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March 2, 2020

To: The Honorable Shane E. Pendergrass
Chair, Health and Government Operations Committee

From: Patricia F. O'Connor, Health Education and Advocacy Unit

Re: House Bill 915 Health Facilities - Hospitals - Disclosure of Outpatient Facility Fees (Facility Fee Right-to-Know Act): Support with Amendments

The HEAU submits the following written testimony in support of House Bill 915, the Facility Fee Right to Know Act, which affirmatively requires that consumers be given notice of hospital facility fees at the time they make their appointments, allowing them to have the information they need to make an informed decision about where to obtain affordable care.

Patients who visit healthcare providers in outpatient offices on a hospital's "campus" are often unaware that their visit is taking place "at the hospital" and that they will be billed by both the healthcare provider *and* the hospital for their provider visit.

EXAMPLE: A patient was referred by her orthopedic surgeon to a neurologist for a neurologic consultation. The neurologist's office was located in a building near, but on a different street than, the hospital. Following her routine office visit, the neurologist billed the patient $119.52. The hospital also billed her $1,465.82 because the building where the neurologist's office was located was "at the hospital". Both charges were within her $3,500 deductible. Had the patient known about the $1,500 hospital charge for the visit, she would not have made or kept the appointment with this neurologist at this location; she would have chosen more affordable care somewhere else.

Hospitals can charge outpatient facility fees if approved by the Health Services Cost Review Commission (HSCRC). Among other things, a facility's location and

signage must alert "the public that a given building or service is either at the hospital or not at the hospital."

Even the clearest signs, if seen by patients when they appear for their appointments, omit material fee information. Patients need to know they will be charged a facility fee and the amount or range of the fee. They need to know this information when making their appointments so they can choose affordable settings.

Maryland's hospital regulatory scheme currently does not expressly require that outpatients be given advance notice of hospital facility fees and alternative fee-free locations to seek their care. Patients know providers will bill them but have complained about surprise bills for facility fees that may be double or triple the provider fee. Information about these fees is material information that should have been provided consistent with the requirements of the Consumer Protection Act, but patients frequently do not receive the information that they need to decide where to receive their care. The Right to Know Act is needed to expressly require information be given to patients so that they may protect themselves from surprise, excessive hospital facility fees like these in complaints filed with the HEAU (Doctor Fee/ Hospital Facility Fee): $119/$1,456; $205/$1,685; $425/$1,141; $454/$1,729.

Consumers harmed by these fees have repeatedly proposed the same solutions to the HEAU: that the State require notification, revision or elimination of outpatient facility fees charged by hospitals. Some revision is planned by the Health Services Cost Review Commission (HSCRC), we recently learned: effective July 1, 2020, evaluation and management (E/M) clinic charges should decrease overall by approximately 25%. The HSCRC also reportedly plans to convene a workgroup in the upcoming year to address the many other clinic charges for facility fees that are billed by hospitals to consumers.

The HEAU appreciates the remedial work being done by the HSCRC, and thanks the regulators for that work and their support of the notification requirement in the Right to Know Act. That support is manifested in amendments proposed by the HSCRC which are adopted by the HEAU in its amendments. To align the Right to Know Act's definition of 'outpatient services' with HSCRC's current regulatory definition, the regulators have proposed a revised definition that will ensure all consumers of hospital outpatient services will be notified, in advance, that they are "at the hospital," that they will be billed by the hospital, and about the fees they face by receiving the service as a hospital outpatient. CareFirst also concurs with this amendment.

The Maryland Hospital Association has not yet committed to the amendment or the basic principle endorsed by the HEAU, HSCRC and CareFirst and, we believe, both chambers when last session's Right to Know Act was unanimously approved: that all outpatients who are charged hospital facility fees deserve advance notice so they may make informed decisions about where to receive their care. MHA may endorse that

principle today or may submit amendments limiting who receives advance notice, e.g., 'clinic' outpatients only (as MHA seemed to suggest in a stakeholder meeting last week), or patients receiving only evaluation and management "E/M" services (as MHA suggested in the November 2019 legislative briefing about facility fees).

