*Our first care is your health care*
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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

## Hospital Charge Master Transparency

January 2014

**AHCCCS and ADHS Charge Master/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) to the Governor, the President of the Senate and the Speaker of the House of Representatives. The report 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, and recommendations to improve 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.

## Background

Hospital price and quality information has gained increased attention recently, due in part to the trend toward patients' increased out of pocket exposure. Unlike other products and services, healthcare market price and quality is opaque to most purchasers of care. The Chargemasters submitted by Arizona hospitals, and the mandated reporting process for Chargemasters are consistent with this lack of transparency, which is also found in many other states.

## Chargemaster Process and Other State Required Reports

The Chargemaster is a price listing for every procedure, service, supply, drug, and room accommodation charged by a hospital. Since 1972, Arizona hospitals have been required to submit their Chargemaster to ADHS at least quarterly. The information is not available to the public except by special request. Hospitals also submit their Medicare Cost Report, Audited Financial Statements, and Uniform Accounting Reports to ADHS. ADHS publishes Arizona Hospital Compare on its website, which includes hospital quality information, health information by county, and hospital cost information. Chargemaster information has no relationship to financial information provided by Arizona Hospital Compare.

## Other States Reporting of Hospital Prices and Recommendations for Arizona

States vary widely on the degree of hospital price and quality information which is publicly available. Some states are similar to Arizona. Others provide publicly accessible procedure specific price and quality information, as well as the actual paid amounts, in contrast to Chargemaster prices. With this wide array of approaches, ADHS and AHCCCS recommend convening key stakeholders to examine options for improving public access to hospital data and to report findings to the Governor and the Legislature by January 1, 2015.

# AHCCCS andADHS
# Charge Master/Transparency Report

Laws 2013, First Special Session, Chapter 10, Section 37, requires the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Health Services (ADHS) to report on hospital charge master transparency. Specifically, Section 37 requires:

> On or before January 1, 2014, 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, 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. For example, before an auto mechanic begins repair work, a quote is provided to the customer. If the price seems too high, the consumer can compare with quotes from other shops. Health care purchasers in Arizona, especially individual patients, purchase services with little or no knowledge what they will pay for the service or related alternative services. In addition, in most cases, they have an extremely limited ability to compare healthcare providers based on quality measures. As stated by economist Uwe Reinhardt, "In a truly competitive market, both the prices and the inherent qualities of the goods or services being traded are known to all parties ahead of any trade. By contrast, in the American health care market, both the price and the quality of health care have been kept studiously hidden from patients."[1] Reinhardt goes on to assert that with the increased out of pocket exposure of employer or exchange based health plans, there is an increasing interest in greater transparency of healthcare prices and quality.[2]

This lack of price and quality transparency is an issue under discussion across the country. Referring to hospital Chargemasters, Steven Brill in his recent Time magazine article "Bitter Pill: Why Medical Bills Are Killing Us" states, "…there seems to be no process, or rationale, behind the core document that is the basis for hundreds of billions of dollars in health care bills."[3] Arizonans who are paying for care "out of pocket" such as those with a high deductible health plan, a Health Savings Account (HSA), and patients with no insurance coverage have little or no ability to meaningfully use information about the price they will be required to pay from the

[1] Reinhardt, Uwe. "Health Care Prices Move to Center Stage", The New York Times December 12, 2013
[2] Ibid.
[3] Brill, Steven. "Bitter Pill: Why Medical Bills Are Killing Us", Time February 22,2013

Chargemaster, or to compare what the price for the services will be at competing hospitals or other providers.

This is an increasingly significant issue. From 2006 to 2012, the percentage of those enrolled in high deductible ($1,000 or more) health plans has grown an average of 23% per year.[4] The Chargemaster is in fact the basis for the hospital bills received by patients without health insurance. Although most hospitals will negotiate discounts from the Chargemaster price if asked, many patients do not know this. According to Joseph Fifer, President and CEO of the *Healthcare Financial Management Association*, the professional association for healthcare organization financial management executives, "For price information to be meaningful to patients, it should focus on a patient's financial obligation-what that individual is expected to pay-and not merely charges."[5]

In order for price and quality information to provide the benefits of transparency, it must be presented in a clear and accessible format, but communicating this information effectively is very challenging.[6] Evidence from Tu and Lauer indicates that approximately one percent of those surveyed nation-wide used price information for 'procedure shopping' and the "sponsors of health care price and quality transparency initiatives often identify all consumers as their target audiences, but the true audiences for these programs are much more limited."[7]

## Arizona Chargemaster Process and Other Hospital Reporting

### *Arizona Chargemaster Overview*

The 'Chargemaster', 'hospital Chargemaster', or 'charge description master' (CDM) is a list of hospital 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.

