



Charles N. Kahn III
President and CEO

December 22, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: Federal Independent Dispute Resolution Operations; CMS-9897-P; 88 Fed. Reg. 75,744 (November 3, 2023).

Dear Secretaries Becerra and Yellen and Acting Secretary Su:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. These tax-paying hospitals account for nearly 20 percent of U.S. hospitals and serve their communities proudly while providing high-quality health care to their patients.

The FAH appreciates the opportunity to submit comments to the Office of Personnel Management, Department of the Treasury, Department of Labor, and Department of Health and

Human Services (HHS), regarding their proposed rules, Federal Independent Resolution Operations, published in the Federal Register (88 Fed. Reg. 75,744) on November 3, 2023. The FAH and its members strongly support the *No Surprises Act* (NSA), which first and foremost ensures that patients have in-network coverage and cost-sharing obligations in circumstances where the patient has no reasonable control over the network status of the facility or health care providers administering care. Surprise medical bills – including those that result from improper payer denials or limitations on coverage – burden our health care delivery system and should be eliminated in a manner that preserves market negotiation of network rates between health plans and providers, consistent with Congress’s intent.

Following the implementation of the NSA in 2022, the FAH has received reports of plan and issuer regular and systemic practices that go against the spirit and letter of the NSA and the Departments’ regulations, leaving providers and facilities without baseline information, including the amount of the qualifying payment amount (QPA), the methodological basis for the initial payment of the non-contracted claim, the identity of the plan or issuer responsible for payment, and the applicable regulatory framework for payment disputes with the plan or issuer. The profound information asymmetry between providers and facilities on the one hand and plans and issuers on the other impedes the efficient resolution of disputes and is contrary to the NSA’s design. And, where providers and facilities are nonetheless successful in initiating and prevailing in the Federal independent dispute resolution (IDR) process, the provider or facility often experiences that the plan or issuer simply fails to pay. Against this backdrop, the FAH appreciates and supports the Departments’ attention to the flow of information in the Proposed Rule and urges the Departments to likewise consider measures to address the serious problem of non-compliance by plans and issuers.

Use of CARCs and RARCs
(Parts II.B and II.H, 45 CFR § 149.100)

Improving the adequacy, usefulness, and consistency of information provided on remittance advices for out-of-network claims is a matter of critical importance, and the FAH strongly supports the Departments’ proposed addition of 26 CFR 54.9816-6A, 29 CFR 2590.716-6A, and 45 CFR § 149.100, applicable beginning on the effective date of the final rules. FAH members report receiving remittance advices from plans and issuers that do not provide basic and essential information or report information in inconsistent ways that require burdensome manual evaluation of remittance advices. The required use of claim adjustment reason codes (CARCs) and remittance advice remarks codes (RARCs) will assist in improving the information flow from plans and issuers to non-contracted providers and facilities in a clear and standardized fashion.

With respect to the implementation timeframe for CARCs and RARCs, the FAH strongly supports prompt implementation with the effective date of the Final Rule, as proposed. Any burden associated with operationalizing the use of CARCs and RARCs does not provide a basis for a prolonged implementation timeframe when providers are not currently receiving the baseline information necessary to understand a plan’s or issuer’s adjudication of an out-of-network claim (including the QPA for each item or service) or to even determine the identity of the payer with certainty.

Although the FAH strongly supports the mandatory use of CARCs and RARCs consistent with the proposed rules, the FAH requests that the Departments closely review and refine the existing RARCs and consider developing new CARCs and RARCs that are more specific and tailored, including RARCs that could be used to provide the information required to be shared about the QPA. A current RARC merely reports that “cost sharing was calculated based on the qualifying payment amount, in accordance with the No Surprises Act.” This information does not actually give the provider or facility the requisite clarity with respect to the actual QPA determined by the plan or issuer, but plans and issuers have used this RARC code in lieu of the disclosures required under 26 CFR 54.9816-6(d), 29 CFR 2590.716-6(d), and 45 CFR 149.140(d). The development of RARCs that provide information required to be disclosed about the QPA would significantly aid efficient communication regarding claims. To the extent that there are information elements that cannot be shared through the use of an existing CARC or RARC, however, the Departments should clarify that the use of CARCs or RARCs does not suffice for compliance with the requirements under 26 CFR 54.9816-6(d), 29 CFR 2590.716-6(d), and 45 CFR 149.140(d).

Information to be Shared About the QPA
(Part II.C, 45 CFR § 149.140(d))

(1) Improving Transparency Regarding the QPA

As noted in the Proposed Rule, the implementation of the NSA has been significantly hampered by inadequate information exchange regarding the QPA. Providers and facilities receive remittance advices that simply fail to clearly disclose the QPA, in violation of existing 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1), and 45 CFR 149.140(d)(1). And, when providers and facilities promptly request the additional QPA information specified in subsection (d)(2), either the information is not provided at all, or it is not provided in a timely fashion as would be required for the provider or facility to understand what the QPA actually represents. The lack of transparency around the QPA and related information is a significant detriment to the efficient resolution of payment disputes, and it serves no purpose but to increase the provider and facility costs associated with providing out-of-network emergency services to plans’ and issuers’ members and enrollees.

