December 22, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9897–P
P.O. Box 8016
Baltimore, MD 21244–8016

The Healthcare Business Management Association is pleased to submit these comments to the Departments on the Federal Independent Dispute Resolution (IDR) Operations proposed rule (CMS-9897-P).

HBMA is a national non-profit professional trade association for the healthcare revenue cycle management industry. 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.

HBMA members have an essential role in the operational and financial aspects of the healthcare system. Our work on behalf of medical practices allows physicians to focus their attention and resources on patient care - where it should be directed - instead of on the many administrative burdens they currently face. The RCM process involves everything from the lifecycle of a claim to credentialing, compliance, coding and managing participation in value-based payment programs.

The No Surprises Act (NSA) impacts HBMA members and our clients in many important ways. HBMA members help our provider clients understand and operationalize the NSA's requirements. Since the NSA was passed, HBMA has served as a resource to help our members understand and comply with the NSA. HBMA appreciates the opportunity to share our suggestions for how NSA implementation can be improved and to discuss how HBMA can be a resource to CMS as it continues to implement the NSA.

This proposed rule attempts to address many of the foundational issues with the NSA IDR process. **HBMA is largely supportive of these proposals.**

HBMA identified many of these issues before the IDR process accepted its first dispute. The NSA statute and the implementing regulations did not provide key details necessary to the operationalization of the IDR process. We appreciate the Departments taking this action to fix these issues. In the future, we suggest that the Departments collaborate more closely with industry partners such as HBMA who have an invaluable "on-the-ground" perspective on how policies are implemented and operationalized.

❖ **Enforcement**

As described below, we are generally supportive of the proposed rule. However, these provisions are only as effective as the enforcement mechanism behind them. Most of the issues related to the IDR process are due to health plans not complying with the letter and the spirit of the law. We believe CMS must engage in stronger enforcement regarding how health plans participate in the IDR process.

Additionally, while not addressed in the proposed rule, there needs to be greater transparency regarding how CMS is auditing health plans for their Qualifying Payment Amount (QPA) calculations. Currently, there is no transparency requirement for these calculations. Internal data from some of our members suggest that many health plans are not accurately calculating the QPA amount. With no faith in the QPA amounts, providers are incentivized to initiate an IDR dispute instead of accepting the QPA.

❖ **Early Communication Between Payers and Providers**

One of the largest sources of frustration for providers and RCM companies that use the IDR process is the lack of accurate information from health plans. The NSA's protections only apply to out-of-network services provided at an in-network facility if the state in which the service was furnished does not have a surprise billing law or lacks the authority to regulate a federal health plan.

Providers have no way of knowing if the patient's plan is regulated by federal or state surprise billing laws. The only way providers can know if the NSA protections apply to a specific item or service is if the health plan notifies the provider.

The NSA statute specifies that health plans must communicate the QPA when making an initial payment or coverage determination if the NSA applies. However, the NSA does not say anything about *how* the QPA must be communicated to the provider. This lack of specificity made it easy to foresee many of the challenges with the IDR process that currently exist.

It is typically very difficult to access the QPA information from the health plans. While some plans use a remittance advice to indicate if the NSA applies, not all use this process and a remittance advice cannot communicate the QPA amount. What's more, health plans can make it very difficult to know which specific health plan a patient is enrolled, thus making it impossible to identify the actual payer for dispute initiation.

Under the new proposed rule, payers would be required to provide additional information to providers when making an initial payment or sending a notice of denial of payment. The proposed rule would also require payers to use specific Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) to communicate information related to whether a claim is subject to the NSA and eligible for the IDR process.

HBMA supports these proposals to improve how information is communicated between the health plan and the provider.

- **IDR Registry**

To address challenges with identifying the payer and correct contact information, CMS proposes that payers subject to the IDR process register with HHS. Upon registration, payers would receive an IDR registration number, making it easier for parties initiating disputes to acquire the necessary information. CMS believes this change would improve information sharing between the parties and distinguish between different types of coverage offered by the same plan sponsor.

This is a welcome proposal that will alleviate one of the greatest frustrations for providers trying to use the IDR process. Health plans are making it increasingly difficult for providers to know which specific plan under the organization's umbrella against which a dispute must be initiated. Many health plans use the "multi plan" concept, which creates an umbrella of hundreds of individual plans. Providers have no way of knowing to which of these plans a patient is a member. The proposed IDR registry will provide this clarity by allowing providers to correctly identify the patient's health plan.

- **Open Negotiation**

Another complaint about the IDR process is that health plans are not meaningfully participating in the open negotiation process. The NSA requires both parties to engage in this 30-day process before an IDR dispute can be initiated. Open negotiation is intended to create an opportunity to avoid IDR and to filter out disputes that are not actually eligible for the IDR process. By not engaging in the IDR process at all, health plans leave providers no choice but to initiate an IDR dispute.

