

## CMS MULLS USING MARKET-BASED PRICING DATA TO INFORM HOSPITAL PAY

The Center for Medicare and Medicaid Services (CMS) is considering using data on the rates hospitals negotiate with private insurers, including Medicare Advantage (MA) plans, to help set future Medicare fee-for-service (FFS) payment rates for hospital procedures.

A wide-ranging executive order signed by the president last fall directed the Department of Health and Human Services (HHS) to modify Medicare fee-for-service payments to more closely reflect what MA plans and commercial plans pay providers. CMS' first outline of how it might do that is included in the proposed fiscal 2021 inpatient hospital rule that CMS recently released.

CMS says that hospitals will already be required to report the data about their payer-specific negotiated rates under the agency's controversial 2019 hospital price transparency rule. That rule is set to take effect January 1, 2021, and it is facing a court challenge from the hospital lobby.

In Monday's proposed rule, CMS goes a step further and says it will consider using the newly required hospital pricing data to calculate diagnosis-related group relative weights. CMS uses the relative weights to designate which patient conditions are entitled to higher or lower payments.

The proposed rule would require a hospital to report two pieces of data on its Medicare cost report: the median payer-specific negotiated charges that the hospital has negotiated with all of its MA plans, by diagnosis-related group, and the

median payer-specific negotiated charges that the hospital has negotiated with all of its third-party payers, by diagnosis-related group. The negotiated charges that hospitals would use to calculate these medians are already required to be disclosed under the transparency rule – though hospitals argue that rule is overly burdensome, exceeds CMS' statutory authority and is unconstitutional.

CMS may then use the median pricing data as the basis for a new method of setting the relative weights for diagnosis-related groups that would take effect in fiscal year 2024. The proposed rule says CMS is specifically considering estimating the relative weights using the median payer-specific negotiated charge for each diagnosis group for MA plans.

"The MA program provides efficient and value-based care to patients through choice and private competition," the agency says in the proposed rule. "We believe using the median payer-specific negotiated charge for payers that are MA organizations within the MS-DRG relative weight calculation would allow for a more market-based approach to determining Medicare FFS reimbursement and reduce our reliance on the hospital chargemaster."

The agency goes on to say that it will consider alternative market-based changes, such as using the median payer-specific negotiated charge for all third-party payers -- rather than the median payer-specific negotiated charge for MA plans -- or other market-based information.