The FAH supports the proposed amendment to the beginning of subsection (d) as it will confirm that information must be disclosed whether the recognized amount is the QPA or the billed amount. As discussed below in connection with bundled payment arrangements (Parts II.A and E), some plans and issuers have failed to disclose the QPA, claiming that the recognized amount is based on the billed amount for one of a number of items and services and then improperly treating that payment for a line item as a bundled payment for all of the items and services. The proposed revisions will make clear that a plan or issuer cannot avoid disclosure of the QPA through such tactics.

The FAH, however, strongly urges the Departments to take more decisive action with respect to the disclosure of information relating to the QPA—including the QPA itself. With the Transparency in Coverage Final Rule, 85 Fed. Reg. 72,158 (Nov. 12, 2020), the Departments have already taken significant steps to promote transparency around plans’ and issuers’ out-of-

network allowed amounts.¹ ***The FAH urges the Departments to modernize the Transparency in Coverage rules to account for the intervening passage of the NSA by requiring public disclosure of the QPA for each item and service in each geographic region where the plan or issuer is not subject to a specified state law for that item or service.*** Because the QPA for established items and services are generally calculated based on the median contracted rate on January 31, 2019, and only change based on the CPI-U, plans and issuers should already have internal QPA data that can be used consistently and uniformly in the adjudication of claims under the NSA. And once the QPA information is loaded, annual updates based on the CPI-U would be relatively simple to implement. Therefore, the expansion of the public machine-readable file to include QPA information would impose only a marginal additional burden on plans and issuers, while providing patients, providers, and facilities with critical information that will aid in assessing the plan’s or issuer’s initial payment on a claim subject to the NSA.

In addition, the FAH continues to urge the Departments to expand the range of QPA-related information that plans and issuers are required to disclose with the initial payment or notice of denial of payment. In comments on the Departments July 13, 2021, Interim Final Rule, the FAH urged the Departments to significantly expand the range of information that is shared with facilities and providers in the normal course.² ***After observing the implementation of the NSA and the profound information asymmetry between plans and issuers on the one hand and providers and facilities on the other, the FAH continues to urge the Departments to incorporate the data elements in subsection (d)(2) into subsection (d)(1) so that this important information regarding the QPA is automatically provided with the initial payment or notice of denial.***

FAH members report that when providers and facilities have requested the additional information specified in subsection (d)(2), plans and issuers generally have not responded with the requested information in a timely manner (if at all). As a result, the requested information cannot aid meaningful negotiations or inform the decision to initiate IDR, undermining the purpose of the regulatory requirement. Because the information specified in subsection (d)(2) is either necessary to the plan’s or issuer’s calculation of the QPA or not applicable to a particular item’s or service’s QPA, the provision of the information specified in subsection (d)(2) should be minimally burdensome to the plan or issuer.

In the alternative, if the information set forth in subsection (d)(2) continues to be provided only upon request, the FAH strongly urges the Department to clarify that “in a timely manner” means within fifteen business days of a request and to establish transparency and accountability around plans’ and issuers’ compliance with this requirement. The FAH recommends a 15-day timeframe for providing this information because this would allow a provider or facility that promptly requests the information to evaluate it before deciding whether to initiate open negotiations. The later in the process that information is provided, the less likely it is to have a meaningful impact. Along these lines, the FAH recommends that the Federal IDR portal be revised to collect information on this QPA-related information. The initiating party’s open negotiation notice and notice of IDR initiation should have optional files that the party can

¹ 26 CFR § 54.9815–2715A3; 29 CFR § 2590.715–2715A3; 45 CFR § 147.212.

² Available at: <https://www.fah.org/wp-content/uploads/2021/09/FAH-Comments-Surprise-Billing-Part-One-FINAL.pdf> (Attachment A).

use to indicate whether a request was made, whether the requested information was provided timely, and the information that was provided. A certified IDR entity should have insight into a plan's or issuer's failure (or refusal) to provide the information under subsection (d)(2) when assessing the QPA and the parties' respective offers.

In addition to the information described in subsection (d), the FAH continues to believe that plans and issuers should provide additional methodological details concerning the calculation of the QPA with each initial payment or notice of denial. In particular, the FAH recommends adding disclosure requirements for the following pieces of information:

- (1) the number of contracted rates that were used to determine the median contracted rate;
- (2) the list of particular providers or facilities whose contracted rates were used to determine the median;
- (3) in cases where an eligible database was used to calculate the QPA under subsection (c)(3)(i) or (ii), the list of each eligible database that the plan or issuer has used to determine any QPA for items or services furnished in the state since January 1, 2021;
- (4) in cases where the QPA for a new service code is determined under subsection (c)(4)(i) or (ii), the QPA for the reasonably related service code, the relativity ratio calculated by the plan or issuer, and the data used to calculate the relativity ratio, as well as this same information for up to five alternative reasonably related service codes designated by the provider or facility;
- (5) in cases where the QPA for a new service code is determined without using Medicare payment rate information under subsection (c)(4)(i)(B) (or updated under subsection (c)(4)(ii)), an explanation of the reasonable method used by the plan or issuer, which should be uniform and consistent across markets.

Compiling and sharing this information with providers and facilities with claims payment would not be unduly burdensome because plans and issuers are already required to consider the foregoing information in order to accurately determine the QPA and this information would not generally change over time.

