



July 10, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1729-P
P.O. Box 8016
Baltimore, MD 21244-8016

SUBMITTED VIA REGULATIONS.GOV

RE: Comments to Notice of Proposed Rulemaking entitled “Medicare Program; 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.” (85 FR 32460) (CMS-1735-P)

Dear Administrator Verma:

Thank you for the opportunity to provide input on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rulemaking entitled “Medicare Program; 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” (Vol. 85 Federal Register 32460, May 29, 2020) (CMS-1735-P) (Proposed Rule).

The Arizona Hospital and Healthcare Association (AzHHA) is Arizona’s largest statewide trade association for hospitals, health systems, and affiliated healthcare organizations. We represent short-term acute care, behavioral health, post-acute care, and critical access hospitals, as well as their affiliated clinics and staff. AzHHA is also contracted with the state of Arizona, the federal government, and private foundations to administer programs to improve quality of care, patient safety, and emergency preparedness. AzHHA and its over 80 members are united with the common goal of improving healthcare delivery in Arizona. Our comments to the Proposed Rule are made in light of this goal.

Proposals Requiring Hospitals to Report Payer-Specific Negotiated Rates by Medicare Severity-Diagnosis-Related Group (MS-DRG) and to Incorporate this Data in MS-DRG Relative Weights Beginning in Fiscal Year (FY) 2024

In the Proposed Rule, CMS proposes to require hospitals to include on the annual Medicare cost report what the agency calls “market-based payment rate information.”¹ Specifically, 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 The agency also requests comment on incorporating this information in the IPPS MS-DRG relative weights beginning in FY 2024.

AzHHA and its member hospitals strongly support price transparency. We believe in driving value by empowering patients to be active consumers. Unfortunately, CMS is pursuing this laudable goal in a way that will severely burden hospitals without any corresponding benefit to consumers.

A hospital typically has a wide range of reimbursement structures depending on the insurers with which it contracts and the types of contracts negotiated, and hospitals often have multiple contracts with a single insurer. Thus, the Proposed Rule would actually require hospitals to publish innumerable variations of separately-negotiated rates across all hospitals and insurers. This would entail immense administrative burdens. We strongly disagree with CMS’s estimate of burden equaling 15 hours, or \$971.10 per hospital. We believe compliance would entail hundreds of staff hours across administration, finance, managed care, information technology and other departments for each hospital. Unfortunately, this administrative burden and the associated costs would be for naught as these proposals will not further CMS’s goal of paying market rates that reflect the cost of delivering care.

Moreover, AzHHA believes that these proposals are unlawful. CMS cites no authority to require hospitals to furnish 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 by MS-DRG. CMS explains that “[t]he 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 under the requirements we finalized in the Hospital Price Transparency Final Rule (84 FR 65524) that can be cross-walked to an MS-DRG. We believe that because hospitals are already required to publicly report payer-specific negotiated charges, in

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).

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

The Hospital Price Transparency Final Rule is scheduled to go into effect on Jan. 1, 2021, but it has been challenged by the AHA 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 requires. Rather, CMS proposes to use this

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.

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).

AzHHA 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 our 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.

Proposed Changes to Medicare Disproportionate Share Hospital (DSH) Payments

Under the current Medicare DSH formula, hospitals receive 25% of the DSH funds they would have received under the prior statutory formula, which are referred to as “empirically justified” DSH payments. The remaining 75% flows into a separate fund, which is reduced as the percentage of uninsured declines. The 75% pool is distributed to Medicare DSH hospitals based on the proportion of total uncompensated care that each hospital provides.

