Hospital Inpatient Prospective Payment System (IPPS) Frequently Asked Questions (FAQs) – Market-Based MS-DRG Relative Weight Data Collection and Change in Methodology for Calculating MS-DRG Relative Weights

Background: This FAQ document discusses the market-based MS-DRG relative weight data collection and the change in methodology for calculating the MS-DRG relative weights finalized in the FY 2021 Medicare inpatient prospective payment system (IPPS) final rule that was issued on September 2, 2020 (85 FR 58873 through 58892). As stated in the final rule, we believe that hospitals have the capacity, based on the instructions provided within the FY 2021 IPPS final rule, and the revision of the Information Collection Request currently approved under OMB control number 0938-0050, expiration date March 31, 2022, to report this market based data on the Medicare cost report for cost reporting periods ending on or after January 1, 2021. We stated in the final rule that we may provide additional guidance as appropriate or as determined necessary. However, absent additional guidance, we stated we believe that hospitals have the capability to report this market-based data for cost reporting periods ending on or after January 1, 2021.

To determine the median payer-specific negotiated charge for Medicare Advantage (MA) organizations for a given MS-DRG, a hospital would list, by MS-DRG, each discharge in its cost reporting period that was paid for by an MA organization, and the corresponding payer-specific negotiated charge that was negotiated as payment for items and services provided for that discharge. The median payer-specific negotiated charge for payers that are MA organizations, for that MS-DRG, would be the median payer-specific negotiated charge in that list of discharges.

This FAQ document provides hospitals with a guide for acceptable approaches they may use to calculate and report median payer-specific negotiated charges by MS-DRG on the Medicare cost report for cost reporting periods ending on or after January 1, 2021. We recognize that not all hospitals and MA organizations may negotiate payer-specific negotiated charges in the same manner or use the MS-DRG patient classification system. For those MA organizations and hospitals that negotiate based on per diem rates, a percentage of basis, based on APR-DRGs, or another means, may crosswalk those rates to determine, calculate and report the median payer-specific negotiated charges by MS-DRG.

Q: What charges are hospitals required to report?

A: Hospitals are required to report on the Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its MA organization payers, by MS-DRG, for cost reporting periods ending on or after January 1, 2021 (85 FR 58891). The definition for payer-specific negotiated charge is the charge that a hospital has negotiated with a third party payer for an item or service (85 FR 58878).

For the purposes of calculating and reporting the median payer-specific negotiated charge the hospital has negotiated with all of its MA organization payers, by MS–DRG, an MA organization is defined the same way as proposed in the FY 2021 IPPS rule, and defined in 42

CFR 422.2; namely, an MA organization means a public entity or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements. The definition of third party payer, for the purposes of reporting median payer-specific negotiated charges as set forth in the FY 2021 IPPS final rule, includes MA organizations that have contracted with CMS (85 FR 58891).

Items and services are defined as all items and services, including individual items and services and service packages that could be provided by a hospital to a patient in connection with an inpatient admission for which the hospital has established a standard charge (85 FR 58878). An MS-DRG, as established by CMS under the MS-DRG classification system, is a type of service package consisting of items and services based on patient diagnosis and other characteristics (85 FR 58878).

Q: How do hospitals calculate the median payer-specific negotiated charge for MA Organizations for a given MS-DRG?

A: To determine the median payer-specific negotiated charge for MA organizations for a given MS-DRG, a hospital would list, by MS-DRG, each discharge in its cost reporting period paid for by an MA organization, and the corresponding payer-specific negotiated charge that was negotiated as payment for items and services provided for that discharge. The median payer-specific negotiated charge for payers that are MA organizations, for that MS-DRG, would be the median payer-specific negotiated charge in that list of discharges.

A simplified example for the purpose of illustrating this process is as follows. Hospital A has negotiated four different payer-specific charges with four MA organizations for hypothetical MS-DRG 123. The four payer-specific negotiated charges are $7,300, $7,400, $7,600, and $7,700. In its cost reporting period, Hospital A had 3 discharges for which $7,300 was the basis for payment for the items and services provided for that discharge, 2 discharges for which $7,400 was the basis for payment for the items and services provided for that discharge, 1 discharge for which $7,600 was the basis for payment for the items and services provided for that discharge, and 1 discharge for which $7,700 was the basis for payment for the items and services provided for that discharge. Therefore, for Hospital A, the payer-specific negotiated charges for its list of discharges paid for by MA organizations in its cost reporting period for MS-DRG 123 is $7,300, $7,300, $7,300, $7,400, $7,400, $7,600, and $7,700. The median of this list is $7,400. Hospital A's median payer-specific negotiated charge for MS-DRG 123 for payers that are MA organizations would be $7,400.

