December 27, 2018

The Honorable Douglas A. Ducey
Office of the Governor
1700 West Washington
Phoenix, Arizona 85007

The Honorable Steve Yarbrough, President
Arizona State Senate
1700 West Washington
Phoenix, Arizona 85007

The Honorable J.D. Mesnard, Speaker
Arizona House of Representatives
1700 West Washington
Phoenix, Arizona 85007

Dear Governor Ducey, President Yarbrough, and Speaker Mesnard:

In accordance with Laws 2018, Chapter 284, Section 28, please find the enclosed report on hospital chargemaster transparency. Please feel free to contact Shelli Silver, Assistant Director, at (602) 417-4647 or shelli.silver@azahcccs.gov if you have any questions or would like additional information.

Sincerely,

Thomas J. Betlach
Director

cc: The Honorable Michele Reagan, Arizona Secretary of State

REPORT TO THE GOVERNOR, PRESIDENT OF THE SENATE AND SPEAKER OF THE HOUSE OF REPRESENTATIVES

Hospital Chargemaster Transparency

January 2019

AHCCCS AND ADHS CHARGEMASTER/TRANSPARENCY REPORT EXECUTIVE SUMMARY

This report is submitted jointly by the Arizona Department of Health Services (ADHS) and Arizona Health Care Cost Containment System (AHCCCS). It describes the state's mandated process for hospitals to report their respective Chargemasters, how billed hospital charges compare to hospital costs, the processes for reporting Chargemasters and hospital prices in other states, progress since last year's report, and recommendations on the state's use of this information. To place these issues in context AHCCCS and ADHS have conceptualized this report through a broader lens of transparency in healthcare of which hospital charges and/or price is a critical element.

AHCCCS and ADHS have little to report since last year specific to Arizona. However, in the Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule (CMS-1694-F), the Centers for Medicare and Medicaid Services (CMS) issued a requirement for hospitals to post a list of their standard charges online in a machine readable format and update the information at least annually.

The information in the Arizona Chargemaster is not meaningful to persons covered by an insurance plan. Virtually all insurance carriers negotiate the prices they pay hospitals and other providers. Because many Chargemaster prices are inflated relative to the hospitals' costs, Medicare rates are often the basis for the negotiated prices which health plans pay. Furthermore, because these contractual arrangements are confidential, the patient can draw little useful information from the Chargemaster, even if the negotiated pricing is a percent discount of charges.

As explained in prior reports, hospital price and quality information has gained increased attention in recent years, due in part to the trend toward patients' increased out of pocket exposure. Prior Hospital Chargemaster Transparency Reports discussed that, in order for health care purchasers to assess value, they need information on both price and quality, and this information must be presented in a clear and accessible format. As noted in prior reports, hospital charges and the chargemaster do not fully address this need.

As explained in the Catalyst for Payment Reform's 2016 Report Card on State Price Transparency Laws and the 2017 Price Transparency & Physician Quality Report Card, states continue to make little progress towards increasing transparency.[1]

[1] https://www.catalyze.org/product-category/scorecards-report-cards/report-cards-on-price-transparency/

AHCCCS AND ADHS CHARGEMASTER/TRANSPARENCY REPORT

Laws 2018, Chapter 284, Section 18, requires the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Health Services (ADHS) to report on hospital chargemaster transparency. Specifically, Section 18[2] requires:

> *On or before January 2, 2019, the director of the Arizona health care cost containment system administration and the director of the department of health services shall submit a joint report on hospital charge master transparency to the governor, the speaker of the house of representatives and the president of the senate and shall provide a copy to the secretary of state. The report shall provide a summary of the current charge master reporting process, a summary of hospital billed charges compared to costs and examples of how charge masters or hospital prices are reported and used in other states. The report shall include recommendations to improve the state's use of hospital charge master information, including reporting and oversight changes.*

BACKGROUND

When consumers make any type of purchase decision among competing products and services, they typically know, or can learn, the price. Often, they are able to make a reasonable assessment of the quality of the item. However, health care purchasers in Arizona, especially individual patients, purchase services with little or no knowledge of what they will pay for the service or related alternative services and have limited ability to compare healthcare providers based on quality measures. This lack of price transparency is becoming increasingly more important for consumers as health care costs continue to rise and consumers pay more for "out-of-pocket" care.

