COLLEGE of AMERICAN PATHOLOGISTS

September 29, 2023

The Honorable Jason Smith
Chairman
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal:

The College of American Pathologists (CAP) strongly supports protections that keep patients out of the middle of billing disputes. We have continually called for safeguarding patients from surprise bills while balancing disputes between our members and insurers. However, we have serious concerns about the implementation of the No Surprises Act and its impact on access to care for patients. 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.

As you know, the CAP worked closely with Congress and other stakeholders in the development of the No Surprises Act. After its passage, the CAP provided recommendations on the implementation of the No Surprises Act in June 2021[1] and submitted comments on the Part I interim final rule (IFR) in September 2021[2] and on the Part II IFR in December 2021[3]. We have also engaged with Centers for Medicare & Medicaid Services (CMS) staff on issues related to the No Surprises Act's good faith estimate requirements, which remain a major concern and source of confusion for our members.

Finally, we communicated many of the below concerns to the CMS in April 2023[4], yet we have seen no recent improvement or action to address these issues. In fact, since we last wrote the CMS, the agency suspended the federal independent dispute resolution (IDR) process and directed certified IDR entities to pause all IDR-related activities[5], which will undoubtably exacerbate the current backlog and other problems that make the IDR essentially inaccessible for many physicians. Continued litigation, while necessary, has led to additional confusion and uncertainty. Further, as recently as July 2023, we have heard from members who have, despite the many hurdles, successfully taken their case through the federal IDR process, received a payment determination in their favor, and are still awaiting payment for their services with no recourse to hold insurers accountable.

The CAP appreciates the September 19 hearing examining the flawed implementation of the No Surprises Act. We understand the work that has been done thus far and as expressed above, we share an interest in the important goal of these efforts. Throughout the COVID-19 pandemic and beyond, what has remained the same for health care providers is our unwavering commitment to care for our patients and communities.

[1] https://documents.cap.org/documents/CAP-Recommendations-No-Surprises-Act-Regulations.pdf
[2] https://documents.cap.org/documents/september-2021-surprise-bill-comments.pdf
[3] https://documents.cap.org/documents/cap-comments-on-surprise-billing-part-ii.pdf
[4] https://documents.cap.org/documents/cap-letter-IDR-april-2023-2.pdf
[5] As of September 20, 2023, the Departments have directed certified IDR entities only to perform limited federal IDR process functions.

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Pandemic or not, pathologists are guiding hospitals and health systems to make decisions that ensure testing and diagnostic accuracy, improve patient care for better patient outcomes, mitigate risks, and ensure quality. Thus, we urge you to consider the below so that pathologists can continue to focus on the essential task of testing and ensuring proper treatment for their patients.

Narrowing Networks and Low Initial Payment

As is called for in the No Surprises Act, insurers are required to send the provider an initial payment or a notice of denial of payment within 30 days of a bill for applicable out-of-network services. If this initial payment represented appropriate reimbursement for services rendered, there would be no need for the IDR process. Yet, as the Departments stated in their December fee guidance amendment[6], between April 15, 2022, and December 5, 2022, disputing parties initiated over 164,000 disputes through the federal IDR portal, which is "nearly ten times greater than the Departments initially estimated it would be over the course of a full calendar year[7]." From the experience of our members, the great number of cases are a direct result of inappropriately and unfeasibly low initial payments received from out-of-network insurers. This is evidenced by the fact that the majority of IDR cases are decided in favor of providers[8].

We share the widespread concern over the volume of cases, as the delay in receiving a payment determination puts physicians and practices in financial limbo as they wait for reimbursement for their services. Additionally, as was expressed by Seth Bleier, MD, FACEP during the September 19 hearing, this "increased focus on our collections and the rates being paid by insurers takes up valuable provider and staff time as well as resources that we would rather devote to patient care." **To minimize insurer manipulation/underpayment and reduce utilization of the IDR process, an insurer's initial payment rate should also be the insurer's offer in IDR, in instances where the dispute is not resolved during the open negotiation period.**

Importantly, we continue to stress that inadequate insurer networks are the root cause of out-of-network payments that then need to be resolved by the federal IDR process. Simply put, if there are more in-network providers, there will be fewer out-of-network bills to arbitrate. Unfortunately, the No Surprises Act is exacerbating this problem, instead of fixing it. For example, recent data from a CAP-conducted survey show that in 2023, 19% of pathology practice leaders reported that 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[9]. Seventeen percent 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. As we expressed to the Committee last year[10], insurers continue to slash reimbursements across the board – or cease reimbursement for critical services altogether, without consideration for an individual physician/practice, leaving many pathologists in serious financial jeopardy across the nation. **We urge Congress to require adequate networks**

[6] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf
[7] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf
[8] [8] https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf
[9] CAP 2023 Practice Leader Survey (forthcoming)
[10] https://documents.cap.org/documents/final-wm-letter-on-private-sector-issues-071322.pdf

in the future, especially as we are now better able to evaluate the implementation of the No Surprises Act.

