

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

January 19, 2023

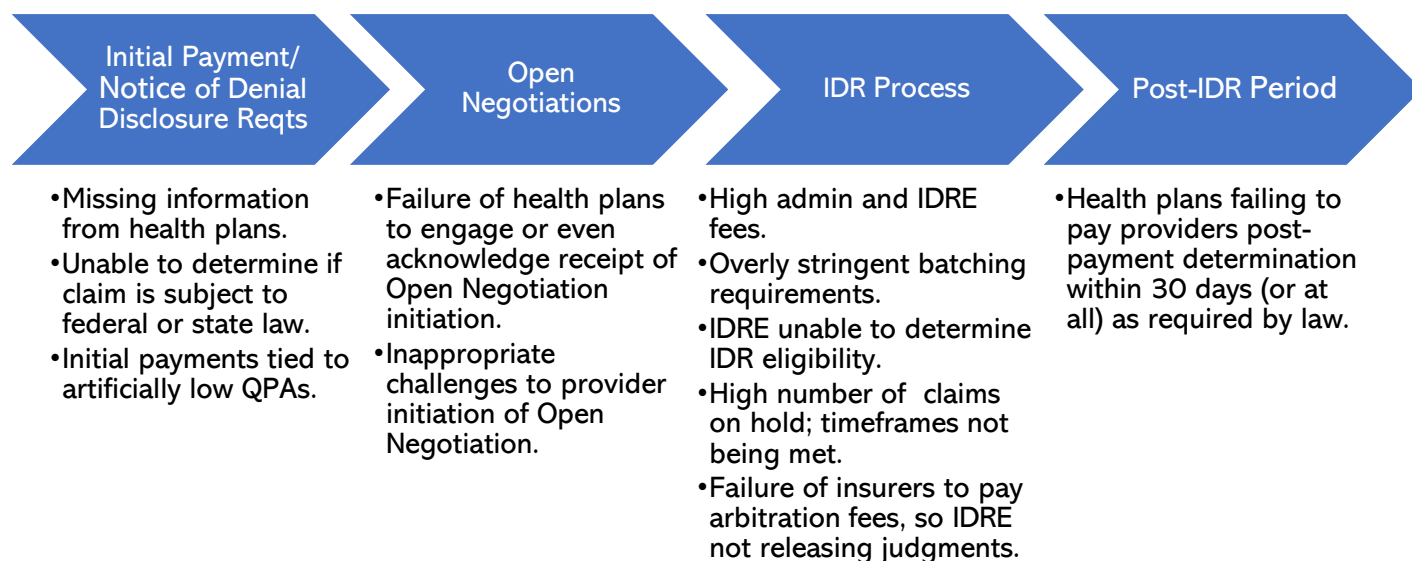
The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

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

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to thank the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) for the opportunity to meet with members of their staff and other stakeholders on January 5, 2023 to discuss issues related to the implementation of the *No Surprises Act* and discuss potential solutions to the challenges our members are experiencing with the federal dispute resolution process. We found the discussion to be very productive, and we hope that we can continue to work collaboratively with the Departments and other stakeholders to find mutually beneficial ways to improve the process.

The figure below presents a high-level summary of the key issues that were discussed during the meeting.



As a follow-up, we are now providing additional input on some of these issues and more detailed recommendations for addressing them. ACEP and EDPMA’s specific recommendations are broken out by the distinct phases of the dispute resolution process.

Before discussing our recommendations, we would like to first note that some of the difficulties with the process have been exacerbated by the unique aspects of how patient care billing works in emergency medicine. Despite the fact that these are universal realities in emergency care, we find they are often confused with the realities of scheduled, non-emergency care.

There is a great deal of variability in the amount of information that emergency medicine groups receive about an individual’s insurance coverage at the time of treatment. Because of the dynamics and realities of acute, unscheduled patient care, emergency medicine providers often only receive limited information (or none at all) at the time they treat the patient in the emergency department (ED). This phenomenon is amplified by an important difference between scheduled care and emergency care due to the Emergency Medical Treatment & Labor Act (EMTALA). Emergency medicine groups do not collect billing or cost-sharing information prior to stabilizing the patient in accordance with the long-standing law, first enacted in the late 1980s.