Our prior reports, particularly the 2014 Report[3], provided considerable detail on price transparency. Since then, our overall observations remain unchanged:

- In order for health care consumers to be able to assess value as they do for other goods and services, reliable and understandable price and quality information must be accessible, and must be comparable across providers to allow a consumer to use it for decision-making.

[2] https://www.azleg.gov/legtext/53Leg/2R/laws/0284.pdf
[3] https://archive.azahcccs.gov/archive/Resources/Reports/Reports%20to%20the%20Arizona%20Legislature/2014/2014Chargemaster.pdf

- Because of significant changes in the healthcare market, the current Arizona Chargemaster reporting requirements provide no public service and do not deliver accurate pricing comparison and transparency as originally intended.

- Outpatient services comprise a large and growing portion of the services provided by hospitals, and should be included in a meaningful reporting structure. However, this would require action by the legislature to enact new reporting requirements.

- All Payer Claims Databases (APCD) can provide a mechanism for significant price transparency by providing credible cost and quality information for most payers. In order to ensure the uniformity, consistency, and transparency of reported data, state agencies serve an important clearinghouse role. However, establishing an Arizona APCD would require legislative action and significant financial support.

Laws 2013, Chapter 202 established additional price reporting requirements for Arizona health care providers. Chapter 202 requires providers to make available on request or online the direct pay prices for at least the 25 most commonly provided services. Health care facilities with more than 50 inpatient beds must make available online or by request the 50 most commonly used Diagnosis Related Group (DRG) and outpatient codes (for facilities with fifty or fewer beds, the mandate declines to the top 35 most used DRG and 35 most used outpatient codes). However, this information is reported separately by each hospital, is not centrally reported or aggregated, and opportunities to compare prices are more limited as the most common procedures can vary between hospitals.

ARIZONA CHARGEMASTER PROCESS AND OTHER HOSPITAL REPORTING

Chargemaster Reporting

Pursuant to A.R.S. §36-436 and A.A.C. R9-11-302, hospitals report their entire Chargemaster and accompanying Overview form to ADHS. ADHS is authorized by statute and rule to "review" these documents, but not to dispute or direct the amounts or methods of charging.

Although hospitals base their charges for the uninsured on information contained in their Chargemaster, the Chargemaster content is of no utility to health care consumers regardless of their health insurance status. The Chargemaster contains charges at the individual detail level (e.g. per dose, per hour, per day, per item). Since every health care encounter includes many separate service components such as physician care, nursing, bed charges, service charges (e.g. venipuncture, radiology, lab), procedures (anesthesiologist, operating room, recovery room), and supply charges (e.g. stents, drugs, IV line), it is impossible for any consumer, whether insured or not, to estimate their cost for any hospital visit from the content of the Chargemaster. Virtually all insurance carriers negotiate the prices they pay hospitals and other providers. Since health plan contractual arrangements are confidential, these pricing structures are not publicly released. While many hospitals will provide an estimated out-of-pocket cost to patients upon request, for the most accurate estimate, insured patients must contact their health plan directly.

As noted above, where pricing information is made available, it must be presented in a clear and accessible format, and must be comparable across providers to allow a consumer to use it for

decision-making. The current Chargemaster reporting requirements do not meet this criteria, because Chargemasters are lists of thousands of individual charges with no relationship to specific procedures or diagnoses, and with no uniformity of format, description or categorization between hospitals.