Misuse of the Open Negotiation Process

As you are aware, before either party may initiate the federal IDR process, the disputing parties must exhaust the 30-business-day open negotiation period. Ideally, the open negotiation period provides an opportunity for the disputing parties to reach an agreement and avoid the federal IDR process. However, it is the experience of our members that instead of using it as an opportunity to engage in good faith negotiations, insurers are making the open negotiations period difficult to initiate and ineffective to navigate. Further, insurers are erecting hurdles and delaying engagement with physicians seeking to receive appropriate payment for their services. **While the CMS has provided some clarity on the inability of insurers to require the use of their own online portals to initiate open negotiation, for example, further formalizing and/or centralizing the open negotiation period would be helpful in ensuring notice is properly/easily provided and the timeline requirements are successfully met.**

Additionally, we echo the American Medical Association's (AMA's) January request[11] that the Departments collect information about parties that "regularly question claim eligibility with a frequency and manner that suggests bad faith and urge the Departments to immediately address the actions of these parties through corrective action and penalties when necessary." A successful open negotiation period benefits all disputing parties and will increase efficiencies later in the IDR process.

Limited Batching and Increased Fees

The ability for physicians and other providers to batch together claims (allowing "multiple qualified IDR dispute items and services" to be "considered jointly as part of a single determination by an entity") was an important provision included in the No Surprises Act. Batching ensures an equitable and accessible IDR system, while also encouraging efficiency and minimizing costs. Especially for pathology services, which often have lower reimbursement rates, 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," while minimizing administrative costs.

Thankfully, a recent court decision vacated regulatory text governing the batching of claims that had made batching more difficult. The regulatory text went beyond the requirement of the No Surprises Act that batched items and services be "related to the treatment of a similar condition," and instead required that the items and services be "the same or similar items or services." Permitting batching only when the items and services are billed under the same service code (such as Current Procedural Terminology (CPT) codes with modifiers), or a comparable code under a different procedural code system, is unduly restrictive and understandably resulted in incorrect batching submissions and, unfortunately, the closing of payment determination as "ineligible for the federal IDR process." As the Departments noted in a 2022 report[12], incorrectly batched disputes result in delays in processing and require additional actions by the parties. Even if promulgated appropriately through notice and comment rulemaking, restrictive requirements around batching will single out and hurt those specialties/practices with

[11] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfr.zip%

[12] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

lower reimbursement rates, such as pathology, while increasing the IDR process' administrative costs and procedural inefficiencies.

Instead, as stated in our 2021 comment letter, **the CAP believes that providers should be able to batch claims at the CPT code *or* CPT *family level* (ie, allowing the same *category* of service codes to be batched together).** Unlike the specificity needed for the Qualifying Payment Amount (QPA) calculation, using the CPT family level for batching purposes would allow a broad, but still cohesive, set of claims to be brought together for consideration. We also urged the Departments to increase flexibility by allowing all claims related to the same patient encounter to be batched together. **Further, as the AMA argues, the Departments could allow claims to be batched together "when they are paid through the same third-party administrator, regardless of whether it is the same employer or payer[13]." Finally, the batching timeframe could be extended to allow more claims to be batched together**[14]. Each of these measures would support efficiency – reduction in the high volume of IDR cases – and better ensure the IDR process is available to pathologists and other providers, as well as small/rural providers/practices.

Regarding costs of the federal IDR process and payment, the Departments' regulations specify that each party must pay to the certified IDR entity (1) the administrative fee due to the Departments and (2) the entire certified IDR entity fee. On December 23, 2022, the Departments increased both fees, including raising the administrative fee from $50 to $350 per party[15]. This drastic increase in the administrative fee, which is not refunded to either party regardless of the outcome of the IDR determination, has been vacated by the same recent court decision. This change would have been extremely harmful for pathologists because most claims will likely be under $350, making the $350 threshold cost prohibitive. This is even more true without any of the flexibility in batching outlined above. On September 20, 2023, the Departments issued notice and comment rulemaking on the administrative fee and the certified IDR entity fee ranges. **While the procedural issues have been fixed, the CAP still has concerns that these increased fees represent a significant barrier for small/rural providers/practices, and for most of pathology, in accessing the IDR process at all**.

