IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	Case No.: 6:23-cv-00059-JDK

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT
AND MEMORANDUM IN SUPPORT THEREOF

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Plaintiffs Texas Medical Association, Dr. Adam Corley, Tyler Regional Hospital, LLC, Texas Radiological Society, and Houston Radiology Associated respectfully move for summary judgment on Counts I and II of their complaint. Attached hereto and incorporated by reference are Exhibits A–D in support of this motion.

INTRODUCTION

In the No Surprises Act ("NSA"), Congress reshaped how out-of-network healthcare providers are compensated for their services. For services subject to the Act, Congress eliminated providers' ability to "balance bill" patients for amounts not covered by their insurers, and instead created an independent dispute resolution ("IDR") process to ensure that providers could obtain reasonable reimbursement for their services from the patient's insurer. This case challenges yet another set of actions taken by defendants ("the Departments") in violation of their obligations under the NSA and the Administrative Procedure Act ("APA") to implement a fair and workable IDR process that allows out-of-network providers to obtain reasonable payment for their services.

Specifically, on December 23, 2022, the Departments increased the nonrefundable administrative fee that each party to an IDR proceeding must pay—win or lose—*sevenfold*, from $50 to $350. This dramatic increase in the cost of accessing IDR will not only make the process significantly more expensive for all IDR participants, but will make IDR cost-prohibitive for many providers, like radiologists, who predominantly have small-value claims. If providers are forced to pay a nonrefundable $350 administrative fee just to be heard, insurers will be able to underpay them with impunity. Whenever the amount in controversy is $350 or less, it will be economically infeasible for the provider to initiate IDR to obtain fair reimbursement. As a result, providers face the Hobson's choice of either submitting claims to arbitration that would cost more to arbitrate than they would recover if they won, on the one hand, or forgoing the IDR remedy Congress afforded them in the NSA when insurers underpay them, on the other.

In making this drastic change, the Departments did not provide notice or an opportunity for affected parties to comment, as the APA requires. Nor did they grapple—*at all*—with how their surprise 600% increase to the administrative fee would affect providers' ability to access the IDR process. Agencies have a fundamental obligation to consider how their actions will affect regulated parties, especially where, as here, the consequences could be economically crippling. Yet the Departments completely ignored how their new $350 administrative fee would affect providers' ability to be fairly paid, and they wholly failed to consider readily available alternatives that would allow them to cover their administrative costs without locking providers out of IDR.

The Departments cannot excuse these problems with their exorbitant fee increase by pointing to their regulations authorizing parties to "batch" related claims into a single IDR proceeding in limited circumstances. To begin, the Departments did not advance that rationale when increasing the fee, so they cannot now rely on it to defend their unlawful action in court. Moreover, the Departments' batching rule is itself unlawful, for largely the same reasons. It, too, was improperly issued without notice and comment, as part of the same package of rules that this Court already held was issued in violation of the APA's notice-and-comment requirement. *See Texas Med. Ass'n v. United States Dep't of Health & Hum. Servs.* ("*TMA I*"), 587 F. Supp. 3d 528, 543–48 (E.D. Tex. 2022). And it, too, unreasonably restricts access to IDR, particularly for providers with small-value claims that cannot be effectively batched under the Departments' rule.

For these reasons, as discussed more fully below, the challenged actions should be swiftly vacated, before they do more harm to the nation's healthcare providers and the patients they serve.

STATEMENT OF THE ISSUES

1. Did the Departments violate the APA by issuing the December 2022 Fee Guidance and the challenged provisions of the September Rule without notice and comment?

2. Are the December 2022 Fee Guidance and the challenged provisions of the September Rule arbitrary and capricious and contrary to law?

STATEMENT OF UNDISPUTED MATERIAL FACTS

A. The NSA and the IDR Process

Congress enacted the NSA to address surprise medical bills.[1] The Act generally limits the amount a patient will pay for medical services furnished by certain providers outside of his or her insurer's network. The statute also requires insurers to reimburse out-of-network providers at an "out-of-network rate." 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D).

Relevant here, the NSA establishes a process to resolve disputes between providers and insurers about the appropriate payment amount. Congress authorized insurers to make an initial payment in whatever amount they choose. *Id.* § 300gg-111(b)(1). If the provider disagrees with the insurer's payment determination, the provider may initiate a period of open negotiation with the insurer over the payment amount. *Id.* § 300gg-111(c)(1)(A). And if the parties cannot resolve their dispute through negotiation, either party may initiate arbitration through the IDR process. *Id.* § 300gg-111(c)(1)(B). The arbitrator (a "certified IDR entity") must choose one of the parties' offers after "taking into account" factors specified in the statute. *Id*. § 300gg-111(c)(5)(A)(i). One (but only one) of those factors is the qualifying payment amount ("QPA"), *id.* § 300gg-111(a)(5)(C)(i)(I), which is generally the median of the insurer's contracted rates for the same or a similar item or service in 2019, with annual inflation adjustments, *id.* § 300gg-111(a)(3)(E)(i)(I).

[1] The relevant statutory and regulatory provisions generally appear in triplicate and are identical in all material respects. The NSA's IDR provisions are codified at 42 U.S.C. § 300gg-111 (PHS Act), 29 U.S.C. § 1185e (ERISA), and 26 U.S.C. § 9816 (IRC). For ease of reference, this memorandum cites the PHS Act and implementing regulations.

Congress took care in designing this process. It was the product of two years of deliberation and compromise, during which legislators considered a variety of approaches. Multiple proposed bills would have restricted the IDR process to claims for which the insurer's median in-network rate met or exceeded a threshold amount—in one bill, $1,250, and in another, $750. H.R. 2328, 116th Cong. (2019); H.R. 5800, 116th Cong. (2020); *see also* H.R. Rep. No. 116-615, at 60 (Dec. 2, 2020). For claims below those amounts, arbitration would not be available, and payment for out-of-network services would be a set amount, such as the insurer's median contracted rate. *See* H.R. 2328; H.R. Rep. No. 116-615, at 48. But Congress ultimately rejected these options in favor of an arbitration process open to all claims, regardless of their dollar amount.

B. Aspects of the IDR Process at Issue: Administrative Fees and Batching Criteria

The NSA authorizes two types of IDR fees: (1) certified IDR entity fees that compensate arbitrators, 42 U.S.C. § 300gg-111(c)(5)(F), and (2) administrative fees that cover government expenses associated with carrying out the IDR process, *id.* § 300gg-111(c)(8). As to the first type of fees, the NSA specifies that "the party whose offer is not chosen" must pay "all fees charged by" the IDR entity. *Id.* § 300gg-111(c)(5)(F)(i). That is, the loser pays the IDR entity's fees.

As to the second type of fee, the NSA requires "[e]ach party" to pay the Departments an "[a]dministrative fee" "for participating in the IDR process." *Id.* § 300gg-111(c)(8)(A). The Departments must "specif[y]" the "time" and "manner" of payment. *Id*. They must also "establis[h]" the "amount" of the fee, such that "the total amount of fees paid" in a given year "is estimated to be equal to the amount of expenditures estimated to be made by the [Departments] for such year in carrying out the IDR process." *Id.* § 300gg-111(c)(8)(B).

The NSA also addresses "batching" of related claims for resolution in a single IDR proceeding. Congress required the Departments to "specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly" by an arbitrator "as part of

a single determination … for purposes of encouraging the efficiency (including minimizing costs) of the IDR process." *Id.* § 300gg-111(c)(3)(A). The statute specifies that "such items and services may be so considered only if": (1) the items and services are furnished by the same provider or facility; (2) payment for the items and services is required to be made by the same plan or issuer; (3) the items and services are "related to the treatment of a similar condition"; and (4) the items and services were furnished within the same 30-day period or an "alternative period as determined by the Secretary, for use in limited situations … to encourage procedural efficiency and minimize health plan and provider administrative costs." *Id.* § 300gg-111(c)(3)(A)(i)–(iv).

C. The September Rule

Congress left certain aspects of the IDR process to be implemented by the Departments, and directed them, "[n]ot later than 1 year after the NSA's enactment," *i.e.*, by December 27, 2021, to "establish" the IDR process "by regulation." *Id.* § 300gg-111(c)(2)(A). On September 30, 2021, the Departments publicly released the rule at issue here. 86 Fed. Reg. 55,980 (Oct. 7, 2021). The September Rule is an interim final rule, and the Departments issued it without providing notice or an opportunity for interested parties to comment. With one exception not relevant here, after almost a year and a half, the Departments have yet to issue a final version of this rule.[2]

1. IDR Entity Fees and Administrative Fees

The September Rule addresses both types of IDR fees. As to IDR entity fees, the rule provides that they must fall "within a pre-determined range … [to be] specified by the Departments through guidance." *Id.* at 56,001. Although under the statute only the losing party is ultimately

[2] In August 2022, the Departments issued a final rule replacing their "rebuttable presumption" in favor of the QPA, which this Court vacated as inconsistent with the statute in *TMA I*. *See* 87 Fed. Reg. 52,618 (Aug. 16, 2022). This Court has also now vacated provisions of the final rule that again unlawfully required arbitrators to privilege the QPA. *See Tex. Med. Ass'n v. United States Dep't of Health & Human Servs.*, No. 6:22-cv-372, 2023 WL 1781801, at *10–14 (Feb. 6, 2023).

responsible for paying the IDR entity fee, *see* 45 C.F.R. § 149.510(d)(1)(i), the rule requires both parties to post the fee with the IDR entity when they "submit their offers," *id.* § 149.510(d)(1)(ii). After an offer is chosen, the prevailing party's fee must be refunded within 30 days. *Id.*

As to administrative fees, the rule specifies that each party "must … pay" the fees "at the time the certified IDR entity is selected." *Id.* § 149.510(d)(2)(i). Like IDR entity fees, administrative fees are paid "to the certified IDR entity," *id*. § 149.510(d)(2)(i), but the IDR entity then remits them to the Departments, 86 Fed. Reg. at 56,001. They are also "non-refundable," 45 C.F.R. § 149.510(d)(2)(i), even if "the certified IDR entity determines that the case does not qualify for the Federal IDR process," 86 Fed. Reg. at 56,001. The rule, tracking the statute, requires that the amount of the fees be set such that the total amount of fees paid in a given year covers the expected costs of carrying out IDR process for that year. *See* 45 C.F.R. § 149.510(d)(2)(ii). But the rule departs from the statute by purporting to authorize the Departments to set the amount of the fee via subregulatory "guidance published annually" rather than by regulation. *Id.*

2. Batched Items and Services

The September Rule also specifies criteria for batching. *See id*. § 149.510(c)(3). For each condition—*except* for the Act's requirement that items and services be "related to the treatment of a similar condition"—the Departments essentially mirrored the NSA's criteria for batching.