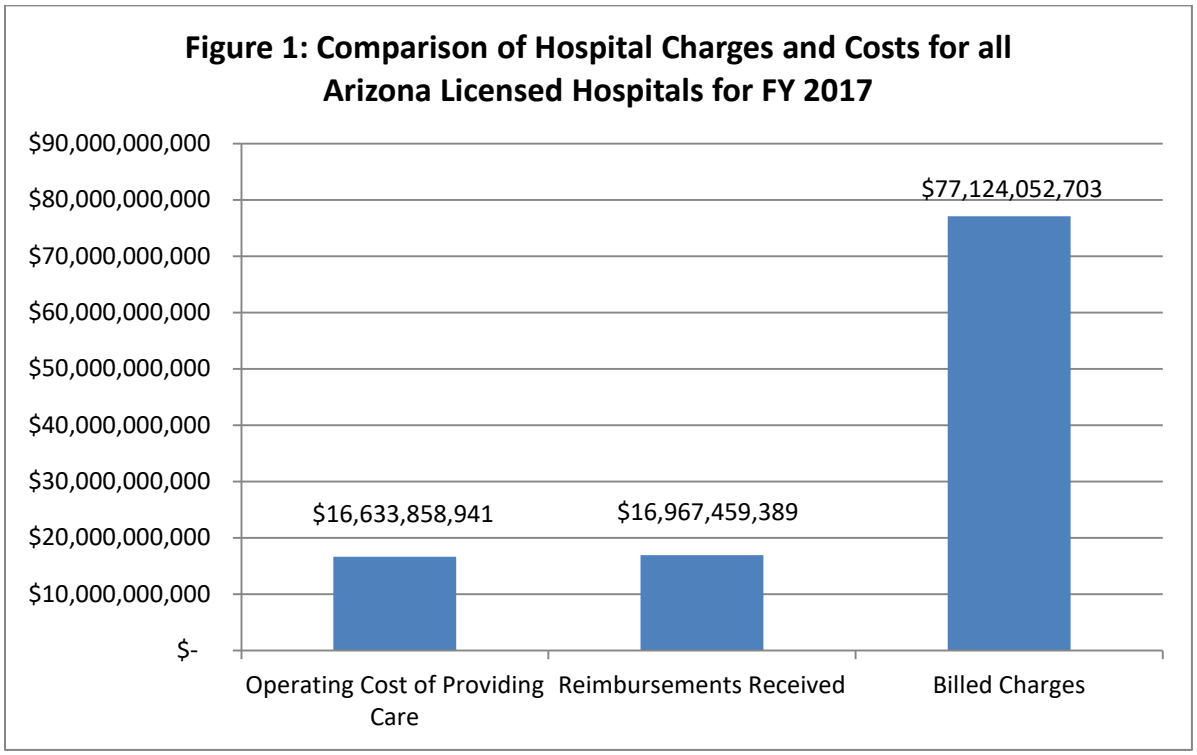
The current Chargemaster reporting requirements were implemented decades ago. The significant changes in health care reimbursement that have occurred over the ensuing years have rendered the current Chargemaster reporting obsolete and of minimal value to health care consumers.

ADHS does not use the collected Chargemasters for any purpose. Neither AHCCCS nor ADHS are aware of any state or other government agency that uses the Chargemasters data for any purpose.

Other Hospital Reporting

Pursuant to A.R.S. §36-125.04, hospitals also report certain financial information to ADHS, including Audited Financial Statements and the state Uniform Accounting Report (UAR). AHCCCS uses the UAR data, as well as other publicly available information to provide a report to the Legislature and Governor's office pursuant A.R.S. §36-125.04. While these reports do not provide pricing information to consumers, they do shed light on the financial status of hospitals for policymakers and provide information used to calculate certain AHCCCS payments to providers.

Figure 1, compares the billed charges, reimbursements, and operating costs for fiscal year 2017 for all ADHS licensed hospitals to illustrate the differences in charges, operating costs, and reimbursements based on the aggregate information from data submitted by hospitals on the UAR. This chart shows that, in aggregate, hospital costs are approximately 22% of billed charges, reflecting the large disparity between charges originally billed for services and the amount ultimately received in payment for those services.



OTHER STATES' REPORTING OF HOSPITAL CHARGES AND PRICES

As outlined in detail in the 2014 report, states have undertaken a variety of initiatives, including making charges and payments available on public websites and establishing all-payer claims databases. In addition, Medicare has moved to release data on hospital charges and payments and, in 2014, expanded this to include physician charges and payments; both of these have generated public interest and significant analysis on the wide variation on charges and payments across the nation.

Recently more states are emphasizing quality transparency in addition to price transparency. Besides providing a more robust means to evaluate value, this addresses a general misconception that higher health care prices indicate better quality. States that provide robust price transparency do not necessarily provide robust quality information, and vice versa.

For example, Minnesota and California received an "A" for quality on the most recent "Price Transparency & Physician Quality Report Card 2017" issued by Altarum and Catalyst for Payment Reform and an "F" on price transparency. New Hampshire received an "A" on price and an "F" on quality.

A summary of enacted state legislation on healthcare cost transparency can be found at http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx.