We have attached several exhibits to explain how many consumers would continue to be harmed if hospitals are permitted to deprive some outpatients of advance notice of facility fees. Exhibit 1 is the table of contents to the billing manual used by hospitals to charge for outpatient services. You will note that only one of the 18 revenue centers is 'Clinics.' We have received complaints from consumers surprised by hospital bills when receiving EMGs in a provider's office or mole biopsies in a dermatologist's office. Both services are billed in a revenue center other than "Clinic", and facility fees are charged for the visits, e.g., $1,746 for the EMG on top of a provider fee of $1,059.

Exhibit 2 is the billing manual page that explains that surgical procedures, diagnostic tests, and other services such as EEG, EKG, laboratory, lithotripsy, physical therapy, occupational therapy, radiation therapy, etc. are provided in outpatient settings but are billed under the specific rate centers, not at the clinic rate. The examples in Exhibit 3 are representative of the HEAU complainants who were billed in various revenue centers.

In short, any approach other than the inclusive approach endorsed by the HEAU, HSCRC and CareFirst would perpetuate the harm suffered by consumers when deprived of advance notice of hospital facility fees. Specifically, the Right to Know Act would require hospitals, at the time of making appointments, to notify consumers:

- that they will get a bill from the hospital separate and apart from their providers' bill;
- the amount or estimate and range of fees the hospital will charge an outpatient;
- if the provider can be seen at a location without facility fees;
- that they should contact their insurance carriers about their coverage for outpatient visits; and,
- that financial assistance is available for eligible consumers.

Last year's Right to Know Act specified notice requirements and directed the HEAU, in consultation with the HSCRC, the MHA, consumers and other stakeholders to develop "the uniform disclosure form required" under the Act by December 1, 2019, House Bill 849, p. 6, l. 18-23. During interim, MHA said hospitals want to be able to draft their own notices, and provided the HEAU a sample notice, attached as Exhibit 4. The HEAU is concerned the sample notice shifts disclosure requirements to carriers, which would confuse consumers and is inconsistent with last year's Act.

We believe uniformity and flexibility for hospitals can be achieved using the statutory form notice in this year's Right to Know Act which incorporates the specific requirements from last year's Right to Know Act. The HSCRC and CareFirst agree with and endorse this approach. The Act requires a hospital to use this form or a substantially similar form as the written notice, an approach used successfully in medical records disclosures.[1]

On behalf of consumers, we ask that there be no further delay in providing them the notification that they have been urgently requesting.

We urge a favorable report for the Facility Fee Right to Know Act with amendments as jointly submitted by HSCRC and the HEAU, with CareFirst concurring.

cc: Sponsors and Members of the Health and Government Operations Committee

[1] Md. Code Ann., Health-Gen., § 4-306. Mandatory disclosure of medical record without authorization.

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
TABLE OF CONTENTS

#

Account Number

6720

OVERVIEW: REPORTING STRUCTURE FOR CLINIC SERVICES

DEFINITION OF CLINIC SERVICES

Clinic Services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services will be provided to inpatients (Examples and discussion are included later in this document.)

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Delivery, EEG, EKG, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, Speech Therapy, are to be reported in those specific rate centers.

Clinic services may include either one or both of the following two components: an evaluation and management (E/M) visit, and non-surgical procedures. To report an E/M visit and a procedure on the same day, the E/M service must be separately identifiable. The Medicare definition of separately identifiable is included in the Evaluation and Management section.

RVU ASSIGNMENT OF CLINIC VISITS

The relative value units (RVUs) for the evaluation and management portion of a clinic visit are based on a 5-point visit level scale, while the RVUs for non-surgical procedures are specified by procedure. The development of the RVU values for each component will be explained in more detail in subsequent paragraphs. Clinic procedures considered surgery are to be reported via operating room minutes. The definition of surgical procedures will be explained in more detail later in this section.