The definitions of "payer-specific negotiated charge," "third party payer," "MA organization" and "items and services" were finalized as proposed. These definitions can be found at 85 FR 58878.

Q: How do hospitals calculate the median payer-specific negotiated charge for a given MS-DRG if the hospital negotiates contracts with MA organizations on a per diem or percentage of basis?

A: As stated previously in this document, we believe that hospitals have the capacity, based on the instructions provided within the FY 2021 IPPS final rule, and the revision of the Information Collection Request currently approved under OMB control number 0938-0050, expiration date March 31, 2022, to currently report this market based data on the Medicare cost reporting for cost reporting periods ending on or after January 1, 2021. However, we recognize that not all hospitals and MA organizations negotiate payer-specific negotiated charges in the same manner. There are several approaches hospitals can use to negotiate payer-specific negotiated charges with MA organizations. The below information provides an example of acceptable steps a hospital may follow to calculate the median payer-specific negotiated charge when the hospital negotiated contracts with MA organizations on a per diem or percentage of basis.

In this example, for hospitals that negotiate contracts with MA organizations on a per diem or percentage of basis, the hospital would calculate the median payer-specific negotiated charge using the process outlined in the QA above, by first calculating the full amount of the payer-specific negotiated charge for each discharge and then use that list of corresponding payer-specific negotiated charges per MA organization patient discharge to calculate the median payer-specific negotiated charge for each MS-DRG, as described previously.

In the first step of this example, the hospital would calculate, for each discharge in its cost reporting period that was paid for by an MA organization, the full amount of the payer-specific negotiated charge that was negotiated as payment for items and services provided for that discharge under that specific contract, by MS-DRG. In the second step of this example, the hospital would use this list of payer-specific negotiated charges by discharges to calculate the median payer-specific negotiated charge across all MA organization contracts for each MS-DRG.

Step One (Calculate the payer-specific negotiated charge)

The hospital would first calculate the payer-specific negotiated charge that it has negotiated with each MA organizations for items and services provided for a specific discharge, for each discharge in its cost reporting period that was paid for by an MA organization,[1] for each MS-DRG. The payer-specific negotiated charges should be comparable across all types of MA organization contracts for which there were MA beneficiary inpatient discharges in that cost reporting period. Identifying the payer-specific negotiated charge for each MA organization inpatient discharge would depend on how the hospital has negotiated contracts with each of its MA organization payers for which it had an inpatient discharge during the corresponding cost reporting period.

[1] In calculating the median payer-specific negotiated charge, the hospital would calculate and include in the list of payer-specific negotiated charges, only discharges for MA organization beneficiaries that occurred within the hospital's cost reporting period. A hospital does not need to have received payment by the MA organization for the MA organization beneficiary's inpatient hospital stay by the close of their cost reporting period to include the payer-specific negotiated charge data within the median payer-specific negotiated charge calculation. In other words, if a hospital had an MA organization beneficiary inpatient discharge during their cost reporting period, the hospital would include that negotiated rate when calculating and reporting the median payer-specific negotiate charge for that MS-DRG.

For example, hospitals may negotiate rates with MA organizations on a per diem basis, as a percent discount off chargemaster rates or Medicare FFS rates, or by another means. If a hospital has multiple MA organization contracts under which a patient discharge occurred in that cost reporting period, and which were negotiated differently, the hospital would identify the full amount it negotiated with each MA organization for that specific patient discharge for each MS-DRG. If there are multiple considerations within the contract, such as an additional payment for a certain technology, or drug or biologic, those negotiated rates would also need to be included when identifying the full amount of payer-specific negotiated charge for that discharge. The hospital would then uniformly group those items and services to MS-DRGs.

Hospitals that negotiate payments on the basis of items and services that are not as familiar with MS-DRGs have access to the most current publicly available version of the CMS Grouper used to group ICD-10 codes to MS-DRGs, and are able to use this software to uniformly group inpatient items and services to MS-DRGs. Hospitals can do this either initially by proactively using the same Grouper version used by CMS for that corresponding year, or retrospectively after an inpatient hospital stay, but prior to submitting the market based information on the hospital cost report. (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software).

