
MARYLAND
OFFICE OF THE
ATTORNEY GENERAL

Outpatient Facility Fees: Consumer Harms and Prevention

Senate Finance Committee Briefing

November 12, 2019

Patricia F. O'Connor, Esq.

Deputy Director

Office of the Attorney General

Health Education and Advocacy Unit

Example

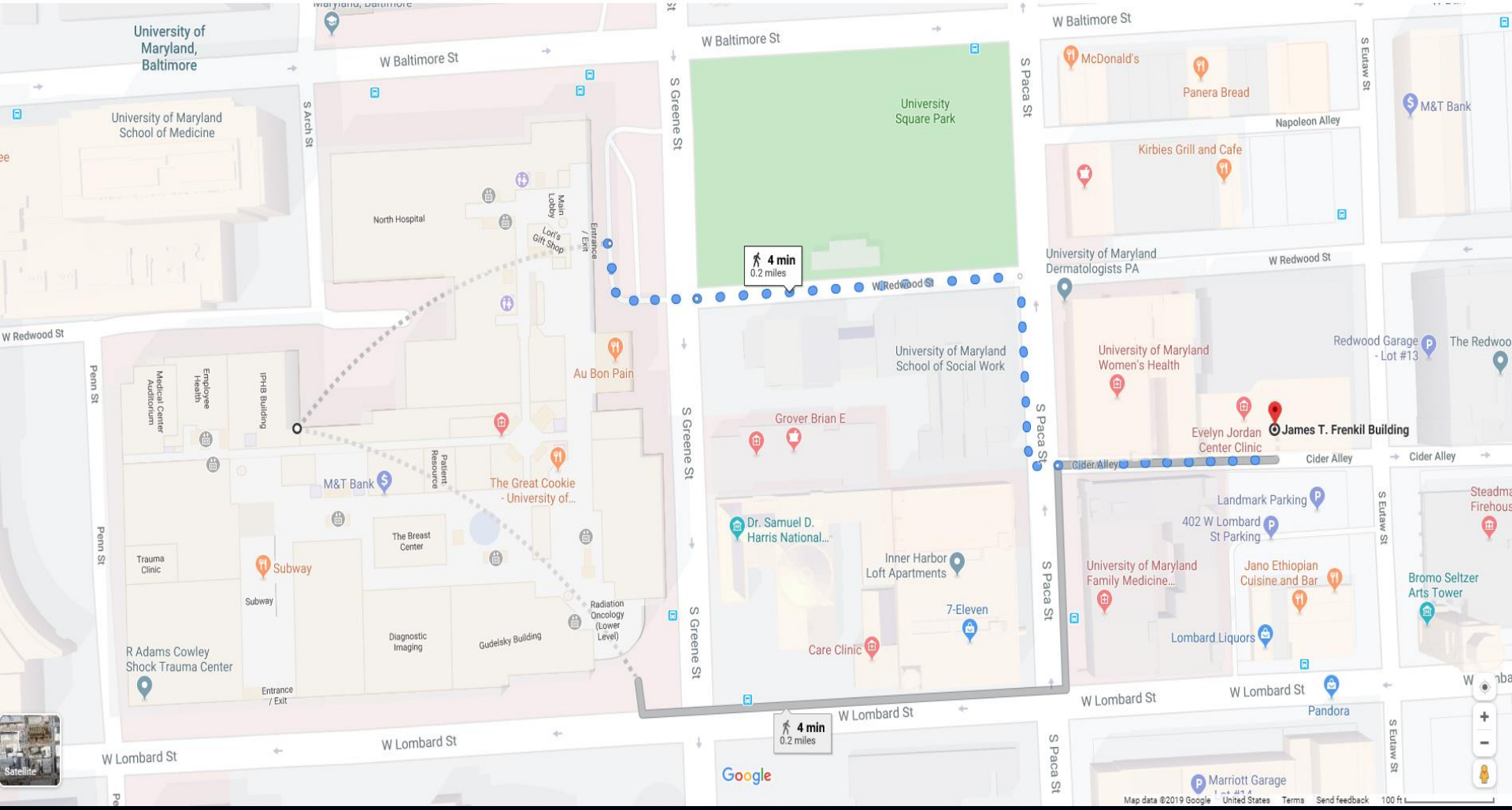
A 47-year old woman was referred by her doctor for a consultation with a neurologist. Her appointment with the neurologist was in a professional building around the corner from a hospital. Following the brief examination she received a $120 bill from the neurologist, which she expected. What she did not expect was a $1,465.82 hospital bill for the same visit.