The reporting of hospital Arizona Charge Description Master [CDM] information to ADHS dates to 1972. A.R.S. § 36-436 requires hospitals to file a schedule of rates, charges and related rules with the ADHS director. The Director is required to review the schedule within 60 days and publish information on gross charges. Hospitals report this information to ADHS at least quarterly.

The Chargemaster typically includes CDM numbers, charge amounts, revenue codes, department numbers, general ledger (GL) numbers -modifiers (hard coded), billing and/or charge descriptions. With the exception of a few hospitals, the AZCDM does not contain critical fields CPT (Current Procedural Terminology)/HCPCS (Healthcare Common Procedure Coding System) codes, and/or DRG (Diagnosis Related Group) codes, which are used to determine

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[4] Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2006-2012

[5] Healthcare Financial Management Association. "Developing a Path to Price Transparency. June 26, 2013

[6] Hibbard, JH. Et al. "An Experiment Shows that a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," Health Affairs 2012; 31(3): 560-568.

[7] Tu, HT, Lauer, JR. Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice. *Research Brief: Findings from HSC,* December 2008; 9:1-9.

procedure charges and inpatient hospitalization payments. An example of an Arizona Chargemaster is shown in Appendix A.

Most hospitals implement a major rate increase once a year. This process includes submission of a complete updated Chargemaster, and a completed Overview form (shown in Appendix B). Some hospitals cannot send a complete updated Chargemaster until the date of implementation, but the Overview form is still submitted prior to implementation of the rate increase.

The Chargemaster and Overview form must be reported to ADHS electronically. Chargemasters are not posted on the internet. However, the Overview forms are posted on the ADHS website, and these postings are updated as new Overview forms are received.

*Other Data Sources*

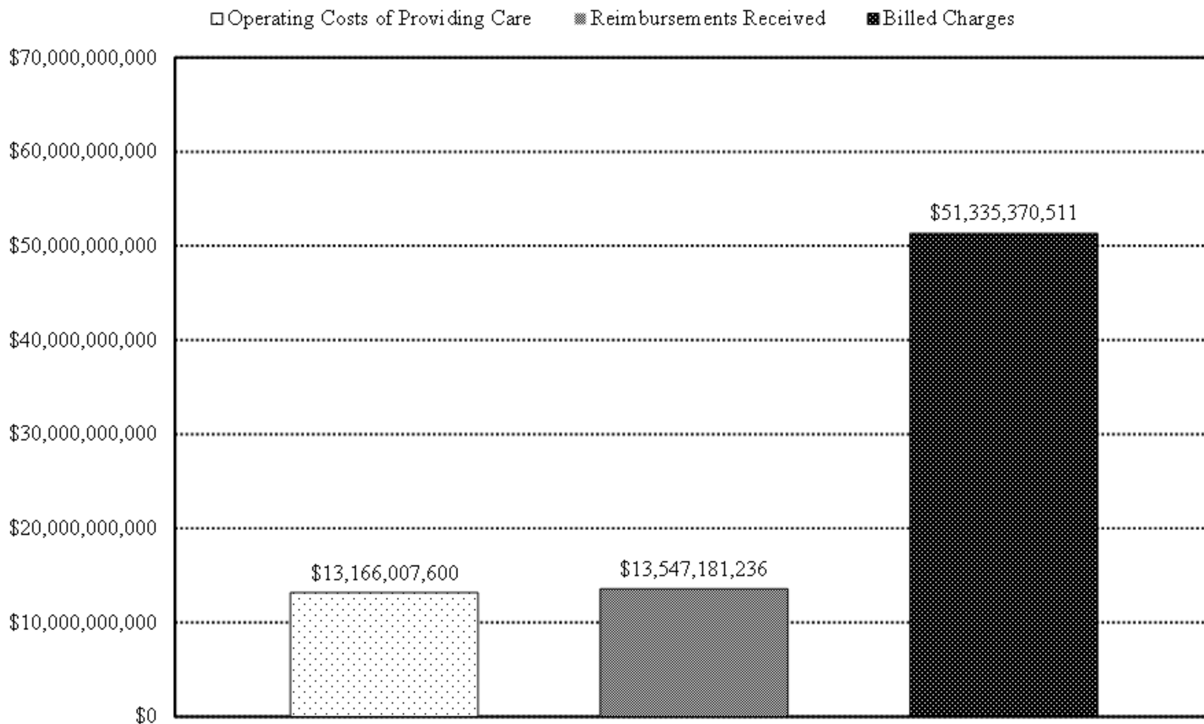
Hospitals also report financial and other information to the federal and state governments through the Medicare Cost Report (MCR), Audited Financial Statements (AFS) and the state Uniform Accounting Report (UAR). This information can be accessed at http://www.azdhs.gov/plan/crr/cr/hospitals.htm. There is no association between the service-level line item charges described in the Chargemaster and the financial information disclosed in the MCR, AFS and UAR. It is possible to present an aggregated summary of billed charges, reimbursements and costs at the hospital level using the UAR, as follows:

