The "Direct Pay Price" Statute

15 Questions and Answers about HB 2045

1) Does HB 2045 apply to my facility?

HB 2045 applies to any "health care facility," which includes the following:

- Hospitals
- Outpatient surgical centers
- Health care laboratories
- Diagnostic imaging centers
- Urgent care centers

The statute does not clearly state how it applies to organizations which consist of more than one type of facility – such as a multi-hospital system - or to facilities that have other types of facilities included as part of their operations, such as a lab within a hospital. We believe that each of the facilities listed above that are separately licensed will be required to make its own lists available, even if part of a larger corporate system.

We also believe that facilities that are integrated into the operations of another type of facility (a lab within a hospital) are not required to create a separate list.

2) What does HB 2045 require a health care facility to do?

HB 2045 requires a health care facility with more than 50 inpatient beds to make publicly available the "direct pay price" for the 50 most used DRG codes and the 50 most used outpatient service codes used at that facility. This will require two lists of 50 items each for hospitals with more than 50 licensed inpatient beds.

For hospitals with 50 or fewer licensed inpatient beds the list of services and prices may be shorter, with only 35 inpatient and outpatient codes required. For non-hospital facilities with no inpatient beds, the 35 code list will satisfy the requirement.

3) How do we determine the "50 (or 35) most used DRG or outpatient service codes" at our facility?

HB 2045 does not provide any direction on how to determine which codes are the "most used" for a particular facility, nor do we anticipate receiving any guidelines from the Department of Health Services. Facilities in which DRGs are not the primary coding methodology (pediatric facilities, for instance), or facilities in which case volumes drop significantly before the 50th code on the list will face particular challenges, and it is clear that in some cases the data a hospital provides may not be particularly useful for a patient looking at the data. Facilities will need to develop

their own methodologies using their best judgment when determining which services and codes should be included on their list.

4) Should we identify the services by CPT code or by plain description?

HB 2045 allows facilities to identify the services **either** by CPT code or by a plain-English description of the procedure or service. Some thought should go into the formatting of this list, however. While a simple list of codes and their associated pricing may be easier to produce, a cryptic list in which the actual services are difficult to decipher is more likely to create confusion among potential patients, and therefore more likely to raise concerns with regulators or outside watchdog groups.

5) How often do we need to update the lists?

A facility's lists must be updated at least annually. This update must include a re-determination of the facility's most used services, and an update of the established Direct Pay Price for those services.

The statute requires the update to evaluate services over a 12 month period, but allows that 12 month period to be taken from within an eighteen month period prior to the update. The effect of this is to allow a facility to set a 12 month period in place, then use up to 6 months to process the data from that measurement period.

6) How should we determine the "Direct Pay Price" we need to publish?

HB 2045 requires that each facility list the "Direct Pay Price" for each of the identified services.

It is important to note that the phrase "Direct Pay Price" was created for the purpose of HB 2045 – it has no independent meaning outside of the statutory definition (though a few other states have used the phrase in similar legislation). As a result, we have very little to go on in determining what is actually required under the statute. At least one national group (HFMA) is currently working to establish guidelines on pricing transparency in health care, but those efforts have not yet ripened into guidance that can be used to comply with HB 2045 in Arizona.

The statute itself defines the phrase as the "entire price" that will be charged by the facility for the identified service if the service is paid for directly, either by a patient (directly or through a Health Savings Account) or by the patient's employer (for instance, through a self-insured plan), and that allows for a payment plan.

This concept creates significant difficulties for hospitals and other health care facilities, as most facilities do not maintain a single identifiable price for a particular service – facilities negotiate different prices for different plans, government payors pay different determined rates, etc. Nonetheless, the statute now requires facilities to establish a rate for each of the identified services that represents payment in full if a patient or a self-insured employer pays that amount directly.

Given the lack of guidance in the statute, we believe facilities have significant flexibility in determining their Direct Pay Price, and we believe facilities will

approach this determination in significantly different ways. Among the approaches we believe hospitals may take are:

- The hospital's existing gross charges
- Medicare rates (most likely for hospitals with payor mixes weighted toward government payors and few commercial contracts)
- The hospital's current cash pay rate (though it would no longer be the cash pay rate, as the Direct Pay Price must allow payment plans)
- A newly established hybrid rate that provides a lower rate than gross charges, but is a rate higher than current cash pay rates or public program rates

7) Can we still offer discounts based on charity care policies or upfront payment?

Establishing the Direct Pay Price does not eliminate a facility's ability to arrange additional income-related discounts under charity care policies, nor the ability to establish a separate cash-pay price. Those calculations may be made separate and apart from the Direct Pay Price.

8) What are our options for making the required information "available?"

HB 2045 requires that the information be "made available on request or online." A list that is publicly available on a facility's webpage will be sufficient to satisfy this requirement. Any individual that requests the list can be given the URL of the specific page, without the need for creating and having a hard copy available in the facility. The URL is not required to be available directly through a link off the facility's website, so a facility could choose to put the list on an unlinked page. Any facility choosing that option should give full consideration to the trend toward transparency, however.

