TASK FORCE TO EVALUATE THE IMPACT OF FACILITY FEES ON PATIENTS

Wednesday, December 13, 2023
10:00 a.m. – 3:00pm

Location: Room 202 (LBHS Committee Room)
Cross State Office Building, Augusta

Public access also available through the Maine Legislature's livestream:
https://legislature.maine.gov/Audio/#202

MEETING AGENDA
(order of agenda items may be adjusted)

1. Welcome
Chairs, Senator Donna Bailey and Representative Poppy Arford
Commission member introductions

2. Follow Up on Information Requests
- Impact of facility fees on cost-sharing for consumers from Maine Association of Health Plans
- Additional information from Maine Health Data Organization

3. Task Force Discussion and Consideration of Proposed Findings and Recommendations
- Review of proposed recommendations suggested by Task Force members

~12:00 pm Break for 30 minutes

4. Continue Task Force Discussion and Consideration of Proposed Findings and Recommendations

5. Finalizing Task Force Report and Next Steps

Adjourn

Follow Up from the Maine Association of Health Plans
For Task Force Review 12/13/23

McCarthyReid, Colleen

From: Dan Demeritt <Dan.Demeritt@MEAHP.com>
Sent: Wednesday, December 13, 2023 7:56 AM
To: McCarthyReid, Colleen
Cc: Dan Demeritt
Subject: Site of Service Coverage Differences

Colleen,

Thank you for reaching out on behalf of the Facility Fee Task Force regarding the question about site specific coverage and cost share obligations from the 1:07:40 Mark of Last Week's Task Force Meeting. We have discussed this request within our association and am sharing a general example of how one of our plans determines benefits based on the site of service.

The limited time we had to respond and our commitment as an association to uphold our antitrust obligations prevent me from providing a comprehensive look at how individual plans competing for customers in the private marketplace manage the coverage and cost share elements of their products.

General Example -- One Plan's Example

This is a situational response that depends on the codes and what forms they are billed on by the provider.

Member benefits are determined based on the claim type, place of service, code, and provider specialty. If the service is done in a provider's office, it would be a place of service processed as an office benefit. If it is done in a hospital it would fall under outpatient benefits unless it is ER or inpatient. The cost sharing amount is based on the Member's provider charges and where they have the service performed in keeping with plan designs.

Additional Information

- Variation by Provider Network: Health plans may use a tiered benefit plan as a tool to steer consumers to higher-performing providers who have been evaluated for quality, cost efficiency, and volume. Please see this link at the Maine Bureau of Insurance's website.

- Cost Share Differences: Deductibles are cumulative across all out-of-pocket expenses while co-insurance and co-pays can vary based on the provider. The Maine Bureau of Insurance's 2024 Final Plan Design illustrates the differences across plan types and providers.

- Public Access to Product Filings: While perhaps beyond the scope and outside the time restraints of this task force, the Maine Bureau of Insurance maintains a product filing system that can be used to search and compare the components of the insurance products sold in Maine. Please use this link to see the SERFF Filing Access website.

Thank you. I will be at the meeting today and hope to as helpful as I can to you and the Task Force.

JANET T. MILLS
GOVERNOR

MHDO Maine Health Data Organization
Information | Insight | Improvement

151 CAPITOL STREET
102 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0102

JOEL ALLUMBAUGH
CHAIR
COMMISSIONER ANNE HEAD
VICE-CHAIR
KARYNLEE HARRINGTON
EXECUTIVE DIRECTOR

Date: December 13, 2023

Submitted To: Senator Bailey, Representative Arford, and Members of the Task Force to Evaluate the Impact of Facility Fees on Patients

CC: Colleen McCarthy Reid, Esq. Principal Legislative Analyst
MHDO Board of Directors

From: Karynlee Harrington

RE: Follow Up

This communication is in response to the request from the Task Force for additional information from MHDO specific to the structure of the claims data that are submitted to the MHDO per the requirements described in 90-590 Chapter 243, *Uniform Reporting System for Health Care claims Data Sets*. Specifically, how MHDO identifies in the claims data a claim billed on a UB-04 (institutional billing) versus a claim billed on a CMS-1500 (professional billing).

As I stated in my presentation, health care billing and coding is a complex system; and although there are national standards and guidelines for billing on an institutional claim form (UB-04) versus a claim form for professional charges (CMS-1500), there are differences in how these standards are applied as requirements may vary based on payer policies, regulations, and public emergencies.

As discussed, the UB-04 is used by **institutional** providers for the billing of claims generated for work performed in hospitals, skilled nursing facilities, and other institutions for outpatient and inpatient services, including physicians' fees, the use of equipment and supplies, laboratory services, radiology services, and other charges. This is the form used to submit charges under Medicare Part A. The CMS-1500 is used by **non-institutional** providers for the billing of claims generated for work performed by physicians, suppliers, and other non-institutional providers for both outpatient and inpatient services. This is the form used to submit charges under Medicare Part B. A CMS-1500 may also include a technical component to account for the cost of equipment, supplies, and/or technical personnel associated with a service.

