TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

January 2, 2024

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

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

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

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

Dear Secretaries Becerra and Yellen and Acting Secretary Su:

On behalf of over 57,000 physician and student members, the Texas Medical Association ("TMA") expresses its appreciation for the opportunity to provide comment on the Departments of Health and Human Services, Labor, and Treasury ("the Departments") proposed rule regarding the Federal Independent Dispute Resolution ("IDR") operations under the No Surprises Act ("NSA"), as published in the Federal Register on November 3, 2023. TMA is a private, voluntary, non-profit association of Texas physicians and medical students and was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its vision is "Improving the Health of all Texans."

TMA has a keen interest in legislation and regulatory efforts relating to "surprise" out-of-network balance bills. We supported surprise billing legislation in Texas (i.e., SB 1264, 86th Regular Session), as passed, due to our commitment to helping patients address "surprise" out-of-network balance bills.

TMA also supports the patient protection goals of the NSA related to surprise billing; however, we have ongoing concerns regarding the implementation of the law. Congress intended for the law to take patients out of the middle of surprise billing disputes while providing a fair, efficient and accessible Federal IDR process to ensure patient access to care. Unfortunately, the implementation of the law has not always aligned with this Congressional intent. The implementation of the Federal IDR process has been problematic from both an operational and fundamental fairness standpoint.

In the rule preamble, the Departments posit multiple reasons that the Federal IDR process has not functioned efficiently, along with several concerns expressed by interested physicians, facilities, and other providers regarding the critical unmet need for the Federal IDR process to generate timely payment determinations.[1]

While TMA does not support all the provisions in the latest rule proposal, we greatly appreciate the Departments' efforts to address some of these previously communicated concerns that are so central to a properly functioning Federal IDR process. We also appreciate the Departments' recent re-opening of the IDR portal for all claims, including batched claims.

Our specific comments on the rule proposal are set forth in more detail, below.

I. Communications Between Parties

A. Required Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes

First, TMA strongly supports the Departments' proposal to impose mandatory requirements on issuers and plans to use certain NSA related Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) when a plan or issuer provides a paper or electronic remittance advice to any entity with which it does not have a direct or indirect contractual relationship with respect the furnishing of an item or service under the plan coverage.

While this measure will not resolve all the confusion surrounding qualified IDR item or service determinations, TMA believes that providing this information earlier in the process (i.e., when providing the initial payment or notice of denial) is an important step in the right direction in terms of attempting to address some of the confusion concerning eligibility determinations. Implementing these provisions could help to reduce: (1) some of the delays associated with ineligible IDR item or service submissions and (2) the amount of resources dedicated to making eligibility determinations.

As the Departments know, Texas' surprise billing law qualifies as a "specified state law" under the NSA. As such, Texas has a bifurcated process in which some out-of-network claims that would otherwise be subject to the Federal IDR process are instead subject to our state IDR process.

[1] 88 Fed. Reg. at 75,754 et seq (*see* discussion on Scope and Purpose of Rulemaking).

This bifurcation in processes is an important feature under the NSA for Texas physicians, as TMA has been supportive of our state law and feedback from our members has reflected that the state process has been running more efficiently and fairly than the federal process.

While the Texas Legislature and the Texas Department of Insurance ("TDI") have always imposed certain requirements that aid physicians and providers in assessing whether a claim is subject to the Texas law or the Federal IDR processes (e.g., certain patient ID card requirements and explanation of benefits ("EOB") requirements), confusion regarding eligibility for the federal or state process continues to exist.

We are, therefore, pleased to see the Departments making efforts to address mandatory standardized NSA-related CARCs and RARCs (and in both paper and electronic remittance advice), so that a more uniform communication approach is implemented across plans and issuers throughout the nation. We also appreciate the Departments noting the following, which provides some clarity regarding the intended interaction between state and federal laws associated with CARCs and RARCs:

> [s]hould these proposed rules be finalized, nothing in these proposed rules would prevent a State from requiring that issuers use specific CARCs or RARCs in addition to those specified in the No Surprises Act-specific Federal guidance that the Departments would be authorized to issue; nor would a State or other entity be prevented from engaging with the relevant committees to request the creation or use of a CARC or RARC in addition to those specified in such guidance.[2]

TMA notes that it will be critical for any state or federally-mandated CARCs and RARCs to be carefully constructed and properly interact with each other so that important NSA-related information is communicated clearly. The devil will be in the details of the sub-regulatory guidance on this proposal. Thus, we urge the Departments to carefully consider any state/federal interactions when developing the sub-regulatory guidance.

We also agree with the Departments that physicians, providers, and facilities "need information to understand not only when items and services are subject to the No Surprises Act, but also when they are not, to avoid submission of ineligible disputes to the Federal IDR process."[3] Thus, we support the Departments' proposal to apply these CARCs and RARCs requirements to plans and issuers when sending remittance advice with respect to items and services to which the NSA surprise billing requirements do **not** apply, in order to properly convey that the NSA does not apply. We agree with the Departments that the enhanced communication offered by the mandatory CARCs and RARCs could reduce the number of ineligible payment disputes submitted to the Federal IDR and decrease the need for outreach by certified IDR entities ("IDREs"), which would allow IDREs to concentrate resources on making payment determinations for eligible disputes.[4]

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[2] 88 Fed. Reg. at 75,761.
[3] Id. at 75,762.
[4] Id. at 75,761.

