



December 21, 2023

CMS-9897-P

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

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

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

RE: Federal Independent Dispute Resolution Operations Proposed Rule

Dear Secretaries Becerra and Yellen and Acting Secretary Su:

On behalf of the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA), we appreciate the opportunity to comment on the Departments of Health and Human Services, Labor, and Treasury (the Departments) proposed rule¹ that proposes reforms to the *No Surprises Act*'s federal dispute resolution process.

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation's only professional trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, billing, coding, and other professional support organizations that assist healthcare clinicians in our nation's emergency departments. Together, EDPMA members see or support 60% of all annual emergency department visits in the country. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings, in all fifty states and the District of Columbia.

ACEP and EDPMA have strongly supported the patient protections embedded within the *No Surprises Act* and have strived to ensure that patients are kept out of the middle of billing disputes. In order to achieve this goal, it is essential to have an effective and efficient Federal dispute resolution process for resolving payment disputes

¹ Federal Independent Dispute Resolution Operations Proposed Rule. 88 Fed. Reg. 75744 (November 3, 2023).

for certain out-of-network services.

Overall, we appreciate the Departments' proposals as policies included in the rule would encourage negotiations prior to the start of the independent dispute resolution (IDR) process, reduce the number of initiated disputes later determined to be ineligible, help speed up payment determinations by certified IDR entities (IDREs), and, with proper enforcement, hold the potential to reduce reliance on initiation of IDR overall. However, to make sure that these policies carry out their intended purposes, **we strongly urge the Departments to take the necessary steps to enforce compliance** with the eventual finalized policies.

Our comments will focus on the following domains:

- Improved Communication Throughout the IDR Process
- Timing of Initial Payment/Denial of Payment
- Open Negotiation Process
- IDR Initiation Process
- Selection of IDRE
- Batching Provisions
- Federal IDR Eligibility Determinations
- Administrative Fees
- Extenuating Circumstances
- IDR Registry
- Enforcement
- Effective Dates

Improved Communication Throughout the IDR Process

Based on input from stakeholders, including ACEP and EDPMA, the Departments identify several areas of confusion reported by disputing parties (providers and health plans) and certified IDREs: (1) whether the consumer protections against balance billing and out-of-network cost sharing under the *No Surprises Act* apply to an item or service; (2) how cost-sharing and the out-of-network rates are determined (that is, through an All-Payer Model Agreement, specified State law, or the Federal rules); (3) how and with whom to initiate Open Negotiation; and (4) which items or services eligible for the Federal IDR process can be batched into a single dispute.

To address these issues, the Departments propose new disclosure requirements that group health plans and health insurance issuers offering group or individual health insurance coverage must include along with the initial payment or notice of denial of payment for services subject to the protections in the *No Surprises Act*, including the business name of the plan, the business name of plan sponsor (if applicable), and the registration identification number that is assigned to the health plan when it registers in the IDR Registry (described below). The proposed rule would also require plans and issuers to communicate information by using claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), as specified in guidance, when providing any paper or electronic remittance advice to an entity that does not have a contractual relationship with the plan or issuer.

RARCs/CARCs

ACEP and EDPMA have previously advocated for the Departments to require health plan use of RARCs and CARCs when providing the initial payment or notice of denial in order to clarify State or Federal eligibility for out-of-network dispute resolution, as well as reduce confusion and unnecessary administrative transactions and delays. We also believe that ensuring the use of the RARCs and CARCs for all claims will give providers the necessary information to assess patient responsibility amounts, keep patients out of the middle of the process, and reduce the need to initiate payment disputes for services furnished out-of-network. Thus, **ACEP and EDPMA strongly support the Departments' proposal to require the use of RARCs/CARCs and urge the**

Departments to finalize this provision as proposed. In addition, we believe that the additional disclosure requirements will be important to distinguish between plans, particularly self-insured plans. Knowing the business name of the plan sponsor, for example, may help providers know who the employer is when trying to batch among self-insured plans. We have previously commented that it is extremely difficult to appropriately batch when self-insured plans are involved because knowing if it is a self-insured plan requires providers to rely on information they simply do not have: the name of the patient’s employer. While we would prefer a broader batching policy for self-insured plans (discussed more in detail later in this letter), we nevertheless appreciate that the Departments would be requiring health plans to provide this additional information to providers.

We appreciate that the Departments have referenced the separate process for setting the specifications for the CARC/RARC codes that will be used to meet these requirements. However, ACEP and EDPMA request that health plans be mandated to use the fields in the 835 remittance advice (RA) that designate and/or describe if the claim is in-network or out-of-network, in addition to the mandates described below on the use of the CARC and RARC codes.

Further, when the Departments issue subregulatory guidance on the codes, they should require health plans to use one of two of the following mutually exclusive RARC codes, which we believe will result in a reduction in the number of ineligible IDR claims—particularly in the top three states where disputes originate: Texas, Florida, and Georgia (each of these states have Specified State Laws):

- *N871 Alert: This initial payment was calculated based on a state specified law, in accordance with the No Surprises Act; or*
- *N859 Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es).*

The use of both N871 and N859 together on a claim renders their use moot and should be prohibited, and the group health plans and issuers should be prohibited from using either RARC code for in-network services. The use of the N830 code should also be prohibited as it lacks clarity on whether State or Federal surprise billing laws would apply. The “Federal/State” is used in the disjunctive, so it lacks the specificity of exclusively state (N871) or federal (N859) as noted above. **ACEP and EDPMA also recommend that CMS request that the X12 committee eliminate the “N830” code² to avoid even the accidental use of the code.**

Enhanced QPA Disclosure Requirement

For items and services covered by the *No Surprises Act*, the statute currently requires that patient cost-sharing is based on the lower of (a) the qualifying payment amount (QPA) or (b) the amount billed by the provider, facility, or provider of air ambulance services. The Departments currently require plans and issuers to disclose the QPA and certain information about the QPA when cost-sharing is calculated using the QPA. In this proposed rule, the Departments propose that plans and issuers must also provide the QPA in instances in which patient cost-sharing is based on the amount billed by the provider, facility, or provider of air ambulance services, and not only when the recognized amount is the QPA. **Because the QPA is a critical piece of information for Open Negotiation and for decisions related to IDR initiation, ACEP and EDPMA support the Departments’ proposal to require QPA disclosure obligations for all items and services covered by the *No Surprises Act*, even where the QPA is not the basis of patient cost-sharing.**