- Line 133 of the UAR Gross Patient Revenue (billed charges)
- Line 140 of the UAR Net Patient Revenue (reimbursements received)
- Line 155 of the UAR Total Expenses (operating costs of providing the care)

Figure 1 on the next page compares the billed charges, reimbursements, and operating costs for 2012 calendar year for all ADHS licensed hospitals to illustrate the differences in charges, operating costs, and reimbursements based on the aggregate information from UAR data submitted by hospitals.

In addition to the UAR, ADHS offers through its website, Arizona Hospital Compare (AZ Hospital Compare http://pub.azdhs.gov/hospital-discharge-stats/2011/index.html), which provides consumers with a tool to compare a variety of quality indicators based on Agency for Healthcare Research and Quality (AHRQ) national quality indicator criteria. These include effectiveness, safety, patient-centeredness, timeliness, efficiency, and equitability. The tool analyzes, summarizes, and presents information in a format intended for use by consumers and other decision-makers on:

- Quality of care at the hospital level;
- Charges, which are based on hospital discharge data (HDD) and estimated hospital costs [not what the patient is expected to pay];
- Health care utilization at the hospital level;
- Preventable hospitalizations at the county level; and
- Rates of conditions and procedures at the county level.




AZ Hospital Compare for the calendar year 2011 is based on 801,926 in-patient discharges. ADHS collects HDD for inpatient and emergency department visits from all Arizona licensed hospitals based on Arizona Revised Statute (A.R.S.) § 36-125-05, and the Arizona Administrative Code Title 9, Chapter 11, Articles 4 and 5.

AZ Hospital Compare was designed using a free customized software tool from AHRQ called MONAHRQ (My Own Network, powered by AHRQ). It enables organizations—such as state and local data organizations, chartered value exchanges, hospital systems, and health plans—to input their own hospital administrative data and generate a data-driven Web site.

The AZ Hospital Compare tool can assist consumers with choosing a hospital by providing information on quality for individualized diagnostic conditions and procedures based on standardized codes. Hospital costs provided by AZ Hospital Compare are calculated by converting total charges (reported by hospitals in the HDD files submitted to ADHS) to costs using cost to charge ratios (http://www.hcup-us.ahrq.gov/db/state/costtocharge.jsp) based on hospital accounting reports from the Centers for Medicare and Medicaid Services (CMS). It does not provide information on what individual diagnostic conditions or procedures cost a patient. Chargemaster information submitted to ADHS has no relationship to information provided by AZ Hospital Compare because financial documentation other than the Chargemaster is used to create each hospital's AHRQ cost to charge ratio.

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. Hospitals with more than 50 inpatient beds must make available the direct pay price for at least the 50 most used Diagnosis-Related Group (DRG) codes, and the 50 most used outpatient codes. Hospitals with 50 or fewer beds must make available the top 35 DRGs and outpatient codes. This information is reported separately by each hospital and is not available in an aggregated form.