Google Maps University of Maryland Medical Center to James T. Frenkil Building

You can enter notes here.

Walk 0.2 mile, 4 min

Cancel Print



Another Example

A 55-year old woman woke up one morning with serious eye pain. She called her eye doctor and was offered an appointment in one of two locations - one was “at the hospital” - one was not. She was **not told** that additional fees would be billed for identical services provided “at the hospital.”

Following her visit she received a $553.71 bill from the hospital and a $182.58 bill from her provider.

What *is* "At the Hospital"?

- At the hospital "means a service provided in a building on the campus of a hospital in which hospital services are provided."

  COMAR 10.37.10.07-1

- But the neurologist in the first example was not at the hospital - he was in a professional building blocks away

- And some floors in the building are deemed at the hospital while others are not

What *is* "At the Hospital"?

-In deciding whether an outpatient service is "at the hospital" HSCRC considers many regulatory factors

-The various factors seem intended to signal to consumers that they are physically at a hospital

"At the Hospital" Factors

Some of the factors HSCRC considers:

- Location of entrances
- Location and signage of parking
- Location and language of signage at entrances and within the campus
- Signage should "effectively alert the public that a given building or service is either at the hospital or not at the hospital."
- Location of registration, changing and waiting areas

"At the Hospital" is Confusing

- Whether there is inappropriate mixing of regulated and unregulated services in the same building, which would tend to have the effect of confusing patients.

- Whether any physical connection from an unregulated facility to the hospital is restricted to ensure that patients don't have access to an unregulated facility from the hospital.

  COMAR 10.37.10.07-1.G(1)-(9)

Remedies Proposed by Consumers Assisted by HEAU

Elimination

Notification

Revision

Revision: Consumers Seek a Common Sense Approach That is Fair

Hospital Necessary

$

Hospital not Necessary

$

Hospital is Not Necessary for E/M Services and Other Procedures

Evaluation and Management (E/M) services have long been provided in offices and so have many other procedures, including:

-Eye exams

-Allergy testing

-EMG testing, EKGs, Radiology

-Dermatology procedures

-Injections and infusions, chemotherapy and non-chemotherapy

-Occupational therapy

-Physical Therapy

Current Regulatory Scheme Ends Up Favoring Hospitals at the Expense of Consumers and the Marketplace

Hospital necessary

$

Hospital not necessary

$

More Examples

SERVICE	PROVIDER FEE	HOSPITAL FEE
EMG in Provider's Office (Not Clinic Rate)	$1,059	$1,746
Annual Eye Exam (Clinic Rate – not E/M)	$ 425	$1,141
EMG/NCS in Provider's Office (Not Clinic Rate)	$1,137	$ 627
Eye Exam (Clinic Rate – not E/M)	$ 345	$ 554
Ear Exam and Cleaning (Not Clinic Rate)	$ 297	$ 557
Rheumatology Visit (Clinic Rate – E/M)	$ 205	$1,685

Current Consumer Harms

- Lack of Notice
- No additional value over a regular office visit
- Outpatients expecting 1 bill end up with 2 bills
- 2 co-pays, not 1
- 2 co-insurance payments, not 1
- If both bills are within unmet deductibles, outpatients must pay both bills on their own
- Debt collection
- Increased costs leading to higher premiums
- Anger, stress, frustration - preventable harm

Hospital Services and Procedures Provided in an Outpatient Clinic

- Clinic services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients

- Services billed as “Clinic Services” are categorized as Evaluation and Management (E/M) services or non-surgical procedures

Surgical procedures, diagnostic tests, and other services such as EEG, EKG, laboratory, lithotripsy, physical therapy, occupational therapy, radiation therapy, etc. are provided in outpatient clinics but are billed under the specific rate centers, not at the clinic rate

HSCRC's Billing Manual, Appendix D, Clinical Services, Standard Unit of Measure References, Page 95