² *N830 Alert: The charge[s] for this service was processed in accordance with Federal/ State, Balance Billing/ No Surprise Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es).”*

We have previously commented that in some cases, the QPA for the item or service billed is not being clearly identified, and a certifying statement that affirms that the QPA was calculated properly and that it serves as the recognized amount for the purposes of calculating patient cost-sharing is missing, which makes it difficult for providers and eventually for certified IDR entities to determine whether a claim is eligible for the Federal IDR process. Even if health plans were fully compliant with the QPA disclosure requirements, the absence of the QPA with an initial payment (or denial of payment) on a claim where the lower amount billed by the provider services as the basis of the patient cost-sharing on claims subject to the *No Surprises Act* could lead a recipient to believe that the claim is not subject to the *Act*. Therefore, **ACEP and EDPMA support the Departments’ proposal to require disclosure of the QPA (and accompanying initial payment/denial of payment disclosure requirements) for all items and services subject to the *No Surprises Act* regardless of the basis of patient cost-sharing.** To augment these proposals and to ensure that the Departments goals are achieved, **ACEP and EDPMA also recommend that the Departments request a modification to the standard 835 remittance form so that all the information, including the QPA, is disclosed uniformly.**

In addition to the enhanced disclosure of the QPA (and related QPA disclosures), the Departments also propose that plans/issuers disclose the the legal business name of the plan/issuer, the legal business name of the plan sponsor (if applicable), and the Federal IDR registration number. **ACEP and EDPMA support the provision of this identifying information with the initial payment or notice of denial of payment because disclosure of such information will help facilitate Open Negotiation and provide information critical to initiation of the IDR process.**

Patient ID Cards

We thank the Departments for seeking comment on “whether ID cards should display the plan or coverage type (such as, self-insured or fully-insured ERISA plan, non-Federal governmental plan, church plan, FEHB plan, or individual health insurance coverage), as well as whether a symbol or code could be included on cards that would indicate the applicable regulatory authority of the plan or coverage (that is, State or Federal entity, or both).”³ **ACEP and EDPMA support the concept of requiring this information to be included on the patient’s ID cards.** At a minimum, the Departments should require insurance cards to clearly identify whether the plan is covered by State or Federal balance and surprise billing protections.

Timing of Initial Payment/Denial of Payment

The *No Surprises Act* requires that plans/issuers “not later than **30 calendar days after the bill for such services is transmitted by such provider or facility**, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment” (emphasis added). The Departments had previously interpreted this timing of initial payment/denial relative to the submission of a “clean claim.”⁴ ACEP and EDPMA have been concerned by the departure from the statutory language (i.e. “after the bill for such services was transmitted”) and, that without a clear definition of “clean claim,” health plans or issuers will be able to pend accurate claims without good reason, forcing patients to remain “in the middle” of a time-consuming dispute. Due to these concerns and out of deference to the text of the *No Surprises Act*, **ACEP and EDPMA are extremely pleased to see the Departmental language revert to the language of the statute in describing the IDR process as it will work if these rules are finalized:**

Within 30 calendar days after the bill for the services is transmitted: The plan or issuer determines whether the services are covered, and if the services are covered, sends to the provider, facility, or provider

³ 88 FR 75805 (November 3, 2023).

⁴ See [Federal IDR Process Guidance for Disputing Parties \(March 2023\)](#).

of air ambulance services an initial payment or notice of denial of payment no later than 30 calendar days after a bill is transmitted.⁵

Open Negotiation Process

The Departments propose amendments to streamline the efficiency and effectiveness of the Open Negotiation process, including:

- An Open Negotiation period must be initiated within 30 business days beginning on the day the provider receives either an initial payment or a notice of denial of payment for the item or service from the plan or issuer.
- To initiate the Open Negotiation period, a party must submit a written Open Negotiation notice and supporting documentation to the other party and to the Departments via the Federal IDR portal.
- The party in receipt of the Notice of Open Negotiation must provide to the other party and to the Departments a written notice and supporting documentation in response to the Open Negotiation notice as soon as practicable, but no later than the 15th business day of the 30-business-day Open Negotiation period (Open Negotiation Response Notice).

Integrating Open Negotiation into IDR Portal

ACEP and EDPMA have previously commented on the lack of plan/issuer participation in the Open Negotiation process, with our physician groups reporting that health plans are sometimes not acknowledging receipt of the Notice of Open Negotiation and/or are not actively engaging in negotiations at any point during the 30-business-day period, which runs counter to the overall intent of the *No Surprises Act* to use the IDR process as a last resort. We have previously suggested that the Departments establish incentives to engage in the Open Negotiation process to improve the likelihood of settlement, and in turn, hopefully reduce reliance on IDR. We also previously recommended that the Open Negotiation process be integrated into the IDR portal. Thus, ACEP and EDPMA appreciate that the Departments incorporated our feedback, and **we are supportive of the Departments' proposals to enhance the content of the Notice of Open Negotiation and to require use of the Federal IDR portal for providing Notice of Open Negotiation.** Under the current email-based initiation process, our members have reported challenges managing and tracking a high volume of email traffic. Requiring the Open Negotiation process to be initiated via the portal will significantly reduce administrative burden and confusion for all parties involved.

ACEP and EDPMA support fully integrating the proposed rule's IDR Registry requirements into the Open Negotiation (and IDR) initiation processes. Portal-based functionality that identifies non-initiating parties by their Plan IDR registration number at the time of Open Negotiation (and IDR) initiation should significantly diminish eligibility errors, such as batching disputes associated with different self-funded plans or submitting items and services eligible for State-based resolution programs to the federal system.

Data Elements for Open Negotiation Initiation and Response

The Departments solicited comments regarding the appropriateness of the additional proposed data elements to be furnished during Open Negotiation initiation and response. ACEP and EDPMA support the inclusion of most new elements and appreciate the Departments' consideration of which party is most likely to possess each element when assigning the responsibility to provide it. **However, ACEP and EDPMA are opposed to the element that would require initiating parties to provide a rationale for the initiation. The rationale is clear in all instances: the provider believes that the health plan has underpaid for the service that was furnished to the health plan's enrollee.** According to EDPMA members, the majority of initiations are the result of clear underpayment for services, representing a departure from acceptable market rates of reimbursement. This is borne

⁵ "Table 1: The Federal IDR Process Under These Proposed Rules," Federal Independent Dispute Resolution Operations Proposed Rule. 88 Fed. Reg. 75744 (November 3, 2023).

out by the 77% IDR success rate of initiating parties that was [recently reported](#) by the Government Accountability Office (GAO).

