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Advancing Health in America

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October 26, 2023

Xavier Becerra
Secretary
Department of Health and Human Services

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

Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
Department of Treasury

Submitted Electronically

Re: Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges, CMS–9890–P, September 26, 2023, Vol. 88, No. 185.

Dear Secretary Becerra, Deputy 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) writes to comment on the proposed rule by the federal agencies related to the fees for the Independent Dispute Resolution Process (IDR) as 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. Congress also intended for plans and other payers to appropriately reimburse providers for these services and included the IDR process should negotiations between the two parties break down. A high-functioning IDR process is crucial for fully realizing the NSA patient protections. Specifically, inappropriate reimbursement by payers can impact providers' ability to continue offering

services or offering them in the timeframe or of the quality that patients deserve. In short, stripping the health care system of necessary resources ultimately impacts patients. While we continue to support the underlying goals of the NSA, we have raised concerns over implementation of the statute particularly regarding the IDR process.[1] We are pleased to provide comments to the proposed rule that specifically address issues resulting from a decision issued on Aug. 3, 2023, by the U.S. District Court for the Eastern District of Texas.[2] The decision vacated two IDR policies related to: 1) increased administrative fees to participate in the process and 2) rules governing when providers can batch multiple items and services into a single dispute. The court found that the federal agencies failed to adhere to the Administrative Procedure Act (APA) by providing a notice and comment process for stakeholders.

ADMINISTRATIVE FEES

The federal agencies propose to set the administrative fee through the APA notice and comment rulemaking process. The fee amount would remain the same until subsequent rulemaking, removing the requirement that the agencies update it annually. However, the agencies solicit comment on whether they should apply an annual inflation adjustment, such as the CPI-U, which would be communicated via sub-regulatory guidance.

The AHA supports the federal agencies' proposal to require the use of the APA process to increase the fees associated with the IDR. Unlike the "considerations in determination" for an arbitrator's determination, which the statute sets forth in a manner that does *not* permit agency supplementation, *see* 42 U.S.C. § 300gg-111(c)(5), the NSA delegated to the secretary the determination of the fee for participating in the IDR process, see 42 U.S.C. § 300gg-111(c)(8). The AHA welcomes the agencies' recognition that input by the regulated community would assist with the determination of the appropriate fee. Indeed, a notice and comment process would allow stakeholders to provide the agency with important information about whether such fee proposals pose a significant barrier to participating in the IDR process, thereby thwarting the fair and balanced IDR process outlined by Congress**.**

This particular proposal demonstrates exactly why public input is needed. **The AHA strongly opposes the agencies' proposal to set the non-refundable administrative fee at $150 beginning Jan. 1, 2024 and recommends the agencies maintain the $50 administrative fee. In addition, the AHA opposes the agencies' using sub-regulatory guidance and an inflationary adjustment such as CPI-U for future increases to the administrative fee.**

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[1] AHA Feb. 15, 2023, letter to NSA tri-agencies: Centers for Medicare & Medicaid Services, Employee Benefits Security Administration, and the Department of Treasury.
[2] Texas Medical Association et al v. United States Department of Health and Human Services et al, No. 6:2023cv00059 - Document 50 (E.D. Tex. 2023)

Leading up to the federal court's 2023 decision on administrative fees, the agencies had increased the non-refundable administrative fee to $350 from $50 effective Jan. 1, 2023. This represented a 600% increase for initiating an IDR dispute and was cost prohibitive for many hospitals and health systems. To fully appreciate AHA's concerns about any fee increases, it would be instructive to review a case example the AHA provided in recent testimony to the House Ways and Means Committee for a hearing on the NSA implementation.[3]