First, tracking the statutory condition that batched claims be "furnished by the same provider or facility," 42 U.S.C. § 300gg-111(c)(3)(A)(i), the Departments permitted batching for "items and services … billed by the same provider or group of providers" or the "same facility," 45 C.F.R. § 149.510(c)(3)(i)(A). Second, parroting the statutory condition permitting batching only if payment must "be made by the same group health plan or health insurance issuer," 42 U.S.C. § 300gg-111(c)(3)(A)(ii), the Departments allowed batching only if payment "would be

made by the same plan or issuer," 45 C.F.R. § 149.510(c)(3)(i)(B). Third, citing the statutory provision permitting batching only if the items or services were provided within the same 30 business days or "an alternative period as determined by the Secretary," 42 U.S.C. § 300gg-111(c)(3)(A)(iv), the Departments permitted batching only where the "items and services were furnished within the same 30-business-day period" or, under certain conditions, within "the same 90-calendar-day period," 45 C.F.R. § 149.510(c)(3)(i)(D).

The final criterion, at issue here, does not parallel the statute, however. Although the NSA's corresponding provision allows the Departments to broadly permit batching whenever "items and services are *related to the treatment of a similar condition*," 42 U.S.C. § 300gg-111(c)(3)(A)(iii) (emphasis added), the rule permits batching only in much narrower circumstances: only if the "items and services are *the same or similar items and services*," 45 C.F.R. § 149.510(c)(3)(i)(C) (emphasis added). And the Departments defined "same or similar items or services" as items or services "billed under the same service code, or a comparable code under a different procedural code system." *Id.* These "codes" include Current Procedural Terminology ("CPT") codes and other comparable codes. 86 Fed. Reg. at 55,994; *see also* 45 C.F.R. § 149.510(c)(3)(i)(C).[3]

In adopting their same-service-code restriction, the Departments never mentioned the statute's language authorizing them to allow batching in a much broader set of circumstances. Nor did

[3] CPT codes are unique five-digit codes assigned to each healthcare service. *See CPT® Overview and Code Approval*, Am. Med. Ass'n, https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval. In other words, CPT codes provide "a uniform language to describe a physician's work, which facilitates patient billing for medical and surgical procedures, diagnostic tests, laboratory studies, and other medical services rendered." *Prompt Med. Sys., L.P. v. Allscriptsmysis Healthcare Sols., Inc.*, 2012 WL 678216, at *1 (E.D. Tex. Feb. 13, 2012). The other types of codes identified in the Departments' rule serve a similar function.

they consider any alternative to their same-service-code criterion, or how that criterion would affect access to IDR for providers with small-value claims. Instead, they simply asserted that batching items and services "involv[ing] the same or similar medical procedure" is "likely to reduce redundant IDR proceedings as well as streamline the certified IDR entity's decision-making" and "avoid combinations of unrelated claims," which "could unnecessarily complicate an IDR payment determination and create inefficiencies." 86 Fed. Reg. at 55,994. In particular, the Departments asserted that batching by service code would allow the IDR entity to "more efficiently focus on where the value" of the item or service is "consistently materially different from the QPA," presumably because QPAs too are calculated at the service code level. *Id.* at 56,064.

3. The Departments' Rationale for Bypassing Notice and Comment

Although the Departments acknowledged that the APA generally requires notice and comment for legislative rules such as the one here, *see* 5 U.S.C. § 553(b)(B), they concluded that "good cause" existed for bypassing that requirement, 86 Fed. Reg. at 56,043. Congress had given the Departments an entire year to promulgate IDR rules—more than enough time to provide notice and comment and issue a final rule by the statutory deadline. *See* 42 U.S.C. § 300gg-111(c)(2)(A). Yet the Departments waited a full nine months to issue the September Rule.

The rule's preamble conceded that a full year "may have" been enough time to "allo[w] for the regulations" to go through notice-and-comment rulemaking before the NSA took effect. 86 Fed. Reg. at 56,043. But the Departments asserted that it was "impracticable and contrary to the public interest to engage in full notice and comment rulemaking" because the "timeframe would not provide sufficient time for the regulated entities to implement the requirements" relating to the IDR process. *Id.* at 56,044. Even in September 2021, however, there were still three months until

the deadline for IDR rules, and five or six months before arbitrators would begin hearing cases.[4] The Departments never explained why the fee and batching rules needed to be in place before then.

D. September 2021 Fee Guidance

On the same day that the Departments issued the September Rule, CMS issued a guidance document relating to the IDR entity fees and administrative fees for 2022. *See Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act* (Sept. 30, 2021) ("September 2021 Fee Guidance").[5] CMS announced that IDR entities would be required to "charge a fixed … fee for single determinations within the range of $200–$500" and "$268–$670" for "batched determinations." *Id.* at 4. In setting the permissible range of IDR entity fees, the Departments considered multiple factors, including the input of "stakeholders," who emphasized the importance of ensuring that the fees would not make "participating in the Federal IDR process … cost-prohibitive, especially for smaller providers and facilities." *Id.* at 3. CMS further announced that the administrative fee for 2022 would be "$50," and specified that the fee would be "due from each party for participating in the [IDR] process," regardless of which party prevailed. *Id.* The fee amount, CMS explained, was based on "review of anticipated expenditures by the Departments in carrying out the Federal IDR process for 2022." *Id.*

[4] The NSA applies only to items and services furnished with respect to plan years beginning on or after January 1, 2022. Given the statutory time periods for initial payments, open negotiations, and initiating IDR, it takes several months after an item or service is rendered for a claim to be presented to an IDR entity for a payment determination. Thus, in *TMA I*, the government represented to the Court that "the first arbitrations of payment disputes will likely begin in April [2022]." Defs.' Cross-Mot. For Summ. J. at 1–2, No. 6:21-cv-425-JDK, ECF No. 62 (E.D. Tex. Jan. 10, 2022).

[5] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.

E. The IDR Process's Implementation and Backlog

On April 15, 2022, the Departments opened the Federal IDR portal, and parties began initiating IDR. *See* Dep'ts, *Initial Report on the Independent Dispute Resolution (IDR) Process April 15–September 30, 2022*, at 3, 7 (Sept. 30, 2022) ("Initial IDR Report").[6] From the get-go, the volume of IDR submissions was higher than anticipated. *Id.* at 7. The Departments had estimated that just over 22,000 claims would be submitted for IDR each year. *See Supporting Statement For Paperwork Reduction Act 1995: Independent Dispute Resolution Process* at 16.[7] As it turned out, more than 18,000 claims were submitted by June 30, 2022. *See* Initial IDR Report at 8. Over the next three months, the number of claims ballooned, with almost 72,000 claims submitted between July 1 and September 30. *Id.* at 7. IDR entities could not keep pace with the volume, closing only about 23,000 disputes by September 30 and creating a massive backlog. *Id.* at 8.

According to the Departments' Initial IDR Report, the "primary cause" for this backlog was not the volume of claims, but rather "the complexity of determining whether disputes [were] eligible for the Federal IDR process" at all. *Id.* at 8–9. IDR entities made payment determinations in only 15% of the disputes closed by September 30, 2022, whereas 69% of the cases closed by that date were found ineligible for IDR. *Id.* at 8. In fact, nearly half of all claims submitted for IDR between April 15 and September 30 were challenged on eligibility grounds. *Id.* at 9.

The Departments' report also identified certain issues that have complicated IDR entities' eligibility determinations. *See id.* at 8–12. To begin with, insurers were not complying with their obligation to disclose certain information—such as the applicable QPA and contact information—"when they make an initial payment or provide a notice of denial of payment" to providers. *Id.* at

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

[7] https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-1.pdf.

9. This meant that "many disputes were initiated with missing or incorrect" information that was necessary for determining eligibility. *Id.* Eligibility determinations were also complicated by the difficulty of determining whether claims are subject to a state law rather than the Federal IDR process. *See id.* at 10. Again, the lack of adequate disclosures by insurers—here, regarding the type of health plan—was a root cause of the problem. *See id.* at 10–11. Lastly, "many disputes were incorrectly batched," which "result[ed] in delays in processing" disputes. *Id.* Batching problems, too, could have been ameliorated by insurer disclosure of "[i]nformation about health plan type," which "helps initiating parties accurately batch items or services together." *Id.* at 11.

Recognizing that insufficient disclosure by insurers was driving the backlog, providers have encouraged the Departments to enforce insurers' existing disclosure obligations and to require further disclosures. *See, e.g.*, Letter from the American College of Emergency Physicians, et al., *Request to Require the Use of Remittance Advice Remark Codes (RARCs)* at 2–3 (Nov. 28, 2022) (explaining that use of uniform remittance advice remark codes would assist eligibility determinations).[8] But the Departments have failed to respond to these requests, even as the backlog has seriously harmed providers—many of whom, after paying administrative fees and fronting IDR entity fees, have yet to be paid for the vast majority of their services in dispute.