Finally, we also agree with the Departments that there would be other efficiency benefits to adopting the proposed requirements, including providing certified IDREs with information earlier to aid them in determining whether or not the disputing parties agree on the dispute's eligibility for Federal IDR.[5]

For all the foregoing reasons and as time is of the essence when it comes to addressing delays and inefficiencies in the Federal IDR process, we urge the Departments to finalize this proposed CARC and RARC requirement as soon as possible.

With regard to the Departments specific solicitation of comment as to whether additional CARCs and RARCs would be valuable, we note that the Department states the following with regard to self-insured plans:

> In addition, a large proportion of the disputes determined ineligible for the Federal IDR process by certified IDR entities involve items or services that providers, facilities, or providers of air ambulance services batched improperly because they did not realize that a TPA was administering coverage for multiple self-insured plans rather than a single issuer or group health plan, and the items and services were thus ineligible to be batched. Certified IDR entities have determined that other disputes are ineligible for the Federal IDR process because the self-insured plan involved in the dispute had voluntarily opted in to a specified State law. A RARC that could clearly identify a payer as a self-insured plan may reduce the number of disputes that are initiated and determined ineligible on the basis of a batching or jurisdictional error.[6]

We concur that additional information related to self-insured plans is needed. In Texas, the Legislature recently enacted a self-funded ERISA opt-in law.[7] Accordingly, in the rulemaking process for this legislation, TMA advocated for TDI to impose a requirement via rulemaking that for claims submitted electronically, the information generally required by TDI rules to be included on an EOB related to application of the state process be "provided in the form of a searchable, standardized remark code or similar searchable language in an electronic explanation of benefits file."[8] Part of the rationale for this recommendation was that even though claims may be submitted electronically and EOBs are returned electronically in an 835-remittance file, "some carriers in Texas have provided information about a claim's eligibility for IDR only in a paper or PDF format, which creates a significant administrative burden."[9]

Ultimately, TDI declined to adopt this requirement, stating (in part) the following:

> The submission of ineligible claims creates a substantial burden for TDI and the responding health plans. TDI agrees that health plans should use a standardized and searchable electronic method for providing the required information within EOBs.

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[5] Id.
[6] Id. at 75,762.
[7] House Bil 1592, 88th Texas Legislature, 2023.
[8] TDI adoption order, Commissioner's Order No. 2023-8410.
[9] Id. at 15.

> TDI will monitor this issue and consider addressing it in future rules if health plans do not conform to best practices for conveying this information.[10]

But, this example underscores the lack of consistency in communications from plans and issuers (even in terms of the format of those communications) regarding IDR eligibility. It also highlights expected issues with the additional layer of complexity associated with eligibility determinations concerning self-insured plans opting into specified state laws. Thus, standardization with mandatory RARCs and CARCS could be useful in the context of determining whether a plan has opted into a specified state law (again, provided that coordination between any state and federal requirements is appropriately considered).

With regard to batching for the Federal IDR process, self-insured plans present extra challenges because in order to batch properly, physicians and other providers need to know the name of the patient's employer and do not always have that information. Providing these additional disclosures would also be beneficial to physicians and other providers and could help reduce the number of improper batching submissions.

B. Information to be shared with the QPA

Next, the Departments propose to expand the QPA disclosure requirements to require issuers and plans to make the same disclosures when the "recognized amount" is the amount billed by the physician, provider, or facility and not only when the recognized amount is the qualifying payment amount ("QPA"), as these items and services would also be eligible for the Federal IDR process if all other eligibility requirements are satisfied. **TMA supports this proposal even when the QPA is not the basis of cost-sharing, because the QPA is important information to have prior to the open negotiation process and when assessing whether to initiate a Federal IDR dispute**.

The Departments also propose to amend the rules to require plans and issuers to disclose (along with the QPA), the legal business name of the plan (if any) or issuer; the legal business name of the plan sponsor (if applicable); and the registration number assigned, as applicable, if the plan or issuer is registered with the Federal IDR registry. **TMA supports these requirements when providing an initial payment or notice of denial of payment as they will be helpful for both open negotiation and IDR initiation purposes.** Again, plan sponsor information is particularly important given the complexity of assessing eligibility related to self-insured ERISA plans.

C. Patient ID cards

Next, in the proposed rules, the Departments solicit comment on "whether ID cards should display the plan or coverage type (such as, self-insured or fully-insured ERISA plan, non-Federal governmental plan, church plan, FEHC plan, or individual health insurance coverage), as well as whether a symbol or code could be included on cards that would indicate the applicable regulatory authority of the plan or coverage (that is, State or Federal entity, or both)."[11] **TMA generally supports provision of this information on patient ID cards.** At a minimum, patient ID cards should

[10] Id.
[11] 88 Fed. Reg. 75,802.

clearly state whether the plan or coverage is subject to federal or state surprise billing protections. However, TMA urges the Departments to consider existing requirements of states with regard to patient ID cards and to coordinate efforts with states when implementing patient ID card requirements. Texas, for example, currently requires state-regulated plans (i.e., PPO, EPO and HMO plans) to have the letters "DOI" (for Department of Insurance) or "TDI" (for Texas Department of Insurance) on the cards.[12] Self-insured ERISA plans that opt-in to Texas's specified state law are required to have "TXI" on the front of the patient ID card.[13]

II. Open Negotiation[14]

A. Use of Federal IDR Portal for Open Negotiation

Next, the Departments propose amending the rules to require the initiating party to provide a written open negotiation notice to the other party and to the Departments through the Federal IDR portal in order to initiate the open negotiation period. **TMA supports integrating the open negotiation notice and open negotiation response notice into the Federal IDR portal.** We agree with the Departments that integration of the open negotiation initiation process into the Federal IDR portal has the potential to improve information exchange between the parties and promote efficiencies in the process.

From an information exchange standpoint, use of the portal to initiate open negotiation should be very helpful in addressing ongoing confusion regarding where initiating parties need to send the open negotiation notice form (as some plans have their own portals that--while not mandatory--create additional confusion and burdens on physicians and other providers). Additionally, emailing open negotiation initiation notices is administratively burdensome for practices to manage, particularly for small practices. The use of the portal as a centralized platform is likely to be a significant improvement over the current disjointed process.

From an efficiency standpoint, the portal would also be useful in maintaining a record of open negotiation initiation and completion periods, which is important when assessing which disputes are eligible for the Federal IDR process.

While TMA supports the Departments' proposal to integrate the Federal IDR portal into the open negotiation initiation notice and response notice processes, TMA urges the Departments not to assess an administrative fee for the use of the portal, as it is important to encourage the parties to negotiate

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[12] See Texas Department of Insurance information: How consumers are protected from surprise medical bills (texas.gov).

[13] TDI adoption order at 32.

[14] Note that we do have concerns about the Departments' statutory authority as applied to detailed procedural rules associated with the open negotiation process (as compared to IDR). From a statutory authority standpoint, it would be better for the Departments to implement many of the procedural elements related to the open negotiation process from the perspective of setting forth incentives, rather than forcing the parties to comply. Setting that aside, we are commenting on the proposal as put forward by the Departments but preserving any future objection regarding statutory authority.

fees and settle at this stage (prior to Federal IDR initiation). Any additional administrative fee assessment for portal use would be at odds with this important, underlying goal. TMA also encourages the Departments to fully integrate the proposed rules' IDR registry information into the open negotiation initiation process (in order to have the portal's functionality identify the plan or issuer by their plan IDR registration number), as this could enhance the rule's goal of reducing the number of ineligible disputes submitted to the Federal IDR process.

B. Open Negotiation Notice Content

Next, the Departments propose adding some new elements and additional information that must be provided in the open negotiation notice. We understand that the goal of these new requirements is to promote consistency between the open negotiation and the Federal IDR process and to streamline the process. Thus, we support many of the new elements (e.g., we support the requirement for the plan to provide the amount of the cost sharing, if initiating) from that perspective; however, we have a few concerns related to some of the new notice content.

First, TMA is concerned about the potential administrative burden associated with providing additional notice elements and information. Thus, TMA encourages the Departments to consider how to implement any proposed changes in the least administratively burdensome manner possible, e.g., using auto-population and check boxes where possible. Texas has many small physician group practices. Reducing administrative burdens associated with these entries is critical to allowing these practices to focus on patient care, rather than red tape.

Second, TMA **opposes** the Departments' proposal to require an initiating party to provide the QPA for the item or service if it has been provided on the initial payment or notice of denial of payment. The Departments state that the rationale for this proposed requirement is "to facilitate better communications between parties in identifying whether there may be a mistake in the identified QPA, such as a typographical error or the incorrect use of the cost sharing amount, rather than the QPA, so the information can be rectified before initiating the Federal IDR process."[15] While we understand this stated goal, TMA has two primary concerns with this requirement. First, the plan already has the QPA information, thus requiring the physician initiating party to recite that information back to the plan is duplicative, creating another unnecessary administrative burden for physicians and providers. Second (and most importantly), requiring provision of the QPA in the open negotiation notice, along with the offer for an out-of-network rate inappropriately signals that the QPA is the most relevant factor in determining the out-of-network rate at the open negotiation stage and that the two amounts should be compared. TMA has consistently noted that Congress did not intend for the QPA to have primacy in the Federal IDR process. It is important not to inappropriately signal or tip the scales in the open negotiation stage of the Federal IDR as well.

Third, TMA **opposes** any requirement for the initiating party to state the rationale for its initiation of open negotiation. The reason that physicians or other providers initiate open negotiation should be readily apparent without requiring it to be stated – i.e., physicians and other providers initiate open negotiation to address their concerns regarding underpayments by a plan or issuer for items or

[15] 88 Fed. Reg. 75,767.

services. Requiring physicians and other providers to state the obvious serves no useful purpose and would only add to the already administratively burdensome Federal IDR process.

C. Open Negotiation Response Notice

Next, TMA has heard concerns about a lack of health plan or issuer engagement in the open negotiation process or health plan failure to even acknowledge the open negotiation notice. **TMA, therefore, strongly supports the Departments' proposal to require an open negotiation response and counteroffer.**

Under the proposed rules the non-initiating party is required to submit an open negotiation notice by the 15th business day of the 30-business day-open negotiation period. We are supportive of the 15th business day deadline. We would not support any extensions to the proposed response time, as we would expect health plans to generally respond by (not before) the deadline. It is important for the Departments to ensure that the proposed timeframe gives both the responding party enough time to complete the notice and the initiating party sufficient time to review the response. We believe the current proposed timeline accomplishes this goal.

Given the critical importance of encouraging settlements before initiation of the Federal IDR process (and the previously expressed concerns about the lack of participation of some insurers in open negotiations or sometimes failure to even acknowledge receipt of open negotiation notices), TMA also recommends that the Departments direct the IDREs to view a plan or issuer's failure to provide a response as evidence of bad faith by the plan or issuer. This would be similar to Texas' surprise billing law (i.e., Tex. Ins. Code §1467.101), which provides that failing to participate in the informal settlement teleconference that precedes Texas' IDR constitutes bad faith. TMA also recommends that strong penalties be imposed for failure to respond during the open negotiation stage, such as requiring the IDRE to select the physician/provider's offer if an insurer fails to respond (i.e., which would function similar to a default judgment). Again, this type of enforcement measure would encourage insurer participation in the open negotiation process.

The proposed rules also delineate numerous elements that plans or issuers must include in the open negotiation response notice. TMA is generally supportive of those elements, as they require health plans to provide some critically important information (e.g., health plan type). Additionally, the rules require the response to include "a statement and supporting documentation that explains why the item or service is ineligible for the Federal IDR process or a statement agreeing that the item or service is eligible for the Federal IDR process."[16] This is important as plans and issuers do not always object to the applicability of the Federal IDR process at the earliest stages and sometimes not until after the certified IDRE has been selected, including at the time of offer submission. This delay is problematic from both a time and resource standpoint. Thus, TMA believes it will be very helpful to have this information earlier in the response notice.

Finally, TMA would like to underscore the importance of inclusion of the counteroffer requirement in the response notice. It is important for the parties to know where each side stands at the outset of

[16] 88 Fed. Reg. at 75,835.

negotiations in order to facilitate the start of those negotiations. It is possible that a plan or issuer may submit a counteroffer that is the same amount as the initial payment, but it is still important for the physician or provider to know this information. Also, it will create a record for the IDRE if the dispute eventually proceeds to the IDRE. TMA also recommends that the Departments direct that if the responding party (i.e., the issuer or plan) did not offer a meaningful increase over its initial payment during open negotiation but did so as part of its offer after proceeding to IDR, certified IDREs should conclude this suggests bad faith by the insurer.

III. Changes to IDR Initiation and Response

A. IDR Initiation Notice and Response

Next, TMA notes that the Departments propose requiring the initiating party to submit its Tax Identification Number (TIN) in the notice of IDR initiation in order to facilitate: (1) the Departments' ability to collect the administrative fees directly; and (2) debt collection from parties that fail to pay their administrative fees. We have concerns about the debt collection component of the use of TIN, as many physician practices face continued practice viability challenges. If a physician practice is not paying the administrative fee, it is likely that there is good cause – i.e., the physician practice is unable to pay the fee and facing financial challenges. The debt collection component of this TIN provision could compromise patient access to care. Thus, we encourage the Departments to bear in mind the challenges faced by physician practices, particularly small physician groups and those in rural and underserved areas if it seeks to implement such a provision.

Additionally, TMA appreciates the Departments' clarification that the QPA is only required to be provided in the initiation notice if the QPA was provided in the initial payment or notice of denial or if the initiating party is a plan or issuer. As noted earlier, plans and issuers do not always provide this information with the initial payment or notice of payment, thus the current requirement for a physician or provider to provide this information in the initiation notice is not always possible. However, TMA encourages the Departments to go one step further and to place the onus for provision of this information directly on the plans and issuers. Health plans are in the best position to provide this information and should incur the administrative burden associated with providing it.

Finally, TMA also generally supports the Departments' proposal to require a response to the notice of IDR initiation, as well as the proposed elements of the response.

B. Selection of a Certified IDRE

Next, TMA supports the Departments' proposed changes to the process for selecting a certified IDRE when the parties fail to jointly agree on a certified IDRE. These proposed changes will aid in preventing plan or issuer gaming of the selection process (e.g., waiting to object to the physician initiator's choice of IDRE until the last minute and proposing their own preferred IDRE without an opportunity for the physician to respond).

IV. Treatment of Batched Items and Services

Next, the Departments propose several changes to the batching rules. TMA appreciates the Departments revisiting the batching rules in an attempt to improve batching in the Federal IDR process. TMA contends that in addition to conflicting with the law (e.g., imposing the same service code limitation), the prior rules in many instances effectively ran counter to Congressional intent, which was to promote efficiency and the cost effectiveness of the IDR process. In operation, the current batching rules and now-vacated batching rules often heightened administrative burdens and slowed the process (which is also reflected in the Departments' description of physician, health plan, and IDRE experiences with attempting to assess eligibility of batched claims under the current and now-vacated rules). Overall, TMA believes that the proposed batching changes are a step in the right direction; however, the Departments need to provide further flexibility to batch. Our specific comments on the batching rules are offered in more detail, below.

A. "Related to the Treatment of a Similar Condition" Requirement

In the proposed rules, the Departments propose expanding the batching options under the statutory "related to the treatment of a similar condition requirement" so that an IDRE's consideration of the items and services in a single payment determination would better promote efficiency in the Federal IDR process. Under the proposal, the new batching criteria could be satisfied using any of the following three new options:

- When items and services were furnished to a single patient during the same patient encounter (which is defined as a patient encounter on one or more consecutive days during which the qualified IDR items or services were furnished to the same patient and billed on the same claim form).
- When items and services were billed under the same service code or a comparable code under a different procedural code system; or
- For anesthesiology, radiology, pathology, and laboratory items and services billed under service codes belonging to subcategories under the same Category I CPT code ranges (as specified in guidance).

1. <u>Single Patient During Same Patient Encounter</u>

First, TMA supports the Departments' proposal to permit batching of items and services furnished to a single patient during the same patient encounter. TMA concurs that this type of batching will "promote efficiency by avoiding the requirement that an initiating party file separate disputes to obtain payment determinations for each of the item and services that were part of a single claim and patient encounter."[17] This type of flexibility is critical for batching items and services with the same episode of care (and thereby reducing the costs associated with separately filing disputes).

TMA also concurs with the Departments that permitting this type of batching will help the non-initiating party identify the claims involved as the dispute would relate to a single claim form (rather

[17] 88 Fed. Reg. at 75784.

than multiple claim forms). This should also aid IDREs in more quickly assessing appropriate batching, since they will be reviewing a single claim form.

2. Same Service Code or a Comparable Code Under a Different Procedural Code System

Next, TMA is generally supportive of the Departments' proposal to permit batching by the same service code or a comparable code under a different procedural code system, provided that: (1) the Departments provide multiple other options and flexibilities for satisfying the "related to the treatment of a similar condition" requirement; and (2) the Departments engage the American Medical Association, state and national medical societies, and coding experts in implementing the proposal. We agree that it is important for physicians and providers to have this flexibility for batching.

As the Departments are aware, TMA successfully challenged the batching limitation in the now-vacated rules that imposed a same service code limitation on batching. That requirement was vacated on procedural grounds in TMA IV as the district court found a lack of notice and comment under the Administrative Procedures Act. We continue to strongly contend that restricting all batching to the same service code would be substantively unlawful. However, since the new rule proposal now presents the same service code language under a different framework (i.e., as one of multiple other options), we would generally not object to its inclusion if the Departments provide sufficient flexibilities for other methods of batching under the statutory "related to the treatment of a similar condition" requirement.

3. Category I CPT Code Range

Next, while TMA is supportive, at least at a very high level, of the Departments' proposal to move toward allowing subcategories of CPT codes in the same Category I CPT Code range to be batched together, TMA largely defers to national and state medical specialty societies regarding the impact of this proposal on each particular specialty. As reflected in the rule preamble, each specialty has nuanced specialty-specific concerns regarding appropriate batching. Thus, we strongly encourage the Departments to heavily weigh state and national medical specialty society input regarding what flexibilities are needed. We do not have the information needed to assess the feasibility of the proposed subcategories for the all the specialties or to know whether there are alternative categories that may be more appropriate.

Additionally, we note that the Departments' specialty-specific proposal concerning Category I CPT Codes does not extend to emergency physicians and encourage the Departments to strongly consider the input of the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) on this issue.

Finally, we also urge the Departments to consider allowances for batching by conversion factor for anesthesiology services (in addition to permitting batching by the subcategories).

B. Same Group Health Plan or Health Insurance Issuer Requirement

Next, TMA opposes the Departments' batching limitation that continues to prohibit batching among multiple self-insured group health plans making payments through the same third-party administrator (TPA).

In the proposed rules, the Departments provide that for self-insured group health plans, the same group health plan or health insurance issuer requirement would be satisfied if the same self-insured group health plan is required to make payment for the qualified IDR items and services, which would include when a plan makes payment through a TPA. The stated rationale for this position by the Departments is that the self-insured group health plan is generally the responsible party for the payment of the service even when a given TPA administers multiple self-insured plans.

TMA urges the Departments to reconsider this limitation in light of: (1) the administrative burdens and difficulties that physicians and other providers face in attempting to identify separate self-insured group plans/employers behind a single TPA; and (2) the significant efficiencies that could be achieved by increasing the number of similar claims batched by grouping across self-insured plans.

As stated earlier in this comment letter, it is important to note that physicians and providers often do not have the name or contact information for self-insured plans. This information has *not* been a standard claims processing data element. Thus, this batching limitation has severely limited the utility of batching in the context of self-insured ERISA claims. While the proposed rules do include some provisions directed at aiding in identifying self-insured health plans (which we appreciate), the proposed rules will not resolve all the administrative complexities or eliminate the significant time commitment necessary to separate out self-insured group plans/employers behind a single TPA. And if the Departments retain the batching limitation, they will certainly not achieve the same level of efficiency that could be gained by allowing these items and services to be batched as a single dispute. Thus, a change in the Departments' position on this issue is important to the future functioning of the Federal IDR process.

C. The 90-calendar-day Cooling Off Period

TMA appreciates the Departments' recognition that the 90-calendar-day cooling off period would present numerous challenges under the proposed rules from an operational, resource, and efficiency standpoint. TMA concurs that under the proposed new batching rules, it would be very confusing, as well as cumbersome and time consuming, to attempt to exclude the specific item or service subject to the cooling offer period from a batch and could present additional burdens on certified IDREs. We also concur with the Departments that, if the 90-calendar-day cooling off period were retained, there could be some scenarios with high volume payers and overlapping cooling off periods that could result in physicians or providers being required to wait for *multiple years* before the Federal IDR process could be initiated again. Needless to say, this is an unacceptable result that would function at cross purposes with the proposed rules' efficiency and cost savings goals and would act as a severe barrier to accessing the IDR process. **We, therefore, urge the Departments to use their statutory waiver authority to shorten the 90-calendar-day cooling off period down to 1 business day for qualified IDR items and services for which a certified IDRE makes a payment determination as part of a batched dispute.**

We also ask that, at a minimum, the waiver apply both when: (1) the item or service subject to the cooling off period is initially submitted as part of a batched claims; and (2) the item or service is initially submitted as a single claim but is later submitted as part of a batched claim.

