

July 7, 2020

Via electronic submission

PUBLIC COMMENT LETTER

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P)

Dear Administrator Verma:

On behalf of our more than 465 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide comments on the above-referenced proposed rule for the hospital inpatient and long-term care hospital prospective payment systems. In its FY 2021 Inpatient Prospective Payment System (IPPS) proposed rule, the Centers for Medicare and Medicaid Services proposes to require hospitals to include on the annual Medicare cost report what the agency calls "market-based payment rate information."¹ Specifically, under the proposed rule, every hospital would be required to report "(1) The median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations . . . by MS-DRG; and (2) the median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA organizations, by MS-DRG."² CMS also requests comment on incorporating this information in the IPPS MS-DRG relative weights beginning in FY 2024. The Texas Hospital Association believes that both proposals are unlawful and urges CMS not to finalize them.

CMS cites no authority to require hospitals to undergo the burdensome task of furnishing median payer-specific negotiated charge information by MS-DRG. Instead, CMS relies exclusively on a rule the agency promulgated in 2019, denominated by CMS as the "Hospital Price Transparency Final Rule,"³ to require disclosure of negotiated charge information (rates) by MS-DRG. CMS explains that:

The payer specific negotiated charges used by hospitals to calculate these medians would be the payer-specific negotiated charges for service packages that hospitals are required to make public

¹ 85 Fed. Reg. 32,460, 32,464 (May 29, 2020).

² 85 Fed. Reg. at 32,791.

³ 84 Fed. Reg. 65,524 (Nov. 27, 2019).

under the requirements we finalized in the Hospital Price Transparency Final Rule (84 FR 65524) that can be crosswalked to an MS–DRG. We believe that because hospitals are already required to publicly report payer-specific negotiated charges, in accordance with the Hospital Price Transparency Final Rule, that the additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals.⁴

In addition to requiring the disclosure of proprietary information subject to an active legal challenge, the task of matching negotiated rates to an MS-DRG is not straightforward and would require significant time and labor by hospitals because reimbursement methodologies vary significantly by payor and may include value-based payment.

The Hospital Price Transparency Final Rule is scheduled to go into effect on Jan. 1, 2021, but it has been challenged by the American Hospital Association and other hospitals on statutory, procedural and constitutional grounds. Although the district court denied hospitals’ motion for summary judgment,⁵ the hospitals have appealed that decision to the United States Court of Appeals for the District of Columbia Circuit. The appeal will be fully briefed by the end of August, and the parties are requesting oral argument as soon after that as possible. Because the information to be furnished under the proposed rule would be derived from information collected under the Hospital Price Transparency Final Rule, the new information collection requirement suffers from the same legal infirmities: It is not authorized by statute and violates both the Constitution and Administrative Procedure Act. Moreover, if the hospital price transparency final rule is found unlawful, then CMS’s requirement for disclosure of median payer-specific charge information by MS-DRG would similarly be unlawful.

The same is true as to the potential approach to change the method of calculation for MS-DRG relative weights beginning in FY 2024. CMS says that it is considering adopting in the FY 2021 IPPS final rule a “change to the methodology for calculating the IPPS MS–DRG relative weights to incorporate this market-based rate information, beginning in FY 2024. . . .”⁶ But if it is unlawful to require disclosure of median payer-specific negotiated charge information by MS-DRG, then CMS could not use that information to change relative weights.

In addition, it would be arbitrary and capricious to use median payer-specific negotiated charge information by MS-DRG to change relative weights. As set forth in section 1886(d)(4)(A) of the Act, relative weights are intended to reflect “the relative hospital resources used with respect to discharges classified within that group” and not the relative price paid. CMS currently uses “a cost-based methodology to estimate an appropriate weight for each MS–DRG.”⁷ In proposing to use median payer-specific negotiated charges to set MS-DRG relative weights, CMS has not adequately explained why it thinks market price rather than costs is a better measure of hospital resources used. Instead, the agency appears to *conflate market price with cost*.

The rationales CMS uses for basing MS-DRG relative weights on price (e.g., promoting transparency, bringing down the cost of health care, wanting to move beyond the chargemaster, etc.) have nothing to do with whether median payer-specific negotiated charges are a measure of “hospital resources used” as the Medicare statute

⁴ 85 Fed. Reg. 32,460, 32,465 (May 29, 2020). We note that, because there is no comparator in the statement, it is not clear what CMS means when it says that reporting median payer-specific negotiated charges is “less burdensome for hospitals.”

⁵ *American Hospital Assn, et al. v. Azar*, No. 19-CV-3619 (D.D.C. June 23, 2020).

⁶ 85 Fed. Reg. 32,460, 32,465 (May 29, 2020).

⁷ *Id.* at 32,791.

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requires. Rather, CMS proposes to use this information to “advanc[e] the critical goals of [Executive Orders] 13813 and 13890, and to support the development of a market-based approach to payment under the Medicare FFS system.”⁸ But that is not the statutory test. Simply put, we believe CMS has not adequately explained why basing IPPS MS-DRG relative weights on market price would result in relative weights being based on hospital resources used. As such, it would be arbitrary and capricious to adopt this proposal. *See Motor Veh. Mfrs. Ass'n v. State Farm Ins.*, 463 U.S. 29 (1983).

THA is hopeful that the appeals court will rule on the challenge to the hospital price transparency final rule before the end of this year. Should the hospital price transparency final rule be found unlawful, CMS would have no legal basis for requiring hospitals to disclose their median payer-specific negotiated charges by MS-DRG. If, despite THA’s and the American Hospital Association’s concerns about CMS’s proposals to collect data and base IPPS MS-DRG relative weights on median payer-specific negotiated charges, the agency nevertheless elects to finalize them, it should not do so unless and until (1) the court upholds the hospital price transparency final rule, (2) the agency has adequately explained the basis for concluding that payer-specific negotiated charges by MS-DRG reflect resources used, and (3) stakeholders have had another opportunity to comment on the proposal.

Thank you for your consideration of these comments. Should you have any questions, please do not hesitate to contact me at cduncan@tha.org or 512/465-1539.

Respectfully submitted,



Cameron Duncan
Associate General Counsel
Texas Hospital Association

⁸ *Id.*