Both the CMS-1500 and UB-04 forms contain many of the same data elements, including patient demographics, provider identification information, procedures and charges, and insurance plan identification information. There are also unique data elements in the UB-04 that are not present in the CMS-1500 form and vice versa.

The screen shot below is copied from Appendix D-2 from MHDO's rule Chapter 243, which provides the payer with the detail for creating the MHDO claims data files, including the specific data element, and where in the standard claim forms (the UB-04 and the CMS-1500) the data element can be located. This structure is what allows MHDO to identify in the claims data what is billed on a UB-04 versus a CMS 1500 claim form.

Specifically, the way MHDO identifies a claim that is generated on a UB-04 is from the presence of a populated MC036 Type of Bill and/or MC054 Revenue Code field, as these fields do not exist on a CMS-1500 form. In addition, we can see when a CMS-1500 includes charges for a technical component when the field MC056_MOD1 Procedure Modifier 1 is set to 'TC' (or "Technical Component").

Appendix D-2
Maine Health Data Organization
Medical Claims File Mapping to National Standards

Data Element #	Data Element Name	UB-04 Form Locator	CMS 1500 #	HIPAA Reference ASC X12N/005010A1 Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC035	Placeholder	N/A	N/A	N/A
MC036	Type of Bill – Institutional	4	N/A	837/2300/CLM/05-1
MC037	Place of Service - Professional	N/A	24B	837/2300/CLM/05-1
MC038	Claim Status	N/A	N/A	835/2100/CLP/02
MC039	Admitting Diagnosis	69	N/A	837/2300/HI/BJ/01-2
MC040	E-Code	72	N/A	837/2300/HI/BN/01-2
MC041	Principal Diagnosis	67	21.1	837/2300/HI/BK/01-2
MC042	Other Diagnosis – 1	67A	21.2	837/2300/HI/BF/01-2
MC043	Other Diagnosis - 2	67B	21.3	837/2300/HI/BF/02-2
MC044	Other Diagnosis - 3	67C	21.4	837/2300/HI/BF/03-2
MC045	Other Diagnosis - 4	67D	N/A	837/2300/HI/BF/04-2
MC046	Other Diagnosis - 5	67E	N/A	837/2300/HI/BF/05-2
MC047	Other Diagnosis - 6	67F	N/A	837/2300/HI/BF/06-2
MC048	Other Diagnosis - 7	67G	N/A	837/2300/HI/BF/07-2
MC049	Other Diagnosis - 8	67H	N/A	837/2300/HI/BF/08-2
MC050	Other Diagnosis - 9	67I	N/A	837/2300/HI/BF/09-2
MC051	Other Diagnosis -10	67J	N/A	837/2300/HI/BF/10-2
MC052	Other Diagnosis -11	67K	N/A	837/2300/HI/BF/11-2
MC053	Other Diagnosis -12	67L	N/A	837/2300/HI/BF/12-2
MC054	Revenue Code	42	N/A	835/2110/SVC/NU/01-2, 835/2110/SVC/04
MC055	Procedure Code	44	24D	835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2
MC056	Procedure Modifier - 1	44	24D	835/2110/SVC/HC/01-3
MC057	Procedure Modifier - 2	44	24D	835/2110/SVC/HC/01-4

Lastly, MHDO was asked about the terms *facility and professional payments* used in the methodology section of CompareMaine. The context for the use of these terms is, they are part of the larger explanation of the steps MHDO takes to calculate procedure payments on CompareMaine found on the Methodology page: Methodology - Calculating Payments - CompareMaine. Specifically, Step 2.

Step 2: Find Claims Associated with a Test or Service

Next, we find the claims associated with a specific test or service. Depending on the procedure, the total payment can include:

Professional Payments: *The portion of the payment paid to the healthcare provider, such as doctor or therapist, who provides direct services or procedures to a patient.*

Facility Payments: *The portion of the payment paid to the organization that provides healthcare services and procedures. This includes hospitals, surgical centers, diagnostic imaging centers, health centers, laboratories, and clinics.*

Our descriptions of these terms are meant to be a simplified working definition of how total payments can break down into a professional and or facility component reported on CompareMaine; and does not get into the detail, the complexity and or differences in payor policies that exists in health care billing and coding.

I hope this information is responsive to the request for information in advance of the release of our first annual facility report.

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Potential Recommendations Suggested by Task Force Members

Note that not all members may have submitted potential recommendations for consideration, that some potential recommendations may have been suggested by more than one member and that potential recommendations may not be consistent with or directly contradict another potential recommendation.

- Recommend that policy recommendations related to facility fees should be made in manner that aligns with federal regulations and guidelines as they currently exist and continue to evolve

- Recommend that the Legislature continue to study the policy issues associated with facility fees with the goal of requiring providers and facilities to be transparent with respect to cost, including facility fees, and of minimizing the burden to participants, beneficiaries, and enrollees that result from imposing facility fees

A. Notice/transparency requirements related to facility fees

1. Require providers to notify patients at the time an appointment is made if they will be charged a facility fee for their scheduled service

2. Require providers/entities that charge facility fees to post information outlining this in plain language on their website and on signs placed in common areas of the facility/office

3. Require providers to provide a standardized bill to patients that clearly lists any facility fee charged and includes information for filing a complaint/appeal.