F. October 2022 Fee Guidance

On October 31, 2022, CMS posted additional guidance setting the IDR fees for 2023. *See Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act* (Oct. 31, 2022) ("October 2022 Fee Guidance").[9] This guidance raised the permitted range for IDR entity fees to "$200–$700" for single determinations and "$268–$938"

[8] https://www.acep.org/globalassets/new-pdfs/advocacy/acep-edpma-rarc-code-request.pdf.

[9] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

for batched determinations. *Id.* at 6. As before, the Departments considered the need to prevent the IDR process from becoming "cost-prohibitive," but they now concluded that a fee increase was necessary given the high volume of disputes and complex eligibility determinations. *Id.* at 5.

The guidance left the $50 administrative fee in place, concluding that existing data did not require a change for 2023. *See id.* at 3–4. Significantly, however, the guidance noted that parties could wait to pay the fee until "the time of offer submission." *Id.* at 1–2. To justify this departure from the September Rule's requirement that parties pay the administrative fee when the IDR entity is selected, the October 2022 Fee Guidance pointed to a previous guidance document issued to clarify the IDR process for disputing parties. *See id.* at 2 n.4 (citing *Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties* (October 2022)[10]). This guidance provided that "[a]dministrative fees may be invoiced by the certified IDR entity at the time of selection and must be paid by the time of offer submission." *Process Guidance for Disputing Parties* at 29; *see also id.* at 18, 20. The guidance thus purported to permit parties to wait to pay administrative fees until *after* the IDR entity "concludes that the Federal IDR Process applies." *Id.* at 18.

G. December 2022 Fee Guidance

On December 23, 2022, less than two months after issuing the October 2022 Fee Guidance, CMS announced that the Departments had adopted an "Amendment," making no change to the IDR entity fees but "increas[ing] the administrative fee … from $50 to $350 per party … beginning January 1, 2023." *Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process under the No Surprises Act: Change in Administrative Fee* at 1

[10] https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf.

(Dec. 23, 2022) ("December 2022 Fee Guidance").[11] The guidance justified this sevenfold fee increase by pointing to the high volume of disputes, many of which were found to be ineligible. *Id.* at 4–5. "This situation," the guidance stated, "has resulted in low collections of the administrative fee relative to the volume of disputes … [and] the Departments' expenditures." *Id.* at 5.

Of course, any increase in the volume of disputes should have meant an increase in the fees collected—and if those fees were paid at the outset (as the September Rule prescribes), eligibility determinations would not affect collection. The reason for the low collection was, the guidance explained, that "the Departments permit parties to pay the administrative fee on or before the time of offer submission." *Id.* at 5 n.22. As a result, "[i]f an offer is not submitted because the certified IDR entity determines the dispute is ineligible[,] … the administrative fee is often not collected." *Id.* at 5 n.22. On this point, the guidance also highlighted that the Departments "have engaged government staff and contractor resources to conduct pre-eligibility reviews by performing research and outreach on disputes pending eligibility determinations." *Id.* at 5. These actions could ameliorate the dispute backlog but would also "increas[e] expenditures." *Id.* at 5–6. The fee increase was intended to "reflect" the Departments' "estimated increased expenditures." *Id.* at 6.

Nowhere, however, does the December 2022 Fee Guidance disclose the data or methodology used to generate those estimated expenditures and justify the fee increase. Nor does the guidance suggest that the Departments considered how a sevenfold increase in the nonrefundable administrative fee could render the IDR process cost-prohibitive for many providers. In fact, the guidance does not suggest the Departments considered *any* alternatives to their massive fee in-

[11] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

crease—or *any* alternatives to their costly efforts to conduct the pre-eligibility reviews that purportedly necessitated the increase. For instance, despite attributing the fee-collection problem to the timing of payment, the guidance nowhere mentions the possibility of resolving that problem by enforcing the Departments' own regulation requiring the parties to "pay" the administrative fee "at the time the certified IDR entity is selected." 45 C.F.R. § 149.510(d)(2)(i).

H. The Adverse Impact on Access to IDR

The 600% increase in the administrative fee will make the IDR process significantly more expensive for all IDR participants. But it is providers, not insurers, who rely on IDR to get paid and who therefore initiate 99% of arbitrations. *See* Initial IDR Report at 15–16. And for many physicians, like radiologists, whose claims rarely exceed $350, the requirement to pay a nonrefundable $350 administrative fee will make participation in the IDR process cost-prohibitive for the vast majority of their claims. *See* HRA Decl. ¶ 9 (stating that in 2022, over 99% of practice's NSA-eligible charges billed to two major insurers had an allowed amount of less than $350); Imagine Decl. ¶ 9 (same for 119 radiology practices across Texas across all commercial insurers).

Batching does not solve the problem. The Departments' restrictive rule permitting batching of items and services only if they are billed under the same service code prevents many providers from joining a sufficient number of claims to bring the amount in controversy for the dispute above $350. For example, a radiologist often performs dozens of different procedures in a single day, all related to the treatment of similar conditions but each corresponding to a different service code. *See* HRA Decl. ¶ 8. Indeed, during a single patient encounter, a radiologist will often furnish multiple services that are all related to the treatment of the patient's condition but involve multiple CPT codes—sometimes as many as a half a dozen or more. *See id*. Because each service corresponds to a different code, the radiologist cannot batch these claims together into one IDR dispute

under the Departments' rule, even though the Departments could have made them eligible for batching consistent with the statute because they all relate to the treatment of a similar condition.

In combination, the Departments' nonrefundable $350 administrative fee and their restrictive same-service-code batching rule will drastically curtail the number of claims that physicians, and especially radiologists, can feasibly submit to IDR. HRA, for example, estimates that it will be cost-prohibitive to initiate IDR for the *vast majority*—a shocking *97%* —of its charges. *Id.* ¶10.

LEGAL STANDARDS

Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "In the context of a challenge under the APA, '[s]ummary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the APA standard of review.'" *Texas v. EPA*, 389 F. Supp. 3d 497, 503 (S.D. Tex. 2019) (quoting *Blue Ocean Inst. v. Gutierrez*, 585 F. Supp. 2d 36, 41 (D.D.C. 2008)). Under the APA, courts will "hold unlawful and set aside" agency action that was taken "without observance of procedure required by law," 5 U.S.C. § 706(2)(D), or that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," *id.* § 706(2)(A).

"The APA's arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained." *FCC v. Prometheus Radio Project*, 141 S. Ct. 1150, 1158 (2021). Although a court must not "substitute its own policy judgment for that of the agency," *id.*, arbitrary-and-capricious review "is not toothless," *Sw. Elec. Power Co. v. EPA*, 920 F.3d 999, 1013 (5th Cir. 2019). "In fact, … it has serious bite." *Wages & White Lion Invs., LLC v. FDA*, 16 F.4th 1130, 1136 (5th Cir. 2021). Agency action is arbitrary and capricious if, *inter alia*, the agency "entirely failed to consider an important aspect of the problem." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Further, a court cannot uphold a rule based on grounds

not given by the agency in the rule. *See SEC v. Chenery Corp.*, 318 U.S. 80, 87 (1943); *Dish Network Corp. v. NLRB*, 953 F.3d 370, 379–80 (5th Cir. 2020).

ARGUMENT

I. The Departments Unlawfully Issued The December 2022 Fee Guidance And September Rule Without The Notice And Comment Required By the APA.

Both the December 2022 Fee Guidance and the September Rule's same-service-code batching rule were unlawfully issued without notice and comment and therefore must be "set aside" as having been issued "without observance of procedure required by law." 5 U.S.C. § 706(2)(D). The Departments' sevenfold fee increase in the nonrefundable administrative fee for accessing IDR is precisely the sort of substantive rule that must be subject to "the full panoply of notice-and-comment requirements." *Texas v. United States*, 809 F.3d 134, 171 (5th Cir. 2015). And the Departments lacked good cause for issuing the batching rule without notice and comment for the same reasons this Court held in *TMA I* that they lacked good cause to bypass notice and comment for other provisions of the September Rule. *See* 587 F. Supp. 3d at 545–46.

A. The December 2022 Fee Guidance is a substantive rule that was unlawfully issued without notice and comment.

The APA requires that, before issuing "substantive rules," agencies must publish a "notice of proposed rule making," 5 U.S.C. § 553(b), and "give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments," *id.* § 553(c); *see Walmart Inc. v. DOJ*, 21 F.4th 300, 308 (5th Cir. 2021) ("substantive rules" must "be preceded by notice and comment"). Certain types of rules—*e.g.*, "interpretative rules" and "rules of agency organization, procedure, or practice"— are exempt from these requirements. 5 U.S.C. § 553(b)(A). But these "exemptions must be narrowly construed." *Texas*, 809 F.3d at 171. And they are "inapplicable" to "substantive" rules. *Id.* Because the December 2022 Fee Guidance is a substantive rule, the Departments violated the APA by issuing it without notice and comment.

To begin with, what the Departments labeled "guidance" was unquestionably a "rule"—and its issuance a "rule making"—under the APA. *See* 5 U.S.C. § 551(4) (defining "rule" to cover actions setting "rates" or "prices"); *id.* § 551(5) ("rule making" includes any "agency process for formulating [or] amending … a rule"); *Five Flags Pipe Line Co. v. DOT*, No. 89-119, 1992 WL 78773, at *3 (D.D.C. Apr. 1, 1992) (holding that an agency's establishment of a fee schedule pursuant to a statutory mandate "falls squarely within" the APA's definition of rulemaking).