(2) **Disclosure of Plan or Issuer Contact Information in Advance of the Federal IDR Registry**

The FAH generally supports the revisions to subsection (d)(1)(iv) and (v) concerning the statement on open negotiations and the Federal IDR process. The FAH, however, recommends that proposed subsection (d)(1)(v) be revised to: (1) require disclosure of an agent with authority to act on behalf of the plan or issuer in open negotiations, along with contact information for such agent; (2) be immediately effective, acknowledging that the requirement to provide a registration number would be inapplicable for disclosures made prior to the applicable date for registration; and (3) require disclosure of the data elements set forth in proposed 26 CFR 54.9816-9, 29 CFR 2590.716-9, and 45 CFR 149.530 if the plan or issuer is not registered more than 30 days after the establishment of the Federal IDR registry.

At present, proposed subsection (d)(1)(v) does not include any requirement to identify the entity that has authority to negotiate (and settle) on behalf of the plan or issuer. In the time period between the effective date of the Final Rule and the establishment of a process for initiating open negotiations through the Federal IDR portal, providers and facilities will depend on plans' and issuers' disclosures to obtain the information necessary to initiate and then participate in meaningful open negotiations. Thus, the current requirement to provide appropriate contact information for initiating open negotiations should, at a minimum, remain in place for this interim period. ***In addition, the FAH strongly recommends that this disclosure be specific to an agent with authority to act (including settle) on behalf of the plan or issuer.*** At present, providers and facilities report that some plans and issuers provide contact information for an individual or entity that purports to engage in negotiations but ultimately lacks the authority to bind the plan or issuer to a settlement. This practice results in disputes that unnecessarily go to IDR for resolution and could have been settled with meaningful participation by the plan or issuer. The FAH also requests that the Department retain the requirement to provide information on the agent with the disclosures under subsection (d) after open negotiations migrate to the portal. Once the portal for open negotiations is operational, the process would still be aided by early and clear communication identifying the agent that is authorized to engage in open negotiations on behalf of the plan or issuer.

The FAH also requests that proposed subsection (d)(1)(v) be revised to be immediately effective. The plan or issuer should be capable of providing the legal business name of the group health plan (if any) or issuer and the legal business name of the plan sponsor (if applicable) upon the effective date of the Final Rule. During any period of time where the plan or issuer is not yet registered under section 149.530, there would be no obligation to provide a registration number under the plain language of subsection (d)(1)(v), so this provision does not warrant a later effective date.

The FAH is also concerned that providers and facilities will be left in the dark regarding critical plan and issuer information even after establishment of the Federal IDR registry because a plan or issuer that fails to register would not be obligated to report most of the data that is intended to be accessible through the registry. Therefore, the FAH requests that the Departments expand subsection (d)(1)(v) to specify that, if a plan or issuer is not registered more than 30 days after the establishment of the Federal IDR registry, the plan or issuer must provide each data element specified in proposed 26 CFR 54.9816-9, 29 CFR 2590.716-9, and 45 CFR 149.530. This addition would further incentivize prompt registration by plans and issuers and ensure that providers and facilities are not penalized should a plan or issuer fail to register.

(3) Enforcement and Applicability

Finally, in light of the significant problems reported by providers and facilities with respect to information disclosures with the initial payment or notice of denial, the FAH urges the Department to take action to ensure that a plans' or issuers' delays or deficiencies do not prejudice providers or facilities in the dispute resolution process. For example, the FAH recommends the creation of a process by which a provider could obtain a case-by-case extension of deadlines based on the plan's or issuer's failure to disclose the information required under subsection (d).

Federal IDR Process Registration of Group Health Plans, Health Insurance Issuers, and Federal Employees Health Benefits Carriers (Parts II.F. & II.G, 45 CFR § 149.530)

The FAH strongly supports proposed 26 CFR 54.9816–9, 29 CFR 2590.716–9, and 45 CFR 149.530 and the prompt establishment of a publicly accessible Federal IDR registry. As noted in the Proposed Rule, providers and facilities are “often missing or cannot locate key information needed for open negotiation and the Federal IDR process despite the disclosure requirements” under the implementing regulations.³ Providers and facilities have confronted missing or contradictory information regarding the identity of the plan or issuer responsible for payment of the out-of-network claim and cannot reliably determine whether the plan or issuer is subject to a specified state law or the contact information for the person or office responsible for open negotiations. A public Federal IDR registry that serves as a single source of truth on these threshold facts would be a significant and critical measure to ameliorate providers’ and facilities’ lack of information regarding non-contracted plans and issuers.

Registration Requirement. The FAH urges the Departments to finalize the registration requirement as proposed. The proposed registration deadline in subsection (b)(1) provides a 30-business-day registration period for existing plans and issuers, which is not unduly burdensome in light of the straightforward nature of the information called for in subsection (b)(2). Any plan or issuer must have this basic information promptly available as part of its normal operations and in order to be able to handle out-of-network claims in compliance with the NSA. As such, the burden associated with registering would not impose an excessive burden on plans and issuers.

Along similar lines, the FAH supports finalization of the registration requirement for all plans and issuers without regard to whether or not the plan or issuer has received any open negotiation notices. Universal registration is necessary to ensure that providers and facilities do not encounter unnecessary difficulty accessing the information necessary to initiate open negotiation and engage in the Federal IDR process. In fact, registration information may be of particularly significant importance in situations involving smaller plans or issuers that are relatively inexperienced with the Federal IDR process as their systems and processes may be less sophisticated and claims may fall within the wrong workflow. Universal registration provides additional assurance that the provider or facility will always have access to certain threshold information about the plan or issuer.

