October 26, 2023

Sent electronically

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave., N.W.
Washington, D.C. 20220

The Honorable Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, D.C. 20210

Subject: CMS-9890 Federal Independent Dispute Resolution Process Fees, Proposed Rule, Federal Register (Vol. 88, No. 185), September 26, 2023

Dear Secretaries Becerra and Yellen, and Acting Secretary Su:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) greatly appreciates the work the departments of Health and Human Services (HHS), Labor, and Treasury (tri-agencies) have done to protect patients when they receive care from out-of-network providers at in-network facilities, or from out-of-network providers and facilities (providers, unless otherwise specified) in emergency situations, by developing regulations implementing the No Surprises Act (NSA). We look forward to continuing to work with the tri-agencies and health plans to implement the law and realize our long-held mutual goal of removing patients from billing disputes that arise when care is provided in situations covered under the NSA.

The independent dispute resolution (IDR) process is an important component of the NSA. In instances where a health plan has excluded a provider from its network, the IDR process was intended by Congress

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to ensure that providers are appropriately compensated for the high-quality care rendered to out-of-network plan members. However, in many instances, the administrative and IDR entity fees present an insurmountable barrier to the IDR process for providers as these fees frequently exceed the potential amounts recovered through the process. This deprives providers of an important venue to seek equitable payment from health plans when their members receive care from a provider who is not included in their network. The barrier posed by excessive fees grew considerably higher after the tri-agencies significantly increased IDR entity fees for single determinations from $200-$500 to $200-$700 and $268-$670 to $268-$938 for batched determinations in the October 2022 guidance, and the per-party administrative fee from $50 to $350 for calendar year 2023 in the December 2022 guidance. Further, the tri-agencies provided no detail as to why the fees associated with the IDR process were increasing, other than it was in response to higher-than-anticipated volumes.

A recent court ruling (TMA IV[1]) found the tri-agencies' approach to setting the administrative fee was impermissible, resulting in this proposed rule. CHA appreciates that CMS attempts to provide additional transparency into the IDR administrative fee-setting process, seeks feedback on the process, and proposes a lower fee. However, this does not ameliorate the harm caused by the tri-agencies to providers who were barred from the IDR process as a result of excessive administrative fees that were set in an impermissible manner. To remedy these harms, CHA respectfully asks that CMS:

1) *Refund Excessive IDR Administrative Fees*: CMS must refund $300 — the amount of the impermissible increase in IDR administrative fees from 2022 to 2023 — to each provider and health plan who participated in the IDR process and paid the administrative fees from Jan. 1 to Aug. 3, 2023.
2) *Reopen Filing Period*: CMS must reopen the window to initiate an IDR dispute for providers and health plans related to claims that would have been eligible for the IDR process from Jan. 1 to Aug. 3, 2023. This will ensure that those claims that were priced out of the IDR process due to an impermissibly set fee have an opportunity to be resolved equitably and for appropriate payment to be determined.

In the proposed rule, CMS proposes to reduce the administrative fee to $150 (effective Jan. 1, 2024) and provides additional detail into the costs that are included in the calculation. Further, CMS proposes to significantly increase the certified IDR entity fee. Like the administrative fee, we have concerns about CMS' approach to determining these amounts. We respectfully encourage CMS to take steps to reduce the fees associated with the IDR process, so as not to bar providers with low-dollar disputes from the only available forum for them to receive equitable payment from health plans that have excluded these providers from their networks.

Below, please find CHA's detailed comments addressing each of these key areas.

IDR Administrative Fee

While CHA appreciates the additional detail related to the calculation of the administrative fee and the reduced fee amount, we still believe it is unnecessarily high and presents an unnecessary barrier to the IDR process — particularly for disputes related to lower dollar services. Based on the detail provided, we question some of the expenses included in the numerator and believe the tri-agencies must expand the denominator to accurately match the expenses in the numerator with the correct cost object. Further,

[1] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:23-cv-00059-JDK (E.D. Tex. January 30, 2023).

we believe the number of disputes inappropriately submitted to the federal IDR process could be significantly reduced if health plans were more transparent about each member's product type.

