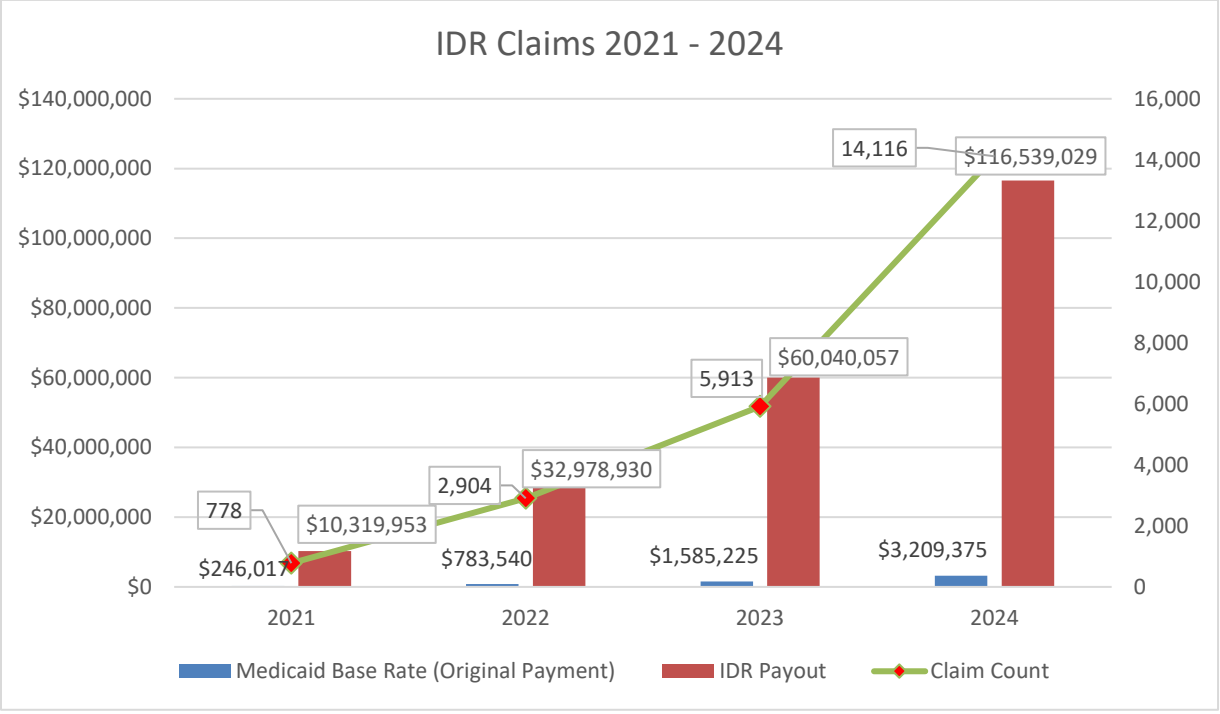
Protecting Patients & Helping Taxpayers: Exempt Medicaid from IDR

Specialty Providers Continue to Abuse IDR

A growing number of high-price providers are exploiting a loophole in New York's Independent Dispute Resolution (IDR) process to generate excessive reimbursements when treating Medicaid patients. The ongoing abuse is costing the state hundreds of millions of dollars, which should be used to protect care for the most vulnerable residents not putting more money in the pockets of well compensated specialists.

According to data collected from health plans covering more than 91% of the Mainstream Medicaid program, in 2024 IDR payouts to providers totaled $116.5 million, compared to $3.2 million that Medicaid would have reimbursed for the same services without the IDR process. The number of Medicaid claims submitted for IDR has grown from 778 in 2021 to over 14,000 (14,116) 2024, a 1,700% increase.



Medicaid's lower reimbursement reflects that this is a taxpayer-funded program intended to expand coverage to vulnerable populations, but the IDR process does not take that into account when determining if what the provider has billed is reasonable. The providers abusing the IDR process aren't primary care physicians but rather high-cost specialties, such as radiologists, anesthesiologists, neurosurgeons, and orthopedists, who are choosing to remain out-of-network and charge excessive rates to Medicaid.

Close the Loophole

Governor Hochul's FY2027 Executive Budget includes a proposal to exempt the Medicaid program from the IDR process. The Division of Budget conservatively estimates this proposal would save New York $28.5 million. In the face of the drastic federal cuts to health care, this is a sensible reform. It will contain costs, provide savings for the state and taxpayers, and ensure vulnerable New Yorkers have access to critical services. It should be included in this year's final budget.

Understanding New York's IDR Process

In 2014, New York adopted one of the first laws in the country to protect patients and hold them harmless from emergency and surprise out-of-network bills. The law included the establishment of the IDR process to resolve payment disputes between providers and health plans. Under the law, an independent arbiter determines whether 1) the provider's fee or 2) the health plan's payment is more reasonable for an out-of-network service, comparing the amount charged for the particular service in the same specialty in the same geographical area. In determining the comparison, the arbiter will consider how closely each side's proposed amount is in relation to the 80th percentile of amounts charged for similar services in that region.

For insurance coverage provided through an employer or the individual market, the IDR process will reflect the rates providers charge the commercial market, but it makes little sense in Medicaid. Patients are already protected from surprise bills and out-of-pocket costs. Additionally, Medicaid's lower reimbursement reflects that this is a taxpayer-funded program intended to expand coverage to vulnerable populations but the IDR process does not take that into account when determining whether what the provider has billed is reasonable.

The current structure has created a loophole allowing providers treating Medicaid patients to charge higher rates than what Medicaid would reimburse, incentivizing them to remain out-of-network while providing no benefit to patients and taking away scarce state funding that could be used more efficiently to provide health care for all New Yorkers. Providers that have issues with the rates Medicaid reimburses should seek other solutions and not misuse state law to get paid more.

Examples of Providers Exploiting the IDR Process to Increase Medicaid Reimbursement:

- An individual needed emergency back surgery at a downstate hospital, which was performed by an out-of-network surgeon. While the Medicaid fee schedule reimbursed for the surgery at nearly $3,000, the provider disputed the amount, submitting a bill in excess of $566,000 – almost 200 times the Medicaid rate. The independent reviewer determined the surgeon should have been reimbursed over $514,000, which became the ultimate cost to the taxpayers.

- A patient with spinal nerve compression that was causing muscle weakness was admitted to a downstate hospital and required surgery. An out-of-network orthopedic surgeon performed the procedure, charging over $563,000, well above the Medicaid fee schedule of roughly $1,300. The independent reviewer rendered a decision that the provider was owed over $507,000.

- A downstate neurosurgery group that was out-of-network performed spinal fusion surgery on an individual at an in-network hospital. The Medicaid fee schedule set a rate of $1,757, while the group charged nearly $81,000, with the independent reviewer determining that the neurosurgery group's requested amount to be more reasonable.