February 28, 2023

Hon. Jason Smith
Chair, Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

Hon. Richard Neal
Ranking Member, Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Hon. Cathy McMorris Rodgers
Chair, Committee on Energy and Commerce
2322 Rayburn House Office Building
Washington, DC 20515

Hon. Frank Pallone
Ranking Member, Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Smith, McMorris Rodgers, Neal and Pallone,

The Healthcare Business Management Association (HBMA) is writing to express our opposition to a decision by the Centers for Medicare and Medicaid Services (CMS) to increase administrative fees for the No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process by 600%. This increase will make the IDR process cost prohibitive for many IDR-eligible claims. Most importantly, this fee increase will not have the desired effect of reducing the volume of initiated IDR cases.

The Healthcare Business Management Association (HBMA), a non-profit professional trade association, is a major voice in the revenue cycle management industry in the United States. HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system. A 2022 survey of our members found that about a third of our members have clients who are engaged in the IDR process.

Background:
Congress established the IDR process to resolve reimbursement disputes between health plans and out-of-network (OON) healthcare professionals in scenarios protected under the NSA. The health plan and the provider must first negotiate with each other for 30 days before a party can initiate the IDR process. Parties are not allowed to take another party to IDR again for the same item or service for 90-days. Clinicians can also batch similar items or services into a single determination. Initiating the IDR process requires both parties to pay two fees 1) a non-refundable IDR administration fee, and 2) an IDR Entity Fee, which is reimbursed to the prevailing party by the losing party (or split evenly if both parties settle before IDR concludes).

On December 23, 2022, the Department of Health and Human Services (HHS) released its (partial) Initial Report on the Federal IDR Process: April 15 – September 30, 2022. Shortly after this report was issued, CMS amended its annual fee guidance for the IDR process – which had originally been issued in October – to increase the IDR administration fee by 600% from $50 to $350.

The higher administration fee must also be viewed in context with the other fees practices must pay to use the IDR process. Each IDR Entity (IDRE) charge their own fees. Unlike the administration fee, the IDRE fee is reimbursed to the prevailing party at the expense of the losing party. The IDRE fee can be as high as $938 for a large batch of claims. The NSA's 90-day cooling period means practices with large volumes of IDR-eligible claims must rely on this cumbersome batching process. Between the new Administration fee and the IDRE fee, practices risk incurring up $1,288 in fees before even receiving a payment determination by the IDRE. This does not include other financial resources that practices have dedicated to the dispute process.

Issue:
We oppose the new IDR Administration fee because the new non-refundable $350 fee is higher than the amount of many claims being disputed in the IDR process. This means many providers will not use the IDR process because the administrative cost is greater than the desired payment amount. This unfairly prevents many IDR-eligible claims from utilizing this process.

Early drafts of the NSA included a financial threshold that claims had to exceed to qualify for the IDR process. Congress chose not to include any financial threshold in the final version of the NSA. The new $350 IDR administration fees is akin to the financial threshold that Congress chose not to include in the statute.

Solutions:
This fee appears intended to reduce the number of IDR claims to alleviate current and prevent future backlogs. There are several causes for the number of initiated IDR disputes. Higher IDR fees will not address these causes. CMS must address the underlying causes of the backlog if it wants a sustainable solution to these challenges. This begins by acknowledging that health plans shoulder much of the responsibility for preventing overutilization of the IDR process.

According to the Initial IDR Report, many of the initiated IDR disputes were not eligible for the IDR process. These disputes could have easily been prevented by health plans. Health plans have the responsibility to inform providers if the NSA applies. Health plans should also identify a claim as ineligible for IDR during the open negotiation window that precedes IDR.

Unfortunately, the regulations do not address important details regarding this notification requirement. The NSA regulations specify that a health plan must notify a provider if the NSA applies by disclosing the QPA amount when making an initial payment or denial. While the regulations are clear about *when* a health plan must inform the provider, the regulations do not

