TASK FORCE TO EVALUATE THE IMPACT OF FACILITY FEES ON PATIENTS

Thursday, December 7, 2023
10:00 a.m. – 3:00pm

Location: Room 220 (HCIFS Committee Room)
Cross State Office Building, Augusta

Public access also available through the Maine Legislature's livestream:
https://legislature.maine.gov/Audio/#220

MEETING AGENDA

(order of agenda items may be adjusted depending on availability of presenters)

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

2. Follow Up on Information Requests from First Meeting
- Maine laws on standardized billing
- Statutory definitions of "facility fee"

OPLA staff

3. Industry practices related to facility fees and impact of fees on patients
Maine Medical Association representatives: Andrew MacLean, Paul Cain and John Wipfler

4. Development of National Academy of State Health Policy Model Legislation other state laws related to facility fees (required by resolve)
Task Force member, Maureen Hensley-Quinn, NASHP

5. Development of Connecticut's laws related to facility fees
Vicki Veltri, Senior Policy Fellow, NASHP, and former Executive Director of the Office of Health Strategy in Connecticut

~12:00 pm Break for 30 minutes

6. Task Force Discussion and Consideration of Preliminary Findings and Recommendations

7. Information requests and next steps

Adjourn

Maine State Legislature
OFFICE OF POLICY AND LEGAL ANALYSIS
www.mainelegislature.gov/opla
13 State House Station, Augusta, Maine 04333-0013
(207) 287-1670

MEMORANDUM

TO: Members, Task Force to Evaluate the Impact of Facility Fees on Patients

FROM: Colleen McCarthy Reid, Principal Analyst

DATE: December 7, 2023

RE: Maine laws related to standardized claim forms and federal standardized claim forms

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I. Maine laws related to standardized claim forms

For your information, the following statutes govern the use of standardized claims forms. Copies of the statutory provisions are attached and hyperlinked below

- 24 MRSA §2985 requiring health care practitioners who directly bills for health care services to use the current standardized claim form for professional services approved by the federal Government (p.3)

- 24-A MRSA §2753 requiring insurers providing individual health coverage to accept the standardized claim for professional services from a health care practitioner: (p. 7)
    - requires all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers;
    - insurers may not be required to accept a claim submitted on another form
    - services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner;
    - *"office setting" defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility*

- 24-A MRSA §2823-B requiring insurers providing group health coverage to accept the standardized claim for professional services from a health care practitioner: (p. 8)
    - requires all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers;
    - insurers may not be required to accept a claim submitted on another form
    - services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner;

- *"office setting" defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility*

- 24-A MRSA §4235 requiring health maintenance organizations providing individual or group health coverage to accept the standardized claim for professional services from a health care practitioner: (p. 9)
  - requires all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers;
  - health maintenance organizations may not be required to accept a claim submitted on another form
  - services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner;
  - *"office setting" defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility*
  -
- 24-A MRSA §1912 requiring third-party administrators who administer claims must accept the standardized claim for professional services from a health care practitioner: (p. 10)
  - requires all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers;
  - administrators may not be required to accept a claim submitted on another form
  - services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner;
  - *"office setting" defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility*

II. Federal standardized claim forms

Attached are sample federal standardized claim forms used by professionals (CMS 1500; p.11) and institutional providers (UB 4 (p. 13) or CMS 1450).

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MED CARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MED CAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
X	X	X	X	X	X	X

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
XXXXXXXXXXXXXXXXXXXXXXXXX

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
XXXXXXXXXXXXXXXXXXXXXXXXX	XX XX XX	M X F X	XXXXXXXXXXXXXXXXXXXXXXXXX

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
XXXXXXXXXXXXXXXXXXXXXXXXX	Self X Spouse X Child X Other X	XXXXXXXXXXXXXXXXXXXXXXXXX

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
XXXXXXXXXXXXXXXXXXXXXXXXX	XXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
XXXXXXXXXXXXX	(XXX) XXXXXXXXXX	XXXXXXXXXXXXX	(XXX) XXXXXXXXXX

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
XXXXXXXXXXXXXXXXXXXXXXXXX		XXXXXXXXXXXXXXXXXXXXXXXXX

a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY	SEX
XXXXXXXXXXXXXXXXXXXXXXXXX	X YES X NO	XX XX XXXX	M X F X

b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
XXXXXXXXXXXXXXXXXXXXXXXXX	X YES X NO XXX	XXXXXXXXXXXXXXXXXXXXXXXXX

c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
XXXXXXXXXXXXXXXXXXXXXXXXX	X YES X NO	XXXXXXXXXXXXXXXXXXXXXXXXX

d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	X YES X NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED XXXXXXXXXXXXXXXXXXXXXXXXX DATE XXXXXXXXXXXXX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

XXXXXXXXXXXXXXXXXXXXXXXXX

SIGNED XXXXXXXXXXXXXXXXXXXXXXXXX

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY	QUAL.	15. OTHER DATE MM DD YY	QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY	MM DD YY
XX XX XXXX	XXX	XX XX XXXX	XXX	FROM XX XX XXXX	TO XX XX XXXX

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. XXX	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY	MM DD YY
XXXXXXXXXXXXXXXXXXXXXXXXX		XXXXXXXXXXXXXXXXXXXX	FROM XX XX XXXX	TO XX XX XXXX

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB?	$ CHARGES
XXXXXXXXXXXXXXXXXXXXXXXXX	X YES X NO	XXXXXXXXX

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. X

A.	B.	C.	D.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
XXXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXX
E. XXXXXXX	F. XXXXXXX	G. XXXXXXX	H. XXXXXXX	23. PRIOR AUTHORIZATION NUMBER	
I. XXXXXXX	J. XXXXXXX	K. XXXXXXX	L. XXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 XX XX XX	XX XX XX	XXXXX		XXXXX	XX XX XX XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
2 XX XX XX	XX XX XX	XXXXX		XXXXX	XX XX XX XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
3 XX XX XX	XX XX XX	XXXXX		XXXXX	XX XX XX XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
4 XX XX XX	XX XX XX	XXXXX		XXXXX	XX XX XX XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
5 XX XX XX	XX XX XX	XXXXX		XXXXX	XX XX XX XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
6 XX XX XX	XX XX XX	XXXXX		XXXXX	XX XX XX XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
XXXXXXXXXXXXX X X	XXXXXXXXXXXXXX	X YES X NO	$XXXXXX XX	$XXXXXXX	XXXXXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION XXXXX	33. BILLING PROVIDER INFO & PH # (XXX) XXXXXXXXX
XXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX
	XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX
	XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXX
SIGNED XXXXXXXXXX DATE XXXX	a. XXXXXXXXXX b. XXXXXXXXXXXXXXX	a. XXXXXXXXXX b. XXXXXXXXXXXXXXX

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c / d / e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
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38		39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

HOW IS FACILITY FEE DEFINED IN STATE LAWS: OVERVIEW OF STATUTORY DEFINITIONS

State law	**Definition of Facility Fee**
Maine	"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 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.
Connecticut	"Facility fee" means any fee charged or billed by a hospital or health system for outpatient services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee.
Colorado	"Facility fee" means any fee a hospital or health system charges or bills for outpatient hospital services that is: **(I)** Intended to compensate the hospital or health system for its operational expenses; and **(II)** Separate and distinct from a professional fee charged or billed by a health-care provider for professional medical services.
Florida	No statutory definition
Georgia	No statutory definition
Indiana	No statutory definition
Maryland	**(i)** "Outpatient facility fee" means a hospital outpatient charge approved by the Commission for an outpatient clinic service, supply, or equipment, including the service of a nonphysician clinician. **(ii)** "Outpatient facility fee" does not include: **1.** A charge billed for services delivered in an emergency department; or **2.** A physician fee billed for professional services provided at the hospital.