See the examples below of acceptable steps a hospital may follow to identify the payer-specific negotiated charges for each discharge and MS-DRG, when the hospital negotiated contracts with MA organizations on a per diem or percentage of basis.

Example One: Hospital paid on a per-diem basis

Under this example, one acceptable approach would be to convert the per diem payment based on the length of stay for each corresponding discharge to identify the full amount of the payer-specific negotiated charge for that particular MA organization inpatient discharge. To do so, a hospital would multiply the per diem amount by the length of stay for the corresponding discharge to determine the full amount of the payer-specific negotiated charge for that particular patient discharge for that specific MS-DRG. A hospital that had multiple discharges during the cost reporting period, paid for by the MA organization, under a contract negotiated on a per diem basis, would repeat this process for all such discharges under that contract during the cost reporting period, for each MS-DRG.

A simplified example for the purpose of illustrating this process is as follows: Assume Hospital A has negotiated a per diem amount of $1,000 for hypothetical MS-DRG 123 under its contract with MA organization X. Assume Hospital A had 3 beneficiary discharges for MS-DRG 123, for which it received payment from MA organization X. Discharge 1 had a length of stay of 1 day, discharge 2 had a length of stay of 2 days and discharge 3 had a length of stay of 3 days. In this case, Hospital A would multiply $1,000 by each corresponding length of stay to identify the full amount of the payer-specific negotiated charge under the MA organization X contract for each discharge for hypothetical MS-DRG 123. The payer-specific negotiated charges for discharge 1 would be $1,000; discharge 2: $2,000; and discharge 3: $3,000. Hospital A would use the full amounts of these payer-specific negotiated charges ($1,000, $2,000, and $3,000) in step two for calculating the median payer-specific negotiated charge for hypothetical MS-DRG 123.

MA Organization X – Per Diem Contract with Hospital A

MS-DRG 123	Per-diem rate negotiated with MA organization X	Length of stay	Payer-specific negotiated charge
Discharge 1	$1,000	1 day	$1,000
Discharge 2	$1,000	2 days	$2,000
Discharge 3	$1,000	3 days	$3,000

Example Two: Hospital paid on a percentage of Medicare fee-for-service rates or chargemaster charges

In this example, one acceptable approach for a hospital that has negotiated rates with MA organizations based on a percentage discount off of the Medicare fee-for-service (FFS) payment amount or a percentage off of the chargemaster amounts for particular items and services, would be to convert that rate based on the percentage that was negotiated between the hospital and MA organization as payment for items and services provided for each patient discharge in the cost reporting year.

In this example, a hospital would multiply the Medicare FFS amount (or chargemaster amount for a particular item or service) by the percentage negotiated with the MA organization.[2] The hospital would repeat this process for all discharges paid for by the MA organization under that contract during the corresponding cost reporting period.[3] For example, assume Hospital A had 2 beneficiary discharges (discharges 4 and 5) for hypothetical MS-DRG 123 paid for by MA organization Y during the cost reporting period. MA organization Y has agreed to pay Hospital A 50% of the Medicare FFS amount. If the Medicare FFS amount for hypothetical MS-DRG 123 is $1,500, the payer-specific negotiated charge for discharges 4 and 5 would be $750 (1,500 x 0.5). Hospital A would use these payer-specific negotiated charge amounts ($750 and $750) in step two for calculating the median payer-specific negotiated charge for hypothetical MS-DRG 123.

MA Organization Y – Percentage of Medicare FFS Amount Contract with Hospital A

[2] If a hospital negotiated a percentage off discount for chargemaster charges with an MA organization, the hospital would need to multiply the chargemaster rate for each item or service provided for a patient discharge by the percentage negotiated with that MA organization. The hospital would then use the correct corresponding CMS Grouper version to group those items and services to the appropriate MS-DRG for that specific discharge. For more information regarding the CMS Grouper, please see additional questions below or 85 FR 58887.

[3] As in the previous example, in calculating the median payer-specific negotiated charge, the hospital would calculate and include in the list of payer-specific negotiated charges, only discharges for MA organization beneficiaries that occurred within the hospital's cost reporting period. A hospital does not need to have received payment by the MA organization for the MA organization beneficiary's inpatient hospital stay by the close of their cost reporting period to include the payer-specific negotiated charge data within the median payer-specific negotiated charge calculation. In other words, if a hospital had an MA organization beneficiary inpatient discharge during their cost reporting period, the hospital would include that negotiated rate when calculating and reporting the median payer-specific negotiate charge for that MS-DRG.