CONCLUDING OBSERVATIONS AND RECOMMENDATIONS

AHCCCS and ADHS Actions
AHCCCS and ADHS will employ the following strategies to continue a focus on increasing price and quality transparency:

1) As the single largest payer in the State of Arizona, AHCCCS will continue to be transparent in sharing information on hospital billed charges and the payment amounts made by AHCCCS.
2) AHCCCS will obtain comparable quality data and consider leveraging the APR-DRG hospital payment system to adjust future reimbursement based on outcomes.
3) AHCCCS, with the support of ADHS, will continue to make publicly available financial information on hospital and other provider types more accessible through the AHCCCS website.
4) Through AHCCCS payment modernization initiatives, AHCCCS will continue to drive improved quality with a goal to decrease costs (e.g., through reduced readmissions, emergency department visits, etc.).
5) ADHS will continue to annually update and post hospital quality information via *AZ Care Check*, a searchable database containing information about deficiencies found against facilities/providers by the Arizona Department of Health Services. The link to that site: http://www.azdhs.gov/licensing/index.php#azcarecheck .
6) AHCCCS and ADHS will continue to review their various transparency initiatives to consolidate or aggregate current reported data and streamline its display to avoid consumer confusion over multiple sets of similar data.

ADHS

AHCCCS Arizona Health Care Cost Containment System

Appendix A

Example of a Hospital Chargemaster Submission Page

DEPT	Proc Number	Charge Description	Current Price
004	13144	R+B INTERMEDIATE ICU	2,280.00
004	33142	R+B INTENSIVE CARE	3,768.00
004	93146	R+B MEDICAL SURGICAL	1,272.00
004	7133903	EXTENDED RECOVERY INTRM PER HR	95.00
004	7621352	DIRECT REFER HOSP OBSERV	119.00
004	8011249	CRRT/SLED	1,500.00
005	3111	R+B OBSTETRICS	1,272.00
005	3129	R+B OBSTETRICS	1,272.00
005	13110	R+B INTERMEDIATE ICU	2,280.00
005	13128	R+B INTERMEDIATE ICU	2,280.00
005	13151	R+B INTERMEDIATE ICU	2,280.00
005	13169	R+B INTERMEDIATE ICU	2,280.00
005	13185	R+B INTERMEDIATE ICU	2,280.00
005	33118	R+B INTENSIVE CARE	3,768.00
005	33126	R+B INTENSIVE CARE	3,768.00
005	33159	R+B INTENSIVE CARE	3,768.00
005	33167	R+B INTENSIVE CARE	3,768.00
005	33183	R+B INTENSIVE CARE	3,768.00
005	93112	R+B MEDICAL SURGICAL	1,272.00
005	93120	R+B MEDICAL SURGICAL	1,272.00
005	93153	R+B MEDICAL SURGICAL	1,272.00
005	93161	R+B MEDICAL SURGICAL	1,272.00
005	93187	R+B MEDICAL SURGICAL	1,272.00
005	7104466	EXTENDED RECOVERY PER HR	53.00
005	7621816	OBSERV/HR MED/SURG	53.00
005	7621824	OBSERV/HR MED/SURG	53.00
005	7621832	OBSERV/HR MED/SURG	53.00
005	7621840	OBSERV/HR MED/SURG	53.00
005	7621857	OBSERV/HR MED/SURG	53.00
005	7622061	DIRECT REFER HOSP OBSERV	119.00
005	8011546	CRRT/SLED	1,500.00
021	11015	R+B INTERMEDIATE ICU	2,280.00
021	91017	R+B MEDICAL SURGICAL	1,272.00
021	7104441	EXTENDED RECOVERY PER HR	53.00
021	7104508	EXTENDED RECOVERY INTRM PER HR	95.00
021	7104524	EXTENDED RECOVERY INTRM PER HR	95.00
021	7620537	OBSERV/HR MED/SURG	53.00
021	7621360	DIRECT REFER HOSP OBSERV	119.00

ADHS

AHCCCS
Arizona Health Care Cost Containment System

Appendix B

Chargemaster Overview Form

Date Submitted to ADHS	
Facility License Number	
Facility Name	
Facility Street Address	
City	
Zip	
County	
Type of Control (Drop Down Box)	
Hospital Classification (Drop Down Box)	
Licensed Capacity	
Implementation Date of Rates and Charges	
Percent Increase	
Gross Patient Revenue - Existing:	
Gross Patient Revenue - Proposed:	
Previous Increase Date	
Previous Increase Percent	
Prepared By	
Phone Number	
E-mail Address	

