ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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KATIE HOBBS
GOVERNOR

VIRGINIA ROUNTREE
DIRECTOR

January 2, 2026

The Honorable Katie Hobbs
Office of Governor
1700 West Washington
Phoenix, Arizona 85007

The Honorable Warren Petersen
Arizona State Senate
1700 W. Washington
Phoenix, AZ 85007

The Honorable Steve Montenegro
Arizona House of Representatives
1700 W. Washington
Phoenix, AZ 85007

Dear Governor Hobbs, President Petersen, and Speaker Montenegro:

In accordance with A.R.S. § 36-2903.12, please find the enclosed report on hospital chargemaster transparency. Please contact Virginia Rountree, Director, at (602) 417-4000 or Virginia.Rountree@azahcccs.gov if you have any questions or would like additional information.

Sincerely,

Virginia Rountree

Virginia Rountree
AHCCCS Director

cc: The Honorable Adrian Fontes, Arizona Secretary of State
Meaghan Kramer, Health Policy Advisor, Office of the Governor

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Hospital Chargemaster Transparency Report to the Governor, President of the Senate, and Speaker of the House of Representatives

January 2026

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, billed hospital charges in comparison to hospital costs, the processes for reporting hospital prices in other states, recent progress, 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 health care of which hospital charges and/or price is a critical element.

Arizona law requires hospitals to publish their Chargemasters, but the information in the Arizona Chargemaster may not be meaningful to persons covered by an insurance plan, paying through private payment or paying through a mechanism such as a Health Savings Account (HSA). Virtually all insurance carriers negotiate the prices they pay hospitals and other providers. Because many Chargemaster prices are not directly related 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.

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.

AHCCCS and ADHS Chargemaster/Transparency Report

A. R. S. § 36-2903.12 requires AHCCCS and the ADHS to report on hospital Chargemaster transparency. Specifically:

On or before January 2, 2020, and each year thereafter, 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 do all of the following:

1) *Summarize the current charge master reporting process and hospital billed charges compared to costs,*

2) *Provide examples of how charge masters or hospital prices are reported and used in other states, and*

3) *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 health care 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 directly for their care through mechanisms such as HSA.

Our prior reports 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.
- Because of significant changes in the health care market, the current Arizona Chargemaster reporting requirements provide little public service and do not deliver accurate pricing comparison and transparency as originally intended.
- All Payer Claims Databases (APCD) can provide a mechanism for significant price transparency by providing credible cost and quality information for most payers, as seen in Washington, Colorado, and other states that have already implemented APCDs with consumer-friendly front-end websites. In order to ensure the uniformity, consistency, and transparency of reported data in an APCD, state agencies would have to serve an important clearinghouse role. However, establishing an APCD for Arizona would require legislative action and significant financial support for the additional agency administrative burden.
- 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.

Federal Requirements

When considering Arizona's Chargemaster reporting requirement it may be informative to consider the recent hospital price transparency actions of the federal government. In 2019, the Centers for Medicare and Medicaid Service (CMS) finalized the Hospital Outpatient Prospective Payment System (OPPS) final rule (CMS-1717-F2). This rule requires each hospital operating within the United States to establish and make public a yearly list of the hospital's standard charges for items and services they provided, starting January 1, 2021. It also requires making public discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 'shoppable' services that are packaged in a consumer-friendly manner[1].

In addition, the 2020 Transparency in Coverage final rule focused on price transparency at the health plan and health insurance issuers level for participants, beneficiaries and enrollees. As part of this rule, certain

[1] https://www.cms.gov/hospital-price-transparency/hospitals

health plans and insurance issuers will be required to make available personalized out-of-pocket cost information and the underlying negotiated rates for all covered health care items and services through an internet-based self-service tool. This information is required to be available by January 1, 2023, for an initial set of 500 services, including items such as major vaccinations and outpatient visits, and January 1, 2024 for the remaining services. In addition, health plans and health insurance issuers will need to produce files with detailed pricing information such as negotiated rates for all covered items and services between the plan or issuer and in-network providers.[2]

The Calendar Year (CY) 2022 OPPS and ASC Payment System Final Rule, published in November 2021, gives further guidance on file availability, requiring that a machine-readable file posted on a hospital website for public consumption be accessible to both automated searches and direct downloads starting January 1, 2022. It also implements an increase in monetary penalties for hospitals in noncompliance with the Hospital Price Transparency Final Rule. Prior to this rule, the monetary penalties consisted of a maximum $300 daily fine, regardless of hospital size. The CY 2022 Final Rule amends the fines to a maximum of $300 per day for hospitals with 30 or fewer beds, with an additional penalty of $10 per bed per day for hospitals with a bed count greater than 30, for a maximum daily fine of $5,500. This increases the maximum yearly fine to $2,007,500, a sharp increase from the original $109,500 yearly maximum.[3] This rule went into effect January 1, 2022.