HOW IS FACILITY FEE DEFINED IN STATE LAWS: OVERVIEW OF STATUTORY DEFINITIONS

State law	Definition of Facility Fee
Massachusetts	No statutory definition
Minnesota	"facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses; and "provider-based clinic" means the site of an off-campus clinic or provider office, located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.
New York	“fee" means any amount charged or billed by a provider for professional health care services provided in a hospital-based facility.
Ohio	"Facility fee" means any fee charged or billed for telehealth services provided in a facility that is intended to compensate the facility for its operational expenses and is separate and distinct from a professional fee.
Texas	No statutory definition
Washington	"Facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses. "Provider-based clinic" means the site of an off-campus clinic or provider office that is owned by a hospital licensed under chapter **70.41** RCW or a health system that operates one or more hospitals licensed under chapter **70.41** RCW, is licensed as part of the hospital, and is primarily engaged in providing diagnostic and therapeutic care including medical history, physical examinations, assessment of health status, and treatment monitoring. This does not include clinics exclusively designed for and providing laboratory, X-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

Sources: State statutes as cited in “Overview of Other State Laws Related to the Regulation of Facility Fees” distributed at December 1, 2023 meeting, https://legislature.maine.gov/doc/10460

Overview of NASHP's Facility Fee Model Law

December 7, 2023

Maureen Hensley-Quinn, Senior Director, NASHP

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

nashp.org

About NASHP

- A national, nonpartisan organization committed to developing and advancing state health policy innovations and solutions to improve the health and well-being of all people.
- NASHP provides a unique forum for the productive exchange of strategies across state government, including the executive and legislative branches.
- To accomplish our mission, we:
- **Advance** innovation in developing new policies and programs
- **Surface** and support implementation and spread of best practices
- **Ensure** availability of info, data, tools
- **Encourage** sustainable cross sector solutions by strengthening partnerships
- **Elevate** the state perspective

Center for Health System Costs

Established by NASHP per state officials' request for hospital cost policy & data analysis, as well as technical assistance with Arnold Ventures support in 2019

Multi-state advisory groups representing a variety of agencies/offices guide the Center's work

- Initial key areas of focus:
  - Lack of transparency on hospital prices and costs
  - Options to address increasing consolidation both vertical and horizontal
    - Policy goal = limit facility fees for routine/preventative care and out-patient services
      - Disincentivize acquisitions of providers
      - Lower costs for consumers and other health care purchasers

Options to Address Facility Fees

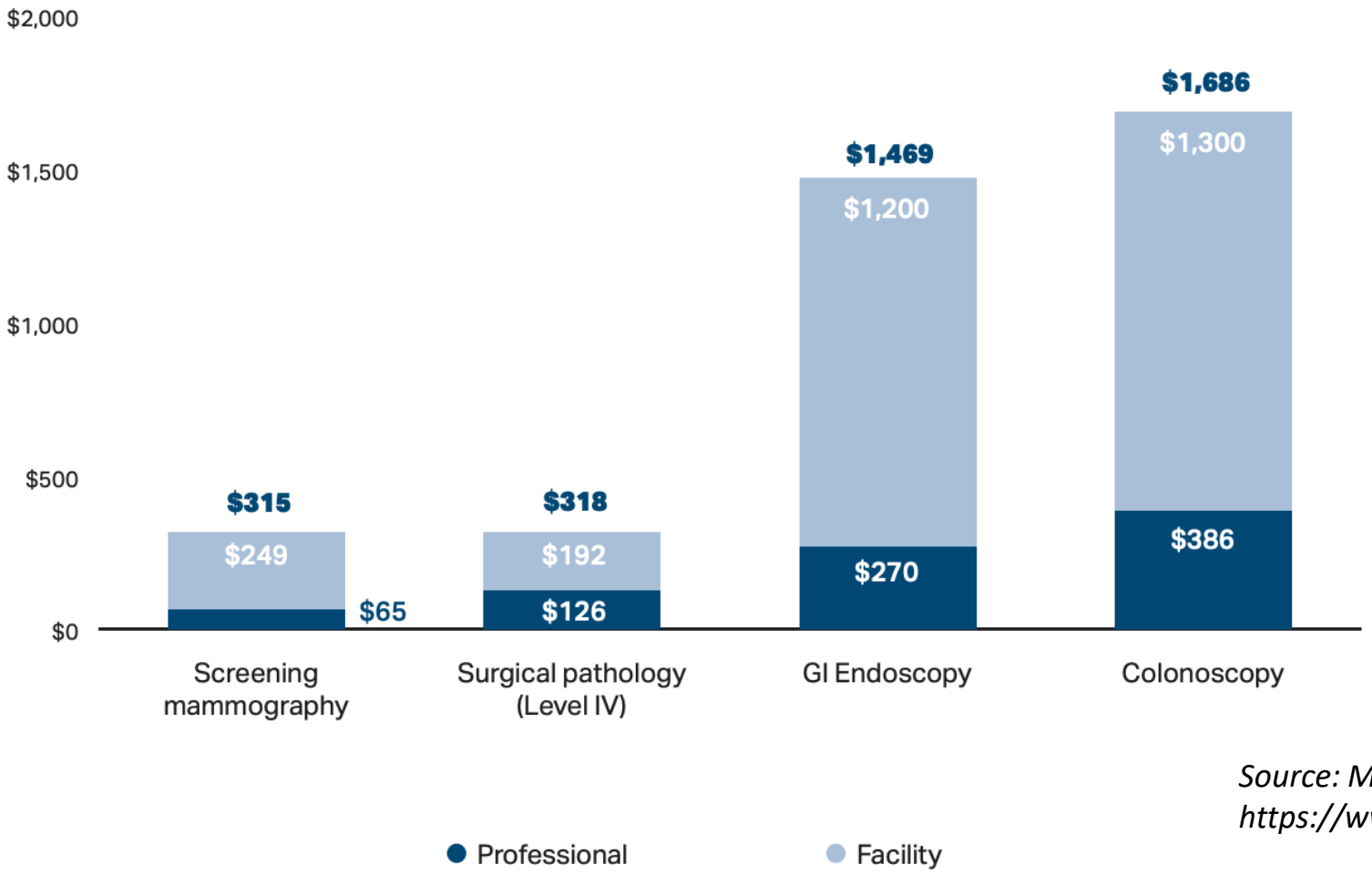
State advisory group recognition: readiness standard for hospitals providing emergency services require funding, so focus on out-patient services

Option: Prohibit providers from charging facility fees for certain services

Option: Adopt a site neutral payment by eliminating differences in price for same services provided at different sites

- Key considerations
  - Identify services considering patient safety and health outcomes
  - Cost burden to provider
  - Ability to effectively implement the policy

Average Price for Common HOPD Services by Professional and Facility Component, 2018 in MA



Services displayed had the highest aggregate HOPD spending in 2018.

For each of these services, the office price is higher than the HOPD professional component alone, but far lower than the total. For example, the office-based price for a colonoscopy was $748 in 2018; a difference of $938.

Source: MA Health Policy Commission, 2021 Cost Trends Report Chart Pack, https://www.mass.gov/doc/2021-cost-trends-report-chartpack/download

NASHP Facility Fee Model Legislation

- Prohibits certain facility fees:
  - For services rendered at physician practices and clinics located more than 250 yards from a hospital campus.
  - For typical outpatient services that are billed using evaluation and management codes, even if those services are provided on a hospital campus.
- Grants authority to the state to annually identify additional services to be subject to limitation of facility fees that may reliably be provided safely and effectively in settings other than hospitals
- Requires annual reporting of facility fees charged or billed by health care providers to the state
- Enforcement includes administrative penalty per occurrence

Thank you!

NASHP's Health System Costs Resources:

- Written research and analysis & state legislative tracking
- Model legislation & regulation to address consolidation and more
- Hospital Cost Calculator & hospital financial transparency reporting template
- Available Now! Interactive Hospital Cost Tool
- https://www.nashp.org/policy/health-system-costs/

Maureen Hensley-Quinn
Senior Director
National Academy for State Health Policy
mhq@nashp.org

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

nashp.org

@NASHPhealth

@NASHP

Maine Medical Association

Paul Cain, MD, President | R. Scott Hanson, MD, MPH, President-Elect | James R. Jarvis, MD, Chair, Board of Directors
Andrew B. MacLean, JD, CEO

TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

BEFORE THE

TASK FORCE TO EVALUATE THE IMPACT OF FACILITY FEES ON PATIENTS

Thursday, December 7, 2023
Room 220, Cross State Office Building
Augusta, Maine

Good Morning Senator Bailey, Representative Arford, and Members of the Task Force.

Thank you for inviting the Maine Medical Association to offer a perspective on facility fees in our health care financing system as part of your charge under LD 1795. I am Andrew MacLean and I serve as CEO of the MMA. The MMA is a professional organization representing more than 4000 physicians, residents, and medical students in Maine whose mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine people. MMA represents members statewide in all medical specialties and all practice settings.

I am accompanied today by Paul Cain, MD, President of MMA, a resident of Oxford. Dr. Cain is a retired orthopedic surgeon who spent his career serving the people of the greater Lewiston/Auburn area as a member of Central Maine Orthopedics. Joining us by Zoom is John Wipfler, JD, MBA, CEO of Eyecare Medical Group in Portland. Dr. Cain and Mr. Wipfler can provide the Task Force with a description of their experience of facility fee payments in an ambulatory surgical facility associated with an independent physician practice.

The MMA understands the legislature's concern about the impact on patients of facility fees, as a component of health care charges, in our current system. The complex financing of our system does affect patients differently, depending on the

site of service. MMA acknowledges this inequity. Physician frustration with the current system is impacting wellness and causing some to consider leaving the profession. The inequities in our current system also is a basis for MMA's recently released *Statement on Reform of the US Health Care System* which urges policymakers to undertake comprehensive reform of it: https://www.mainemed.com/sites/default/files/content/statement_hcr_mma_board_adopted_6_7_23_FINAL.pdf. But, until our society is persuaded to support policymakers adopting comprehensive health care reform, MMA represents physicians in all practice settings under different payment methodologies who work hard to provide high quality care to the patients entrusted to them in a very difficult practice and payment environment.