The December 2022 Fee Guidance also bears all the hallmarks of a *substantive* rule: it has "the force of law, meaning that [it] bind[s] the regulated" parties, *Walmart*, 21 F.4th at 308; and it both "*modifies* [and] *adds* to" the current price of accessing IDR "based on the agency's *own authority*," *Syncor Int'l Corp. v. Shalala*, 127 F.3d 90, 95 (D.C. Cir. 1997). Of course, the Departments have authority under the NSA to "establis[h]" the "amount" of administrative fees in order to cover the Departments' estimated expenditures in carrying out the IDR process. 42 U.S.C. § 300gg-111(c)(8)(B). But nothing in the NSA exempts that authority from the APA's procedural requirements—or, for that matter, from the NSA's own mandate that the Departments "establish" the IDR process "by *regulation*." *Id.* § 300gg-111(c)(2)(A) (emphasis added).

To the contrary, a decision setting fees so as to "recover 'the full costs of operation of'" an agency program is precisely the sort of substantive "determination" an "agency is required to subject to rulemaking." *Am. Med. Ass'n v. Reno*, 57 F.3d 1129, 1133–34 (D.C. Cir. 1995). And that makes sense. Setting the administrative fee for accessing IDR is not a ministerial task. It is a decision requiring the exercise of judgment and discretion on a number of matters, including which expenses properly relate to the Departments' carrying out of the IDR process and how those expenses should be spread across IDR participants. Here, for example, the Departments set the fee to cover the Departments' expenses to assist IDR entities with eligibility determinations, even

though the Departments insist it is IDR entities' responsibility to determine eligibility and the NSA envisions that the cost of the IDR entity's services will be covered by the losing party's IDR entity fee. The Departments' decision should also have involved the weighing of numerous policy considerations and alternative measures, *see infra* at 24–25, as well as disclosure of the data on which they relied, *see Am. Med. Ass'n*, 57 F.3d at 1132–33. It is for just such complex and consequential determinations that the APA's rulemaking requirements exist, so as "to ensure that" before an agency imposes substantial costs on regulated parties, the agency must confront "the broadest base of information" provided "by those most interested and perhaps best informed on the subject of the rulemaking at hand." *Phillips Petroleum Co. v. Johnson*, 22 F.3d 616, 620 (5th Cir. 1994).

The Departments cannot excuse their failure to provide notice and comment by pointing to the APA's exemptions. As noted, those exemptions are "narrowly construed." *Texas*, 809 F.3d at 171. And none applies here. The December 2022 Fee Guidance clearly was not an "interpretive" rule because it: (i) "does not purport to interpret" anything, (ii) "is not a mere clarification," (iii) "defines no ambiguous term[s]," and (iv) "gives no officer's opinion about the meaning of the statute or regulations." *Phillips Petroleum Co.*, 22 F.3d at 619. Instead, the guidance has "the force and effect of law," *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995), "effect[ing]" a dramatic "change" in the fees that regulated parties must pay to access IDR, *Phillips Petroleum Co.*, 22 F.3d at 619. "As such, it is a new rule and cannot be interpretive." *Id.* at 619–20; *see Five Flags Pipe Line Co.*, 1992 WL 78773, at *4 (holding that "fee schedule was a legislative rather than interpretive rule, and that notice and comment under [APA] section 553 was required").

Nor can the Departments characterize the fee increase as a "rul[e] of agency organization, procedure, or practice." 5 U.S.C. § 553(b)(A). As a threshold matter, this exemption is inapplicable because the December 2022 Fee Guidance did not establish any internal *agency* procedures or

practices; it imposed a condition for accessing a *private* arbitration process external to the agencies. To be sure, virtually every rule the Departments have promulgated regarding the IDR process is "procedural" in some sense: the NSA instructs the Departments to "establish by regulation one independent dispute resolution *process*." 42 U.S.C. § 300gg-111(c)(2)(A) (emphasis added). But that does not exempt all IDR rulemaking under the NSA from the APA's notice-and-comment requirement. *See Phillips Petroleum Co.*, 22 F.3d at 620 ("the mere fact that [agency action] may guide … procedures does not mean that [it] is a 'procedural' rule for purposes of the APA").

Moreover, under longstanding Fifth Circuit precedent, agency actions that have "a 'substantial impact' on those regulated" cannot qualify as "procedural" rules under the APA. *See id.* ("Our inquiry … is not whether the rule is 'substantive' or 'procedural,' but rather whether the rule will have a 'substantial impact' on those regulated."); *Texas*, 809 F.3d at 176. Here, the "impact" of the Departments' sevenfold fee increase is plainly "substantial." *See Brown Exp., Inc. v. United States*, 607 F.2d 695, 702 (5th Cir. 1979) ("economic consequences to those affected" precluded application of the procedural rule exemption). The sheer magnitude of the fee increase will impose grave economic consequences on healthcare providers, especially those with predominantly small-value claims, who will be effectively excluded from IDR for the vast majority of their claims. *See supra* at 14–15. And even for those who are not completely barred from IDR, the fee increase will materially limit the scope and volume of claims many providers can submit.

Finally, the Departments cannot justify their failure to provide notice and comment by recourse to their September Rule, in which they purported to authorize themselves to set the fees through guidance. *See* 45 C.F.R. § 149.510(d)(2)(ii). Because these fee rules are substantive, the APA requires that "the full panoply of notice-and-comment requirements must be adhered to scrupulously." *Texas*, 809 F.3d at 171. The Departments cannot authorize themselves to violate the

APA, so their regulation is substantively unlawful. In addition, it is procedurally unlawful because, as discussed next, it was itself issued in violation of the APA's notice-and-comment requirement.

B. The Departments lacked good cause for issuing the batching and administrative fee rules without notice and comment.

There is no question that the September Rule is a substantive rule subject to the APA's notice-and-comment requirement.[12] The Departments, however, claimed there was "good cause" to bypass that requirement for the September Rule because providing notice and comment was purportedly "impracticable and contrary to the public interest." 86 Fed. Reg. at 56,043; *see* 5 U.S.C. § 553(b)(B). But that exception is not an "'escape clause' from the requirements Congress prescribed." *United States v. Johnson*, 632 F.3d 912, 928 (5th Cir. 2011) (quoting *United States v. Garner*, 767 F.2d 104, 120 (5th Cir. 1985)). Thus, the "good cause" exception must be "narrowly construed." *Texas*, 809 F.3d at 171. It generally applies to "true emergencies only," *United States v. Rainbow Fam.*, 695 F. Supp. 294, 305 (E.D. Tex. 1988), meaning situations "where delay would do real harm," *U.S. Steel Corp. v. EPA*, 595 F.2d 207, 214 (5th Cir. 1979).

This Court already held that the Departments lacked good cause for issuing the September Rule's QPA presumption without notice and comment. *See TMA I*, 587 F. Supp. 3d at 545–46. And the Court's reasoning applies equally to the batching and fee rules at issue here. Most fundamentally, the Departments have "fail[ed] to justify why they could not have provided notice and comment in the time they had—a full year." *Id.* at 545. That is more than enough time for notice and comment. *See, e.g.*, *id.* (citing cases in which much shorter timeframes were held sufficient to provide notice and comment); *Rainbow Fam.*, 695 F. Supp. at 305 ("Even a six-month deadline has been held sufficient time in which to offer proposed regulations for comment.").

[12] This Court in *TMA I* correctly rejected the Departments' meritless contention that their organic statutes override the APA's notice-and-comment requirement. 587 F. Supp. 3d at 543–44.

That the Departments waited to act until late September 2021—a full nine months after the NSA's enactment—is no excuse. The Departments cannot rely on their own "dilatory tactics" to create an exigency justifying dispensing with notice and comment. *Rainbow Fam.*, 695 F. Supp. at 305; *see also NRDC v. Nat'l Highway Traffic Safety Admin.*, 894 F.3d 95, 114 (2d Cir. 2018) ("Good cause cannot arise as a result of the agency's own delay."). In any event, even by late September 2021, there was no exigency that could justify issuing the batching and administrative fee regulations without notice and comment. At that time, there remained three full months until the NSA took effect, and five or six months until the first arbitrations would begin in March or April 2022. *See supra* at 9 n.4. There was still enough time to provide notice and comment.

Nor does the Departments' stated "desire to provide immediate guidance" to regulated parties "suffice for good cause." *TMA I*, 587 F. Supp. 3d at 546 (quoting *Johnson*, 632 F.3d at 929). In setting the December 27, 2021 deadline for IDR rules, Congress decided that regulated parties would have sufficient lead time if the IDR rules were adopted by that date—nearly three full months after the Departments issued the September Rule. The Departments cannot override that judgment. *See id.* at 545–46 ("Congress could have expressly waived the APA procedural requirements … if it feared those requirements would produce significant harm or excessive delay." (quoting *Johnson*, 632 F.3d at 928)). In any event, as in *TMA I*, the Departments' request for post-promulgation comment "undercuts the claimed need for certainty." *Id.* at 546.

Further, even if regulated parties needed lead time for *some* of the IDR rules established in the September Rule, "good cause [did] not exist to rush the provisions of the Rule at issue here." *Id.*; *see also Garner*, 767 F.2d at 120 ("[W]e will not allow a regulation otherwise subject to section 553 procedures to piggyback on regulations properly issued in response to a sudden exigency."). The batching and fee rules require little advance notice to implement—they mandate determining

how to group claims before submitting them and paying a fee at the outset of IDR. There was no good cause to issue these rules without notice and comment *months* before the first arbitrations would begin, when that time could have been used to comply with the APA.

II. The Challenged Actions Are Arbitrary And Capricious And Contrary To Law.

Given that the Departments imposed their fee increase and batching rule without considering the input of regulated parties, it is no surprise that those actions failed to satisfy the APA's basic requirements of "reasoned decisionmaking." *DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1905 (2020). For both actions, the Departments failed to consider the adverse effects their decisions would have on providers' ability to access the IDR process—an important aspect of the problem, if ever there was one. They also ignored obvious alternative measures that could mitigate those effects. Ultimately, the challenged actions combine to bar access to IDR for far too many claims and, in so doing, fail to reasonably implement the NSA.