On November 2, 2023, changes to hospital price transparency requirements were established in the 2024 Hospital Outpatient Prospective Payment System and ASC rule.[4] Beginning July 1, 2024, CMS requires hospitals to report pricing information in a standard machine-readable format (MRF) and conform to CMS template layout and data specifications. Beginning January 1, 2025, CMS requires additional data elements to be reported, including: “Estimated Allowed Amount”, “Drug Unit of Measurement”, “Drug Type of Measurement”, and “Modifiers”. [5]

On May 22, 2025, CMS published the “Updated Hospital Price Transparency Guidance Implementing the President’s Executive Order *Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information*”, adding clarifications to Executive Order 14221, issued February 25, 2025.[6] The Executive Order states that the Departments of the Treasury, Labor, and Health and Human Services (HHS) shall take action to:

1. Require the disclosure of the actual prices of items and services, not estimates;
2. Issue updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans; and
3. Issue guidance or proposed regulatory action updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data.[7]

[2] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf
[3] https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0
[4] https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0
[5] https://www.cms.gov/files/document/cms-hpt-webinar-10-21-2024.pdf
[6] https://www.cms.gov/files/document/updated-hpt-guidance-encoding-allowed-amounts.pdf
[7] https://www.whitehouse.gov/presidential-actions/2025/02/making-america-healthy-again-by-empowering-patients-with-clear-accurate-and-actionable-healthcare-pricing-information/

The report provides updated guidance that hospitals must encode a standard charge amount in the machine-readable file, including the amount negotiated for the item or service, the base rate negotiated for a service package, and a dollar amount if the standard charge is based on a percentage of a known fee schedule. Hospitals should also discontinue using "999999999" in the estimated dollar amounts and should instead use an average dollar amount that the hospital has received for the item or service.

To meet requirements of Executive Order 14221, CMS published a Hospital Price Transparency Accuracy and Completeness Request for Information, seeking public comment to improve compliance and identify challenges related to the hospital transparency reporting by July 21, 2025.[8] CMS offers a resources page to support hospitals in meeting the Hospital Price Transparency MRF requirements, including FAQs, guides, and links to GitHub-based tools and templates.[9]

A Semi-Annual Hospital Price Transparency report published by Patient Rights Advocate in November 2024 found only 21.1% of 2,000 sampled hospitals met the full price transparency requirements, a significant decrease from 34.5% in February 2024.[10] The study reviewed over 2,000 provider websites across all 50 states and deemed hospitals non-compliant if they had not published five standard charges, negotiated rates, and a display of shoppable services, all in both a machine-readable file and consumer friendly file.

In a 2024 report from the Government Accountability Office (GAO), they suggest that CMS should assess whether hospitals' pricing data are sufficiently complete and accurate. GAO recommends additional enforcement activities of the HPT requirements.[11]

As of April 2023, CMS issued over 730 warning notices and 269 Corrective Action Plan (CAP) requests.[12] As of 2025, 27 hospitals have faced Civil Monetary Penalties (CMPs) for noncompliance, with these penalties publicly accessible on the CMS website.[13] Other hospitals subject to comprehensive compliance reviews have either resolved their deficiencies or are actively working towards compliance, receiving technical assistance from CMS throughout the process.

[8] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/accuracy-and-completeness-rfi
[9] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/resources
[10] https://www.patientrightsadvocate.org/seventh-semi-annual-hospital-price-transparency-report-november-2024
[11] https://www.gao.gov/products/gao-25-106995
[12] https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparency-enforcement-updates#_ftnref1
[13] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions

Current Chargemaster Reporting Process and Hospital Charges Compared to Cost

Chargemaster Reporting

Pursuant to A.R.S. §36-436 and A.A.C. R9-11-302, Arizona 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 these 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 Chargemaster data for any purpose.

See the appendices for more Chargemaster information.

