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Strengthening the No Surprises Act's Independent Dispute Resolution Process

Stakeholder Perspectives

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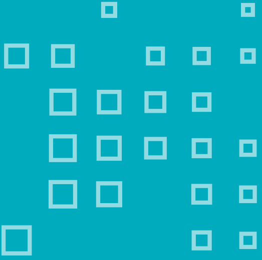
Strengthening the No Surprises Act's Independent Dispute Resolution Process

Stakeholder Perspectives



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Executive Summary

This project was designed to collect a broad range of perspectives from stakeholders and the literature to (1) understand the current state of the implementation of the Independent Dispute Resolution ("IDR") process, and (2) arrive at a set of productive, broadly supported recommendations—however narrow—for its reform and improvement. We interviewed stakeholders from all relevant categories involved in IDR, including providers, payers, regulators, experts, and Independent Dispute Resolution Entities ("IDREs"), with the aim of avoiding the most contentious questions under litigation and focusing on areas of potential agreement. By necessity, these areas turned out to be technical, system-focused, and incremental.

Interviewees described operational and technical problems at multiple stages of the IDR process. Stakeholders discussed frustrations with the lack of resolution of claims during the open negotiation period prior to the start of the IDR process. With the routine failure of open negotiation to resolve disputes, interviewees described an IDR system clogged with claims (some of which are ineligible), biased IDREs, a lack of rigor by IDREs that creates a black box on their decision-making rationales, and the lack of recourse when decisions have some sort of deficiency under the statute. The technical limitations of the web portal through which disputes are filed and tracked was also found lacking.

While there was not unanimity among stakeholders on solutions to every problem, consensus approaches emerged across multiple groups in some key areas.

Open Negotiation
- Help initiating parties identify the correct payer and how to contact them
- Require detailed reasoning for payment decisions at the front of the process
- Require detailed reasoning for payment decisions later in the process

IDR Eligibility Determinations
- Provide robust explanation of, and training on, eligibility rules
- Pre-screen eligibility and/or automate eligibility checks
- Issue detailed guidance on appropriate evidence of claim eligibility or ineligibility

IDR Determinations
- Require IDREs to provide detailed reasoning for decisions
- Provide guidance on appropriate types of supporting evidence
- Require additional IDRE and arbitrator training and certification
- Establish an appeal or audit process
- Improve the complaint systems
- Disclose more IDRE data

Portal Functionality
- Add functionality to track case status
- Allow payment tracking
- Automate notifications to parties when documents are submitted or deadlines approach

Introduction

Every year, millions of people receive balance bills—additional out-of-pocket charges after insurance has paid its share—from out-of-network health care providers, facilities, or air ambulance providers,[1] many of which are unexpected (colloquially known as "surprise" bills). In December 2020, Congress enacted the *No Surprises Act* (the "NSA"), a provision of the *Consolidated Appropriations Act, 2021*, to protect patients from surprise medical bills in certain circumstances and establish a process for providers and health insurance issuers and group health plans[2] to determine out-of-network reimbursement.[3] Specifically, the law protects commercially-insured patients from surprise bills after emergency treatment by an out-of-network provider, treatment by an out-of-network provider at an in-network facility, or transport by an out-of-network air ambulance provider.[4] In these cases, the NSA requires plans to charge patients only their in-network cost-sharing amount and separately determine provider reimbursement. To settle these payment disputes, the NSA created a federal arbitration process, commonly referred to as IDR, in which certified entities ("IDREs") adjudicate disputes based on several statutory factors and render payment determinations.

To implement the NSA, the Departments of Health and Human Services, Labor, and the Treasury (the "Departments") promulgated rules and guidance for disputing parties and IDREs. The federal insurance regulators within the Center for Consumer Information and Insurance Oversight ("CCIIO"), a division of the Centers for Medicare and Medicaid Services ("CMS"), oversee the IDR process. CCIIO engaged a contractor to build an internet portal (the "portal") through which parties could initiate and respond to payment disputes and the IDRE could process those disputes.[5]

The Departments' implementation approach has been successfully challenged by providers in several lawsuits. In lawsuits brought by the Texas Medical Association (the "TMA") and others, a Texas federal district court overturned multiple portions of rules and guidance, primarily those concerning calculation and IDRE consideration of the median in-network reimbursement rate (termed in statute the "qualifying payment amount" or "QPA") and administrative fees.[6] In response to these rulings, CMS has periodically paused the IDR system for resolving certain types of cases, allowing it time to alter guidance and make system adjustments to comply with the court decisions.[7] This report does not address the core issues litigated in the *TMA* cases, since those issues are not directly related to the operational efficiency and smooth functioning of the system and are sufficiently controversial that interviewees likely would not agree on ways to address them.