A. The December 2022 Fee Guidance is arbitrary and capricious.

The December 2022 Fee Guidance must be set aside as arbitrary and capricious because the Departments completely ignored the adverse effect a 600% increase in the nonrefundable administrative fee would have on healthcare providers' ability to access IDR. The Departments thus "entirely failed to consider an important aspect of the problem." *State Farm*, 463 U.S. at 43. "[P]aying attention to the … disadvantages of agency decisions," is "ordinarily" a precondition of "reasonable regulation." *Michigan v. EPA*, 576 U.S. 743, 753 (2015). So, when an agency raises fees, the agency must "grapple with the effect these fee increases would have," including "the extent to which the fee increases would impose barriers to obtaining the benefits at issue or would impose other hardships on" regulated parties. *Nw. Immigr. Rts. Project v. U.S. Citizenship & Immigr. Servs.*, 496 F. Supp. 3d 31, 78 (D.D.C. 2020) (preliminarily enjoining agency fee increase

for failure to consider adverse impacts on regulated parties); *see also Cath. Legal Immigr. Network, Inc. v. Exec. Off. for Immigr. Rev.*, 513 F. Supp. 3d 154, 172 (D.D.C. 2021) (same).

Here, the Departments entirely failed to grapple with "the extent to which [their] fee increas[e] would impose barriers to" IDR access. *Nw. Immigr. Rts. Project*, 496 F. Supp. 3d at 78. In particular, they failed to consider "that the higher fees will be prohibitively expensive" for physicians with small-value claims. *Cath. Legal Immigr. Network*, 513 F. Supp. 3d at 172. This omission is especially glaring because, with regard to IDR entity fees, the Departments "recogniz[ed] the need to keep the Federal IDR process from being cost prohibitive for disputing parties." December 2022 Fee Guidance at 6. Yet, for administrative fees, the Departments inexplicably ignored this crucial consideration, even though administrative fees pose a greater threat to IDR access because (unlike IDR entity fees) they are nonrefundable even for the prevailing party.

The Departments offered no excuse—let alone a "reasoned explanation," as the APA requires, *DHS*, 140 S. Ct. at 1916—for failing to consider the extent to which their sevenfold fee increase would impact IDR access. It cannot be that they lacked sufficient data to assess that impact. The NSA *requires* the Departments to obtain (and publish) information regarding the dollar amount of parties' offers. *See* 42 U.S.C. § 300gg-111(c)(7)(B)(iii); 45 C.F.R. § 149.510(f)(1)(v)(C). So they should know how often the amount in controversy is below $350. In all events, even if the "magnitude of an effect is uncertain," that is "no justification for *disregarding* the effect entirely." *Nw. Immigr. Rts. Project*, 496 F. Supp. 3d at 79 (cleaned up).

Yet the Departments did precisely that, entirely disregarding the devastating effect the fee increase would have on providers' access to IDR—along with the ensuing adverse consequences. The Departments turned a blind eye to these harms, even though they themselves previously recognized that exclusion from IDR "could threaten [providers'] viability" and "lead to … [patients]

not receiving needed medical care, undermining the goals of the No Surprises Act." 86 Fed. Reg. at 56,044. It is thus "difficult to imagine a more important 'aspect of the problem.'" *Cigar Ass'n of Am. v. FDA*, 964 F.3d 56, 62 (D.C. Cir. 2020) (quoting *State Farm*, 463 U.S. at 43).

Relatedly, the Departments failed to consider multiple "obvious and less drastic alternative[s] to" their sevenfold fee increase that would have allowed them to cover their IDR costs without so severely curtailing access to IDR. *See Yakima Valley Cablevision, Inc. v. FCC*, 794 F.2d 737, 746 & n.36 (D.C. Cir. 1986) ("The failure of an agency to consider obvious alternatives has led uniformly to reversal."); *Spirit Airlines, Inc. v. DOT*, 997 F.3d 1247, 1255 (D.C. Cir. 2021) (an agency's obligation to consider reasonable alternative measures "goes to the heart of reasoned decisionmaking"). The Departments justified the fee increase by pointing to (1) their failure to collect administrative fees in many cases dismissed as ineligible and (2) their additional expenditures assisting IDR entities with eligibility determinations. *See supra* at 13. But the Departments nowhere entertained the possibility of addressing the collection problem by enforcing their own regulation requiring parties to pay administrative fees at the *outset* of IDR, when the IDR entity is selected. 45 C.F.R. § 149.510(d)(1)(i); *see also* 86 Fed. Reg. at 56,001 (explaining that "the parties should still be expected to pay the fee" even if a dispute is found to be ineligible).

The Departments' reason for not enforcing their regulation as written appears to be that, after promulgating the September Rule, they issued inconsistent guidance permitting parties to delay paying administrative fees until they submit their IDR offers. *See supra* at 12. But subregulatory guidance cannot "effectively amen[d]" a binding regulation. *See Flight Training Int'l, Inc. v. FAA*, 58 F.4th 234, 2023 WL 368471, *4 (5th Cir. 2023) ("notice and comment is 'required' if a rule 'adopt[s] a new position inconsistent with any … existing regulations'" (quoting *Guernsey*

Mem'l Hosp., 514 U.S. at 100)). The Departments' "fail[ure] to comply with [their] own regulations" was thus unlawful. *Nat'l Env't Dev. Assoc.'s Clean Air Project v. EPA*, 752 F.3d 999, 1009 (D.C. Cir. 2014) (cleaned up). And insofar as the Departments' fee increase was "based on"—or necessitated by—the erroneous guidance, that is yet another reason the fee increase "cannot stand." *See Transitional Hosps. Corp. of La. v. Shalala*, 222 F.3d 1019, 1024, 1029 (D.C. Cir. 2000) (agency must reconsider action based on "assumption [that] is incorrect").

The Departments also ignored obvious alternative measures that could significantly decrease the number of ineligible disputes submitted to IDR and, correspondingly, the need to expend resources on pre-eligibility review. A primary driver of the IDR backlog has been insurers' failure to disclose information providers need to assess eligibility. *See supra* at 10–11. Yet the Departments did not consider enforcing existing disclosure requirements or adding new ones—even though stakeholders notified them that doing so could substantially reduce the number of ineligible disputes. *See supra* at 11 (discussing comment requesting that insurers use remittance advice remark codes when providing required disclosures). By failing even "to consider those alternatives," the Departments ignored "another reasonable path forward." *Spirit Airlines*, 997 F.3d at 1255.

The Departments similarly neglected the possibility of apportioning the administrative fee in ways that could mitigate the access problem. Nothing in the NSA requires the administrative fee to be the same for both parties. So, for example, the Departments could have imposed an enhanced fee for insurers that fail to comply with their disclosure obligations. Because the Departments considered none of these "obvious and less drastic alternative[s]," their fee increase "was arbitrary and capricious." *Yakima Valley Cablevision*, 794 F.2d at 746.

Finally, to the extent the Departments try to defend their fee increase based on post-hoc rationales (*e.g.*, that batching of small-value claims could mitigate the impact of the fee increase),

such arguments are forfeited. The Departments' action must stand or fall on the reasoning—or, as here, the lack thereof—they advanced when taking it. *See Dish Network Corp.*, 953 F.3d at 379.

B. The same-service-code batching rule is arbitrary and capricious.

Even if the Departments had invoked batching, it would not matter because a crucial provision of the Departments' batching rule itself is unlawful. The rule narrowly permits batching only when the disputed items and services are "the same or similar items or services," *i.e.*, "if each is billed under the same service code." 45 C.F.R. § 149.510(c)(3)(i)(C). The Departments failed to give a reasoned explanation for this unreasonably restrictive batching rule.

Although the statute authorizes the Departments to permit broad batching of claims for *all* the treatments or procedures furnished to a single patient or to multiple patients with "similar condition[s]," 42 U.S.C. § 300gg-111(c)(3)(A)(iii), the Departments chose instead to strictly limit batching to claims involving the same exact service code. In doing so, they arbitrarily prohibited batching in many commonsense circumstances. For example, a single encounter between a single radiologist and a single patient can involve a half dozen or more items or services. *See supra* at 14. Yet, under the Departments' rule, each claim must be submitted and reviewed separately in IDR, likely by different arbitrators. Consider a patient who arrives at the emergency room after a serious car crash, who might receive CT scans of the chest, pelvis, and cervical spine, as well as multiple x-rays. Although each of these critical services was provided to the same patient on the same day in the same place, *each* CT scan and *each* x-ray must be submitted separately to IDR under the Departments' rule—with each claim now incurring a separate $350 administrative fee—because each involves a different service code.

The Departments ignored this obvious flaw. Indeed, they made essentially no effort to explain why their restrictive approach made sense or how it would work. Nor did they grapple with how it would adversely impact IDR access for providers who predominantly have small-value

claims that cannot be effectively batched under a same-service-code rule. *See supra* at 14–15. Agencies must "come to grips with the obvious ramifications of [their] approach and address them in a reasoned fashion." *NRDC, Inc. v. EPA*, 859 F.2d 156, 209–10 (D.C. Cir. 1988). The Departments' failure to do so here "renders [their] decision arbitrary and capricious." *Wages & White Lion Invs.*, 16 F.4th at 1138 (cleaned up); *see also Cigar Ass'n*, 964 F.3d at 62.

Further, just like in the December 2022 Fee Guidance, the Departments failed to consider "less drastic alternative[s] to" their same-service-code batching rule. *Yakima Valley Cablevision*, 794 F.2d at 746 & n.36. And there were obvious, sensible alternatives—including allowing batching by episode of care, by provider sub-specialty, and/or by service code sections (*e.g.*, CPT Codes 70000–79999—Radiology Procedures), rather than by individual service codes alone. Most puzzlingly, the Departments ignored the option to mirror the statutory text by permitting batching of all claims "related to the treatment of a similar condition," 42 U.S.C. § 300gg-111(c)(3)(A)(iii), despite essentially parroting the statute's other conditions for batching claims, *see supra* at 6–7.