Other Hospital Reporting

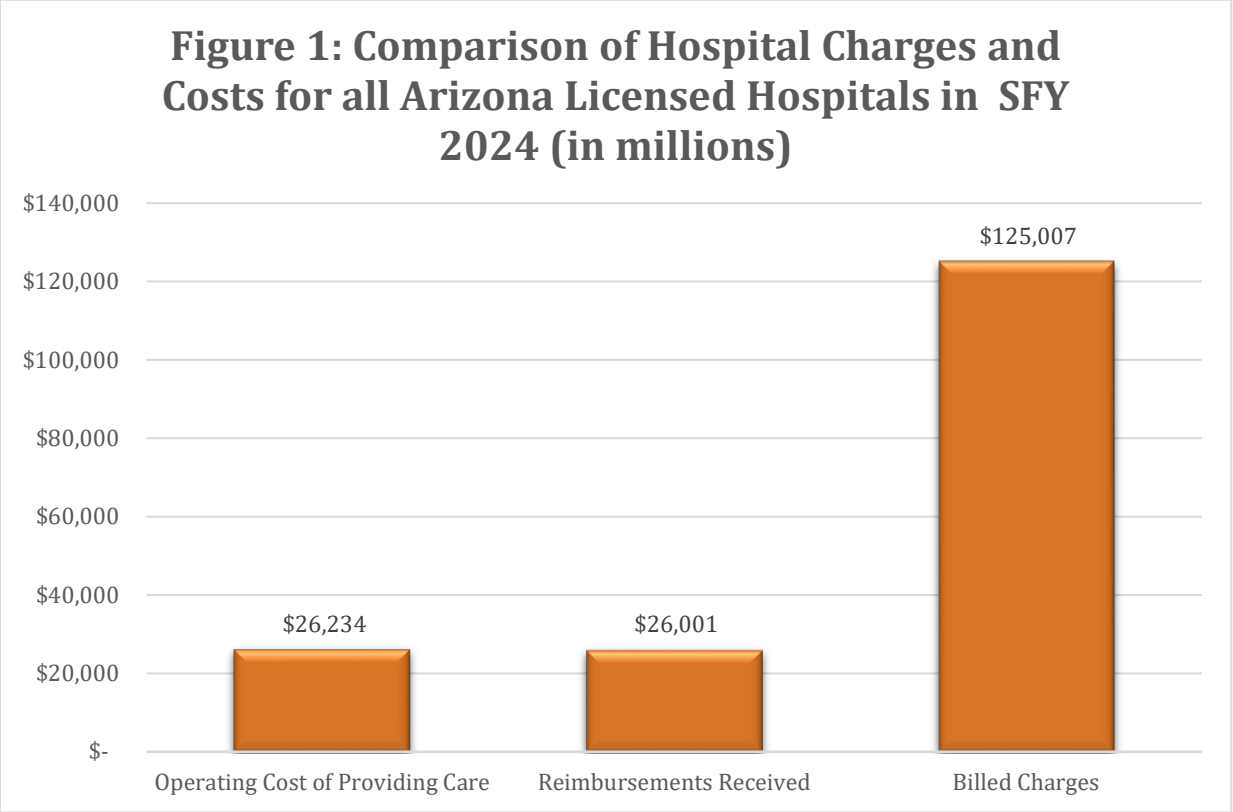
Pursuant to A.R.S. §36-125.04, hospitals also report certain financial information to ADHS, including Audited Financial Statements and the state Uniform Accounting Report (UAR). AHCCCS uses the UAR data, as well as other publicly available information, to provide a report to the Legislature and Governor's office pursuant A.R.S. §36-2903.08.

Laws 2013, Chapter 202 established additional price reporting requirements for Arizona health care providers[14]. Chapter 202 requires providers to make available (online or by request) the direct pay prices for at least the 25 most commonly provided services. Heath care facilities with more than 50 inpatient beds must make available (online or by request) the 50 most used DRG codes and 50 most used outpatient codes, and facilities with 50 or fewer beds must make available the top 35 most used DRG

[14] https://azmemory.azlibrary.gov/nodes/view/21020

codes and 35 most used outpatient codes. This information is reported independently by each hospital and is not centrally reported or aggregated, so opportunities to compare prices are limited as the most common procedures can vary significantly between hospitals.

Figure 1 compares the billed charges, reimbursements received, and operating costs for fiscal year 2024 for all ADHS licensed hospitals based on the aggregate information from data submitted by hospitals on their 2024 Unified Accounting Reports (UARs). This chart shows that in aggregate, hospital reimbursements are approximately 20.8% of billed charges, reflecting the large disparity between billed services and the amount ultimately received in payment for those services. The reimbursements received cover 99.1% of the operating costs.



Hospital Reporting in Comparative States

Across the country, progress in Hospital Price Transparency reporting has also varied. In the most recent Semi-Annual Hospital Price Transparency Report from Patient Rights Advocate, issued in November 2024, 20% of hospitals in Arizona were compliant with the federal price transparency law.

All Payer Claims Databases can provide a mechanism for significant price transparency for consumers by providing credible cost and quality information for most payers. Washington[15], Colorado[16], and several other states have already implemented robust consumer-facing websites that allow consumers to compare shoppable services using data from their APCDs, according to the National Conference of State Legislatures (NCSL).[17] They note that implementing and maintaining an APCD involves cooperation among many stakeholders, including payers, providers and consumers of health care. To ensure the uniformity, consistency, and transparency of reported data in an APCD, state agencies would also likely have to serve an important clearinghouse role. Along with Arizona, Indiana and Virginia have also codified federal price transparency rules into their state statute.

Recommendations to Improve the State's Use of Hospital Chargemaster Information

AHCCCS and ADHS Observations
AHCCCS and ADHS will employ the following strategies to continue focusing on changes in 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, 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.
3) Through AHCCCS payment modernization initiatives, AHCCCS will continue to drive improved quality with a goal of decreasing costs (e.g., through reduced readmissions, emergency department visits, etc.).
4) 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 database can be found at this link: www.azdhs.gov/licensing/index.php#azcarecheck.
5) 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.

[15] https://www.wahealthcarecompare.com/
[16] https://www.civhc.org/shop-for-care/
[17] https://www.ncsl.org/health/state-actions-to-control-commercial-health-care-costs

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

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!	
Mimimum 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 'chargemaster', '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.
- ***Cost to Charge Ratio (CCR):*** The Cost to Charge Ratio is used to estimate the actual cost of providing services based on the charges billed. It is the ratio of a hospital's total costs to its total charges received from patients.
- ***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. 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)***: 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.