It is also important to note that the statute does not **require** an online listing, and as an alternative a facility can make the information "available on request." A facility could therefore choose to limit its list to a hard copy version, providing it to a potential patient upon request, but not pushing it out to patients electronically.

9) Are any facilities exempt from HB 2045?

HB 2045 exempts Veteran's Administration facilities, facilities on military bases, Indian Health Services facilities, tribal clinics, and the Arizona State Hospital from the bill's price transparency requirements. The Director of the Department of Health Services may also grant an exemption for a facility that "does not serve the general public."

10) Do we need to report our list to the State Department of Health Services?

No. The pricing list does **not** need to be reported to the Department or any other governmental agency. HB 2045 applies only to making prices available to the public - no approval of those prices or any change to those prices is required.

11) Is there additional information we need to provide someone who pays the "direct pay price" for an identified service?

Yes, in certain cases. If a patient is enrolled as a beneficiary in a health plan in which the facility is a contracted provider, and that patient (or his or her employer) wants to pay the Direct Pay Price instead of having the claim paid by his or her health plan, the facility must give the patient or employer a notice containing certain specific information. The notice must be in a form that is substantially equivalent to the notice attached to this memo as Attachment 1, and the patient or employer representative must sign the notice to acknowledge having received it.

12) What happens if a patient or a patient's self-insured employer plan pays the amount the facility has listed for the designated service?

If a patient or a patient's employer pays the facility the amount listed as the Direct Pay Price for the service provided, the facility must accept that amount as payment in full. Once the Direct Pay Price has been paid, the facility may not submit a claim to any health plan or other payor for that service. The facility is not, however, required to make any refund or adjustment for any capitated or bundled payment it may have received on behalf of the patient.

If a health care facility is paid the Direct Pay Price for a service it is not required to submit any documentation for that service to a health plan or payor, unless the facility is obligated to do so under a federal or state contract in which the facility participates.

13) How should a facility comply with the requirements of HB 2045 that apply to health care providers?

Separate but very similar transparency provisions also apply to most licensed health care professionals under HB 2045 (specifically, physicians, podiatrists, chiropractors, optometrists, physical therapists, and occupational therapists). Providers must make available their "most commonly provided services," though they are only required to list 25. As in the facility provision, the bill provides no guidance regarding what services should be considered for this list, and we have received no indication that the licensing boards of the various professions intend to provide any further direction at this time.

In the absence of such guidance we conclude that this list can reasonably be identified either by E+M or other codes (though this may provide more information than a practice will wish to disclose) or more generally by category ("office visit," "suture removal," etc.).

Hospitals face additional challenges in responding to these requirements for their employed providers. In the case of an employed multi-specialty practice, for instance, does the statute require the hospital/employer to identify 25 services for each individual physician? Such a reading would have a tremendous impact on the data gathering required, and in many cases the lists would be largely duplicative for physicians in the same department. While further guidance may emerge to address

these issues, until it is issued we anticipate facilities with large physician groups may consider whether creating lists on a department level satisfies a reasonable reading of the statute.

14) What are the consequences of not complying with HB 2045?

HB 2045 allows the Department of Health Services to perform an investigation of a health care facility's compliance with the requirements of the statute, but at the same time expressly prohibits it from revoking a facility's license for failing to comply. The Department has other enforcement options at its disposal (including fines), but license revocation is not one of them.

As of the date of this memo we have not yet received any indication from the Department regarding how it will approach investigating or enforcing HB 2045.

15) When are we required to comply with HB 2045?

The requirements of HB 2045 go into effect on December 31, 2013.

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This memo is being provided for informational purposes and does not constitute legal advice to AzHHA members. AzHHA members should confer with their attorneys for any legal advice related to compliance with H.B. 2045, as codified at A.R.S. §36-437. Please also keep in mind that hospitals must comply with these provisions prior to December 31, 2013.

Attachment 1

Important Notice about Direct Payment
for Your Health Care Services

The Arizona Constitution permits you to pay a health care facility directly for health care services. Before you make any agreement to do so, please read the following important information:

If you are an enrollee of a health care system (more commonly referred to as a health insurance plan) and your health care facility is contracted with the health insurance plan, the following apply:

1. You may not be required to pay the health care 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 deductible amounts.

2. Your provider's agreement with the health insurance plan may prevent the health care facility from billing you for the difference between the facility's billed charges and the amount allowed by your health insurance plan for covered services.

3. If you pay directly for a health care service, your health care 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 you to provide information and submit documentation necessary to determine whether the services are covered under your plan.

4. If you do not pay directly for a health care service, your health care facility may be responsible for submitting claim documentation to your health insurance plan for the health care service.

Your signature below acknowledges that you received this notice before paying directly for a health care service.

Acknowledged

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