In fact, the Departments never even mentioned the statutory language on which their same-service-code batching rule is premised, much less explained how their rule relates to the statutory condition. It is thus impossible to tell whether the Departments understood themselves to be interpreting the statutory text or exercising their discretion to adopt a more restrictive rule than the statutory text requires. That, in itself, renders their action arbitrary and capricious, for an agency's explanation must be sufficient to permit a reviewing court to "discern the agency's path." *Garner*, 767 F.2d at 123. Moreover, agency "discretion must be exercised through the eyes of [officials] who realize[they] posses[s] it." *Transitional Hosps.*, 222 F.3d at 1029. Reasoned decisionmaking therefore required the Departments at least to display *awareness* that they were exercising their discretion to impose a significantly more restrictive batching rule than the statute allows (to the

extent that was, in fact, what they were doing). *See, e.g.*, *PDK Labs. Inc. v. DEA*, 362 F.3d 786, 798 (D.C. Cir. 2004) (before exercising discretion agency "necessarily had to decide what [statute] meant"); *Univ. of Tex. M.D. Anderson Cancer Ctr. v. HHS*, 985 F.3d 472, 476 (5th Cir. 2021) (faulting agency that "steadfastly refused to interpret [its] statutes at all").

That is especially the case here, because the Departments' rule is not only narrower than it *could* be given the statutory text—it is "narrower than it *should* be given the purposes of the statutory scheme and congressional intent." *Teva Pharm., USA, Inc. v. FDA*, 182 F.3d 1003, 1011 (D.C. Cir. 1999). Congress explicitly instructed the Departments to adopt batching criteria that "encourag[e] the efficiency (including minimizing costs) of the IDR process." 42 U.S.C. § 300gg-111(c)(3)(A). Yet the Departments failed to explain how their restrictive same-service-code rule could achieve the efficiencies and cost-savings that Congress intended. The Departments' "failure to discuss how [their] rule squares with [the NSA's] objective is arbitrary and capricious." *City of New York v. FCC*, 814 F.3d 720, 728 (D.C. Cir. 1987).

The rationales the Departments did give for their batching rule are plainly inadequate. They claimed that allowing batching only by service code was "likely to reduce redundan[cy]" and "streamline the certified IDR entity's decision-making." 86 Fed. Reg. at 55,994. But the only basis they gave for this belief was that QPAs are service-code specific, *see id.*, and the Departments offered no legitimate reason for designing their batching criteria around the QPA.[13] The Departments also asserted without explanation that their batching criteria would "avoid combinations of

[13] The Departments apparently acted on the assumption that the QPA would anchor the arbitrator's decisionmaking pursuant to the "rebuttable presumption" adopted in the same rule. *See* 86 Fed. Reg. at 55,995–97 (requiring arbitrators to select the offer closest to the QPA unless "credible information … demonstrates that the QPA is materially different from the appropriate out-of-network rate"). *TMA I* vacated this presumption because the NSA prohibits the Departments from instructing arbitrators to elevate the QPA above the other factors. 587 F. Supp. 3d at 540.

unrelated claims … that could unnecessarily complicate an IDR payment determination and create inefficiencies." *Id.* at 55,994. And they guessed that their batching criteria *might* "reduce the per-service cost" of the IDR process by creating "at least some economies of scale," while essentially admitting that this was pure speculation, because (having failed to give notice or request comment) they did not know "how prevalent batching will be" or the "potential cost savings." *Id.* at 56,054. Agency "ipse dixit" and guesswork cannot substitute for reasoned explanation. *Music Choice v. Copyright Royalty Bd.*, 970 F.3d 418, 429 (D.C. Cir. 2020). Because that is all the Departments gave, the same-service-code rule must be set aside as arbitrary and capricious.

C. The challenged actions unreasonably block access to IDR.

Finally, the nonrefundable $350 administrative fee and the restrictive same-service-code batching rule are unlawful because they "do not reasonably effectuate Congress's intent." *Texas v. United States*, 497 F.3d 491, 506, 509 (5th Cir. 2007). The NSA's text, structure, history, and purpose make clear that Congress intended the IDR process to be meaningfully available to ensure fair reimbursement of covered claims. Although Congress considered imposing a dollar-value threshold to access IDR, it ultimately rejected such a requirement, choosing instead to make IDR broadly available to all covered claims, regardless of their dollar amount. *See supra* at 4.

Therefore, although the NSA authorizes the Departments to set the administrative fee in an amount sufficient to cover their costs of carrying out the IDR process, 42 U.S.C. § 300gg-111(c)(8)(B), and to "specify criteria" for batching, *id.* § 300gg-111(c)(3)(A), the Departments plainly must exercise their authority under these provisions in such a way that IDR does not become cost-prohibitive for significant numbers of claims, let alone for entire provider specialties.

Because the challenged actions do just that, they do not reasonably or permissibly implement the NSA and are "not in accordance with law." 5 U.S.C. § 706(2)(A); *see Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 321 (2014) (invalidating rules that produced results that "would be

inconsistent with—in fact, would overthrow—the Act's structure and design"); *Chamber of Commerce v. Dep't of Lab.*, 885 F.3d 360, 385 (5th Cir. 2018) (finding rule "unreasonable" because it "outflank[ed]" congressional efforts to regulate in a different manner).

III. The Court Should Vacate The Challenged Actions, Order The Departments To Refund Unlawfully Exacted Administrative Fees, And Extend IDR Deadlines.

"[V]acatur of an agency action is the default rule in this Circuit." *Cargill v. Garland*, 57 F.4th 447, 472 (5th Cir. 2023) (en banc). This case is no exception. The "seriousness of the deficiency weighs heavily in favor of vacatur," and it is unlikely that the Departments will be able to "rehabilitate or justify" the challenged actions on remand. *TMA I*, 587 F. Supp. 3d at 548.

In addition, this Court should order the Departments to refund the administrative fees that were unlawfully exacted pursuant to the December 2022 Fee Guidance. *See, e.g.*, *Texas v. United States*, 336 F. Supp. 3d 664, 675 (N.D. Tex. 2018) (exercising equitable discretion under the APA to order disgorgement of unlawfully imposed fees), *rev'd on other grounds*, *State v. Rettig*, 987 F.3d 518 (5th Cir. 2021); *Am.'s Cmty. Bankers v. FDIC*, 200 F.3d 822, 830 (D.C. Cir. 2000) (same); *Steele v. United States*, 200 F. Supp. 3d 217, 224 (D.D.C. 2016) (same).

Finally, to create an effective remedy for providers who forwent submitting claims to IDR because of the challenged actions, the Court should extend (or order the Departments to extend) IDR deadlines to allow those claims to be submitted now. *See* 42 U.S.C. § 300gg-111(c)(1)(A)–(B); *id.* § 300gg-111(c)(9); *Gomez v. Trump*, 490 F. Supp. 3d 276, 286–87 (D.D.C. 2020).

CONCLUSION

For these reasons, the Court should vacate the challenged actions, order a refund of administrative fees, and extend IDR deadlines, as set forth in the attached proposed order.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing document has been served on all counsel of record in accordance with the Federal Rules of Civil Procedure and this Court's CM/ECF filing system on February 13, 2023.

/s/ *Eric D. McArthur*
Eric D. McArthur

Exhibit A

DocuSign Envelope ID: 43DE0890-1843-4066-A2D7-284CAC4527E5

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, DR. ADAM CORLEY, TYLER REGIONAL HOSPITAL, LLC, TEXAS RADIOLOGICAL SOCIETY, and HOUSTON RADIOLOGY ASSOCIATED, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF PERSONNEL MANAGEMENT, DEPARTMENT OF LABOR, DEPARTMENT OF THE TREASURY, CENTER FOR MEDICARE & MEDICAID SERVICES, XAVIER BECERRA *in his official capacity as the Secretary of Health and Human Services*; KIRAN AHUJA *in her official capacity as the Director of the Office of Personnel Management*, JANET YELLEN *in her official capacity as the Secretary of the Treasury*, MARTIN J. WALSH *in his official capacity as the Secretary of Labor*, and CHIQUITA BROOKS-LASURE *in her official capacity as Administrator of the Center for Medicare & Medicaid Services*, *Defendants*.	Civil Action No. 6:23-cv-00059-JDK

DECLARATION OF HOUSTON RADIOLOGY ASSOCIATED

I, Joseph Seale, solemnly declare under penalty of perjury and to the best of my knowledge, information, and belief as follows:

1. I am the practice administrator for Houston Radiology Associated ("HRA"). My responsibilities include oversight of the billing process and of the NSA arbitration process.

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2. This declaration is based on my personal knowledge and is made with the authority of HRA.

3. HRA is a radiology group practice representing more than 80 radiologists in 17 locations throughout the Houston metropolitan area. HRA is Houston's oldest established radiology group practice and has its headquarters and principal place of business in Houston, Texas.

4. HRA physicians practice in numerous radiology subspecialties, including musculoskeletal, general/body interventional, cardiovascular interventional, neurovascular interventional, and nuclear medicine radiology. HRA physicians provide in-network medical care to thousands of patients each year across all of its subspecialities.

5. Some of HRA's physicians are also members of the Texas Radiological Society.

6. HRA physicians provide out-of-network services that are covered by the No Surprises Act's ("NSA") balance billing prohibition and the independent dispute resolution ("IDR") process for determining reimbursement rates for certain out-of-network services. HRA utilizes the IDR process to obtain reimbursements for the radiology services that HRA radiologists furnish on an out-of-network basis.

7. HRA radiologists provide numerous services for out-of-network patients. Services like Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Ultrasound (US), X-Ray Radiography, Fluoroscopy, Nuclear Medicine, and Positron Emission Tomography (PET).