Within MMA's membership of more than 4000 are physicians in a wide variety of practice settings, each of which has a different financing methodology, while the physician and the physician employer try to recruit staff; provide facilities, medical equipment, and supplies; pay professional liability insurance costs; and invest in professional development in an effort to meet an evolving standard of care expected by the community served. These practice settings include:

- Integrated health system which has chosen "provider-based" reimbursement (42 CFR §413.65);
- Integrated health system which has not chosen "provider-based" reimbursement;
- Independent community hospital;
- Critical access hospital;
- Federally-qualified health center (FQHC);
- Independent, multi-disciplinary physician practice;
- Specialty physician practice with associated ambulatory surgical facility;
- Specialty physician practice with no associated ambulatory surgical facility;
- Traditional small/solo independent physician practice (primary or specialty care);
- "Direct contracting" independent physician practice, such as "direct primary care" (primary or specialty care).

In each of these practice settings, physicians and their administrative staff must attempt to meet that constantly evolving standard of care by investing in infrastructure (physical plant/facilities; medical equipment from simple to very complex; health information technology) and the workforce necessary to meet our expectations as patients.

The disparities in the payment methodologies applicable in these practice settings are the result of a fundamental problem of our heath care financing – the "cost-shifting" to the private health insurance market resulting from the reality that the principal government programs, Medicare and Medicaid (MaineCare), do not pay sufficiently to cover the cost of providing the level of care expected in any of these settings.

Much of the health care policy debate and efforts to develop innovative "payment reforms" continue to avoid the fundamental problem of "cost shifting" in our system.

The foundation of the payment methodology in our health care is the "professional fee," meaning the amount paid for a physician's or other clinical professional's medical service as classified by the Current Procedural Terminology (CPT) for which a Medicare RBRVS (resource-based relative value scale) value is applied. The RBRVS includes three separate components: physician work; practice expense; and professional liability. Commercial health insurance payers apply a "conversion factor" to the annual Medicare RBRVS to set their payment rates to providers. Physicians face yet another payment reduction in the 2024 Medicare Physician Fee Schedule and the inadequacy of Medicare physician payment rates has been the most significant issue for the AMA, other national physician organizations, and state medical societies for the past 30+ years.

In some of the practice settings mentioned above, a facility fee is a component of reimbursement designed, as the name suggests, to cover the real additional costs of providing services in an operating environment. Because of additional staffing, medical equipment, licensing, regulatory, and certification requirements not required of an independent clinical practice, this facility fee is necessary to support medical services in the inpatient hospital or ambulatory surgical facility setting. The "provider-based" reimbursement program is based on the hospital or health system providing financial and clinical systems infrastructure and support to associated outpatient practices and this program has been part of the primary care base in rural Maine for more than 20 years and prevented the closure of many primary care practices under the cost burden of investment necessary to keep up with the standard of care.

It is true that a patient who seeks medical service or procedure "X" might be subject to a facility fee depending on the site of service he or she chooses and, in keeping with health care price transparency statutes already in place in Maine, we should continue our efforts to educate Maine consumers about the cost of medical care

and to encourage them to seek care in lower cost settings whenever possible. But, facility fees are an integral part of current health care financing and should be viewed in that context.

The Task Force members know that our current health care system has inequities and trade-offs, and patients/consumers face different out-of-pocket costs depending on their health insurance coverage and the practice setting in which they seek care. MMA acknowledges these financing system issues and will participate in any policy discussions to address the concerns of patients/consumers. However, since our health care financing is driven by federal health care policy, all stakeholders and, indeed, all of us as voters must continue to advocate for change in Washington, DC. Thank you again for this opportunity to share some thoughts with you and please let us know if we can assist further in the work of the Task Force.

Frank O. Stred Building | 30 Association Drive | PO Box 190 | Manchester, Maine 04351

TEL: 207-622-3374 | FAX: 207-622-3332 | www.mainemed.com

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS IS TAKING STEPS TO IMPROVE OVERSIGHT OF PROVIDER-BASED FACILITIES, BUT VULNERABILITIES REMAIN

Daniel R. Levinson
Inspector General

June 2016
OEI-04-12-00380

EXECUTIVE SUMMARY

WHY WE DID THIS STUDY

We reviewed the Centers for Medicare & Medicaid Services' (CMS) oversight of provider-based billing to ensure that only facilities that met provider-based requirements were receiving higher payments allowed by the provider-based designation. Under Medicare, payments for services performed in provider-based facilities are often more than 50 percent higher than payments for the same services performed in a freestanding facility. This increased cost is borne by both Medicare and its beneficiaries. "Provider based" is a Medicare payment designation established by the Social Security Act that allows facilities owned by and integrated with a hospital to bill Medicare as a hospital outpatient department, resulting in these facilities generally receiving higher payments than freestanding facilities. Provider-based facilities, which may be on or off the main hospital campus, must meet certain requirements (e.g., the facility generally must operate under the same license as the hospital). In addition, under current policy, hospitals may, but are not required to, attest to CMS that their provider-based facilities meet requirements to bill as a hospital outpatient department.

Dating back to 1999, the Office of Inspector General (OIG) has identified vulnerabilities associated with the provider-based status designation. These include oversight challenges and increased costs to Medicare and its beneficiaries, with no documented benefits. On the basis of these findings, OIG has recommended eliminating the provider-based designation. Further, the Medicare Payment Advisory Commission has recommended equalizing payment for selected services provided in hospital outpatient departments and physician offices. The Bipartisan Budget Act of 2015 partially accomplished this by eliminating higher payment for new off-campus provider-based facilities. However, it permits existing off-campus, as well as existing and new on-campus, facilities to continue to receive higher payment.

HOW WE DID THIS STUDY

We surveyed a projectable random sample of 333 hospitals to determine the number of provider-based facilities they owned. Next, we collected and analyzed supporting documentation from a purposive sample of 50 hospitals that reported owning off-campus provider-based facilities but had not voluntarily attested that the facilities met requirements. We limited our review to off-campus facilities because CMS requires that owning hospitals submit supporting documentation when attesting that off-campus – but not on-campus – provider-based facilities meet requirements. Further, off-campus facilities may have more difficulty meeting integration requirements because of their distance from the main hospital. We determined the extent to which these 50 hospitals and their off-campus facilities met provider-based requirements. We also collected information from CMS to determine the extent to which CMS has systems and procedures to oversee provider-based billing and had conducted analysis to determine the benefits of the provider-based designation. Finally, we collected information from CMS about its attestation reviews and challenges associated with its review process.

WHAT WE FOUND

Half of hospitals owned at least one provider-based facility. However, CMS does not determine whether all provider-based facilities meet requirements for receiving higher provider-based payment. Moreover, because the attestation process is voluntary, not all hospitals attest for all of their facilities. CMS is taking steps to improve its monitoring of provider-based billing; however, vulnerabilities associated with provider-based billing remain. For example, CMS cannot identify all on- and off-campus provider-based billing in its aggregate claims data, a capability that is critical to ensuring appropriate payments. Further, CMS may have difficulty implementing recent legislative changes because of its inability to segregate all provider-based billing from other claims data.

Whether or not hospitals voluntarily attest, provider-based facilities must meet specific requirements to receive higher provider-based payment. However, more than three-quarters of the 50 hospitals we reviewed that had not voluntarily attested for all of their off-campus provider-based facilities owned off-campus facilities that did not meet at least one requirement. Examples of requirements not met include demonstrating that an off-campus facility was operating under the control of the main provider and that beneficiaries were notified of potential cost increases for services at the provider-based facility. These facilities may be billing Medicare improperly and may be receiving overpayments. Further, beneficiaries may be overpaying for services in these facilities. CMS's efforts to gather information on the volume of the services provided by off-campus provider-based facilities are positive steps to improve oversight. However, CMS has no independent way to determine the amount of overpayments for on-campus provider-based facilities or multiple off-campus facilities owned by the same hospital in one building or campus, when the physician claim does not specify the exact location of the service. Further, CMS reported that it often has difficulty obtaining the hospital documentation needed to support its attestation reviews.

WHAT WE RECOMMEND

CMS is taking steps to improve its oversight of provider-based facilities; however, vulnerabilities identified in this review continue to limit its ability to ensure that all provider-based facilities bill appropriately. CMS also has not provided OIG with evidence that services in provider-based facilities deliver benefits that justify the additional costs to Medicare and its beneficiaries. Therefore, we continue to support previous OIG and MedPAC recommendations to either eliminate the provider-based designation or equalize payment for the same physician services provided in different settings – actions that go beyond those required by the Bipartisan Budget Act of 2015. If CMS elects not to seek authority to implement these measures, we recommend that it (1) implement systems and methods to monitor billing by all provider-based facilities, (2) require hospitals to submit attestations for all their provider-based facilities, (3) ensure that regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews, and (4) take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements. CMS partially concurred with our first new recommendation, did not concur with the second, and concurred with the third and fourth.

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OBJECTIVES

To determine the extent to which:

1. hospitals owned provider-based facilities,
2. Centers for Medicare & Medicaid Services (CMS) has procedures to oversee provider-based billing,
3. hospitals and their off-campus provider-based facilities met provider-based requirements, and
4. CMS and its contractors identified challenges associated with the attestation review process.