Facility Fee = Rate x RVUs

- The facility fee for **E/M SERVICES** is the product of the hospital's clinic rate multiplied by the assigned billing units (RVUs)
- Hospitals charge 7 RVUs to a patient receiving 45 minutes worth of "hospital services" or "clinical care time" during an E/M doctor's visit (p. 97)
- But the prices vary due to different clinic rates:

Mercy $29.12 x 7 = $203.84

UMMC $79.73 x 7 = $558.11

Sinai $88.91 x 7 = $622.37

Limited Clinic Facility Fees
Outside Providers

Exception

- When patient sees only an *outside provider*, the hospital may only report a Level 1 E/M visit (2 RVUs) (p. 97)
- *Outside Provider* – physician or other provider who bills professionally and is not included on the hospital's wage and salary reporting schedule (p. 97)

E/M Clinical Care Time "CCT"

- Combined total amount that each non-physician spends treating the patient
- It doesn't have to be face-to-face
- Multiple people can provide CCT to the same patient simultaneously
- Can be direct (e.g. wound cleansing) or indirect patient care (e.g. calling for lab results) (pp. 95-96)

- The facility fee for **a PROCEDURE** is based on assigned RVUs *or* a hospital's internal guidelines (p. 97)

EXAMPLE

92083 Visual field exam 6 units (p. 104)

- The prices vary due to hospitals' different rates:

Mercy $29.12 x 6 = $174.72

UMMC $79.73 x 6 = $478.38

Sinai $88.91 x 6 = $ 533.46

EXAMPLE

95886 EMG 13 units (p. 51)

Mercy $14.66 x 13 = $190.58

UMMC $14.151 x 13 = $183.95

Sinai $11.66 x 13 = $151.58

- This procedure is not billed at the clinic rate even though it is delivered in the clinic

HSCRC: Notice is Feasible

Hospitals are able to provide price information to consumers before they commit to an appointment because:

- Rates are set by HSCRC
- RVUs are assigned by HSCRC for most procedures (Clinic E/M services, Clinic non-E/M services, other commonly performed outpatient procedures)
- New or rare procedures must be billed according to standardized, internal guidelines maintained by each hospital

2019 Facility Fee Right to Know Act

Hospitals charging outpatient facility fees must tell consumers ORALLY AND IN WRITING, *WHEN THEY MAKE AN APPOINTMENT:*

- That the appointment will take place at the hospital
- That the hospital will charge an outpatient facility fee that is separate from the professional fee charged by the provider
- Whether the same service could be obtained from the provider at a non-hospital location (with instructions to check with carrier about network status of other location)
- That receiving services at the hospital may result in greater financial liability than receiving the services at another location
- That consumers should contact their carrier to determine coverage and estimated financial responsibility, including co-payments, coinsurance, or deductible amounts

2019 Facility Fee Right to Know Act

- The amount of the facility fee, if known, otherwise the range of fees including an estimate based on typical or average fees for the same or similar appointment

- That actual amount incurred will depend on services actually provided

- Hospitals cannot collect fee unless consumer was notified

- Notices must be in plain language and available in alternative languages, as practicable

2019 Facility Fee Right to Know Act

- Hospitals report yearly to HSCRC all rate-regulated outpatient services
- HSCRC posts the list and provides to HEAU and MIA
- Also discussion about posting all rate-regulated locations (posted by HSCRC now but list is not current or easy to find)

What Have Other States Done?

Alaska: Alaska Stat. 18.23.400 (effective January 1, 2019)

California: Cal. Health & Safety Code 1323.1 (effective January 1, 2017)

Connecticut: Conn. Gen. Stat. 19a-508c (effective October 1, 2014); C.G.S.A 38a-477bb (effective October 1, 2015)

Florida: Fla. Stat. 395.301 (effective July 1, 2019)

Massachusetts: Mass. Gen. Laws. 111 § 228 (effective January 1, 2014); 170 § 23 (effective October 1, 2014)

Minnesota: Minn. Stat. 62J.824 (effective August 1, 2019)

Nebraska: Neb. Rev. Stat. §44-1404 (effective July 19, 2019)

Texas: V.T.C.A., Health & Safety Code §254.156 (effective September 1, 2019)

Washington: Wash. Rev. Code 70.01.040 (effective January 1, 2013)

Alaska

Annual List (Providers and Hospitals)

