

2003 DRAFTING REQUEST

Bill

Received: **02/13/2003**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Mark Miller (608) 266-5342**

By/Representing: **Jamie Kuhn**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters:

Subject: **Health - miscellaneous**

Extra Copies: **RLR**

Submit via email: **YES**

Requester's email: **Rep.Miller@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Require health care providers to state charges in relation to Medical Assistance fee schedule

Instructions:

See Attached

Drafting History:

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Required</u>
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per
Jamie*

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Jamie Kuhn

Rush

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FE Sent For:

2/13/03 Mtg: Jamie Kubu, Fred Evert, DAK

Providers to state charges in relation to ^{Medicare} value schedule

Standard would be Medicare payment system

Physician charges wd be constant for a year

Exceptions: Medicare, MA, charity care
BadgerCare, HIRSP

regardless when Medicare changes

DHFS annually makes available the Medicare standard

April 1 annually Providers ~~submit rates~~ must state rates in relationship to standard - must be made available to consumers shall be posted and avail. upon request
Send to consumers once a year

Penalties: Providers submit their fees ~~to st~~ in rel. to standard, annually to DHFS

For providers who violate

Consumer + those who K on his/her behalf for payment wd. not be liable for balance.

physician performance. A centralized transaction system would reduce health care costs by eliminating administrative waste, and, by gathering usable information on the type of care being delivered, improve health care quality.

Reform Three: Transparency of Health Care Costs

A major problem with the current health care system is that patients don't know how much a particular medical procedure costs or what the patient's health plan will reimburse. This makes comparison-shopping virtually impossible.

We can reform this system by establishing a relative value fee schedule (like Medicare's) and requiring providers to declare each year at what percent of the schedule they will set their fees (e.g., 120%, 130%, 150%). Providers will not be limited in what they could charge, but once they have established their fees, they would be required to charge every patient the same percentage for their services. On the other side, insurers and health plans would be required to declare at what percentage they will reimburse for any given service (health plans could offer different plans with different reimbursement levels). In this way, cost shifting, which adversely impacts those without insurance and small businesses the most, would be eliminated and consumers and their doctors would know, in advance, what procedures cost and what the patient's health plan would pay for them.

By shining a bright light on health care costs and eliminating cost shifting, we would create a more open health care marketplace and make everyone accountable for their health care decisions. Patients will be able to make decisions about their care knowing what a physician will charge and what their health plan will pay.

Reform Four: Health Care Accessibility

We have all heard the sage advice that an ounce of prevention is worth a pound of cure. Unfortunately, when it comes to health care for the poor, we simply don't practice what we preach. Too often, their needs are not addressed until they appear in our emergency rooms or hospital beds, often with high-cost consequences. Access to basic preventive care is a prerequisite for a healthy state.

On the other end of the spectrum, small businesses swoon under the rate increases brought about by catastrophic claims, with both individuals and groups losing coverage as a result. There is reliable evidence that facilities that perform a very high number of open-heart surgeries, transplants, and other high-tech procedures often excel at them, and those that do fewer procedures don't do them as well. Yet, we see a proliferation of facilities in the state attempting to do all types of expensive procedures. The result is poorer quality and higher cost.

If we are to meet the future health care needs of all citizens, we can take two important steps. First, we can create a health program to provide every resident a basic level of preventive health care. Such a plan would cover routine physical exams, immunizations, and evidence-based diagnostic procedures suitable to a person's age, gender, and family health history. The plan



The **New** Wisconsin Idea A Health Care Reform Plan for Wisconsin

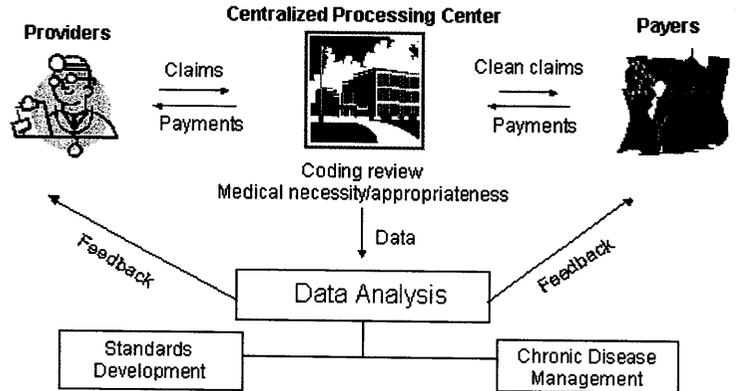
First reform

Statewide prescription drug purchasing

- Standards-based prescription drug formulary
- Statewide purchasing
- Education of doctors and the public
- Computerized prescription drug order entry system

Second reform

Centralized transaction processing



Third reform

Transparency of health care costs

- Establish a standardized fee schedule
- Providers charge a uniform percent of the schedule for all patients
- Insurers pay based on a uniform percent of the schedule

Provider charge	
Dr. A	120%
Dr. B	150%
Dr. C	140%
Dr. D	135%



Patient

Health Plan
Pays up to 130% of schedule

If patient selects Dr. B, she must pay 20% of costs in addition to any applicable deductibles or coinsurance. If she selects Dr. A, only her deductible and coinsurance costs apply.

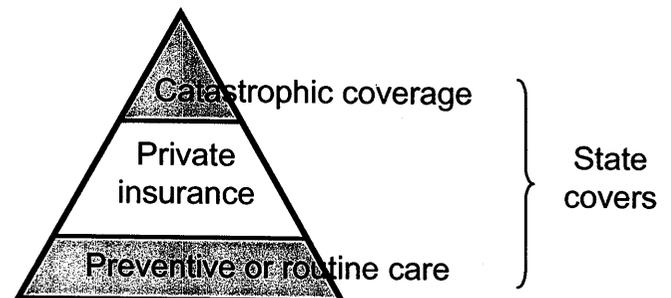
Fourth reform

Health care accessibility

- State covers preventive care*
 - Immunizations, pre- and post-natal care, physical exams, maintenance medications
- State covers catastrophic care**
 - Transplants, neonatal care, advanced cardiac and cancer care, other high-cost care

* Plan would cover all state residents who meet minimum residency requirements

** High-cost care would be provided through a centers of excellence program





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This site provide links to pages containing informational materials on Medicare payment systems.