BACKGROUND

Medicare Part B pays for medically necessary physician services, such as office visits and surgical procedures. Medicare payments for physician services vary depending on whether they were rendered at a freestanding facility[1] or provider-based facility.[2] According to MedPAC, from 2012 to 2013, the use of Medicare services provided in a hospital outpatient setting, which includes provider-based facilities, increased by nearly 4 percent, and over the past seven years, the cumulative increase was 33 percent.[3] This increase was due, in part, to hospitals purchasing freestanding facilities and converting them to provider-based facilities.[4] The increase in volume of Medicare services provided in a hospital outpatient setting has been accompanied by a shift in Medicare billing to

[1] A freestanding facility is an entity that furnishes health care services that is not integrated with or part of a hospital. Freestanding facilities include independent physician practices. 42 CFR § 413.65(a) (2).

[2] In this report, the term, provider-based facility, refers to an on-or off-campus outpatient facility that (1) operates under the same name, ownership, and financial and administrative control of a main provider; and (2) furnishes the same types of services as the main provider. These are outpatient departments with provider-based status. 42 CFR § 413.65(a)(2). In contrast, provider-based entities are providers with provider-based status that (1) are under the ownership and administrative and financial control of the main provider; and (2) furnish services of a different type than those of the main provider. 42 CFR § 413.65(a)(2). Certain regulatory requirements set forth in 42 CFR § 413.65(g) are applicable only to provider-based facilities (i.e., hospital outpatient departments), and others are applicable to both provider-based facilities and provider-based entities. Provider-based entities are outside the scope of this report; consequently, this report addresses only those statutory and regulatory requirements applicable to provider-based facilities.

[3] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2015.

[4] Ibid. A freestanding facility may be owned by a hospital without being integrated with it (i.e., the facility does not operate under the hospital's administrative and financial control).

provider-based facilities for services that previously were performed in either a freestanding facility or an inpatient hospital setting.[5]

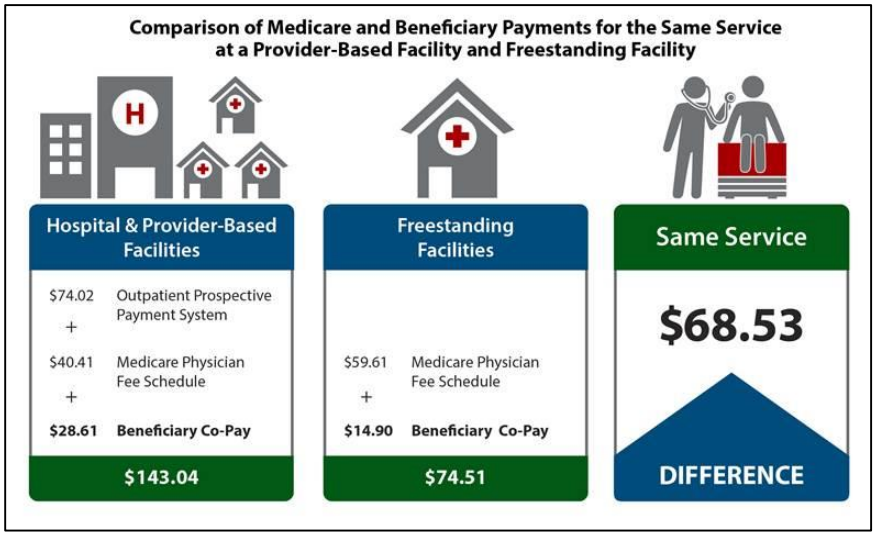
Medicare Provider-Based Status

Provider-based status is a Medicare payment designation established by the Social Security Act. It allows health care facilities with this designation to bill Medicare as a hospital outpatient department and thereby receive higher payments. CMS has asserted that provider-based facilities offer important potential benefits, such as increased beneficiary access and integration of care, which may improve quality of care. However, CMS has not provided the Office of Inspector General (OIG) with any documentary support for this assertion.

Medicare often pays over 50 percent more for services performed in provider-based facilities than for the same services performed in a non-hospital based facility (i.e., a freestanding facility).[6] Further, Medicare beneficiaries are responsible for copayments of 20 percent of the Medicare-approved amount for Part B services in both freestanding and provider-based facilities. Therefore, beneficiaries generally are responsible for higher copayments for most services in provider-based facilities than in freestanding facilities.

The example below illustrates the differences in Medicare and beneficiary costs for the same service in provider-based and freestanding facilities.

Comparison of Medicare and Beneficiary Costs for the Same Service at a Provider-Based and Freestanding Facility



Source: OIG analysis of average 2014 Medicare Physician Fee Schedule and Outpatient Prospective Payment System payments for Healthcare Common Procedure Coding System code 99202 for an office or other outpatient visit for the evaluation and management of a new Medicare patient.

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[5] Ibid.

[6] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2011, p.44.

A freestanding facility, such as a physician's office, furnishes services to Medicare beneficiaries but is not integrated with a hospital.[7] Physicians who provide services in freestanding facilities are required to bill Medicare using a place-of-service code on the Medicare claim, indicating where the services were furnished.[8]

Medicare pays for physician services provided in freestanding facilities using the Medicare Physician Fee Schedule (MPFS). Under MPFS, CMS sets payment rates for individual services.[9] The MPFS payment reimburses the provider for the cost of the physician service (i.e., the professional component) and the operational expense for the facility, such as the cost of equipment and overhead (i.e., the facility component).[10]

In contrast, a provider-based facility, which operates under the ownership, administrative, and financial control of a hospital, bills as an outpatient department of the hospital.[11] Provider-based facilities may be on campus (within 250 yards of the main buildings of the main provider) or off campus (more than 250 yards but less than or equal to 35 miles from the main buildings of the main provider).

Because provider-based facilities bill as outpatient departments of the hospital, two claims are submitted for services rendered in these facilities. The hospital submits one claim for the component of the service related to the facility's operating costs. Medicare pays this claim through the Outpatient Prospective Payment System (OPPS).[12] This payment covers the operational expenses of the owning hospital. However, OPPS does not

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[7] 42 CFR § 413.65(a)(2).

[8] CMS defines "office" as a location other than a hospital, skilled nursing facility, military treatment facility, community health center, State or public local health clinic, or intermediate care facility, where the physician routinely provides health examinations, diagnoses, and treatment of illnesses or injuries on an ambulatory basis. CMS, *Medicare Claims Processing Manual*, ch. 26, § 10.5.

[9] These services are identified by Current Procedural Terminology (CPT) codes included in the Healthcare Common Procedure Coding System (HCPCS). **The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2011 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

[10] 77 Fed. Reg. 68891, 68897 (Nov. 16, 2012). See also, CMS, *Payment System Fact Sheet Series: Medicare Physician Fee Schedule*, December 2011. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedcrephysFeeSchedfctsht.pdf on May 9, 2014.

[11] 42 CFR § 413.65(a)(2). The hospital that owns and controls the provider-based facility is known as the *main provider* in this relationship.

[12] Under OPPS, each code is grouped into an ambulatory payment classification, which CMS translates into a dollar amount.

cover the costs of the professional component of the patient's medical care.[13]

The physician submits a separate claim for the professional component of the same service. The claim contains a place-of-service code to indicate the setting in which the service was performed (e.g., off-campus or on-campus provider-based facility).[14] For services in provider-based facilities, the physician typically uses place-of-service code 22 on the claim and includes the address of the facility where the physician provided the service.

Since January 1, 2016, CMS has required physicians to use different place-of-service codes on claims to distinguish between services performed in on- or off-campus provider-based facilities. Physicians use place-of-service code 22 for services in on-campus provider-based facilities and place-of-service code 19 for services in off-campus provider-based facilities.[15]

Physician claims for the professional component of the services are billed under the attending physician's national provider identifier number. Medicare pays the claim using a reduced MPFS (i.e., non-facility) rate because it does not include the facility component cost.[16] For services in provider-based facilities, the combination of OPPS and MPFS payments generally results in higher payments than if the services were provided in a freestanding facility.[17]

On November 2, 2015, the President signed into law the Bipartisan Budget Act of 2015.[18] This law mandates that, effective January 1, 2017, only off-campus outpatient departments billing the OPPS for services before November 2, 2015, (grandfathered provider-based facilities) may continue to receive payment from the OPPS. This will allow the grandfathered facilities to continue to generally receive higher payments (i.e., payments from both the OPPS and MPFS) for services than if the same services were provided in a freestanding facility (i.e., receiving payment only from

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[13] CMS, *Medicare Claims Processing Manual*, ch. 6, § 20.1.1.2; CMS, *Medicare Benefit Policy Manual*, Ch. 15, § 30.1.

[14] CMS, *Medicare Claims Processing Manual*, ch. 26, § 10.5.

[15] CMS, *New and Revised Place of Service Codes (POS) for Outpatient Hospital*, Transmittal 3315 (Change Request 9231; August 6, 2015).

[16] CMS, *Medicare Claims Processing Manual*, ch. 12, § 20.4.2. All Medicare providers are assigned a unique 6-digit identification number. All claims from Medicare providers must contain this number.

[17] According to CMS, for a small number of services, the payment is less when the service is furnished in an outpatient department or provider-based facility of the hospital than in a freestanding facility.

