional time to develop the necessary communication channels to enable a convening provider to timely provide a GFE that includes all the expected charges for items and services anticipated to be furnished by co-providers/co-facilities in conjunction with the primary services during a period of care. Therefore, between January 1, 2022 and December 31, 2022, HHS announced it will exercise its enforcement discretion in situations where a GFE provided to an uninsured or self-pay individual doesn't include the expected charges of co-providers or co-facilities. In the meantime, HHS has encouraged convening providers to include a range of expected charges for these items and services.

3. **What is the general process for resolving a billing dispute with an uninsured or self-pay patient?**
   Within 120 calendar days of receiving an initial bill for charges that exceed a GFE by at least $400, an uninsured/self-pay patient may initiate the dispute resolution process by filing a completed patient-provider dispute initiation form through the federal IDR portal and paying an administrative fee, expected to be no more than $25. Upon receipt, HHS will appoint a "Selected Dispute Resolution" ("SDR") entity to adjudicate the dispute.

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

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

4. **How will the SDR determine the amount payable for the items and services in dispute?**
   The SDR entity will review each unique item or service in the bill provided to the patient, and all documentation submitted by the patient and the provider or facility to determine whether the

difference between the billed charges and the GFE:

(i) reflects the cost of medically necessary items and services, and
(ii) is based on changes in circumstances that the provider/facility could not have reasonably anticipated when the GFE was provided.

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

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

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

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