Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400
www.aamc.org

Submitted electronically to regulations.gov

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The Honorable Xavier Becerra
Secretary
Department of Health and Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Admin.
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Douglas W. O'Donnell
Deputy Commissioner For Services
and Enforcement, IRS
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, DC 20220

Ms. Laurie Bodenheimer
Assoc. Director, Healthcare and Insurance
Office of Personnel Management
1900 E Street, NW
Washington, DC 20405

Re: Federal Independent Dispute Resolution Operations Proposed Rule (RIN 0938-AV15)

Dear Secretary Becerra, Deputy Commissioner O'Donnell, Assistant Secretary Gomez, and Associate Director Bodenheimer:

On behalf of the Association of American Medical Colleges (AAMC or the Association), we are writing to provide comments on the proposed rule regarding the Federal independent dispute resolution process (IDR) operations (RIN 0938-AV15), which was published in the Federal Register at 88 *Fed. Reg.* 75744 (November 3, 2023).

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The welfare of patients, families, and communities is the highest priority of the AAMC and our members support safeguards that protect patients from surprise medical bills and promote

transparency. Many AAMC members have made substantial investments in working to achieve this goal. Most have dedicated staff to assist patients in navigating the complex health insurance system and educate them as it relates to their benefits and cost-sharing liabilities.

Teaching hospitals often are where individuals go when experiencing an emergency or emergent complex care issue—either by choice, during an emergent transfer to an institution with greater capabilities, or because the teaching hospital is where the ambulance takes them—and it is a time when patients are at their most vulnerable. We are pleased that the No Surprises Act (NSA, "The Act") prohibits balance billing and holds patients harmless by only requiring them to pay the in-network cost-sharing amount for out-of-network emergency care, and care provided by ancillary providers.

In our discussions with Congress, we supported the establishment of an independent dispute resolution (IDR) process to resolve any disputes between payors and providers about payment amounts and emphasized the importance that the process accounts for the unique qualities of teaching hospitals and the patients they serve. While protecting patients from out-of-network costs, it is also important to ensure reasonable payment rates for providers and a balanced IDR process. Inappropriate reimbursement by payers can impact a provider's ability to offer services, ultimately impacting patients.

While we continue to support the goals of the NSA, we have been concerned over the implementation of the statute, particularly the IDR process. The implementation of the statute, specifically with respect to the IDR process, has disadvantaged providers, ultimately impacting access to care. We appreciate the opportunity to provide comments on this proposed rule that specifically addresses issues resulting from a decision issued on August 3, 2023, by the U.S. District Court of the Eastern District of Texas[1] and other concerns with the IDR process raised by providers. It is crucial for the Departments to establish rules that ensure that the IDR process is fair, unbiased, results in appropriate payment amounts, is efficient, and that cost of the IDR process is not a barrier to resolve disputes. Our comments on specific proposals in the rule follow.

TREATMENT OF BATCHED ITEMS AND SERVICES

The Act allows providers to batch together for consideration during the IDR process claims submitted within a 30-day period that are furnished by the "same provider or facility" under the "same plan" and for the "same or similar items or services." Specifically, the No Surprises Act directs the Departments to specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination to encourage efficiency and minimize costs for disputing parties (referred to as a "batched disputes."). Many providers, including AAMC and our members, raised concerns with the requirements for batching services in prior rulemaking and asked the Departments to allow more flexibility in the requirements for which items and services can be batched. On August 3, 2023, the U.S. District Court of the Eastern District of Texas issued an order vacating the batching provisions

[1] See Memorandum Opinion and Order, *Tex Med. Ass'n v. U.S. Dep't of Health and Hum. Servs*, No. 6:23-cv-00059-JDK (E.D. Tex. August 3, 2023).

established under October 2021 interim final rule[2] on surprise billing, which required that items and services batched in one IDR dispute be billed under the same service code or a comparable code under a different procedural code system. In this rule, the Departments propose new batching provisions that are intended to ensure that the batching rules do not unreasonably impede parties' access to the IDR process, considering relative costs and administrative burden while avoiding new operational complexities.