In addition, in contrast to emergency care, insurance verification for pre-scheduled health care involves far more than the name of the insurance plan. With respect to scheduled health care, administrative staff not only verify first-level insurance information, but they also drill down to the patient’s individual health plan type before the patient enters the exam room or treatment space. This type of information is critical and necessary not only for the payment process, but also for the federal dispute resolution process under the *No Surprises Act*. Administrative staff also pre-identify the correct co-pays, deductibles, and other pertinent benefit information, and, often, will require pre-payment of some or all patient-responsibility amounts, **all before health care is delivered**.

Emergency medicine practices, on the other hand, must wait until *after* the episode of care has occurred, and then wade through the morass of individual policy benefits, relying on costly and time-consuming administrative back-and-forth that may again involve the patient for more clarification (who often, will not know a sufficient level of detail, and must go back to the insurance plan, who *does* have the information). Therefore, requiring key information exchange between health insurers and providers proactively reduces administrative cost and keeps patients out of the middle.

The following table provides more detail and articulates a basis for ACEP and EDPMA’s recommendations below, particularly around proactively communicating the health plan type and the *No Surprises Act* Remittance Advice Remark Codes (RARCs) and making accurate insurance information readily available to both providers and patients.

Step in the Emergency Encounter	Accompanying Data
<p>1. A person presents to an emergency department (ED) believing they have an emergency medical condition (EMC). The hospital collects enough information from the patient so that care can be initiated.</p> <p>As mandated by the federal Emergency Medical Treatment and Labor Act (EMTALA) statute, a clinician performs a medical screening exam (MSE) – which may or may not include testing – to determine if an EMC exists.</p>	<p>Name, date of birth, allergies, etc.</p> <p><i>This basic information is sufficient to initiate treatment, but insufficient for billing purposes.</i></p>

<p>2. If the clinician reasonably believes an EMC exists, stabilizing treatment must be rendered to the patient. If the EMC can be stabilized and treated in the ED, the patient is discharged from the ED once that is complete (and, if necessary, any post-stabilization care will be addressed as appropriate).</p> <p>The hospital will collect more in-depth information from the patient prior to discharge from the ED.</p>	<p>Insurance coverage (if any), detailed contact information, demographics, employer, etc.</p> <p><i>Note that patients often have outdated or inaccurate insurance cards or no information in hand at the time of their emergency, so emergency physician groups and billing companies may never have access to the patient's actual insurance card.</i></p> <p><i>In addition, certain health plan coverages in effect may not apply to this emergency (for example, auto insurance or workers' compensation is actually the payor for the claim). Due to EMTALA restrictions, the patient and the provider cannot definitively determine the health plan that is responsible for payment, the deductible amount, or co-insurance at the time care is rendered.</i></p>
<p>3. If the patient requires further care to stabilize the EMC, the patient may be admitted to the hospital or transferred— in compliance with EMTALA mandates.</p>	<p><i>Comprehensive billing information is gathered if the patient is admitted from the ED to the hospital but may <u>not</u> be gathered if the patient is transferred to another hospital (a higher level of care). These patients are often unstable. Financial discussions are inappropriate at the time of transfer; information must be obtained later.</i></p>
<p>4. Following the patient's visit, the hospital shares patient information with the emergency physician group and/or billing company as part of a regular data transfer—usually daily.</p>	<p><i>The physician group usually receives billing information routinely from the hospital, but its accuracy and thoroughness for ED patients is highly variable. This requires additional or more accurate data to supplement the initial data feed. Hospitals are subject to EMTALA and have the same limitations in their ability to gather data at the time of care as noted above.</i></p>
<p>5. The physician group or billing company submits a claim to the patient's insurance company for the encounter.</p>	<p><i>The physician group or billing company determines whether to submit a claim based on the best information available. The patient is re-contacted or directly billed if there is no information or if the information is inaccurate or incomplete.</i></p>
<p>6. The insurance company responds to the physician or its billing group with an initial payment or denial, and an accompanying remittance.</p>	<p><i>The health plan is responsible to remit timely payment under the No Surprises Act's provisions. In order to do that, it must receive, evaluate, and process the claim, and remit timely payment. In doing so, it must also be able to identify the health plan type and other critical information. In service of reducing administrative burden, keeping patients out of the middle, reducing cost, and reducing reliance on IDR, EDPMA and ACEP strongly advocate for requiring and enforcing transparency and communication at the time of initial payment, including health plan type, RARCs, and claim adjustment reason codes (CARCs).</i></p>
<p>7. If the patient's insurance coverage has a deductible that has not yet been met, the physician group or billing company sends a bill to the patient for their cost-sharing responsibility.</p>	<p><i>Patient responsibility amounts are determined by the Qualifying Payment Amount (QPA) as set forth in the No Surprises Act. It is important that the QPA be identified (as required) at the time of initial payment.</i></p>