ACEP and EDPMA also suggest requiring insurers to additionally include which methodology was used to calculate the QPA and which year's inflationary update has been applied to the QPA calculation, particularly since health plans are almost always non-compliant with the requirement to supply this information upon request from providers.

Open Negotiation Response Notice

ACEP and EDPMA support the proposal to require a response to a Notice of Open Negotiation. We believe that the 15-day response deadline proposed by the Departments provides non-initiating parties sufficient time to respond while also ensuring initiating parties have enough time to consider any response. This deadline should not be extended beyond 15 days, as non-initiating parties are most likely to respond by, rather than ahead of, any deadline created by the Departments. ACEP and EDPMA request that the Departments direct IDREs to consider a failure to submit a response as evidence of bad faith by the health plan. There should be significant consequences if health plans fail to adhere to this requirement and not respond at all during the Open Negotiation period, including possibly having certified IDREs automatically deciding in favor of the provider in these cases.

ACEP and EDPMA also strongly support the information that health plans must provide in the proposed Open Negotiation Response Notice, including the requirement that health plans provide the plan type. ACEP and EDPMA had previously strongly recommended that the Departments require health plans to provide this information as it would help providers distinguish between fully-insured and self-insured plans and determine whether a particular service is eligible for the Federal dispute resolution process.

ACEP and EDPMA also urge the Departments to finalize their proposal that the non-initiating party either affirm the accuracy of the QPA as provided with the initial payment amount (or denial of payment) or, if the QPA had not been properly provided with the initial payment (or denial of payment), that the non-initiating party provide the QPA via the Open Negotiation Response Notice. This will ensure that parties are able to comply with timelines dictated by the *No Surprises Act* and corresponding regulations in instances where plans/issuers have not met their full disclosure obligations with the initial payment (or denial of payment).

As part of the new content requirements of the Open Negotiation Response Notice, the Departments propose that the non-initiating party also include a counter offer. **ACEP and EDPMA applaud the Departments on the decision to require provision of a counter offer as part of the response to the Notice of Open Negotiation.** Even if the plan/issuer submits a counteroffer that is the same as the initial payment, this will still confirm receipt and understanding of the initiating party's position, create an affirmative starting point for negotiations, and create a low burden documentation record of each party's position in the event the dispute advances for review by a certified IDRE. We also appreciate that the content of the Open Negotiation Response Notice as proposed by the Departments contemplates acceptance of the initiating party's offer, as it is our hope that this improved system will result in an increase in the number of settlements during the Open Negotiation process due to increased ease for plans/issuers to engage in Open Negotiation rather than disputes falling through the cracks, thus defaulting to initiation of IDR in those instances.

Other Operational Suggestions for the Open Negotiation Process

ACEP and EDPMA also wish to offer several operational suggestions that will aid implementation of the new requirements.

- The Departments should prioritize standardization and ease of data ingestion for disputing parties and certified IDREs when integrating the web-based Open Negotiation initiation and response platform into the IDR portal. To accomplish this, all required information should be entered via drop-down selection or text-entry-box related to each individual data element (e.g., date of service, initial payment amount, claim number, proposed offer amount, etc.). While certain requirements (e.g., providing a copy of the initial payment or notice of denial) will necessitate uploading non-standard documents, such uploads should be limited to supporting documentation rather than as a substitute for direct entry into web-based data fields.
- The proposed rule would create a new requirement for initiating parties to provide a copy of the initial payment or notice of denial associated with each item or service at the time of initiation of Open Negotiation. The Departments should clarify that this requirement may be fulfilled by providing any human-readable remittance advice document derived from the relevant 835 Electronic Remittance Advice, Paper Remittance Advice, or insurer-provided Remittance Advice. Initiating parties should NOT be required to provide any proprietary remittance advice documents available only directly from the insurer. These proprietary remittances require significant administrative effort to obtain and contain non-standard comments and remarks that have not been reviewed or established by ANSI X12.
- While the proposed rule's further integration of the IDR process into a unified web-based portal is a significant and impactful step in the right direction, the Departments should create a long-term goal of developing an application programming interface (API) that would allow direct integration with existing billing and claims and data management systems. Direct integration with existing platforms would further improve process efficiency and reduce the overall administrative cost and burden of the IDR process.

IDR Initiation Response

ACEP and EDPMA urge the Departments to finalize the proposal to require a response (and the corresponding response content elements) to the Notice of IDR Initiation. We also believe that all offers or counteroffers made during Open Negotiation should be universally available to the certified IDRE if the claim proceeds to IDR. That way, all the information is clearly on the table and the certified IDRE can make its payment determination based on all the relevant facts.

Selection of a Certified IDRE

ACEP and EDPMA support the proposed rule's changes to the certified IDRE selection process, especially the elimination of selection gaming frequently employed by certain health plans. These insurers have regularly objected to the initiating party's selection of a certified IDRE at the literal eleventh hour, proposing their own preference without the opportunity for the initiating party to respond. This openly bad-faith practice provides context into the character of several bad-actor plans and their overall approach to the NSA's implementation.

Batching Provisions

ACEP and EDPMA believe that the *No Surprises Act* included batching criteria within the IDR process with the primary goal of efficiency of dispute resolution. As described in this proposed rule's preamble, several factors have led to batched disputes having the opposite effect: slowing the resolution process and creating significant administrative burdens for certified IDREs. If implemented effectively, several of the changes proposed in this rule will dramatically improve batched submission efficiency, allowing certified IDREs to resolve large numbers of similar disputes quickly.

ACEP and EDPMA also firmly believe that the Departments’ proposed Plan Registration process has the potential to effectively eliminate this issue. Requiring plans to provide relevant information within this proposed registry, such as whether it is subject to State or Federal dispute resolution, the plan type, and plan sponsor, should immediately allow disputing parties and certified IDREs to resolve the status quo’s most pressing eligibility and batching concerns.

ACEP and EDPMA appreciate the intent of the Departments’ proposals to add more flexibility to batching disputes. We believe, however, that incorporating the following suggestions will support the *No Surprises Act*’s goal of promoting efficiency in the IDR system via batched disputes.