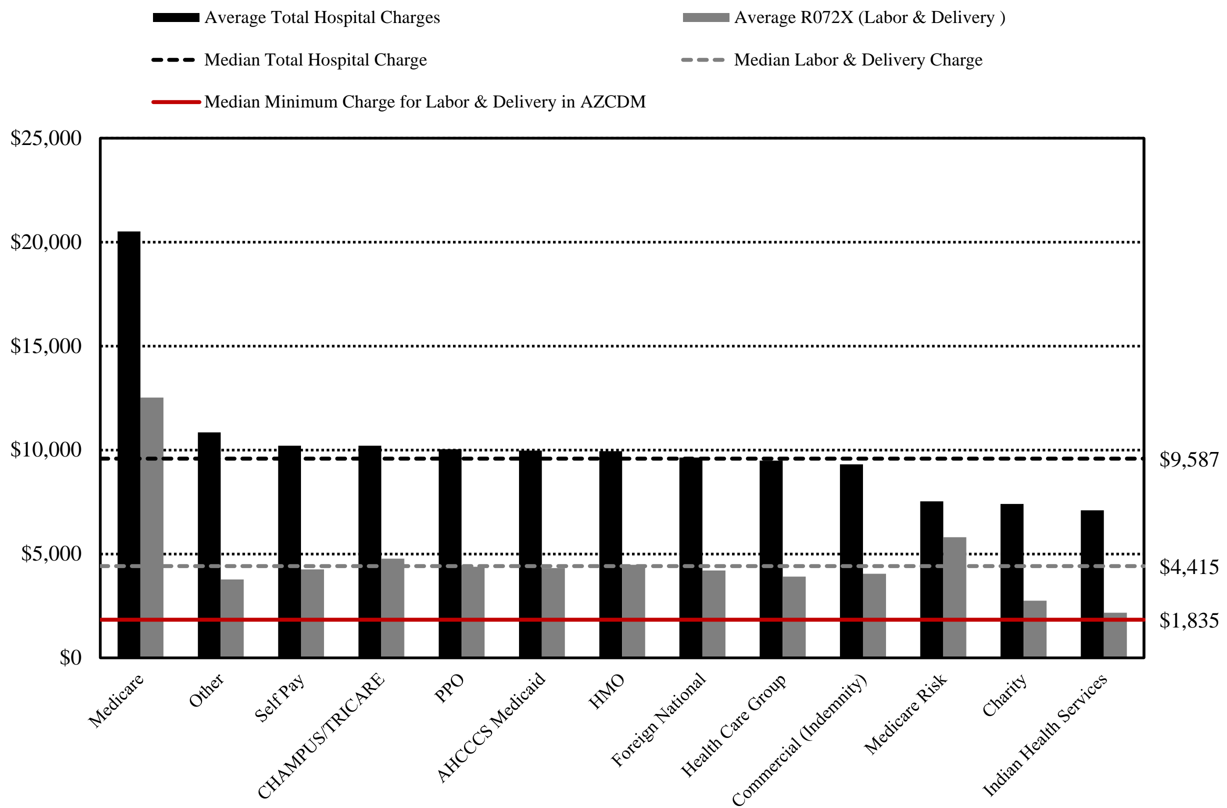
*Limitations of Chargemaster Data for Transparency Purposes*

The Chargemaster information submitted by Arizona hospitals is not available to the public, except through a special request process, and it has an opaque relationship to what the payers, be they individuals, commercial insurance plans, or AHCCCS, actually pays the hospital for its services. It is also not in a format which enables a payer of services to understand the information or to use it to estimate what their financial obligation will be. For example,

1) There is no uniform format in which the hospitals submit the information. Therefore, comparing among the hospitals' data is virtually impossible to a lay person.
2) The information is a list of thousands of individual charges with no relationship to specific procedures or diagnoses. The description and categorization of individual charges in one hospital do not correspond to the description and categorization in another.

To illustrate, in Figure 2 on the next page, the "Median Minimum Charge for Labor and Delivery in AZCDM" comes from the specific line item for the labor and delivery room and board charge on the Chargemaster, and so does not include all the possible line item charges associated with a normal delivery. In contrast, the "Median Labor & Delivery Charge" derived from the HDD charges [which is also provided by the hospitals to ADHS], reflects the actual charges associated with the normal delivery. So the median minimum charge reported for a normal delivery from the AZCDM data was half (i.e. $1,835) compared to the median labor delivery actual charge (i.e., revenue code 072X) of $4,415 in the hospital discharge data provided to ADHS.

**Figure 2. Arizona Hospital Charges for 2012 Calendar Year by Payer Status for a Normal Delivery¶**




**¶ ICD 9CM code 650 with DRG 775 for singleton delivery (excludes multiple births i.e. twins, triplets etcetera).**

The information in the Arizona Chargemaster is essentially meaningless 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 extremely inflated relative to the hospitals' costs, Medicare rates are often the basis for the negotiated prices which health plans pay. 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. While the Arizona Chargemaster is not useful to persons with health insurance, it may have an impact on the deductibles and other amounts for which they are responsible if such cost sharing is tied to a percentage of charges. If an insured patient can get an estimate of what his or her out of pocket responsibility will be, it is most likely because their health plan has provided it. However, the availability of this information has historically been limited, although it has been improving as attention to health care pricing has increased. Other sources publicly available to patients such as the Uniform Accounting Report (UAR) offer little to the person trying to understand the price they will pay for pre-scheduled hospital care.