Overall, this process demonstrates how emergency care is substantially different due to EMTALA's requirements for provision of a medical assessment and stabilizing care without prior review of the patient's ability to pay (or health insurer's willingness to pay). As a result, the emergency care system has significant and unique dependency on payment and billing processes *after* care has been rendered.

With that context in mind, here are our additional recommendations related to the federal dispute resolution process:

Initial Payment and Notice of Denial Phase

Information Disclosures

As discussed in the meeting, in many cases, the provider does not receive all the information required to be disclosed by health insurers at the time of the initial payment or notice of denial. In some cases, the qualifying payment amount (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. This lack of information makes it difficult for providers and eventually for certified IDR entities to determine whether a claim is eligible for the federal IDR process.

We have [previously made recommendations](#) about how to address the lack of information that providers are receiving from health insurers both during the initial payment and notice denial phase, and during the rest of the dispute resolution process. These recommendations were made with the intention of reducing the frequency on IDR, reducing administrative cost, and providing time- and cost-saving interventions early in the process. While our key recommendations are found below, we have also included a table in the *Appendix* that provides an overview of how our recommendations align with the major regulatory requirements of the dispute resolution process.

Recommendations

- **Mandate Plan Type Disclosure:** The Departments should require that the plan type be disclosed at the time of the initial payment or notice of denial, as this information is not available on a patient's insurance ID card (if that is even obtainable). Without knowing the type of plan early in the dispute resolution process, it will be extremely difficult for the provider to know whether the plan is a fully insured or self-insured plan, and whether it is therefore subject to the federal or state dispute resolution process.
- **Mandate Use of RARCs:** The Departments should require health insurer and issuer use of the [Remittance Advice Remark Codes \(RARCs\)](#) when providing the disclosures that regulation requires accompany the initial payment or notice of denial. Ensuring the use of the RARCs for all claims will also 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 out-of-network services. Further, the RARCs will provide certified IDR entities with dispositive information about whether a particular claim is eligible for the federal IDR process.

QPAs and Initial Payments Being Artificially Low

During the January 5 meeting, ACEP and EDPMA emphasized some key points about the QPA and the initial payments:

- The QPA methodology finalized by the Departments is leading to artificially low QPAs that do not reflect market-rates. It was designed to limit cost-sharing liabilities and is not a market-based indicator of appropriate payment for an item or service.
- We are also hearing complaints that health insurers 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 QPAs that “don’t even pass the laugh test”—those that are so low that they are even significantly below Medicare and Medicaid payment rates.

