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Small Win for Healthcare Providers: CMS Issues New Guidance Under No Surprise Billing Rules and DHHS' Appeal

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On April 12, 2022, CMS issued new guidance[1] for the independent dispute resolution ("IDR") process under the No Surprise Billing Rules ("Rules") in response to a U.S. District Court for the Eastern District of Texas judge vacating an insurer-friendly provision,[2] handing a small win to healthcare providers.

The Court's holding would apply when a patient unexpectedly receives care from an out-of-network ("OON") provider. In those situations, if the health insurance payor and OON provider cannot agree on an amount the payor must reimburse the OON provider, both the payor and OON providers will submit their respective preferred payment amounts ("PPA") to the IDR arbitrator. The arbitrator will then select one of the proposed payment amounts. At issue in the case is how the IDR arbitrator decides which PPA a payor must pay an OON provider for services rendered.

The Rules, published on October 7, 2021, implemented certain parts of the No Surprises Act (the "Act") that, absent the Court's holding, would have required IDR arbitrators to primarily consider the qualifying payment amount ("QPA") when determining how much payors, typically insurers, would pay OON providers through the IDR process.[3] However, the Court determined that those Rules conflict with the statutory text of the Act.[4] Rather than instructing IDR arbitrators to consider all relevant factors to determine the amount payors must reimburse OON providers, the Rules required the IDR arbitrators to select the PPA closest to the QPA, which is an insurer-determined number.[5] Thus, the Court struck down the portion of the rules instructing IDR arbitrators to primarily consider the QPA when determining the appropriate OON reimbursement.[6]

In response to the Court's holding, CMS issued new guidance for the IDR process. The new guidance clarifies that, when determining which PPA to select, the IDR arbitrator must consider the following:

1. The QPA for the applicable year the qualified item or services were provided.
2. Additional credible information relating to the PPAs submitted by the payor and OON provider, including information the IDR arbitrator requests and information submitted by the payor and OON provider that relates to the following circumstances:

a. The level of training, experience, and quality and outcomes measurements of the OON provider or facility that furnished the qualified IDR item or service.
b. The market share held by the OON provider or facility or that of the plan in the geographic region in which the qualified IDR item or service was provided.
c. The acuity of the participant, beneficiary, or enrollee receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or services to the participant, beneficiary, or enrollee.
d. The teaching status, case mix, and scope of services of the OON facility that furnished the qualified IDR item or service.
e. Demonstration of good faith efforts (or lack thereof) made by the OON provider or facility or the plan to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan during the previous four (4) plan years.[7]

3. Information that is not prohibited by the new CMS guidance. Prohibited factors include the following:
    a. Usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges);
    b. The amount that would have been billed by the provider, facility, or provider of air ambulance services with respect to the qualified IDR item or service had the provisions of 45 CFR 149.410, 149.420, and 149.440 (as applicable) not applied; or
    c. The payment or reimbursement rate for items and services furnished by the provider, facility, or provider of air ambulance services payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act; the Medicaid program under title XIX of the Social Security Act; the Children's Health Insurance Program under title XXI of the Social Security Act; the TRICARE program under chapter 55 of title 10, United States Code; chapter 17 of title 38, United States Code; or demonstration projects under Section 1115 of the Social Security Act. This provision also prohibits consideration of payment or reimbursement rates expressed as a proportion of rates payable by public payors.[8]

However, the new CMS guidance and the ruling from the federal district court may not last for long because the U.S. Department of Health and Human Services (“HHS”) filed its notice of appeal on Friday, April 22, 2022. Until the appeal can be heard by a federal appellate court, CMS' new guidance prevails.[9]

For more information on the Rules and the IDR process, please refer to our previous articles: New Guidance on Self-Pay Patients Under No

Surprise Billing Rules, No Surprise Billing Rules: Good Faith Estimates and Unscheduled Services, and No Surprise Billing Rules: Checklist for Providers.

[1]Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities.

[2]Tex. Med. Ass'n v. U.S. Dep't. of Health and Human Servs., No. 6:21-cv-425-JDK, 2022 U.S. Dist. LEXIS 31807 (E.D. Tex. Feb. 23, 2022).

[3]45 CFR 149.510 et. seq.

[4]*Tex. Med. Ass.,* 2022 U.S. Dist. LEXIS 31807 at *20.

[5]*Id.* at *20-21.

[6]*Id.* at *21.

[7]Centers for Medicare & Medicaid Services, Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities (2022).

[8]*Id.*

[9]Notice of Appeal at 1, Tex. Med. Ass'n v. U.S. Dep't of Health and Human Servs., (No. 6:21-cv-425-JDK), 2022 U.S. Dist. LEXIS 31807 (E.D. Tex. Apr. 22, 2022).