Numerator: Qualifying Payment Amount (QPA) Audits and Associated Costs

The tri-agencies propose to include the costs associated with QPA audits in the calculation of IDR administrative fees. CHA questions the appropriateness of including these costs in the numerator. While the QPA is one of the factors that may be considered by IDR entities when resolving disputes, its primary purpose is for use by health plans to determine the appropriate cost-sharing when a member receives care from a provider that has been excluded from the health plan's network. **Therefore, CHA believes that it is inappropriate to include the costs associated with the QPA audit in the calculation of the IDR administrative fees and respectfully asks the tri-agencies to exclude them from the calculation.**

Further, as CMS is aware, there continues to be considerable concern in the provider community about the accuracy of the QPA calculation. **CHA respectfully asks that CMS make the results of the QPA audits performed to date publicly available.**

In response to *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-450-JDK (E.D. Tex.) (hereafter TMA III) the tri-agencies recently released FAQs[2] related to recalculating the QPA. In the ruling, the district court found the tri-agencies' guidance allowing health plans to include "contracted rates for items and services 'regardless of the number of claims paid at that contracted rate,' the use of contracted rates of all self-insured group health plans administered by the same entity, rules governing the calculation of the QPA for providers 'in the same or similar specialty,' the exclusion of bonus, incentive, and risk-sharing payments, and the exclusion of single case agreements," violated the statute. In the FAQs, CMS first notes that it will not provide additional guidance on how plans should calculate the QPA. Instead, they should use "a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the *TMA III* decision" to calculate the QPA for each item and service. CHA believes that the tri-agencies must provide specific guidance to health plans on how to calculate the QPA. Otherwise, we are concerned that each plan will calculate it using methodologies that artificially depress the QPA and underpay providers in instances where they are excluded from a health plan's network. **Therefore, CHA respectfully asks the tri-agencies to issue regulations related to the QPA using the notice and comment process as outlined in the Administrative Procedures Act.**

Second, in the FAQs, the tri-agencies delay enforcement of the revised QPA calculation for at least six months, until May 1, 2024. The FAQs also note they may provide enforcement discretion for up to 12 months or until Nov. 1, 2024. The tri-agencies justify the delay by noting that health plans, due to administrative challenges, will need additional time to recalculate the QPAs. While CHA appreciates the administrative challenges facing health plans when calculating the revised QPA, we are frustrated that the tri-agencies are not addressing the underpayment issue caused by artificially depressed QPAs. This is an issue that was raised repeatedly by CHA and others in comments on the July 2021 interim final rule. **Therefore, CHA respectfully asks the tri-agencies to take the following actions to ensure that providers are not harmed by the unlawful calculation of the QPA:**

[2] https://www.cms.gov/files/document/faqs-part-62.pdf

1) **CMS should require health plans to recalculate any cost-sharing based on the QPA calculated in accordance with the statute as understood by the decision in TMA III, and automatically pay it to providers — without billing patients — for all cost-sharing that was determined using QPAs calculated based on the July 2021 guidance.**
2) **Allow any IDR decision that was based on an artificially depressed QPA — as a result of the July 2021 guidance — to be revisited (without payment of new IDR administrative or entity fees) once accurately calculated QPAs are available.**
3) **Instruct IDR entities to underweight the QPA in IDR entity decision-making and more heavily weigh the other factors submitted by providers when considering payment disputes for out-of-network services.**

Numerator: Investigate Relevant Complaints

The tri-agencies propose to include the cost associated with "investigating relevant complaints, which is intended to ensure compliance with the federal IDR process." **CHA strongly encourages the tri-agencies to aggressively investigate complaints regarding compliance with the IDR process.** Specifically, we note that health plans are not adhering to the requirement that they pay providers within 30 days of an IDR decision. One CHA member reports[3] that over 75% of its cases successfully appealed through the IDR process are not receiving full payment within 30 days. This health system has received full payment on only 18% of its cases. More concerning, an analysis of a representative sample of 26 successful IDR cases from this health system finds that they have still not been fully paid an average of 261 days from the date of the IDR determination. This is almost nine times longer than allowed by statute. Unfortunately, CHA notes that this experience is the rule, not the exception. According to a recent survey of clinicians,[4] 52% of payments determined by IDR entities were not made at all and 33% were made in an incorrect amount.

In terms of the cost associated with investigating allegations of non-compliance with the IDR process, CHA believes that when an entity is found to be non-compliant, that entity should pay for the costs of the investigation. Other participants in the IDR process should not be forced to assume the cost of policing another entity's non-compliance with the law. **Therefore, these costs should be excluded from the IDR administrative fee calculation.** Finally, CHA respectfully asks the tri-agencies to provide transparency into the number of investigations opened and closed during the course of a year, the results, and what percentage of the IDR compliance investigation costs are paid for by a non-compliant entity vs. those included in the administrative fee calculation.