Public Availability. In order to maximize the effectiveness of the Federal IDR registry, the FAH requests that the Departments make it publicly available. Broad access to the registry will ensure that each provider and facility has a reliable source through which it can confirm basic plan and issuer information. And, the simple information disclosed in the registry does not include trade secrets, private information, or other data that should be insulated from public disclosure. In short, public availability would create an informational safety net of significant value and would create minimal (if any) risks.

Membership ID Cards. In Part II.G. of the Proposed Rule, the Departments note that they are considering, under their general rulemaking authority to establish the Federal IDR

³ 88 Fed. Reg. at 75,804.

process, requiring certain NSA-related disclosures on plan or insurance cards. *The FAH strongly supports improving the information disclosed on member ID cards so that the provider or facility has basic information relating to the plan or issuer and the NSA before any bill is submitted for out-of-network care.* The types of information described in the proposed rule—applicability of State or Federal surprise billing protections, coverage type, and regulatory authority—would be significant for providers, and the FAH would support such proposals. But the FAH recommends that the Departments consider requiring each plan or issuer to instead include the applicable registration number assigned under proposed 26 CFR § 54.9816–9, 29 CFR § 2590.716–9, and 45 CFR 149.530. As long as the Federal IDR registry is publicly available, by displaying the registration number on the ID card, a plan or issuer could effectively and efficiently provide patients, providers, and facilities with key NSA-related information in a minimum of space.

Enforcement. Finally, with respect to enforcement of the registration requirement, the FAH supports the Departments’ use of their investigative and referral authority, including HHS’s authority under 45 CFR 149.150 and 45 CFR Part 150, to promote compliance and the accuracy of the registry. In addition, the FAH recommends that, if a plan or issuer fails to register through the Federal IDR registry by the time an offer is due in IDR, the plan’s or issuer’s offer should not be considered received in the same way that an offer is not considered received if a party fails to pay the certified IDR entity fee.⁴ Moreover, a plan or issuer should be bound by its IDR registration information in IDR and should not be permitted to take an inconsistent positions with respect to eligibility for IDR during the course of the Federal IDR process.

Open Negotiation and Initiation of the Federal IDR Process **(Part II.D., 45 CFR § 149.510(b))**

(1) Initiation of Open Negotiations

The FAH appreciates the Departments’ recognition that excessive disputes regarding receipt of the open negotiation notice burdens the Federal IDR process and contributes to the significant backlog of disputes at IDR. The FAH likewise supports the Departments’ proposal to move the exchange of open negotiation notices to the Federal IDR portal as a pragmatic measure to reduce these disputes and promote efficiencies. This proposal will be particularly useful once the Federal IDR registry is operational because there will then be transparency on two critical fronts—basic information about the plan and issuer and documentation of the initiation of open negotiations.

In implementing this proposal, the FAH urges the Departments to ensure that the portal allows the provider or facility initiating open negotiations to select “not provided” or “unknown” for plan- or issuer-specific information that the plan or issuer has failed to provide. For example, in many cases the plan or issuer fails to provide the QPA with the initial payment or notice of denial of payment, such that an initiating provider cannot supply the QPA information. It appears from proposed subsection (b)(1)(ii)(6) that the Departments contemplate that a provider or facility can properly initiate open negotiations even if it has not received the QPA from the plan or issuer, but it is important to ensure that this is accounted for when this

⁴ Proposed 26 CFR 54.9816–8(d)(1)(ii), 29 CFR 2590.716–8(d)(1)(ii), and 45 CFR 149.510(d)(1)(ii).

component of the portal is operationalized. At present, FAH members report problems when initiating the IDR process without QPA information, including burdensome requests from the certified IDR entity for the provider or facility to provide QPA information when the plan or issuer has failed to disclose it. It is the FAH's hope that a portal-based open negotiation notice exchange and the response notice will provide a backstop for adequate information exchange, as long as the open negotiation initiation notice form on the portal permits initiation by a party that has not received required information.

(2) **Meaningful Participation in Open Negotiation and the Response Notice**

The FAH strongly supports initiatives designed to ensure that both parties actively participate in open negotiations and to promote the effectiveness of open negotiations. Such active participation should include the exchange of threshold information and positions and should be undertaken in good faith through agents with settlement authority. Consistent with the reports of certified IDR entities described in the Proposed Rule, FAH members confirm that plans and issuers wait until the selection of the certified IDR entity to raise objections to the applicability of the Federal IDR process or dispute the accuracy of basic information relating to the dispute, a practice that exemplifies the failure to participate in good faith in open negotiations, increases the number of disputes that proceed to IDR initiation, and slows down the processing of disputes at IDR. In addition, FAH members report that a number of plans and issuers have limited their participation in open negotiations to negotiation companies or other agents that lack the authority to bind the plan or issuer to a resolution of the dispute, resulting in disputes that must proceed to IDR, despite an agreement in principal between the negotiating agents.

Consistent with the foregoing discussion, *the FAH strongly supports the proposed requirement that the party receiving the open negotiation notice (generally a plan or issuer) respond with a written open negotiation response notice and supporting documents as specified in proposed subsection (b)(1)(iii)*. The threshold exchange of information that would necessarily occur by virtue of the response notice requirement would provide an improved foundation for a meaningful open negotiation process.