Unfair Weighting of IDR Factors

As you are aware, regulatory requirements around what IDR entities must consider when making the payment determination have been the subject of multiple lawsuits. The CAP has supported this litigation, including with an amicus brief[16], as we strongly believe the regulations contravene both the terms of the statute and congressional intent, and would result in inadequate reimbursement for health care providers, which in turn would harm patients as they lose access to pathologists and other physicians. It is our understanding that Congress rejected approaches that would have tied health care provider reimbursement to the QPA, opting instead for a balanced process in which an independent, expert arbitrator would consider all the relevant facts and circumstances in a particular case. The courts agreed; and at this time, arbitrators are directed to apply the

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

[14] An alternative period of time may be determined by the Secretary, for use in limited situations.

[15] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/Amended-CY2023-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf

[16] https://documents.cap.org/documents/Amicus_Curiae_Brief_by_COLLEGE_OF_AMERICAN_PATHOLOGISTS.pdf

plain language of the statute and make a payment determination without giving any statutory factor special weight.

If this current direction were to change again, **we strongly urge Congress to intervene and clarify through statute, if necessary, that IDR entities must consider the full range of statutory factors that Congress directed them to consider in determining health care provider reimbursement, without an administratively manufactured thumb on the scales in favor of the QPA.** Not only will any presumption/weighting in favor of the QPA cause substantial harm, but the continued need for litigation heightens uncertainty around the availability of IDR, increases the backlog and volume of IDR cases, and emboldens insurers' bad behavior. The ultimate losers will be patients, who will have less access to care and suffer worse health outcomes, contrary to Congress's intent.

Lack of Enforcement

Perhaps most critically, we urge Congress to ensure robust oversight and strengthen enforcement of the No Surprises Act's dispute resolution requirements. **Specifically, either through statute or direction to the Departments, Congress must impose strong financial penalties for those insurers that do not comply with the 30-day statutorily required timeframe post-payment determination**. As noted above, the CAP heard from our members who were named the prevailing party by a certified IDR entity that they have not received payment from insurers within the required timeframe. Despite sharing this information with the CMS, there has been no action to require payment from insurers, and our members are left with no recourse to recoup the full payment for services rendered, as determined by the IDR entity and required by statute. Strong regulations/penalties are needed to stop health plan manipulation and gaming that harms patients.

At the same time, Congress and the Departments must ensure an accessible and transparent audit/complaint process. We understand that the Center for Consumer Information and Insurance Oversight (CCIIO) may be investigating complaints against insurers but the results of any audit or other investigation have not been made public. At the very least, we urge Congress to increase transparency around enforcement and call on CCIIO to publicly share any information related to the number of complaints received as well as the status of any audits and investigations conducted.

At the same time, the CAP has urged the CMS to increase the ease of submitting a formal complaint against an insurer. Currently, there is an email address that provides little support and, in many cases, "takes several weeks for physicians to even receive confirmation that the request has been received or is being addressed[17]." More problematic is the fact that our members have faced confusion/contradictions in the complaint submission process around various requirements for – and at the same time, prohibitions on – the provision of protected health information (PHI). An evaluation by Congress or the Departments of the complaint submission process, improvement around submission and PHI, and enforcement of non-compliance issues would help ensure the equitable system Congress intended.

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

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Summary

As we have previously argued, insurers, not small/rural providers/practices, benefit from the added costs or complexity around the implementation of the No Surprises Act. As such, it is vital that Congress ensure an even and fair playing field for all IDR parties. Additionally, network inadequacy is a growing problem that will only get worse, as "there will be even less incentive by health plans to offer physician practices a fair contract, or keep contracted physicians in their network, because their ability to underpay these physicians while out-of-network is now even easier."

Again, the CAP appreciates the hard work put forward on the No Surprises Act, but we strongly believe that its implementation must support an accessible and equitable system for resolving payment disputes, to ensure fair reimbursement for out-of-network services. **In summary, we urge Congress to consider the concerns and recommendations outlined by:**

1. **Strengthening enforcement and addressing non-compliance issues,**
2. **Clarifying consideration of IDR factors,**
3. **Ensuring broader batching and appropriate fees,**
4. **Further formalizing and/or centralizing the open negotiations period, and**
5. **Bringing down the need for IDR disputes through appropriate reimbursement and network adequacy.**

Congress can help ensure a more equitable, accessible, and efficient system to fairly resolve payment disputes between providers and health plans.

Please contact Michael Hurlbut, CAP Assistant Director, Legislation and Political Action as mhurlbu@cap.org if you have any questions on these comments.

Sincerely,

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