U.S. Department of Justice
Civil Division, Appellate Staff
950 Pennsylvania Ave. NW, Rm. 7243
Washington, DC 20530

Tel: (202) 353-8189

September 25, 2020

VIA CM/ECF

Mark Langer
Clerk of Court
U.S. Court of Appeals for the D.C. Circuit
333 Constitution Ave. N.W.
Washington, D.C. 20001

RE: *American Hospital Association, et al. v. Azar*, No. 20-5193 (argument scheduled October 15, 2020)

Dear Mr. Langer:

The recent Department of Health and Human Services (HHS) rule cited in plaintiffs' 28(j) letter does not support plaintiffs.

That rule announces a new methodology (effective in FY2024) for calculating certain Medicare rates. 85 Fed. Reg. 58,432 (Sept. 18, 2020). Under the Medicare statute, reimbursement amounts for Medicare Severity diagnosis-related groups depend in part on a "weighting factor," "which reflects the relative hospital resources used" for treating patients within a group. 42 U.S.C. § 1395ww(d)(4)(A)-(C). Under the new rule, HHS will calculate the weighting factor utilizing the median rates hospitals have negotiated with Medicare Advantage organization payers, reported by Medicare diagnosis-related group, and will reduce its reliance on chargemaster charges. 85 Fed. Reg. at 58,880-83. To implement this new methodology, the rule requires hospitals, in their Medicare cost reports, to provide to HHS their median negotiated charges with Medicare Advantage organization payers, grouped by Medicare Severity diagnosis-related group. *Id.* at 58,877.

The rule cited by plaintiffs has no bearing on the reasonableness of the Rule at issue in this case, which interprets a different statutory provision, 42 U.S.C. § 1395gg-18(e), and serves an entirely different purpose. There is nothing contradictory about HHS requiring hospitals to report a subset of negotiated charges to it for purposes of

Medicare ratesetting, and requiring hospitals under § 1395gg-18(e) to "make public" all of their payer-specific negotiated charges. For example, median rates are useful to HHS in setting Medicare reimbursement values, *see id.* at 58,875, 58,882; but median rates are less useful to insured patients attempting to determine their out-of-pocket costs, which depend not on median values, but rather the specific rates the hospital has negotiated with a patient's insurance company. *See, e.g.*, Gov't Br. 24, 30. Similarly, the rates hospitals have negotiated with Medicare Advantage payers are useful in setting Medicare reimbursement values, 85 Fed. Reg. at 58,881; but those rates are not useful to insured patients who are not participating in the Medicare Advantage program and who want to budget and shop for care. The Rule at issue in this case reasonably interprets § 1395gg-18(e)'s text and faithfully implements its purpose.

Sincerely,

Scott R. McIntosh
/s/ Courtney L. Dixon
Courtney L. Dixon
Attorneys, Appellate Staff
Civil Division
U.S. Department of Justice

cc: all counsel (via CM/ECF)