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September 21, 2020

VIA ELECTRONIC FILING

Mr. Mark J. Langer
Clerk of the Court
United States Court of Appeals for the D.C. Circuit
E. Barrett Prettyman U.S. Courthouse and
William B. Bryant Annex
333 Constitution Avenue, NW
Washington, D.C. 20001

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

Dear Mr. Langer:

Under Federal Rule of Appellate Procedure 28(j), Appellants attach a final HHS rule that expressly builds upon HHS's challenged price-disclosure rule to impose additional reporting obligations under Medicare. 85 Fed. Reg. 58,432, 58,873-92 (Sept. 18, 2020). The rule supplements hospitals' reporting obligations for diagnosis-related groups—the suites of items and services CMS uses to reimburse hospitals for treating Medicare patients. Until now, CMS relied in part on hospitals' gross charges for items and services—as reflected in chargemasters—to generate diagnosis-related-group reimbursements. *Id.* at 58,874-76; AHA Br. 11-12. But "to reduce the Medicare program's reliance on the hospital chargemaster," the rule imposes a new approach based on insurer-negotiated rates. 85 Fed. Reg. at 58,875. As of January 1, 2021, hospitals must report the de-identified median negotiated rate, for each diagnosis-related group, among all contracted insurers participating in the Medicare Advantage program. *Id.* at 58,891-92. This data will ultimately "replace the current use of gross charges that are reflected on a hospital's

chargemaster" in CMS's diagnosis-related-group ratesetting. *Id.* at 58,875. If a hospital fails to comply with the new reporting requirements, "then potentially no Medicare payments will be provided." *Id.* at 58,890.

The new rule pertains to Appellants' challenge in several respects:

- The rule identifies chargemasters as central to diagnosis-related-group rates. Appellants argue that section 2718(e)'s cross-reference to the Medicare provision refers to reimbursement rates for diagnosis-related groups, which derive from chargemasters, not to negotiated rates for other items and services. AHA Br. 35-37.

- The rule rejected disclosure of median diagnosis-related-group rates negotiated among all third-party payers due to "challenges in comparing data across all third party payers based on the variety of ways hospitals and other third party payers negotiate charges" and the "myriad of negotiation tactics" payers use. 85 Fed. Reg. at 58,881, 58,883. Appellants argue that HHS's interpretation of section 2718(e) as referring to third-party-payer rates is implausible and that HHS overlooked compliance difficulties with disclosing such rates in the manner required. AHA Br. 28-35, 53-56.

- The rule relies on de-identified median rates. Appellants argue that HHS had less-restrictive alternatives to its disclosure mandate. AHA Br. 50-51.

Respectfully submitted,

/s/ *Lisa S. Blatt*
Lisa S. Blatt
Counsel for Appellants

cc: Counsel of Record via ECF

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing letter complies with the type-volume limitations of Fed. R. App. P. 28(j) and the D.C. Circuit local rules because the body contains 350 or fewer words. This letter also complies with the typeface and type style requirements of Fed. R. App. P. 32(a)(5)(A) because this letter was prepared in Word using the proportionally spaced typeface, 14-point Times New Roman.

CERTIFICATE OF SERVICE

I hereby certify that, on September 21, 2020, I electronically filed the foregoing with the Clerk of the United States Court of Appeals for the District of Columbia Circuit using the CM/ECF system. I further certify that all party participants are registered CM/ECF users and will be served by the appellate CM/ECF system.

Dated: September 21, 2020

/s/ *Lisa S. Blatt*
Lisa S. Blatt
Counsel for Appellants