January 2, 2024

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-9897-P Federal Independent Dispute Resolution Operations, Proposed Rule, Federal Register (Vol. 88, No. 212), November 3, 2023

Dear Secretaries Becerra and Yellen, and Acting Secretary Su:

On behalf of more than 400 member hospitals and health systems, the California Hospital Association appreciates the work the departments of Health and Human Services (HHS), Labor, and Treasury (subsequently referred to as the "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). CHA looks forward to continuing to work with the tri-agencies and health plans to implement the law and agrees with the long-held 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

to ensure that providers are appropriately compensated for the care rendered to out-of-network plan members.

However, based on significant feedback from California hospitals, current implementation of the IDR process heavily favors health plans over providers in several ways. On multiple occasions, a federal court has found this to be the case and ordered the tri-agencies to remedy these implementation deficiencies. These deficiencies — in part — are addressed in the batching provisions in this proposed rule, a framework that CHA generally supports. **However, as detailed below, there are many concerns about the proposed limitation on the number of line items that can be batched into a single dispute.**

The rule proposes a number of new requirements for the non-initiating party intended to encourage participation in the open negotiation process, assist providers in understanding if a claim is eligible for the federal IDR process, and improve the efficiency of the IDR process in general. CHA appreciates these proposals. However, providers are concerned the rule includes no ramifications for non-initiating parties that refuse to participate in the negotiation process or provide inaccurate information at any step of the IDR process. **This must be addressed in the final rule due to evidence of continued non-compliance by health plans with all aspects of the IDR process.**

As just one example of this non-compliance, health plans are not adhering to the requirement that they pay providers within 30 days of an IDR decision. One CHA member reports[1] 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 it took an average of 261 days from the date of the IDR determination to receive full payment. This is almost nine times longer than allowed by statute.

Unfortunately, this experience is the rule, not the exception. According to a recent survey of clinicians[2], 52% of payments determined by IDR entities were not made at all and 33% were made in an incorrect amount. The tri-agencies are well aware of these issues and **should aggressively investigate complaints regarding compliance with the IDR process, take actions against plans found to be in violation of the statute, and promulgate clear penalties associated with non-compliance to these statutory requirements. Additionally, in instances where health plans fail to pay providers within the statutorily required time frame, providers should be entitled to interest in addition to the amount awarded by the IDR entity.**

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

Claims Batching

The proposed rule allows interested parties to batch qualified IDR items and services if the:

- Items and services are furnished to a single patient on one or more consecutive dates of service and billed on the same claim form (a single patient encounter).

[1] 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
[2] https://www.healthleadersmedia.com/revenue-cycle/providers-insurers-not-adhering-no-surprises-act-payments

- Items and services are billed under the same service code or a comparable code under a different procedural code system.
- Anesthesiology, radiology, pathology and laboratory items and services are billed under service codes belong to the same Category I Current Procedural Terminology (CPT) code section, as specified in guidance by the departments (intended to address the unique circumstances of these medical specialties and provider types).

In addition, the rule proposes to limit batched determinations to 25 qualified IDR items and services (or "line items") in a single dispute. The proposed rule notes certified IDR entities recommended implementing a 25 line item cap on the number of qualified IDR items and services (or "line items") included in batched disputes to ensure that they can resolve payment determinations within the 30-business day requirement.

On Aug. 3, 2023, a federal court in *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:23-cv-59-JDK (*TMA IV*) vacated the batching regulation, including the definition of "same or similar service." The court found the department failed to consider "broader batching criteria that would give providers increased opportunity to bring their claims to arbitration."

The proposed 25 line item cap does not constitute "broader batching criteria" as it undermines potential efficiencies for claimants and IDR entities. Separating claims for similar items and services is costly and discourages participation, as parties are responsible for fees related to each dispute brought through the IDR process. Further, IDR entities stand to gain financially from increased fees if more disputes are submitted that could otherwise be bundled into larger batches. Therefore, there is legitimate concern about whether the IDR entities' recommendation is informed by concerns about process efficiency or financial interests.

Related to items and services furnished to a single patient on one or more consecutive dates of service and billed on the same claim, there should be no cap on the number of line items that can be batched into a single dispute. When the IDR portal opened in April 2022, the portal instructions allowed a party to dispute a total patient encounter, including all items and services related to the encounter, into one dispute. In September 2022, however, the tri-agencies changed their guidance and adopted the current narrow and unworkable definition of "item or service" that essentially makes each line of a hospital outpatient claim its own item or service that must be disputed separately.