Overall, the IDR process has been utilized much more than the Administration projected, with over 490,000 disputes submitted through the IDR portal between its start in April 2022 and June 2023—more than 25 times higher than originally projected.[8] As of June 2023, 61% of disputes submitted remained unresolved.[9]

Federal Reports on IDR Implementation

In December 2023, the Government Accountability Office ("GAO") released a report, as required by the NSA statute, on the early implementation experience of IDR.[10] To evaluate the IDR process, GAO reviewed dispute data and guidance; interviewed disputing parties, IDREs and CMS officials; and conducted a performance audit. GAO documented the difficulty of the IDR launch, with a higher-than-expected volume of disputes resulting in backlogs and delays in determinations. While the Departments have been working to address concerns, budget constraints have limited the speed and scope of improvements.[11]

The statute also requires CCIIO to periodically publish data on the IDR process.[12] The agency's year-end report for 2022 indicated a higher-than-expected volume of disputes and significant delays in IDRE processing of claims.[13] For example, less than a third of disputes initiated during the fourth quarter of 2022 were resolved. The complexity of determining eligibility for the dispute process was cited as the most common reason for delays in the process. About one-third of disputes that were closed between April 15, 2022 and March 31, 2023 were ultimately determined ineligible. Disputes that were not closed due to ineligibility were closed owing to factors such as withdrawal, outside settlement, or unpaid fees.

Overview of the Proposed Rule

The Departments and the Office of Personnel Management[14] released a proposed rule in fall 2023 intended to smooth some of the operational barriers to timely IDR determinations and payments.[15] The proposed rule aims to keep more ineligible claims out of the process, improve the functionality of the IDR portal, increase the communication between parties, and change the rules for consideration of multiple claims at the same time ("batching"). Changes would be made to the selection of the IDREs, the eligibility determination process, and withdrawal of disputes. To make it easier to initiate a dispute against the correct party, insurers and health plans would be required to have uniform identifiers. Insurers would also be required to use claims adjustment reason codes ("CARCs") and remittance advice remark codes ("RARCs") on claims to convey additional information to providers as they consider initiating a dispute. Several of these proposed changes are discussed below, to the extent they relate to concerns raised by interviewees.

Methodology

Manatt sought to find areas of common agreement for technical and policy recommendations to strengthen the IDR process. To do this, Manatt conducted an analysis of the federal IDR process established under the NSA through interviews with a diverse set of stakeholders and supplemented by a review of existing literature. Perspectives included: regulators, IDREs, providers, insurers, and subject-matter experts. Interview questions focused on practical regulatory and process solutions and did not solicit comment on desired statutory changes. Interviews focused on stakeholders' experiences with, and insights related to, open negotiation, dispute initiation, dispute eligibility, submission of supporting evidence, IDRE determinations,

and the IDR portal. The interviews and literature review did not focus on the issues currently being litigated, such as the batching of claims or QPA calculations. All interviewees were guaranteed that their participation and responses would remain anonymous.[16]

Many concerns about the dispute resolution process were shared across multiple stakeholder categories, and some common recommendations also arose. To appear as a recommendation in this report, a policy idea needed to have support from multiple categories of stakeholders. Unanimous support was not required for inclusion.

Findings and Recommendations to Strengthen IDR

Open Negotiation

Background

If a provider disputes the payer's initial out-of-network payment amount (or denial of payment), either of which are due within 30 days of receipt of a "clean claim,"[17] the provider has 30 days to initiate open negotiation, a required precursor to IDR initiation. The open negotiation period lasts an additional 30 days, intended for the parties to agree on a payment amount for the out-of-network service. If the negotiation is not successful, either party has four business days after the 30-day period has expired to initiate the IDR process.

Concerns

Overall, stakeholders expressed frustration that the open negotiation stage did not lead to more communication between parties or negotiation and resolution of payment disputes. Interviewees had three primary concerns: (1) overutilization of claim submission, (2) underutilization of good faith negotiation, and (3) genuine confusion or misunderstanding of the applicable timeframes for the process.

Overutilization of claim submission: First, many stakeholders bemoaned the sheer volume of disputes entering open negotiation, though stakeholders had different views on the root cause. Initiating parties argued that unreasonably low reimbursement rates trigger what can be a cumbersome and expensive process, while non-initiating parties felt that many initiating parties were throwing all claims (including ineligible ones) into dispute without a clear rationale. One interviewee said that they have received a bundle in excess of 20,000 claims for a single month, representing every radiology service performed by a large provider. Since the IDREs do not perform eligibility checks until an IDR dispute is filed, parties' failure to communicate at the open negotiation stage results in ineligible claims unnecessarily staying in the process, rather than detecting eligibility issues and negotiating those claims outside of IDR. Allowing ineligible claims to persist is not in the interest of either side—payers spend time and resources responding to improper claims, while providers face the risk of non-payment even if they prevail in IDR.

Underutilization of good faith negotiation: Parties generally panned the ability of the process to prompt good faith negotiation, resulting in underutilization of the open negotiation period to settle disputes. For example, one stakeholder cited what appeared to be automated emails to the initiating party declining open negotiation participation, sent seconds after an open negotiation initiation notice was issued, while another claimed it was in the financial interest of the insurers to effectively boycott open negotiation and only reimburse at the end of a protracted IDR process.

Parties indicated that many disputes submitted for open negotiation do not include the full set of information necessary to facilitate more productive negotiation or to determine eligibility. Initiating parties cited the difficulty of even identifying the appropriate counter party (in the case of self-funded employer plans that use a third-party administrator, or "TPA") or the correct contact information for an insurer.[18] Payers also expressed frustration that disputed claims were being brought against them when they were only acting as the TPA and the appropriate party was the employer's health plan.

Recommendations

Multiple stakeholders agreed on recommendations to improve the utilization of the open negotiation stage.

- **Help initiating parties identify the correct payer and how to contact them.** This could help providers identify when an insurer is acting on their own behalf versus as the TPA for a self-funded employer plan (and therefore not the correct party). Having the accurate contact information would also prevent stalls in the 30-day open negotiation period and give parties additional time to come to agreement.
- **Require detailed reasoning for payment decisions at the front of the process.** Today, insurers can use RARCs on their electronic disclosures to explain why claims are denied or adjusted. Some of these codes are specific to the NSA, but the NSA list of codes does not address all required QPA disclosures. Some stakeholders recommend requiring the use of RARCs and CARCs on insurers' claim remittances to improve communication and reduce inefficiencies that hinder dispute resolution. Other stakeholders noted that technical barriers may need to be resolved to ensure that claims systems can enter multiple codes.
- **Require detailed reasoning for payment decisions later in the process.** Multiple stakeholders described how the brevity or, in some cases, absence, of IDREs' explanation of their decisions discourages meaningful, good faith engagement at the open negotiation stage. Since parties cannot predict with any reasonable certainty how IDREs approach a given dispute, they cannot set realistic bargaining positions for a negotiation with the counterparty. As further described below, greater clarity from IDREs would allow parties to incorporate assumptions about IDRE behavior into their bargaining positions, resulting in settlement of more disputes during open negotiation.

The proposed rule addresses some of these issues and, in some cases, goes further. The proposed rule would require parties to file the open negotiation notice and supporting documentation in the portal and for non-initiating parties to respond in the portal within 15 days.[19] This change is intended, in part, to improve the engagement of both parties and thus encourage negotiation. In addition, the proposed rule would add required fields to the open negotiation notice and response, aimed at clearing out ineligible disputes before they enter the IDR process.[20] To facilitate the negotiation, the proposed rule would also require all insurers, including self-funded employer health plans, to promptly acquire a new federal identification number.[21] This

new registry would make it easier for initiating parties to correctly identify the issuer or health plan and have that claim routed to the accurate contact. Further, the proposed rule would mandate the use of RARCs and CARCs.[22]

IDR Dispute Initiation

Background

If parties do not settle on a payment amount within the 30-day open negotiation period, either party can initiate the IDR process within four business days of its expiration. In its notice of IDR initiation, the initiating party must recommend an IDRE for consideration by the non-initiating party; if the parties cannot agree, CMS randomly assigns an IDRE. Once selected, the IDRE has three business days to attest that it does not have a conflict of interest and that the parties' dispute is within the jurisdiction of the federal IDR process.

Concerns

Interviewees expressed concerns regarding system capacity and administrative fees.

System capacity: Multiple parties remarked on the high volume of disputes going through the IDR process, and the IDR system's unpreparedness for such volume. CMS estimates that nearly one-half million disputes will be filed annually.[23] Notably, ten parties initiated 71% of all disputes involving emergency and non-emergency items and services in the fourth quarter of 2022 (the latest date for which data on parties is available).[24] The top ten parties represent 94% of air ambulance out-of-network disputes.

Administrative fees: Stakeholders interviewed were divided on the appropriate fee level. The statute requires that an administrative fee be set at the amount necessary to fully cover the administrative cost of carrying out the IDR process for that year.[25] A recent rule established the administrative fee at $115 per party per dispute.[26] This came after an initial dispute filing fee of $50, then an increase to $350 established by guidance that was struck down by the court in *TMA IV*.

Recommendation

No common recommendation emerged to address these concerns, but stakeholders expressed strong opinions about administrative fees that are noteworthy.

Multiple stakeholders suggested setting an administrative fee that raises the financial stakes of participating in the IDR process, but parties had divergent views on how to do this and why. Some parties advocated a "loser pays" system for the administrative fee, as is true for the fee paid directly to IDREs; others would like to see an increase in the dollar value of the fee. (For the most part, parties that favored one of those options strongly opposed the other.) The parties' reasoning for preferring one option over the other varied. Some thought it would increase payers' incentive to bring out-of-network providers in network, increase the effort made to resolve disputes during open negotiation, or raise the dollar value of negotiated offers, while others stated that higher fees could disincentivize parties from initiating "borderline" disputes with questionable merits or simply increase the funding available to expand capacity of the Departments to better handle the dispute volume. Finally, other parties were concerned that increased fees would block smaller providers from filing meritorious disputes, since the cost of filing could exceed claim amounts for some providers.

The proposed rule would require more fulsome disclosure of information by both parties at the IDR initiation stage, generally mirroring the proposals on notices described above.[27] Specifically, the proposed rule would require the initiating party to include a statement describing key aspects of the claim discussed by the parties during open negotiation, whether its reasons for initiating IDR are different than those discussed during open negotiation, and an explanation of why the party is initiating IDR. These notices and their supporting documentation would be submitted through the portal.

IDR Eligibility Determinations

Background

The federal IDR process is available for disputes arising in commercial insurance markets, except in fully-insured commercial markets governed by a state law that provides for a method for determining the amount of payment owed to out-of-network providers (a "specified state law") or as applied to a self-funded plan that has "opted in" to regulation by such a state law.[28] Other claims—such as those from Medicaid or Medicare—do not qualify for the federal process. If the non-initiating party believes that the federal IDR process should not apply to a dispute, it must indicate this through the IDR portal as a part of the IDRE selection process.[29] However, once an IDRE has been chosen, the IDRE is charged with determining the applicability of the federal IDR process regardless of whether the dispute's eligibility has been challenged. In that case, the IDREs' eligibility inquiry is limited to reviewing whether any specified state laws or All-Payer Model Agreements remove the dispute from the federal process.[30]

Since the IDR process started in April 2022, it has had significant backlogs in claim adjudication, many of which have been attributed to the complexity of eligibility determinations. While portal improvements have been made to weed out ineligible disputes, reviewing the documents parties file to prove or challenge eligibility is still largely a manual process. To help address the bottleneck, starting in November 2022, the Departments engaged contractors and staff to support IDREs with pre-eligibility reviews.[31] The proposed rule would formalize CMS eligibility reviews when backlogs form.[32]

Concerns

While stakeholders noted improvement, interviewees across all categories still raised concerns about lack of rigor, efficiency, and accuracy in eligibility determinations.

Delay: As described above, multiple parties told us that eligibility determination has caused significant delays in IDRE decisionmaking, although those delays are lessening. When the IDR portal was first launched, few automatic or prompted eligibility checks were incorporated. Significant processing delays arose due to the unanticipated volume of disputes and their complexity and the manual nature of IDRE eligibility determinations.[33] The Departments reported that, in the first nine months of operation, the most common reasons for eligibility determination delays were missing documentation (including incorrect or missing contact information, missing QPAs, or missing proof of open negotiation, which required additional and time-consuming outreach from IDREs to parties) and the complexity of the federal-state interaction of surprise

billing laws.[34] However, multiple interviewees told us that the eligibility determination process has improved and backlogs have dropped substantially. One interviewee told us that rates of ineligible claims submitted have dropped to roughly 10%.

Inaccuracies and errors: Many interviewees said that large numbers of ineligible cases were being submitted for IDR, some of which made it all the way to final IDRE adjudication without detection. For example, insurers cited Medicare Advantage claims that have made it to final IDRE decision. Stakeholders also made the inverse point—IDREs make erroneous decisions of ineligibility. For example, some stakeholders said that certain IDREs seem to not understand that all timely out-of-network air ambulance disputes are eligible for the IDR process, since state law cannot apply. It is notable that IDREs are not required to provide written rationales for eligibility determinations.

Lack of appeal: Stakeholders expressed frustration that there is no recourse if a determination was made on an ineligible claim, since the statute provides for no appeal of IDRE decisions nor has CCIIO addressed in guidance how insurers should handle this problem.

Failure to enforce "cooling off" period: In addition, interviewees indicated that the statutory "cooling off" period—the 90-day post-IDRE decision period during which a new dispute against the same party for the same or similar service may not be filed[35]—is generally not being observed or enforced. One reason offered for this is the challenge posed by IDRE backlogs, in which similar claims have been submitted involving the same parties but to different IDREs; if one IDRE renders a decision that would trigger the cooling off period for a service category, claims still under consideration by another IDRE in the same category could be subject to the cooling off period. However, nothing in the current IDRE guidance addresses how to detect this issue, nor does the guidance charge IDREs with examining whether initiating parties and claims are subject to a cooling off period.[36]

Recommendations

Multiple categories of stakeholders coalesced around the need for continued development of robust eligibility screening and more explicit guidance on what constitutes evidence of an eligible or ineligible claim.

- **Provide robust explanation of, and training on, eligibility rules.** Parties report confusion about which disputes are eligible for the federal IDR process, and multiple interviewees stated that the Departments should provide more comprehensive eligibility guidance for parties and IDREs. Interviewees from multiple stakeholder categories also agreed that additional training for IDREs and their arbitrators on eligibility standards would be helpful.
- **Create additional pre-screening and automation of eligibility checks.** Others recommended that CCIIO develop more robust pre-screening criteria and automate more eligibility checks to reduce the number of ineligible disputes that IDREs must sift through and improve the integrity of the process. For example, the portal asks the initiating party to check a box indicating claim eligibility for the federal IDR process. More could be done to guide the party through the eligibility criteria. Automation could also be developed to punt certain disputes. In implementing one state's surprise billing law, for example, the Department of Insurance has requested that insurers share a list of ineligible plan identification numbers (e.g., self-insured plans governed by federal IDR) and has built a function in its portal to flag ineligible submissions up-front.

CMS could consider adding such a functionality in the federal portal, enabled by the plan registry in the proposed rule. (The system requirements of such a screening process would obviously be much more significant on a national scale.)

- **Issue detailed guidance on appropriate evidence of claim eligibility or ineligibility.** Multiple stakeholders suggested that more detailed guidance from the Departments, for parties and IDREs, on what is or is not appropriate evidence of eligibility could reduce the number of ineligible claims filed or the amount of follow-up needed from the IDREs. For example, one interviewee cited lack of clarity on what evidence could support a challenge to eligibility on the grounds that a plan is retiree-only.

The proposed rule addresses the eligibility determination process by lengthening the period for IDREs to make an eligibility finding from three to five days, and by explicitly allowing CMS to conduct eligibility determinations (including finding certain disputes ineligible) to backstop IDREs when volume is high.[37]

Furthermore, as described above, the proposed rule would create a registry in which health plans (fully-insured and self-funded, as well as FEHB carriers) would register with the Departments and receive a numerical identifier to help initiating parties identify the correct payer to designate when filing an IDR dispute.[38] Interviewees generally supported this proposal. Interviewees particularly pointed to the difficulty, under the current system, of identifying when a self-funded plan has "opted in" to a specified state law (thus removing itself from federal IDR jurisdiction). The new registry would allow identification of those plans.

Finally, under the proposed rule, beginning in 2025, the initiating party in a dispute would pay their full administrative cost when a dispute is found to be ineligible, while the non-initiating party would pay only 20% of the standard fee.[39] This could reduce the burden on non-initiating parties when disputes are determined to be ineligible for the process.

IDRE Determinations

Background

Within ten days of the selection of an IDRE, the parties must submit an offer to the IDRE or the reimbursement rate, along with any information the IDRE requests. Parties may also submit additional supporting evidence not prohibited by law. Interviewees report that supporting evidence was previously submitted via email or other channels outside of the portal, which resulted in a lack of transparency about evidence submitted and grounds for the IDRE determination. Now, supporting evidence is submitted through the portal, which helps disputing parties track information.

Within 30 days of its selection, the IDRE must select one of the parties' offers as the final reimbursement rate for the item or service provided. CCIIO's IDRE guidance requires the IDRE to notify the parties and the Departments and provide a written decision through the portal. The Departments have published specific guidance on what data elements IDREs should include in written decisions. In addition to the payment determination (single or batched, as applicable), the guidance directs IDREs to provide a written decision, including "the underlying rationale for its determination."[40] This guidance, however, is broad and does not contain many specifics of what must be included within the written decision. CCIIO has provided a template that IDREs may, but are not required to, use in issuing a determination.

Concern

A broad swathe of stakeholders expressed frustration with the lack of detail, inconsistency, and inaccuracy of IDRE decisions.

"Black box": Stakeholders from multiple categories felt that IDREs provided little useful explanation of how they reached their final decisions, creating a "black box" effect. Stakeholders said that the optional CCIIO-provided decision template for IDREs is of limited use, describing it as "just check boxes" that do not meaningfully standardize information. In their analogous process, at least one state requires arbitrator decisions to include an explanation of elements used to make a decision and why those elements are relevant.

Bias: Both initiating and non-initiating parties asserted that certain IDREs show extreme bias against either providers or insurers and that both sides know which IDREs to select to "game" the process. In a resonant example from the GAO report, for example, one initiating party said they had a 100% loss rate from one IDRE, despite a 90% IDR process win rate overall.[41]

Inaccuracies and inconsistencies: Stakeholders also stated that, where decision rationales were discernible, IDREs inconsistently followed legal requirements for permissible factors in making a determination (e.g., prohibition on considering Medicare or Medicaid payment rates). Stakeholders also noted inconsistent IDRE decisions on similar fact patterns. For example, one stakeholder cited opposite decisions on very similar claims from the same IDRE, with no explanation of the disparity provided.

Recommendations

Stakeholders recommended requiring that IDREs provide detailed reasoning for decisions and that CCIIO provide guidance on appropriate types of supporting evidence, provide additional trainings, improve the complaint system, and establish an audit/appeal process.

- **Require IDREs to provide detailed reasoning for decisions.** Multiple stakeholder groups stated that having more information about arbitrators' reasoning for a particular decision would be beneficial. Stakeholders from multiple categories focused on two positive effects:
  - **Greater understanding of, and confidence in, the process by parties.** For example, if IDREs discussed which supporting documents from the parties were, or were not, relevant to its decision (on eligibility or the merits), parties would be able to adjust their behavior to avoid filing meritless disputes and focus on relevant arguments and evidence – thus increasing efficiency and reducing system cost.
  - **Increased negotiation and settlement.** Stakeholders expressed the view that the more parties are familiar with IDRE "rules of decision," the less likely they are to utilize the IDR process. Studies of dispute resolution bear this out: clarity about a decisionmaker's rationale gives parties a shared understanding of expected outcomes.[42] That shared understanding leads to more rational bargaining positions and successful negotiations. When the parties don't share the same understanding of likely outcomes, settlement is less likely.

Some stakeholders disagreed with this recommendation, especially if the consequence of requiring more descriptive determinations is a higher IDRE fee. One efficient compromise recommended by a stakeholder is to improve the quantitative information supplied by the IDRE instead of requiring detailed qualitative rationales. This could involve ranking or highlighting the most decisive factors in a determination. Given that this option would be less burdensome for IDREs, it would mitigate the risk of a fee increase.

- **Provide guidance on appropriate types of supporting evidence.** Multiple interviewees stated that it would be helpful for CCIIO to issue guidance for arbitrators and parties describing the appropriate types of supporting evidence, especially for those with lack of experience in the IDR process, such as small practices. For example, guidance could address the types of evidence relevant to show certain facility attributes (teaching status, case mix, and scope of services[43]) that are not built into a billing code, emphasize that Medicare or Medicaid rates cannot be submitted for consideration, or provide guidelines on the types of clinical information useful to demonstrate patient acuity or complexity of treatment.[44]
- **Require additional IDRE and arbitrator training and certification.** Stakeholders from multiple categories believed that requiring additional training for IDREs and their arbitrators would be useful. This could be operationalized as an annual requirement for arbitrators to undergo a training course or be certified and/or a requirement for annual or periodic IDRE recertification.[45] (Notably, there is no process for IDRE recertification; over time, such a process could be needed to ensure that entities continue to meet certification requirements.) Enhanced training could improve the quality of decisions and reduce errors.
- **Establish an appeal or audit process.** Interviewees expressed frustration about the lack of recourse for clear IDRE errors, both on eligibility and the merits of a dispute. While multiple stakeholders supported creation of an appeals process, they disagreed on its scope. Several interviewees argued that permissible grounds for appeal should be quite narrow to avoid meritless appeals aimed only at slowing down the system. While even a narrow process would counter one of the benefits of the arbitration—finality—it would offer a route to vacate a determination when there is a clear error in violation of a statutory rule, such as claim ineligibility. While there may be statutory constraints on CCIIO's ability to create a formal appeals process, stakeholders agreed that clear guidance from CCIIO establishing a mode of accountability like an IDRE audit plan would be helpful. Audits that assess the consistency, accuracy, and reasoning of IDRE decisions could publicly highlight the issues described in this section and point toward corrective action steps for IDREs and parties.[46]
- **Improve the complaint systems.** The Departments have created a complaint system for parties to seek help with or register a grievance about another party in the dispute or the IDRE. While CMS and the Department of Labor (the "DOL") maintain complaint systems, stakeholders view them as inadequate. As noted by GAO, the complaint systems have generally been overwhelmed by volume and moved slowly.[47] A responsive complaint system, which provides meaningful and timely feedback to IDREs and parties, could both improve trust in the IDR system by assuring parties that concerns are heard and acted upon, and mitigate the problems discussed in this section—for example, by alerting IDREs to inconsistent reasoning on similar fact patterns and triggering corrective action.

- **Disclose more IDRE data.** Multiple stakeholders agreed in general terms that greater disclosure of data on each IDRE's decisions would be beneficial for reasons like those cited in the first recommendation above: the parties will be able to understand and better predict the process, trust will be enhanced, and increased scrutiny may promote greater rigor and consistency among IDREs. That said, stakeholders disagreed about the details of such a disclosure requirement; for example, payers opposed disclosure of QPA values, while others supported it. Interviewees suggested an array of data be disclosed, including "win rate" by specialty, arbitrator identity, QPA calculation specifics, and QPA values.

IDR Portal Functionality

Background

CCIIO created the IDR portal in April 2022 as a centralized platform for disputes. CCIIO has indicated the purpose of the portal is to "maximize efficiency and reduce burden" in the IDR process,[48] and the agency has made improvements since its inception. The Departments have stated that they plan on continuing to automate the portal to improve both the dispute process and reporting.[49]

Concerns

Interviewees noted some ways in which the portal could be improved.

Volume of claims: Stakeholders agree the portal was not set up to manage the volume of disputes received. In addition, there is an over-reliance on email, especially at the start of the process, instead of communication between parties via the portal. Some portal functionalities have been improved since the portal opened (e.g., now allowing parties to upload information supporting eligibility or ineligibility of a claim). The overarching unresolved concern shared by multiple stakeholders is the lack of portal functionality to allow parties to track all disputes in which they are involved, from start to finish.

Timeframe confusion: Finally, interviewees pointed to their confusion about where any given claim stood in the process at any given time. Today, open negotiation communication is generally through email rather than in the portal, which can make it difficult to track. This is problematic because, once open negotiation is started, there are "clocks" on IDRE selection, eligibility determination, payment determination and payment intended to keep the process moving. Some stakeholders said there is genuine confusion in tracking what stage a dispute is in, but both initiating and non-initiating parties accused each other of not negotiating in good faith in hopes that the other would violate a timing deadline, resulting in rejection of a claim, determination of IDRE selection, or a "default" judgment.[50]

Recommendations

Multiple interviewees suggested that a variety of tracking functionalities be added to the portal. (In addition, stakeholders suggested additional automation of eligibility checks, as discussed above.)

- **Add functionality to track case status.** Multiple stakeholders argued that tracking cases, in general, is difficult and encouraged additional functionality in the portal to enable them to easily see a report of the status and outcome of a case. Specifically, stakeholders advocated a "lookup" function that allowed parties to see a list of disputes, across IDRE, to which they are a party, categorized as open, pending, and closed

(noting the current stage of the process and including determination made and payment status). Though not specifically addressed by interviewees, this function could facilitate greater use of the proposed rule's provision allowing parties to withdraw disputes under certain circumstances, since parties handling large volumes of disputes may have lost track of submissions.[51] For example, several interviewees noted that already-settled disputes were adjudicated by IDREs or resubmitted by a party; a tracking system could avoid such inefficiency and confusion.

- **Allow payment tracking.** Multiple stakeholders suggested that the portal allow tracking of when payment for an adjudicated claim is due, whether it has been paid, and the number of days overdue. Such a functionality could address provider frustration with an information void on unpaid claims, as well as prompt communication between parties on the reasons for delay. Insurers stated, however, that instances of "lump sum" determinations, instead of line-by-line adjudication, means they do not have the information necessary to issue payment. (Improvements to IDRE determinations could help smooth this process.)
- **Improve the IDR portal's functionality to provide automated notifications to parties when documents are submitted or deadlines approach.** Though several stakeholders were bearish on CCIIO's ability to improve the IDR portal, they agreed that doing so regarding timeline notifications could incentivize more frequent and productive negotiation.

The proposed rule would reform the portal in several ways, aimed at further centralizing parties' submissions, increasing IDREs' and the Departments' capacity to monitor the process, and increasing communication between the parties. For example, the proposed rule would require initiating parties to submit the open negotiation initiation notice through the portal and add further description to that notice and, within 15 days, require non-initiating parties to upload a response in the portal (including supporting documentation). The notice of IDR initiation and notice of initiation response would also be submitted through the portal. The Departments state that these operational changes would further streamline the IDR initiation stage by prepopulating the IDR initiation and initiation response notices with information from the open negotiation initiation notice and response.[52] This would provide parties, IDREs, and the Departments more centralized access to and uniformity in all relevant dispute information.