4. Recommend notice and transparency requirements based on Connecticut law

5. Recommend that MHDO develop information on its publicly accessible webpage designed to educate patients about facility fees and whether and in what circumstances depending on payor (Medicare, Medicaid, military coverage, commercial insurer, self-pay) and site of service a facility fee may be charged

6. Take steps necessary to limit the ability of nonparticipating providers and nonparticipating emergency facilities to evade the charges otherwise prohibited under the No Surprises Act as "facility fees"

B. Definition of facility fee

1. Recommend that the Legislature establish a definition for facility fee that is used by all within the state's health system, including hospitals, providers, health plans, state agencies, including

Medicaid, and Maine's Health Data Organization. The definition for facility fee should be distinct from the definition for professional fee to ensure no purchaser of care services (health plan or consumer/patient) duplicate payments and should align with Medicare's definition to decrease billing and other administration burden on providers, payers, etc.

2. Propose to define "facility fee" to mean 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 intended to compensate the health care provider for the operational expenses of the health care provider, separate and distinct from a professional fee, and charged or billed regardless of how a health care service is provided

3. Rather than attempting to create a statutory definition of facility fee, the Legislature should focus on whether clarifications are needed to current law, which restricts the use of institutional claims forms and therefore the ability to charge any form of facility fees

C. Data collection and reporting associated with facility fees

1. Require that the same definition of "facility fees" be used in all State- mandated and approved data reports

2. Recommend that the Legislature require providers to report their collection of facility fees to MHDO, including information related to which providers are collecting these fees, for which services, the site the services are rendered, the payers that reimburse the facility fees, and when there is a corresponding a professional fee for the same service *(consider timing of reporting—quarterly, annually?)*

3. Following review of the report on facility fees provided by MHDO, recommend that the HCIFS Committee consider whether any clarifications to reporting are necessary, particularly as it relates to the accuracy of data submitted on claims regarding the physical location of the service

4. Recommend that the Legislature defer any action or recommendations related to additional data reporting requirements to allow for consideration of the MHDO report regarding facility fees expected in January 2024 and consider the re-establishment of the task force to allow for continued review during the Second Regular Session or in the interim before the convening of the 132nd Legislature

D. Telehealth--Limitations on facility fees associated with telehealth services

1. Prohibit facility fees from being charged for telehealth services
    a. *Also specify that facility fees are prohibited only when patient is not physically located in the facility*

2. Recommend that the Legislature should consider adding language to the existing statute on standard billing to clarify that only non-institutional billing forms should be used in any case where the originating site of a telehealth visit is located outside a hospital campus

3. Recommend that there be further study to better understand the issue of billing for facility fees associated with telehealth services

E. Limitations on facility fees based on location, type of service, billing, etc.

1. Prohibit facility fees from being charged for services not provided on a hospital campus

2. Prohibit charging a facility fee for an office visit where preventative, evaluation or care management services are delivered regardless of setting (prohibit fees for evaluation and management" codes also known as "E&M" codes that would ensure preventative and chronic care management office visits, mammograms, colonoscopies and other tests are provided without facility fee charges)

3. Prohibit charging more than one facility fee per incident of care

4. Recommend that the Legislature should affirm, and clarify if necessary, existing state law that mandates that providers utilize only the standard federal form for non-institutional providers for all services provided in an office setting

5. Recommend the Office of Affordable Health Care look at other prohibitions in other states to determine if similar prohibitions would reduce the cost of care in Maine

6. Recommend that the Legislature should not further regulate or limit the charging of facility fees of patients that are covered by commercial insurance (beyond existing law) because there is no justification or evidence to support the need for further limitation in State law of facility fees charged to commercially insured patients

7. Recommend that there should be no State regulation of Medicare and Medicaid (MaineCare) billing of facility fees in deference to federal requirements and billing standards under those programs

8. Recommend that hospitals must bill uninsured patients in a standardized way in a manner similar to the requirements that providers have for billing insured patients, e.g. using one standard claim form, to eliminate potential for receiving more than one bill

F. Enforcement/appeals/assistance to patients

1. Provide consumers with an opportunity to file complaints to a state agency or regulatory authority if they believe they have received a bill from a provider erroneously or that is not in compliance with state requirements

2. Recommend creation of a Health Care Ombudsman

3. Establish an explanation and/or complaint mechanism for patients with a facility fee (Consider CT law as a potential model)

4. Provide for enforcement of the existing statutory requirements that require use of standardized claim forms

G. Cost-sharing for Insured Patients: Financial impact on patients for services depending on the setting or site of service

1. Limit consumer cost-sharing requirements for facility fees charged for outpatient services

2. Prohibit insures from imposing any cost-sharing for facility fees charged in relation to a preventive health service or other service for which cost-sharing is prohibited under state law

3. Cost sharing rules must be universal and included in the members certificate of coverage

4. If different levels of cost-sharing apply vary in practice depending on the location where a patient seeks out a service, the Legislature should consider requirements to mitigate the issue either by standardizing cost sharing, or strengthening transparency requirements