8. On average, HRA radiologists perform almost 5,000 procedures per weekday for just over 4,151 unique patients, using an average of 270 unique CPT codes per day to bill third-party insurers. Indeed, during a single patient encounter, a radiologist will often furnish multiple

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services that are all related to the treatment of the patient's condition but involve multiple CPT codes.

9. In 2022, on an individual CPT code basis, more than 99% of CPT codes HRA billed to two major out-of-network insurers for NSA eligible claims for radiology services had an allowed amount of less than $350.

10. HRA would like to batch as many claims as possible as part of its submissions to the IDR process, in order to minimize the non-refundable administrative fees it must pay to the government. However, the Departments' current batching rules make it very challenging to meaningfully batch claims. For example, for a representative 30-day service period in 2022, HRA estimates that it could not batch 97% of the claims HRA submitted to IDR. Even with a $50 administrative fee applicable to IDR claims submitted during calendar year 2022, it was not economically viable under the Department's batching rules to utilize the IDR process for 30% of the radiology services that HRA radiologists furnished.

11. However, due to the 600% increase in the IDR administrative fee on top of the Departments' batching rules, HRA radiologists have been effectively locked out of IDR. The $350 fee now exceeds the amount in controversy—*i.e.*, the difference between the reimbursement rate HRA seeks and the reimbursement rate offered by the payor as an initial payment and through open negotiation—for the vast majority of HRA's radiology claims, even when batched to the maximum extent permitted by the Departments' rules. In light of the $350 administrative fee, it is financially infeasible for HRA radiologists to pursue the IDR process for an estimated 97% of their claims, because the total amount in controversy (across a single claim or a batch of claims, as applicable) is less than $350.

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12. Even complicated radiology services with a relatively high reimbursement rate, as compared to most other radiology services, are generally not economically viable to submit to IDR. For example, when an HRA radiologist furnishes an abdominal and pelvic CT without contrast material to a patient, HRA bills an insurer for that service using CPT code 74176. The FAIR Health 80th percentile allowed amount for CPT code 74176 is $242.29 and a typical qualifying payment amount ("QPA") for this CPT code is $90.66. Assuming the insurer only offers to pay its QPA, the amount in controversy for each claim billed under CPT code 74176 is $151.63. Due to the Departments' current batching rules, however, in a typical 30-day period, 88% of the claims for CPT code 74176 cannot be batched together. As a result, HRA would have to submit almost all claims for CPT code 74176 to the IDR process *individually* if it sought to challenge the reimbursement rate of only the QPA. In light of the $350 fee, it is economically irrational for HRA to submit those claims to the IDR process, as paying for the fee itself far outweighs any possible "recovery" of $151.63 per claim.

13. Moreover, HRA's losses are compounded by the internal costs of participating in the IDR process. At HRA's current rate of participating in the NSA's IDR process, HRA estimates between $140,000–$234,000 in additional costs per year, and a pro rata share of these costs must be included in the estimated costs for participating in the IDR process.

14. Between November 2022 and January 2023, HRA has modified its monthly claim batch submission in the IDR process. Those modifications include not entering the IDR process for any claim or batch that is not economically feasible to pursue. The percentage of our claims or batches that are not economically feasible to pursue through IDR has significantly increased following the imposition of the $350 administrative fee.

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15. As this Court recently concluded, the Departments have consistently advanced a "goal of privileging the QPA [in IDR], tilting arbitrations in favor of insurers, and thereby lowering payments to providers." *Texas Med'l Ass'n v. HHS*, No. 22-cv-372 (E.D. Tex.), slip op. at 28. The skewed manner in which the Departments have implemented the IDR process has increased insurance company leverage. Knowing the challenges of utilizing, in an economically viable manner, the NSA's statutory process for obtaining reasonable reimbursement, it is cheaper for an insurance company to push HRA out of network than to contract with HRA. Between 2020 and 2022, HRA has experienced terminated payor contracts that are attributable to insurers' new leverage under the NSA. For example, in March and May of 2021, two major carriers unilaterally reduced HRA's in-network reimbursement by almost 60%. Despite HRA's attempt to negotiate, the carriers did not materially alter their offers, and HRA was forced out-of-network because it could not accept nearly 60% rate cuts.

Pursuant to the requirements of 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on: 2/13/2023

DocuSigned by:
Joseph Seale
32820014D4E1478

Joseph Seale
Houston Radiology Associated

Exhibit B

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, DR. ADAM CORLEY, TYLER REGIONAL HOSPITAL, LLC, TEXAS RADIOLOGICAL SOCIETY, and HOUSTON RADIOLOGY ASSOCIATED, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF PERSONNEL MANAGEMENT, DEPARTMENT OF LABOR, DEPARTMENT OF THE TREASURY, CENTER FOR MEDICARE & MEDICAID SERVICES, XAVIER BECERRA *in his official capacity as the Secretary of Health and Human Services*; KIRAN AHUJA *in her official capacity as the Director of the Office of Personnel Management*, JANET YELLEN *in her official capacity as the Secretary of the Treasury*, MARTIN J. WALSH *in his official capacity as the Secretary of Labor*, and CHIQUITA BROOKS-LASURE *in her official capacity as Administrator of the Center for Medicare & Medicaid Services*, *Defendants*.	Civil Action No. 6:23-cv-00059-JDK

DECLARATION OF WAYNE KOCH

I, Wayne Koch, solemnly declare under penalty of perjury and to the best of my knowledge, information, and belief as follows:

1. I am over 18 years of age and with capacity, and I provide this declaration based on my personal knowledge.

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2. I work at Technology Partners, LLC d/b/a ImagineSoftware ("ImagineSoftware"), and Phicure Next, LLC ("Phicure Next") as an Executive. My role includes management of a team of personnel that supports the claim and payment data of our clients, and the reporting and analysis of that data.

3. ImagineSoftware has more than 20 years of experience of providing software as a service for the healthcare industry. Among its professional capabilities, ImagineSoftware has created tools that can pull, compile, and analyze high-volume data sets of complex medical billing information across multiple specialties—including radiology, anesthesiology, pathology, urgent care, and emergency medicine. ImagineSoftware acquires this data through, among other methods, its customers' use of its clearinghouse subsidiary, Phicure Next. The ImagineSoftware process is consistent with 45 C.F.R §164.514 and we only aggregate such data with the customers' explicit written permission in a Business Associate Agreement regarding the handling of patient protected health information under HIPAA.

4. ImagineSoftware has been asked to analyze data on reimbursement rates for out-of-network radiology services made by commercial payers for the years 2021 and 2022 for 119 Texas radiology providers, to whom we provide services and can make such information available.

5. To identify the relevant set of data, ImagineSoftware relied in part on Current Procedural Terminology codes, commonly known as "CPT codes." CPT codes assign a unique five-digit code to each healthcare service provided. Both public and private insurers use CPT codes to identify the provided healthcare services and to make coverage and reimbursement decisions for each service.

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6. When providers use CPT codes to bill insurers for medical services, CPT codes can be associated with the following non-exclusive list of attributes: date of service, location of service, associated patient encounter, providing physician, provider facility, in-network or out-of-network service, provider's requested dollar amount, insurer's paid dollar amount, allowed amount,[1] and frequency of use. To identify the relevant data set for radiology services furnished on an out-of-network basis in Texas during calendar years 2021 and 2022, ImagineSoftware filtered the data based on these attributes as necessary.

7. ImagineSoftware reached the following conclusions regarding out-of-network radiology claims in Texas for the 119 providers:

8. In 2021, on an individual CPT code basis, more than 98% of CPT codes billed to out-of-network insurers for radiology services had an allowed amount of less than $350, across all commercial payers.

9. In 2022, on an individual CPT code basis, more than 99% of CPT codes billed to out-of-network insurers for radiology services had an allowed amount of less than $350, across all commercial payers.

10. In 2022, on an individual CPT code basis, more than 97% of CPT codes billed to out-of-network insurers for radiology services had an allowed amount of less than $200, across all commercial payers.

11. In 2021, the average allowed amount for five of the top six most prevalent out-of-network radiology CPT codes (codes 71045, 77067, 71046, 70450, and 77063) decreased, in an amount between 15.69% and 57.15%.

[1] An "allowed amount" is the amount an insurer voluntarily pays for an out-of-network service.

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12. In 2021, only one of the top six most prevalent out-of-network radiology CPT codes increased in average allowed amount (code 74177). That code increased by 1.93%.

13. In 2021, the average allowed amount for the most prevalent out-of-network radiology CPT code (code 71045) decreased by 36.11%.

14. In 2021, the average allowed amount for the second most prevalent out-of-network radiology CPT code (code 77067) decreased by 57.15%.

Pursuant to the requirements of 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on: 2/13/2023

DocuSigned by:
Wayne Koch
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Wayne Koch
On Behalf of ImagineSoftware

Exhibit C

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, DR. ADAM CORLEY, TYLER REGIONAL HOSPITAL, LLC, TEXAS RADIOLOGICAL SOCIETY, and HOUSTON RADIOLOGY ASSOCIATED, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF PERSONNEL MANAGEMENT, DEPARTMENT OF LABOR, DEPARTMENT OF THE TREASURY, CENTER FOR MEDICARE & MEDICAID SERVICES, XAVIER BECERRA *in his official capacity as the Secretary of Health and Human Services*; KIRAN AHUJA *in her official capacity as the Director of the Office of Personnel Management*, JANET YELLEN *in her official capacity as the Secretary of the Treasury*, MARTIN J. WALSH *in his official capacity as the Secretary of Labor*, and CHIQUITA BROOKS-LASURE *in her official capacity as Administrator of the Center for Medicare & Medicaid Services*, *Defendants*.	Civil Action No. 6:23-cv-00059-JDK

DECLARATION OF DR. STEVEN FORD

I, Dr. Steven Ford, solemnly declare under penalty of perjury and to the best of my knowledge, information, and belief as follows:

1. I am over 18 years of age and with capacity, and I provide this declaration based on my personal knowledge.

2. I am a neuro-anesthesiologist, a resident of Dallas, Texas, and a member of the Texas Medical Association (TMA). As a neuro-anesthesiologist, I perform the anesthesia for

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operations on the brain and spine, while a neurosurgeon performs the surgery. The anesthesia for neurosurgical operation, whether brain or spine, commonly require special anesthesia techniques to facilitate intraoperative neuro-monitoring, which is totally unique to these types of operations and often requires invasive monitoring to maintain hemodynamic stability and manage blood loss. None of these caregiving services are ever provided as telemedicine or from a laptop home; they all require in-person, intensive one-on-one interactions between the neuro-anesthesiologist and patient, which begins at the time the patient leaves the preoperative area, continues through the completion of the operation, and remains ongoing while the patient is transferred to a post-anesthesia care unit or intensive care unit after the operation.