MS-DRG 123	Percentage of Medicare FFS amount for MA Organization Y	Medicare FFS amount for MS-DRG 123	Payer-specific negotiated charge
Discharge 4	50%	$1,500	$750
Discharge 5	50%	$1,500	$750

Example 3 – Complex Contracting Arrangement

This example describes an acceptable approach for identifying the payer-specific negotiated charge for a particular discharge if a hospital has agreed to a complex contracting arrangement with MA organizations. In this hypothetical instance, the hospital has a contract in which the insurer pays a base rate for MS-DRG 123 of $5,000. In addition, the hospital is paid for 50 percent of the chargemaster (gross) rates for the implant chosen by the hospital for the surgery. In this example, if the patient stays in the hospital longer than 5 days, then the hospital is not paid according to the base rate and the percentage of chargemaster rate for the device as described above, but is instead paid a negotiated per diem rate of $1,000 per day.

MA Organization Z – Complex Contracting Arrangement

MS-DRG 123	Base Rate	Chargemaster Rate for the Device	Length of Stay	Per Diem Rate	Payer-Specific Negotiated Charge
Discharge 6	$5,000	$2,000	4	$1,000	$6,000
Discharge 7	$5,000	$1,000	3	$1,000	$5,500
Discharge 8	$5,000	$2,000	8	$1,000	$8,000
Discharge 9	$5,000	$2,500	7	$1,000	$7,000

In this example, there are two discharges with a length of stay of less than 5 days (discharge 6 and 7). In those cases, the payer-specific negotiated charge for the discharge is determined by adding the base rate of $5,000 to 50% of the chargemaster rate for the device. Discharges 8 and 9 are longer than 5 days, therefore the base rate and chargemaster rate for the device no longer determine the payer-specific negotiated charge for those discharges. Instead, the payer-specific negotiated charge for these discharges is determined by multiplying the corresponding length of stay by the negotiated per diem rate of $1,000. The table below blacks out the sections of the formula that do not apply in determining the payer-specific negotiated charge for each discharge.

MA Organization Z – Complex Contracting Arrangement

MS-DRG 123	Base Rate	Chargemaster Rate for the Device	Length of Stay	Per Diem Rate	Payer-Specific Negotiated Charge
Discharge 6	$5,000	$2,000			$6,000
Discharge 7	$5,000	$1,000			$5,500
Discharge 8			8	$1,000	$8,000
Discharge 9			7	$1,000	$7,000

Step Two (Calculate the median payer-specific negotiated charge for the MS-DRG)

To determine the median payer-specific negotiated charge for MA organizations for a given MS-DRG, a hospital would list, by MS-DRG, each discharge in its cost reporting period that was paid for by an MA organization, and the corresponding payer-specific negotiated charge that was negotiated as payment for items and services provided for that discharge. The median payer-specific negotiated charge for payers that are MA organizations, for that MS-DRG, would be the median payer-specific negotiated charge in that list of discharges. (See the previous QA or 85 FR 58878 for a simplified example.)

Using the examples above, we can calculate Hospital A's median payer-specific negotiated charge for hypothetical MS-DRG 123 using the payer-specific negotiated charges for discharges 1-9 paid for by MA organizations X, Y and Z.

MA Organization X – per diem contract arrangement

MS-DRG 123	Per-diem amount for MA organization X	Length of stay	payer-specific negotiated charge
Discharge 1	$1,000	1 day	$1,000
Discharge 2	$1,000	2 days	$2,000
Discharge 3	$1,000	3 days	$3,000

MA Organization Y – Percentage of Medicare FFS amount contract arrangement

MS-DRG 123	Percentage of Medicare FFS amount for MA Organization Y	Medicare FFS amount for MS-DRG 123	payer-specific negotiated charge
Discharge 4	50%	$1,500	$750
Discharge 5	50%	$1,500	$750

MA Organization Z – Complex Contracting Arrangement

MS-DRG 123	Base Rate	Chargemaster Rate for the Device	Length of Stay	Per Diem Rate	Payer-Specific Negotiated Charge
Discharge 6	$5,000	$2,000	4	$1,000	$6,000
Discharge 7	$5,000	$1,000	3	$1,000	$5,500
Discharge 8	$5,000	$2,000	8	$1,000	$8,000
Discharge 9	$5,000	$2,500	7	$1,000	$7,000

To determine the median payer-specific negotiated charge for MS-DRG 123, Hospital A would list each discharge for that MS-DRG in its cost reporting period that was paid for by an MA organization and the corresponding payer-specific negotiated charge that was negotiated as payment for items and services provided for that discharge. The median payer-specific negotiated charge for MS-DRG 123 would be the median payer-specific negotiated charge in that list of discharges.

