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Advancing Health in America

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February 5, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Center for Medicare & Medicaid Services
Department of Health & Human Services

The Honorable Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Douglas W. O'Donnell
Acting Commissioner
Internal Revenue Service
Department of Treasury

Submitted Electronically

Re: Federal Independent Dispute Resolution Operations, CMS–9897–P, November 3, 2023, Vol. 88, No. 212.

Dear Administrator Brooks-LaSure, Acting Commissioner O'Donnell and Assistant Secretary Gomez:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the proposed rule related to the operations of the Independent Dispute Resolution Process (IDR) established by the No Surprises Act (NSA).

AHA strongly supports Congress' approach to protecting patients from unexpected medical bills through the passage of the NSA. Patients are protected against unexpected medical bills for certain types of health care services when provided by out-of-network providers, and Congress allowed for providers and payers to work collaboratively to determine reimbursement; the IDR process is included should negotiations between the two parties break down.

While we support the underlying goals and structure of the NSA, we have raised concerns over implementation of the statute particularly regarding the IDR process.[1] A high-functioning and unbiased IDR process is crucial for fully realizing the NSA's patient protections, as inappropriate reimbursement can impact providers' ability to offer services or offer them in the timeframe or of the quality that patients deserve. We are pleased that the proposals in this rule address many of the areas of concern to hospitals and health systems and, if finalized, should significantly improve the process.

Specifically, the AHA supports the following proposals:

- Enabling parties to include (or batch) all items and services associated with a single patient encounter, rather than needing to adjudicate individual line items.
- Requiring payers to share additional information with providers, including information on whether the claim is eligible for the federal IDR process and other information supplied through claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs).
- Creating a process for the government to assist IDR entities in reducing any backlogs in processing disputes.
- Requiring parties to document in the federal portal the open negotiation process.
- Requiring that payers subject to the IDR process register with the departments and provide general information regarding the applicability of the IDR process to items or services covered by the plan.

At the same time, we are concerned that some of the proposals are inadequate to substantially improve the IDR process. These include:

- Limiting batched claims to 25 line items, especially in the context of a single episode of care.
- Barring providers from batching claims for self-insured employers by third-party administrators.
- Charging high fees and only reducing for non-initiating parties the fees for claims found ineligible.

While the proposed rule includes many important provisions, several issues critical to the functionality of the IDR process need to be addressed. Of greatest importance are how payers calculate the qualifying payment amount (QPA) and the information regarding these calculations being made available to providers and IDR entities. QPAs are one of the statutorily mandated factors for IDR entities to consider and, as such,

[1] AHA Feb. 15, 2023, letter to NSA tri-departments: Centers for Medicare & Medicaid Services, Employee Benefits Security Administration and the Department of Treasury.

QPA accuracy and transparency is fundamental to a functioning and efficient IDR process.

In addition, the departments do not fully address how they intend to conduct oversight in certain situations, such as when a health plan fails to pay a provider, subsequent to an IDR determination. Hospitals and health systems report that payers consistently are not complying with IDR determinations, including one member who testified before Congress earlier this year that payers had made timely payment in only one-third of the disputes decided in the health system's favor.[2] The health system was still owed $40 million in reimbursement for disputes that had been decided but for which the payer had not remitted payment within the required timeframe. This behavior cannot persist. The delay or loss of millions of dollars in reimbursement only harms patients by starving providers of the resources they need to deliver care. Indeed, the loss described above has contributed to this health system operating with negative margins.

We have long urged greater oversight of payers as it relates to the NSA. It is deeply concerning that the departments have not completed a single audit of payers when the law has been in effect for nearly two full years. For example, should one of the audits conclude that a payer inappropriately suppressed its QPAs, how do the departments envision remedying this situation if hundreds (or more) IDR disputes have been impacted?

These delays in oversight have contributed to a fundamentally imbalanced situation where payers are able to inappropriately withhold providers' revenue — the revenue they need to finance patient care — knowing that the likelihood of being caught or challenged is low. All of the control rests with the payer; all of the risk resides with the provider and, ultimately, the patient. As such, we were unsurprised to see analysis of the most recent National Health Expenditure data from the Centers for Medicare & Medicaid Services' (CMS) actuaries. Specifically, they found "the net cost of private health insurance, which represents the difference between revenues received by private health insurers and the amounts paid by those insurers for medical care incurred, increased 8.0 percent in 2022," and that "…increases in net gains or profits for insurers contributed to faster price growth in the net cost of insurance."[3] While we expect multiple factors contributed to insurers' increased profits, we point to the concerns we have long raised about the ability of payers to take advantage of the NSA to withhold appropriate revenue from providers to enrich themselves and not return the savings to consumers.