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- Medicare [PPS Excluded Cancer Hospitals](#)
- ~~National Physician Fee Schedule Relative Value File~~
- [Physician Fee Schedule](#)
- Physician Fee Schedule [Payment Amount File National/Carrier](#)
- [Place of Service Coding System](#)
- [Prospective Payment System \(PPS\) PC PRICER](#)
- Skilled Nursing Facility (SNF) [Prospective Payment System](#)
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Last Modified on Wednesday, September 25, 2002

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MEDICARE AND MEDICAID GUIDE

Issue No. 1221

No. **1216**

Part 3
July 16, 2002

Medicare Physician Fee Schedule Calendar Year 2003 Proposed Rule

- Refinement of Practice Expense RVUs
- Revised Medicare Economic Index Methodology
- Coverage of Telehealth Services
- Therapy Payment Caps
- Other Part B Coding and Payment Policies

(As published in the *Federal Register* for June 28, 2002)

CCH INCORPORATED
4025 W. Peterson Ave., Chicago, IL 60646-6085
1 800 449 9525
health.cch.com

About This Report

This report—No. 1216, Part 3—contains a *Proposed Rule* updating the physician payment rates under the Medicare physician fee schedule for calendar year 2003 and revising other policies affecting Medicare Part B payment for physicians and other providers. In conjunction with this proposed rule, CMS has published an interim final rule to make it easier for the agency to use supplemental practice expense data submitted by physician groups. The proposed rule is reported for Online, Internet, and CD-ROM customers at ¶ 220,162, and the interim final rule is reported at ¶ 180,265. Comments on the proposed rule and the interim final rule must be submitted to CMS by August 27, 2002.

Relative value units

In 2002, CMS completed a four-year transition to resource-based practice expense relative value units (RVUs). Thus, beginning in 2002, all three components of the fee schedule (physician work expenses, practice expenses, and malpractice expenses) reflect the relative costs of resources used in providing physician services. The proposed physician fee schedule rule for 2003 makes various refinements to resource-based practice expense RVUs.

CMS continues to consider alternatives to the zero physician work pool, which the agency created as an interim measure to allocate practice expenses for services that involve no physician work. Although a General Accounting Office report recommended eliminating the zero physician work pool, CMS does not believe the pool should be eliminated at this time, because such a change would result in large payment reductions for some medical specialties whose services are included in the pool. The proposed rule states that CMS would welcome a multi-specialty practice expense survey from all of the medical specialties that have payments affected by the zero physician work pool.

The proposed rule makes various changes to the zero physician work pool, including: (1) creating the pool using the highest staff time in place of average staff time; (2) at the request of physician groups, removing the non-invasive vascular diagnostic study codes from the pool; and (3) removing immunization administration services from the pool, which will nearly double the Medicare payment for administration of some vaccine immunizations.

For procedure codes not included in the zero physician work pool, CMS is proposing to make the technical component value equal to the difference between the global and the professional component. CMS plans to develop the practice expense RVUs for 2003 using utilization data from the 1997 to 2000 time period, and to continue using that data without further updates until the agency undertakes the five-year review of practice expense RVUs. The proposed rule also assigns site-of-service designations for several new places of service and revises the facility or non-facility designation for several existing places of service.

Regarding CMS' five-year review of work RVUs for anesthesiologists, the American Medical Association's Relative Value Update Committee (RUC) recently presented CMS with the analysis and findings of the RUC's anesthesia workgroup. The RUC concluded that it was unable to make a recommendation regarding modification to the physician work valuation of anesthesia codes. CMS will review the RUC's findings and all comments received during the comment period to determine if an appropriate adjustment can be made to anesthesia work values.

This has been delayed and will not go into effect until March 1, 2003.



MEDICARE AND MEDICAID GUIDE

Issue No. 1225

No. 1220

Part 2
August 13, 2002

PPS for Inpatient Hospital Services Final Rule for 2003 Fiscal Year

- Changes to DRGs and Wage Index
- Rates for Operating and Capital-Related Costs
- Rates for Excluded Hospitals and Units
- Rebasing and Revision of the Market Basket

(As published in the *Federal Register* for August 1, 2002)

CCH INCORPORATED
4025 W. Peterson Ave., Chicago, IL 60646-6085
1 800 449 9525
health.cch.com

About This Report

This Report—No. 1220, Part 2—contains the *Final rule* revising the Medicare hospital inpatient prospective payment system (PPS) and rates for federal fiscal year (FY) 2003 (beginning Oct. 1, 2002). The rule also changes payments for critical access hospitals (CAHs), graduate medical education (GME) costs, and excluded hospitals and units. The *Proposed rule* was published at 67 FR 31404 on May 9, 2002, sent to print subscribers as Part 2, of Report—No. 1208, and reported electronically for Online, Internet, and CD-ROM subscribers at ¶ 220,128. The *Final rule* was published at 67 FR 49981 on Aug. 1, 2002, and reported electronically at ¶ 180,231.

Prospective payment rate update for FY 2003

CMS has issued a prospective payment rate update of 2.95 percent, effective Oct. 1, 2002, for acute care hospitals participating in Medicare. The update represents a market basket increase of 3.5 percent minus 0.55 percentage points, which is an increase over the market basket of 3.3 percent minus 0.55 percent that was proposed earlier this year.

Two new diagnosis-related groups (DRGs), for drug-eluting stents, with and without acute myocardial infarction, were established. Several other DRGs were revised or reclassified. CMS also approved Xigris™, used to treat patients with severe sepsis, for a new medical service or technology add-on payment under Reg. § 412.88.

