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Swing and a Miss: CMS Strikes Out on Its Second Attempt to Set Arbitration Procedures under No Surprises Act

The saga between health care providers and the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury (collectively, "Departments") continues apace, as a federal district court has just invalidated the Departments' second attempt to set the arbitration procedures governing out-of-network reimbursement disputes under the federal No Surprises Act ("NSA"). The same court had previously invalidated an earlier regulation from the Departments.

This decision marks yet another victory for providers worried that the QPA—which is the median in-network rate—would not fully compensate for the complexities and costs of their services, especially tertiary care providers. However, there remains substantial uncertainty with respect to what the arbitration standard will be moving forward.

The court found in each opinion that the regulations failed for the same fundamental defect: they tilted the scales in favor of the out-of-network reimbursement rate being set as the "qualifying payment amount" ("QPA") (i.e., the median in-network rate), even though the QPA is merely one of several factors that Congress directed arbitrators to consider in setting an appropriate out-of-network rate.

The Departments are thus back to the proverbial drawing board. Indeed, as of February 10, 2023, the Centers for Medicare & Medicaid Services ("CMS") of the Department of Health and Human Services has directed Independent Dispute Resolution ("IDR") Entities to recall any payment determinations issued after February 6, 2023, and to hold all payment determinations until the Departments issue further guidance. The key question moving forward will be whether the Departments will yet again try to find a way to skew out-of-network reimbursements towards the QPA or whether they will embrace a more holistic approach utilizing the other statutory factors.

BACKGROUND

The NSA was enacted to protect consumers from large, often unpredictable, bills for out-of-network emergency care services or non-emergency services provided by an out-of-network provider at an in-network facility. Under the NSA, in these "surprise billing" situations,

consumers are generally only liable for the in-network cost-sharing payment. The out-of-network provider and the health plan are then tasked with negotiating an appropriate reimbursement rate for these out-of-network services. If the provider and the health plan fail to reach a resolution, the NSA provides for "baseball arbitration," administered by the CMS, in which the arbitrator must choose between the parties' competing rate proposals.

To guide the arbitrator in making this decision, the statutory text of the NSA lists six factors that arbitrators "shall consider" in determining the appropriate out-of-network rate:

1. The qualifying payment amounts [i.e., the median in-network rate];
2. The market share held by the provider or facility in which the … item or service was provided;
3. The acuity of the recipient of the … item or service;
4. The teaching status, case mix, and scope of services of the facility that provided the … item or service; and
5. Demonstration of good faith efforts (or lack thereof) made by the provider, facility, or plan to enter into network agreements with each other.

In a previous lawsuit, the Texas Medical Association filed a complaint against the Departments challenging the validity of an interim rule that effectively created a "rebuttable presumption" that the amount closest to the QPA was the proper payment amount.[1] The interim rule required the arbitrator to select the proposed payment amount closest to the QPA unless "credible" information, including information supporting the "additional factors," "clearly demonstrate[d] that the [QPA] [was] materially different from the appropriate out-of-network rate."[2] The court held that this presumption conflicted with the NSA's plain text, which listed a series of factors (only one of which was the QPA) to be considered in determining an appropriate out-of-network rate, none of which were entitled to greater weight than the others.[3]

THE NEW EASTERN DISTRICT OF TEXAS DECISION

After the Eastern District of Texas set aside the first regulation promulgated by the Departments, they issued a new, second regulation on August 26, 2022. Once again, the Texas Medical Association sued, arguing that the regulation still unfavorably tilted in favor of the QPA and against the other statutory factors. And once again, the court agreed and set aside the Departments' regulation as contrary to the plain statutory text.

The court reasoned that the NSA's use of the phrase "shall consider" showed Congress's unambiguous intent that arbitrators consider ***all*** of the statute's specified factors in determining the rate of reimbursement for out-of-network providers.[4] The court reasoned that "[n]othing in the Act, moreover, instructs arbitrators to weigh any one factor or circumstance more heavily than the others … [and that a] statute's 'lack of text' is sometimes 'more telling' than the text itself."[5]

Despite this clear statutory language, the court nevertheless found that the new regulation placed multiple improper procedural hurdles for arbitrators seeking to evaluate non-QPA factors in out-of-network reimbursement rate determinations. For example, the regulation stated that "[i]f the certified IDR entity relies on [any of the non-QPA factors] in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount."[6] At the same time, the statute did not require IDR entities to provide written explanations for payment determinations based solely on the QPA.

Additionally, the Final Rule stated that "[i]n weighing the considerations described in paragraphs (c)(4)(iii)(B) through (D) of this section, the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination."[7] This language essentially required arbitrators to presume the credibility of the QPA, while "evaluat[ing]" the credibility of the non-QPA factors.[8]

Finally, the regulation prohibited arbitrators from "giv[ing] weight to" the non-QPA factors unless certain prerequisites were met.[9] For example, the Final Rule states that arbitrators should not give weight to non-QPA factors "to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR item or service, or it is already accounted for by the qualifying payment amount under paragraph (c)(4)(iii)(A) of this section or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section."[10] The court found these requirements to "place[] its thumb on the scale for the QPA, requiring arbitrators to presume the correctness of the QPA [only to] impose a heightened burden on the remaining statutory factors to overcome [that] presumption."[11]

Accordingly, the court once again held that the new regulation "conflicted with the Act, [because it] unambiguously require[d] arbitrators to consider '***all*** the specified information in determining which offer to select.'" The court reasoned that "nowhere [in the statute] instructs [IDR entities from] 'weigh[ing] any one factor or circumstance more heavily than the others.'"[12] The court thus held the Final Rule to be unlawful and set it aside under the Administrative Procedure Act.

The court seems to have further dug in its heels against any changes that would strip away or limit an arbitrator's discretion to weigh all statutorily proscribed factors in determining out-of-network reimbursement rates for providers. The Departments are currently reviewing the court's decision and have yet to indicate the path forward they will take.

For additional information or assistance, contact Barak A. Bassman, Triston Chase O'Savio, or another member of Blank Rome's Healthcare industry group.

Barak A. Bassman
215.569.5785 | barak.bassman@blankrome.com

Triston Chase O'Savio
202.420.2244 | triston.osavio@blankrome.com

1. 86 Fed. Reg. 56,056–61
2. 45 C.F.R. § 149.510(c)(4)(ii)(A)
3. *Tex. Med. Ass'n v. United States HHS,* 2022 WL 542879, at *1, *15 (E.D. Tex. 2022).
4. *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.,* No. 6:22-CV-372-JDK, 2023 WL 1781801, at *11 (E.D. Tex. Feb. 6, 2023).
5. *Id.*
6. § 149.510(c)(4)(vi).
7. § 149.510(c)(4)(iii)(E).
8. *Id.*
9. *Id.*
10. *Id.*
11. *Texas Medical Association,* 2023 WL 1781801, at 11.
12. (emphasis added) *Id.* at 10