Numerator: Assisting with IDR Eligibility Determinations

The tri-agencies propose to include costs associated with assisting with eligibility determinations when the volume of disputes submitted exceeds the capacity of IDR entities. **CHA respectfully requests the tri-agencies remove this expense from the calculation of the administrative fee.** When IDR entities set their fees, those fees should cover all costs, including ensuring adequate staffing levels. It is incumbent on the IDR entity to ensure they have sufficient staff to cover the costs of reviewing the eligibility of submitted disputes. Otherwise, the tri-agencies are incentivizing the IDR entities to

[3] Statement of CommonSpirit Health for the Committee on Ways and Means of the U.S. House of Representatives, "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections," September 19, 2023
[4] https://www.healthleadersmedia.com/revenue-cycle/providers-insurers-not-adhering-no-surprises-act-payments

understaff their operations to improve their margins, knowing that HHS will step in to address the staffing shortage at no cost to the IDR entity.

Additionally, the proposed rule notes that from April 15, 2022, to March 31, 2023, non-initiating parties challenged the eligibility of 122,781 disputes submitted to the federal IDR portal. CHA's members report the information provided on a plan member's identification card and the related explanation of benefits is frequently insufficient to determine whether a dispute for inadequate out-of-network payment should be submitted to the federal IDR portal or the process for state-regulated products. We believe that the volume of disputes challenged would be significantly lowered if this information was clearly displayed for providers on both the member's health plan identification card and the related explanation of benefits. **Therefore, CHA respectfully asks the tri-agencies to require all plans to include this information.**

Further, given that this additional expense related to qualifying claims submitted to the federal IDR process is unnecessary if plans would provide sufficient information on the product type (as described above), **we respectfully ask the tri-agencies to remove this expense from the calculation of the IDR administrative fee.** Instead, we believe this cost should be assessed to the party that raises a challenge to a claim's eligibility for the federal IDR process given this cost is completely avoidable if sufficient information is provided by the health plan.

Denominator Calculation

The tri-agencies propose using the projected volume of closed disputes as the denominator when calculating the administrative fee. The tri-agencies also anticipate that as a result of TMA IV, which will allow for broader batching, there will be a 25% reduction in the number of disputes submitted.

First, CHA believes the tri-agencies have defined the projected denominator too narrowly. As a result, the IDR administrative fee will be artificially inflated, which will bar some providers from using the process due to cost. Given the administrative fee can be collected by IDR entities until the moment the parties submit their offers, CHA is concerned that using the projected number of settled disputes does not capture all disputes for which the tri-agencies will incur costs, which are included in the numerator. **Therefore, we respectfully ask the tri-agencies to base the IDR administrative fee on the projected number of disputes for which an IDR entity fee will be paid as this is the more appropriate cost object.**

Second, CHA respectfully asks the tri-agencies to provide additional details on how the projected 25% reduction factor as a result of TMA IV was determined.

Certified IDR Entity Fee Ranges

The tri-agencies propose that for disputes initiated on or after the later of the effective date of these rules or Jan. 1, 2024, certified IDR entities would be permitted to charge a fixed certified IDR entity fee for single determinations within the range of $200-$840. This fee range represents a 20% increase to the upper limit from the 2023 single determination fee range. Further, for batched disputes, the rule proposes to permit certified IDR entities to charge a fixed tiered fee within the range of $75-$250 for every additional 25 line items within a batched dispute, beginning with the 26th line item. CHA notes this represents approximately a 25% increase in fees for batched submissions.

The proposed rule attempts to justify allowing this range, stating it "allow(s) for each IDR entities' costs and to account for the wide variability of IDR entities' operations, structures, staffing patterns, and expenses." **CHA respectfully requests the tri-agencies reduce the fee range for single items and batched disputes.** We note that when CMS purchases health care services for Medicare beneficiaries, it does not give providers carte blanche to determine their fees. Instead, the agency sets prices in line with congressional requirements. The net result is that in most instances, payments are below the cost to deliver care to encourage efficiency (or in limited circumstances are cost-based — e.g., critical access hospitals, organ acquisition costs). However, the tri-agencies' current approach to setting the IDR entity fee encourages them to be inefficient as there is no penalty for increasing costs up to a certain ceiling. **We do not believe it was Congress' intent to encourage the IDR entities to be inefficient in their provision of services to the federal government by setting rates based on such a wide range. Therefore, CHA strongly encourages the tri-agencies to determine what it should cost an efficient IDR entity to process a dispute and set the IDR entity fee based on that amount, like CMS currently does for providers who care for Medicare beneficiaries.** Allowing the cost associated with inefficient IDR entity operations to be passed along to stakeholders not only wastes stakeholders' funds but serves as a bar to submitting lower dollar claims disputes to the IDR process.

CHA appreciates the opportunity to offer comments to the tri-agencies on issues related to calculating fees associated with the IDR process. We look forward to partnering with the tri-agencies and health plans to develop and implement a regulatory framework that achieves the goals of the NSA. If you have any questions about the comments, please contact me at (202) 270-2143 or cmulvany@calhospital.org.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy