



COLLEGE of AMERICAN PATHOLOGISTS

December 31, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9897-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Federal Independent Dispute Resolution Operations

Dear Administrator Brooks-LaSure:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the proposed rule related to the federal independent dispute resolution (IDR) process established by the No Surprises Act. As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

We commend the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services together with the Department of the Treasury and the Department of Labor (the Departments) for their openness in hearing stakeholder concerns and for including important improvements to the IDR process in these proposed rules. We continue to strongly support the protections that keep patients out of the middle of billing disputes. However, as we have previously explained, our members have reported significant difficulties in resolving payment disputes for certain out-of-network services since the launch of the federal IDR portal. From the burdensome open negotiation process to the “large number” of disputes still awaiting payment determinations, the IDR process has been fraught with interruptions, complications, misuse, and confusion. We are hopeful that the changes proposed by the Departments will help address many of these problems. Specifically, we strongly support the new disclosure requirements, centralizing the open negotiations process, increasing flexibility around batching, and promoting equitable access to IDR for low-dollar disputes.

Still, we wish to continue to call attention to the issue of non-payment by insurers after a final payment determination. As we have shared earlier¹, we are greatly concerned that insurers are failing to make timely, legally mandated payment to providers within 30 days following an IDR determination. Unfortunately, recent years have shown that health insurance companies will increasingly flex their market power to impose drastic rate cuts

¹ <https://documents.cap.org/documents/cap-letter-IDR-april-2023-2.pdf>



and other unworkable new payment terms on pathologists.² **Additionally, recent data from a CAP-conducted survey shows that in 2023, 19% of practice leaders reported their practice had been denied continued participation in a commercial health plan or insurer network in which it was previously a participating provider, up from 9% in 2021.**³ 17% reported their practice attempted to join a commercial health plan or insurer network but was denied participating provider status or were unable to reach agreement, up from 12% in 2021. And these kinds of problems will only worsen if insurers continue to face no adverse consequences for non-compliance with the payment determinations and other federal IDR requirements, as such apparent impunity encourages insurers not to engage in serious and realistic efforts to negotiate participating provider agreements.

Therefore, in addition to considering our comments below, we urge the Departments to increase the ease of submitting a formal complaint against an insurer and to strengthen enforcement, including meaningful financial penalties, of No Surprises Act dispute resolution requirements. We also urge the Departments to make public on a quarterly basis the number of health care provider complaints filed against insurers, by health plan type (ERISA or non-ERISA), and the disposition and resolution of these complaints. Public transparency regarding failure to pay an IDR determination is imperative to determine with greater statistical certainty the magnitude and pervasiveness of this compliance failure by health insurance companies.

Finally, we continue to stress that inadequate insurer networks are the root cause of out-of-network payments that then need to be resolved through the use of the federal IDR process. Simply put, if there are more in-network providers to begin with, there will be fewer out-of-network bills to arbitrate. Additionally, adequate networks that include a variety of care settings ensure continuity/coordination of care, increase patient access and ease, and avoid added costs down the road. The CAP urges the Departments to consider additional proposals to address network adequacy, especially as we are now better able to evaluate the implementation of the No Surprises Act.

Disclosure Requirements and Information to Be Shared About the QPA

We agree with the Departments that gaps in communication between plans/issuers and providers/facilities “contribute to inefficiencies in resolving disputes in the federal IDR process.” This is why we have previously argued that the Departments should require the disclosure of as much information upfront at the initial payment or notice of denial of payment, without having to first request that information. We support the proposed new disclosure rules and are hopeful that the requirement for plans/issuers to use claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) in their communications will help ensure all parties have the information necessary to

² <https://documents.cap.org/documents/final-wm-letter-on-private-sector-issues-071322.pdf>

³ CAP 2023 Practice Leader Survey (forthcoming)



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determine whether a payment dispute is eligible for the federal IDR process. We also support the standardization of communication between plans/issuers and providers/facilities to ensure consistency no matter the manner of transmittal.

Further, the CAP strongly supports the additional disclosure of information with the qualifying payment amount (QPA), but we urge the Departments to go further to truly ensure the transparent and meaningful disclosure of information relating to the calculation of the QPA. For example, the Departments should require disclosure of the information a provider/facility can now receive from the plan/issuer if requested, and should require disclosure of the data and methodology used to calculate the QPA. This is critical information in helping providers/facilities effectively navigate the IDR process. We agree with the American Medical Association (AMA) that without seeing this data, “a physician has little chance of effectively disputing it as a relevant factor in determining the appropriate payment amount.”⁴ Ensuring that all parties have the information needed to determine eligibility of a payment dispute is important, but it is also important that both parties are fully informed and approaching the entire IDR process on equal footing.

Open Negotiation

Ideally, as the Departments know, the open negotiation period provides an opportunity for the disputing parties to reach an agreement and avoid the federal IDR process altogether. However, as we shared earlier⁵, it is the experience of our members that instead of using this time as an opportunity to engage in good faith negotiations, insurers are making the open negotiations period difficult to initiate and ineffective to navigate, using the requirement as a delay/deter tactic or other hurdle for the physicians who are trying to receive appropriate payment for their services. For example, because the open negotiation period must be exhausted as an eligibility requirement for the IDR process, we believe insurers have used proprietary portals or disputes around receipt of the open negotiation notice to challenge IDR eligibility. Additionally, as the Departments note, our members have also reported that insurers “rarely respond to the notices initiating open negotiation,” which obviously defeats the purpose of the open negotiation requirement.

For these reasons, we strongly support the proposed requirement that parties utilize the federal IDR portal to initiate the open negotiation period. This centralization and standardization will provide clarity and consistency for our members seeking to start negotiations around a payment dispute. As the Departments explain, having one central location to initiate open negotiations would also “provide a record of whether and when the open negotiation period was properly initiated” and would create greater transparency among parties engaged in open negotiation. We also strongly support the proposed requirement for an open negotiation response notice. We agree that

⁴ <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fifr.zip%2F2023-1-23-Letter-to-Becerra-Walsh-Yellen-re-No-Surprises-Act-v2.pdf>

⁵ <https://documents.cap.org/documents/cap-letter-IDR-april-2023-2.pdf>



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meaningful participation in open negotiations is vital to an effective and efficient process. We would urge the Departments to consider, as mentioned, requiring the open negotiation response notice to be furnished earlier than the proposed time, as the more time for the parties have to review the information, the more likely they can appropriately consider and engage “in a meaningful manner prior to the deadline for initiation of the federal IDR process.” Finally, we support enforcement actions for those parties who do not engage in good faith or at all, including by allowing the certified IDR entities to take into consideration a party’s compliance with the deadline for the open negotiation response notice.

In addition to centralizing open negotiation, the Departments propose to add to the list of elements required to be included in the open negotiation notice. We appreciate that the added requirements are meant to help parties identify whether the federal IDR process applies or whether an applicable specified state law or All-Payer Model Agreement governs the out-of-network payment amount, but we are concerned about added administrative burdens that could increase complexity and confusion, creating hurdles to initiating open negotiation. Similarly, we are worried that information on eligibility in the open negotiation response notice, if not accurate, could deter providers/facilities from bringing forward eligible and legitimate disputes. We understand and agree with the need to expedite agreement about the accuracy of information, including the applicability of the federal IDR process, accuracy of the QPA, or accuracy of information relevant to the claim under dispute. However, information exchanged during the open negotiations period should encourage better communication and not preemptively or inappropriately shut down dispute resolution discussions.

Importantly, we oppose the proposal to require the party submitting the open negotiation notice to provide a statement describing why the party is initiating the open negotiation period, including any considerations that serve as the basis for the initiation of open negotiation for the item or service. This appears to us to be an added administrative burden with little benefit, as the reason for initiating the open negotiation period is to resolve a payment dispute and there is ample time provided to make those respective arguments once the open negotiation period is initiated.

Initiation of the Federal IDR Process

The CAP supports the goal of an efficient and transparent federal IDR process where both parties are active participants. At the same time, we support mitigating additional burden on the disputing parties. We therefore appreciate proposals that appropriately balance these interests, including using the federal IDR portal to prepopulate information included in the open negotiation notices and open negotiation response notices.