Recommendations

- **Increase Transparency Around Calculation of the QPA:** It is essential that the Departments require health insurers to disclose the methodology used to calculate the QPA for an out-of-network claim, so that providers are ensured it is calculated correctly and in line with the regulatory requirements. Currently, there is little to no recourse for providers who believe that the QPA is miscalculated. While they can submit a complaint, the initial payment they receive for that service is still, in most cases, based on an incorrectly calculated QPA. Currently, providers are restricted from requesting from health insurers specific information on how the QPA was calculated (i.e., to “check their math”), so requiring more transparency is the **ONLY** way to ensure that health insurers actually adhere to the methodology.
- **Scale up and Publicize Auditing of the QPA:** ACEP and EDPMA understand that the Departments have begun with their statutorily required audits of the QPA calculations. However, to enhance transparency, the Departments should scale up and publicly report on the results of these audits. That way, health insurers will be able to better understand the common mistakes that are being made when calculating the QPA and, hopefully, the number of miscalculations will decrease over time.
- **Modify the QPA Methodology to Ensure that the QPA Reflects Market Rates:** Our organizations have requested numerous modifications to the QPA methodology in [previous comments](#). We continue to be especially concerned about the decision to use each contracted rate as a single data point when calculating a median contracted rate. The rate negotiated under a contract constitutes a single contracted rate regardless of the number of claims paid at that contracted rate. We request that the Departments base the rate on the total number of actual payments issued to individually contracted physicians. By basing the contract on claims rather than contracts, the QPA would more accurately reflect the actual negotiated rates between payors and providers. **Health insurers should also be reminded that they are not required to tie the initial payment to the artificially low and potentially miscalculated QPA. The initial payment is supposed to represent a reasonable payment in full for the service that was delivered—and in many cases, the QPA, which was designed to keep patient cost-sharing low, does not reflect a reasonable payment.**

Open Negotiations Phase

There was ample discussion during the meeting about the lack of active negotiations during the Open Negotiations phase of the dispute resolution process. Our physician groups report that health insurers are sometimes not acknowledging receipt of the notice to initiate Open Negotiations and/or are not actively engaging in negotiations at any point during the 30-day period. The lack of engagement by health insurers to come to a resolution before

the IDR process is initiated is counter to the overall intent of the *No Surprises Act* to use the IDR process as a last resort-- and is a significant contributing factor toward the high number of disputes that advance to Federal IDR.

Some stakeholders did note that part of the reason why there may not be much engagement during this part of the dispute resolution process is the fact that both the statute and the regulations do not lay out a particular structure to Open Negotiations nor do they articulate any goals or parameters of the negotiations. Health insurers also reported that the notice of Open Negotiations was frequently going to the wrong contact person, so they had no way of tracking which claims had entered into the Open Negotiations Process.

Recommendation

- **Include the Open Negotiations Process in the IDR Portal:** The Departments should consider incorporating the Open Negotiations Process into the IDR portal. Doing so could help both health insurers and providers better track what claims are entering the dispute resolution process and when the 30-day Open Negotiations Process begins. There could also be a way to assign an identification number to specific items or services under dispute to better track them through the process. The updated portal could also clearly include the contact information, including the email addresses, for all the key contacts involved in the dispute. Finally, it would formalize the Open Negotiations Process and provide a more structured way for health insurers and providers to share information and try to resolve disputes before the IDR process. Therefore, it could track the level of engagement by both health insurers and providers and provide more data to the Departments about the level of compliance among the disputing parties to the statutory and regulatory requirements.

If the Departments were to move in this direction, they must take the following into account:

- *Administrative Complexity:* It is important that such a change is done in a manner that *reduces* administrative burden and does not create even more complexity.
- *Terms of Open Negotiations NOT a Factor in the IDR Process:* If disputes go to the IDR phase of the dispute resolution process, the certified IDR entity should not be privy to the specific discussions that took place during Open Negotiations, including the amounts of any offers or counteroffers exchanged between the parties. The **ONLY** factor the certified IDR entity should take into account (or perhaps even be privy to) from Open Negotiations is the ***level of engagement*** of each party during that phase of the process.
- *Batching Flexibility:* There are different rules around how claims can go through the Open Negotiations Process versus how they can be batched during the IDR process. If Open Negotiation is moved into the portal, we want to ensure that providers would continue to have the flexibility to decide how they want to batch certain claims at the beginning of the *IDR* process, rather than having to already make that decision at the start of Open Negotiations. Yet this could also offer providers an incentive and mechanism to enter some groups of claims into Open Negotiation organized according to the batching criteria, which could ease throughput pressure on certified IDR entities.