## Other States' Reporting of Hospital Charges and Prices

*Movement Toward Transparency*

An increasing number of states are moving to increase price transparency for outpatient care as well as for inpatient hospital services. According to *Catalyst for Payment Reform (CPR)*, a nationally recognized independent organization supported by major employers who are also major health care purchasers like Boeing, IBM and Safeway, there are three reasons why health care consumers and purchasers benefit from increased transparency. CPR defines price transparency "as the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties."[8]

1) Transparency helps purchasers contain health care costs;
2) It informs consumers' health decisions as they assume greater financial responsibility;
3) It reduces unknown and unwarranted price variation.

As the trend toward patients assuming a greater share of costs through out of pocket expenses grows, in order to be prudent shoppers for health care services, they need information on price and quality. Improving transparency, linking price and quality data together, helps consumers assess their treatment options. Studies show that accessible price and quality information results in 80% of consumers selecting the highest value provider.[9]

Multiple studies have found significant price variation for hospitals and other provider services across and within markets, which have no relationship to quality. Without transparency, health care purchasers are unable to benefit from the customary market forces which keep price variation in check. A report from the *Health Care Cost Institute* shows a 4.6% nationwide increase in health care spending from 2010 to 2011, due almost entirely to higher prices, not increased utilization or intensity of services.[10] According to a recent report in the *Journal of the American Medical Association*, between 2000 and 2011, increase in price, not intensity of service or demographic change has produced 91% of the increase in health's share of GDP.[11]

All health care purchasers, ranging from an individual with a HSA, to large employers, to state Medicaid programs, are concerned with what they are required to pay for care and services. To make an informed decision, they need information about provider price and quality. Policymakers, employers, health plans, and even providers are coming to this conclusion, and health care cost and quality information is becoming increasingly available around the country.

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[8] Catalyst for Payment Reform. "Price Transparency: An Essential Building Block for a High Value Sustainable Health Care System."

[9] Hibbard, JH. et al. "An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," Health Affairs 2012; 31(3): 560–568.

[10] Health Care Cost Institute. "Health Care Cost and Utilization Report: 2011." September 2012

[11] Hamilton Moses III, MD; David H. M. Matheson, MBA, JD, et al. "The Anatomy of Health Care in the United States", JAMA November 13, 2013 Volume 310, Number 18

*CPR Report Card*

State laws requiring the public release of health care pricing information vary widely. In March 2013, *Health Care Incentives Improvement Institute*, and *Catalyst for Payment Reform*, published "Report Card on State Price Transparency Laws".[12] The Report was an effort to "examine existing transparency laws in all 50 states and grade them using well-defined criteria, based on how well they support the information needs of consumers" and to "inform advocates, lawmakers and policy experts about today's best practices."

Figure 3 below illustrates various levels of price transparency in states.