Conclusion

While these recommendations are only a subset of interviewees' ideas for reform, they warrant attention disproportionate to their number because of cross-category stakeholder agreement underlying them. Stakeholders have disagreed vehemently about multiple aspects of IDR implementation, as demonstrated by ongoing lawsuits. In that polarized environment, these recommendations deserve serious consideration by policymakers as ways to both improve IDR's operational efficiency and enhance stakeholder confidence in the program.

Area	Recommendations
Open Negotiation	• Help initiating parties identify the correct payer and how to contact them • Require detailed reasoning for payment decisions at the front of the process • Require detailed reasoning for payment decisions later in the process
IDR Eligibility Determinations	• Provide robust explanation of, and training on, eligibility rules • Pre-screen eligibility and/or automate eligibility checks • Issue detailed guidance on appropriate evidence of claim eligibility or ineligibility
IDRE Determinations	• Require IDREs to provide detailed reasoning for decisions • Provide guidance on appropriate types of supporting evidence • Require additional IDRE and arbitrator training and certification • Establish an appeal or audit process • Improve the complaint systems • Disclose more IDRE data
IDR Portal Functionality	• Add functionality to track case status • Allow payment tracking • Improve the IDR portal's functionality to automate notifications to parties when documents are submitted or deadlines approach

1. Herein, health care facilities, providers, and providers of air ambulance services will be termed "providers."

2. Herein, health insurance issuers and group health plans will be termed "insurers."

3. Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 1182, 2757 (2020) (codified at 42 U.S.C. § 300gg-111).

4. The IDR framework does not apply to Medicare (including Medicare Advantage), Medicaid, TRICARE, the Children's Health Insurance Program, states with specified state laws, and states with an All-Payer Model Agreement.

5. CMS, Federal Independent Dispute Resolution Process Status Update, August 2022, https://www.cms.gov/files/document/federal-idr-process-status-update-august-2022.pdf.

6. A slew of lawsuits have been filed challenging the NSA. For details, see Manatt, *No Surprises Act*, https://www.manatt.com/hot-topics/no-surprises-act. Four notable cases have been won by plaintiff Texas Medical Association (TMA). *TMA I* overturned portions of an interim final rule directing arbitrators to provide a "rebuttable presumption" that the offer closest to the QPA is the appropriate out-of-network amount. TMA II overturned the Departments' final rule attempting to address the issues in *TMA I*, holding that the Departments could not require arbitrators to look at the QPA first and then only consider other factors if guardrails were met. *TMA III* overturned several provisions of the July 2021 interim final rule concerning calculation of the QPA, disclosure requirements applicable to QPA calculations, and certain air ambulance dispute filing requirements, *TMA IV* overturned the Departments' increase in the administrative fee and its rules for "batching" multiple related claims into a single dispute. *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, 587 F. Supp. 3d 528 (E.D. Tx. 2022) (*TMA I*). *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-373-JDK (*TMA II*). *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-00450 (*TMA III*). *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:23-cv-00059 (TMA IV).

7. As of December 15, 2023, the IDR portal is re-opened to all dispute types. For a chronicle of pauses in the IDR process, see CMS, https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans.

8. U.S. Government Accountability Office (GAO), Private Health Insurance: Roll Out of Independent Dispute Resolution Process for Out-Of-Network Claims Has Been Challenging, December 2023, https://www.gao.gov/products/gao-24-106335. The Departments originally anticipated 17,000 IDR requests. See Frequently Asked Questions Regarding the Federal Independent Dispute Resolution Process, February 2022, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/guidance-faqs-federal-independent-dispute-reolution-process.pdf.

9. GAO, p. 12.

10. Pub. L. No. 116-260, div. BB, tit. I, § 109(d) (not codified).

11. GAO, p. 38.

12. Pub. L. No. 116-260, div. BB, tit. I, § 105(a) (not codified). Required data elements for the public reports: number of notices of IDR initiation; the size of provider practices and facilities submitting notices of IDR initiation (excluding air ambulance services); the number of cases for which IDREs make a final determination; the number of times the payment determination exceeds the qualifying payment amount (QPA); the expenditures made by the Departments to carry out the IDR process; total administrative fees paid by the parties; and total compensation paid to IDREs.

13. Departments of HHS, Labor, and Treasury, Federal Independent Dispute Resolution Process—Status Update, April 27, 2023, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/federal-idr-process-status-update.pdf.

14. The Office of Personnel Management, which administers benefits for federal employees, is also subject to certain NSA provisions and has co-authored some implementing regulations. For simplicity, herein, we refer to only the Departments.

15. 88 Fed. Reg. 75744, Federal Independent Dispute Resolution Operations, November 3, 2023, https://www.federalregister.gov/d/2023-23716. Cited throughout as "Proposed Rule." For an overview of the proposed rule, see, Tara R. Straw, Steven C. Chiu, and Harvey L. Rochman, Proposed Rule Intended to Smooth *No Surprises Act* Independent Dispute Resolution Operations, Manatt Health Highlights, November 14, 2023, https://www.manatt.com/insights/newsletters/health-highlights/proposed-rule-intended-to-smooth-no-surprises-act.

