Trinity Health

December 20, 2023

Chiquita Brooks-LaSure, Administrator
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: RIN 0938-AV15; Federal Independent Dispute Resolution Operations

Submitted electronically via http://www.regulations.gov

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies set forth in RIN 0938-AV15. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high-quality care for all, especially among vulnerable populations.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 121,000 colleagues and nearly 36,500 physicians and clinicians caring for diverse communities across 27 states. Nationally recognized for care and experience, the Trinity Health system includes 101 hospitals, 126 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. In fiscal year 2023, the Livonia, Michigan-based health system invested $1.5 billion in its communities in the form of charity care and other community benefit programs. Trinity Health is committed to serving as a critical provider in our communities and coordinating care across settings and the care continuum, with 41% of our revenue coming from Medicare and 18% from Medicaid and uninsured patients.

Trinity Health is a strong proponent of value-based care delivery. We have 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 11 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participate in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). Two of the 14 markets also participate in CPC+. In addition, we participated in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Trinity Health strongly supports protecting patients from unexpected medical bills. In our comments below, we urge the departments to:

- Not place a numerical cap on the total number of items or services that can be batched and determined jointly for purposes of a payment determination during the Independent Dispute Resolution ("IDR") process. Should the departments finalize the policy, we recommend the cap be increased to 100.
- Include penalties or other actions that would incentivize payers to comply with providing the proposed claim information, which we agree is critical to improving both the open negotiation and IDR process.
- Strongly encourage the use of electronic remittances and not allow payers to use paper if they otherwise use electronic. If a payer does submit paper remittances, providers should be given additional time after the initial payment or denial is received to initiate the open negotiation period.
- Require plans share with providers the data used to calculate the qualified payment amount (QPA) at the time the QPA is conveyed and conduct frequent oversight of plans' calculation of the QPA.
- Award the party that initiated open negotiations its proposed out-of-network rate (as submitted during the IDR process) by default if the receiving party fails to respond in a timely manner as outlined in the proposed rule. As an alternative, the Independent Dispute Resolution Entities (IDREs) should defer to the position of the party that initiated open negotiations, by treating the initiating party's proposed out-of-network rate (as submitted during the IDR process) as the presumptively appropriate out-of-network rate.
- Maintain the existing grace period that allows parties initiating IDR to resubmit their dispute if the IDRE determines it to be ineligible.
- Include a penalty or other structure to incentivize payers to comply with the proposed IDR registry.

<u>Batching and Bundling of Claims</u>

Batched Claims

The departments outlined several objectives in proposing new batching requirements which allow interested parties to include multiple items or services as separate determinations in a single dispute.

In reviewing the care provided to our patients, **Trinity Health has determined capping the number of items and services that can be batched in the IDR process would not be appropriate.** For example, the departments' proposal to allow items and services furnished to a single patient on one or more consecutive dates of service and billed on a single claim form ("single patient encounters") will, we believe, help achieve the departments' goal of improved flexibility relative to batched payment determinations. However, imposing a cap on the total number of items and services that can be included in an otherwise single patient encounter will result in the services being artificially split, as it is fairly common for single patient encounters to include more than twenty-five items or services, especially for those encounters requiring complex care. In such situations, IDREs will be unable to review and consider all of the relevant factors in determining the appropriate out-of-network rate. Moreover, with respect to batched payment determinations that include more than a single patient encounter, if bundled correctly, IDREs would not need additional time or resources to review more than 25 items or services as these items and services would still be billed under the same service code or a comparable one. Considering that such codes will relate to items and services provided by the same facility or

provider, they will be sufficiently similar in nature. In addition, the timelines outlined in the existing regulations ensure only services from a specific timeframe would be submitted in a batch, effectively creating a natural cap or cut off for the number of services and items that would be submitted for review. **Trinity Health strongly urges the departments to not place a numerical cap on batched items or services. Should HHS finalize the policy, we recommend the departments increase the cap to 100.**

Bundling Claims
Independent dispute resolution (IDR) items and services that meet the definition of a bundled payment arrangement (e.g., DRG) may be submitted and considered as a single payment determination and the IDR entity must make a single payment determination for the multiple qualified IDR items and services included in the bundled payment arrangement.

To ensure IDREs apply consistent methodologies to resolve disputes, we recommend that the IDREs should be required to use Medicare bundling to determine if the items and services should be bundled for payment.

Payer Information Exchange
The departments are proposing new requirements for payers regarding critical claim information they must include when initiating a payment or a notice of payment denial, including the legal business name of the health plan, the health plan's sponsor and the health plan sponsor's IDR registration number. Payers will also be required to include in these disclosures to providers a statement that providers must notify the departments to initiate the open negotiation period. In addition, the rule proposes that payers are to communicate information to providers using specific claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), when they provide a paper or electronic remittance advice to a provider that does not have a contractual relationship with the payer.