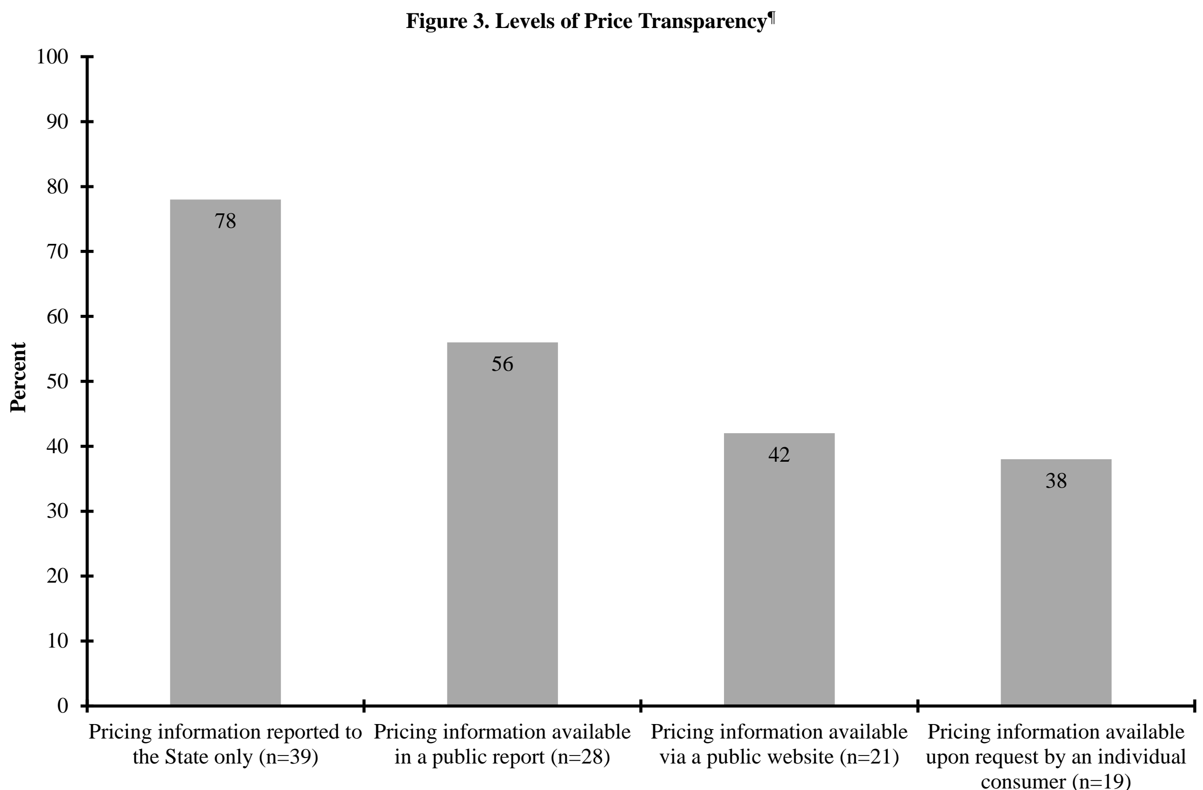


**Figure 3. Levels of Price Transparency¶**

**¶Counts and percents are not mutually exclusive. Data are based on Catalyst for Payment Reform (CPR) and Health Care Incentives Improvement Institute (HCIII) Report Card on State Price Transparency Laws, March 18, 2013.**

The Report examined state specific laws focused on price transparency for health care services. It found varying levels of price information, and varying degrees of public access to the information.

[12] Catalyst for Payment Reform & Health Care Incentives Improvement Institute. "Report Card on State Price Transparency Laws". March 18, 2013

Four criteria were used to assess the laws:

1) Does the law require public access to charges and/or paid amounts?
2) Does the law make price information available on providers, facilities, or both?
3) Does the law make price information available for inpatient and/or outpatient procedures?
4) Does the law make information accessible to consumers, especially through a searchable website?

State results varied widely; however, most states did not receive high marks for transparency, with Arizona and 28 other states receiving an "F" grade and only 2 states receiving an A grade.

Table 1 on the next page summarizes the Report Card grades for all states.

**Table 1**

| Grade | States | Minimum Requirements/ Common Elements | Example |
|---|---|---|---|
| A | 2: MA, NH | Charge Information and paid amounts for facilities and other practitioners (e.g., physicians) on public website, upon request and in public report. Full array of information for inpatient and outpatient available. | New Hampshire has a searchable public website with charges and paid amounts for hospitals and providers for most common inpatient and outpatient procedures. Subset of information also available upon request in a public report. Website also includes quality measures. http://www.nhhealthcost.org/costByProcedure.aspx |
| B | 5: CO, ME, MN,VA,WI | Make both provider and facility charge information available on a website, and facility and practitioner charges and paid amounts available in a public report (and include all inpatient and outpatient procedures in report). Have charge data and paid amounts for hospitals and providers for all procedures available online. | Virginia has charge data for hospitals and providers, for most inpatient and outpatient procedures, publicly available on a website. A public report contains charge data and paid amounts for providers and hospitals for all procedures. http://www.vhi.org/health_care_prices.asp |
| C | 7: IL, IA, KY, NV, SD, UT, VT | Make facility charge information for the most common inpatient and outpatient procedures available to the state, available by request, in a public report, and posted on a website. Make facility charge information for all procedures available online and in a report. Make charge data and paid amounts for both facility and practitioner for all procedures available in a written report and by request. | Illinois has hospital and provider charges online, but only for the most common inpatient and outpatient procedures. The state also makes the same information—but for all procedures--publicly available in a report. http://www.healthcarereportcard.illinois.gov/hospitals/view/101276 |
| D | 7: AR, CA, FL, LA, OH, TX, WV | Collect facility charge information and make at least some of it available online (the most common in-patient and outpatient procedures) and also available by request or in a public report. Make charge data and paid amounts for practitioners and facilities for all procedures available to the state and public by request. | California has a public website with hospital charge data only for the most common procedures. Charge data on a wider array of procedures is available by request. http://www.oshpd.ca.gov/chargemaster/ |
| F | 29:AL,AK,AZ, CT, DE, GA, HI, ID, IN, KS, MD, MI, MS, MO, MT, NE,NJ,NM, NY,NC, ND, OK, OR, PA, RI, SC, TN, WA, WY | Collect little to no hospital charge data and does not make it public, or does so only by request or only in a written report. | Arizona has only some hospital charge data reported to the state and in a report, and some hospital or provider charge data available by request. The 2012 data is currently under development.. |

