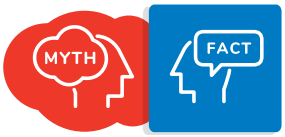
Texas Hospital Association

Facility Fees: Myths vs. Facts

Money Making Scheme?



MYTH

Myth: *Hospitals are buying up physician practices as moneymakers, padding profits by tacking on facility fees to services. Therefore, laws are needed to ban facility fees and increase reporting when hospitals buy physician practices.*

FACT

Fact: Hospitals buy physician practices when a physician determines their practice is not financially viable or it is too administratively burdensome to operate. Those burdens are often insurance related. The "facility fee" levied by hospital outpatient departments is simply the non-doctor part of the bill, not a superfluous extra charge. It covers anything and everything beyond the doctor.

Most physicians think it has become more financially and administratively difficult to operate their own practice. *Insurance red tape is a prime reason.*

Physician Practices Face Extreme Administrative Costs

- Billing, claims and prior authorizations caused by insurance
- Nurses and office staff
- Electronic health records and patient portals
- Office rent, supplies, infrastructure and other expenses

Physician Practices Face Intense Insurance Burdens

- Physicians and staff report spending two business days per week on prior authorizations alone.
- 84% of physicians report that insurance-related administrative burdens impacted their employment decisions.
- 81% of physicians report that insurance-related practices interfered with their ability to practice medicine.
- 88% of physicians characterize the burden of prior authorization as high/extremely high.
- 77% of practices have hired or redistributed staff to process prior authorizations.

There's a "new" fee on my bill

In reality, it's ***newly visible*** – but **not new.**

In a physician practice, the doctor's bill seamlessly includes administrative costs. This is not obvious to the patient.

When a practice is purchased by a hospital, the doctor's fee is reduced to cover only the doctor. The administrative costs shift to the hospital.

The hospital must calculate and charge a facility fee to cover that overhead. While the total cost is often the same, the facility fee is suddenly evident to the patient as a separate line item.

Same Services?

MYTH

Myth: *Hospitals charge facility fees for the same services as those available in a physician's office. Therefore, facility fees are not warranted and should be banned.*

FACT

Fact: Hospital outpatient departments are required to comply with many more regulatory and safety codes than other care settings and provide 24/7 standby capacity for emergencies, disasters and traumatic events.

- They maintain higher capabilities to treat complex injuries, like burns, and provide neonatal, psychiatric and other services.

- They accrue uncompensated care costs as safety-net providers.
- They are obligated to follow EMTALA standards and other stringent regulations, including life safety codes, essential electrical systems, architectural standards, Medicare conditions of participation and Joint Commission standards.

Hospitals receive no special payments for any of these obligations; they must somehow cover them only with revenue they receive from billing for direct patient care. These costs can amount to over $200 per patient, resulting in hospitals losing money when providing certain services.

Unclear Location?

MYTH

Myth: *Health insurance companies can't tell where a service is taking place. Therefore, each hospital outpatient department should have its own NPI number.*

FACT

Fact: Hospitals already bill according to federal regulations, which require them to bill Medicare and Medicaid **using codes that indicate the location of where a service is provided.**

- Specifically, the code "TOB 13X" identifies that the bill is for a "hospital outpatient department ."
- Off-campus services must include the correct modifiers on the bill, per Medicare regulations.
  - Modifier "PO" must be noted on all services paid under the "outpatient prospective payment system" and delivered in an off-campus HOPD.
  - Modifier "PN" must be noted on all services paid under the Medicare physician fee schedule and delivered in an off-campus HOPD.
  - Modifier "ER" must be noted for services in an off-campus emergency department.
  - Also, the Centers for Medicare & Medicaid Services requires the name and service location of the provider submitting the claim.

Same Standards?

MYTH

Myth: *All drug administration sites – places that administer chemotherapy, insulin, fluids, etc. – provide the same standard of care, so there's no need to reimburse hospital costs for drug administration. Thus, facility fees are not warranted and should be banned for clinician-administered drugs, especially cancer treatments.*

Fact: Hospital outpatient departments provide a higher standard of care for drug infusion services than other sites of care.

FACT

Hospitals are required to take additional steps to ensure drugs are prepared and administered in a safe manner for both patients and providers. This includes compliance with safety standards required by the Food and Drug Administration, U.S. Pharmacopeia and The Joint Commission.

As a reminder, outpatient drug administration reduces patient travel and wait times and creates greater access to convenient care.