In order to further support meaningful open negotiations, the FAH continues to believe that subsection (b)(1) should be revised to require the parties to participate in open negotiations in good faith. Experience with the open negotiation process has shown that some plans and issuers fail to participate in open negotiations in good faith under the current rules, making the open negotiation process an exercise in futility in too many cases. As such, the FAH urges the Departments to go beyond “encourag[ing] disputing parties to negotiate in good faith during” the open negotiation period⁵ by formally adding a good faith requirement. In addition, the FAH believes that such a good faith requirement should be appropriately enforced by HHS or State regulators, and the IDR entity should consider information regarding a party's failure to negotiate in good faith when making its payment determination.

⁵ 88 Fed. Reg. at 75,764.

With respect to the content of the notices, *the FAH appreciates and strongly supports the Departments’ proposal that the open negotiation notice (subsection (b)(1)(ii)(3)) and the open negotiation response notice (subsection (b)(1)(iii)(3)) each include an “attestation that the third party [submitting the notice] has the authority to act on behalf of the party it represents in the open negotiation.”* As described above, FAH members report plans or issuers participating through agents that purport to have authority to act on behalf of the plan or issuer but ultimately lack the authority to bind the plan or issuer to a settlement. In these cases, the agents participating in open negotiations might reach agreement concerning the out-of-network rate, but that agreement among the agents does not resolve the dispute because the agent cannot bind the plan or issuer. As a result, disputes that should be resolved at open negotiation nonetheless proceed to a determination through the Federal IDR process at the same time that disputes are backlogged in IDR. It is the FAH’s understanding that “authority to act on behalf” of a party includes the authority to bind that party to an agreement regarding the out-of-network amount such that the required attestation would end this practice, but the FAH recommends that the Departments confirm this point in the Final Rule.

In addition, the FAH recommends that the Departments expand the content requirements for both the open negotiation initiation notice and response notice exchange information regarding the parties’ preferred certified IDR entities should the dispute proceed to IDR. An early exchange of this information could facilitate the prompt selection of a certified IDR entity at IDR because it would provide the party initiating IDR with the option to select the responding party’s preferred certified IDR entity at initiation, thereby streamlining the process and minimizing later delays in the process.

With respect to the timing of the notice, the FAH urges the Departments to *advance the deadline for open negotiations to the tenth business days after the submission of the open negotiation notice.* A response period of ten business days would ensure that the parties have the majority of the open negotiation period to actually conduct open negotiations after the initial exchange of information through these notices. In addition, the content specified in proposed subsection (b)(1)(iii) should be readily available to the responding party such that a longer period is unnecessary.

Lastly, in order to ensure that the response notice requirement meaningfully advances the goal, the FAH recommends that the Departments expressly address the consequences and penalties for a responding party’s failure to provide a response notice. For the initiating party, the written open negotiation notice is necessary to initiate the open negotiation period and ultimately access the Federal IDR process, creating inherent and necessary consequences for the initiating party if it fails to make the submission. But the Proposed Rule does not establish consequences should the responding party fail to submit a response notice. *The FAH urges the Departments to address this asymmetry by providing that the non-initiating party’s offer will not be considered received if it failed to submit the required open negotiation response notice.* in the same way that a party’s offer will not be considered received if the party fails to pay the certified IDR entity fee under subsection (d)(1)(ii).

(3) Initiation of the Federal IDR Process

The FAH supports the Departments’ plans to enhance the Federal IDR portal to allow the transmission of notices, including supporting documentation through the portal and to streamline the notice process. It is particularly important that, with the migration of the open negotiation notice to the Federal IDR portal, that the portal be modified to pre-populate the notice of IDR initiation so that the initiating party is not burdened with the re-entry of duplicative data. Likewise, supporting documentation that is uploaded to the portal in connection with open negotiations should also be considered supporting documentation to the notice of IDR initiation so that documents (e.g., the remittance advice) do not need to be re-uploaded at each stage of the process.

The FAH also asks the Departments to ensure that the portal allows the provider or facility initiating the IDR process to select “not provided” or “unknown” for plan- or issuer-specific information that the plan or issuer has failed to provide. As explained in connection with the notice of initiation of open negotiations, non-compliance by plans and issuers has resulted in providers and facilities proceeding to open negotiations without key information, including in particular the QPA. Finalizations of certain elements of the Proposed Rule will hopefully improve information exchange such that these situations become less common, but the option to leave the QPA field blank in the IDR initiation notice is important to ensure that a provider or facility is not be effectively barred from initiating IDR by virtue of the plan’s or issuer’s failure to disclose the QPA.

Federal IDR Process Following Initiation (Part II.E., 45 CFR § 149.510(c) et seq.)

(1) Eligibility Determinations—Reconsideration and Appeal Processes

The FAH is concerned that proposed subsection (c)(2) contemplates eligibility determinations that cannot be reconsidered or further reviewed, even where the determination is based on a clerical or factual error. In the course of eligibility reviews, it is inevitable that an item or service that is in fact a qualified IDR item or service will be mistakenly determined to be ineligible due to simple error (e.g., mistakenly failing to consider data properly submitted or a clerical error concerning the entry of deadlines). Under the NSA, only a determination of the amount of payment for a qualified item or service is a determination that is binding upon the parties and shielded from judicial review.⁶ A determination that an item or service is not a qualified item or service, on the other hand, is given no special status under the NSA. The Proposed Rule does not provide any rationale that would support treating an eligibility determination as final and unreviewable, but instead simply includes finality language in the proposed regulation without discussion. *The FAH believes that simple factual errors should be reviewable and remediable through an informal reconsideration request, an appeal to the Departments or judicial review, and urges the Departments to expressly establish a simple*

⁶ Section 102 of the NSA (adding section 9816(c)(5)(E) of the Internal Revenue Code, section 716(c)(5)(E) of ERISA, and section 2799A-1(c)(5)(E) of the Public Health Services Act).

process for obtaining such review, particularly in cases involving simple mistakes of fact or clerical errors.

