# HOUSE OF REPRESENTATIVES

## HB 2045

**AHCCCS; hospital reimbursement methodology**
**Sponsor: Representative Carter**

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**DP** Committee on Health

**DP** Caucus and COW

**X** As Transmitted to the Governor

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**OVERVIEW**

HB 2045 outlines provisions related to direct pay prices for health care providers and facilities and requires the Arizona Health Care Cost Containment System (AHCCCS) to adopt a hospital reimbursement methodology consistent with Title XIX of the Social Security Act (SSA) effective October 1, 2014.

**HISTORY**

Laws 1981, Chapter 1, established AHCCCS, the Arizona Medicaid program that oversees contracted health plans for the delivery of health care for certain low-income individuals and families in Arizona. Medicaid is a federal healthcare program jointly funded by the federal and state governments. AHCCCS operates under a managed care system, contracting with health plans that coordinate and pay for medical services from health care providers. As of January 1, 2013 there were approximately 1.27 million individuals enrolled in the AHCCCS program.

Laws 2012, Chapter 122, allowed AHCCCS to adopt a hospital reimbursement methodology consistent with Title XIX of the SSA, with legislative approval. Additionally, AHCCCS was required to establish workgroups and provide for public meetings before implementing a new or amended rule on a new hospital reimbursement methodology.

**PROVISIONS**

***Health Care Provider***

- Requires, if applicable, a health care provider to provide upon request or online the direct pay price for at least 25 of the most common services updated at least annually and based on the services from a 12 month period that occurred within the 18 month period preceding the annual update.
- Exempts a health care provider who is an owner or an employee of a legal entity with fewer than three licensed health care providers from the requirement to provide direct pay prices.
- Exempts a health care provider from making the direct pay prices available for emergency services.
- States that health care services provided by health care providers in Veteran Administration facilities, health facilities on military bases, Indian health services hospitals and other Indian health service facilities, tribal owned clinics, the Arizona State Hospital and any health care facility that does not serve the general public is exempt from providing direct pay prices.
- Provides that a health care provider who does not comply with the requirements of this section commits unprofessional conduct. Any disciplinary action taken by the health

professional's licensing board may not include revocation of the health care provider's license.

***Health Care Facilities***

- Requires, if applicable, a health care facility with more than 50 inpatient beds to make available on request or online the direct pay price for at least 50 of the most used diagnosis-related group codes and the 50 most used outpatient service codes. The health care facility must update the direct pay prices at least annually based on the services from a 12 month period that occurred within the 18 month period preceding the annual update.
- Requires, if applicable, a health care facility with 50 or fewer inpatient beds to make available on request or online the direct pay price for at least 35 of the most used diagnosis-related group codes and the 35 most used outpatient service codes. The health care facility must update the direct pay prices at least annually based on the services from a 12 month period that occurred within the 18 month period preceding the annual update.
- The two provisions noted above do not apply if a discussion of the direct pay price would be a violation of the federal Emergency Medical Treatment and Labor Act.
- States that Veteran Administration facilities, health facilities on military bases, Indian health services hospitals and other Indian health service facilities, tribal owned clinics and the Arizona State Hospital are exempt from providing direct pay prices. If the director of the ADHS determines that a health care facility does not serve the general public then the facility is exempt.
- Allows the ADHS to perform an investigation of a health care facility under the department's powers and duties. If a health care facility fails to comply the penalty must not include the revocation of the license to deliver health care services.

***Health Care Provider/Facilities***

- Outlines that the direct pay services may be identified by a common procedural terminology code or by a plain English description.
- States that direct pay requirements do not prevent a health care provider/facility from offering additional discounts or additional lawful health care services for an additional cost to a person or an employer paying directly.
- Stipulates that the direct pay price must be for the standard diagnosis for service and may include any complications or exceptional treatment.
- States that a health care provider/facility is not required to report the direct pay price to any government or government authorized entity for review or filing.
- Restricts a government, government authorized or government created entity from approving, disapproving or limiting a health care provider's/facilities' direct pay price for services or adjustment of prices.
- States that a health care system may not punish a person or employer for paying directly for lawful health care services or a healthcare provider/facility for accepting direct payment from a person or employer for lawful health care services.
- Outlines that a health care provider/facility that accepts direct payments from a person or employer for a lawful health care service is deemed paid in full if the entire fee for the

