NASHP Model State Legislation to Prohibit Unwarranted Facility Fees

Model Act Summary: *This model legislation prohibits site-specific facility fees for services rendered at physician practices and clinics located more than 250 yards from a hospital campus. It also prohibits all service-specific facility fees for typical outpatient services that are billed using evaluation and management codes, even if those services are provided on a hospital campus.*

The act requires annual reporting of facility fees charged or billed by health care providers, delegates implementation authority to a relevant state agency, and provides three enforcement mechanisms:

- *An annual facility fee audit by the relevant state agency;*
- *A private right of action for consumers; and*
- *Administrative financial penalties against health care providers for violations.*

(1) Definitions. As used in this section,

(A) "Campus" means: (i) a hospital's main buildings; (ii) the physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within two hundred fifty (250) yards of the main buildings, or (iii) any other area that has been determined on an individual case basis by the Centers for Medicare & Medicaid Services to be part of a hospital's campus.

(B) "Facility fee" means any fee charged or billed by a health care provider for outpatient services provided in a hospital-based facility [or freestanding emergency facility] that is: (i) Intended to compensate the health care provider for the operational expenses of the health care provider, (ii) separate and distinct from a professional fee; and (iii) regardless of the modality through which the health care services were provided.

(C) "Freestanding emergency facility" means an emergency medical care facility that is licensed under [reference to code section that regulates freestanding emergency facilities], and shall not include urgent care clinics.

(D) "Health system" means: (i) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (ii) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means.

(E) "Hospital" is a hospital licensed under [code section for hospital licensure.

(F) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital where hospital or professional medical services are provided.

(G) "Professional fee" means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility.

(H) "Health care provider" means an individual, entity, corporation, person, or organization, whether for profit or nonprofit, that furnishes, bills or is paid for health care service delivery in the normal course of business, and includes, without limitation, health systems, hospitals, hospital-based facilities, [freestanding emergency facilities,] and urgent care clinics.

(2) Limits on Facility Fees.

(A) *Site-specific limits.* No health care provider shall charge, bill, or collect a facility fee, except for: (i) services provided on a hospital's campus; (ii) services provided at a facility that includes a licensed hospital emergency department[; or (iii) emergency services provided at a licensed freestanding emergency facility].

(B) *Service-specific limits*. Notwithstanding subsection (A) and whether or not the services are provided on a hospital's campus, no health care provider shall charge, bill, or collect a facility fee for (i) outpatient evaluation and management services; or (ii) any other outpatient, diagnostic, or imaging services identified by the [Department/Commission] pursuant to subsection (C).

(C) *Identification of services.* The [Department/Commission] shall annually identify services subject to the limitations on facility fees provided in subsection (B) that may reliably be provided safely and effectively in settings other than hospitals.

(3) Reporting. Each hospital and health system [and freestanding emergency facility] shall submit a report annually to [the Department/Commission] concerning facility fees charged or billed during the preceding calendar year. The report shall be in such format as [Department/Commission] may specify. The [Department/Commission] shall publish the information reported on publicly accessible website designated by the [Department/Commission].

At the discretion of the state pursuing this model, Section 4 (the following language detailing reporting requirements) could be removed from legislation and instead be used to inform implementing regulations promulgated under the model act.

(4) Reporting Requirements. Such report shall include, without limitation, the following information:

(A) The name and full address of each facility owned or operated by the hospital or health system [or freestanding emergency facility] that provides services for which a facility fee is charged or billed;

(B) The number of patient visits at each such hospital-based facility [or freestanding emergency facility] for which a facility fee was charged or billed;

(C) The number, total amount, and range of allowable facility fees paid at each such facility by Medicare, Medicaid, and private insurance;

(D) For each hospital-based facility and for the hospital or health system as a whole [or freestanding emergency facility], the total amount billed and the total revenue received from facility fees;

(E) The top ten procedures or services, identified by current procedural terminology (CPT) category I codes, provided by the hospital or health system [or freestanding emergency facility] overall that generated the greatest amount of facility fee gross revenue, the volume each of these ten procedures or services and gross and net revenue totals, for each such procedure or service, and, for each such procedure or service, the total net amount of revenue received by the hospital or health system [or freestanding emergency facility] derived from facility fees;

(F) The top 10 procedures or services, identified by current procedural terminology (CPT) category I codes, based on patient volume, provided by the hospital or health system [or freestanding emergency facility] overall for which facility fees are billed or charged [based on patient volume], including the gross and net revenue totals received for each such procedure or service;

(G) Any other information related to facility fees that the [Department/Commission] may require.]

(5) Regulatory Authorization. The [Department/Commission] may promulgate regulations necessary to implement this section, specify the format and content of reports, and impose penalties for noncompliance consistent with the department's authority to regulate health care providers.

(6) Enforcement.

(A) Any violation of any provision of this act shall constitute an unfair trade practice pursuant to [reference to code section for state unfair trade practices statute].

(B) A health care provider that violates any provision of this act or the rules and regulations adopted pursuant hereto shall be subject to an administrative penalty of not more than $1,000 per occurrence.

(C) The [Department/Commission] or its designee may audit any health care provider for compliance with the requirements of this section. Until the expiration of [four (4)] years after the furnishing of any services for which a facility fee was charged, billed, or collected, each health care provider shall make available, upon written request of the [Department/Commission] or its designee, copies of any books, documents, records, or data that are necessary for the purposes of completing the audit.