IDR Process and Beyond

Accessibility, Transparency, and Enforcement

Participants in the meeting discussed the results of the Department's [first report](#) on the IDR process that included data from the initial reporting period, April 15 to September 30, 2022. There was particular interest in understanding the geographic variation among the total number of initiated IDR claims and the number of claims determined to be ineligible for the IDR process—as most of the disputes were concentrated in a select few states.

Further, ACEP and EDPMA pointed out that the reason the majority of the initiating parties were large practice management companies, medical practices, or revenue management companies representing hundreds of individual groups was that many smaller groups simply did not have the resources or administrative capability to engage in the complex and administratively burdensome (and often fruitless) process. In fact, because of the high cost of the process and the fact that many IDR claims are currently on hold, some billing companies are instructing smaller groups not to use the process at all.

Finally, provider groups in the meeting noted the extremely concerning trend related to health insurers' failure to pay what they owe to the provider if a certified IDR entity finds in favor of the provider. ***Many health insurers are simply not paying the amount owed within the required 30-day period, if at all***, despite numerous attempts by providers to collect the payment they are entitled to under the terms of the arbitration. One group noted during the meeting that it has not received the amount owed to it in ***over 90 percent*** of the cases in which the certified IDR entity ruled in its favor (the eligibility rate and win rate was also over 90 percent, demonstrating a high level of reasonableness and good faith in utilizing the IDR process).

Recommendations

- **Reduce the IDR Fees in 2023:** The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge. These fees already create a financial barrier that prevents physician practices from participating, especially smaller and rural practices. These increases will further limit what types of claims go through the IDR process.
- **Make Enforcement and Auditing More Transparent:** The primary mechanism for addressing non-compliance with the *No Surprises Act* is on a case-by-case basis through the submission and resolution of individual complaints.

We therefore recommend that the Departments release aggregated information about these cases, 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

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.

Releasing all of this information will reduce the overall number of complaints and increase compliance of all *No Surprises Act* requirements. Further, analysis of these complaints could help determine which health insurers need to be audited. **Auditing is critical to ensuring that health insurers have an incentive to comply with the statutory and regulatory requirements.** The Departments should therefore publicly report auditing results, as well as best practices.

- **Enforce Required Payments:** Health insurers who are not paying what they owe to a provider after the IDR process is completed *must be penalized and forced to compensate the provider the total amount owed plus interest.*

Batching Issues

During the meeting, multiple participants stated that the rules and requirements around batching are leading to significant confusion as well as an *increase* in the number of claims going through the IDR process (rather than the decrease batching was intended for). One of the major batching issues relates to “the same group health plan or health insurance issuer.” This policy alone has created so much confusion that some providers are simply not even trying to batch self-insured claims. Further, these criteria require providers to know the employer of a product. This information is frankly not readily available to out-of-network providers, thus injecting a batching criterion that has thrown the entire system into disarray.

We believe that the statute was clear that all disputes (that otherwise met the batching requirements) from the same group health plan (or health insurance issuer) could be batched. The statute did *not* state that batching was limited to individual insurance products offered by a group health plan. Moreover, it is unworkable from the provider’s perspective because in order for it to work, it relies on out-of-network providers organizing disputes based on information that they simply do not have.

Not having the plan type (as described earlier with regard to eligibility for IDR) also creates issues with batching, as providers do not know whether the health plan is a self-insured plan or the employer corresponding to the plan. Requiring health plans to provide the plan type at the time of the initial payment or notice of denial (one of our previous recommendations) would therefore also help reduce some of the errors in batching.

Having to put small batches through the IDR process has become even more concerning given the significant increase in IDR fees in 2023. Not only did the Departments [announce](#) a 40 percent increase to the maximum amounts that certified IDR entity fees could charge in 2023, but the Departments also just recently [announced](#) a 600 percent increase in the administrative (non-refundable) IDR fee that the Departments charge—from \$50 to \$350. With these increases, the financial burden of entering the IDR process will become even more cost-prohibitive for many physician groups who have limited infrastructure or resources. The high administrative fee of \$350 specifically creates an artificial threshold for the IDR process—a **barrier that Congress explicitly omitted from the statute despite several proposals for thresholds offered along the way**. If claims are less than \$350 and cannot be batched together to exceed this threshold, it is actually more expensive to enter the IDR process than to adjudicate a low payment to a claim, thereby limiting what types of claims can go through the IDR process, and unfairly providing insurers with further advantages in the process.