Specifically, the Departments propose to allow the following qualified IDR items and services to be batched:

- Services that were provided to a single patient during the same patient encounter (which can be on one or more consecutive days) that are billed on the same claim form (a single patient encounter);
- Services billed under the same service code or a comparable code under a different procedural code system; or
- Anesthesiology, radiology, pathology, and laboratory items and services billed under service codes belonging to the same Category 1 CPT code section.

The Departments propose to limit batched determinations to 25-line items in a single dispute. The Departments seek comments on this limit and whether an alternative line-item limit that is higher would be more appropriate, such as a 50-line-item limit or whether the limit should vary depending on the type of dispute.

The AAMC strongly supports the revisions that would allow batching of all services that were provided to a single patient during the same patient encounter over a period of consecutive days that are billed on the same claim form. The batching requirements set forth in previous rulemaking (which were vacated by the federal court) made it extremely difficult for hospitals to effectively participate in the IDR process by narrowly defining an "item or service." This proposed change that will allow a provider to initiate a dispute for a patient's entire claim will improve providers' ability to access the IDR process. As an example, a patient who comes to the emergency department (e.g. for pneumonia) is likely to receive multiple services (e.g. laboratory tests, imaging, physician visits, supplies) that would be included on multiple service lines on a claim form. These items and services relate to the diagnosis and treatment of the same or similar condition and therefore should be combined into one dispute. Evidence submitted to support the claim would generally be identical for each qualified IDR item and service furnished during a single patient encounter. If each service on the claim under dispute had to be separately adjudicated (as was required in prior rulemaking), it would be cost prohibitive for the hospital that would need to pay a fee[3] for each line item to use the IDR process and would increase burden for IDR entities. This proposed change would simplify and encourage efficiency in the process.

[2] 86 Fed Reg 55980 (Oct. 7, 2021)

[3] A final rule was issued in December 2023 establishing an administrative fee of $115 per party and an increase to the fee range for certified IDR entities to $200-$840 for single determinations and $268-$1,173 for batched determinations. (Federal Independent Dispute Resolution Process Administrative Fee and Certified IDR Entity Fee Ranges Final Rule. (December 18, 2023). 2023-27931.pdf (federalregister.gov)

While we appreciate the proposals to expand the definition of items and services that may be batched, we oppose the Departments proposal to limit batched disputes to 25 items or services in a single dispute. When providers identify underpayments by a payer, if those services are commonly furnished services, the occurrences of the underpayments for the same exact or similar item and service would be significantly higher than 25 and could be many times in the hundreds. Additionally, patients that go to the emergency room typically receive numerous different items and services to diagnose and treat their illness or injury, which may exceed 25-line items. Capping batch appeals at the arbitrary number of 25 will increase the administrative burden for both providers, payers and IDR entities. Instead of setting a limit on batch disputes, we urge the Departments to focus efforts on ensuring that batched disputes strictly adhere to the batching guidelines set forth in the proposed rule.

The Departments propose to allow batching if the same issuer is required to pay for the qualified IDR item and services, even if the qualified IDR items and services relate to claims from different group health plans or individual market policies. However, for self-insured group health plans (i.e. employer sponsored plans), claims may only be batched if coverage is from the same employer, even if multiple employers use the same third-party administrator. In most cases, the employers' third-party administrators (TPAs) determine the initial payment amount and reimburse the provider. Most TPAs are paying the providers the Qualifying Payment Amount (QPA), which is the median contracted rate for the same or similar item or service. The TPAS are calculating the QPA based on all their TPA business in the same market. While the TPA's initial payment to the provider is the same regardless of the employer, the providers would still not be allowed to batch these claims under this rule. The inability to batch these claims is complicated by the fact that the provider typically does not know which employer the patient is associated with since their insurance card and remittance usually typically includes the TPA information only. This policy on batching disadvantages providers and results in unnecessary utilization of the IDR process, thereby increasing costs and burden. Therefore, we recommend the agencies revise the rules to allow batching at the TPA level for employer-sponsored insurance claims.