Other changes include: rebasing and revision of the market baskets based on fiscal year (FY) 1997 cost data, payments for GME, payments to excluded hospitals and units, and amendments to the criteria for sole community hospital (SCH) status.

Hospital wage index

The FY 2003 wage index would be updated using FY 1999 wage data. The FY 2003 wage index includes salaries and hours from short-term acute care hospitals, home office costs and hours, certain contract labor costs and hours and wage-related costs. The FY 2003 wage index continues to exclude the direct and overhead salaries and hours for services not paid through the inpatient PPS.

Additionally, CMS has removed from the FY 2003 wage index calculation 100 percent of the costs related to GME and certified registered nurse anesthetist (CRNA) costs. Medicare payments for these costs are not included in PPS rates. CMS anticipates that the impact of removing these costs from the wage index is generally positive and relatively small.

Rebasing and revision of the market basket

CMS also rebased and revised the hospital market basket in developing the FY 2003 update factor. The new market basket is rebased to reflect FY 1997, rather than FY 1992, cost data. Although CMS had proposed recalculating the labor-related share of the standardized amount, it did not do so.

Transfer payment policy

Pursuant to the Social Security Act, the Secretary is authorized to expand the postacute care transfer policy to additional DRGs. CMS had proposed two options: (1) expand this policy to all DRGs or (2) expand it only to additional DRGs that have high rates of transfers. CMS has decided not to expand the number of DRGs subject to the post-acute transfer policy at this time so it can conduct additional research on the impact of such a change.



MEDICARE AND MEDICAID GUIDE

Issue No. 1238

No. **1233**

Part 2
November 12, 2002

Prospective Payment System For Hospital Outpatient Services Calendar Year 2003

Final Rule

- Ambulatory Payment Classification Groups
- Transitional Pass-Through Payment Issues
- Criteria for New Device Categories
- Coinsurance & Copayment
- Payment Suspension for Unfiled Cost Reports

(As published in the *Federal Register* for November 1, 2002)

CCH INCORPORATED
4025 W. Peterson Ave., Chicago, IL 60646-6085
1 800 449 9525
health.cch.com

About This Report

This Report—No. 1233, Part 2, contains the *Final rule* that changes the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the outpatient prospective payment system (OPPS) for calendar year (CY) 2003. The *Proposed rule* was published at 67 FR 52092 on Aug. 9, 2002, sent to print subscribers as Part 2, of Report—No. 1221 and reported electronically for Online, Internet, and CD-ROM subscribers at ¶ 260,163. The *Final rule* was published at 67 FR 66718 on Nov. 1, 2002, and reported electronically at ¶ 180,235. The *Final rule* is effective Jan. 1, 2003.

CMS announced a conversion factor of \$52.151 for CY 2003 based on a 3.5 percent increase in the hospital market basket and a wage index adjustment of .98778. The CY 2003 conversion factor is an increase from the CY 2002 conversion factor of \$50.904. The threshold for outlier payments for 2003 has been set at 2.75 times the ambulatory payment classification (APC) payment amounts and the payment percentage applicable to costs over the threshold has been set at 45 percent. CMS reduced the payment percentage over the threshold from 50 percent in the Aug. 9, 2002, *Proposed rule* to 45 percent to meet the target amount for outlier payments, which was set at 2 percent of total payments.

2003 marks the first year that the 569 APCs are set using actual data from claims submitted under OPPS. The proportion of claims used for setting APC weights has almost doubled from roughly 40 percent for 2002 to more than 80 percent for 2003.

Transitional pass-through payments

One of the most significant provisions in the 2003 rule concerns the methods used to recognize the cost of former pass-through items. Under Medicare law, transitional pass-through drugs and devices are eligible for special payments for two to three years. Beginning Jan. 1, 2003, 95 categories of devices and approximately 240 drugs, basically those that have received transitional pass-through payments since the first year of the OPPS, will lose this eligibility. Although they will continue to be paid under OPPS, they must be paid under a different method. The rule includes a method for incorporating expiring transitional pass-through devices and drugs into the regular payment system.

Under the new rule, the costs for the expiring categories of devices are folded into the APCs with the procedures they were billed with in 2001. Drugs costing \$150 or less per patient encounter will also be folded into the associated APCs. On an interim basis, however, more expensive drugs will be assigned a separate APC until CMS has collected enough data to incorporate these higher costs.

Additionally, to ensure that Medicare beneficiaries will continue to have access to cutting-edge technology, CMS has limited the impact of payment reductions for APCs that would have decreased by more than 15 percent in 2003. Most of the affected APCs include those drugs and devices that will no longer be eligible for pass-through payments. To limit the impact of the reduction, CMS decreased the 2003 reduction in median cost by half of the difference between the value derived from the claims data and 15 percent.

By law, if CMS estimates the total pass-through payments for the year will exceed the statutory limit, CMS must reduce the amount of each pass-through payment by an applicable percentage (2.5 percent for 2003). After refining and finalizing its estimate of pass-through spending in 2003, CMS concluded that a pro rata reduction of pass-

Section #. 632.745 (15) of the statutes

632.745 (15) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers health ~~benefit~~ ^{care} plans covering individuals in this state or eligible employees of one or more employers in this state. The term

includes a health maintenance organization, a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

History: 1995 a. 289, 453; 1997 a. 27; 1999 a. 9; 2001 a. 38.

~~health benefit plans~~, as defined in s. 628.36 (2)(a)1.,

Intend to prohibit providers from entering into discount agreements, who may well do under HIRSP and other programs?



State of Wisconsin
2003 - 2004 LEGISLATURE

LRB-2171/P1

DAK: [Signature]

D-NOTE

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

Gen. Act.