Recommendations

- **Modify Batching Rules to Have Fewer, Larger Batches Rather than More, Smaller Batches or Individual Disputes:** The Departments should take a careful look at all their batching requirements and ensure that they are 1) simple and easy to understand; and 2) do not require providers to have access to information that they do not have. This should at least include a modification to how batching is conducted for self-insured claims. In the alternative, the Departments must require that health insurers provide all information necessary to correctly batch claims in tandem with delivery of the initial payment.

Collection and Exchange of IDR Fees

Some stakeholders during the meeting raised the issue that it was difficult to transfer both the IDR administrative fee and the certified IDR entity fee to the certified IDR entity, as required. If the certified IDR entity does not receive the fees for both parties, the entity cannot render a decision—and this has contributed to some delays in the IDR process. One provider group said that certified IDR entities have different systems in place to electronically collect the fees (and noted that at the be process, one entity actually at one point had even required the use of PayPal to receive the fees).

Recommendation

- **Require Electronic Payment Uniformity Among Certified IDR Entities:** Certified IDR entities should have a uniform process in place to electronically collect all the IDR fees and refund the winning party the certified IDR entity fee. By creating a streamlined process of exchanging fees associated with the IDR process, there would be less interruptions to process and more adherence to the statutorily required timeframes.

Conclusion and Summary

We hope our letter sufficiently summarizes the major issues that providers are experiencing and provides more detail about the recommendations we discussed during the meeting. Overall, as stated throughout the letter, we recommend that the Departments *immediately* take the following steps:

Initial Payment and Notice of Denial Phase

- **Mandate Plan Type to Be Disclosed:** The Departments should require that the plan type be disclosed at the time of the initial payment or notice of denial.
- **Mandate Use of the RARCs:** The Departments should require health insurer use of the Remittance Advice Remark Codes (RARCs) when providing the disclosures that are required along with the initial payment or notice of denial
- **Increase Transparency around the Calculation of the QPA:** The Departments should require that health insurers demonstrate to providers that they are following the methodology outline in regulation and ensuring that QPAs are calculated correctly.
- **Scale up and Publicize Auditing of the QPA:** The Departments should scale up and publicly post the results of the ongoing QPA audits.
- **Modify the QPA methodology to ensure that the QPA reflects market-rates:** The Departments should modify the QPA methodology by basing the median contracted rate on the total number of actual payments issued to individually contracted physicians.

Open Negotiations Phase

- **Include the Open Negotiations Process in the IDR Portal:** The Departments should consider incorporating the Open Negotiations Process into the IDR portal. If the Department do pursue this

approach, there are a number of factors that ACEP and EDPMA believe the Departments must take into account when doing so.

IDR Process and Beyond

- **Reduce the IDR Fees in 2023:** The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge.
- **Make Enforcement and Auditing More Transparent:** The Departments should release information about the complaints they receive—broken out by state. Auditing is also critical to ensuring that health insurers have an incentive to comply with the statutory and regulatory requirements. The Departments should therefore publicly report auditing results, as well as best practices.
- **Enforce Required Payments:** Health insurers who are not paying what they owe to a provider after the IDR process is completed must be penalized and forced to compensate the provider the total amount owed plus interest.
- **Modify Batching Rules So That There Will be fewer LARGER Batches Rather Than More SMALLER Batches or Individual Disputes:** The Departments should take a careful look at all their batching requirements and ensure that they are 1) simple and easy to understand; and 2) do not require providers to have access to information that they do not have.
- **Require Electronic Payment Uniformity Among Certified IDR Entities:** Certified IDR entities should have a uniform process in place to collect all the IDR fees and refund the winning party the certified IDR entity fee.