Similarly, while we support efforts to encourage a more informed offer or for parties to reach a settlement before the certified IDR entity makes a payment determination, we do have some concerns about creating added burdens in initiating IDR by trying to increase



information exchange in ways that could be adequately addressed during the IDR process. For example, the Departments outline that to “improve communications between the parties to a dispute,” these proposed rules would require the initiating party to include a statement describing the key aspects of the claim discussed by the parties during open negotiation that relate to the payment for the disputed claim, whether the reasons for initiating the federal IDR process are different from those aspects discussed during the open negotiation period, and an explanation of why the party is initiating the federal IDR process. By assuming that initiating parties are not already actively evaluating eligibility before initiating the federal IDR process, and therefore requiring the initiating party to attest that the item or service under dispute is a qualified IDR item or service, and to identify the basis for the attestation, the Departments are simply adding administrative burdens on initiating parties without providing an efficiency benefit. It is our experience through reports from our members that they would not be taking on the time and effort to initiate federal IDR if they did not firmly believe the items or services under dispute were eligible for the process.

Finally, for the reasons outlined by the Departments, we support the proposal that a party must furnish to the other party and the Departments the notices and supporting documentation through the federal IDR portal using standard forms developed by the Departments. As expressed above, these requirements will provide clarity and consistency for our members, greater transparency, and a much-needed clear record.

Federal IDR Process

We support proposals to ensure there is a true joint selection of the certified IDR entity, as well as proposals to provide additional clarity around timeframes and other requirements/details around the selection of the certified IDR entity. As a general matter, we also reemphasize that our primary concerns in this area remain that the IDR entity have sufficient medical, legal, and other expertise (including medical coding and billing), while also being free of conflicts of interest, such as a direct or indirect affiliation with a group health plan/payer, provider, facility, or payer/provider organization.

While we have no concern with the Departments proposing to provide two additional business days for certified IDR entities to review the notices and make an eligibility determination, we continue to highlight the need to have more timely dispute processing. Further, we appreciate the comment that a non-initiating party's attestation that a dispute is ineligible for the federal IDR process, alone, would be insufficient to substantiate a determination of ineligibility. As has been previously reported⁶, non-initiating parties have challenged eligibility in nearly half of disputes. And as outlined above, we are concerned with this being used as a tactic to delay/deter physicians who are trying to receive appropriate payment for their services.

⁶ <https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf>



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Batched Items and Services

We commend the Departments for including in these proposed rules new batching provisions that allow for ranges of CPT codes. Especially for pathology services, which often have lower reimbursement rates, additional flexibility that facilitates broader batching of qualified IDR items and services will ease access to the IDR process and further the statute's goals of encouraging procedural efficiency and minimizing administrative costs. We also support the proposal to update periodically as necessary the allowable ranges of service codes.

Still, we are concerned with the 25-line-item limit for a single batched dispute. The No Surprises Act already provides for reasonable limits on what can be included in a batched dispute, including the 30-day time period. While we oppose the imposition of a line-item limit at all, at a minimum, we support the 50-line-item limit in consideration, especially for items and services furnished to one or more patients under the same service code or code range. We appreciate the feedback from certified IDR entities and understand the need for efficiency, but believe a reasonable cap must be higher to ensure an equitable and accessible IDR system.

Finally, we strongly urge the Departments to keep the flexibility in place that allows parties to resubmit disputes that were originally inappropriately batched or bundled, as long as the qualified IDR items and services that are subject to the disputes meet all other applicable requirements. While providers/facilities will certainly work to adjust to the new proposed batching rules, good faith mistakes should not preclude physicians from receiving fair reimbursement for their services.