*All-Payer Claims Database*

In addition to these state laws for reporting hospital charges and process, twelve states have enacted legislation and adopted All Payer Claims Database (APCD) reporting requirements. APCDs are essentially an aggregated repository for all health encounters paid by a third party within a state. As described by *The Commonwealth Fund*, "Every health encounter creates a claim for payment, and both public and private insurance plans routinely aggregate these claims data into their own administrative databases. APCDs combine data from all payers in a state, giving policymakers statewide information on costs, quality, utilization patterns, and both access and barriers to care, as well as numerous other health care measures. When these data are made publically available, consumers and purchasers also have the tools they need to compare prices and quality as they make health care decisions."[13]

APCDs can provide a significant vehicle for enhancing healthcare transparency by enabling a stronger understanding of quality and cost across populations and through use in research, public health, and consumer information. APCD implementation can be challenging both politically and operationally. States must determine governance, funding, data sources and comparability, and data accessibility structures. Self-pay and certain public payers such as Tricare are not included in APCDs at this time and limited Medicare inpatient data was only recently made available.

States with APCDs have taken varying approaches to implementation, but all have passed enabling legislation which is then executed by a state agency or a community coalition entity with the participation of stakeholders. These operational decisions are shaped by policymakers' goals. For example, Utah supported an APCD to facilitate cost savings through payment reform and value purchasing. Tennessee uses its data to compare costs across treatment settings and providers and to provide the public with information on health care quality. The degree of public accessibility of the data varies by state. The APCD Council http://www.apcdcouncil.org/ serves as a clearinghouse for states' use of the data and standardizing as feasible.

*Medicare*

In June 2013, Medicare released data on hospital specific charges for the 100 most frequently billed discharges and the actual payment for those discharges paid by Medicare. The data generated a great deal of analysis particularly regarding the wide variation in charges for identical services among hospitals within a geographic area, and the difference between charges and actual amounts paid by Medicare. This was the first report of its kind. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Downloads/IPPS_DRG_XLSX.zip.

[13] The Commonwealth Fund. "All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency." Issue Brief September 2010.

## Concluding Observations and Recommendations

*Summary*

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.

- Price transparency without quality information can lead consumers to believe that high priced care is better quality care.[14]
- Lack of meaningful price information negates patients' ability to include cost as part of their clinical and treatment decision making, inhibiting patient engagement in decisions about their care.[15]
- Price is a significant driver of health care inflation. Providing health purchasers with price transparency may allow market forces to reduce the significant price variation across facilities in the same geographic area.
- In addition to impacting consumers with HSA's or without insurance, the Chargemaster prices may affect some insured individuals due to annual limits and high deductibles in circumstances where such out of pocket payments are tied to reported charges.
- Charge and paid amounts must be presented by specific procedure or treatment using uniform criteria as to what is included in the price to be meaningful to users of the information.
- Charges alone provide a very limited perspective on the actual price paid by most purchasers, so including the price paid fosters market forces.
- Outpatient services comprise a large and growing portion of the services provided by hospitals, and should be included in a meaningful reporting structure.
- In order to ensure the uniformity, consistency, and transparency of reported data, state agencies serve an important clearinghouse role. APDCs can provide a mechanism for significant price transparency by providing credible cost and quality information for most payers.
- The current Arizona Chargemaster reporting requirements serve no public good, because the line item format of the data is not uniform and it is virtually inaccessible to the public.
- There are opportunities to use existing data sources to generate more meaningful information for consumers and payers, and the state should explore such opportunities.

*Recommendations*

To improve the availability of health care price and quality information and to enable consumers to make informed decisions about health care purchasing, Arizona has a number of options. However, the most successful initiatives have stakeholder input and support. Therefore, AHCCCS and ADHS recommend that the two agencies convene key stakeholders with the goal of reaching consensus on ways to improve the availability of price and quality information in a

[14] Hibbard, JH. et al. "An Experiment Shows that a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," Health Affairs 2012; 31(3): 560-568.
[15] Ubell, PA. et al. "Full Disclosure- Out of Pocket Costs as Side Effects", The New England Journal of Medicine October 17, 2013; 369:1484-1486.

format that is useful to consumers and payers, and provide a report to the Governor and the Legislature January 15, 2015.