Further, we note that since plans and issuers have generally not been engaging in negotiation, the cooling-off period has only served to further delay revenue cycles generally. This delay in revenue is very challenging for physician practices to shoulder, which heightens the practice viability issues that many physician practices are already facing. **Thus, we also request that the Departments consider using its statutory waiver authority to reduce the cooling off period for *all* disputes (not just batching related disputes) to one business day.**

D. Line-Item Limit for Batched Items and Services

Next, TMA opposes the Departments' proposal to limit batched determinations to 25 line items in a single dispute. As noted in the proposal, the Departments state that this limitation is needed because without it, new batching rules "could increase the time and level of effort certified IDR entities spend on resolving payment determinations, which, in turn, would hinder their ability to make timely payment determinations."[18] While we understand that IDREs have previously expressed concerns regarding large batches and meeting the 30-business-day determination deadline, we respectfully disagree that a 25-line item limitation is needed. We believe that many of the other provisions in the rules already limit the number of line items (e.g., rules that limit batching to items/services paid by the same insurer or self-insured group health plan and those that limit batching to claims within a 30-business day period). We are concerned that placing such an additional and strict limit will undermine many of the efficiencies and cost savings contained in the other proposed batching changes. **Thus, we urge the Departments not to adopt the 25-line item limit. If, over our stated objections, the Departments move forward with a line-item limitation, we ask at the very least that the Departments increase the limit to 75 line items.**

E. Resubmission of Inappropriately Batched Items

Under current August 22 guidance, the Departments permit inappropriately batched or bundled disputes to be resubmitted as properly batched or bundled disputes if the items meet all the other qualified IDR criteria. The Departments are now considering removing this flexibility 90 business days after the proposed batching provisions, as finalized become applicable. **TMA strongly opposes the proposed removal of this flexibility.** The new batching rules (if finalized) will require adjustments for physicians and providers to properly batch that are likely to exceed the 90-day flexibility period. But perhaps even more critically, the new batching rules do not remedy one of the underlying contributors to batching failures, which is plan and issuer failures to disclose information needed to properly batch. Although health plans are required to provide certain information at the time of initial payment or notice of denial of payment, (as discussed previously), this often does not occur, which compromises the ability of physicians and providers to properly batch.

[18] 88 Fed. Reg. 75,783.

TMA appreciates the Departments' efforts to improve information exchange in this rule proposal, but we are skeptical as to how soon or even *if* plans will generally comply. **Moreover, removal of the resubmission flexibility would run counter to the Departments' enhanced communication efforts as it would incentivize plans and issuers to withhold information and avoid being transparent about eligibility.**

TMA understands that retaining resubmission flexibility could result in the non-initiating party (i.e., the plan or issuer) paying the applicable administrative fee, potentially multiple times. But it is important to note that the physician or provider is also required to pay the fee when that happens (so the physician is already incentivized to try to batch appropriately and penalized for failing to do so). Given the complexity of the proper batching process, a technical batching failure (and especially one that may be predicated on a plan failure or a plan gaming of the system) should not preclude a physician or provider from accessing the IDR process. Simply put, such a result would be fundamentally unfair.

V. Administrative Fees

A. Establishment of the Administrative Fee Amount

Next, the Departments address administrative fees in the rule proposal. As background, in response to district court's decision in TMA IV (striking down the $350 administrative fee), the Departments issued the Federal IDR Process Administrative Fee and Certified IDR Entity Fee Ranges final rule in December. Under that final rule, the Departments: (1) set the administrative fee at $115 per party per dispute; and (2) provided that the administrative fee amount would remain in effect until a new administrative fee was established in future rulemaking.

In the current rule proposal, the Departments propose adjusting the methodology for calculating the administrative fee amount. This new methodology would apply to administrative fees for disputes initiated on or after January 1, 2025 and would continue until modified by later rulemaking. The amount of the full administrative fee would be $150 per party per dispute. The Departments note that they calculated this fee amount by dividing projected annual expenditures of approximately $100.2 million to carry out the Federal IDR process (if the proposal in the rules is finalized) by the projected annual number of administrative fees to be paid by the disputing parties of 691,000.[19]

TMA has serious concerns with the proposed rules' methodology for calculation of the administrative fee as it lacks transparency and has many of the same flaws that TMA previously expressed in our October 26, 2023 comment letter to the Departments regarding the proposed Federal Independent Dispute Resolution Process Administrative Fee and Certified IDR Entity Fee Ranges rule.

[19] 88 Fed. Reg. at 75,793.

Put simply, the proposed rule's estimation of 100.2 million in costs lacks justification for two basic reasons. First, the proposal fails to disclose the basis of the estimated $100.2 million in costs. Second, the proposal includes irrelevant and indefinite categories of costs.

1. Failure to Disclose the Basis of the Costs

Although the Departments once again list eight categories of expenses, they again fail to disclose estimated expenditures for any of them or their underlying data.[20]

As TMA indicated in our prior comments, this violates the Departments' obligations under the Administrative Procedure Act ("APA"), which "requires the agency to make available to the public, in a form that allows for meaningful comment, the data the agency used to develop the proposed rule."[21] Without disclosure of the estimated expenses for the categories of activities described in the proposal, let alone the data underlying those estimates, IDR participants cannot meaningfully comment on the reasonableness of the proposed fee increase.

TMA notes that the Departments could have provided estimated costs by category, as they have not treated this financial information as confidential in the past. In defending the December 2022 Guidance in *TMA IV*, the Departments submitted the administrative record that purportedly justified their $350 administrative fee.[22] As part of that record, the Departments included—without moving to seal the record or redact any information—a detailed analysis of the costs of administering the IDR process along with the estimated collection of fees that would be necessary to cover those costs.[23] That analysis included an exact breakdown of costs for 2021, 2022, and 2023 estimated spending for services, including: "Complaints Collection," "IDR Certification and Data Collection," "Collect IDR User Fees," and "IDR Decision Audits."[24] Those detailed expenditures overlap almost entirely with the currently proposed rule's reference to certain undisclosed costs, such as "Certifying IDR entities and collecting data from them," "Collecting administrative fees," and "IDR decision audits."[25] Thus, the Departments should have disclosed the broken down cost estimates for each category in the rule proposal.