The following example is from an AHA member hospital where the hospital billed a health plan for an out-of-network Level 4 emergency visit that included 30 unique "items or services" using the agencies' definition. The total value of the charges was $68,880 and the payer reimbursement was $1,614 for only one single line item. However, to dispute the remainder of the unpaid amounts, the hospital would need to file 29 unique disputes — one for each unpaid item or service. During the timeframe applicable to this claim, the administrative fee was set at $350. As such, the hospital would have spent $10,150 in administrative fees alone to contest the massive underpayment for this one claim, not including the IDR fees. While the proposed administrative fee of $150 would reduce the fee in this example for the remaining 29 items in dispute from $10,150 to $4,350, this would still be a significant amount on a claim valued at $68,880. These fees create an inappropriate financial barrier to the IDR process and therefore further tilt the process in payers' favor as they are aware that many providers will be unable to use the process due to the expense, further incentivizing payers to underpay claims and abuse the NSA process.[4]

In addition, the AHA raises additional concerns regarding the methodology for determining the administrative fee. As outlined by the proposed rule, the agencies are using several factors for determining the administrative fee such as expenses and projected volume of IDR disputes. With regard to administrative expenses, the agencies point to federal costs and resources related to program integrity activities such as audits of qualifying payment amounts (QPA) and IDR decisions. To date, there is no information available to the public about the level of program activities the agencies are engaged in including how many QPA and IDR decision audits have been conducted, are underway or are planned for the future. With regard to projecting the volume of IDR disputes, the agencies inexplicitly project a drop in volume of 25% due to the vacated batching policies resulting from the federal court decision without identifying how the agencies will change the batching policies.[5] **AHA recommends that the federal**

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[3] https://www.aha.org/testimony/2023-09-19-aha-statement-record-house-ways-and-means-committee-september-19-2023
[4] https://www.aha.org/system/files/media/file/2023/09/aha-ama-urge-appeals-court-to-invalidate-nsa-dispute-resolution-process-amicus-brief-9-18-2023.pdf
[5] https://www.govinfo.gov/content/pkg/FR-2023-09-26/pdf/2023-20799.pdf p 65893.

agencies, in the spirit of transparency, disclose more fully the information related to federal costs associated with program integrity activities such as QPA and IDR decision audits as well as more detailed rational for projecting the volume of closed IDR disputes based on policy, including how batching of claims is and will be treated. In addition, the agencies should provide the public the opportunity for notice and comment regarding the quantitative factors for determining the administrative fees rather than just providing a qualitative description of these factors.

IDR ENTITY FEES AND BATCHING AND BUNDLING

In addition to administrative fees, IDR entities are allowed to set IDR entity fees based on whether the dispute is a single claim or determination, or whether the dispute is for batched determinations. In the proposed rule, the agencies propose to set the allowable ranges for the IDR entity fees through the notice and comment process. The rule proposes to set the parameters of the certified IDR entity fee range between $200 to $840 for single determinations and between $268 to $1,173 for batched determinations. The upper limit of these ranges reflects a 20% and 25% increase from the current 2023 rates, respectively. The rule further proposes that each certified IDR entity must, on an annual basis, provide a fixed fee for single determinations and separate fixed fees for batched determinations within the agencies' established ranges and seeks comment on whether the IDR entity fees should be adjusted for inflation and whether IDR entities should have flexibility to set fixed fees or tiered fees. Currently IDR entities may charge a specified percentage for batched determinations based on the number of line items initially submitted in the batch.

The AHA supports the agencies use of the notice of comment process to establish the IDR entity fee ranges but opposes the proposed increase in the ranges. The AHA also opposes using an inflationary adjustment for the fee ranges and allowing IDR entities increased flexibility in setting the IDR entity fees. Specifically, with regard to an IDR entity using a tiered pricing approach for batched determinations, the AHA recommends that a single hospital claim with multiple lines should be exempt from the tiered batched pricing and charged a fixed fee.