We support the proposed changes to the open negotiation process, which includes centralizing it through the Federal IDR portal, introducing an open negotiation notice with new content elements, and an open negotiation response notice. These changes will help parties communicate more efficiently during open negotiations and reduce the number of ineligible disputes submitted to the Federal IDR process.

Centralizing the open negotiation process through the federal IDR portal will allow CMS more oversight. The proposed rule requires responses from health plans to indicate the reasons for the denial of payment or initial payment amount, and whether the Federal IDR process applies.

CMS proposes establishing an open negotiation response notice that must be furnished by the party in receipt of the open negotiation notice to the other party and CMS by the 15th business day after the open negotiation process is initiated. The open negotiation response notice would be required to include a statement as to whether the initial payment amount and qualifying payment amount reflected in the open negotiation notice accurately reflect the initial payment amount and qualifying payment amount disclosed with the initial payment for the item or

service. If not, the response must include the correct initial payment amount and/or qualifying payment amount and supporting documentation. The notice must also include the amount of cost-sharing imposed for any item or service, the counteroffer for an out-of-network rate for each item or service, or an acceptance of the other party's offer.

- **Batching**

We are supportive of CMS' proposed changes to the batching process which are intended to allow the grouping of qualified IDR items and services in cases where they relate to the treatment of a similar condition, share the same service code, or belong to certain medical specialties.

The NSA allows for batching of "same or similar" items or services. The existing batching requirements are too narrow to fully realize the efficiencies gained from batching. This proposal will help reduce administrative burdens for using the IDR process by making it easier to batch similar items or services.

CMS is also proposing to create a limit of 25 qualified IDR items and services in a single dispute. This is intended to simplify the process for IDR entities and ensure all claims in the batch are eligible for the IDR process. CMS is seeking input on whether they should increase the limit to 50 qualified IDR items and services in a dispute.

The changes CMS is proposing in the proposed rule would improve eligibility determinations by having these determinations take place earlier in the process. Currently, due to the lack of information from health plans, eligibility is determined after the dispute has been initiated. This can cause issues for batched disputes which could contain ineligible claims in the batch. CMS' proposals would result in eligibility determinations occurring during the open negotiation period instead of after the dispute has been initiated. HBMA is confident that if the proposed changes are finalized, the eligibility concerns would be addressed before the claim reaches the IDR Entity. Therefore, there is less of a concern over ineligible disputes in the batch.

The current batching rules contemplate batches of more than 81 claims with fees based on the number of claims in each batch. CMS' earlier proposed rule on the IDR Administrative fee would reform how batching fees are paid based on sets of 25 claims per batch with no upper limit.

We do not believe an upper limit to the batching is necessary. CMS's proposals will address many of the eligibility concerns and the earlier proposed rule on the IDR Administrative fee would create a reasonable fee methodology for batched claims.

- **Administrative Fee**

HBMA has opposed CMS' decision to raise the non-refundable IDR administrative fee from $50 to $300. The higher fee amount is exclusionary for many IDR disputes which are for amounts below $300. In response to a successful legal challenge, CMS proposed to set the IDR

administrative fee at $150. We believe this amount is still too high. Our position is that the IDR administrative fee should remain at $50 to avoid excluding IDR disputes.

The new IDR proposed rule would add flexibility for the IDR administrative fee to prevent disputes from being excluded. CMS is proposing to set the IDR administrative fee at $75 if the dispute is for an amount that is less than the IDR administrative fee (which was subsequently finalized at $115 for single disputes).

While we appreciate CMS' attempt to provide this flexibility, we maintain our position that the IDR fee should be $50 for all disputes.

CMS calculated the proposed $150 fee amount based on its anticipated costs for administering the IDR process – though, CMS finalized a $115 IDR Administrative fee for single disputes. We believe the other proposals in this proposed rule will help lower CMS' costs by filtering out ineligible disputes and making the process more efficient.

❖ Conclusion

Thank you for considering our comments. We want to reiterate our appreciation for this effort to improve the IDR process for providers. We are optimistic that, with proper enforcement, these provisions will result in a more efficient and less burdensome IDR process for all parties. HBMA foresaw many of these issues when the NSA was passed and its implementing regulations were published. We hope that the Departments will continue to engage with stakeholders such as HBMA who can offer perspectives on how the NSA is operationalized.

Please do not hesitate to contact HBMA Director of Government Affairs Matt Reiter (reiterm@capitolassociates.com) or HBMA Executive Director Brad Lund (brad@hbma.org) if you wish to discuss our recommendations in more detail.

Sincerely,

Landon Tooke

Landon Tooke, CHC, CPCO
President
Healthcare Business Management Association