1 AN ACT **relating to:** health care provider service rates and insurer health care
2 reimbursement rates.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided on a subsequent version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

3 SECTION 1. 146.385 of the statutes is created to read:
4 **146.385 Health care provider charges; limitations.** (1) In this section:
5 (a) "Health care provider" has the meaning given in s. 146.81 (1).
6 (b) "Medicare" has the meaning given in s. 632.897 (1) (e).
7 (c) "Insurer" means an insurer that is authorized to do business in this state,
8 in one or more lines of insurance that includes health insurance, and that offers
9 health care plans, as defined in s. 628.36 (2) (a) 1., covering individuals in this state.

every [Handwritten arrows pointing from lines 6, 7, and 9 to a common point]

1 (d) "Relative value unit" means the components of a fee schedule that recognize
2 health care provider work expenses, practice expenses, and malpractice expenses in
3 reflecting the relative costs of resources used in providing the services of the health
4 care provider.

5 (2) By April 1[✓] annually, the department shall make available on the
6 department's website and by mail, upon request, the current Medicare fee schedule
7 for services of health care providers.

8 (3) (a) By April 15 annually, a health care provider shall provide to the
9 department, on a form provided by the department, a statement of the provider's
10 rates for the period from the following May 1 to April 30 of the following year. The
11 rates shall be stated as a percentage of the Medicare fee schedule for services of
12 providers, as specified by the department under sub. (2).

13 (b) Beginning ^{on} May 1 annually, a health care provider shall provide a statement
14 of the provider's rates for the period from that date to April 30 of the following year
15 to all of the following:

16 1. By mail, to each patient who received services from the health care provider
17 in the previous 12 months.

18 2. In person, to each patient to whom the health care provider provides services.

19 (c) Each health care provider shall charge identical rates for services to each
20 patient served by the health care provider.

21 (4) By April 15 annually, an insurer shall provide to the department, on a form
22 provided by the department, and to the insurer's insureds a statement of the
23 insurer's rates of reimbursement for services of health care providers for the period
24 from the following May 1 to April 30 of the following year. The rates of

1 reimbursement shall be stated as a percentage of the Medicare fee schedule for
2 services of health care providers, as specified by the department under sub. (2).

3 (5) (a) Before April 1 annually, no health care provider may charge rates for
4 services of the health care provider that exceed the rates stated by the provider under
5 sub. (3) for the 12-month period prior to that April 1.

6 (b) If a health care provider violates par. (a), neither the patient for whom the
7 health care provider's services were rendered and for whom the excess rate was
8 charged nor the patient's insurer is liable to the health care provider for the
9 difference between the health care provider's rate, as specified under par. (a), and the
10 actual rate charged.

11 (END)

D-NOTE

**DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU**

LRB-2171/P1dn

DAK:/:...

Kmg

To Representative Miller:

I am providing you with this preliminary draft to permit you the opportunity to revise it before it is in introducible form and because the following issues have arisen in the course of drafting:

1. Is the definition of ⁽⁽health care provider⁾ sufficiently inclusive? Overly inclusive?
2. Would you want DHFS (or OCI) to provide to the public information on the health care providers' and insurers' rates?
3. Is there any need for an entity to provide a fee schedule for services that are not covered under Medicare?
4. At my request, Pamela Kahler, the insurance drafter, reviewed this draft. With respect to possible effects resulting from the creation of s. 146.385 (3) (c) in the bill, she suggested that I inquire whether it is your intent to prohibit providers from entering into discount agreements, which they currently seem to do under HIRSP and other programs.

Please let me know if I may provide you with further assistance on this draft.

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.state.wi.us

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-2171/P1dn
DAK:kmg:rs

August 26, 2003

To Representative Miller:

I am providing you with this preliminary draft to permit you the opportunity to revise it before it is in introducible form and because the following issues have arisen in the course of drafting:

1. Is the definition of "health care provider" sufficiently inclusive? Overly inclusive?
2. Would you want DHFS (or OCI) to provide to the public information on the health care providers' and insurers' rates?
3. Is there any need for an entity to provide a fee schedule for services that are not covered under Medicare?
4. At my request, Pamela Kahler, the insurance drafter, reviewed this draft. With respect to possible effects resulting from the creation of s. 146.385 (3) (c) in the bill, she suggested that I inquire whether it is your intent to prohibit providers from entering into discount agreements, which they currently seem to do under HIRSP and other programs.

Please let me know if I may provide you with further assistance on this draft.

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.state.wi.us

10/24/03 Mtg. w/ Jamie + Sandy Louergan

-2171/PI

Ans. to DNote: 1. "Health care provider" should cover any health care provider who charges a fee for health or mental health care

Yes;
✓ 2. DHFS should be agency

✓ 3. Medicaid fee schedule, rather than Medicare

✓ 4. No; is not intent, just to provide accurate portrayal of what is charged - If necessary to make a specific exclusion for HIRSP, MA, Badger Care, etc., do so

In addition

In bill, fix

Managed care lang + rewrite of managed care lang. ^{re defined network}

(ch 609) - hard copy or posting on website

is provided to insured - see language

p. 2, lines 12-14

INS 9

From Sandy Louergan 10/30/03:

leave as drafted right now

↳ additional change (above)

11/3/03 From Jamie

~~Required~~ by posting on the internet
or

upon request, by mail, FAX, or email

Provider shall post info on internet if have website

If requested by consumer, must provide:
tel, email, or FAX, as requested by
the consumer

Questions to Jamie:

Thoughts about the draft:

146.385(2) "Services of the providers" - individualized service, or cost of procedure as a whole? For example, average rate for physician to perform appendectomy - or average cost of appendectomy (including phys., nurse, anesthes., supplies, op. room, etc.)

(4) ~~(3) (a)~~ Should this separately include start.

of monthly premium rates for defined network plans (HMO's + PPP's)? [NOTE: the May 1-Apr. 30 date probably doesn't work]

Also, isn't this duplicative of what's done every year in open enrollment period for defined network plans? ↑

~~(3)~~

Add def of defined network plans?