(2) **Administrative Fees**

The FAH strongly urges the Departments to extend the timeframe for the initiating party's payment of the administrative fee to ten days after the date of preliminary selection of the certified IDR entity so that the initiating party has enough time to make payment by check or another preferred payment method. The Proposed Rule does not discuss the methods of payment that could be used to pay the administrative fee, but concludes that a two-day period provides "adequate time to pay the fee."⁷ The FAH is concerned that this tight proposed deadline would effectively limit the initiating party to using a credit card to pay the administrative fee, and urges the Departments to finalize a deadline that is sufficient for payment of the administrative fee by check.

With respect to the proposed administrative fee amounts, the FAH has concerns with some of the reduced administrative fee amounts and urges the Departments to distinguish between disputes that are ineligible for the Federal IDR process but are submitted to IDR in reliance on information provided by the plan or issuer on the remittance advice, in the open negotiation response notice, or otherwise and those that are erroneously submitted without such reliance. A provider or facility should be entitled to rely on disclosures by the plan or issuer relating to the eligibility of a dispute for resolution through the Federal IDR process. Where a dispute is ultimately found to be ineligible for the Federal IDR process and the provider or facility so relied on a disclosure by the plan or issuer, the plan or issuer should be required to pay 100 percent of the administrative fee (or 50 percent, in the case of a low-dollar dispute), and the provider's or facility's administrative fee should be reduced to 20 percent. If it is unduly burdensome to assess responsibility for the submission of an ineligible item or service to IDR, the FAH would alternatively support mutually reducing the parties' administrative fees to 60 percent (standard dispute) or 35 percent (low-dollar dispute) that is ineligible for the Federal IDR process. The FAH, however, opposes a policy that presumes that the submission of an ultimately ineligible dispute to the Federal IDR process is the fault of the initiating party and should produce higher fees for the initiating party.

(3) **Plan or Issuer Failure to Timely Pay the Out-of-Network Amount**

As the Departments note, the timeframe for payment between the parties after the payment determination is set by statute at 30 calendar days and cannot be extended.⁸ This deadline is clear in both the NSA and the Departments' implementing regulations, but FAH members report that plans and issuers frequently fail to make payment within this timeframe or at all, forcing the prevailing provider or facility to incur even more costs to collect appropriate payment for the qualified IDR item or service furnished to the plan's or issuer's member. *The FAH therefore urges the Departments to improve oversight, accountability, and enforcement of the obligation to pay the out-of-network amount within 30 days.* In particular, the FAH requests that the Departments require payment through the Federal IDR portal or the submission

⁷ 88 Fed. Reg. at 75,797.

⁸ 88 Fed. Reg. at 75,780.

of proof of payment through the portal so that a plan's or issuer's compliance or non-compliance with its payment obligation can be readily assessed and an appropriate investigation or enforcement action can be initiated. In addition, the FAH urges the Departments to explore their regulatory authority to impose interest on past-due payments and to use their civil monetary penalty authority to penalize non-compliance with payment obligations.

Bundled Payment Arrangements
(Parts II.A. & II.E, 45 CFR §§ 149.30, 149.510(c)(3)(ii))

The FAH is concerned with the ongoing and inappropriate use of bundled payments by out-of-network plans and issuers for claims subject to the NSA. As a threshold matter, the FAH continues to believe that bundled payment arrangements should not be imposed on non-contracted claims subject to the NSA because there is, by definition, no arrangement between the provider or facility and plan or issuer. ***Thus, the provisions of the NSA referencing the treatment of bundled payments in IDR⁹ should properly be read as requiring that the Federal IDR process address in a single determination all items and services furnished in a single episode of care and billed on a single claim form, but not as permitting the unilateral imposition of a bundled payment arrangement by a plan or issuer.*** Under the bundled payment provision of the NSA, a provider or facility should always be permitted to obtain a single determination at IDR for all items and services furnished in single episode of care and billed on a single claim form, and there should be no requirement that the provider, facility, plan, or issuer bill or pay under a single service code for all of these items or services in order to obtain such bundled payment treatment at IDR. It is inappropriate to subject these disputes to the batching rules under proposed section 149.510(c)(4). Rather, batching—and the limitations on batching—should be properly reserved for claims involving more than one episode of care (e.g., multiple patients).