	Hospital Charge Code	Proposed Rate	Existing Rate	Increase Amount	Percent Increased	Comments
Daily Charge for:						
Private Room				$ -	#DIV/0!	
Semi-Private Room				$ -	#DIV/0!	
Pediatric Bed				$ -	#DIV/0!	
Nursery Bed				$ -	#DIV/0!	
Pediatric Intensive Care Bed				$ -	#DIV/0!	
Neonatal Intensive Care Bed				$ -	#DIV/0!	
Cardiovascular Intensive Care Bed				$ -	#DIV/0!	
Swing Bed				$ -	#DIV/0!	
Rehabilitation Bed				$ -	#DIV/0!	
Skilled Nursing Bed				$ -	#DIV/0!	
Minimum Charge for:						
Labor and Delivery				$ -	#DIV/0!	
Trauma Team Activaton				$ -	#DIV/0!	
EEG				$ -	#DIV/0!	
EKG				$ -	#DIV/0!	
Complete Blood County with Differential				$ -	#DIV/0!	
Blood Bank Crossmatch				$ -	#DIV/0!	
Lithotripsy				$ -	#DIV/0!	
X-ray				$ -	#DIV/0!	
IVP				$ -	#DIV/0!	
Respiratory Therapy session with a Small Volume Nebulizer				$ -	#DIV/0!	
CT scan of a head without contrast medium				$ -	#DIV/0!	
CT scan of an abdomen with contrast medium				$ -	#DIV/0!	
Abdomen Ultrasound				$ -	#DIV/0!	
Brain MRI without contrast medium				$ -	#DIV/0!	
15 minutes of Physical Therapy				$ -	#DIV/0!	
Daily rate for Behavioral Health Serivces for:						
Adult Patient				$ -	#DIV/0!	
Adolescent Patient				$ -	#DIV/0!	
Pediatric Patient				$ -	#DIV/0!	

Appendix C
Definitions

- ***Charge Description Master (CDM):*** The 'charge master', 'hospital chargemaster', or the 'charge description master' (CDM) is primarily a list of services/procedures, room accommodations, supplies, drugs/biologics, and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim.
- ***Charge-to-cost ratios***: According to Anderson, "the ratio of charges to costs measures the relationship between actual hospital charges for services (what self-pay patients are generally asked to pay) and Medicare-allowable costs (what the CMS has determined to be the costs associated with care for all patients, not just Medicare patients)."[4]
- ***Diagnoses Related Groups (DRG)***: Codes assigned to hospital inpatient claims for reimbursement purposes. Although created and required by CMS for Medicare billing, most other payers also utilize DRG for determining reimbursement on inpatient hospital claims. The current MS-DRG ("medical severity") code sets are severity adjusted, so claims for care of patients with complications or comorbidities receive a higher level of reimbursement. A special software called a "grouper" program uses ICD diagnosis and procedures codes, sex, discharge status, and the presence of complications or comorbidities to group clinically similar patients expected to use the same amount of hospital resources, and assigns an appropriate DRG code to the claims. The DRG code determines the amount of reimbursement the hospital will receive for that patient stay. MS-DRG is currently the national standard for Medicare hospital inpatient billing. AHCCCS utilizes the APR-DRG version.
- ***All Patient Refined Diagnostic Related Groups (APR-DRG)***: is a classification system that classifies patients according to their reason of admission, severity of illness and risk of mortality. It is the inpatient rate methodology utilized by AHCCCS. The APR-DRGs expand the basic DRG structure by adding four subclasses to each DRG. The addition of the four subclasses addresses patient differences relating to severity of illness and risk of mortality. The four severity of illness subclasses and the four risk of mortality subclasses are numbered sequentially from 1 to 4 indicating respectively, minor, moderate, major, or extreme severity of illness or risk of mortality.
- ***Hospital Charges***: The amount the hospital billed for the entire hospital stay; not the charges for any specific procedure or condition. Total charges do not reflect the actual cost of providing care nor the payment received by the hospital for services provided.

[4] Anderson GF. From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing. *Health Aff.* May-June, 2007; 26(3):780-789.