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CMS PROPOSES MAJOR OVERHAUL TO INCORPORATE PAYER PRICING INTO MEDICARE COST REPORT DATA AND MS-DRG SYSTEM

On May 11, 2020, the Centers for Medicare & Medicaid Services ("CMS") released the 2021 Inpatient Prospective Payment System ("IPPS") Proposed Rule ("Proposed Rule"). One of the most significant updates is the proposed addition of a new requirement to the Medicare cost report submission process. Specifically, hospitals would be required to provide the median payer-specific negotiated charge that a hospital has with all of its contracted Medicare Advantage ("MA") plans, as well as its commercial payers. CMS is taking comments on whether this median charge information would be the basis from which the weights of the MS-DRG system are calculated. Hospitals should consider submitting comments by the July 10, 2020 deadline.

DISCUSSION

On November 27, 2019, CMS published a Final Rule requiring hospitals to post on their websites certain "standard charges" for each item and service, which is defined to include the following five types of charges:

1. The "gross charge" is the charge that is reflected on a hospital's chargemaster without any discounts reflected.
2. The "payer-specific negotiated charges" are the rates that the hospital has *negotiated* with each third-party payer. A third-party payer does not include self-pay patients or governmental payers (such as Medicare or Medicaid fee-for-service) because those rates are not negotiated but does include charges for Medicare and Medicaid managed care plans because those rates are negotiated.
3. The "discounted cash price" is the charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service.
4. The "de-identified minimum negotiated charge" is the lowest charge that the hospital has negotiated with a third-party payer.
5. The "de-identified maximum negotiated charge" is the highest charge that the hospital has negotiated with a third-party payer.

The second type of standard charge would be the basis for an additional component of the Medicare Cost Report. Under the Proposed Rule, hospitals would need to compute the median of the negotiated payer prices and include that information into presumably a new section or worksheet on the Medicare Cost Report. CMS believes this reporting requirement, which is slated to take effect for cost reporting periods beginning on or after January 1, 2021, will not be burdensome for hospitals, given that the hospitals will presumably already be publishing this information as of January 1, 2021.[1] The cost report requirement would require hospitals to produce, by MS-DRG, the median payer-specific charge for its MA plans and a separate list, by MS-DRG, of the median payer-specific charge for commercial payers. If the commercial payer does not pay according to MS-DRG, the hospital would be required to "crosswalk" that payer's information to the corresponding MS-DRG.

CMS repeatedly indicates a desire to lessen its dependence on hospital chargemasters for certain reimbursement methodologies and would replace this median payer-specific charge information where chargemaster information now appears. This could affect certain reimbursement methodologies that are currently dependent on the cost-to-charge ratio, like the outlier reconciliation process for hospitals receiving outlier payments. (The outlier reconciliation process is triggered when there is a ten percent difference in the cost-to-charge ratio from the prior year, and seemingly this would potentially cause more hospitals to be subject to that reconciliation without redress.) The Proposed Rule does not provide any details about what CMS would do to address the effect this change would have on reimbursement calculations that use the cost-to-charge ratio. Instead, CMS provides research to suggest payer-specific charges negotiated between hospitals and MA organizations are generally well-correlated with Medicare IPPS payment rates, and payer-specific charges negotiated between hospitals and commercial payers are generally not as well-correlated with Medicare IPPS payment rates.

Additionally, CMS is seeking comments on utilizing these median negotiated third-party payer charges to overhaul the computation of MS-DRG weights beginning in FFY 2024. This notion seems to conflict with the statutory definition of how MS-DRGs are computed, and implementation may not be possible absent Congressional action to change the Social Security Act.

PRACTICAL TAKEAWAYS

1. If this proposal is finalized, hospitals will have an additional, potentially burdensome requirement incorporated into the Medicare cost report completion process for cost reporting periods beginning on or after January 1, 2021.
2. This Proposed Rule builds on the new hospital price transparency requirements, which were not well received by many providers.
3. CMS may use this median payer-specific charge information to re-do the MS-DRG weighting system beginning in FFY 2024, but whether they have statutory authority to make this change remains unclear.
4. Hospitals are encouraged to comment on the cost report requirement, as well as the MS-DRG reweighting proposal.

If you have questions or would like additional information about this topic, please contact:

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[references]

[1] The hospital price transparency rule is the subject of current litigation, however, with many providers hoping that it will be overturned prior to implementation.

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