hfma
healthcare financial management association

December 1, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave., N.W.
Washington, D.C. 20220

Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, D.C. 20210

Subject: CMS-9897-P Federal Independent Dispute Resolution Operations, Proposed Rule, Federal Register (Vol. 88, No. 212), November 3, 2023

Dear Secretaries Becerra, Yellen, and Su:

The Healthcare Financial Management Association (HFMA) would like to thank the tri-agencies for the opportunity to comment on the Federal Independent Dispute Resolution Operations, Proposed Rule. HFMA is a professional organization of more than 100,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

The independent dispute resolution (IDR) process stands as a vital pillar, affirming the principles set forth by the No Surprises Act. The IDR process was originally conceived to guarantee just compensation for essential medical care provided to out-of-network patients in situations when insurers and health plans fail to reach mutually agreeable terms with providers for establishing member networks. Regrettably, HFMA and our members continued to witness a surge in unsuccessful provider network agreements since the enactment of the No Surprises Act. This trend results from some payers manipulating reimbursement rates to levels below the actual cost of care for many community hospitals and providers, often camouflaged by false Qualified Payment Amounts (QPAs). Given the instability within the IDR process and the backlog of unresolved disputes, it is evident that the No Surprises Act is falling short in its mission to support community hospitals and providers nationwide, primarily due to the dysfunctional QPA and IDR process.

Compounding the challenges, the operational costs and burdens associated with securing fair payment for items and services persistently surpass any advantages derived from the IDR process for community hospitals and providers. Operational bottlenecks, including a multitude of pending disputes left unanswered, QPAs dispatched by insurers and payers lacking proper identification, non-initiators unwilling to engage in open negotiation periods, and the delayed reprocessing of appropriate reimbursement following IDR entity rulings on disputes, all persist as substantial hurdles.

Within the proposed rule, the tri-agencies propose enhancing the functionality of the IDR process under the No Surprises Act. The proposed rule introduces requirements for plans to include claim adjustment reason codes and remittance advice remark codes, along with other new information, accompanying the initial payment or notice of payment denial for specific items and services covered by No Surprises Act protections.

The rule proposes modifications to batching requirements, allowing items and services to be batched in the same payment determination under certain conditions. This includes instances where they are furnished to a single patient on consecutive dates of service and billed on the same claim form (a single patient encounter); billed under the same service code or a comparable code in a different procedural code system; or anesthesiology, radiology, pathology, and laboratory items and services billed under service codes belonging to the same Category I CPT code section, as outlined in agency guidance. Batched items would be restricted to 25 qualified IDR items or services (line items) in a single dispute.

In addition, the proposed rule would amend requirements pertaining to the open negotiation period, initiation of the process, dispute eligibility review, and the payment and collection of administrative fees and certified IDR entity fees.

HFMA is grateful for the chance to provide input and collaborate with the departments on the proposed adjustments to the operational aspects of the IDR process.

Batching Requirements

Though HFMA appreciates the tri-agencies efforts to streamline and simplify the batching process for the IDR process, we raise serious concern about the arbitrary cap the departments propose to limit batch appeals to 25 items or services in a single dispute.

When providers identify underpayments for services by an insurer or payer, if those services are common services provided to communities, the occurrences at which those underpayments occur are many times in the hundreds for the same exact or similar item or service. Capping batch appeals at the arbitrary number of 25 will not only drive up the administrative burden and confusion for providers, payers and IDR entities, but it will inflate the administrative costs to the program and add to healthcare costs overall.

Although the current proposal represents an improvement over narrow policies that were implemented in 2022, the 25-line item does not align with reimbursement grouping or established

billing methodologies. It is common practice for insurers and plans to consolidate multiple CPT codes on a single claim depending on grouper methodology. Requiring providers to fragment a claim exceeding a 25-line-item cap not only raises the provider's submission costs to the IDR process but also severs related items and services furnished during that encounter. This division complicates the task for IDR entities to accurately determine the appropriate payment amount for emergency and out-of-network services and in other circumstances would be construed as fraudulent billing since it could secure higher payment by circumventing bundling methodologies.

Therefore, HFMA respectfully urges the tri-agencies to reconsider implementing the proposed cap on all batch appeals. Instead, the focus should be on ensuring rigorous verification and enforcement that batched appeals strictly adhere to the proposed batching guidelines outlined in the rule. These guidelines permit items and services to be batched in the same payment determination only when they are furnished to a single patient on consecutive dates of service and billed on the same claim form; billed under the same service code or a comparable code in a different procedural code system; or anesthesiology, radiology, pathology, and laboratory items and services billed under service codes belonging to the same category.

Claim Adjustment Reason Codes and Remittance Advice Remark Codes

HFMA supports the tri-agencies proposal to require plans to include claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), along with other new information, accompanying the initial payment or notice of payment denial for specific items and services covered by the No Surprises Act. HFMA believes the additional details provided through the accurate use of CARC and RARC codes will be effective in greatly reducing ineligible claims being submitted to the federal IDR process.

HFMA respectfully urges the tri-agencies to furnish explicit timelines for compliance, offer guidance on CARC and RARC proper usage, outline and set monetary penalties for non-compliance, and provide federal contact information for filing grievances against parties failing to comply with the regulations.