While this proposal is an improvement over current policy, the 25 line item cap still does not reflect how hospital billing and health plan claims processing work. In many instances, a health plan will process multiple CPT codes together on a single claim while not processing other CPT codes included on that same claim. Requiring hospitals to break a single claim that exceeds the 25 line item cap (or even the alternative 50 cap) would increase a hospital's cost to submit a claim to the IDR process. Also, this unnecessary separation of related items and services will make it more difficult for IDR entities to render an accurate decision about the correct payment amount for an emergency service provided to an individual whose health plan's network is narrow.

Requested Action: The tri-agencies should eliminate the line item cap for single patient encounter disputes.

Further, for items billed under the same or comparable service code and those in the same CPT code family for select specialties, the 25 line item cap is overly narrow and will reduce the efficiencies Congress intended to create for participants in the IDR process. The narrowing of the framework for what can be batched in both of these instances is sufficient to address IDR entities' concerns about inefficiencies and delays associated with processing arbitrations for unrelated items and services.

Requested Action: The tri-agencies should increase the cap to at least 100 items.

The tri-agencies propose that qualified IDR items and services may be batched and considered jointly as part of one payment determination if payment for the qualified IDR items and services is made by the same group health plan or health insurance issuer.

Requested Action: The tri-agencies clarify that qualified IDR services be considered jointly and batched.

For self-insured group health plans, the proposed rule states that this requirement would be satisfied if the same self-insured group health plan is required to make payment for the qualified IDR items and services, including when the plan makes payments through a third-party administrator (TPA). However, qualified IDR items and services may not be batched or considered jointly if they are made by multiple self-insured group health plans, even if those group health plans make payments through the same TPA.

In most cases, it is the employers' TPAs that determine the initial payment amount and reimburse the provider. In addition, it appears that most TPAs are using a single qualified payment amount (QPA), which is calculated based on all of their TPA business in the same market. The TPA's initial payment is the same regardless of an individual's employer.

Requested Action: The tri-agencies should allow providers to batch these claims.

Unless the TPA provides specific information for which employer group/contract an out-of-network payment is made, it will be impossible in practice for providers to identify claims from different employer groups/contracts administered by the same TPA as this information is currently not typically included on most health insurance identification cards.

While this rule proposes to require plans to include their employer identification number (EIN) in the information submitted when they register, the rule does not require this information to be included on the remittance advice with claims payment or denial or the member's health insurance card. Including it on the remittance advice and health insurance card will help providers more efficiently process potential disputes and understand which process is applicable.

Requested Action: Unless the tri-agencies explicitly require health plans to include this information with the initial payment or denial and on the insurance card, the final rule should allow batching at the TPA level for employer-sponsored insurance claims.

If the proposed batching provisions are finalized, the tri-agencies are considering using waiver authority to reduce the 90-day cooling off period with respect to items and services that are part of a batched dispute.

Requested Action: The tri-agencies should reduce and/or eliminate the cooling off period.

Increased Transparency for Regulations Governing Out-of-Network Claims

The proposed rule would require health plans to provide information such as the legal business name of the health plan, the health plan's sponsor, and the health plan sponsor's IDR registration number. The rule proposes that payers are to communicate information to providers using specific claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) when they provide paper or electronic remittance advice to a provider that does not have a contractual relationship with the payer. Payers would provide the applicable CARCs and RARCs to communicate to the out-of-network provider whether the claim for the furnished item or service is or is not subject to the NSA provision as eligible for the IDR process.

These provisions and this additional information will eliminate claims submitted to the federal IDR process that are not eligible for resolution in this venue. However, the rule is silent on what happens if a health plan fails to provide this information as required or provides inaccurate information.

Requested Actions:

- **CMS should detail what enforcement actions it will take in instances where a plan fails to comply or provides inaccurate information.**
- **If a provider files an ineligible dispute to the federal IDR process because the plan failed to provide the required information or failed to provide accurate information, the plan must pay any costs incurred by the provider associated with that dispute.**
- **When inaccurate information provided by the plan results in an ineligible dispute being submitted to the federal IDR process, the tri-agencies should allow that dispute to proceed through the federal process if the provider so desires as the plan has indicated that the claim is eligible for the federal process.**

Increasing Plan Engagement in the Open Negotiation Process

The tri-agencies propose requiring that an interested party provide an open negotiation notice to the other party and to the tri-agencies through the federal IDR portal to initiate the open negotiation period. The rule also proposes that the 30-business day open negotiation period commences when the party submits the open negotiation notice and a copy of the remittance advice or notice of denial of payment to the other party through the federal IDR portal. This proposal includes new data elements for the open negotiation process to help the interested parties identify the item or service in question, the reason for the denial of payment, or the initial payment amount. **The proposed additional requirements are supported.**