Batching Criteria: “Related to the Treatment of a Similar Condition”

The Departments seek to revise how to define the statutory batching criteria of “related to the treatment of a similar condition.” The Departments propose three mechanisms in which an initiating party can meet the batching criteria of “related to the treatment of a similar condition”:

- Services that are billed under a comparable code within a different procedural code system (similar to the current “same or similar service code” interpretation)
- Buckets of CPT codes that specific specialties typically provide
- All the services that were provided to a patient during a single encounter that billed on the same claim

With respect to the specialty-specific batching proposal, the Departments propose to allow batching of anesthesiology, radiology, pathology and laboratory items and services billed under service codes that belong to the same Category I CPT code sub-categories. These CPT code sections would focus on a particular body part. The Departments, however, do not allow this flexibility for emergency care providers, who had asked for the ability to batch across the five levels of evaluation and management codes that are typically billed as emergency department (ED) services (i.e., CPT codes 99281 – 99285). The Departments believe that there is too much variability among the conditions across these codes—thereby increasing the likelihood for “dissimilar conditions and patient acuities” to permit effective batching. If extremely different conditions were batched together (e.g., an insect bite and a heart attack), the Departments argue that it would be untenable for IDR entities to resolve the batches (even though an insect bite and a perceived heart attack could be found in a current batch limited to the same CPT code and we are not aware of certified IDREs having issues resolving those disputes). The Departments seek comment on whether there are ways to provide additional batching flexibility for emergency department (ED) services in a way that mitigates the Departments’ concerns.

ACEP and EDPMA do not support the Departments’ decision to exclude emergency medicine from the list of specialties that can bill among Category I CPT code sections. The Departments’ logic for excluding emergency medicine is flawed for a number of reasons.

- First, the Departments claim that that there is too much variability among the conditions across all five ED evaluation and management (E/M) services. However, when a patient presents to the ED, regardless of their ultimate diagnosis, the clinical service they receive **contains common elements that are required by the longstanding federal law Emergency Medical Treatment and Labor Act (EMTALA), which dictates the extent of the evaluation and clinical stabilization mandated for each patient, and which is independent of the later selection of the CPT code for the service.** In other words, regardless of the CPT code that is ultimately billed, the patient’s condition (an emergency medical condition) and the provider’s approach to treating the patient are effectively the same. Even from the patient’s perspective, the experience they have at the ED and their encounter with a clinician is the same regardless of their ultimate diagnosis. Patients present to the ED with a complaint, based on symptoms they are experiencing, and a clinician treats them. The ultimate CPT code that is billed has no impact on the patient’s actual experience during the encounter, nor on the clinician’s required approach to the initial evaluation and

stabilization of the clinical presentation. In that way, it makes logical sense to group all ED E/M services together. Therefore, **ACEP and EDPMA urge the Departments to modify their proposal and allow all ED E/M visit levels to be batched (if other batching criteria are met)**. This flexibility is directly in line with the statutory requirement of “related to the treatment of a similar condition,” as every case in the match will have involved an “emergency medical condition” as defined under EMTALA.

- While batching all ED E/M codes together would result in the most efficient IDR process, as an alternative, the Departments should at least allow certain ED E/M codes and other emergency medicine codes including critical care codes to be batched together in a single dispute. Looking at data from emergency medicine groups who are utilizing the IDR process regularly, it may make sense to be able to batch ED levels 1-3 together (CPT 99281-99293) and ED levels 4-5 (CPT 99284-99285) or Levels 4-5 **and** critical care codes (CPT 99284-99285; and CPT 99291-99292). We believe that this alternative approach could alleviate the Departments’ concern about the wide variety of clinical severity of cases that could be batched together while improving the efficiency of the Federal IDR process. In addition, this alternative approach preserves some portion of the rationale noted immediately above.
- Finally, we are extremely concerned that the Departments have embarked on a slippery slope by referencing “an insect bite and a heart attack” relative to ED visits. It is not the ultimate diagnosis that identifies an emergency medical condition as recognized by the Federal Prudent Layperson Standard. It is the clinical requirement for assessing and stabilizing the patient’s **presentation to the emergency department**, including fully assessing the presence or absence of an emergency medical condition, **ruling out serious or significant alternative diagnoses**, and stabilizing patients consistent with evidence-based and best clinical practices, and consistent with the requirements of EMTALA. In fact, the limitless number of different injuries and clinical ailments that can present within the context of a single ED E/M level is supportive of the ACEP and EDPMA position that the “condition” *is* “an emergency medical condition.”⁶

Batching Criteria: “Same Group Health Plan or Health Insurance Issuer”

For self-insured group health plans, the Departments continue to state that batching can only be among the same self-insured group health plan (regardless of whether the plan makes payments through a third-party administrator, or TPA). The Departments state that while a given TPA may administer multiple self-insured plans, the self-insured group health plan generally is the responsible party for payment or reimbursement of the qualified IDR items and services, and therefore, batching can only be among the same self-insured health plan.

ACEP and EDPMA urge the Departments to reconsider the proposal to limit batching to the same self-insured health plan. Interpreting the statute to require that a batch for a self-insured plan is limited to that of single employer has rendered the batching section of the statute essentially meaningless for ERISA claims. That criteria requires providers to know the name and contact of the self-insured group health plan, which is not a standard data element to the claims process and therefore often not available to emergency providers (whether in- or out-of-network). The Departments have also yet to issue regulations regarding plan or insurance identification cards as included in Sec. 107 of the *No Surprises Act* that might work to resolve these issues. This highlights the complications raised by attempting to restrict batching by an element that is not delineated in statute or regulation and is not a part of the current claims process. It is unreasonable to ask initiating parties to batch disputes based on an element to which they have no visibility, leading to confusion in and pressure on the IDR system. Additionally, many times the providers only are informed of the TPA with the initial payment, and not the self-insured group health plan that actually manages and funds the plan on behalf of its members. While we appreciate the Departments’ proposals to help providers distinguish between self-insured health plans, allowing batching across the TPAs would increase the number of similar claims that could be batched together—thereby reducing the total number of disputes that go through the IDR process.

⁶ For example, there are a large range of clinical diagnoses that are all Level 4 (99284) CPT codes.