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[2] https://gop-waysandmeans.house.gov/wp-content/uploads/2023/09/Budzinski-Testimony.pdf
[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01360

We recognize that the departments are working on additional rulemaking related to the NSA, and we urge the departments to address these issues through that process.

Our detailed comments on the proposals in this rule follow.

BATCHING OF CLAIMS

The departments propose several changes to when and how providers may batch items and services in a single dispute. We focus our comments on three particular aspects of these proposals:

- Batching all items and services for a single patient encounter.
- Limiting batches to no more than 25 items and services.
- Requiring that batching be done at the employer level for self-insured claims, as opposed to at the insurer or third-party administrator level.

First, **the AHA strongly supports the proposal to allow providers to batch all items and services associated with a single patient encounter**, something for which we have long advocated. Our longstanding concerns over the existing, narrow definition of "item or service" for purposes of batching claims for IDR disputes has made the IDR process effectively unworkable for hospitals. Facility claims routinely include more than one item or service. Requiring providers to break up claims and adjudicate line items individually creates an untenable situation, no matter what the provider decides to do. Disputing all line items would be cost-prohibitive, given the fees associated with the IDR process; selecting only one or several line items to adjudicate forces the provider to forgo potential reimbursement for the full scope of services provided, thereby complicating adjudication of a dispute for the IDR entity, who is forced to evaluate only a partial claim.

For the same reasons, we urge the agency not to finalize the proposal to limit the number of line items to 25 (or 50). It is not uncommon that a facility-based episode of care, especially for an emergency medical condition that requires substantial post-stabilization care, will include numerous individual items and services. While many claims would likely have less than 25 individual items and services, some of the most complex — and expensive — care may not. One hospital system shared that, for a single episode of care, their outpatient emergency claims range between two and 85 line items.

Forcing providers to arbitrarily break up claims to submit to the IDR process places them exactly back in the situation they are in today. As a result, we expect this proposal would not meet the finding of the federal court in *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:23-cv-59-JDK,

which found the department failed to consider "broader batching criteria that would give providers increased opportunity to bring their claims to arbitration." An arbitrary limit of 25 lines would certainly *decrease* a provider's ability to bring many full claims to arbitration.

We urge the departments to either refrain from limiting the number of line items that may be included in a batch or, as an alternative, exempt facility-based claims from this policy. A possible, though less favorable, further alternative would be to cap batched claims to 100 items and services, as this would likely capture most facility-based claims in whole.

Finally, **we continue to oppose the departments' position that claims for patients with self-funded coverage should be batched at the employer level and not at the level of the third-party administrator administering the benefits.** While we recognize that the employer is ultimately responsible for reimbursement of claims, most employers contract with their third-party administrators to manage these functions and, as such, it is the administrator, and not the employer, that is setting the payment amount, remitting the payment and participating in any disputes that progress to the IDR process. We therefore urge the departments to reconsider this policy, as it severely limits the ability of providers to batch items and services that are for all meaningful purposes from the same payer. A less-preferred alternative would be to require that claims be batched by employers *when the employers themselves are adjudicating the claim* and by third-party administrators *when those entities are adjudicating the claims*.

However, if this policy is finalized, **we urge the departments to require the payer to include the employer identification number on the remittance advice.** Otherwise, providers may not necessarily know with which employer the claim is associated. Tracking down this information after the fact adds burden on all parties, including IDR entities that receive ineligible claims, due to a provider's lack of knowledge about the employer.

BUNDLING

The departments propose that items and services that meet the definition of a bundled payment arrangement (e.g., DRG) may be submitted and considered as a single payment determination, and the IDR entity must make a single payment determination for the multiple qualified IDR items and services included in the bundled payment arrangement. **The AHA supports this proposal.** However, to ensure consistency, we ask that the departments specify that Medicare bundling rules (MS-DRGs) are to be used by providers *and* IDR entities.

INFORMATION SHARING BETWEEN PLANS AND PROVIDERS

The departments propose to require that payers include additional information in certain communications with providers. Specifically, payers would be required to include CARCs and RARCs when they provide paper- or electronic-remittance advice to a provider that does not have a contractual relationship with the payer. These codes would be used to clearly communicate to the provider whether the claim for the furnished item or service is, or is not, subject to the NSA provision, as well as eligible for the IDR process. In addition, payers would be required 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. Payers would also be required to include in a disclosure to the provider a statement that providers must notify the departments to initiate the open negotiation period (described below).