Timeframes Within the Federal IDR Process

While HFMA acknowledges the tri-agencies' efforts to establish transparent expectations and streamline timeframes within the Federal IDR process, we advise caution to the departments regarding setting timeframe requirements that might prove exceedingly challenging for all parties to comply with, potentially leading to increased confusion, frustration, and excessive administrative costs within the Federal IDR process.

Hence, HFMA respectfully requests the tri-agencies to make the following adjustments to their proposed timeframes, ensuring that all parties participating in the process have clear, achievable goals that will help support the Federal IDR process workflows:

1) Initial Payment or Notice of Denial of Payment: The department's timeline in the proposed rule outlines that the plan or issuer determines whether the services are covered, and if the services are covered, sends to the provider, facility, or provider of air

ambulance services an initial payment or notice of denial of payment no later than 30 calendar days after a bill is transmitted. **- HFMA respectfully urges the departments provide clarification on the governing body that will be providing oversight and enforcement and/or accessing civil monetary penalties that will be imposed in the event of non-compliance with the requirements for plans or issuers.**

2) Open Negotiation Response Notice: The party in receipt of the open negotiation notice must provide to the other party and to the Departments as soon as practicable, but no later than the 15th business day of the 30-business-day open negotiation period, a written notice and supporting documentation in response to the open negotiation notice (open negotiation response notice). **- HFMA respectfully requests the departments to provide clarification on the governing body that will be providing oversight and enforcement and the specific action that will be taken in the event of non-compliance with the requirements for the party in receipt.**

3) Notice of IDR Initiation Response: Within 3 business days of receipt of the notice of IDR initiation, the non-initiating party must submit the notice of IDR initiation response form, attesting to whether the Federal IDR process applies to the item(s) or service(s) included in the notice of IDR initiation. The non-initiating party must agree or object to the preferred certified IDR entity identified in the notice of IDR initiation by indicating its agreement or objection in the notice of IDR initiation response. If the non-initiating party objects to the preferred certified IDR entity identified in the notice of IDR initiation, the non-initiating party must designate an alternative preferred certified IDR entity. Direct IDR entities to assign less weight to the QPA in IDR entity decision-making and assign greater significance to other factors submitted by providers when evaluating payment disputes for out-of-network services. **- HFMA respectfully requests the departments to provide clarification on the governing body that will be providing oversight and enforcement and the specific action that will be taken in the event of non-compliance with the requirements for the non-initiating party.**

4) Administrative Fee Collection from the Initiating Party: The initiating party must pay the administrative fee directly to the Departments within 2 business days of the date of preliminary selection of the certified IDR entity. If the initiating party fails to pay its administrative fee, the dispute will be closed. **– HFMA requests that the departments allow 5 business days for the initiating party to pay the administrative fee to the Departments to allow a grace period for unforeseen logistical and technical issues that could occur.**

5) Administrative Fee Collection from the Non-Initiating Party: The non-initiating party must pay the administrative fee directly to the Department within 2 business days of an eligibility determination. – **HFMA requests that the departments allow 5 business days for the non-initiating party to pay the administrative fee to the Departments to allow a grace period for unforeseen logistical and technical issues that could occur. HFMA also seeks clarification on what specific enforcement actions will be taken if the non-initiating party does not pay within the set timeline**

required. Enforcement details were provided within the proposed details of the initiating party's non-compliance scenario, but not for the non-initiating party's non-compliance.

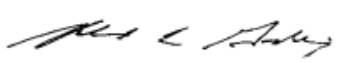
6) Eligibility Review: The certified IDR entity that was finally selected must review the information in the notice of IDR initiation, notice of IDR initiation response, and any additional information and determine whether the items or services is a qualified IDR items or services that is eligible for the Federal IDR process. The certified IDR entity must notify the Departments and both parties of its determination within 5 business days after the date of final selection of the certified IDR entity. **– HFMA requests that the departments allow the IDR entity 10 business days to notify the Departments and both parties of eligibility status after the date of final selection of the certified IDR entity. HFMA does not believe that 5 days is an adequate time frame to facilitate a proper and thorough eligibility review of all documents.**

7) Payment Between Parties of Payment Determination Amount: Any amount due from one party to the other party must be paid not later than 30 calendar days after the payment determination by the certified IDR entity. **- HFMA respectfully seeks clarification on the governing body responsible for overseeing and enforcing, as well as assessing civil monetary penalties or interest in the event of non-compliance with the requirements for the party responsible for making payment to the other party. This payment is expected to be made in full no later than 30 calendar days after the payment determination is issued by the certified IDR entity.**

8) Refunding the Certified IDR Entity Fee to the Prevailing Party: The certified IDR entity must refund the prevailing party's certified IDR entity fee within 30 business days after the payment determination. **– HFMA respectfully requests that the departments allow 5 business days for the certified IDR entity fee to be refunded to the prevailing party after the payment determination. This timeline aligns and is more consistent with the administrative fee timelines.**

HFMA looks forward to any opportunity to provide assistance or comments to support the tri-agencies. We take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS and advisory groups. We are at your service to help the tri-agencies gain a balanced perspective on these complex issues. If you have additional questions, please reach out to me or Shawn Stack, Director of Perspectives and Analysis, at sstack@hfma.org or at 708.571.3955 ext. 607

Sincerely,



Richard L. Gundling, FHFMA, CMA
Senior Vice President, Professional Practice
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 107,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.