RVUs were assigned based on clinical care time (CCT), as described in the E/M section, with a rule of 5 minutes of CCT per 1 RVU. This same logic should be applied to any services that are "by report".

PART 1: EVALUATION AND MANAGEMENT (E/M) COMPONENT

CLINICAL CARE TIME

The evaluation and management portion of the clinic visit is based on a 5-point visit level scale. The amount of clinical care time provided to the patient during the E/M portion of the visit determines the visit level. Clinical care time is the combined total amount of time that each non-physician clinician spends treating the patient. The time does not necessarily have to be face-to-face with the patient, but the patient must be present in the department. The time spent by physicians, and other –physician providers, who bill professionally for their services is not included. It is possible for

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

EXHIBIT 3

Maryland
Hospital Association

NOTE: These requirements do not apply to Medicaid or Medicaid Managed Care patients because there are no out-of-pocket costs.

HOSPITAL FACILITY FEE DISCLOSURE – UNIFORM REQUIREMENTS STANDARDS AND EXAMPLE SCRIPT

BILLING AND FEE DISCLOSURE

- The [ABC MEDICAL PRACTICE] is **an outpatient department** of [MARYLAND HOSPITAL].
- You will receive **two charges** for your visit.
  1. A **physician services bill** from the doctor
  AND
  2. A **hospital facility bill** from [MARYLAND HOSPITAL].
- [MARYLAND HOSPITAL] will charge your insurance company for the hospital facility charge.
- You will receive a bill for any remaining amount you owe after your insurance claim has been processed.
- **For more information on your health insurance, please contact your insurance company. Your insurer can tell you what you should expect to pay.**
  - The average amount billed to your insurance company for the hospital office visit is likely to range from [$XXX to $YYY], based on the level of service required. These estimates are updated at least annually.
  - This is an estimate. The actual charge to your insurance company may change based on the length of your visit and the services you receive. Your costs will depend on your insurance coverage, including any deductibles or co-pays.
  - This estimate is for the hospital fee only. It does not include the doctor's time or other services like minor surgical procedures, X-Ray, MRI, lab, injections, administration of IV therapy, or other treatments. If you need these other services, call your insurance company to find out about additional charges.
- **Financial help for your portion of the hospital bill may be available.** If you need financial help for the hospital services bill, please contact [HOSPITAL/HEALTH SYSTEM CONTACT INFORMATION].

If you have questions or concerns about your insurance payment, please contact your insurance company.

For additional information about insurance or to seek additional consumer support with a compliant contact the Maryland Insurance Administration or the Health Education and Advocacy Consumer Protection Division in the Office of the Attorney General.

Health Education and Advocacy Consumer Protection Division
Call: 410-528-1840 or email heau@oag.state.md.us
http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx

Maryland Insurance Administration
Complaint Phone Number: **410-468-2340** or **1-800-492-6116** select **option 3**, then **option 1**.
https://insurance.maryland.gov/Consumer/pages/FileAComplaint.aspx

DISCLOSURE OF PHYISICAN ALTERNATIVE: Telephone script, website or hard copy

- The services provided by this **physician** or **physician practice [ARE or ARE NOT]** available at a location other than the hospital.
  - **If physician or practice is available at another location**, disclose location and contact information for alternative site.
  - As a patient, you should check with your insurance company to see if there is a lower cost at another location.
  - **If physician or practice is NOT available, remind patient to check with their insurance company to understand their responsibility.**

PATIENT ACKNOWLEDGEMENT *(NOTE: this could be a screen, hardcopy or documentation of verbal notification)*

- As a patient, I acknowledge that the hospital provided information about my visit. I understand I will be billed for the hospital facility AND also for the doctor's fee. The hospital provided me an estimated range of the charges billed to my insurance carrier, that the final charge may vary based on the services I use, and, that my out of pocket costs depend on my insurance coverage. The hospital provided me with billing and insurance contact information.
- By clicking yes (website), confirming verbally (telephone) or signing form (mail), I acknowledged that I've received this information.