11/11/03 From Jamie: do not change the provisions - ok as they are



TODAY, if possible
State of Wisconsin
2003 - 2004 LEGISLATURE

LRB-2171/1

DAK:kmg

D-NOTE

~~PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION~~

1 *Gen. Cat.*
AN ACT to create 146.385 of the statutes; relating to: health care provider
2 service rates and insurer health care reimbursement rates.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided on a subsequent version.

INSERT
ANAL

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

3 SECTION 1. 146.385 of the statutes is created to read:
4 **146.385 Health care provider charges; limitations.** (1) In this section:
5 (a) "Health care provider" has the meaning given in s. 146.81(1).
6 (b) "Insurer" means an insurer that is authorized to do business in this state,
7 in one or more lines of insurance that includes health insurance, and that offers
8 health care plans, as defined in s. 628.36 (2) (a) 1., covering individuals in this state.
9 (c) "Medicare" has the meaning given in s. 632.897 (1) (e).

INSERT
1-5

, upon request,

Medical Assistance

1 (2) By April 1 annually, the department shall make available on the
2 department's website and by mail, ~~upon request,~~ the current ~~Medicare~~ fee schedule
3 for health care services of health care providers.

4 (3) (a) By April 15 annually, a health care provider shall provide to the
5 department, on a form provided by the department, a statement of the provider's
6 rates for the period from the following May 1 to April 30 of the following year. The
7 rates shall be stated as a percentage of the ~~Medicare~~ fee schedule for services of
8 providers, as specified by the department under sub. (2).

9 (b) Beginning on May 1 annually, a health care provider shall ~~submit a~~
10 ~~statement~~ *, with respect to* of the provider's rates for the period from that date to April 30 of the
11 following year *, do* all of the following:

12 1/ By mail, to each patient who received services from the health care provider
13 in the previous 12 months

1. Except as provided in sub. 2.,

14 ~~2. In person, to each patient to whom the health care provider provides services.~~

15 (c) ~~Each~~ health care provider shall charge identical rates for services to each
16 ~~patient~~ *identical health care* served by the health care provider.

17 (4) By April 15 annually, an insurer shall provide to the department, on a form
18 provided by the department, and to the insurer's insureds a statement of the
19 insurer's rates of reimbursement for health care services of health care providers for the period
20 from the following May 1 to April 30 of the following year. The rates of
21 reimbursement shall be stated as a percentage of the ~~Medicare~~ fee schedule for Medical Assistance
22 services of health care providers, as specified by the department under sub. (2).

23 (5) (a) Before April 1 annually, no health care provider may charge rates for
24 services of the health care provider that exceed the rates stated by the provider under
25 sub. (3) for the 12-month period prior to that April 1.

health care

INSERT 2-14

INSERT 2-16

MOVE TO P. 3, after line 5

health care

1 (b) If a health care provider violates par. (a), neither the patient for whom the
2 health care provider's services were rendered and for whom the excess rate was
3 charged nor the patient's insurer is liable to the health care provider for the
4 difference between the health care provider's rate, as specified under par. (a), and the
5 actual rate charged.

6

(END)

Material from p. 2, ll. 17-22 goes HERE

D-NOTE

(as defined in the bill)

the

INSERT ANAL

This bill requires the Department of Health and Family Services (DHFS) annually by April 1 to make available, on the DHFS website and, upon request, by mail, the current Medical Assistance (MA) fee schedule for services of health care providers. The bill requires health care providers ~~(as defined in the bill)~~, annually by April 15, to provide to DHFS a statement of the providers' rates for the following May 1 to April 30 of the following year, stated as a percentage of the MA fee schedule. In addition, health care providers, annually beginning on May 1, must post their rates on an internet website, if the health care provider has such a website, and, if requested by a health care consumer, provide a statement of the rates by mail, facsimile transmission, or electronic mail. Each health care provider must charge identical rates for identical health care services to each patient served by the health care provider, except for individuals under programs with limits on health care provider reimbursement rates, such as Health Insurance Risk-Sharing Plan or MA. Before April 1 annually, no health care provider may charge rates for health care services that exceed rates stated by the provider for the 12-month period prior to that April 1; if a health care provider violates this prohibition, neither the patient for whom the services were rendered and the excess rate was charged nor the patient's insurer is liable for the difference between the health care provider's stated rates and the actual rate charged.

Lastly, the bill requires insurers, annually by April 15, to provide to DHFS and to the insurers' insureds a statement of the insurers' rates of reimbursement for health care provider services for the following May 1 to April 30, stated as a percentage of the MA fee schedule.

For further information see the *state and local* fiscal estimate, which will be printed as an appendix to this bill.

INSERT 1-5

1 (a) "Health care provider" means any of the following that receives income from
2 the provision of health care or mental health services, items or supplies in this state:

3 1. An individual who is licensed, registered, permitted, or certified by the
4 department ^{of health and family services} or by the department of regulation and licensing to provide health care
5 or mental health services, items, or supplies.

6 2. A partnership, corporation, or limited liability company of individuals
7 specified in subd. 1.

1 3. A facility or agency that provides health care or mental health services,
2 items, or supplies.

INSERT 2-14

I

3 1. If the health care provider has an internet website, post the rates on the
4 website.

5 2. If requested by a health care consumer, provide a statement of the rates by
6 mail, facsimile transmission, or electronic mail.

INSERT 2-16

7 2. Subd. 1. does not apply to required limitations on health care provider
8 reimbursement rates for health care services to persons who have coverage under the
9 health insurance risk-sharing plan under ch. 149 or are recipients under
10 publicly funded health care programs, including Medical Assistance.