MS-DRG 123	Payer-specific negotiated charge

Discharge 4	$750
Discharge 5	$750
Discharge 1	$1,000
Discharge 2	$2,000
Discharge 3	**$3,000**
Discharge 7	$5,500
Discharge 6	$6,000
Discharge 9	$7,000
Discharge 8	$8,000

In this case, Hospital A would report on its cost report the median payer-specific negotiated charge of $3,000 for hypothetical MS-DRG 123.

Q: We have a contract that changed during our hospital cost reporting period. How do we account for that in calculating the median payer-specific negotiated charges for each MS-DRG?

A: If a hospital's contract with an MA organization changed over the course of the hospital's cost reporting period, the hospital should calculate the payer-specific negotiated charges based on the contract in effect at that time of that inpatient discharge. If that hospital's cost reporting period spans multiple versions of the CMS Grouper, the hospital may also need to confirm that the payer-specific negotiated charge for those items and services is assigned to the correct MS-DRG.

Since hospitals assign the underlying ICD-10-CM principal diagnosis, and any other secondary diagnosis codes and ICD-10-PCS procedure codes, which determine how patients are assigned to an MS-DRG, hospitals are able to associate those items and services to MS-DRGs for each discharge. Hospitals have access to the most current publically available version of the CMS Grouper used to group ICD-10 codes to MS-DRGs, and are able to use this software to uniformly group inpatient items and services to MS-DRGs, either initially by proactively using the same Grouper version used by CMS, or retrospectively after an inpatient hospital stay, but prior to submitting this information on the hospital cost report. In the event the hospital's cost reporting year spans two fiscal years, hospitals can identify which version of the CMS Grouper to use based on the corresponding date of discharge.

The CMS Grouper software is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.

Q: How do we account for separate payment for high-cost implantable devices, or drugs or biologics, in determining the payer-specific negotiated charge for the MA organization inpatient discharge?

A: Separate payment for high-cost implantable devices, or drugs or biologics should be accounted when identifying the payer-specific negotiated charge and when calculating the median payer-specific negotiated charge by MS-DRG. Under the acceptable approach we outlined in step one of the QA above, when determining the payer-specific negotiated charge for

a MA organization patient discharge, the separate payment for the implantable device (or drug or biologic) would be included in the identification of the payer-specific negotiated charge since it was a payment negotiated for an item or service that was provided during that particular MA organization beneficiary's inpatient stay.

An example of this acceptable approach is as follows: Assume Hospital B negotiated a $1,200 base rate for hypothetical MS-DRG 123, but also negotiated a $1,000 separate payment if a specific device was used or implanted. For a discharge under MS-DRG 123 where this implantable device (or drug or biologic) was used, the total amount of the payer-specific negotiated charge for this MA organization payer would be $2,200 ($1,000+$1,200). Hospital B would use this payer-specific negotiated charge amount ($2,200) in step two when listing the discharges for MS-DRG 123 used to then calculate the median payer-specific negotiated charge for MS-DRG 123.

Q: How do we report and calculate the median payer-specific negotiated charge by MS-DRG if we contract with several different MA organizations, and each MA organization contract had varying numbers of patient discharges during our cost reporting year?

A: Once a hospital has identified the payer-specific negotiated charge for each discharge in its cost reporting period paid for by an MA organization, the median for a given MS-DRG is determined by identifying the middle[4] payer-specific negotiated charge. See the example below.

Payer-specific negotiated charge for sample MS-DRG 123	MA Organization Payer	Number of Discharges
$7,300	Payer A	3
$7,400	Payer B	2
$7,600	Payer C	1
$7,700	Payer D	1

In this case, the median payer-specific negotiated charge for sample MS-DRG 123 would be $7,400 because the payer-specific negotiated charges for its list of discharges paid for by MA organizations in its cost-reporting period for the sample MS-DRG 123 is $7,300, $7,300, $7,300, **$7,400**, $7,400, $7,600, and $7,700.