3. I work at Optima Anesthesia PLLC, a small practice of four physicians that provide M.D.-only anesthesia services. All physicians are board certified, two of the physicians have had additional formal fellowship training, and I have additional board certification in critical care medicine. Two of us, including myself, were on faculty at large medical schools in the U.S. in the past at the Assistant Professor or Associate Professor level. I received my anesthesia and critical care training from Stanford University.

4. I am one of three owners of this small medical practice. After all expenses are paid—including but not limited to credentialing expenses, scheduling expenses, revenue cycle management expenses, malpractice premiums, cross coverage expenses, profit sharing expenses, legal expenses, banking fees, accounting expenses, hospital privilege expenses, state franchise taxes, arbitration fees, and mediation fees—the remaining revenue is distributed to the three separate professional associations of the three owners. Each professional association has many additional expenses including but not limited to continuing medical education expenses, health

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insurance premium expenses, transportation expenses, legal expenses, banking expenses, accounting expenses, and retirement plan expenses.

5. All of the caregiving that I and other physicians furnish through Optima Anesthesia PLLC, if provided out-of-network, is subject to the No Surprises Act's ("NSA") balance billing prohibition for patients with health insurance covered through an ERISA plan. Out-of-network non-ERISA patients are generally subject to SB 1264, which is the State of Texas' version of the NSA and is implemented by the Texas Department of Insurance. Some of the out-of-network services I provide qualify as "emergency services" covered under the NSA. Other out-of-network services I provide are non-emergency medical services in which I am out-of-network, but the facility in which I am providing the services is in-network for my patient. Under the NSA, patients cannot consent to being balanced billed for either emergency services or "ancillary services" such as the anesthesiology services I furnish.

6. Since January 1, 2022, I have furnished anesthesia services for patients who were out-of-network and covered by ERISA plans, and my out-of-network reimbursement rate for those caregiving services was subject to the NSA's IDR process.

7. Although my medical practice attempts to engage in open negotiation with these patients' out-of-network insurers for a reasonable out-of-network reimbursement rate, the insurance plans refuse to negotiate in any way during the 30 business day mandated open negotiation period. This further delays appropriate out-of-network reasonable payment for patient care and further enriches the insurance plan by postponing reasonable payment. This forces Optima Anesthesia PLLC to pursue arbitration to maintain practice solvency to provide patient care and access. In these circumstances, I work with Optima Anesthesia PLLC's Revenue Cycle Management, the other physicians in our practice, and our practice management staff to

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submit claims to the NSA's IDR process. A certified IDR entity then determines the reimbursement rate that Optima Anesthesia PLLC receives, according to processes set forth in the NSA and the Departments' regulations.

8. I would like to batch as many claims as possible as part of the submissions to the IDR process for my anesthesia services, in order to minimize the non-refundable administrative fees owed to the government. However, under the Departments' current batching rules, 100% of claims submitted to IDR for services I furnished were not allowed to be batched by the Departments.

9. Due to the 600% increase in the IDR administrative fee on top of the Departments' batching rules, Optima Anesthesia PLLC cannot fairly utilize the IDR process. For many claims that we could submit into IDR for our anesthesia services, the $350 fee now exceeds the amount in controversy—*i.e.*, the difference between the reimbursement rate we seek and the reimbursement rate offered by the payor as an initial payment. For example, if I was willing to accept $850 for anesthesia services for procedures on the thorax, CPT code 00400, and the insurer only offers to pay $550, then it is economically irrational for me to proceed to the IDR process to attempt to obtain the difference of $300. With the $350 fee, even if I won the IDR proceeding, I would "recover" a net loss of $50—and way more loss once the internal costs of preparing an IDR submission are considered. This preparation takes at least an hour of uncompensated physician time per claim submitted to IDR, to prepare an appropriate offer with supporting documents. In addition, I must post the certified IDR entity's fee at the time I submit a bid to IDR, which can be up to $700 for a single determination and $938 per batched determination. I will lose this amount if my bid is not selected, and I have to take this into account when submitting a bid. I fear that after the Departments have been very clear that they

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expect the IDR entities they certify to pick the bid closest to the QPA, the deck is stacked against me. In light of having to post the certified IDR entity's fee to an escrow account when I submit my bid, my small business independent medical practice is in the red for hundreds of dollars for a single claim until a determination is made.

10. Unfortunately, the Departments and IDR entities have rampantly ignored statutory deadlines since belatedly initiating the IDR process in April 2022. On average, I have waited nine months between a date of service and receiving a decision from an IDR entity. Even after I win a payment determination in the IDR process, I suffer financially, because IDR entities do not always refund the certified IDR entity I posted to escrow, and insurers do not always pay me after I prevail. To my knowledge the Departments have never initiated an enforcement action against an insurer for failing to timely remit payment after losing during the IDR process. I do not expect to remain solvent and execute this process in the long-term.

11. Solely taking the $350 administrative fee into account, it is financially infeasible to pursue the IDR process for 30% of the claims for services I furnish, because the amount in controversy is less than $350. Once I account for my other costs, it is financially infeasible to submit 50% of my out-of-network claims subject to the NSA to the IDR process. I expend at least an hour of my time, all uncompensated, to prepare and process each claim submitted to IDR, and I rely on the assistance of others to engage in the administrative work necessary to prepare claims.

12. The financial challenges imposed by the $350 administrative fee and "same service code" and other batching rules compound the challenges we have already faced with an IDR process that has been poorly implemented by the federal government, to the detriment of providers seeking relief through this process.

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13. Optima Anesthesia PLLC has not been able to receive timely, consistent payment through the IDR process, and as a result, I have not been able to receive timely, consistent payment for services furnished through Optima Anesthesia PLLC. As of February 7, 2023, more than 80% of the claims Optima Anesthesia PLLC submitted to IDR remain pending before arbitrators in violation of the NSA's requirement that arbitrators reach a payment decision no later than 30 days after the date on which the arbitrator is selected to preside over a payment dispute. The total amount we are seeking through these claims is $174,841.96. This amount does not include the value of claims that I would have submitted to IDR, but for the fact that it was not financially viable to do so.

14. Making matters worse, even when an arbitrator concludes that the insurer loses, insurers do not always timely remit payment, even though the NSA sets a specific statutory deadline that the non-prevailing party in IDR must meet, which is 30 calendar days to remit payment. After 13 months, 100% of the time Optima Anesthesia PLLC wins a claim in IDR, the insurer pays us late, and 45% of the time the insurer does not pay us at all. I am not aware of the Departments ever initiating any enforcement actions in response to these statutory violations.

15. The broken IDR process has increased insurance company leverage. Knowing that we struggled to utilize the NSA's statutory process for obtaining reasonable reimbursement, it is cheaper for an insurance company to have Optima Anesthesia PLLC out of network than to contract with us. From September 2022 through the end of January 2023, our revenue has plummeted 36%, despite unusually high inflation, compared to the same period a year earlier.

16. Optima Anesthesia PLLC has attempted in good faith to negotiate in-network agreements with major insurance plans. We have proposed written good faith offers based on verifiable FAIR Health median in-network amounts for our market combined with the amounts

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of our determinations under the Texas No Surprises Act, SB1264, implemented by the Texas Department of Insurance ("TDI"). We win over 90% of formal arbitrations under SB1264 that go through the TDI portal and are consistently paid in a timely manner for those wins. Optima Anesthesia PLLC has received offers for contracted rates less than 40% of our proposed rates or else no response at all to our offers. The reimbursement rates proposed by the insurance plans will not maintain practice solvency.

Pursuant to the requirements of 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on: 2/13/2023

DocuSigned by:
Steve Ford
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Dr. Steven Ford

Exhibit D

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	Case No.: 6:23-cv-00059-JDK

[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Before the Court is plaintiffs' motion for summary judgment. Being fully advised in the premises, the Court finds that the motion should be **GRANTED**.

It is therefore **ORDERED** that the motion is hereby **GRANTED** and the following provisions are hereby **VACATED**:

a. The December 2022 Fee Guidance's $350 administrative fee;

b. 45 C.F.R. § 149.510(d)(2)(ii); 26 C.F.R. § 54.9816-8T(d)(2)(ii); 29 C.F.R. § 2590.716-8(d)(2)(ii); and

c. 45 C.F.R. § 149.510(c)(3)(i)(C); 26 C.F.R. § 54.9816-8T(c)(3)(i)(C); 29 C.F.R. § 2590.716-8(c)(3)(i)(C).

It is further **ORDERED** that defendants must refund to plaintiffs and their members the administrative fees they paid pursuant to the December 2022 Fee Guidance.

And it is further **ORDERED** that the IDR deadlines specified in 42 U.S.C. § 300gg-111(c)(1)(A)–(B) are hereby extended, with a new 30-day period for open negotiations beginning on the day of this order, to allow plaintiffs and their members to submit claims that would have been submitted on or after January 1, 2023, but for the requirement to pay a $350 administrative fee pursuant to the December 2022 Fee Guidance.

SO ORDERED.