Administrative and Certified IDR Entity Fee Collection

In addition to the IDR Process Fees proposed rules released September 2023, the Departments here propose changes around the methodology that the Departments use to determine the administrative fee. Importantly, while the proposed administrative fee amount would remain \$150 per party per dispute, the Departments propose a reduced administrative fee in low-dollar disputes. This particular consideration is critical for pathology as approximately 85% of pathology claims are less than \$150 according to the 2021 Medicare carrier file. However, we continue to believe that any increase in the administrative fee amount, especially as it is non-refundable, imposes added burdens and potentially a complete barrier for physicians in accessing the federal IDR process. While we understand the No Surprises Act establishes the requirements for the administrative fee, by setting this amount at a cost prohibitive level, the regulations effectively implement the very threshold that Congress chose not to adopt. **Even with the reduced fee amount, the current and proposed administrative fee requirements preclude the majority of pathology claims from the IDR process, therefore injecting a serious inequity into the process and undercutting the critical balance the legislation sought to achieve.**



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We appreciate the proposed inclusion of a reduced administrative fee for both parties in low-dollar disputes, but believe it must be adjusted to better promote equitable access to specialties – such as pathology – that regularly bill for services that have low-dollar costs. As the Departments outline, this is also especially important for parties from rural communities and smaller organizations. Specifically, the Departments propose to charge both parties a reduced administrative fee when the initiating party attests that the highest offer made during open negotiation by either party was less than the predetermined threshold proposed in these rules. The Departments further propose that the reduced administrative fee amount for these low-dollar disputes would be 50 percent of the administrative fee amount, equating to \$75 per party per dispute for disputes initiated on or after January 1, 2025, if the proposed administrative fee amount of \$150 per party per dispute is finalized. **However, as pathology’s median payment amount per claim using 2021 Medicare carrier file is \$53.08, the \$75 amount is still cost prohibitive for over half of pathology claims.** Indeed, any set fee amount implicitly bars access to this resolution process for disputed amounts that are less than the fee.

Our concern is that as long as it is cost prohibitive to any given practice to appeal small numbers of small amount claim reductions, there is clearly an incentive for insurers to systematically underpay many of those small amounts and a related incentive for insurers to not contract with specialties with low charge structures. Pathologists’ livelihoods depend upon sizable volumes of low-level charges, and without an IDR backstop, there is nothing to prevent insurers from going after these low-level charges as a payment reduction target. As we explained above, insurers have been imposing increasingly drastic rate cuts and other unworkable new payment terms on pathologists – and again, 19% of pathology practice leaders in 2023 reported their practice had been denied continued participation in a commercial health plan or insurer network in which it was previously a participating provider, up from 9% in 2021.

We would therefore propose instead that there be a proportional fee set, so that the reduced administrative fee amount for low-dollar disputes would be 50 percent of the highest offer made during open negotiation (the same number used to determine applicability of the reduced administrative fee). This would help ensure that no administrative fee amount bars access to the IDR process. Alternatively, the Departments could require certain low-dollar claim amounts to be paid at the charged amount, which would eliminate the need to use the IDR process for low-dollar disputes entirely. Especially if batching is able to diminish the number of low-dollar disputes, we view these options as workable ways to ensure the equitable access for all specialties that the Departments are hoping to achieve. **We urge CMS to reach out to us and schedule a meeting with CAP leaders so we can further explain our concerns and discuss options for low-dollar disputes.**

Finally, while we appreciate the Departments concern about potential abuse, we oppose at this time a cap on the offers of parties to a low-dollar dispute. Currently, our top



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priority is ensuring all physicians can appropriately access the federal IDR process and receive fair reimbursement for their out-of-network services – and we strongly believe that as long as it is cost prohibitive to a practice to appeal a small number of small amounts, there is clearly an incentive for insurers to systematically underpay many of those small amounts, threatening access to care for patients. We urge the Departments to finalize the reduced administrative fee in low-dollar disputes without a cap on offers, and consider any guardrails at a later date, as needed.

Summary

The CAP appreciates the work put forward to address these important issues. The ability for stakeholders to provide input is critically important in ensuring an equitable and balanced system for resolving payment disputes and an IDR process that is accessible to all physicians, and we thank the Departments for hearing our concerns. Again, we strongly support the new disclosure requirements, centralizing the open negotiations process, increasing flexibility around batching, and promoting equitable access to IDR for low-dollar disputes. We also urge the Departments to increase the ease of submitting a formal complaint against an insurer and to strengthen enforcement, including financial penalties, of No Surprises Act dispute resolution requirements.

Please contact Elizabeth Fassbender, JD, CAP Director of Economic and Regulatory Affairs at efassbe@cap.org if you have any questions on these comments.