Health Industry Alert

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CMS Proposes New Hospital Reporting Requirements and Signals Major Shift in Hospital Rate-Setting Methods

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Key Points

- Tucked into a massive Medicare payment rule is a proposal to fundamentally change how CMS sets hospital payment rates.
- Recognizing that a hospital's chargemaster rarely reflects true market costs, CMS seeks to use hospital-reported, payer-specific negotiated charges to adjust Medicare payment rates so that they reflect the relative market value for inpatient items and services.
- The proposal is part of the administration's broader goal of injecting market pricing into Medicare fee-for-service reimbursement.

On Monday, the Centers for Medicare & Medicaid Services (CMS) released its annual proposal for the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System, which includes proposed policy changes and rates for the 2021 Fiscal Year (FY). In this rule, CMS lays out a long-term vision for injecting market pricing into Medicare reimbursement and proposes near-term requirements for disclosure of negotiated commercial rates to inform a new rate-setting paradigm. Specifically, CMS seeks comment on a potential change to the methodology for calculating the Medicare Inpatient Prospective Payment System (IPPS) and Medicare Severity-Diagnosis Related Group (MS-DRG) relative weights to incorporate this market-based rate information, beginning in FY 2024.

Under the proposal, hospitals would be required to report: (1) the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) payers, by MS-DRG; and (2) the median, payer-specific negotiated charge the hospital has negotiated with all of its third-party payers (including MA payers), by MS-DRG. CMS notes that these medians would be calculated using a subset of the payer-specific negotiated charges that, starting January 1, 2021, hospitals are required to make public under 45 CFR part 180. This information would be reported on the hospital cost report, for cost reporting periods ending on or after

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January 1, 2021, and, according to CMS, would be used to adjust Medicare payment rates so that they reflect the relative market value for inpatient items and services.

CMS seeks comment on a new rate-setting methodology, which could apply as early as FY 2024, that would use the median payer-specific negotiated charge for each MS-DRG for payers that are MA organizations to determine the market-based relative weight estimation. This process would first involve standardizing these median charges in order to ease comparison between hospitals. The agency would also create a single weighted average across hospitals of the median charge and a single national weighted average across all MS-DRGs. The market-based relative weight would then be calculated as the ratio between these two numbers and normalized by an adjustment factor. CMS says it is focusing on MA payer negotiated charges because those are generally well-correlated with Medicare IPPS payment rates, though there may be instances where those negotiated charges may reflect the relative hospital resources used within an MS-DRG differently than the current cost-based methodology. Payer-specific charges negotiated between hospitals and commercial payers, on the other hand, are generally not as well-correlated with Medicare IPPS payment rates.

The new proposed reporting requirement is itself significant, as it represents a doubling-down on the requirements finalized in last year's Hospital Price Transparency Rule. Under these requirements, which are currently set to take effect on January 1, 2021, hospitals must publically post their payer-specific negotiated charges, as well as their gross charges, discounted cash prices and minimum and maximum negotiated charges. The Hospital Price Transparency Rule is currently the subject of litigation in the United States District Court for the District of Columbia, and plaintiffs have asserted, among other challenges, that the rule exceeds CMS' statutory authority to mandate disclosure of "standard charges" under 42 U.S.C. § 300gg-18(e).[1] In this proposal, CMS relies on different statutory authority—Sections 1815(a) and 1833(e) of the Social Security Act—to require hospitals to report market-based data on the cost report, and points out that cost reports are made public. Because hospitals are already required to assemble this data, CMS believes that the new cost reporting requirements will be "less burdensome" for hospitals.

The proposal also reflects the agency's efforts to reduce reliance on the chargemaster, which it says can lead to charges that are "inherently unreasonable when judged against prevailing market rates."[2] Replacing the chargemaster and traditional cost report information with market-based pricing is part of a broader effort to inject market-based pricing into Medicare fee-for-service (FFS) rates. According to the agency, the new proposals fulfill directives in the President's Executive Orders, including Executive Order 13890, which directed the Department of Health and Human Services (HHS) to identify, "approaches to modify Medicare FFS payments to more closely reflect the prices paid for services in MA and the commercial insurance market, to encourage more robust price competition, and otherwise to inject market pricing into Medicare FFS reimbursement."

Any MS-DRG relative weight changes would be implemented in a budget neutral manner, and CMS notes that the impact of such changes on an individual hospital would depend on the mix of services provided by that particular hospital. For instance, CMS cites one study finding that there are some DRGs where the average MA price was much higher than FFS and there were some DRGs where the average MA price was a bit lower than FFS. CMS states that once it has access to the proposed payer-

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specific negotiated charge information at the MS-DRG level, it can more precisely estimate the potential payment impact of any potential changes to the MS-DRG relative weight methodology beginning in FY 2024.

If you have any questions about this specific Medicare proposal, other aspects of the 2021 IPPS rulemaking, or would like assistance with submitting comments on these proposals, which will be due on July 10, 2020, please let us know.

[1] The case is *American Hospital Association et al. v. Azar*, No. 1:19-cv-3619 (CJN) (D. D.C. filed December 4, 2019). The statutory provision in question was added by section 1311(e)(3), of the Patient Protection and Affordable Care Act, and reads as follows:

Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title.

[2] Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals, Proposed Rule, Unpublished, *available at* https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-10122.pdf.

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