10 services most commonly performed in prior year for each of 6 CPT sections

- Procedure Code
- Undiscounted Price
- Facility Fees
- Right to request estimate for non-emergent care
- Can include statement that undiscounted price may be higher or lower than the amount the individual actually pays

Alaska

Annual List (Providers and Hospitals)

- Provided to Department for posting
- Posted in conspicuous public reception area in font no smaller than 20 points
- Posted on website
- Lists any insurers the provider/facility is contracted with as an in-network preferred provider

Alaska

Estimate Request

(Provider, Facility, Insurer)

- Good faith
- Non-emergent services
- Before services provided, but not later than 10 business days of request
- In format patient requests
- Fees or reasonable range if services could vary significantly

Alaska

Estimate Request

(Provider, Facility, Insurer)

- Brief description of services included
- Network status (specific language)
- Procedure codes
- Facility fees, along with fee explanation
- The identity of anyone else who might charge the patient for the services, and if their fees are included in the estimate

California

Notice of Non-Hospital Based Location

Shall notify each patient scheduled for a service in a hospital-based outpatient clinic (department of a provider that is more than 250 yards from the main campus) when that service is available in a non-hospital based location

- You may have higher costs
- Check with [named office and phone number] for another location or insurance carrier about other locations

Connecticut

- **Requires oral notice when scheduling** services for which a facility fee may be charged, including that:
  - the facility is part of a hospital system
  - the hospital system may charge a facility fee on top of the provider's professional fee, and
  - the patient may call a telephone number for information about the patient's potential financial liability
- **Prohibits facility fees for E/M services provided off-site** from a hospital campus (campus includes the area within two hundred fifty yards of the main hospital buildings)

Connecticut

Requires written notice of facility fees for E/M services provided on campus, including:

- There will be a hospital facility fee on top of the provider's professional fee
- **The amount of the patient's potential financial liability**, including any facility fee and any professional fee likely to be charged, or, if the professional medical services needed are not known or health insurance coverage is not known with reasonable certainty, **an estimate of the patient's financial liability based on typical or average charges for visits to the facility**

Connecticut

- A statement that actual financial liability depends on the services actually provided
- An explanation that you may pay more here than at a non-hospital based facility
- A **telephone number to call for more information about potential financial liability**, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services
- That the patient should ask the health insurer for more information about the hospital's charges and fees, including the patient's potential financial liability, if any, for such charges and fees

Connecticut

FORM

Written notice shall be in **plain language** and in a form that may be **reasonably understood by a patient** who does not possess special knowledge regarding hospital facility fee charges

TIMING

- For appointments **ten or more days after the appointment is made**, written notice shall be sent to the patient by **first class mail, encrypted electronic mail or a secure patient Internet portal** within than **three days** after the appointment is made
- For an appointment scheduled to occur **less than ten days after the appointment is made** or if the patient arrives without an appointment, notice shall be **hand-delivered upon arrival**

Connecticut

Yearly report to Office of Health Strategy concerning facility fees charged

- Name and location of each facility that charges fee
- Number of patient visits at each facility
- The number, total amount and range of allowable fees paid at each facility by Medicaid, Medicare, private policies
- Total facility fee revenue
  - Ten procedures that generated the most fees

Florida

- Publish on website, in plain language, information on payments made for defined bundles of services and procedures
- Estimated average payment received from all payers (excluding Medicare and Medicaid) for service bundles and the estimated payment ranges for such bundles
- Notice that payment ranges are an estimate of costs and that the actual costs will be based on services actually provided to the patient
- Information about financial assistance policy
- Notify patients that other providers may separately bill and may or may not participate with the same health insurers as the facility

Florida

- Inform patients that they can request a more personalized estimate of charges from the facility and should contact each health care provider who will provide services to determine network status
- Provide names and contact information of providers with whom the facility contracts and instructions on how to contact them to determine network status

Florida

- Upon request, and before providing non-emergent services, shall provide, in writing or electronically, a good faith **estimate** of reasonably anticipated charges
- Not required to adjust the estimate for potential insurance coverage
- Estimate may be based on descriptive service bundles unless the patient requests a more specific estimate
- Inform the patient that she may contact carrier for additional information on cost-sharing
- Inform the patient about financial assistance policy
- Estimate must clearly identify any facility fee, the purpose of the fee and that the patient may pay less in another setting
- Revise estimate on request
- Public outreach about right to estimates