The Departments' failure to provide any visibility into their cost estimates or the data underlying them deprives the public of the opportunity to meaningfully comment and fails to provide information

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[20] *Id.* at 75, 792.
[21] *See Am. Med. Ass'n v. Reno*, 57 F.3d 1129, 1133 (D.C. Cir. 1995); *see also Engine Mfrs. Ass'n v. EPA*, 20 F.3d 1177, 1181 (D.C. Cir. 1994) (an agency must "provide a 'public explanation of the specific expenses included in the cost basis for a particular fee, and an explanation of the criteria used to include or exclude particular items'") (quoting *Electronic Indus. Ass'n v. FCC*, 554 F.2d 1109, 1115 (D.C. Cir. 1976)).
[22] *See* Notice of Filing of Certified Administrative Record, *TMA IV*, 2023 WL 4977746 (No. 6:23-CV-59-JDK), ECF No. 43.
[23] *See* Updated Admin Fee Spend Plan Cash Flow (Dec. 19, 2022) at 009885–00987, *TMA IV*, 2023 WL 4977746 (No. 6:23-CV-59-JDK), ECF No. 43-12.
[24] *Id.* at 009886–009887; *see, e.g., id.* at 009887 (in 2022, CMS spent $8,740,410 on complaints collection, $13,775,238 on IDR certification and data collection, $1,992,975 on IDR eligibility determinations, and $2,084,597 on collecting IDR user fees).
[25] *See* 88 Fed. Reg. at 65,893.

"sufficient to enable [a court] to conclude that [the proposed fee increase] was the product of reasoned decisionmaking."[26]

2. Inclusion of Irrelevant and Indefinite Categories of Costs

The proposed rule also improperly includes (1) costs that are irrelevant to carrying out the IDR process, and (2) costs that lack a definite scope.

First, the proposed rule states that the Departments' total estimated cost of $100.2 million relies, in part, on expenditures related to conducting QPA audits.[27] But not all expenditures related to QPA audits are relevant to carrying out the IDR process. The QPA does not only relate to IDR determinations; it also is used for calculating patient cost sharing, which has nothing to do with the IDR process.[28] Other funds from the NSA's $500 million appropriation should therefore cover at least a portion of the Departments' expenses related to conducting QPA audits. To address these different categories of costs, the Departments should disclose their total expenditures on QPA audits and the portion proposed to be funded by administrative fees versus other sources.[29] And, to the extent QPA audits are funded by IDR administrative fees, the Departments owe it to the parties funding those audits to publicly disclose the results and any errors identified through auditing.

Second, the proposed rule includes the cost of "[i]nvestigating relevant complaints."[30] As written, this cost is indefinite and open to potentially unlawful interpretations. The Departments must ensure that their estimated costs actually relate to "carrying out the IDR process."[31] To that end, a "relevant" complaint should only cover complaints specific to the IDR process. Any expansion of this term and category of "relevant" complaints beyond the IDR process would inappropriately place the administrative fee outside of its statutorily-prescribed limits.

For all the foregoing reasons, TMA opposes the methodology proposed by the Departments.

B. Timing of Collection of Administrative Fee

TMA also opposes the Departments' proposal to impose different timeframes for the collection of the administrative fee based upon whether the party is the initiating or non-initiating party.

Under the Departments' proposal, the initiating party (likely the physician or provider) would be required to pay the nonrefundable administrative fee within two business days of the date of the preliminary selection of the certified IDR entity. In contrast, the non-initiating party (likely the plan or issuer) would be required to pay the administrative fee at a later time (i.e., within two business

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[26] *See Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 52 (1983).
[27] 88 Fed. Reg. at *75,793.*
[28] *See* 42 U.S.C. § 300gg-111(a)(3)(H)(ii).
[29] *See, e.g., Am. Med. Ass'n*, 57 F.3d at 1133 (agency violated the APA because it "failed to provide any data underlying the budget of the diversion control program or its basis for attributing particular costs to that program").
[30] 88 Fed. Reg. at 75,793.
[31] 42 U.S.C. § 300gg-111(c)(8)(B).

days of the date of notice that an eligibility determination for the Federal IDR process has been reached by either the certified IDR entity or the Departments). Then, the non-initiating party would pay only 20 percent of the administrative fee if a dispute is deemed ineligible.

TMA strongly contends that this proposed new timing requirement adds unnecessary complexity to the rule proposal and fails to recognize that there are also issues with collecting fees from non-initiating parties. **Thus, we strongly recommend that the Departments provide a process that requires the initiating and non-initiating parties to pay the administrative fee at the same time.**

C. Administrative Fee Structure for Non-Initiating Parties in Ineligible Disputes

Next, TMA also has concerns about the Departments' proposal to provide a reduced administrative fee (i.e., 20% administrative fee) only to the non-initiating party when a dispute is determined to be ineligible. **TMA strongly recommends that the reduced fee be provided to both the initiating and the non-initiating parties in this circumstance.**

IDRE eligibility determinations are complicated (as reflected in the amount of time that IDREs have dedicated to making these determinations). Good faith errors will occur. Physicians should not be penalized for those good faith errors. Additionally, as stated throughout this comment letter, many ineligible disputes stem from the non-initiating parties (the plans or issuers) failing to provide the required disclosures at the initial payment or denial of payment stage and/or failure to engage in open negotiations. Thus, it is additionally not fair to penalize physicians or providers for the plan's failure.