Batching Criteria: Furnished within the same 30-business-day period (or the 90-calendar-day suspension period/cooling off period)

The Departments continue to reference the statutory language that batched services must have been furnished within the same 30-business-day period following the date on which the first item or service included in the batched determination was furnished and have been the subjects of a 30-business-day open negotiation period that ended within 4 business days of IDR initiation (except as provided during the 90-calendar-day “cooling off” period). As the Departments are aware, the full text of this statutory provision states,

(iv) such items and services were furnished during the 30 day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

Many emergency medicine practices, particularly in states with a Specified State Law where the Federal provisions apply only apply to ERISA plans, have found it difficult to batch disputes due to other criteria, which has resulted in a less efficient IDR process than envisioned by the statute. **ACEP and EDPMA urge the Departments to exercise the authority granted in this paragraph to ensure efficiencies and reduce administrative costs by extending the batching requirement from 30 business days following the date on which the first item was furnished to 90 business days.**

The Departments also solicit comment on the application of the cooling off period after a determination on a dispute consisting of multiple items and services batched by patient encounter or CPT code ranges, including the length of the period itself. The Departments are seeking comments on alternative, shorter periods, including decreasing the period down to one business day.

ACEP and EDPMA appreciate that the Departments recognize that 90 days is too long a cooling off period for batched disputes. Under the new batching criteria for “related to treatment of a similar condition,” the variations associated with a batch could become limitless. Identifying disputes that are captured by the cooling off period will become administratively burdensome for parties and also add an extraordinary amount of work for IDREs and the Departments as they conduct eligibility determinations. It is also important to note that while disputes are blocked from resolution for 90 business days, the health plans involved in that cooling off period have no obligation to pay a reasonable amount and the provider has no recourse from underpayments for whatever length of time the cooling off period exists. **This fundamental imbalance argues for the Departments to shorten the cooling off period, which ACEP and EDPMA hope will result in fewer eventual IDR initiations** as health plans begin to recalibrate initial payments based on market-based inputs, *including* information from IDRE payment determinations. Even more confrontational to the statute’s concept of the cooling off period: many health plans simply are not paying after IDREs have issued payment determinations. If common health plan practice is to not adhere to IDRE payment determinations, health plans should not be afforded an unfettered ability to pay below market levels on all similar items and services for 90 days. Finally, as the Departments are well aware, there remains a significant backlog of disputes for IDREs to adjudicate. We believe that many of the Departments’ proposals will help address that backlog, but we believe that these improved policies would be undermined if new backlogs were created by a continued 90-day cooling period (which has clearly not provided an incentive for health plans to remedy their initial payments for subsequent similarly situated items and services to those that have already received a payment determination).

For these reasons, **ACEP and EDPMA recommend that the Departments finalize their suggestion that the cooling off period for batched disputes be shortened to one business day.** Further, **ACEP and EDPMA believe that for the reasons articulated in this section, the Departments should consider reducing the**

cooling off period to one business day for *all* disputes, not just cooling off periods triggered by a batched dispute.

New Proposed Limit on Line Items in a Batch

The proposed rule places an overall limitation of 25 on the qualified items or services (line items) that can be in a single batch. This proposal intends to prevent extremely large batches and highlights concerns from the Departments that IDREs may not be able to process larger groupings of claims and meet required deadlines.

ACEP and EDPMA do not support the proposal to limit batching to 25 line items. Based on our members' experience, we believe that a higher limit of no less than 75 items per batch is more appropriate. Further, the Departments do not seem to contemplate the statutory provision that allows disputes that collect during the 90-day cooling off period to move through IDR together at the end of cooling off period. We believe it is possible that there will be instances in which the number of disputes that collect during the cooling off period could result in more than 25 disputes in need of resolution and the *No Surprises Act* explicitly allows that these cases be able to move through IDR together if the initiating party so chooses.

Inappropriately Batched Items and Services

Under current guidance, the Departments have created an allowance for inappropriately batched or bundled disputes to be re-submitted as properly batched or single disputes (assuming the qualified IDR items and services meet all other requirements, including timely initiation of the Federal IDR process). In this proposed rule, The Departments state that 90 business days after the proposed batching provisions are finalized, the Departments are considering revoking the flexibility to resubmit inappropriately batched disputes. **ACEP and EDPMA urge the Departments to maintain the flexibility for re-submitting inappropriately batched items, even if only temporarily.** The ability to appropriately batch is predicated on health plans providing complete and accurate information in tandem with the initial payment or notice of denial of payment. While we firmly believe the Departments' proposals will help better facilitate the exchange and confirmation of that information, health plan compliance with their disclosure obligations to date have not inspired confidence, and until there is a stable, clear pattern of compliance on the part of the health plans, we believe that it is fundamentally unfair to eliminate the flexibility to re-submit appropriately organized disputes (including re-submission as single disputes) if the Departments or the IDREs are able to obtain information to determine eligibility that the non-initiating party was unable to obtain leading up to point at which the disputes needed to be batched. A procedural error should not be fatal to this process.

Federal IDR Eligibility Determinations

The Departments note that there has been significant confusion around the eligibility of out-of-network disputes in the Federal IDR process, and such eligibility determination challenges have been a major factor in the delayed adjudication and increased costs for tens of thousands of out-of-network claims. The Departments are therefore proposing that providers submit additional information when they initiate the IDR process, including the date the item or service was furnished; a copy of the initial payment or notice of denial of payment or other remittance advice with respect to the item or service; and a statement describing the key aspects of the claim discussed by the parties during open negotiation that relate to the payment for the disputed claim, whether the reasons for initiating the Federal IDR process are different from those aspects discussed during the Open Negotiation period, and an explanation of why the party is initiating the Federal IDR process. Health plans must also provide a response to the IDR notice with specific information.

The Departments also propose to require that, once a certified IDRE is selected, it must review the information in the Notice of IDR Initiation, Notice of IDR Initiation Response, and any additional information and determine whether the item or service is a qualified IDR item or service that is eligible for the Federal IDR process and notify the Departments and both parties of its determination within 5 business days after the date of final selection

of the certified IDRE. The Departments also propose that they could, for a temporary period of time, take over this responsibility from certified IDREs of determining eligibility.

Overall, we appreciate the Departments' proposals to make it easier for certified IDREs to identify whether disputes are eligible for the IDR process and speed up that process to ensure that the overall timelines included in the *No Surprises Act* are met.

However, we are also aware of cases where health plans interfere with the certified IDRE's assessment of whether a claim is eligible for the IDR process, providing additional, conflicting information to IDREs that was not disclosed previously. Sometimes, health plans try to challenge the eligibility of a dispute even after the IDRE has made its initial decision—and IDREs are expected to consider these challenges. IDREs must be allowed to make an eligibility determination based on information that is available and presented (and hopefully, shared between provider and health plan during Open Negotiations). Health plans should not be allowed to interfere with this process and/or challenge a dispute's eligibility after the IDRE has rendered its decision.