PROPOSALS TO IMPROVE COMMUNICATION AND TRANSPARENCY PRIOR TO IDR

We commend the Departments for the proposed changes in the rule that would improve transparency and communications between payers, providers and certified IDR entities. One of the reasons that there has been a higher-than-expected volume of disputes initiated under the IDR process, is that providers have experienced challenges negotiating with plans during the 30-day open negotiation period. Providers have reported difficulties communicating and obtaining key information needed to resolve payment disputes. A substantial number of health plans have been unwilling to negotiate with providers during the open negotiation period. The lack of engagement has resulted in very few disputes being settled outside of the IDR process. Due to lack of communication between the disputing parties, initiating parties have also been submitting ineligible disputes.

To ensure that all parties have the information necessary to determine whether a payment dispute is eligible for the Federal IDR process, the Departments propose to require that payers provide additional information at the time of initial payment or notice of denial of payment. We support the Departments' proposal to create an IDR registry in which all self-insured and fully insured

health plans must register and provide information that would help providers identify and contact their plans. This information would help providers to identify which plans are self-insured plans versus fully insured plans, which is important when identifying which claims may be batched and other requirements that apply under the No Surprises Act.

Additionally, we support the Departments' proposal that would require payers to communicate information to out of network providers by using specific claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) that would include information related to whether a claim for an item or services is subject to the federal dispute resolution process, a specified state law or all-payer models. This would better facilitate communication between parties and reduce the number of payment disputes that are ineligible but submitted to the Federal IDR process. We also urge the Departments to require that reimbursement remittances include information about the QPA amount.

The Departments propose additional improvements to help facilitate negotiations before the IDR process, including integration of the Open Negotiations process into the IDR portal. We support the proposals that the initiating party must send an Open Negotiations notice to both the Departments and the non-initiating party as this will alleviate confusion about when the Open-Negotiations process begins. In addition, we support the requirement that the non-initiating party send a notice back to the initiating party within 15 days, and that the non-initiating party must provide the cost-sharing amount and the plan type (fully insured or self-insured).

We commend the Departments for these proposals that would improve communication and transparency between providers and plans, and thereby reduce the volume of disputes initiated under the IDR process. However, the effectiveness will hinge on whether payers are compelled to comply with these new requirements. We request that the Departments establish penalties and enforcement mechanisms for failure to comply. For example, we recommend that if the non-initiating party does not make a timely response (within the 15-day time frame), it should result in a default, which could be set aside for good cause.

OVERSIGHT OF QPA CALCULATIONS

While the QPA was established to calculate patient cost-sharing and as a factor for consideration by IDR entities, many health plans are inappropriately using the QPA to set initial payment determinations. Providers have reported that the payers are offering very low rates based on their calculation of the QPA. We believe that payers are not accurately calculating the QPA (median contracted rate) by including "ghost rates" in the QPA. A ghost rate occurs when a provider and plan have a dollar value for service in their contract, but the provider does not offer the service and therefore does not negotiate on the amount, resulting in a very low payment amount. We urge the Departments to require that payers provide details regarding their QPA calculations to enable providers to fairly engage in the IDR process and to ensure IDR entities have the information they need to inform their decisions. Payers should be required to demonstrate that they are accurately calculating the QPA, which should be an accurate representation of the median contracted rate. We urge the Departments to conduct a rigorous review of the plans' QPA calculations. We remain concerned that underpayments will negatively impact access to care.

EXERCISE OVERSIGHT OF IDR PROCESS

It will be essential for the Departments to exercise oversight over the arbitration process to ensure that all parties are complying with the new requirements regarding communication, transparency, and batching, that the process results in fair payment amounts for the parties involved and does not cause an undue administrative burden or high costs. We urge the Departments to provide clarification regarding how oversight and enforcement will be provided and specific actions that would be taken in the event of non-compliance.

CONCLUSION

Thank you for the opportunity to provide input as you develop regulations that protect patients from surprise medical bills and ensure appropriate payment to providers. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic medical center community and their patients and communities. If you have questions regarding our comments, please feel free to contact Gayle Lee at galee@aamc.org.

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief, Health Care Affairs

cc: David Skorton, M.D., AAMC President and Chief Executive Officer

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