If each MA organization discharge had a different payer-specific negotiated charge (i.e. Payer A had 3 discharges with 3 different payer-specific negotiated charges because the contracts were negotiated on a per diem basis and each discharge had a different length of stay) then the hospital would list each of those different corresponding payer-specific negotiated charges for those MA organization discharges when calculating the median, similar to the example above.

Q: What do we report for the median if there is an even number of payer-specific negotiated charges by discharges for that specific MS-DRG?

[4] See question below for calculating the median in instances with an even number of payer-specific negotiated charges.

A: If a hospital has listed an even number of payer-specific negotiated charges by discharge for that specific MS-DRG, the hospital, in its calculation of the median, would use the average of the two remaining payer-specific negotiated charges in order to calculate the median. See the example below:

Payer-specific negotiated charge for sample MS-DRG 456	MA Organization Payer	Number of Discharges
$7,000	Payer A	2
$8,000	Payer B	1
$9,000	Payer C	1
$10,000	Payer D	2

In this case the median would be $8,500, because the payer-specific negotiated charges for its list of discharges paid for by MA organizations in its cost reporting period for the sample MS-DRG 456 is $7,000, $7,000, **$8,000, $9,000**, $10,000, $10,000. $8,500 is the median, because it is the average of the two remaining figures ($8,000 and $9,000).

If each MA organization discharge had a different payer-specific negotiated charge (i.e. Payer A had 3 discharges with 3 different payer-specific negotiated charges because the contracts were negotiated on a per diem basis and each discharge had a different length of stay) then the hospital would list each of those corresponding payer-specific negotiated charges for those MA organization discharges, similar to the example above.

Q: Why did CMS decide to utilize the median?

A: CMS will collect the median of the hospital payer-specific negotiated charges because the median is a common measure of central tendency that is less influenced by outlier values.

Q: When should hospitals report their data for cost reporting periods?

A: CMS requires hospitals to begin reporting the information for cost reporting periods ending on or after January 1, 2021. For example, a hospital with a July 2020-June 2021 cost reporting period would need to begin reporting this information when it submits the cost report after June 2021. A hospital with a January 2021 - December 2021 cost reporting period would need to begin reporting this information when it submits the cost report after December 2021. We note that hospital have a 5-month period after its cost reporting period ends to submit the Medicare cost report.

Q: How does the Market-Based MS-DRG Relative Weight Data Collection reporting requirement coincide with the requirements finalized in the Hospital Price Transparency Rule?

A: The market-based MS-DRG relative weight data collection policy, as required under the FY 2021 IPPS final rule, is separate from the requirements and penalties set forth under the Hospital

Price Transparency Final Rule (84 FR 65524). The market-based data collection and MS-DRG relative weight methodology were finalized in the FY 2021 IPPS final rule to reduce the Medicare program's reliance on the hospital chargemaster by incorporating market-based data within Medicare FFS inpatient payments, under the authority provided under Sections 1815(a), 1833(e), 1886(d)(4)(A), 1886(d)(4)(B), and 1886(d)(4)(C) of the Social Security Act. In contrast, the Hospital Transparency Final Rule relied on the statutory authority under Section 2718(e) of the Public Health Service Act. Please direct all questions related to the Hospital Price Transparency final rule requirements (84 FR 65524) and associated penalties, to PriceTransparencyHospitalCharges@cms.hhs.gov.

Q: Will CMS deny Medicare payment if hospitals do not report the median payer-specific negotiated charges on the Medicare cost report S-12 worksheet?

A: The FY 2021 IPPS final rule requires the calculation and reporting of the median payer-specific negotiated charge by MS–DRG for payers that are MA organizations. Sections 1815(a) and 1833(e) of the Social Security Act state that no Medicare payments will be made to a provider unless it has furnished information requested by the Secretary to determine payment amounts due under the Medicare program. Sections 1815(a) and 1833(e) of the Act pertain to CMS's authority to collect information on the Medicare cost report. If a Medicare provider does not furnish payment information on the cost report, then potentially no Medicare payments will be provided (85 FR 58890).

These requirements are distinct from the requirements and associated penalties under the Hospital Price Transparency final rule (84 FR 65525). Under the Hospital Price Transparency final rule hospitals must publicly post certain standard charge data. Hospitals that do not meet this requirement are notified and given the opportunity to complete a corrective action plan, but could face a civil monetary penalty if they fail to complete the corrective action plan (84 FR 65584). Please direct all questions related to the Hospital Price Transparency final rule requirements (84 FR 65524) and associated penalties, to PriceTransparencyHospitalCharges@cms.hhs.gov.

