Maryland
Hospital Association

Senate Bill 632-Health Facilities-Hospitals-Disclosure of Outpatient Facility Fees (Facility Fee Right-To-Know)

Position: ***Support with Amendments***
March 5, 2020
Senate Finance Committee

MHA Position

Maryland's 61 nonprofit hospitals and health systems care for over 5 million people each year, treating 2.3 million in emergency departments and delivering more than 67,000 babies. The 108,000 people they employ are caring for Maryland around-the-clock every day. Hospitals are committed to ensuring patients are informed of their financial obligations and choices for care. We believe that patients should be protected and better understand their insurance coverage to plan for out-of-pocket expenses. *With the changing insurance market, individuals are bearing greater financial burdens due to increased out-of-pocket expenses and higher deductibles*. As a result, it is imperative to find solutions that provide relief for patients while maintaining a robust healthcare system.

All hospitals in Maryland are regulated by the Health Services Cost Review Commission (HSCRC). HSCRC sets rates that are mandated by statute to be charged for all services provided "at the hospital," including outpatient clinics that operate within the hospital itself. These rates, often called facility fees, are required to cover direct hospital costs associated with operations–nurses, physical space, etc.–and the indirect overhead costs that are allocated to all services in the hospital–maintenance, housekeeping, malpractice, and more. Private physician practices charge similar fees; however, they bundle these fees under professional services within one bill.

Hospitals cannot negotiate rates with different payers to discount services. All payers are required to pay the charges as set by HSCRC. Ultimately, the patient's insurance coverage determines what portion of the facility fee, and overall bill, the patient pays. A patient's out-of-pocket costs are directly based on insurance benefit design (e.g., co-payments and deductibles). Currently, a majority of hospitals notify patients in writing of facility fees associated with hospital-based services, and upon request, hospitals must provide a written estimate of the cost of services. This bill requires verbal and written notification with additional details of such fees when the patient schedules an appointment. ***It is important to note that the disclosure of these fees is not the actual amount owed given the limited insurance information available at the time of scheduling an appointment. It will be critical that a patient calls their insurance provider for the actual out-of-pocket costs.***

In response to recent concerns expressed by the Health Education and Advocacy Unit of the Consumer Protection Division on the issue of facility fee notification for patients, HSCRC developed language to modify COMAR 10.37.10.26 – Rate Application and Approval Procedures - Patient Rights and Obligations to address this issue. Maryland's hospitals support

the proposed language, with additional consideration regarding the definition to which disclosing hospital facility fees for outpatients is required.

The bill reminds patients of their right to request and receive a written estimate of charges before non-emergent services. We agree that hospitals can continue to improve patient education and communication for hospital-based physicians office visits, both through written materials and verbal disclosure.

Given the desire to further improve this process, MHA worked with hospital members over the interim to implement transparent standards as outlined in last year's legislation. In light of the increasing out-of-pocket cost exposure that patient's face, all key stakeholders (HSCRC, MHA and HEAU work with the Maryland Insurance Administration, consumer groups and health plans) must work together to improve consumer understanding of health plan benefits and avoid surprise out-of-pocket expenses, particularly as health plans shift a greater share of financial responsibility to patients and hospitals.

We thank the committee for careful consideration of this issue. We ask that MHA and other relevant parties be able to continue to work with the sponsors on consensus amendments. Please find MHA's requested amendments attached.

For more information, please contact:
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MHA Draft Amendments for SB 632
March 5, 2020

AMENDMENT NO. 1

On page 2, line 12 strike beginning with "**APPROVED**" down through "**SERVICES**" in line 16 and substitute "**AS DEFINED IN COMAR 10.37.10.26A (1)(F)**".

RATIONALE: We agree this definition should align with instances in which the term has already been defined. To accomplish this, we believe that the definition in **COMAR 10.37.10.26A** should be modified to more clearly define outpatient facility fees that relate to clinic-type services received at hospitals.

AMENDMENT NO. 2

On page 3 Insert under line 1, new section before line 2:
5. PATIENTS REPRESENATIVE INCLUDES ANY INDIVIDUAL THAT CONTACTS A HOPITALS TO SCHEDULE A PATIENT APPPOINTMENT OR OTHERWISE FACILITATES THE SCHEDULING OF A PATIENT APPOINTMENT

On page 3, line 4 insert after patient, **OR THE PATIENT'S REPRESENTATIVE**

RATIONAL: MHA heard from legislators and hospital members that there are several circumstances when a patient is not directly making the appointment. The disclosure information is required at time of scheduling; therefore, we need to ensure the same information is shared with the person making the patient's appointment. This is important when hospitals require patients later to confirm they received notification. We need to confirm that this is compliant with HIPPA rules.

AMENDMENT NO. 3

On page 3, line 5 strike **FORM OR A SUBSTANTIALLY or take out the entire section as a template within statue and list out the requirements within legislative language.**

RATIONAL: MHA would prefer the provisions that are enumerated within the form not be in a template form within the statute. This is an uncommon drafting and if there should be future changes, statutory language may need to be revised. If the form remains we request flexibility for how the form is development with key provisions listed in the bill.

AMENDMENT NO.4

On page 3, line 19 after $------ need to add, OR
On page 3, line 21 after both $------- to $----- need to add, OR
On page 3, line 23 after $----- need to add, OR

RATIONAL: The intention with this section is allowing the hospital to provide information about the facility fee charges either if the amount is known, if there is a range or by an estimation based on similar scheduled appointments. The is section is not intended to share all three options as that would confuse the patient or patient's representative.

AMENDMENT NO. 5

On page 4, in line 28, strike "**FACILITY FEE COMPLAINT, YOU SHOULD FILE IT**" and substitute "**INQUIRES ABOUT AN OUTPATIENT FACILITY FEE CHARGE, PLEASE FIRST CONTACT THE HOSPITAL (HOSPITAL BILLING OFFICE CONTACT INFORMATION). IF THE INQUIRY IS UNRESOLVED, YOU MAY THEN FILE THE COMPLAINT**".

RATIONALE: MHA agrees with this HSCRC-HEAU amendment. Hospitals should be the first entity patients call with any question on their bill. A patient should first contact the hospital they were charged by in case the hospital can *provide clarification on the bill or the patient needs financial assistance*. If patients still have a complaint or concerns with their bill, they can contact HSCRC or HEAU.

AMENDMENT NO. 6

On page 5, line 5-6 strike (the facility fee charge)(a range of facility fees and an estimate of the facility fee charges), should just state the hospitals provided information about the facility fee charge that will be billed for my appointment.

RATIONALE: This aligns with the form standards.

AMENDMENT NO. 7

One 5, 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 the possible service combinations that patients may receive. MHA agrees with HSCRC And HEAU on this approach outlined in this amendment.

AMENDMENT NO. 8

On page 6, on line 23 add after patient, or a patient's representative.

RATIONALE: This aligns with section above to include patient representative.

AMENDMENT NO. 9

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 4.

AMENDMENT NO. 10

On page 7, line 17 **strike October 1, 2020 and replace by July 1, 2021**

RATIONALE: Hospitals will have significant clinical process changes, staff training and IT upgrades that will need to be taken into consideration. Several hospitals have national contract with IT vendors that are only changed once a year. The changes required in the legislation will result in a significant modification spread over hundreds of clinics. The hospitals will have to shift resources to accommodate these requirements. Some estimations for implementation range from $200K to $1 million.