ARIZONA STATE SENATE

Fifty-First Legislature, First Regular Session

FINAL AMENDED

FACT SHEET FOR H.B. 2045

AHCCCS; hospital reimbursement methodology

Purpose

Requires the Arizona Health Care Cost Containment System Administration (AHCCCS) to adopt a diagnosis-related group (DRG) based hospital reimbursement methodology for inpatient services beginning October 1, 2014. Requires outlined health care providers and facilities to make the direct pay prices available for the most used services or codes.

Background

Current law requires AHCCCS to reimburse hospitals for inpatient services using a prospective tiered per diem methodology. In using this methodology, AHCCCS reimburses hospitals based on the number of days a patient is in the hospital, taking into account other prescribed factors.

Laws 2012, Chapter 122 required AHCCCS to obtain legislative approval before adopting a new hospital reimbursement methodology for inpatient services and required AHCCCS to establish workgroups to provide input on a new methodology. The workgroups were to consist at least of representatives from the urban, rural and critical access hospital communities, the health plan industry and consumer advocacy groups. The law also required AHCCCS to provide for public hearings before the effective date of any new or amended rules.

Current procedural terminology codes were developed by the American Medical Association to standardize the terminology used when describing medical services and procedures. These codes provide a uniform language, which can be used for communication between providers, patients and third parties, such as insurers to determine the amount of reimbursements (www.ama-assn.org/).

DRG codes *classify hospital patients on the basis of diagnosis consisting of distinct groupings. A DRG assignment to a case is based on a patient's principal diagnosis, treatment procedures performed, age, gender and discharge status* (medical-dictionary.thefreedictionary.com). Outpatient service codes do the same, except with outpatients (Jones, LM, "Coding and Reimbursement for Hospital Outpatient Services," 2005).

In 2010, voters passed Proposition 106, which amends the Arizona Constitution by adding language related to health care services. The amendment stipulates that a person shall not be required to pay fines for paying directly or accepting payment for lawfully provided health care services (Arizona Constitution, Article XXVII, Section 2).

The fiscal impact to the state General Fund associated with this measure is undetermined.

Provisions

Inpatient Hospital Reimbursement Methodology

1. Extends the current AHCCCS methodology (prospective tiered per diem) used for reimbursing hospital inpatient services from September 30, 2013 to September 30, 2014, and allows AHCCCS to establish a separate reimbursement methodology for claims with extraordinarily high costs as outlined.

2. Requires AHCCCS to adopt a DRG based hospital reimbursement methodology for inpatient services beginning October 1, 2014 and removes the requirement for AHCCCS to seek legislative approval before adopting such methodology.

3. Allows AHCCCS to make additional adjustments to the inpatient rates for hospitals that are publicly operated or based on other factors, including the bed number, specialty services available, geographic location and DRG codes that are made publicly available.

4. Allows AHCCCS to:
   a) provide additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment; and
   b) establish a separate payment methodology for specific services or hospitals serving unique populations.

5. Sets the inpatient hospital prospective tiered per diem payment rates, to the rates effective on October 1, 2011, rather than September 30, 2011.

6. States it is the Legislature's intent that the reimbursement methodology developed by AHCCCS be budget neutral in the aggregate and that AHCCCS may consider the unique financial characteristics of particular hospitals, including low patient volume of rural hospitals, when developing the payment methodology.

7. Requires AHCCCS, for contract years 2015 through 2019, to report annually to the Governor and Legislature on the implementation of the new payment methodology, including concerns raised by hospitals and any realized costs savings.

8. Stipulates that prior to AHCCCS changing the type of payment methodology used to reimburse inpatient hospital services as established in this act, AHCCCS must obtain legislative authorization. This does not preclude AHCCCS from making necessary adjustments for the implementation and ongoing administration of the DRG based payment methodology.

Health Care Providers and Facilities ~ Direct Pay Price

~~9.~~ Requires, effective January 1, 2014, health care providers (provider to make available on request or online, the providers' direct pay price (price) for at least the 25 most commonly provided services.

10. Requires, effective January 1, 2014, a health care facility (facility) with more than 50 inpatient beds to make available on request or online, the facility's price for at least the 50 most used DRG codes and at least the 50 most used outpatient service codes; for a facility with 50 or fewer inpatient beds, the facility must make at least 35 of the outlined codes available.

11. Allows the services to be identified by a common procedural terminology code or by a plain-English description and stipulates the price shall be for the standard treatment provided for the service and may include any complications or exceptional treatment.

12. Requires the prices to be updated at least annually as outlined and states the requirement to make prices available does not prevent a provider or facility from offering either additional discounts or services at an additional cost.