[18] Bipartisan Budget Act of 2015, P.L. 114-74, Title VI, § 603.

the MPFS). Off-campus provider-based facilities that are not grandfathered would be paid under another applicable payment system, beginning January 1, 2017, resulting in lower overall payment. Table 1 provides the effective dates and descriptions of important changes to provider-based billing.

Table 1: Dates and Descriptions of Important Changes to Provider-Based Billing

Date	Description
November 1, 2015	Off-campus provider-based facilities that began billing for provider-based services after this date may continue to receive higher provider-based payment only until December 31, 2016.
January 1, 2016	Date after which physicians must use place-of-service code 19 on professional claims for services in off-campus provider-based facilities and code 22 for services in on-campus provider-based facilities. Hospital claims must contain a modifier for services in an off-campus outpatient facility.*
January 1, 2017	Only those off-campus provider-based facilities that billed for provider-based services before November 2, 2015, may continue to receive the higher provider-based payment after this date.**

*CMS, *April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)*, Transmittal 3238 (Change Request 9097; April 22, 2015); CMS, *New and Revised Place of Service Codes (POS) for Outpatient Hospital*, Transmittal 3315 (Change Request 9231; August 6, 2015).
**All off-campus provider-based facilities that are dedicated emergency departments defined by regulations will continue to receive the higher provider-based payment after December 31, 2016. On-campus provider-based facilities, as well as on- and off-campus provider-based entities, may continue to receive higher payments regardless of when they began billing for provider-based services.
Source: OIG analysis of Federal regulations and Bipartisan Budget Act of 2015, 2015.

Provider-Based Requirements and Attestations

Hospitals and their provider-based facilities have to meet specific requirements described in 42 CFR § 413.65 and CMS Transmittal A-03-030 to appropriately bill Medicare as a provider-based facility.[19] Provider-based requirements apply to hospitals and their provider-based facilities, and additional requirements apply to off-campus facilities. These include practice licensure, integration of clinical services and financial operations, and compliance with nondiscrimination and health and safety rules. Additional requirements, such as administration and supervision and location, apply to off-campus provider-based facilities. See Appendix A for a detailed list of provider-based requirements.

Although not required, hospitals may submit an attestation to CMS that a facility meets provider-based requirements. If a hospital chooses to submit an attestation, it is required to maintain supporting documentation indicating that its on- and off-campus provider-based facilities for which it

[19] CMS Transmittal A-03-030 does not contain requirements other than those listed in 42 CFR § 413.65; however, it notifies providers of actions they must take to implement the regulations.

is attesting comply with all provider-based requirements.[20] Hospitals that attest for on-campus facilities do not have to submit documentation with the attestation. In contrast, hospitals that attest for off-campus facilities must submit documentation demonstrating that the requirements are being met.

A hospital that voluntarily attests must first submit the attestation form and, if applicable, supporting documentation, to Medicare Administrative Contractors (MACs).[21] MACs review these documents to determine whether they comply with all provider-based requirements and recommend approval or denial of provider-based status to the appropriate CMS regional office.

Next, CMS regional offices conduct reviews and make decisions regarding the approval or denial of provider-based status on the basis of the attestations and MAC reviews. These reviews and decisions are tracked in CMS's Management Information System database. Regional offices and MACs also may return an attestation to a hospital if the attestation is incomplete or does not include sufficient documentation, giving the hospital additional time to gather and submit necessary documentation.

If a regional office denies an attestation, CMS may recoup the overpayments to the facility related to its provider-based billing. The overpayment amount is the difference between the OPPS and MPFS (provider-based) and the MPFS (freestanding) payments.[22] However, to calculate these overpayments, CMS must rely on hospitals to self-report the claims billed for services in the provider-based facility.

CMS provides incentives for hospitals to voluntarily submit provider-based attestations by reducing the amount of overpayments it seeks if the hospital and facility do not meet provider-based requirements.[23] Specifically, if a hospital submits an attestation that is denied, CMS will seek to recover overpayments made only after the date the attestation was submitted, rather than seeking to recover all overpayments made since the

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[20] The attestation must also include general information such as the identity of the hospital and the facility(ies) seeking provider-based status, an enumeration of each facility and a statement of its exact location (i.e., street address and whether it is on- or off-campus), the date on which the facility became provider-based to the main provider, and contact information should the regional office have further questions.

[21] CMS contracts with MACs primarily to process medical claims for Medicare beneficiaries and to serve as the primary operational contact between the Medicare Fee-For-Service program and enrolled health care providers.

[22] This applies to all cost reporting periods subject to reopening. 42 CFR § 413.65(j) (1) (ii).

[23] CMS may use several methods to find that a hospital and facility do not meet provider-based requirements. These include attestation reviews, provider self-disclosure, or audits.

hospital and facility began billing as provider-based. For example, if a hospital and facility began billing as provider-based on January 1, 2014, and submitted an attestation on June 1, 2015, that CMS denied, CMS would seek to recover overpayments made only after June 1, 2015. However, had the hospital not submitted an attestation and CMS determined the hospital and facility did not meet provider-based requirements, it would seek to recover overpayments going back an additional year and a half, to January 1, 2014.

Related Work

In 1999, OIG reported that hospitals were purchasing physician practices (i.e., freestanding facilities) in significant numbers.[24] OIG also found that CMS was unaware both of the extent of hospital ownership of these facilities and that provider-based status increased costs to Medicare and its beneficiaries, with no apparent benefit. OIG recommended that CMS eliminate the use of the provider-based status designation and require hospitals to report purchases of freestanding facilities. CMS did not concur with the recommendation to eliminate provider-based status and stated that provider-based billing encouraged integrated health care delivery systems. Instead, CMS produced a set of standards (i.e., 42 CFR § 413.65) for provider-based facilities and entities designed to guard against abuse of the payment system.[25] To date, CMS has not provided OIG with any evidence that provider-based facilities produce specific benefits, such as integrated or improved quality of care, that justify the higher costs compared to freestanding facilities.

In 2000, OIG found that CMS regional offices do not follow consistent processes for the review and approval of voluntary provider-based attestations and that CMS's data systems were inadequate for managing provider-based status.[26] Specifically, CMS could not identify (1) the number of hospitals denied provider-based status or (2) hospitals billing as provider-based. OIG again recommended that CMS discontinue its use of the provider-based status designation, and, if CMS did not do so, that it develop reliable data systems for program management. Again, CMS did not concur with OIG's recommendation. CMS maintained that increased payments were appropriate to accommodate higher costs resulting from

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[24] OIG, *Hospital Ownership of Physician Practices* (OEI-05-98-00110), September 1999, pp. 5-6. Recommendations were made to the Health Care Financing Administration, which is now CMS.

[25] Ibid., pp. 23-24.

[26] OIG, *Health Care Financing Administration Management of Provider-Based Reimbursement to Hospitals* (OEI-04-97-00090), August 2000, pp. 1-2. Recommendations were made to the Health Care Financing Administration, which is now CMS.

financial and clinical integration. However, CMS concurred with the recommendation to develop reliable data systems for program management.[27] Since then, CMS has developed a management information system that contains the results of provider-based reviews and enables CMS to monitor review status.

In 2011, OIG found that physicians in provider-based facilities (i.e., hospital outpatient departments) did not always use correct place-of-service codes. For example, they used code 11 for a freestanding physician's office instead of code 22 for a hospital outpatient department on Part B claims submitted to and paid by Medicare contractors.[28] OIG estimated that as a result of these errors, Medicare contractors overpaid physicians $9.5 million during 2009. OIG recommended that CMS recover overpayments for the sampled physician services, educate physicians about the importance of correctly reporting the place of service, and encourage physicians to implement internal control systems to prevent such incorrect billings. CMS concurred with these recommendations and stated that it was developing detailed guidance on the proper use of place-of-service codes.

Finally, in a 2012 report, the Medicare Payment Advisory Commission (MedPAC) recommended to Congress that it equalize payment for evaluation and management office visits, one type of physician service provided in hospital outpatient departments, provider-based facilities, and physician offices. MedPAC stated that this change could decrease Medicare spending by more than $10 billion in over 5 years.

METHODOLOGY

To determine the number of facilities that were billing as provider-based, we selected a random stratified statistical sample of 333 hospitals.[29] Of these, 272 responded to our request, a weighted response rate of 84 percent. Next, we collected information from CMS regional offices and MACs regarding the extent to which CMS had procedures to oversee provider-based billing. We asked CMS whether it has conducted analyses to determine the benefits of the provider-based designation. We collected and analyzed supporting documentation from a purposive sample of 50 of the 272 hospitals that reported owning off-campus provider-based

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[27] Ibid, p. 18.

[28] OIG, *Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009* (A-01-10-00516), September 2011, pg. 4.

[29] Hereafter, unless otherwise noted we refer to facilities billing as provider based as "provider-based facilities," regardless of whether CMS approved an attestation for the facility.

facilities but had not voluntarily attested that all of their facilities met requirements. We determined the extent to which these hospitals and one of their selected off-campus facilities met provider-based requirements. Finally, we collected information from CMS and MACs about attestation reviews in 2012 as this was the most current and complete data available at the time of our review. We also asked CMS whether there were any challenges associated with the review process.