These stakeholder meetings will examine options for improving public access to data, including:

- Establishing hospital reporting in a format that is useful to purchasers of health care services (e.g., by reporting data by procedure, not thousands of individual charge lines).
- Structuring uniform reporting requirements, so that a given charge or procedure at one hospital is comparable to that charge or procedure at all other hospitals, enabling purchasers to determine value.
- Including hospital outpatient services in addition to inpatient data
- Making the data accessible via a searchable website
- Including prices for selected common diagnoses and procedures
- Making charge and paid amounts for procedures and diagnoses available online or a public report.
- Determining strategies to make pricing available to patients prior to rendering of services

In addition to conducting these stakeholder meetings, AHCCCS and ADHS will employ the following strategies:

1) As the single largest payer in the State of Arizona, AHCCCS will be more transparent in sharing information on hospital billed charges and the payment amounts made by AHCCCS for common inpatient and outpatient procedures. Under the Payment Modernization section of the AHCCCS website, detailed information will be made available by hospital that shows the wide range of billed charges and the payments made for these common inpatient diagnoses, and hospital outpatient procedures. The website will also provide links to recognized sources for assessing hospital performance such as Leapfrog.org and hospitalsafetyscore.org.
2) AHCCCS will also be working toward making similar information on other types of providers for common procedures available in the future.
3) ADHS will continue to update AZ Hospital Compare as data becomes available.
4) ADHS will continue to annually update and post hospital quality information.
5) AHCCCS and ADHS will 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.

# 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 '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)."[16] In the context of *AZ Hospital Compare*, the cost-to-charge ratios are provided by the Agency for Healthcare Research and Quality (AHRQ) based on all-payer inpatient cost information obtained from the hospital financial reports collected by the Centers for Medicare and Medicaid Services (CMS). Within the tool used to create *AZ Hospital Compare*, the hospital total charge data is converted to cost estimates by simply multiplying total charges with the hospital-specific cost-to-charge ratio.
- ***Current Procedural Terminology (CPT)***: CPT (also see *HCPCS)* is a proprietary product of the American Medical Association (AMA), and a national standard code set utilized nationwide for healthcare billing. This uniform coding system of descriptive terms with identifying codes for reporting medical services and procedures provides a uniform coding structure to accurately describe and bill for medical, surgical and diagnostic services. CPT is used for billing primarily by physicians and other health care professionals, including outpatient services in the hospital setting. The CPT code sets are maintained by an editorial panel at AMA consisting of physicians nominated by National Medical Specialty Societies, and physician representatives from Blue Cross and Blue Shield Association, America's Health Insurance Plans, the American Hospital Association and CMS.
- ***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 hospital inpatient billing.
- ***Healthcare Common Procedure Coding System (HCPCS):*** HCPCS is a standardized coding system for claims processing by Medicare/Medicaid and other health insurance providers. The HCPCS is divided into two principal subsystems, categorized as *Level I* and *Level II*. Level I is the CPT code set (defined above). Level II (commonly referred to simply as *"Hic-Pics"*) is used to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. HCPCS are also referred to as alpha-numeric codes because they consist of a single

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

alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.[17]

- ***Hospital Discharge Data (HDD)***: Pursuant to Arizona Revised Statute (A.R.S.) § 36-125.05. and Arizona Administrative Code Title 9, Chapter 11, Articles 4 and 5, the Arizona Department of Health Services (ADHS) collects hospital discharge records for inpatient and emergency department visits from all Arizona licensed hospitals. The records are collected twice each year based upon patient discharge date, January 1 through June 30 discharges comprising the first data reporting and July 1 through December 31 comprising the second. Approximately 3 million discharge records are collected annually. ADHS requires and enforces accuracy and completeness in reporting. All Arizona licensed hospitals (i.e. regulated by the Arizona Department of Health Services), are required to report. However, hospitals such as Veteran's Administration, Department of Defense, and those located on tribal land are not included in the reporting.
- ***International Classification of Diseases (ICD)***: The International Classification of Diseases (ICD) is developed by the World Health Organization (WHO) and used by WHO Member States. This standard code set is used for epidemiology, health management, clinical purposes and claims billing. The current ICD-10 version is used to code and classify mortality data from death certificates in the United States. However, the older ICD-9-CM is currently the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. "CM" means *clinical modification*, a modified version of the ICD specific to usage in the United States. The responsible parties overseeing all changes and modifications to the clinical modification versions are The National Center for Health Statistics (NCHS) and CMS. Under the leadership of Health and Human Services through CMS, the United States is scheduled to transition to ICD-10-CM for claims billing and processing on October 1, 2014, the first day of the US 2015 federal fiscal year.[18]
- ***Total 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.
- ***Uniform Accounting Report***: A summary document of various hospital financial information submitted by hospitals to ADHS once each year in a format specified by ADHS and containing the information required under A.A.C.R9-11-203.

[17] Center for Medicare and Medicaid Services. http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. Accessed on November 28, 2013

[18] World Health Organization. http://www.who.int/classifications/icd/en/. Accessed on November 28, 2013.