Trinity Health supports the requirement for payers to provide critical claim information when initiating a payment or notice of denial. However, we have concerns that payers will fail to submit this information, directly impacting the ability of providers to pursue a claim and impeding the efficiencies the departments intend to create. **We urge the departments to include penalties or other actions that would incentivize payers to comply with the proposed requirements.** In addition, the proposed rule is silent on whether CARCs or RARCs must be submitted through electronic or paper remittance. When payers use paper remittances, it takes providers additional resources and time to pull this information. **The departments should strongly encourage electronic remittances and not allow payers to use paper if they otherwise use electronic remittances. If a payer does submit paper remittances, providers should be given additional time (i.e., 45 business days) after the initial payment or notice of denial is received to open negotiations.**

In addition, plans must provide a statement that the QPA was calculated consistent with regulations; however, they are not required to give providers meaningful information on how the QPA was calculated. There is no way for providers or the departments to know if plans truly calculated the QPA in accordance with regulation. **Trinity Health urges the departments to require plans share with providers the data used to calculate the QPA at the time the QPA is conveyed and conduct frequent oversight of plans' calculation of the QPA. Further,**

regulations must clearly state health plans are responsible for any consequences resulting from inaccurate calculations of the QPA, including making patients whole for any excess cost sharing, and the IDR process must have a mechanism for revisiting decisions that took into account a QPA that was later found to be inaccurately calculated.

Open Negotiation

The rule proposes changes to the open negotiation requirements to require that an interested party provide an open negotiation notice to the other party and to the departments through the federal IDR portal to initiate the open negotiation period. The rule also proposes that the beginning of the open negotiation period (30 business days) commences when the party submits the open negotiation notice and a copy of the remittance advice or notice of denial of payment to the other party through the federal IDR portal. In addition, the proposal would require that the departments establish an open negotiation response notice to be furnished by the party in receipt of the open negotiation notice. The response notice would be furnished to the other party as well as to the departments by the 15th business day of the 30-business-day of the open negotiation period.

Trinity Health supports the proposed timeframes as well as the requirement that a party receiving an open negotiation notice respond to that notice by the 15th business day of the open negotiation period; however, there is no penalty if a party doesn't send the response. Most of the open negotiation notices will be submitted by providers and the rule does not include any actions—penalties or otherwise—that would incentivize payers to respond. **It is critical that the departments get payers to engage more meaningfully to reduce the burden on IDREs and reduce the volume of IDR submissions. Trinity Health strongly urges the departments to award the initiating party their proposed out-of-network rate (as submitted during IDR) by default if the secondary party had failed to respond to the initiating party's offer during the open negotiation period as outlined in the proposed rule. As an alternative, the IDRE should presume that the out-of-network rate proposed by the initiating party (as submitted during IDR) is the appropriate out-of-network rate.**

IDR Process Improvements

IDR Eligibility

The proposed rule would require that the IDREs determine a claim's eligibility within five business days of the IDR entity selection and notify the disputing parties and the departments. The disputing parties, under this proposal, would be required to submit additional information requested by the IDR entity or the departments within five business days of the request.

We support the proposed time frame; however, current regulations allow for a grace period that would allow initiating parties to resubmit their claim if the IDRE determines it to be ineligible. We urge the departments to maintain this grace period.

IDR Registry

The proposed rule would require that payers subject to the IDR process register with the departments and provide general information regarding the applicability of the IDR process to items or services covered by the plan.

Trinity Health supports requiring payers to register with the departments and provide the general information outlined in the rule. **We urge the departments to include a penalty or other structure to incentivize payers to comply.**

IDR Administrative Fee

The departments propose to streamline the collection of the required non-refundable IDR administrative fees by requiring that the initiating party pay the administrative fee within two business days after the IDR entity selection while the non-initiating party would pay within two days of the notice of receiving the IDR eligibility determination. The rule proposes to charge both parties a reduced administrative fee for low dollar disputes when the highest offer made during the open negotiation period by either party was less than a predetermined threshold. Lastly, the rule outlines the administrative fees for 2025:

- Full administrative fee per party per dispute would be $150;
- Reduced administrative fee for low-dollar disputes would be $75 for both parties; and
- Reduced administrative fee for non-initiating parties in disputes found ineligible for IDR would be $30.

Providers will undoubtedly be initiators for the majority of the IDR submissions. The $150 administrative fee creates an inappropriate financial barrier to the IDR process and therefore further tilts the process in payers' favor as they are aware that the expense of the initiating fee could present a challenge, further incentivizing payers to underpay claims and abuse the NSA process.

Conclusion

If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health