We appreciate the opportunity to lay out our concerns and provide potential solutions to help improve the implementation of the *No Surprises Act*. If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,



Christopher S. Kang, MD, FACEP
ACEP President



Don Powell, DO
Chair of the Board, EDPMA

Appendix: Information Needed for Federal Dispute Resolution Process

Major Regulatory Requirement	Regulatory Citation	Are Health Insurers Complying?	Recommendations
<i>Disclosures Required at the time of the Initial Payment/Notice of Denial</i>			
Qualified Payment Amount (QPA)	45 CFR § 149.140(d)(1)(i)	Rarely	<ul style="list-style-type: none"> • Mandate RARCs. • Publish audits of the QPA. • Require insurers to display the methodology used to calculate QPA. Information could include: <ul style="list-style-type: none"> ○ Number of contracts used to calculate the QPA; ○ Whether QPA was calculated using contracts with clinicians in same or similar specialty; ○ Geography used to calculate the QPA (i.e., Single MSA, all MSAs in a state, Census Division); ○ Percentage of total claims covered by contracts used to calculate QPA (in-network percentage); ○ Percentage of in-network claims attributable to each contract; ○ Whether plan or issuer's QPA calculations have had an audit result of anything other than "clean" within the last 3 years; ○ If the plan or issuer uses a standard fee schedule, the amount for the service as it

			<p>appears on the fee schedule for the specific market; and</p> <ul style="list-style-type: none"> ○ If plan or issuer uses contracts from a plan year other than January 31, 2019 to calculate the QPA.
<p>Statement that the QPA is Calculated Accurately and Can be Used for Cost-Sharing: Statement certifying that, based on the determination of the plan or issuer: (1) the QPA applies for purposes of the recognized amount each QPA; and (2) the QPA shared with the provider or facility was determined in compliance with the methodology outlined in these interim final rules.</p>	45 CFR § 149.140(d)(1)(iii)	Rarely	<ul style="list-style-type: none"> • Mandate RARCs. • Require health insurers to disclose the plan type.
<p>Statement Regarding Initiation of Open Negotiations: A statement that if the provider wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period. The plan or issuer must provide contact</p>	45 CFR § 149.140(d)(1)(iv); 45 CFR § 149.140(d)(1)(v)	Rarely	<ul style="list-style-type: none"> • Better enforcement of this requirement. • Include contact information as an element in combined Open Negotiations and IDR Portal.

information, including a telephone number and email address, for the appropriate office or person to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.			
Information about Contracted Rates not Based on FFS: Upon request of the provider, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis.	45 CFR § 149.140(d)(2)(i)	Sometimes	<ul style="list-style-type: none"> Better enforcement of this requirement.
Information about Cost-sharing Rates including Incentive Payments: Upon request, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded for purposes of calculating the QPA.	45 CFR § 149.140(d)(2)(iv)	Sometimes	<ul style="list-style-type: none"> Better enforcement of this requirement.
Downcoding: If the QPA is based on a downcoded service code or modifier: <ul style="list-style-type: none"> a statement that the service code or modifier billed by the provider or facility was downcoded; 	45 CFR § 149.140(d)(1)(ii)	Sometimes	<ul style="list-style-type: none"> Better enforcement of this requirement.

<ul style="list-style-type: none"> • An explanation of why the claim was downcoded, including a description of which service codes or modifiers were altered, added, or removed, if any; and • The amount that would have been the QPA had the service code or modifier not been downcoded. 			
Open Negotiations			
Notice to Initiate Open Negotiations: To initiate the open negotiation period, a party must send a notice to the other party (open negotiation notice) that includes information outlined in 45 CFR § 149.510(b)(1)(ii).	45 CFR § 149.510(b)(1)	Rarely acknowledging receipt of the Open Negotiations notice or actively engaged in negotiations.	<ul style="list-style-type: none"> • Consider combining the Open Negotiations and IDR Portal in order to make sure Open Negotiations Process can be better tracked and actually help facilitate negotiations prior to the IDR process.
IDR Process and Beyond			
Notice of IDR Initiation: To initiate the Federal IDR process, a party must submit a written notice of IDR initiation to the other party and to the Secretary, using the standard form developed by the Secretary, during the 4-business-day period beginning on the 31st	45 CFR § 149.510(b)(2)	Since health insurers rarely provide this information at the time of initial payment or notice of denial, it is difficult for initiating parties (providers) to include all the required information.	<ul style="list-style-type: none"> • Better enforcement of previous requirement for health insurers to provide certain disclosures at the time of the initial payment/notice of denial.