Administrative Fees

Methodology for Calculating Administrative IDR Fee

The Departments propose to amend administrative fee and certified IDRE fee provisions to adjust the timing of collection of the administrative fee and make changes to the administrative fee structure to ensure that the financial costs to the Departments to administer the Federal IDR process align with the assessed administrative fees, to encourage disputing parties to engage in meaningful open negotiations, to accelerate dispute processing, and to reduce the burden on certified IDR entities.

Earlier in December, the Departments issued the *Federal IDR Process Administrative Fee and Certified IDR Entity Fee Ranges* (“IDR Fees”) final rule⁷ in response to *TMA IV*⁸ which struck down the increased 2023 administrative fee of \$350 from the original \$50. In the *IDR Fees* final rule, the Departments established an administrative fee of \$115 per party per dispute. Additionally, the Departments finalized that the administrative fee amount specified in rulemaking would remain in effect until a new administrative fee amount is specified in subsequent rulemaking.

In this rule, the Departments are proposing a new methodology for calculating the administrative fee. Using the proposed methodology, the administrative fee for disputes initiated on or after January 1, 2025, and continuing until changed by subsequent rulemaking. This was calculated by dividing the projected annual expenditures of approximately \$100.2 million to be made by the Departments in carrying out the Federal IDR process by the projected annual number of administrative fees to be paid by the disputing parties of 691,000. This results in a full administrative fee amount of \$150 per party per dispute.

ACEP and EDPMA reiterate our previous comments that the Departments should make their estimate of expenditures more transparent. It is unclear why expected expenditures increased significantly from \$56.6 million in the IDR fees final rule to \$100.2 million in this rule. We also support the proposal to use the volume of disputes that may be initiated instead of the number of IDR claims that have closed in the administrative fee calculation, as we do agree with the Departments that the proposals in this rule will hopefully decrease the backlog and reduce the number of disputes that are open and unresolved.

Timing of Payments

⁷ The unpublished version of the rule is available here: <https://public-inspection.federalregister.gov/2023-27931.pdf>.

⁸ *Tex. Med. Ass'n, et al. v. U.S. Dep't of Health and Human Servs*, No. 6:23-cv-00059-JDK (E.D. Tex. August 3, 2023).

Regarding the timing of certified IDR entity fee payments, the Departments propose that each party to a dispute must pay the predetermined certified IDR entity fee to the certified IDRE no later than the time the parties submit their offers. Further, the Departments propose to codify the current practice that the certified IDRE must retain the certified IDR entity fee paid by the party whose offer was not selected, consistent with the *No Surprises Act*. Additionally, the Departments propose to provide that when the parties reach an agreement on an out-of-network rate for qualified IDR items or services, or agree to withdraw a dispute, for a dispute that has already been assigned to a certified IDRE and determined eligible for the Federal IDR process but for which the certified IDRE has not made a payment determination, the certified IDRE must return half of each party's certified IDR entity fee within 30 business days of the agreement or withdrawal, unless directed otherwise by both parties.

With respect to administrative fee payments, the Departments propose to require the initiating party to pay the administrative fee within two business days of the date of preliminary selection of the certified IDR entity. The Departments further propose that the non-initiating party must pay the administrative fee within two business days of the date of notice that an eligibility determination for the Federal IDR process has been reached by either the certified IDRE or the Departments. Each party would be required to pay the administrative fee directly to the Departments instead of to the certified IDRE for remittance by the Departments.

ACEP and EDPMA generally appreciate the Departments' review of the timing of payment of the administrative fee and certified IDR entity fee. However, we are concerned about the complexity and imbalance created by the proposal for initiating to pay fees upfront but where non-initiating parties are allowed to pay at a later date. Given the delays and issues with collecting fees from non-initiating parties, we believe that the Departments should implement a more efficient, upfront process for fee collection from the non-initiating parties as well.

Different Fee Amounts

The Departments are proposing two circumstances in which particular parties would not pay the full administrative fee.

- Reduced Administrative Fee for Non-Initiating Party When Dispute Ruled Ineligible: First, if a dispute is determined to be ineligible, the non-initiating party would be required to pay 20% of the fee two business days after the determination is made. The initiating party would still pay the full administrative fee for eligible disputes.
- Reduced Administrative Fee for Disputes with Low Dollar Amount: Second, the Departments are proposing a low dollar dispute reduced administrative fee. Starting in 2025, disputes eligible for the reduced fee must meet the low dollar threshold, which the Departments propose to set at the level of the administrative fee itself (\$150). Whether the dispute is deemed a "low dollar" dispute would be predicated on the highest offer made during Open Negotiation. If that highest offer is below that low-dollar threshold, the administrative fee would be 50% of the full administrative fee (so, under current parameters, \$75.00).

Regarding the reduced administrative fee for non-initiating parties when a dispute is ruled ineligible, we appreciate that disputes that do not complete the process should not be subject to the full administrative fee amounts. However, ACEP and EDPMA urge the Departments to finalize a reduced fee policy for ineligible disputes that would also apply to the initiating party. As we have articulated to the Departments on countless occasions, disputes that are ruled to be ineligible often make their way into the Federal IDR process in the first place because of the failure of non-initiating parties to provide the required disclosures at initial payment and a failure to meaningfully engage in the Open Negotiation process. It is precisely this information in possession of the health plans that, when not provided, leads to confusion among the parties and advances disputes not eligible for Federal IDR into that venue. Providers have no reason to present a dispute to Federal IDR when it is not eligible. These disputes end up in Federal IDR when health plans do not provide the information to accurately ascertain jurisdiction over these disputes. Thus, we stress that the Departments should reduce the administrative

fees for initiating parties when a dispute is ruled ineligible when the non-initiating party has failed to make the required disclosures.

With respect to the low-volume threshold proposal, while we appreciate the intent of the proposal, we are concerned that the goal of ensuring that the administrative fee is not an undue barrier to fair resolution of payment disputes would never be met. This is because the barrier is not the “highest offer” relative to the amount of the administrative fee, but rather, the “amount-in-dispute” relative to the amount of the administrative fee.