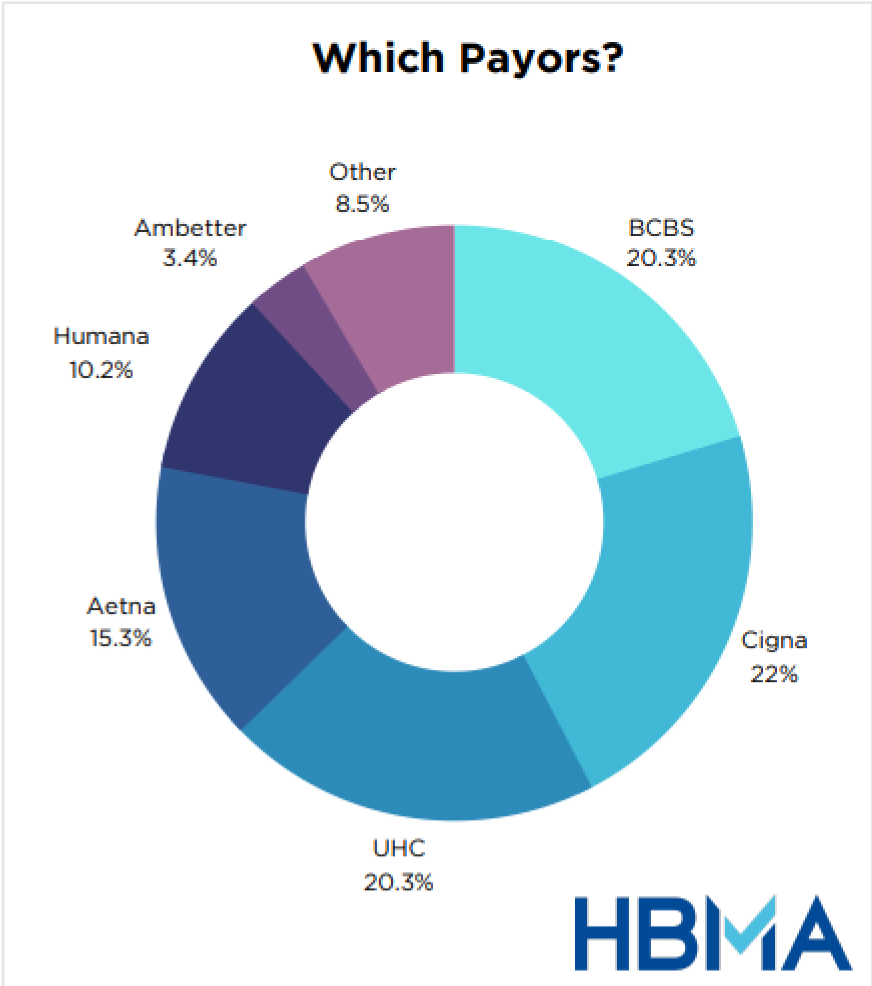
specify any other standards for *how* health plans must notify a provider if the NSA applies to a claim.

CMS should establish a notification process that uses existing remittance advice standards. Many plans already use remittance advice to communicate this information but not all do. Standardizing this process will reduce administrative burdens for practices and reduce the number of ineligible IDR disputes.