See Appendix B for a more detailed description of our methodology. See Appendix C for the sample size, point estimates, and 95-percent confidence intervals for statistics in our report for hospitals that reported owning provider-based facilities. Additionally, all references to hospitals and their off-campus provider-based facilities for which they had not voluntarily attested apply only to our sample of 50 and are not projected to the population.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

CMS is taking steps to improve its monitoring of provider-based billing; however, vulnerabilities remain. For example, CMS does not determine whether all provider-based facilities meet requirements to bill at the higher provider-based rate. This is, in part, because the attestation process is voluntary and not all hospitals attest for all facilities. Further, CMS cannot segregate billing by provider-based facilities, which is critical to ensuring appropriate payments and implementation of the Bipartisan Budget Act of 2015. In addition, some facilities may be improperly billing at the higher provider-based rate, as we identified hospitals with a provider-based facility that did not meet at least one requirement. Finally, CMS reported challenges with the provider-based attestation review process because of difficulties obtaining supporting documentation.

Half of hospitals owned at least one provider-based facility, but CMS does not determine whether all meet provider-based billing requirements

As of May 2013, half of hospitals owned at least one on- or off-campus provider-based facility.[30] The average number of provider-based facilities that each hospital owned was 6, and the number of provider-based facilities owned by hospitals in our review ranged from 1 to 84.

CMS does not determine whether all facilities meet the requirements for receiving the higher provider-based rate because the attestation process is voluntary and not all hospitals attest for all of their facilities. Nearly two-thirds (61 percent) of hospitals that owned provider-based facilities had not attested for at least one of those facilities.[31] The remaining hospitals (39 percent) that owned provider-based facilities had attested for all of them. Table 2 shows the percentage of hospitals that attested for none, some, or all of their provider-based facilities that hospitals owned.

[30] See Appendix C for the sample size, point estimates, and 95-percent confidence intervals for statistics in this report. For purposes of this report, we define provider-based facilities as those that are owned by and integrated with a hospital to bill Medicare as a hospital outpatient department.

[31] Ibid.

Table 2: Percentage of Hospitals That Attested for None, Some, or All of Their Provider-Based Facilities, 2013

Portion of Hospitals' Provider-Based Facilities for Which They Voluntarily Attested	Percentage of Hospitals With Provider-Based Facilities
No Facilities	43%
Some Facilities	18%
All Facilities	39%
Total	**100%**

Source: OIG analysis of 2013 hospital respondent data, 2015.

CMS is taking steps to improve its oversight of provider-based billing; however, vulnerabilities remain

CMS initiatives in early 2016 to improve its oversight of provider-based facilities include implementing new place-of-service codes and modifiers on claims. However, CMS may not be able to identify all provider-based billing and potential overpayments based on claims data, even with the new place-of-service codes. Moreover, the vulnerabilities in CMS's oversight make it difficult to implement the Bipartisan Budget Act of 2015.

New and revised claim processing procedures will allow CMS to identify off-campus provider-based facility billing

As of January 2016, CMS has made two changes that will help it identify off-campus provider-based-facility billing. First, CMS requires physicians to use a new place-of-service code (code 19) to distinguish between services provided in an off-campus outpatient hospital setting and those provided in an on-campus hospital outpatient setting.[32] The latter will continue to use code 22, whether the service is provided in a hospital outpatient department or on-campus provider-based facility. Second, CMS requires that all facility (i.e., hospital) claims contain a specific two-digit modifier for services in an off-campus provider-based facility.[33]

These are positive steps designed to support CMS's efforts to determine the frequency, type, and cost of services furnished in off-campus provider-based facilities. Further, these changes will support CMS's ability to

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[32] CMS, *New and Revised Place of Service Codes (POS) for Outpatient Hospital*, Transmittal 3315 (Change Request 9231; August 6, 2015).

[33] *Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Report Programs; Physician-Owned Hospitals; Data sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors: CMS-identified Overpayments Associated with Submitted Payment Data* (79 Fed. Reg. 66769, 66910-66914 (Nov. 10, 2014)). This modifier must contain the label "PO".

match the facility and professional components of a claim from claims data.

CMS cannot identify billing for all provider-based services from claims data

CMS's implementation of new place-of-service codes to distinguish between claims for services in off-campus and on-campus provider-based facilities should significantly enhance the agency's ability to segregate provider-based services within claims data. However, despite the implementation of new codes, vulnerabilities remain. For example, although payment amounts are identical for the same service, CMS may not be able to distinguish between billing for services in on-campus provider-based facilities and outpatient hospital departments because professional claims for services in both types of locations will continue to use the same place-of-service code (22). Further, MAC staff in one region stated that they use beneficiary numbers and dates of service on claims to match facility and professional claims, which can lead to false positives (i.e., matching claims that appear to be for the same service, but are not) when the patient receives multiple services performed on the same day.

The inability to identify all facilities billing as provider-based limits CMS in calculating and recouping potential overpayments to facilities that do not meet provider-based requirements. For instance, an on-campus provider-based facility is subject to provider-based requirements that do not apply to a hospital outpatient department. If CMS determines that an on-campus provider-based facility does not meet requirements, but the professional claims for services in this facility do not specify the facility's address (e.g., suite or building number) from the hospital's address, CMS would not be able to determine the payment amounts for claims billed for provider-based services in this facility. This vulnerability also applies to off-campus provider-based facilities if a hospital owns multiple off-campus facilities in one building or campus, and the physician claim does not specify the exact location of the service.

Further, CMS's inability to identify all facilities billing as provider-based limits its full enforcement of the Bipartisan Budget Act of 2015, which mandates that, effective January 1, 2017, off-campus outpatient facilities cannot be paid the higher payment rate under the OPPS unless they had been billing for services under that system as of November 1, 2015. Before January 2016, CMS could not distinguish billing from on- and off-campus provider-based facilities owned by the same hospital, or among multiple off-campus provider-based facilities. Therefore, CMS cannot create a population of off-campus provider-based facilities that should be grandfathered (i.e., exempt) from new legislation.

CMS also does not match the facility component of a claim to the associated professional component of a claim. Therefore, CMS still has no means of ensuring that claims for the professional component of provider-based services use the correct place-of-service code, resulting in the appropriate lower payment for this component of the claim. For example, a hospital might bill Medicare for the facility component of a provider-based service, and the physician might use place of service code 11 instead of 19 or 22 on the claim, which would result in additional payment for the operational expense for the facility.[34] This would result in an overpayment that CMS could not identify from the claims data.

More than three-quarters of the 50 hospitals we reviewed that had not voluntarily attested for all of their provider-based facilities owned off-campus facilities that did not meet at least one requirement

We found that 39 of the 50 hospitals in our purposive sample that had not voluntarily attested for all of their provider-based facilities owned off-campus facilities that did not meet at least one provider-based requirement (see Table 3). However, the remaining 11 of 50 hospitals and the facilities they owned met all requirements.

Because the Medicare attestation process for provider-based status is voluntary, facilities may bill Medicare at the higher provider-based rate without demonstrating to CMS that they meet provider-based requirements. Thus, these hospital facilities may be improperly billing Medicare at the higher provider-based facility amount and may be receiving overpayments.

The 39 hospitals owned off-campus facilities that did not meet at least one provider-based requirement because the hospital (1) provided information (e.g., documentation or responses) that did not support compliance with provider-based requirements, or (2) stated that they did not have the required documentation to support compliance. See Table 3 for the number of hospitals that owned provider-based facilities that did not meet each provider-based requirement. See Appendix D for a description and number of the hospitals that owned off-campus provider-based facilities that did not meet at least one provider-based requirement. See Appendix A for a description of the provider-based requirements and examples of documents hospitals could have submitted to demonstrate compliance with these requirements.

[34] Code 11 is for freestanding physician offices and codes 19 and 22 are for hospital off- and on-campus provider-based facilities, respectively.

Table 3: Number of Hospitals That Owned Off-Campus Provider-Based Facilities That Did Not Meet At Least One Provider-Based Requirement

Category of Requirements	Number of Hospitals That Owned Provider-Based Facilities That Did Not Meet Requirements		
	Provided Information That Did Not Support Meeting Requirements	Stated That They Did Not Have Required Documentation to Support Meeting Requirements	Total Number of Hospitals
Administration and Supervision	21	4	25
Operation Under the Control of the Hospital	24	3	24
Clinical Services Integration	18	9	23
Beneficiary Awareness	10	0	10
Compliance With Hospital Rules	2	0	2
Licensure	0	5	5
Financial Integration	0	1	1
Public Awareness	0	1	1
Location	0	1	1
Total	**37**	**19**	**39***

*The sum of certain columns exceeds their total because some hospitals owned facilities that did not meet more than one requirement. The sum of certain rows also exceeds their total because some hospitals owned facilities that did not meet requirements for both methods we used to determine compliance.
Source: OIG analysis of hospitals' supporting documentation for off-campus provider-based facilities, 2015.