Δ

**DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU**

LRB-2171/1dn

DAK:kmg:rs



To Representative Miller:

1. It may be difficult for some insurers that are defined network plans (health maintenance organizations and preferred provider plans) meaningfully to comply with s. 146.385 (5) in this bill. Most defined network plans operate on the basis of a capitated rate for services; this corresponds more to a premium rate charged to beneficiaries by an indemnity insurer than to a reimbursement rate paid by the indemnity insurer to a health care provider. Also, some defined network plans directly employ their staff, and it may be difficult to translate staff wages into reimbursement to the staff per health care service rendered. Would it be more helpful to have in the bill, besides reporting by health care providers and insurers, a third category of reporting entities that are defined network plans and health care providers associated with them?

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.state.wi.us

2. Please note that I interchange^{s.} d^{s.} 146.385(4) with 146.385(5) in this redraft and that I added the word "identical" to "services" in s. 146.385(3)(c).

Please let me know if I may provide you with further assistance concerning this draft.

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-2171/1dn
DAK:kmg:rs

November 13, 2003

To Representative Miller:

1. It may be difficult for some insurers that are defined network plans (health maintenance organizations and preferred provider plans) meaningfully to comply with s. 146.385 (5) in this bill. Most defined network plans operate on the basis of a capitated rate for services; this corresponds more to a premium rate charged to beneficiaries by an indemnity insurer than to a reimbursement rate paid by the indemnity insurer to a health care provider. Also, some defined network plans directly employ their staff, and it may be difficult to translate staff wages into reimbursement to the staff per health care service rendered. Would it be more helpful to have in the bill, besides reporting by health care providers and insurers, a third category of reporting entities that are defined network plans and health care providers associated with them?
2. Please note that I interchanged s. 146.385 (4) with s. 146.385 (5) in this redraft and that I added the word "identical" to "services" in s. 146.385 (3) (c).

Please let me know if I may provide you with further assistance concerning this draft.

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.state.wi.us

Kennedy, Debora

From: Miller, Mark
Sent: Thursday, January 22, 2004 11:30 AM
To: Kennedy, Debora
Cc: Kuhn, Jamie
Subject: LRB2171/1 Informed medical Consumer

Debora,

Please redraft LRB2171 to:

1. page 3, (beginning with the last word on page 2), lines 1-2: modify to give the department the discretion to determine how the rates will be stated which may include "percentage of the Medical Assistance fee schedule," i.e., the department may require dollars/cents and/or any other form including percentage of MA fee. I want to include reference to the MA fee, but not require that the rates be stated in comparison to the fee.

2. page 3, delete lines 10-16

Please let me know if you think these changes require changes elsewhere in the bill.

I hope this is a simple change which can be accomplished by Friday (tomorrow).

Thank you.

Mark

Mark Miller

48th Assembly District

P.O. Box 8953

Madison, WI 53708

Phone 608.266.5342, FAX 608.282.3648

rep.miller@legis.state.wi.us



2003 BILL

The rates must be stated in a form, as determined by DHFS, that may include statement

- 1 AN ACT to create 146.385 of the statutes; relating to: health care provider
2 service rates and insurer health care reimbursement rates.

Analysis by the Legislative Reference Bureau

This bill requires the Department of Health and Family Services (DHFS) annually by April 1 to make available, on the DHFS website and, upon request, by mail, the current Medical Assistance (MA) fee schedule for services of health care providers (as defined in the bill). The bill requires health care providers, annually by April 15, to provide to DHFS a statement of the providers' rates for the following May 1 to April 30 of the following year ^{stated} as a percentage of the MA fee schedule. In addition, health care providers, annually beginning on May 1, must post their rates on an Internet website, if the health care provider has such a website, and, if requested by a health care consumer, must provide a statement of the rates by mail, facsimile transmission, or electronic mail. Each health care provider must charge identical rates for identical health care services to each patient served by the health care provider, except for individuals under programs with limits on health care provider reimbursement rates, such as the Health Insurance Risk-sharing Plan or MA. Before April 1 annually, no health care provider may charge rates for health care services that exceed rates stated by the provider for the 12-month period prior to that April 1; if a health care provider violates this prohibition, neither the patient for whom the services were rendered and the excess rate was charged nor the patient's insurer is liable for the difference between the health care provider's stated rates and the actual rate charged.

Lastly, the bill requires insurers, annually by April 15, to provide to DHFS and to the insurers' insureds a statement of the insurers' rates of reimbursement for

BILL

health care provider services for the following May 1 to April 30, stated as a percentage of the MA fee schedule.

For further information see the *state and local* fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

1 **SECTION 1.** 146.385 of the statutes is created to read:

2 **146.385 Health care provider charges; limitations.** (1) In this section:

3 (a) “Health care provider” means any of the following that receives income from
4 the provision of health care or mental health services, items, or supplies in this state:

5 1. An individual who is licensed, registered, permitted, or certified by the
6 department of health and family services or by the department of regulation and
7 licensing to provide health care or mental health services, items, or supplies.

8 2. A partnership, corporation, or limited liability company of individuals
9 specified in subd. 1.

10 3. A facility or agency that provides health care or mental health services,
11 items, or supplies.

12 (b) “Insurer” means an insurer that is authorized to do business in this state,
13 in one or more lines of insurance that includes health insurance, and that offers
14 health care plans, as defined in s. 628.36 (2) (a) 1., covering individuals in this state.

15 (2) By April 1 annually, the department shall make available on the
16 department’s website and, upon request, by mail, the current Medical Assistance fee
17 schedule for health care services of health care providers.

18 (3) (a) By April 15 annually, a health care provider shall provide to the
19 department, on a form provided by the department, a statement of the provider’s
20 rates for the period from the following May 1 to April 30 of the following year. The

BILL

in a form determined by the department that may include statement

1 rates shall be stated as a percentage of the Medical Assistance fee schedule for
2 services of providers, as specified by the department under sub. (2).

3 (b) Beginning on May 1 annually, a health care provider shall, with respect to
4 the provider's rates for the period from that date to April 30 of the following year, do
5 all of the following:

6 1. If the health care provider has an Internet website, post the rates on the
7 website.