AHA's recommendations are based on our longstanding concerns over the agencies' policy position that narrowly defined "item or service" for purposes of batching claims for IDR disputes. This policy makes the IDR process effectively unworkable for hospitals in that a claim for an episode of care involving multiple line items on the bill could not be submitted to the IDR process as a single dispute. While the federal court vacated the agencies' rules regarding batching of claims, we await further guidance from the

agencies on how batched claims will be treated. [6] It is, however, worth sharing several examples from our testimony before the House Ways and Means Committee and communications with the agencies to illustrate how challenging the agencies' batching policy has been for our hospital members.[7]

In the example provided earlier in this comment letter, the out-of-network hospital that submitted its claim valued at $68,880 for a Level 4 emergency visit that included 30 unique "items or services" per the agencies' definition received payment of $1,614 for only one item of service. In addition to the IDR administrative fee the hospital could be facing $19,400 in upfront IDR entity fees (some of which may be refunded depending on the outcome of the disputes). This same hospital would have to evaluate each underpaid line item and determine which to adjudicate. To select one item or service to dispute leaves the hospital significantly underpaid for the totality of services already rendered to a covered patient; but to initiate individual disputes for all unique items and services is extremely costly in terms of both money and time. This policy gives payers tremendous opportunity to abuse the system, as they have sole discretion over how to make an initial payment (i.e., whether they pay a single bundled amount, pay on each individual line item or a combination).

In another example, a hospital served a patient that presented to the emergency department with less severe aliments. The hospital claim sent to the insurer included 11 line items totaling $12,370 and included services such as pharmaceuticals, imaging, evaluation and management services, and more. The payer reimbursed the hospital for $2,732, or 22% of charges, on nine line items. Each of the under-reimbursed lines is low-cost enough that any more than one dispute for the entire claim would be cost prohibitive. To dispute the 10 other claim lines would cost $10,200 ($3,500 in administrative fees and $6,700 in upfront IDR fees), which is more than the remaining claim. In this case, the hospital is effectively unable to dispute more than $10,000 in charges as a result of the batching and bundling policies.[8,9] If the IDR entity applied tiered batch pricing to the above examples with a claim with 30 items or a claim with 11 lines the outcome is similar in that the hospitals would be discouraged from accessing the IDR process because of prohibitive IDR entity fees and the batching tiered fee structure.

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[6] On Aug. 3, 2023, the U.S. District Court for the Eastern District of Texas vacated the batching provisions of the NSA regulations. Further guidance from the agencies is forthcoming.
[7] https://www.aha.org/testimony/2023-09-19-aha-statement-record-house-ways-and-means-committee-september-19-2023
[8] The administrative fee in this example is based on $350, the amount of the fee established by the agencies, and which was in effect prior to the federal court's decision to vacate it.
[9] AHA Feb. 15, 2023, letter to NSA tri-agencies: Centers for Medicare & Medicaid Services, Employee Benefits Security Administration, and the Department of Treasury.

Other aspects of the batching rules also have a bearing on the IDR process. Specifically, how the agencies have defined payer for purposes of batching severely limits providers' ability to batch like claims together. Under the law, claims may only be batched together if they meet certain conditions, including that the "payment for such items and services is required to be made by the same group health plan or health insurance issuer."

Under the agencies' guidance, claims for individuals enrolled in employer-sponsored coverage may only be batched if the coverage is from the same employer. Yet, in most cases, it is the employers' third-party administrators (TPAs) that both determine the initial payment amount and reimburse the provider. In addition, it appears that most TPAs are using the QPA, which they are calculating based on all their TPA business in the same market. The TPA's initial payment is the same regardless of an individuals' employer, and yet providers may not batch these claims. This policy practice is further complicated as the provider generally does not know which employer the patient is associated with as their insurance card, as well as the remittance, may only indicate the TPA information, and the TPAs and payers are not required to provide the provider with timely and accurate information about the applicable payer. This double standard in the definitions disadvantages providers and allows for abuse of the NSA process.

The AHA strongly recommends that as the agencies revise the batching guidance per the federal court decision, the agencies allow for a more rational process for facilities to dispute inappropriate reimbursement, move away from the impractically narrow definition of "item and service" and allow a hospital to initiate a dispute for a patient's entire claim. In addition, we strongly urge the agencies to revise the guidance to allow batching at the TPA level for employer-sponsored insurance claims.

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 Molly Smith, AHA's group vice president of public policy, at mollysmith@aha.org or Molly Collins Offner, AHA's director of policy development, at mcollins@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
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