CMS reported challenges with the provider-based review process primarily because of difficulties obtaining documentation

Eight of 10 CMS regional offices and six of 14 MACs reported challenges with the provider-based review process primarily because they experienced difficulties obtaining documentation from hospitals. CMS regional offices and MACs also reported challenges associated with unclear CMS guidance regarding documentation necessary to support compliance with provider-based requirements.

Four CMS regional offices reported receiving incomplete provider documentation from MACs or hospitals. As a result, CMS regional offices had to request additional information from MACs. This increased the workload for CMS regional offices and may further contribute to delays in attestation approvals and denials.

Two CMS regional offices reported challenges related to the lack of CMS guidance regarding specific documents hospitals must submit with attestations for off-campus provider-based facilities to demonstrate compliance with provider-based requirements.[35] Of the two remaining

[35] CMS Transmittal A-03-030 provides background on the provider-based regulations at 42 CFR § 413.65, and includes provider-based requirements and instructions to providers for submitting provider-based attestations.

regional offices, one reported challenges related to working with a new MAC and another reported inconsistencies between requirements in the regulation and the CMS transmittal.

In addition, of the six MACs reporting challenges with the provider-based review process, five reported challenges obtaining the required documentation from hospitals. These challenges may delay the attestation review process if MACs must review attestation multiple times because they received multiple rounds of documentation. The remaining MAC reporting challenges indicated that different CMS regional offices in the same MAC jurisdiction look for varying types of supporting documentation from providers for the same requirement.

The lack of specific guidance on the documentation needed to support compliance with provider-based requirements may contribute to inconsistencies in the attestation approval process across CMS regional offices, as well as delays and review burden. Separate offices may apply different thresholds for the documentation needed to support the same requirement. These differences may account for the range of attestation approval rates found across CMS regional offices. For instance, in 2012, the percentage of attestations that regional offices approved ranged from 21 to 98 percent. This may indicate that some CMS regional offices have different approval thresholds (e.g., lower documentation thresholds may contribute to a greater approval rate). See Appendix E for the number and percentage of attestations that CMS regional offices approved for on- and off-campus provider-based status in 2012.

CONCLUSION AND RECOMMENDATIONS

Dating back to 1999, OIG has identified vulnerabilities associated with the provider-based status designation. These include oversight challenges confronting CMS and increased costs to Medicare and its beneficiaries, with no documented benefits. Based on these findings, OIG has recommended eliminating the provider-based designation. MedPAC has recommended equalizing payment for certain services in hospital outpatient departments and physician offices. The Bipartisan Budget Act of 2015 eliminates higher payment for new off-campus provider-based facilities. However, it permits existing off-campus, as well as existing and new on-campus, facilities to continue to receive higher payment.

CMS is taking steps to improve its monitoring of provider-based billing; however, vulnerabilities remain. Changes, effective January 2016, in the way CMS distinguishes off-campus provider-based services on Medicare claims should improve oversight of provider-based billing. Specifically, CMS now requires claims for services provided in off-campus provider-based facilities to be billed using a new place-of-service code. In addition, CMS now requires a modifier on hospital outpatient claims identifying when a service has been provided in an off-campus provider-based facility. These are positive steps designed to support CMS's efforts to determine the frequency, type, and cost of services furnished in off-campus provider-based facilities. Further, these changes should support CMS's ability to match the facility and professional components of a claim from claims data. However, CMS has not taken similar actions for on-campus provider-based facilities, which have also been of concern to OIG. Further, the new modifier and place-of-service code do not allow CMS to distinguish when services are furnished in different off-campus provider-based facilities owned by the same hospital.

In addition, not all hospitals voluntarily attest to CMS that all of their provider-based facilities meet requirements, and for those that do, CMS may have challenges obtaining supporting documentation from hospitals. Some hospitals' off-campus facilities with a provider-based designation do not meet all requirements and may be billing Medicare improperly, resulting in overpayments by Medicare and its beneficiaries for services in these facilities. CMS's efforts to gather information on the volume of costs associated with off-campus provider-based facilities are positive steps to improve oversight. However, CMS has no independent way of determining the amount of overpayments to on-campus provider-based facilities or hospitals with multiple off-campus facilities.

Finally, CMS has not provided OIG with evidence to support its contention that the provider-based billing designation delivers benefits that

justify the additional costs. Therefore, we continue to support previous OIG and MedPAC recommendations to either eliminate the provider-based designation or equalize payment for the same physician services provided in different settings – actions that go beyond those required by the Bipartisan Budget Act of 2015. If CMS elects not to seek authority to implement these changes, we recommend that it do the following:

Implement systems and methods to monitor billing by all provider-based facilities

CMS should implement systems and methods to monitor on- and off-campus billing by provider-based facilities to help it implement the Bipartisan Budget Act of 2015 and better monitor billing by individual facilities. To implement the Bipartisan Budget Act of 2015, CMS should develop methods for monitoring off-campus outpatient facilities that did not bill under the OPPS before November 2, 2015, and ensuring that these facilities do not receive payment from the OPPS on or after January 1, 2017.

CMS also issued new requirements for provider-based facilities to include new modifiers or codes effective 2016; however, CMS will still be unable to fully match all facility and professional claims to specific provider-based facilities or determine which services are furnished in on-campus provider-based facilities. To address this issue, CMS could require all provider-based facilities to have a unique identification number on their claims.

Require hospitals to submit attestations for all their provider-based facilities

To ensure that hospitals and their facilities meet provider-based requirements, CMS should require hospitals to submit attestations for all of their provider-based facilities, both on and off campus. CMS also should require hospitals to submit documentation for on-campus facilities, so regional office and MAC staff may review it for compliance with provider-based requirements. Further, CMS should establish a deadline after which it would deny claims for services in provider-based facilities that do not have an attestation on file with CMS. Finally, CMS should determine how to address the issue of grandfathered facilities that do not meet regulatory requirements after January 1, 2017, and determine whether they may continue billing as provider-based facilities if they later come into compliance.

Ensure that regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews

CMS should ensure that its regional offices and MACs apply provider-based requirements appropriately when reviewing documentation during their attestations reviews. Specifically, CMS should further specify and provide guidance to its regional offices, MACs, and hospitals regarding the documentation necessary to demonstrate compliance with provider-based requirements. Such actions could reduce delays, burden, and inconsistencies that CMS regional offices and MACs reported in the attestation review process. In addition, the CMS central office could review a sample of attestations for selected provider-based facilities to ensure that its regional offices and MACs are applying the requirements consistently and accurately and that the facilities are submitting acceptable documentation and meeting requirements.

Take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements

In a separate memorandum, we will refer to CMS for appropriate action the hospitals and their off-campus facilities that did not meet provider-based requirements. At a minimum, CMS should determine whether additional followup is necessary to ensure that these hospitals meet provider-based requirements. Moreover, if CMS determines that hospitals and facilities were improperly billing as provider-based, it should seek to recover overpayments and take action to ensure they do not receive higher provider-based payment in the future until non-compliance is corrected.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Of the four new recommendations in our report, CMS partially concurred with one recommendation, did not concur with one recommendation, and concurred with our remaining two recommendations.

CMS partially concurred with our first recommendation to implement systems and methods to monitor billing by all provider-based facilities. CMS's view is that the primary policy concerns regarding this issue apply to off-campus provider-based facilities (i.e., those that are more than 250 yards but less than or equal to 35 miles from the main buildings of the main provider), and CMS does not have the same concerns for on-campus provider-based facilities (i.e., those within 250 yards of the main buildings of the main provider). Therefore, CMS does not believe it is prudent to focus its resources on distinguishing among services provided in on-campus provider-based facilities and those on the main campus of the hospital. However, OIG continues to believe that monitoring appropriate billing is important for both off-campus and on-campus provider-based facilities.

CMS did not concur with our second recommendation to require hospitals to submit attestations for all of their provider-based facilities. CMS stated that it shares OIG's concerns about vulnerabilities in provider-based billing and described steps it has taken to address this issue. These include implementing a new modifier and place-of-service codes for claims furnished in an off-campus provider-based facility. Although these are positive steps, we do not believe they fully address vulnerabilities. We continue to recommend that CMS require hospitals to submit attestations for all provider-based facilities, to ensure that CMS is aware of all provider-based facilities and that they meet provider-based requirements.

CMS concurred with our third recommendation to ensure that regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews, and it described actions it has taken toward this end.

Finally, CMS concurred with our fourth recommendation to take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements and indicated that it will work with the MACs to recover any overpayments and revise the provider's prospective payment to those for freestanding units found to be out of compliance.

For the full text of CMS's comments, see Appendix F.

APPENDIX A

42 CFR § 413.65(d) and Transmittal A-03-030 describe the following requirements that are applicable to both hospitals and on- and off-campus provider-based facilities, as well as additional requirements applicable only to off-campus facilities.

Provider-Based Requirements

(1) Licensure: A provider-based facility and the main provider must be operated under the same license, unless State laws prohibit this or require separate licenses. Documentation may include a copy of the State license or documentation that the State in which the facility is located requires a separate license.