The AHA strongly supports these proposals. One of the biggest challenges for providers has been obtaining sufficient information about claims, including whether or not a claim is eligible for the IDR process. While the departments established the CARC and RARC codes to facilitate this information sharing, hospitals and health systems report that payers are not consistently using them. We believe this proposal would go a long way towards reducing the volume of ineligible disputes. However, we urge the departments to incentivize payers to consistently use electronic remittance advice, rather than paper versions. Paper versions add complexity and cost for providers to manage. **Should payers use a paper remittance, we request that the departments give providers additional time after the initial payment or notice of denial to open negotiations.**

OPEN NEGOTIATION PROCESS

The departments propose changes to the open negotiation process to improve communication and information exchanges between disputing parties. The current statutory and regulatory requirements establish a 30-business-day open negotiation period between disputing parties to resolve payment disputes prior to initiating the IDR process and incurring fees. The departments are proposing new requirements to encourage good faith negotiations to occur during this window. Specifically, the departments propose to require that an interested party use the federal IDR portal to communicate to both the other party and to the departments about the intent to negotiate. This proposal also would include new content elements for the open negotiation notice to help the affected parties identify the item or service, the reason for the denial of payment and the initial payment amount. In addition, the rule would require that the party on the receiving end of the open negotiation notice acknowledge its receipt of the notice by issuing a response, which also would be filed in the federal IDR portal and shared with the departments.

The AHA supports these proposals. Failure by plans to meaningfully engage in the open negotiation process has rendered it ineffective. We believe these proposals will encourage payers to respond to providers' efforts to negotiate, which should in turn result in more claims disputes being resolved without the need for IDR. In order for this to have the intended effect, however, the departments must set clear expectations for payers regarding monitoring of compliance and implications for failure to engage, including any penalties.

ADMINISTRATIVE FEES

The departments propose to streamline the collection of the IDR administrative fees from the disputing parties. The departments would collect the administrative fees directly from the disputing parties rather than have the IDR entity collect the fees on behalf of the departments. The proposal would require that the initiating party pay the administrative fee within two business days after the IDR entity selection, while the non-initiating party would pay within two days of the notice of receiving the IDR eligibility determination. If the initiating party fails to pay the administrative fee, the dispute would be closed for non-payment and neither of the disputing parties would owe the administrative fee. If the non-initiating party fails to pay the administrative fee, the party's offer would not be considered received. The rule proposes to charge both parties a reduced administrative fee for low dollar disputes when the highest offer made during the open negotiation period by either party was less than a predetermined threshold.

Lastly, the rule outlines the administrative fees for 2025:

- Full administrative fee per party per dispute would be $150.
- Reduced administrative fee for low-dollar disputes would be $75 for both parties.
- Reduced administrative fee for non-initiating parties in disputes found ineligible for IDR would be $30.

The AHA agrees with the proposals to have the departments collect the relevant fees and the handling of non-payment by the non-initiating party. However, we remain concerned that the amount of the fees may be cost-prohibitive, especially depending on the final rules related to batching. We encourage the departments to reduce the fees for at least twelve months after any new batching rules go into effect, such that the departments can better evaluate the cost of administering the IDR process under these new rules.

IDR ELIGIBILITY DETERMINATIONS PROCESS

The departments propose several new requirements in addition to the mandatory use of the CARC and RARC codes to address concerns that numerous claims filed through the IDR process are proven to be ineligible, wasting IDR entities' time and resources. First, the rule would establish new timelines for evaluating and communicating to interested parties whether or not a claim is eligible for the IDR process. The rule would require IDR entities to determine a claim's eligibility within five business days of the IDR entity selection and to notify the disputing parties and the departments. The disputing parties would then have five business days to submit additional information requested by the IDR entity. The rule also proposes that the departments establish a departmental eligibility review process to determine eligibility during periods of systemic delays or other extenuating circumstances. This review process would be limited only to determining IDR eligibility and not to payment determinations. **The AHA supports these proposals. However, we also request that the departments maintain the existing grace period for initiating parties to resubmit a claim that is wrongfully determined to be ineligible.**

IDR REGISTRY

The rule would require that payers subject to the IDR process register with the departments 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. The proposal is intended to make it easier for interested parties to determine if their dispute is eligible for the IDR process. In addition, the departments believe this proposal would help interested parties distinguish types of coverage the payer may provide or administer via different plans. **The AHA supports this proposal.**

We appreciate your consideration of these issues and look forward to working with your teams to improve the implementation of the IDR process. Please contact me if you have questions or feel free to have a member of your team contact Ariel Levin, AHA's director of coverage policy, at alevin@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
Government Relations and Public Policy