service is paid and must not submit a claim for payment or reimbursement for the service to any health care system. This subsection does not:
  - Prevent a health care provider from pursuing a health care lien.
  - Affect the ability of a health care provider to submit claims for the same service provided on other occasions to the same or a different person if no direct payment occurs.
  - Require a health care provider/facility to refund or adjust any capitated payment, bundled payment or other form of prepayment or global payment made by a health care system to a health care provider/facility.

- Stipulates that before a health care provider/facility contracted as a network provider for a health care system accepts direct payment from a person or employer, the health care provider/facility must obtain the person's or employee's signature on a notice that includes language similar to the following:
  - The Arizona Constitution permits you to pay a health care provider/facility directly for health care services.
  - If you are a member of a health care system and your health care provider/facility is contracted with the health insurance plan, the following apply:
    - You may not be required to pay the health care provider/facility directly for the services covered by your plan, except for cost share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductable amounts.
    - Your provider's agreement with the health insurance plan may prevent the health care provider/facility from billing you for the difference between the provider's billed charges and the amount allowed by your health insurance plan for covered services.
    - If you pay directly for a health care service, your health care provider/facility will not be responsible for submitting claim documentation to your health insurance plan for that claim. Before paying your claim, your health insurance plan may require information and the submission of documentation to determine if services are covered.
    - If you do not pay directly for a health care service, your health care provider/facility may be responsible for submitting claim documentation to your health insurance plan for the health care service.

- States that a heath care provider/facility who receives direct payment for a lawful health care service is not responsible for submitting any documentation for reimbursement to any health care system for that claim. If the failure to submit documentation does not conflict with the terms of any federal or state contracts that a health care system is a party and the health care provider has agreed to serve patients under or with applicable state or federal programs in which a health care provider/facility and health care system participate.

- Outlines that direct pay regulations do not impair the provisions of a heath care system's private health care network provider/facility contract, except:
  - That a health care provider may decline to bill the heath care system directly for services paid directly by a person or employer if the health care provider/facility has obtained the signed notice, the health care provider's receipt of direct payment and if the declination to bill the health care system does not conflict with the terms of any federal or state contract to which the health care system is a party and the heath care provider/facility has agreed to serve patients under or with applicable state or federal programs in which a health care provider/facility and health care system participate.

- Exempts the revocation of a license to deliver lawful health care services as a penalty for health care providers/facilities that fail to comply with direct pay regulations.
- Defines for both providers/facilities: *direct pay price, enrollee, health care plan, health care provider, health care system, health insurer, lawful health care services* and *punish,* for the provider section *emergency services.* for the facility section *health care facility.*
- Contains a repeal date from and after December 31, 2021.
- Contains an effective date from and after December 31, 2013.
- Contains a severability clause.

***AHCCCS Hospital Reimbursement Methodology***

- Allows AHCCCS to establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by AHCCCS.
- States that for inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amount payable for those services as of October 1, 2011.
- Requires AHCCCS to adopt a hospital reimbursement methodology consistent with Title XIX of the SSA, effective October 1, 2014.
- Allows AHCCCS to make additional adjustments to the rates established for hospitals that are publicly operated or based on other factors, such as the number of beds in the hospital, the specialty services available, the geographic location of the hospital and the diagnosis-related group codes that are made publicly available.
- Permits AHCCCS to provide additional reimbursement for extraordinarily high cost cases.
- Permits AHCCCS to establish a separate payment methodology for specific services or hospitals serving unique populations.
- Contains an intent clause that specifies the payment methodology be budget neutral in the aggregate.
- Requires AHCCCS, for contract years 2015 through 2019, to report on the implementation of the new payment methodology including any concerns raised by hospitals and any realized cost savings.
- Mandates that AHCCCS, prior to changing the type of payment methodology utilized to reimburse hospitals for inpatient services beyond those authorized by this act, receive legislative authorization.