- For example, a service with a “highest offer” of \$200 would not be eligible for the reduced administrative fee, but might very well have an “amount-in-dispute” that is less than the administrative fee of \$150, which would prevent the rational actor from accessing the IDR process.
- Likewise, a dispute that with a “highest offer” of \$120 would be eligible for the reduced administrative fee, but if the amount-in-dispute is still under \$75 (which it likely would be), there is still no rational access to IDR.

Thus, ACEP and EDPMA urge the Departments to anchor the reduced administrative fee to the “amount in dispute” rather than the “highest offer.” In the alternative and in response to the Departments’ question about whether the “offer cap” should be higher than the administrative fee threshold “to allow for some increases between offers made during open negotiation and offers made during the Federal IDR process,” ACEP and EDPMA would urge the Departments to set an “offer cap” that is much higher than the administrative fee to account for the fact that the dispute is not over the entire offer, but rather, the difference between the highest offer and the other party’s offer.

Overall, **it is the “amount-in-dispute” relative to the amount of the administrative fee that is the barrier to accessing IDR, and ACEP and EDPMA urge the Departments to enact a low dollar amount reduced administrative fee that reflects that.** ACEP and EDPMA articulated one potential option in our response to the *IDR Fees* proposed rule, which we repeat here due to its relevance. We suggest setting a cap on the administrative fee relative to the amount-in-dispute. The Departments could operationalize this by creating a “base fee amount” plus a “tiered payment subject to the cap” relative to amounts-in-dispute. The amount-in-dispute could be the difference between the initial payment and the initiating party’s offer (making the amount-in-dispute knowable from the moment of initiation of IDR). By linking the fee to the amount being disputed, there could be more transparency around how the fee is established, and the Departments will have a mechanism, by instituting a cap, to ensure that the fee, in many circumstances, is not larger than the amount-in-dispute. To illustrate:

If the Departments were to finalize the general \$150 administrative fee it has proposed, this could be separated into a \$50 “base fee amount,” plus a “tiered payment subject to a cap” of up to \$100. For large amounts-in-dispute, this would come out to the \$150 administrative fee the Departments have currently proposed. For a case that has an identifiable \$350 amount-in-dispute, the administrative fee would be \$70.00 (\$50 “base fee” + \$20 “tiered payment” capped so total does not exceed 20% of the amount-in-dispute). Under this structure, the Department would also be able to ensure that all disputes, no matter how small the amount-in-dispute, must always pay an at least \$50 administrative fee, which is the level of the administrative fee currently in place, and would not exceed the \$150 currently being proposed.

Extenuating Circumstances

The Departments propose to include flexibilities throughout the Open Negotiation period and IDR processes in the event of extenuating circumstances. We appreciate the Departments' inclusion of these exceptions, which may help limit the "timing out" of disputes in which a party loses the dispute due to non-action rather than erroneous evidence. However, these flexibilities may not have any impact on improved efficiency in the IDR process.

ACEP and EDPMA caution the Departments to only use the extenuating circumstances flexibility in rare circumstances. It is important to stick to the timelines articulated in the *No Surprises Act* in most, if not all, cases.

IDR Registry

The Departments propose to require that plans and issuers subject to the Federal IDR process submit certain information to the Departments through a registry. These plans and issuers would then receive an IDR registration number which would facilitate ease of acquisition of information needed to ensure those disputes are eligible for the Federal IDR process including: (1) the legal business name (if any) of the group health plan, issuer, or FEHB carrier and, if applicable, the legal business name of the group health plan sponsor; (2) whether the plan or coverage is a self- or fully-insured group health plan subject to ERISA, individual health insurance coverage, a plan offered by a FEHB carrier, a self- or fully-insured non-Federal governmental plan, or a self- or fully-insured church plan; (3) the State(s) in which the plan or coverage is subject to a specified State law for any items or services to which the protections against balance billing apply; (4) the State(s) in which the plan or coverage is subject to an All-Payer Model Agreement under section 1115A of the Social Security Act for any items or services to which the protections against balance billing apply; (5) for self-insured group health plans not otherwise subject to State law, any State(s) in which the group health plan has properly effectuated an election to opt in to a specified State law, if that State allows a plan not otherwise subject to the State law to opt in; and, for FEHB plans that adopt a specified State law pursuant to their FEHB carrier's contract terms, any State(s) in which they have made such an adoption; (6) contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service; (7) the 14-digit Health Insurance Oversight System (HIOS) identifier, or, if the 14-digit HIOS identifier has not been assigned, the 5-digit HIOS identifier, or if no HIOS identifier is available, the plan's or the plan sponsor's Employer Identification Number (EIN) and the plan's plan number (PN), if a PN is available; or for FEHB carriers, the applicable contract number(s) and plan code(s); (8) any additional information needed to identify the plan or issuer and the applicable Federal and State requirements for determining appropriate out-of-network payment rates for items or services to which the protections against balance billing apply, as specified by the Departments in guidance, or such additional information needed with respect to FEHB carriers as specified by OPM in guidance; and (9) any additional information needed for purposes of administrative fee collection, as specified by the Departments in guidance, or such additional information needed with respect to FEHB carriers as specified by OPM in guidance.

ACEP and EDPMA are strongly supportive of the Departments' proposal to establish an IDR Registry and are supportive of the required elements that health plans would be required to submit in order to receive a registration number. We have previously stated that the prior process exacerbated administrative burden and was unnecessarily complex and challenging to find contact information for key contacts in the dispute. A more structured approach, such as the IDR Registry, would streamline the process, make eligibility determinations easier, mitigate the administrative burden to facilitate ease of the IDR process, and allow for plans and issuers to make changes to contacts and processes on their end that could be centrally updated in the IDR registry rather than outreach to all parties in process of Open Negotiation or IDR.