If the Departments nonetheless retain the concept of a bundled payment arrangement, the FAH respectfully urges the Departments to ***limit bundled payment arrangements to: (1) situations where the provider or facility and the plan or issuer mutually agree to bundling (e.g., the provider or facility bills on a bundled basis and the plan or issuer likewise makes a bundled payment); or (2) items and services represented by an all patients refined diagnosis related group (APR DRG) code.*** In addition, the FAH strongly urges the Departments to ensure that plans and issuers provide appropriate information regarding bundled payments by enforcing the rules at 45 CFR § 149.140(d) and adopting CARCs and RARCs specific to bundled payment under proposed § 149.100. ***Ultimately, the application of a bundled payment arrangement and the scope of bundling should be clear in the remittance advice, and the application of a bundled payment arrangement does not excuse a plan or issuer from its obligation to calculate and provide a QPA for each item or service on the claim.***

At present, some plans and issuers apply proprietary or payer-specific bundled payment arrangements that are not widely recognized on claims for items and services that were not bundled by the provider or facility, producing confusion and uncertainty. This misalignment produces situations where a provider or facility receives payment that is a small fraction of the

⁹ Section 102 of the NSA (adding section 9816(c)(3)(B) of the Internal Revenue Code, section 716(c)(3)(B) of ERISA, and section 2799A-1(c)(3)(B) of the Public Health Services Act).

QPA because the plan or issuer has paid one single item or service as a “bundled” payment at the amount billed for the single item or service and then denied and excluded the charges billed for each of the other items and services purportedly included in the bundled payment. For example, if there are three items or services reported with billed charges of \$600, \$1,000, and \$400 and the plan or issuer acknowledges \$1,200 as appropriate payment when bundling these items and services, one would expect a minimum payment of \$1,200 on the claim. But facilities and providers have seen the plan or issuer inappropriately limited total payment on the bill to the charges for the first item or service (\$600), ignoring the billed charges for the other items and services purportedly “bundled” with the first. This situation is compounded by the lack of clear information about plan or issuer bundling – it is often unclear from the remittance advice which items and services were paid, which were bundled, how the bundled payment was applied, and what the QPA is for each item and service billed.

Existing section 149.510(c)(3)(ii) and the newly proposed definition of “bundled payment arrangement” (proposed section 149.30) both fail to expressly exclude the *unilateral* imposition of bundling by a plan or issuer or to limit bundling to items and services represented by DRG or APR DRG codes. As the FAH emphasized in prior comments submitted in response to the October 7, 2021, interim final rule,¹⁰ in the absence of a direct or indirect contractual relationships with respect to the furnishing of the items or services at issue, there is no payment arrangement permitting the plan or issuer to bundle. The FAH believes that there are only two situations where bundling could be appropriate: (1) where the provider or facility and plan or issuer agree on bundling (*i.e.*, a mutual bundling arrangement); or (2) a recognized DRG or APR DRG applies to the claim. In any case, the unilateral imposition of a proprietary or payer-specific bundling arrangement should not be permitted under the NSA rules.

In addition, the FAH urges the Departments to expressly address ongoing and critical problems in the flow of information from plans and issuers to facilities and providers regarding bundled payments. The Departments’ regulations properly require that the QPA be calculated separately for each item and service, even where the plan or issuer uses bundling or capitation for in-network claims.¹¹ And likewise, under section 149.140(d)(1)(i),¹² the plan or issuer is required to provide the QPA “for each item or service involved” with each initial payment or notice of denial of payment. Despite these clear and express requirements under existing law, FAH members report receiving bundled payment without QPA information for each individual item or service billed. ***This practice is contrary to law, and the FAH urges the Departments to investigate such non-compliance and enforce the QPA requirements for bundled payments.*** Moreover, the information disclosures provided with the initial payment should provide enough information for the provider or facility to determine whether the payment amount represents a bundled payment arrangement and which items and services were bundled. ***Thus, the FAH***

¹⁰ Available at: <https://www.fah.org/wp-content/uploads/2021/12/Surprise-Billing-Part-2-IDR-Good-Faith-Estimate-External-Review-FINAL.pdf> (Attachment B).

¹¹ 26 CFR § 54.9816-6T(b)(2)(iii), 29 CFR § 2590.716-6(b)(2)(iii), 45 CFR § 149.140(b)(2)(iii) (“In calculating the median contracted rate, a plan or issuer must: . . . (iii) In the case of payments made by a plan or issuer that are not on a fee-for-service basis (such as bundled or capitation payments), calculate a median contracted rate for each item or service using the underlying fee schedule rates for the relevant items or services. If the plan or issuer does not have an underlying fee schedule rate for the item or service, it must use the derived amount to calculate the median contracted rate.”)

¹² 26 CFR § 54.9816-6T(d)(1)(i), 29 CFR § 2590.716-6(d)(1)(i).

urges the Departments to develop and require the use of CARCs and RARCs that provide specific information for bundled payments applied to non-contracted claims. These CARCs and/or RARCs should disclose the application of a bundling methodology and specifically identify each item or service that was included in such bundling.

Batching Items & Services
(Part II.E.2, 45 CFR 149.510(c)(4))

The FAH supports the broader availability of batching to help reduce the IDR backlogs that have frustrated the efficient resolution of disputes through the Federal IDR process. In particular, the FAH supports eliminating artificial limitations on batching that themselves burden the IDR process. As certified IDR entities have reported to the Departments, certified IDR entities find batched disputes more burdensome than non-batched disputes “due to the extra time and resources they must expend in verifying that the items and services are properly batched and eligible for the Federal IDR process.”¹³ In fact, the substantive payment determinations in batched disputes are able to be made “relatively efficiently,” and a “substantial portion of the time and expense related to resolving disputes is spent on . . . administrative and eligibility-related tasks.”¹⁴ *Against this backdrop, the FAH supports simple and practical batching rules that allow providers to broadly batch similar items and services while minimizing the certified IDR entity’s eligibility-related tasks for batched disputes.*

(1) Line-Item Limit

The FAH strongly opposes the application of an artificial line-item limit for batched items and services because separating items and services that could otherwise be batched and addressed in a single determination into two or more determinations will increase the burden on the system while offering few or (in some cases) virtually no efficiencies. The problems of a line-item limit are particularly evident in cases where the batched items and services involve the same episode of care, involve a single code, or were subject to a uniform payment methodology by the plan or issuer.