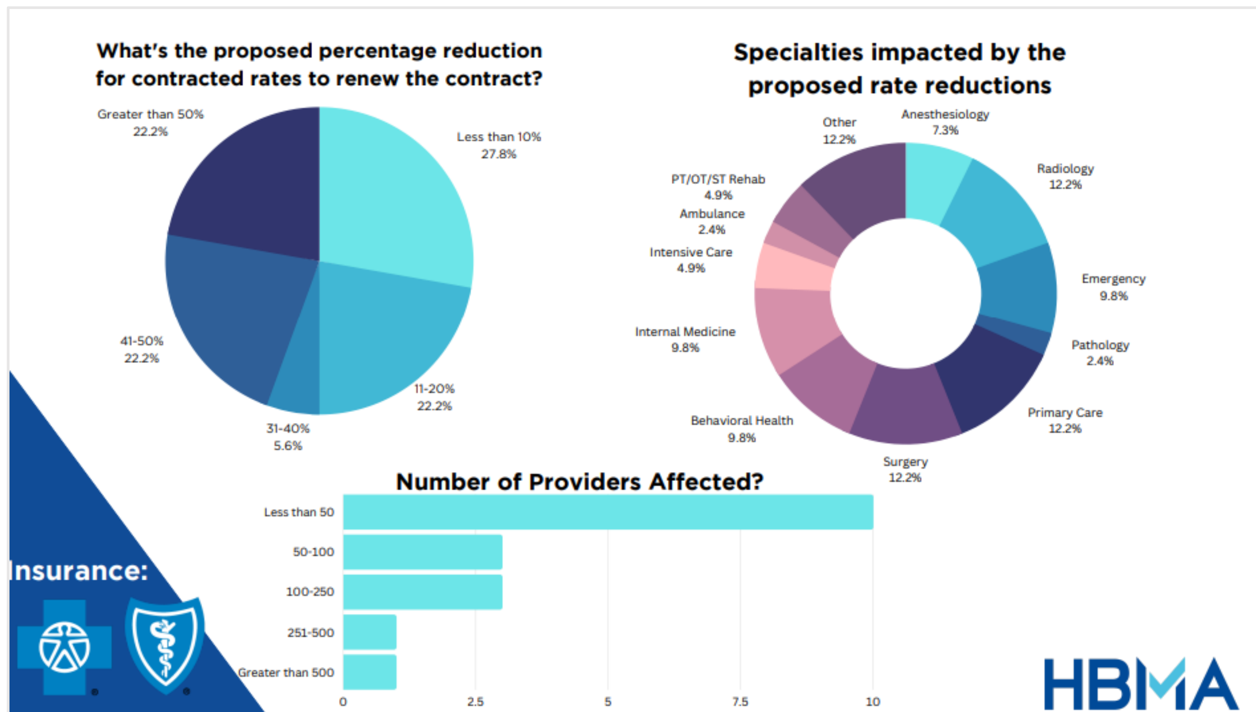
CMS must also require health plans to provide contact information for someone within that specific health plan who can answer questions from providers. Currently, there is no easy way for providers to contact health plans with questions about how the NSA might apply to a specific claim. In some cases, health plans use a “multi plan” format that makes it impossible for the provider to identify the patient’s correct health plan. These multi plan lists are sometimes pages in length. If the provider has a question, they must manually call the health plan without even knowing if this is the correct plan for the patient. Requiring health plans to provide a meaningful contact who can help answer questions will help prevent providers from initiating ineligible disputes.

The fee increase also does not change the fact that many health plans are forcing in-network providers out of their networks through massive rate decreases of up to 50% or simply terminating their contracts instead of negotiating new rates. This forces the newly out-of-network providers to use the IDR process to resolve payment disputes. More OON providers is also a reason why there were more IDR disputes than CMS initially expected.

In 2022, HBMA conducted an internal survey of our members about the prevalence of health plans proposing major rate reductions. The survey provides insight into how health plans, including the five largest health insurers, are forcing providers out of their networks with unreasonable rate reduction proposals.



We are also including an example of one payer from this survey to illustrate the severity of this issue and how it impacts at least a dozen specialties.



Conclusion:
CMS should take the following steps to ensure the IDR process is accessible to all providers who wish to use it:

- Reverse its decision to raise the IDR Administration fee from $50 to $350. The 2023 IDR Administration fee should be $50, as originally intended. CMS should also not increase this fee beyond annual inflationary adjustments. Exceeding that threshold creates a financial threshold that claims must meet to be eligible for IDR – something Congress deliberately did not include in the NSA statute.
- CMS must create a standardized, electronic process that health plans must use to notify providers if the NSA protections apply to a specific claim. This process should use the standard 835 transaction to communicate this information with remittance advice. Many health plans are already using this method voluntarily. CMS should require all plans to use this method. Such a requirement would prevent many ineligible claims from reaching the IDR process.
    - To further alleviate burdens on providers, CMS should also require health plans to communicate the QPA amount using remittance advice.
- CMS must conduct vigorous oversight of health plans contracting practices. Health plans are contributing to the high IDR utilization by forcing more providers out of network, which puts a greater strain on the IDR process. CMS's efforts to give the QPA added weight compared to other factors is the primary motivation for health plans to drop providers from their networks. This creates an incentive for health plans to remove all providers who earn more than the QPA from their networks. CMS must ensure that IDREs are empowered to weigh all factors equally – as the NSA intended – to maintain adequate provider networks.

- To help prevent providers from initiating ineligible disputes, CMS should require health plans to make contact information publicly available that providers can use if they have questions about how the NSA applies to a specific claim.
- In future versions of HHS' report on IDR results, HHS should include more information about initiated disputes that were ineligible for the IDR process. Specifically, the report should include information about disputes that were ineligible due to health plans not communicating the correct or necessary information about the NSA's applicability to the clinician.

Thank you for considering our recommendations. Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com) or Brad Lund (brad@hbma.org) if you wish to discuss our recommendations further.

Sincerely,

Landon Tooke

Landon Tooke, CHC, CPCO
President
Healthcare Business Management Association