8 2. If requested by a health care consumer, provide a statement of the rates by
9 mail, facsimile transmission, or electronic mail.

10 (c) 1. Except as provided in subd. 2., each health care provider shall charge
11 identical rates for identical health care services to each patient served by the health
12 care provider.

13 2. Subd. 1. does not apply to required limitations on health care provider
14 reimbursement rates for health care services to persons who have coverage under the
15 Health Insurance Risk-sharing Plan under ch. 149 or are recipients under publicly
16 funded health care programs, including Medical Assistance.

17 (4) (a) Before April 1 annually, no health care provider may charge rates for
18 health care services of the health care provider that exceed the rates stated by the
19 provider under sub. (3) for the 12-month period prior to that April 1.

20 (b) If a health care provider violates par. (a), neither the patient for whom the
21 health care provider's health care services were rendered and for whom the excess
22 rate was charged nor the patient's insurer is liable to the health care provider for the
23 difference between the health care provider's rate, as specified under par. (a), and the
24 actual rate charged.

Kennedy, Debora

From: Miller, Mark
Sent: Wednesday, January 28, 2004 6:26 PM
To: Kennedy, Debora
Cc: Kuhn, Jamie
Subject: FW: Medical Transparency, LRB 2171
Importance: High

Debora,

I thought I included you among the cc addresses, but see I did not. The parties all concur with these drafting instructions.

I will be in Thursday morning if you have questions on these.

Mark

Mark Miller

*48th Assembly District
P.O. Box 8953
Madison, WI 53708
Phone 608.266.5342, FAX 608.282.3648
rep.miller@legis.state.wi.us*

-----Original Message-----

From: Rep.Miller
Sent: Wednesday, January 28, 2004 11:40 AM
To: Rep.Underheim; Sandra Lonergan (E-mail); Rep.Gielow
Cc: Kuhn, Jamie; Thorson, Randy
Subject: Medical Transparency
Importance: High

Sandra Lonergan, Randy, and I met this morning to coordinate the FINAL drafting instructions for LRB2171, Medical Transparency, also known as the Informed Medical Consumer Act. Below are the proposed instructions. Please get back to me with your concurrence of objections **today** so I can send these instructions to Debora Kennedy, the LRB attorney who is drafting this legislation NLT Friday morning.

- ✓ 1. Delete the requirement that the charges be held constant for a year. Price increases are effective upon posting and transmittal to the Department.
- ✓ 2. Charges posted to a website must be in downloadable form.
- ✓ 3. Providers must take reasonable steps to assure that customers are aware that price information is available and how to access the information.
- ✓ 4. Allow the Department the option of contracting for the receipt and posting of price information, but require the Department to enter into a formal RFP process for such a contract.

Thank you.

Mark

01/29/2004

Mark Miller

48th Assembly District

P.O. Box 8953

Madison, WI 53708

Phone 608.266.5342, FAX 608.282.3648

rep.miller@legis.state.wi.us

1/29/04 From Rep Meehan:

DHFS shd have option of posting re provider rates (but must post MA fee schedule)

DHFS shd also have option of posting itself or King out for it to be done.



2003 BILL

INSERT ANAL 2

INSERT ANAL 1

services

for health care services

STET

1 AN ACT to create ^{gen. cat.} 146.385 of the statutes; relating to: health care provider
2 service rates and insurer health care reimbursement rates.

Analysis by the Legislative Reference Bureau

This bill requires the Department of Health and Family Services (DHFS) annually by April 1 to make available, on the DHFS website and, upon request, by mail, the current Medical Assistance (MA) fee schedule for services of health care providers (as defined in the bill). The bill requires health care providers, annually by April 15, to provide to DHFS a statement of the providers' rates for ~~the following~~ May 1 to April 30 ~~of the following year~~. The rates must be stated in a form, as determined by DHFS, that may include statement as a percentage of the MA fee schedule. In addition, health care providers, annually beginning on May 1, must post their rates on an Internet website, if the health care provider has such a website, and, if requested by a health care consumer, must provide a statement of the rates by mail, facsimile transmission, or electronic mail. Before April 1 annually, no health care provider may charge rates for health care services that exceed rates stated by the provider for the 12-month period prior to that April 1; if a health care provider violates this prohibition, neither the patient for whom the services were rendered and the excess rate was charged nor the patient's insurer is liable for the difference between the health care provider's stated rates and the actual rate charged.

~~lastly~~ the bill requires insurers, annually by April 15, to provide to DHFS and to the insurers' insureds a statement of the insurers' rates of reimbursement for health care provider services for the following May 1 to April 30, stated as a percentage of the MA fee schedule.

INSERT ANAL 3

BILL

For further information see the *state and local* fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

⑧ service rate

1 SECTION 1. 146.385 of the statutes is created to read:

② 146.385 Health care provider charges; limitations. (1) In this section:

3 (a) "Health care provider" means any of the following that receives income from
4 the provision of health care or mental health services, items, or supplies in this state:

5 1. An individual who is licensed, registered, permitted, or certified by the
6 department of health and family services or by the department of regulation and
7 licensing to provide health care or mental health services, items, or supplies.

8 2. A partnership, corporation, or limited liability company of individuals
9 specified in subd. 1.

10 3. A facility or agency that provides health care or mental health services,
11 items, or supplies.

, in a form that is downloadable,

12 (b) "Insurer" means an insurer that is authorized to do business in this state,
13 in one or more lines of insurance that includes health insurance, and that offers
14 health care plans, as defined in s. 628.36 (2) (a) 1., covering individuals in this state.

15 (a) (2) By April 1 annually, the department shall make available on the
16 department's website and, upon request, by mail, the current Medical Assistance fee
17 schedule for health care services of health care providers.