The empirically justified DSH payments are determined by a formula that utilizes historical data including the number of Medicaid enrollees. At the time the DSH estimates for FY 2021 were developed, the significant economic changes and increases in Medicaid enrollment resulting from the COVID-19 pandemic could not have been anticipated. The Kaiser Family Foundation has estimated that approximately 12 million Americans who experienced job loss by May 2020 have become eligible for Medicaid.⁹ **Consequently, we urge CMS to adjust the Medicare DSH amount for FY 2021 to more accurately reflect the increased Medicaid enrollment for 2020 and 2021.**

As mentioned above, the distribution of the 75% pool reflects changes in the percentage of uninsured, which is based on National Health Expenditure Accounts (NHEA) data. The Proposed Rule states that, based upon NHEA historical data through 2018, the Office of the Actuary (OACT)

⁸ *Id.*

⁹ Kaiser Family Foundation. (2020). Eligibility for ACA Health Coverage Following Job Loss.

<https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/>

has estimated a 9.5% uninsured rate for FY 2020 and FY 2021. Unfortunately, this does not account for the extensive unemployment and economic hardship that is occurring during the COVID-19 crisis. For example, the Pew Research Center and the Bureau of Labor Statistics have estimated that unemployment increased from approximately 3.8% in February to as high as 16.3% in May.¹⁰ It has been estimated that as many as 40 million individuals could be left without health insurance due to the effects of COVID-19.¹¹ Utilizing these estimates results in approximately 11-12% uninsured, and would lead to more than \$1 billion in additional funds in the 75% pool for uncompensated care payments.

Because current OACT projections significantly underestimate the percentage of uninsured and would lead to artificially reduced DSH payments in FY 2021, we urge CMS to use more recent and representative data or otherwise apply an upward adjustment to estimate a more appropriate uninsured rate for the FY 2021 75% DSH pool.

Proposed Bad Debt Policy Changes

The Medicare program reimburses Prospective Payment System hospitals 65% of their allowable bad debt resulting from eligible unpaid, uncollectible deductibles and coinsurance amounts, as defined in the Medicare Provider Reimbursement Manual. In the Proposed Rule, CMS proposes a number of bad debt policy changes, including altering the definition of indigence and how to treat bad debt for dually-eligible beneficiaries, as well as the retroactive application of several of its proposals.

In the Proposed Rule, CMS posits that retroactive implementation of bad debt policy proposals would advance the public interest. AzHHA is concerned that retroactive implementation would actually have the opposite effect. Providers likely would request re-opening and re-submitting cost reports out of an abundance of caution to ensure compliance with retroactive rules. In fact, providers may feel compelled to re-assess all previous cost reports if policies were made retroactive, leading to increased burden on provider and government resources.

AzHHA is also concerned that the rule does not acknowledge that several of CMS's bad debt proposals would transform recommended activities into mandated actions, such that new requirements would be applied to past behavior. This fact alone would make retroactive

¹⁰ Pew Research Center. (2020). Unemployment rose higher in three months of COVID-19 than it did in two years of the Great Recession. <https://www.pewresearch.org/fact-tank/2020/06/11/unemployment-rose-higher-in-three-months-of-covid-19-than-it-did-in-two-years-of-the-great-recession/> ; Washington Post. (2020). "A 'misclassification error' made the May unemployment rate look better than it is. Here's what happened." <https://www.washingtonpost.com/business/2020/06/05/may-2020-jobs-report-misclassification-error/>

¹¹ Health Management Associates. (2020). COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State. <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf> and <https://www.healthmanagement.com/blog/hma-updates-forecast-of-covid-19-impact-on-medicare-marketplace-uninsured/>

Administrator Seema Verma

July 10, 2020

Page 6

application inappropriate since a retroactive effective date could put providers out of compliance by default, despite them having followed applicable conventions of an earlier time period.

Given these concerns, AzHHA urges CMS to withdraw proposals to retroactively apply proposed policies related to Medicare bad debt. Instead, we would recommend that the agency only apply any finalized bad debt proposals to cost reporting periods ending on or after Oct. 1, 2020.

Thank you for the opportunity to comment on the Proposed Rule. The health and well-being of our state and our nation is our top priority, and we look forward to continuing to work with you to serve that goal.

Sincerely,

A handwritten signature in cursive script, appearing to read "Ann-Marie Alameddini".

Ann-Marie Alameddini
President and Chief Executive Officer
Arizona Hospital and Healthcare Association