Massachusetts

PROVIDER NOTICE

- Prior to an admission, procedure or service, or upon request
- Disclose the allowed amount or charge, including any facility fee
- If unable to quote specific amount due to inability to predict specific treatment – disclose estimated maximum allowed amount or charge, including any facility fees required
- In-network providers shall, upon request, provide sufficient information for the patient to obtain out-of-pocket costs from the consumer's health plan
- Health plan must provide toll free number and website consumers can use to obtain out-of-pocket costs

Massachusetts

CARRIER INFORMATION

- Establish toll-free telephone number and website that enables consumer to request and obtain, in real time:
  - The estimated or maximum allowed amount or charge for a proposed admission, procedure or service
  - The estimated amount the insured will be responsible to pay
  - Based on information available to the carrier at the time the request is made
  - Includes any facility fee, copayment, deductible, coinsurance or any other out-of-pocket costs
- Consumer not required to pay more than the disclosed amounts, except for unforeseen services that arise
- Alert consumer that costs are estimated and could vary due to unforeseen services that could arise

Minnesota

- Prior to delivery of non-emergent services, a provider-based clinic (off-campus – at least 250 yards from main hospital/some exceptions noted) that charges a facility fee, shall provide notice that the clinic is part of the hospital and the patient may receive a separate charge for the facility component, which may result in higher out-of-pocket expense
- Post a statement on the website and in prominent locations that the clinic is part of the hospital and patient may receive a separate charge, which may result in higher out-of-pocket costs

Nebraska

PROVIDER NOTICE

- Prior to non-emergent admission, procedure or service or upon request
- Health care entity within patient's network shall disclose the allowed amount or charge, including any facility fee
- Health care entity outside the patient's network shall disclose the amount that will be charged, including any facility fee
- If unable to quote specific amount due to inability to predict specific treatment:
  - – disclose estimated maximum allowed amount or charge, including any facility fees required
  - - disclose incomplete nature of the estimate and right to obtain updated estimate once additional information is obtained
- In-network providers shall, upon request, provide sufficient information for the patient to obtain out-of-pocket costs from the consumer's health plan

Nebraska

CARRIER INFORMATION

- Establish interactive mechanism on website that enables consumer to request and obtain:
  - Information on the payments made by the insurance carrier to network providers for healthcare services
  - The cost of a particular service to compare costs among network providers

Nebraska

CARRIER INFORMATION

- Within 2 working days of request, shall provide good faith estimate of consumer's out-of-pocket costs for a proposed admission, procedure or service from carrier's in-network provider
- Based on information available to the carrier at the time the request is made
- Includes any facility fee, copayment, deductible, coinsurance or any other out-of-pocket costs
- Carrier not prohibited from imposing cost-sharing not disclosed for unforeseen healthcare services
- Alert consumer that costs are estimated and could vary due to unforeseen services that could arise

Texas

FREESTANDING EMERGENCY CARE FACILITIES

Facility shall post easily accessible and understandable disclosures on its website:

- The facility's standard charges, including the observation and facility fees that may result from the visit, and for each, the facility's median facility fee, a range of possible facility fees, and the facility fees for each level of care provided at the facility
- In-network and out-of-network information
- Updated at least annually

In the alternative, the facility shall provide written disclosures, and have patients sign them

All facilities must post physical notices about facility fees

Washington

OFF-CAMPUS CLINIC OR PROVIDER OFFICE

If the facility charges a facility fee, it shall provide a **notice** (which is not specified) to any patient that the clinic is licensed as part of the hospital and the patient may receive a separate charge or bill, which may result in a higher out-of-pocket expense

The facility must prominently post this information in locations visible and accessible to patients, including its website

Hospitals that own or operate the facilities must annually report the number of facilities; the number of patient visits with a facility fee; the annual revenue for each facility; and the range of facility fees paid by public or private payers at a facility

Preventing Consumer Harm in Maryland

- Consumers don't expect to pay overhead costs unrelated to the outpatient services they receive
- Consumers don't think they should have to pay those costs, based on common sense and fairness
- If required to pay unanticipated costs, consumers want to know about it beforehand so they can make informed decisions and avoid financial harm