✓ INSERT 2-17

STET

18 (3) (a) By April 15 annually, a health care provider shall provide to the
19 department, on a form provided by the department, a statement of the provider's
20 rates for the period from ~~the following~~ May 1 to April 30 ~~of the following year~~. The
21 rates shall be stated in a form determined by the department that may include

for health care services

INSERT 2-20

BILL

1 statement as a percentage of the Medical Assistance fee schedule for services of
2 providers, as specified by the department under sub. (2). (a)

3 (b) Beginning on May 1 annually, a health care provider shall, with respect to
4 the provider's rates for the period from that date to April 30 of the following year, do
5 all of the following: , including any rate increases,

6 1. If the health care provider has an Internet website, post the rates on the
7 website. , in a form that is downloadable

8 2. If requested by a health care consumer, provide a statement of the rates by
9 mail, facsimile transmission, or electronic mail.

10 (4) (a) Before April 1 annually, no health care provider may charge rates for
11 health care services of the health care provider that exceed the rates stated by the
12 provider under sub. (3) for the 12-month period prior to that April 1.

13 (b) If a health care provider violates par. (a), neither the patient for whom the
14 health care provider's health care services were rendered and for whom the excess
15 rate was charged nor the patient's insurer is liable to the health care provider for the
16 difference between the health care provider's rate, as specified under par. (a), and the
17 actual rate charged.

18 (5) By April 15 annually, an insurer shall provide to the department, on a form
19 provided by the department, and to the insurer's insureds a statement of the
20 insurer's rates of reimbursement for health care services of health care providers for
21 the period from ~~the following~~ May 1 to April 30 of ~~the following year~~. The rates of

22 reimbursement shall be stated as a percentage of the Medical Assistance fee
23 schedule for health care services of health care providers, as specified by the
24 department under sub. (2). (a)

(END)

INSERT
3-17

STET

INSERT
3-21

INSERT ANAL 1 ✓

no # Health care providers must also inform DHFS, during this period, of any increase in any of their rates over the amounts provided to DHFS.

INSERT ANAL 2 ✓

no # take reasonable steps to ~~assure~~^{ensure} that their health care services consumers are aware that rate information is available and are informed about how to obtain the information. Any increase in a health care provider's rates is chargeable only after the health care provider has notified DHFS and, if the health care provider has a website, has posted information on the website about the rate increase.

INSERT ANAL 3 ✓

no # Insurers must also inform DHFS, during this period, of any increase in any of their rates over the amounts provided to DHFS.

DHFS may make available, on the DHFS website and, upon request, by mail, the health care provider rate and insurer reimbursement rate information, including increases, provided to DHFS. DHFS is also authorized to contract for the receipt and posting of this information and the current MA fee schedule for health care provider services, in accordance with ~~the~~ DHFS^{request} request-for-proposal procedures.

INSERT 2-17 ✓

1 (b) The department may make available on the department's website, in a form
2 that is downloadable, and, upon request, by mail, all of the following:

3 1. The current insurer rates of health care providers provided to the
4 department under sub. (3) (a), including any rate increases about which the
5 department is informed under sub. (3) (a).

6 2. The current rates of reimbursement for health care services of health care
7 providers provided to the department under sub. (5), including any rate increases
8 about which the department is informed under sub. (5).

9 (c) The department may contract for the receipt of information under sub. (3)
10 (a) or (5) and for the posting of the information under par. (a) or (b), in accordance
11 with the department's request-for-proposal procedures.

No R

INSERT 2-20

If during this period the health care provider increases any of the rates from the amount stated, the health care provider shall so inform the department, on a form provided by the department.

ensure

INSERT 3-17

2. Take reasonable steps to assure that health care consumers of services of the health care provider are aware that information on the provider's rates for health care services is available and are informed about the means by which the rate information may be obtained.

(4) Any increase in a rate for the health care service of a health care provider is chargeable only after the health care provider has under sub. (3) (a) informed the department of the increase and has, if applicable, posted the rate increase under sub. (3) (b) 1.

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INSERT 3-21

If during this period the insurer increases any of the rates of reimbursement from the amount stated, the insurer shall so inform the department, on a form provided by the department.

Memo

To: Senator

Representative

Miller

(The Draft's Requester)

Per your request: ... the attached fiscal estimate was prepared for your unIntroduced 2003 draft.

LRB Number: LRB

-2171

Version:

“/3”

Fiscal Estimate Prepared By: (agency abbr.)

DHFS

If you have questions about the enclosed fiscal estimate, you may contact the state agency representative that prepared the fiscal estimate. If you disagree with the enclosed fiscal estimate, please contact the LRB drafter of your proposal to discuss your options under the fiscal estimate procedure.

Entered In Computer And Copy Sent To Requester Via E-Mail:

02 / 23 / 2004

* * * * *

To: LRB – Legal Section PA's

Subject: *Fiscal Estimate Received For An Unintroduced Draft*

> **If redrafted** ... please insert this cover sheet and attached early fiscal estimate into the drafting file ... after the draft's old version (the version that this fiscal estimate was based on), and before the markup of the draft on the updated version.

> **If introduced** ... and the version of the attached fiscal estimate is for a **previous version** ... please insert this cover sheet and attached early fiscal estimate into the drafting file ... after the draft's old version (the version that this fiscal estimate was based on), and before the markup of the draft on the updated version. Have Mike (or Lynn) get the ball rolling on getting a fiscal estimate prepared for the introduced version.

> **If introduced** ... and the version of the attached fiscal estimate is for the **current version** ... please write the draft's introduction number below and give to Mike (or Lynn) to process.

THIS DRAFT WAS INTRODUCED AS: 2003 _____

Barman, Mike

From: Barman, Mike
Sent: Monday, February 23, 2004 8:52 AM
To: Rep.Miller; Kuhn, Jamie
Subject: LRB 03-2171/3 (FE by DHFS - attached - for your review)



FE_Miller.pdf