16. Some interviews were conducted before the release of the proposed rule and others immediately afterwards, before parties had the opportunity to fully formulate their positions. As such, we did not ask every interviewee about the proposed rule, but, as demonstrated, the proposed rule does address some of the themes we uncovered.

17. The definition of a "clean claim" is under litigation in *TMA III*.

18. CCIIO developed a checklist of requirements for insurers in November 2022, available at: https://www.cms.gov/files/document/caa-nsa-issuer-requirements-checklist.pdf.

19. Proposed Rule, 88 Fed. Reg. at 75878.

20. Proposed Rule, 88 Fed. Reg. at 75878-9. Additional elements proposed for the notice include specific contact information; information about the care setting, the state the care was provided in, and the claim number to correctly identify the service at issue; and a copy of the initial payment or notice of the denial. Additional elements proposed for the response include contact information; a counteroffer (or acceptance of the initiating party's offer); and a statement of why any information in the open negotiation notice is inaccurate.

21. Proposed Rule, 88 Fed. Reg. at 75887.

22. Proposed Rule, 88 Fed. Reg. at 75877.

23. Departments of Treasury, Labor, and HHS, Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges, December 21, 2023, 88 Fed. Reg. 88494, 88516 (2023). (Herein, "Administrative Fee Rule.")

24. Departments of HHS, Labor, and Treasury, Partial Report on the Independent Dispute Resolution Process, October 1-December 31, 2022, April 27, 2023, https://www.cms.gov/files/document/partial-report-idr-process-octoberdecember-2022.pdf.

25. 42 U.S.C. 300gg–111(c)(8).

26. Administrative Fee Rule, 88 Fed. Reg. 88497.

27. Proposed Rule, 88 Fed. Reg. at 75879-80.

28. 42 U.S.C. 300gg–111(a)(3)(I). The federal IDR process also does not apply in states with an All-Payer Model Agreement or where an OPM contract with an FEHB Carrier includes terms that adopt the state process. As of January 2023, six states permitted self-insured plans to opt into state law: Georgia, Maine, Nevada, New Jersey, Virginia, and Washington. See generally, CMS, Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process, https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf. For detailed information, see letters executed between CMS and each state describing the applicability of each state's law at https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-caa.

29. Departments of the Treasury, Labor, and HHS, Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities, December 2023, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/federal-independent-dispute-resolution-process-guidance-for-certified-idr-entities.pdf. Section 4.4.

30. Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities, Section 4.6.2.

31. Partial Report on the Independent Dispute Resolution Process, October 1-December 31, 2022.

32. Proposed Rule, 88 Fed. Reg. at 75882-3.

33. Federal Independent Dispute Resolution Process—Status Update.

34. GAO, p. 22-23.

35. 42 U.S.C. 300gg-111(c)(5)(E)(ii).

36. Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities, Section 7.1.

37. Proposed Rule, 88 Fed. Reg. at 75882.

38. Proposed Rule, 88 Fed. Reg. at 75887.

39. Proposed Rule, 88 Fed. Reg. at 75885. In low-dollar ineligible disputes, initiating parties would pay 50% of their administrative fee and non-initiating parties would pay 20%.

40. Departments of the Treasury, Labor, and HHS, APPENDIX 6: Certified Independent Dispute Resolution (IDR) Entity's Written Decision of Payment Determination Data Elements, OMB Control No. 1210-0169, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-11.pdf.

41. GAO, p. 32.

42. See e.g., George L. Priest & Benjamin Klein, *The Selection of Disputes for Litigation*, 13 J. Legal Stud. 1 (1984).

43. Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities, Table 1, Factor 4.

44. *Ibid.*, Table 1, Factor 3.

45. For example, federal health insurance marketplace Navigators have training and certification at both the entity and individual Navigator level. Here, both IDREs and their individual arbitrators could have training and certification programs.

46. This type of audit would be distinct from the audits of the QPA authorized by the No Surprises Act (42 U.S.C. 300gg-111(a)(2)).

47. GAO, p. 35-37. As of May 2023, CMS had received 281 complaints against certified IDREs and 115 complaints against issuers or providers. GAO was told that 186 of the 281 complaints against IDREs have been closed, and 46 of the 115 complaints against plans and issuers have been closed. DOL officials told GAO that as of August 2023, DOL had received 12,585 complaints related to the NSA and 11,485 of those complaints had been closed.

48. Proposed Rule, 88 Fed. Reg. at 75749, endnote 33.

49. See generally, Proposed Rule and Partial Report on the Independent Dispute Resolution Process, October 1–December 31, 2022.

50. Under the statute and regulations, the IDR process can be initiated only during a four business day window after the 30-day open negotiation period has expired. Failure to meet that window results in disqualification from the process. Once IDR has been initiated, the non-initiating party has three business days after receipt of the notice to object to the proposed IDRE and propose another. After the IDRE has been selected, the parties must submit their offers to that IDRE within 10 business. Failure to do so will result in a default judgment in favor of the party who has submitted.

51. Proposed Rule, 88 Fed. Reg. at 75780. The proposed rule would allow withdrawal when the non-initiating party is nonresponsive to a withdrawal request by the initiating party, when both parties are nonresponsive, or when neither party submits an offer for the out-of-network payment amount.

52. Proposed Rule, 88 Fed. Reg. at 75773.

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