The Departments also seek comments in several other areas related to the implementation of the IDR Registry. ACEP and EDPMA seek to provide input in the following areas:

- **Public Availability:** The Departments seek comment on whether the information in the IDR Registry should be made available to the public. **ACEP and EDPMA urge the Departments to make the IDR Registry and its content available to the public.** First, we believe that transparency is an important pillar to successful implementation of these policies. In addition, we believe that public availability of the information will help to facilitate engagement and compliance with the entire process because prospective initiating parties would be able to better update their processes and information with access to the IDR Registry before they are an actual “party” to an Open Negotiation.
- **Timing of Registration:** **ACEP and EDPMA also support the Departments’ proposal to require registration within 30 business days of the registry becoming available.** For the same reasons we have provided for making the IDR Registry open to the public, we believe it is also essential that all plans/issuers subject to the *No Surprises Act* and its protections affirmatively register. Missing and incomplete health plan information has plagued the implementation of the IDR process thus far. We believe that the potential for continued missing or incomplete information will only increase if plans/issuers are not required to submit information to the registry until they have received a Notice of Open Negotiation or crossed a threshold of a certain number of disputes. The promise of the Departments’ proposals to improve the efficiency of these processes rest on universal compliance with the requirements and efforts to collect complete information, which means all plans/issuers subject to the *No Surprises Act* must promptly provide information to the IDR Registry upon its launch. We strongly agree with the Departments’ suggestion that failure to register should come with a penalty, such as losing the ability to submit an offer for disputes that are initiated until the health plan registers.
- **Updates to Registry Information:** **ACEP and EDPMA strongly support the Departments’ proposal that plans/issuers provide updated information within no greater than 30 business days of the change of the information as well as the proposal that all registrants confirm the accuracy of information in the 4th quarter of each year.** These improved processes and efficiencies are dependent on plans/issuers providing complete and accurate information, and these proposals to update and verify information will help ensure that the contents of the IDR Registry facilitate those goals.

Enforcement

While ACEP and EDPMA are generally supportive of the proposed rule, we are concerned with the lack of enforcement mechanisms explicitly mentioned. While the Departments periodically refer to enforcement and compliance in the rule, there is no comprehensive strategy or plan to ensure that all stakeholders adhere to the new requirements. Further, there are no overarching instructions for how disputing parties or certified IDR entities should handle instances of non-compliance or specific penalties or consequences of non-compliance mentioned. We understand that enforcement is done both at the State and Federal level depending on the type of plan and the state in which the service was delivered, but we still believe that it is essential for the Departments to articulate a well-thought-out enforcement strategy and that disputing parties fully understand the consequences of non-compliance.

We believe there are several promising proposals in this rule that need stronger incentive and enforcement mechanisms.

- The Departments should meaningfully **incentivize compliance with the new Open Negotiation Response requirements.** ACEP and EDPMA encourage the Departments to treat a non-initiating party’s failure to respond to a Notice of Open Negotiation in the same manner as a party’s failure to provide a Notice of Offer to an IDRE. If the non-initiating party fails to respond to the Open Negotiation notice and a dispute is later found to be ineligible, the non-initiating party should be held responsible for both parties’

administrative fees. Further, as stated above, if the health plan does not engage at all during the Open Negotiations process, including not sending the required response notice, the IDRE should automatically rule in favor of the provider during the IDR process.

- The same should apply when a plan fails to provide the most relevant CARC/RARC codes under the proposed rule. Should the provider not receive a RARC code delineating whether State or Federal rules apply to a claim for an item or service furnished out-of-network with the initial payment or denial and the provider has reason to believe the federal rules apply, the Open Negotiation notice platform should allow for the input of a notation indicating each item or service that did not receive a CARC/RARC.
- For any instance of non-compliance with the 835 RA and/or CARC/RARC code requirements, the initiating party shall have the right (but not the obligation) to request an extension and the certified IDRE shall grant such a request.
- Those found to engage in a pattern and practice of noncompliance with these requirements should face additional monetary penalties sufficient to compel compliance.

We also have previously commented that plans and insurers have taken advantage of regulations in prior rules due to the case-by-case nature of submission and resolution of complaints as previously established. We believe that that process allows insurers to circumvent important protections intended in the passage of the *No Surprises Act*. We recommended that the Departments release aggregated information about the cases in which they received complaints including:

- The total number of cases
- The total number of cases that are resolved
- The total number of cases that are unresolved
- The most common issues raised and how these issues were addressed
- Best practices to avoid issues that are commonly leading to complaints

We suggested that this information should also be broken out by state to help provide more granular data and potentially answer some of the questions posed during the meeting about the possible reasons for geographic variation among IDR cases, and that releasing all of this information will reduce the overall number of complaints and increase compliance of all *No Surprises Act* requirements. We reiterate our recommendations for releasing these reports.

Finally, we would like to reiterate our previous concerns about the lack of compliance of QPA calculations. We have also heard complaints that health plans are miscalculating the QPA, leading to QPAs even lower than what proper adherence to the methodology would dictate. This combination of the QPA methodology and the miscalculations has led to artificially low QPAs that are even significantly below Medicare and Medicaid payment rates. In our prior comments, we suggested that the Departments require insurers to display the methodology used to calculate QPA. Thus, while we are in support of the Departments' proposals and urge the Departments to finalize them as proposed, we also encourage the Departments to require plans to "show their work" and disclose their QPA calculations upon the request of the provider or certified IDRE.

Effective Dates

The proposed rule lays out various effective dates for the different proposals. The proposed modifications to the batching and IDR processes would apply to disputes with Open Negotiation periods beginning on or after the later of August 15, 2024, or 90 days after the effective date of the final rule. However, the requirement for health plans to register on the IDR portal would take effect immediately upon publication of the final rule, and the changes to IDR fees would apply to disputes initiated on or after January 1, 2025. The Departments are also seeking comment on whether the new disclosure requirements would be effective six months or a year after additional sub-regulatory guidance is provided.

Overall, ACEP and EDPMA believe that all the effective dates in the rule would provide too much of a gap between current policies and what we believe to be improvements in the IDR process.

- The batching provisions should be effective no more than 60 days after the rule is finalized—as is the standard implementation timeline for major regulations.
- Further, the new disclosure requirements should be effective immediately once the rule is finalized.

We urge the Departments to put out guidance related to the disclosure requirements, including the use of RARC and CARC codes as soon as possible and even consider finalizing the RARC/CARC requirements separately in order to release those provisions more quickly. Health plans already have experience using the RARC/CARC formatting, and we do not believe it would take much time for those plans that are not using them to start doing so. The future success of the IDR process depends on these operational improvements being implemented efficiently, and, as stated above, that all parties adhere to them. We therefore urge the Departments to expeditiously finalize the proposals and set effective dates that go into effect as soon as practically possible.

We appreciate the opportunity to provide feedback. If you have any questions, please do not hesitate to contact EDPMA’s Executive Director, Cathey Wise, at cathey.wise@edpma.org or Laura Wooster, ACEP’s Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org.

Sincerely,



Andrea Brault, MD, MMM, FACEP
Chair
Emergency Department Management Association



Aisha T. Terry, MD, MPH, FACEP
President
American College of Emergency Physicians