Q: How does the median payer-specific negotiated charge data collection policy impact the methodology for calculating the IPPS MS-DRG relative weights?

A: CMS finalized the adoption of a market-based MS-DRG relative weight methodology effective for FY 2024. CMS will use the median payer-specific negotiated charge by MS-DRG for MA organizations data collected on the Medicare cost report to calculate the MS-DRG relative weights beginning with the relative weights calculated for FY 2024. This new market-based MS-DRG relative weight methodology was described in the FY 2021 IPPS proposed rule and finalized without modification in the final rule. The step by step process for calculating the MS-DRG relative weights can be found beginning at 85 FR 58880.

Q: How will CMS use the payer-specific negotiated charge data to establish MS-DRG relative weights?

A: CMS will establish the relative weight for an MS-DRG by calculating the ratio of the single weighted average standardized median MA organization payer-specific negotiated charge for *that* MS-DRG across hospitals to the single national weighted average standardized median MA organization payer-specific negotiated charge across *all* MS-DRGs. The step by step process for calculating the relative weights can be found beginning at 85 FR 58880.

Q: When will the market-based MS-DRG relative weight methodology for calculating the weights effect hospital payments? Will there be a transition period from the current methodology?

A: CMS will begin using the market-based MS-DRG relative weight methodology for calculating the relative weights, which are used in part to determine hospital payments, in FY 2024 (beginning October 1, 2023). We did not adopt a transition period to this market-based MS–DRG relative weight methodology in the FY 2021 IPPS final rule, but may consider this in future rulemaking prior to FY 2024.

Q: What are the steps that CMS will use to calculate market-based MS-DRG relative weights?

A: The steps that CMS will use to calculate the market-based MS-DRG relative weights using the median payer-specific negotiated charge data are summarized below. We refer readers to the final rule for additional information (85 FR 58880). As finalized in the FY 2021 IPPS final rule, CMS adopted this market-based MS-DRG relative weight methodology for calculating the MS-DRG relative weights beginning in FY 2024.

Step One: Standardize the Median MA Organizations Payer-Specific Negotiated Charges

CMS would standardize the median payer-specific negotiated charges by removing the effects of differences in area wage levels, and cost-of living adjustments for hospital claims from Alaska and Hawaii.

Step Two: Create a Single Weighted Average Standardized Median MA Organization Payer-Specific Negotiated Charge by MS-DRG Across Hospitals

For each MS-DRG, CMS would create a single weighted average across hospitals of the standardized median payer-specific negotiated charges. CMS would weight the standardized payer-specific negotiated charge for each MS-DRG for each hospital using that hospital's Medicare transfer-adjusted case count for that MS-DRG, with transfer adjusted case counts calculated exactly the same way as under the current MS-DRG relative weight methodology.

Step Three: Create a Single National Weighted Average Standardized Payer-Specific Negotiated Charge Across all MS-DRGs

CMS would create a single national weighted average across MS-DRGs of the results of Step Two, where the weights are the national Medicare transfer adjusted case counts by MS-DRG.

Step Four: Calculate the Market-based Relative Weights

For each MS-DRG, the market-based relative weight would be calculated as the ratio of the single weighted average standardized median MA organization payer-specific negotiated charge for *that* MS-DRG across hospitals from Step Two to the single national weighted average standardized median MA organization payer-specific negotiated charge across *all* MS-DRGs from Step Three.

Step Five: Normalize the Market-based Relative Weights

As under the current cost-based MS-DRG relative weight methodology, the market-based relative weights would be normalized by an adjustment factor so that the average case weight after recalibration would be equal to the average case weight before recalibration. The normalization adjustment is intended to help ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

Q: Will CMS provide the public the opportunity to review the market-based data collected prior to the utilization of the MA organization median payer-specific negotiated charge data in the market-based MS-DRG relative weight methodology beginning in FY 2024?

A: We intend to provide an opportunity for the public to review our analysis of the median payer-specific negotiated charge data received, which we intend to do prior to the utilization of the MA organization median payer-specific negotiated charge data in the market-based MS-DRG relative weight methodology beginning in FY 2024. We believe this allows for additional discussions, public review, and conversation about utilizing this market-based data in the MS-DRG relative weight methodology.