If finalized, submitting the open negotiation notice through the IDR portal along with the proposed data elements will create a concrete document trail to affirm that an attempt was made to initiate the open negotiation as required by statute. The proposed rule also clarifies that providers and facilities are not considered to have failed to provide an open negotiation notice or open negotiation response notice solely because they did not use a plan's or issuer's proprietary portal. **This clarification by the tri-agencies is supported.**

The proposed rule also establishes that parties in receipt of an open negotiation notice provide a response notice to the initiating party and the tri-agencies by the 15th business day of the 30-business day open negotiation period. The rule clarifies that if a party fails to furnish an open negotiation response notice containing all required information to the other party and the tri-agencies, failure to timely furnish an open negotiation response notice in any specific open negotiation would not extend the open negotiation period, delay the timeframe for initiation of the federal IDR process, or affect either party's ability to initiate the federal IDR process. **The proposed requirement that parties in receipt of an open negotiation notice must provide a response notice within 15 business days is supported. The clarification that failure to provide a response to the open negotiation notice would in no way impact the negotiation time frame or the ability to initiate the federal IDR process is also supported.**

The proposed rule notes that when a party fails to provide a response to the open negotiation notice, the tri-agencies would review these instances and determine whether enforcement actions may be appropriate. Hospitals believe that the open negotiation process is the most appropriate venue to resolve insufficient payment for medically necessary services delivered to individuals whose health plans maintain an inadequate network.

Requested Action: In instances where a party fails to respond to the open negotiation notice, the IDR entities should be instructed to take this as evidence the non-responsive the party agrees with the amount proffered by the provider in the open negotiation notice and that should therefore be the amount paid to the provider for the out-of-network service in question.

Using this enforcement mechanism will greatly increase the likelihood that health plans engage in the open negotiation process as envisioned by Congress. Increasing participation in the open negotiation process by health plans will significantly reduce the number of items and services submitted to the federal IDR process.

Improvements to the IDR Process

The proposed rule requires IDR entities to determine a claim's eligibility within five business days of the IDR entity selection and notify the disputing parties and the departments. The disputing parties, under this proposal, would be required to submit additional information requested by the IDR entity or the departments within five business days of the request. **This provision is supported.**

The disputing parties under this proposal are required to submit additional information requested by the IDR entity or the tri-agencies within five business days of the request. **This provision is supported.** Health plans — most often the non-initiating party — are the natural source of the information necessary to determine if a claim is eligible for the federal IDR process. As such, providers are concerned the rule is silent on how IDR entities or the tri-agencies will address situations where health plans fail to respond in a timely manner.

Requested action: The final rule should codify that in instances when a health plan does not respond in a timely manner that the IDR entity (or tri-agencies) should assume that the claim is eligible for the federal IDR process and the appropriate payment for the item or service subject to the dispute is the amount submitted by the provider to the IDR entity.

The rule proposes the tri-agencies would act as a backstop during high-volume times when IDR entities are unable to process dispute eligibility determinations in a timely manner. **It is appreciated that the tri-agencies have incorporated a mechanism to ensure that eligibility is determined in a timely manner.** However, providers are concerned that this is only one area where the IDR process can fall out of compliance with statutory timelines.

In instances when IDR entities are unable to make dispute eligibility determinations in a timely manner, it is also likely that they will be unable to render decisions within 30 days as required by statute. The rule is silent, aside from the discussion of the tri-agencies processing eligibility determinations, on any consequences for IDR entities that frequently experience backlogs and are unable to resolve IDR disputes within the statutorily required timeframes.

Requested Action: The tri-agencies should provide an enforcement mechanism to ensure that IDR entities are appropriately staffed to process the volume of eligible IDR disputes. At a minimum, IDR entities that are consistently unable to process disputes within the statutory time frames should not have their contracts renewed.

Finally, the tri-agencies propose to require payers subject to the IDR process to register with the tri-agencies and provide general information regarding the applicability of the IDR process to items or services covered by the plan. Payers would receive an IDR registration number upon submission of the information. This is intended to help determine if a claim is eligible for the federal IDR process. It would also help identify types of coverage, when coverage is offered by an issuer or when the issuer serves as a TPA for a group health plan. **This provision is supported.**

Hospitals agree that this additional information will facilitate determining if a claim is eligible for the federal IDR process. If health plans comply with this requirement, submit information to the registry, and keep that information current, this provision will drastically reduce the number of ineligible claims submitted to the federal IDR process. However, the rule is silent on any enforcement actions the tri-agencies might take when plans either fail to register as required or register but fail to keep the submitted information current.

Requested Action: CMS should articulate how it will enforce this requirement in the final rule.

CHA appreciates the opportunity to offer comments to the tri-agencies to improve the IDR process and looks 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