With respect to the batching of items and services furnished to a single patient in a single patient encounter and reported on a single claim form, as explained above, the FAH supports treating such a claim as a bundled payment dispute that is the subject of a single determination without regard for any batching rules or fees. But, if items and services furnished in a single patient encounter are instead considered batched under proposed 26 CFR § 54.9816–8(c)(4)(i)(C)(1), 29 CFR § 2590.716–8(c)(4)(i)(C)(1), and 45 CFR § 149.510(c)(4)(C)(1), any line-item limit would still be inappropriate. Carving such a case into multiple IDR determinations would result in piecemeal, inconsistent, and inefficient determinations regarding payment involving a single episode of care. A certified IDR entity addressing payment for 25 line items involved in such a single episode would necessarily need to assess a number of considerations that would likewise be relevant to a determination of the remaining items and services furnished beyond the 25 line items. And limiting the certified IDR entity’s scope of

¹³ 88 Fed. Reg. at 75,782.

¹⁴ *Id.*

review to a specified number of line items would not meaningfully narrow the considerations before the certified IDR entity in a way that could expedite the payment determination.

Likewise, a line item limit should not be applied to items and services represented by an identical or comparable code under proposed subsection (c)(4)(C)(2) or service codes belonging to the same Category I CPT code range under proposed section (c)(4)(C)(3). In both cases, the limitation that the batched services must have been furnished within the same 30-business-day period is sufficient to limit the volume of batched services, and the imposition of an additional line-item limit will perpetuate and exacerbate the existing IDR backlog and result in piecemeal determinations rather than promoting efficiencies. In fact, in some of these cases, the plan or issuer might have applied the same payment methodology to 50 or more of the same or similar items and services furnished by the same provider, confirming that the services can be efficiently batched at the election of the initiating partner. In short, existing limitations on batching preclude the presentment of “large and complicated batches”¹⁵ that might warrant a line item limit, as confirmed by the relative efficiency with which certified IDR entities make payment determinations in batched disputes, and the FAH does not support the finalization of any line item limit for the batching of items and services described in proposed subsection (c)(4)(C).

(2) Category I CPT Code Subsections

The FAH strongly supports the Departments proposal to permit the batching of some services billed under service codes belonging to the same Category I CPT code range and urges the Departments to expand this proposal to permit additional batching, including the batching of evaluation and management CPT codes across levels. As proposed, new subsection (c)(4)(C)(2) would appropriately enable providers to obtain payment determinations of batched items and services that might not be cost-effective to dispute individually or on a code-by-code basis.

The FAH also strongly supports policies that promote the efficient resolution of payment disputes involving emergency department evaluation and management codes (namely, CPT codes 99281-99285). Non-contracted emergency providers frequently receive low payments on out-of-network claims for evaluation and management services that are financially significant in the aggregate but are not cost-effective to dispute on an individual basis. This situation produces a condition of circularity that discourages plans and issuers from contracting with emergency providers and could even place emergency services at risk. Briefly, if it is not cost-effective to dispute individual evaluation and management codes or to dispute them in multiple batches based on the applicable evaluation and management code level, emergency providers are at risk for further erosion in payments from out-of-network plans and issuers that understand the low likelihood of a payment going to IDR. This situation further disincentivizes the out-of-network plan or issuer to negotiate for network participation at reasonable rates and even incentivizes non-renewal of contracts by other plans and issuers. The aggregate impact of these pressures may prompt emergency providers to relocate, resulting in diminished access to care in the community. It is thus of critical importance that the IDR process include the opportunity to meaningfully batch emergency department evaluation and management services.

¹⁵ 88 Fed. Reg. at 75,783.

In the Proposed Rule, the Departments seek comment on ways that emergency department providers might be permitted to batch items and services across the five evaluation and management Level 1 CPT codes “without a commensurate increase in the diversity of documentation that certified IDR entities would need to review to evaluate disputes related to different, but similar conditions.”¹⁶ It is the FAH’s understanding, however, that the variability between encounters represented by different emergency department evaluation and management codes is not significantly wider than the variability between encounters represented by the same emergency department evaluation and management code, such that the items and services represented by these codes are similar (*i.e.*, an emergency department visit for the evaluation and management of a patient, including a history, examination, and medical decision-making). The availability of batching for emergency department evaluation and management codes would be particularly useful and efficient in the many situations where non-contracted plans and issuers apply a uniform, cookie-cutter payment methodology to these claims and the provider is seeking to address, in a cost-effective manner, the routine underpayment of these evaluation and management codes. Should the Departments remain concerned that the batching of emergency department evaluation and management services across similar codes would burden the IDR process, a reasonable line-item limit on batching for these services only (*e.g.*, 50 line items per batch) could be a reasonable measure to promote efficiency and address certified IDR entity concerns.

The FAH appreciates the opportunity to submit these comments on these important issues to patients and providers. If you have any questions, please contact me or any member of my staff at (202) 624-1500.

Sincerely,



¹⁶ 88 Fed. Reg. at 75,790.