business day after the start of the open negotiation period. The notice must include information outlined in 45 CFR § 149.510(b)(2)(iii).			
Batched items and services: Batched items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet the requirements listed in 45 CFR § 149.510(c)(3)(i).	45 CFR § 149.510(c)(3)(i)	The batching rules are difficult to adhere to and result in more, not less, batches.	<ul style="list-style-type: none"> • Modify batching rules so that there will be fewer larger batches rather than more smaller batches or individual disputes.
IDR Offer: Not later than 10 business days after the selection of the certified IDR entity, the plan or issuer and the provider, facility, or provider of air ambulance services must each submit to the certified IDR entity: an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount; information requested by the certified IDR entity relating to the offer; and additional information listed in 45 CFR § 149.510(c)(4)(i)(3).	45 CFR § 149.510(c)(4)(i)	In many cases, the offer submitted by the health insurer is close to the initial payment, which mirrors the QPA. It is difficult for providers to develop a counteroffer when there is limited transparency over how the QPA is calculated.	<ul style="list-style-type: none"> • Remind health insurers that the initial payment does not need to be based on the QPA. • Publicize audits of the QPA. • Require more transparency over how the QPA is calculated.

Payment Determination and Notification: Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must select as the out-of-network rate for the qualified IDR item or service one of the offers as the out-of-network rate.	45 CFR § 149.510(c)(4)(ii)	Certified IDR entities rarely meet this 30-business-day timeline for making a payment determination.	<ul style="list-style-type: none"> • Reduce the backlog of claims and enforce the 30-day requirement.
Written Decision: The certified IDR entity must explain its determination in a written decision submitted to the parties and the Secretary that includes specific information outlined in 45 CFR § 149.510(c)(4)(vi)(B).	45 CFR § 149.510(c)(4)(vi)	Certified IDR entities meet this requirement, but sometimes do not fully explain how they came to their decision.	<ul style="list-style-type: none"> • Better transparency around how certified IDR entities render their decisions.
Payment by Losing Party: If applicable, the amount of the offer selected by the certified IDR entity (less the sum of the initial payment and any cost sharing paid or owed by the participant or beneficiary) must be paid directly to the provider, facility, or provider of air ambulance services not later than 30 calendar days after the determination by the certified IDR entity.	45 CFR § 149.510(c)(4)(ix)	Insurers rarely pay within 30-day period in cases where certified IDREs select the provider's offer.	<ul style="list-style-type: none"> • Penalize health insurers not paying what they owe to a provider after the IDR process is completed. • Compel health insurers to compensate the provider the total amount owed plus interest.
Costs of IDR Process: Each party must pay the predetermined certified IDR entity fee charged by the certified IDR entity to the	45 CFR § 149.510(d)	Sometimes Certified IDREs do not receive the IDR fees from health insurers.	<ul style="list-style-type: none"> • Certified IDR entities should have a uniform process in place to collect all the IDR fees and refund the winning party the certified IDR entity fee.

<p>certified IDR entity at the time the parties submit their offers.</p> <p>Each party must, at the time the certified IDR entity is selected, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary for participating in the Federal IDR process.</p>		<p>The high IDR fees are making it cost-prohibitive for many physician groups to participate in the IDR process.</p>	<ul style="list-style-type: none"> • The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge.
<p>Extension of Time Periods for Extenuating Circumstances: The time periods for the IDR may be extended in extenuating circumstances at the Secretary's discretion if certain conditions, found in 45 CFR § 149.510(g)(1).</p>	<p>45 CFR § 149.510(g)</p>	<p>The timelines are being extended routinely even in the absence of a formal extension request.</p>	<ul style="list-style-type: none"> • Reduce the backlog of claims. • Enforce timelines mandated by statute and regulation.