13. Exempts certain facilities from the requirements of making prices available, including facilities that do not serve the general public, entities with fewer than three licensed providers and facilities where a discussion of the prices would be a violation of the Federal Emergency Medical Treatment and Labor Act (EMTALA).

14. Stipulates a facility or provider is not required to report the prices for review (or filing for a provider) to a government agency or department or to an entity authorized or created by the government, and prohibits such agency, department or entity from approving, disapproving or limiting a facility or provider's prices or ability to change the prices.

15. Prohibits a health insurer from punishing a person for paying directly or accepting payment for lawful services.

16. Deems a provider or facility that accepts direct payment as paid in full if the entire fee is paid, prohibits the provider or facility from submitting the claim to an insurer for payment, except as outlined and clarifies practices pertaining to health care liens and prepayments refunds.

17. Requires a provider or facility that is contracted as a network provider, before accepting direct payment from a person or employer, to obtain the person's (or employer's) signature on a prescribed notice (notice).

18. States a provider or facility that accepts direct payment is not responsible for submitting a claim for reimbursement, if not submitting such documentation does not conflict with contract terms or programs to which the provider or facility has agreed.

19. Stipulates this law does not impair an insurer's private network provider contracts, except that a provider or facility may accept direct payment or decline to bill an insurer for services directly paid for, if the provider or facility has complied with the requirements of the notice and if declining to bill does not conflict as outlined.

20. States a provider who does not comply with the price requirements commits unprofessional conduct and that any disciplinary action may not include license revocation.

21. States the Department of Health Services (DHS) is not prevented from investigating facilities under DHS's jurisdiction and stipulates that if a facility fails to comply with requirements of making prices available, the penalty shall not include license revocation.

Definitions

22. Defines *direct pay price* as the entire price that will be charged by a health care provider (or facility) for a lawful health care service, regardless of the health insurance status of the person, if the entire fee for the service is paid in full directly to a health care provider (or facility) by the person, including the person's health savings account, or by the person's employer and that does not prohibit a provider (or facility) from establishing a payment plan with the person.

23. Defines *health care facility* as a hospital, outpatient surgical center, health care laboratory, diagnostic imaging center or urgent care center.

24. Defines *health care provider* as a person licensed pursuant to statutes governing podiatry, chiropractic, medicine and surgery (MD), optometry, osteopathic physicians and surgeons (DO), physical therapy or occupational therapy.

25. Defines *emergency services, enrollee, health care plan, health care system, health insurer, lawful health care services* and *punish.*

Miscellaneous

26. Contains a severability clause related to the direct payment sections.

27. Repeals the sections related to direct payment on January 1, 2022.

28. Becomes effective on the general effective date, with delayed effective dates as noted.

<u>Amendments Adopted by the HHS Committee</u>

1. Specifies the type of methodology to be adopted for inpatient services.

2. Allows AHCCCS to establish a separate methodology for specific services or hospitals serving unique populations.

3. Requires AHCCCS to obtain legislative authorization prior to changing the type of methodology AHCCCS uses, if different than the methodologies allowed in this act.

4. Requires AHCCCS to annually report on the implementation of the new methodology, including hospitals' concerns and realized costs savings.

Amendments Adopted by Committee of the Whole

1. Requires health care providers (providers) and health care facilities (facilities) to make available the direct pay price (price) for their most common services or codes as outlined and delineates price details related to additional costs and complications.

2. Stipulates a facility or provider is not required to report the prices for review or filing to a government entity as outlined and prohibits such an entity from limiting a provider or facility's ability to change posted prices.

3. Outlines provider and facility responsibilities for when a person chooses to pay directly for services, including a prescribed notice that must be completed by the patient and stipulations related to insurance claims.

4. Clarifies this law does not prevent regulatory boards or DHS from performing investigations as outlined.

5. States a provider or facility may not have a license revoked for not making prices available and exempts certain health care entities from the requirement of making prices available.

6. Includes definitions, a severability clause and a delayed repeal date.

Amendments Adopted by Conference Committee

1. Exempts certain providers and facilities from the price requirements.

2. Clarifies practices related to refunding prepayments and for noncompliance.

3. Modifies price requirements based on facility size.

4. Adds a delayed effective date, extends the repeal date, modifies definitions and makes additional changes.

House Action				Senate Action			
Health	1/30/13	DP	8-0-0-0	HHS	3/20/13	DPA	5-2-0-0
3rd Read	2/21/13		43-15-2-0	3rd Read	4/15/13		19-10-1-0
Final Read	5/15/13		31-25-4-0	Final Read	5/16/13		25-5-0-0

Signed by the Governor 6/19/13
Chapter 202

Prepared by Senate Research
July 29, 2013
MY/tf