Furthermore, both parties should have reduced fees in these scenarios because the dispute that the certified IDRE fee is addressing in these instances has not progressed as far as other disputes (i.e., hasn't proceeded through the whole IDR process). This limited use of the process alone should justify a reduced fee for both parties.

For all the foregoing reasons, we urge the Departments to apply the reduced fee to *both* initiating and non-initiating parties in cases of ineligible disputes. If the Departments, over our stated objections, adopt the one-sided reduced administrative fees for ineligible disputes, we urge the Departments to charge the initiating party nothing and require the non-initiating party to pay both administrative fees if the non-initiating party failed to supply any required information bearing on claim eligibility.

D. Administrative Fee Structure for Disputing Parties in Low-Dollar Disputes

Next, The Departments proposed a reduced administrative fee structure of fifty percent for low-dollar disputes (which the Departments propose to set at the same level as the administrative fee –i.e., $150). TMA appreciates the Departments making efforts to make the IDR process more accessible to physicians by proposing a reduced administrative fee for lower-dollar amount disputes. As the Departments know, TMA has previously expressed many concerns regarding the cost-prohibitive

nature of the Departments' administrative fee increases. As TMA has stated previously, whenever the amount in controversy (*i.e.*, the difference between the amount requested by the physician or provider and the amount the insurer has offered) is the same as the administrative fee or less, IDR would be entirely cost-prohibitive because the cost of submitting the claim would exceed the amount the physician or provider would recover if it won.

We are concerned, however, that the Departments' proposal does not sufficiently meet its goal of addressing the financial barrier that physicians and providers may encounter when attempting to access the IDR process with low-dollar disputes. As currently proposed, the Departments' low dollar threshold determination is based upon the highest offer made during the open negotiation. In other words, the administrative fee would only be 50% of the full administrative fee if the highest offer is below the low-dollar ($150) threshold.

TMA contends that this is problematic, because we believe the difference between the amount in controversy and the administrative fee is more determinative of a financial barrier to IDR access than the difference between the highest offer and the administrative fee. For example, one could have a highest offer amount of $300 (i.e., above the low-dollar threshold), but the amount in controversy may be only $100 (i.e., below the low-dollar threshold). Such a dispute would not qualify for a reduced administrative fee but should as it would otherwise be cost-prohibitive for the physician or provider to seek IDR. To address this issue, we recommend that the Departments use the amount in controversy (rather than the highest offer) as the comparison point for the low-dollar threshold reduced fee.

TMA also recommends that Departments explore additional options for reduced fees, such as those that we referenced in our previous letters. For example, TMA previously noted that the Departments could consider a variable fee keyed to the amount in controversy. Or the Departments could set the fee as a percentage of the amount in controversy (subject to caps to avoid excessive fees).

VI. Extension of Time Periods for Extenuating Circumstances

Next, the Departments propose language that would permit IDR extensions if the Departments make a determination that an extension is necessary due to "extenuating circumstances that contribute to systemic delays in processing disputes under the Federal IDR process, such as a high volume of disputes or Federal IDR portal failures."[32]

While TMA can understand the need for extensions in some extenuating circumstances, TMA is very concerned that the Departments have indicated that a high volume of disputes alone qualifies as an "extenuating circumstance." It is axiomatic that health plans typically benefit from delayed payment determinations; physicians and other providers, in stark contrast, can be severely harmed by such delays. Thus, TMA urges the Departments to: (1) have a higher bar for defining "extenuating

[32] 88 Fed. Reg. 75,802.

circumstances" and (2) remove a high volume of claims from constituting an "extenuating circumstance" on its own. It is critical that there be more specific criteria for stakeholders to comment on and for the Departments to have as parameters for any extensions.

Moreover, extensions should only be applied in very narrow circumstances and only if the Departments penalize IDREs for failing to request extensions when needed and/or otherwise missing deadlines to issue payment determinations. If the IDREs request an extension, the IDRE must set forth their plan to come into compliance with the statutory deadlines within 30 days.

VII. Federal IDR Registry

Finally, TMA strongly supports the Departments' proposed requirements for plans and issuers subject to the IDR process to register with a centralized IDR registry that would be made available through the IDR portal. All plans and issuers should be required to register with the IDR registry. There should be no minimum threshold of NSA disputes in a calendar year. Further, the IDR registry should be open to the public for transparency purposes and to enable physicians and providers to use the information to update their processes before they become a party to an open negotiation.

TMA also supports the Departments' proposal to require plan/issuer registration within 30 business days of the registry becoming available. TMA believes this is sufficient time for plans and issuers to come into compliance. Additionally, TMA strongly agrees that a plan or issuer's failure to register should be penalized. For example, a plan or issuer who fails to register should not be permitted to submit an IDR bid, which should result in a default judgment in the physician or provider's favor.

CONCLUSION

TMA appreciates the opportunity to provide comments regarding this proposed rule. Please feel free to contact Kelly Walla, TMA Vice President & General Counsel, at kelly.walla@texmed.org if we can provide any further information. We look forward to continuing to engage with the Departments on these important issues.

Sincerely,

Richard W. "Rick" Snyder, II, MD
President
Texas Medical Association