HEAU Amendments for HB 915/SB 632
March 2, 2020

AMENDMENT NO. 1

On page 5, in line 1 strike www.Marylandcare.org and substitute **www.MarylandCares.org**

RATIONALE: Correcting error in web address from "care" to "cares" and removing the "." at the end of the web address that could cause problems linking to the webpage.

AMENDMENT NO. 2

On page 5, in lines 23 through 24 strike "WRITTEN NOTICE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION" and substitute **"NOTICE REQUIRED IN THIS SECTION"**

RATIONALE: Both the written and oral notices should be provided in an alternative format, to the extent practicable.

The HEAU adopts HSCRC's March 2, 2020 Proposed Amendments 1 through 4

HSCRC AMENDMENT NO. 1.

On page 2, strike beginning with "**SERVICES**" in line 12 down through "**SERVICES**" in line 16 and substitute **", INCLUDING THE USE OF HOSPITAL FACILITIES, CLINICS, SUPPLIES AND EQUIPMENT, AND NONPHYSICIAN SERVICES, INCLUDING BUT NOT LIMITED TO THE SERVICES OF NONPHYSICIAN CLINICIANS, IN ADDITION TO PHYSICIAN FEES BILLED FOR PROFESSIONAL SERVICES PROVIDED AT THE HOSPITAL".**

RATIONALE: This definition aligns with the language used in COMAR 10.37.10.26A (1)(F).

HSCRC AMENDMENT NO. 2

On page 4, in line 26, strike "**FACILITY FEE COMPLAINT, YOU SHOULD FILE IT**" and substitute **"COMPLAINT ABOUT AN OUTPATIENT FACILITY FEE CHARGE, PLEASE FIRST CONTACT THE HOSPITAL (HOSPITAL BILLING OFFICE CONTACT INFORMATION). IF THE COMPLAINT IS UNRESOLVED, YOU MAY THEN FILE THE COMPLAINT".**

RATIONALE: HSCRC should not be the first ones patients call with any question on their bill, as hospitals are the ones generating those bills. A patient should therefore first contact the hospital they were charged by in case the hospital can provide clarification on the bill. If patients still has a complaint with the charge after that conversation, they can then contact the HSCRC.

HSCRC AMENDMENT NO. 3

Strike beginning with "**THE**" in line 28 on page 5 down through "**SECTION**" in line 1 on page 6 and substitute "**A HOSPITAL SHALL DETERMINE THE RANGE OF HOSPITAL OUTPATIENT FACILITY FEES AND FEE ESTIMATES, BASED ON TYPICAL OR AVERAGE FACILITY FEES FOR THE SAME OR SIMILAR APPOINTMENTS, TO BE PROVIDED IN THE NOTICE REQUIRED IN THIS SECTION CONSISTENT WITH THE HOSPITAL'S MOST RECENT RATE ORDER AS APPROVED BY THE COMMSSION AND THE COMMISSION'S ACCOUNTING AND BUDGET MANUAL FOR FISCAL AND OPERATING MANAGEMENT**".

RATIONALE: The current version of the bill indicates that the HSCRC and Health Education and Advocacy Unity (HEAU) "shall determine the range of hospital outpatient facility fees and fee estimates to be provided in the written notice…" Neither the HSCRC nor HEAU will be able to develop a range of hospital facility fees or fee estimates that encompass all of the possible service combinations that patients may receive. The HSCRC believes the approach outlined in this amendment should be used by hospitals to determine the range for facility fees or fee estimates that is provided to consumers.

HSCRC AMENDMENT NO. 4

On page 7, strike beginning with "SECTION" in line 10 down through "Act" in line 15.

RATIONALE: This language is redundant given the process described in Amendment 3.