(2) Clinical Services Integration: A provider-based facility and main provider must have integrated clinical services as evidenced by the following:

- professional staff of the provider-based facility have clinical privileges at the main provider;
- the main provider maintains the same monitoring and oversight of the facility as it does for any other hospital department;
- the medical director of the provider-based facility maintains a reporting relationship with the main provider's chief medical officer or other similar official who has the same frequency, intensity, and level of accountability as the relationship between this official and other medical directors within the main provider;
- medical staff committees or other professional committees at the main provider are responsible for medical activities in the provider-based facility, including quality assurance, utilization review, and the coordination and integration of services, to extent practicable, between the provider-based facility and the main provider;
- the main provider and facility seeking provider-based status have a unified retrieval system for medical records; and
- inpatient and outpatient services of the main provider and provider-based facility are integrated and patients have full access to all services of the main provider.

Documentation may include information about whether professional staff of the provider-based facility have clinical privileges at the main provider, a copy of the record retrieval policy of the main provider and provider-based facility, and examples of inpatient and outpatient service integration.

(3) Financial Integration: The main provider and a provider-based facility must have fully integrated financial operations. The costs of a provider-based facility must be reported in the appropriate cost center on the main provider's cost center and the financial status of any provider-based facility must also be incorporated and readily identified in the main provider's trial balance. Documentation may include the appropriate section of a main provider's cost report or trial balance that show the provider-based facility's revenues and expenses.

(4) Public Awareness: The provider-based facility is held out to the public and other payers as part of the main provider. Documentation may include letterhead with a shared name, websites, and other examples to show that the facility is part of the main provider.

(5) Compliance with Hospital Rules: Hospital-based entities and on- and off-campus provider-based facilities (i.e., hospital outpatient departments) must comply with applicable hospital anti-dumping, nondiscrimination, and health and safety rules.[36] Provider-based facilities are also subject to the main provider's agreement with Medicare and must also meet Medicare payment rules. Documentation may include copies of anti-dumping and nondiscrimination policies.

Additional Provider-Based Requirements for Off-Campus Facilities

(1) Operation Under the Ownership and Control of the Main Provider: An off-campus provider-based facility must operate under the ownership and control of the main provider. The main provider must own 100-percent of the provider-based facility and have final responsibility and approval for administrative and personnel decisions. A provider-based facility and main provider must also have the same governing body and operate under the same organizational documents. Documentation may include bylaws for the main provider and provider-based facility.

(2) Administration and Supervision: The reporting relationship between an off-campus provider-based facility and main provider must have the same frequency, intensity, and level of accountability that exists between the main provider and one of its existing facilities. This criterion includes additional requirements concerning direct supervision, monitoring, and oversight of the provider-based facility and the integration of administrative functions (e.g., billing services, payroll). Documentation

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[36] 42 CFR § 413.65(g) sets forth requirements applicable only to provider-based facilities (i.e., hospital outpatient departments), as well as requirements applicable to both provider-based facilities and hospital-based entities. For hospital antidumping rules, see 42 CFR §§ 489.20(1), (m), (q), and (r) and § 489.24. For hospital nondiscrimination rules, see 42 CFR § 489.10(b). For hospital health and safety rules, see 42 CFR part 482.

may include an organizational chart that reflects reporting relationships and a list of the integrated administrative functions.

(3) Location: A provider-based facility must be located within a 35-mile radius of the main provider's campus. There are several exceptions to this criterion, including facilities that are owned by the main provider with a disproportionate share adjustment, facilities that demonstrate high levels of integration with the main provider, and rural health centers that meet the other provider-based requirements.[37] Documentation may include maps indicating the location of each facility.

(4) Obligation to Deliver Written Notice to Beneficiaries: When providing treatment to a Medicare beneficiary that is not required by anti-dumping rules, off-campus provider-based facilities (i.e., hospital outpatient departments) must give beneficiaries written notice of potential co-insurance liabilities before delivering the service.[38] This notice must indicate the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital, as well as for the physician's service and an estimate of the amount of that additional liability. Documentation may include a copy of the form given to patients and a copy of policies regarding distribution of the form.[39]

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[37] Disproportionate share adjustments (i.e., increased payments) are available to certain hospitals that serve a disproportionate share of low-income patients. 42 CFR § 412.106.

[38] If a provider-based facility provides examination or treatment that is required to be provided by the antidumping rules of 42 CFR § 489.24, notice must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

[39] Notices are not required if the facility furnishes services for which the beneficiary will not be charged coinsurance. However, an Advance Beneficiary Notice (ABN) does not meet this requirement. An ABN must be issued when a provider believes that Medicare may not pay for an item or service that it usually covers because the item or service is not considered medically reasonable and necessary. In these cases, the beneficiary must pay the provider directly for any noncovered services.

APPENDIX B

Detailed Methodology

To determine the number of provider-based facilities that hospitals owned, we selected a random stratified statistical sample of hospitals from the population of hospitals participating in Medicare nationwide. We sent an information request to each hospital selected. We collected information from CMS regional offices and MACs to determine the extent to which CMS has procedures to oversee provider-based billing. We also asked CMS whether it has conducted analyses to determine the benefits of the provider-based designation.

We collected and analyzed supporting documentation from a purposive sample of 50 hospitals that reported owning off-campus provider-based facilities but had not voluntarily attested that these facilities met all provider-based requirements. We determined the extent to which these hospitals and their off-campus provider-based facilities met all provider-based requirements.[40] Finally, we collected and analyzed data to determine the number of attestations that CMS reviewed in 2012 and the results of these reviews, as well as whether there were challenges associated with this review process.

Data Collection and Analysis

Determining the Number of Hospitals That Owned Provider-Based Facilities. We sent an information request to 333 sampled hospitals. To select our sample, we used CMS's Certification and Survey Provider Enhanced Reporting database to identify the population of 5,119 hospitals that participated in Medicare and received OPPS payments in 2012. We organized these hospitals into three strata based on the number of beds in the hospital.

We randomly selected hospitals from each strata, resulting in a total of 333 hospitals. Of these 333 hospitals, 272 responded to our request, a weighted response rate of 84 percent. Table B-1 shows the number of hospitals in each stratum, the number of sampled hospitals in each stratum, the number of hospital respondents, and response rate for each stratum.

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[40] We collected and analyzed supporting documentation from off-campus provider-based facilities because the hospitals that own them must maintain supporting documentation for these facilities even if they do not submit a voluntary attestation. Hospitals that own on-campus provider-based facilities and choose to submit a voluntary attestation have to attest only that these facilities meet requirements but are not required to submit supporting accompanying documentation.

Table B-1: Hospital Response Rate by Stratum, 2013

Stratum	Number of Hospitals in Stratum	Number of Hospitals in Sample	Number of Hospital Respondents	Response Rate
0–300 Beds	4,232	150	127	85%
301–1,000 Beds	854	150	123	82%
Greater Than 1,000 Beds	33	33	22	67%
Total	**5,119**	**333**	**272**	**84%***

Source: OIG analysis of CMS's Certification and Survey Provider Enhanced Reporting database and 2013 hospital respondent data, 2015.
*Total response weight is weighted by each stratum.

The estimates in this report were derived from measures obtained from the 272 responding hospitals in our sample of 333 hospitals.

We sent an information request to hospitals in May 2013 to obtain information about the provider-based facilities the hospitals' owned. The information request asked hospitals to report the following information:

- the number of provider-based facilities the hospital owned and the number that were on and off campus,
- the number of provider-based facilities for which the hospital had attested,
- the distance in miles between the provider-based facility and the owning hospital for all provider-based facilities owned by the hospital, and
- ownership type (e.g., part of a health system).[41]

We analyzed the responses to determine the extent to which hospitals owned provider-based facilities and to identify the locations of these facilities.

Assessing CMS Oversight of Provider-Based Billing. We sent a separate information request to all 10 CMS regional offices and 14 MAC

[41] For purposes of this report, we define provider-based facilities as those that are owned by and integrated with a hospital and billing Medicare as a hospital outpatient department. Additionally, according to the American Hospital Association, a system is either a multihospital or a diversified single hospital system. A multihospital system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization. Single, freestanding hospitals may be categorized as a system by bringing into membership three or more, and at least 25 percent, of their owned or leased non-hospital preacute or postacute health care organizations. American Hospital Association, Fast Facts on US Hospitals. Accessed at www.aha.org/research/rc/stat-studies/fast-facts.shtml on February 26, 2016.

jurisdictions that were operational in 2012.[42] We asked them to document the procedures they used to ensure appropriate provider-based billing, such as how CMS identified facilities that were improperly billing as provider-based (i.e., hospitals and provider-based facilities billing Medicare but not meeting these requirements), and whether resulting overpayments were recouped from these facilities and owning hospitals.

We also asked CMS and MAC staff how CMS calculates overpayment amounts to facilities improperly billing as provider-based.

We received responses from all 10 CMS regional offices and 14 MAC jurisdictions. We reviewed responses and supporting documentation.

We also spoke with CMS staff to determine whether they have conducted analyses to determine the benefits of the provider-based designation.

Determining the Extent to Which Hospitals and Off-Campus Facilities That They Owned Met Provider-Based Requirements. Of the 272 hospitals that responded to our request, 84 hospitals reported a total 694 off-campus provider-based facilities for which they had not voluntarily attested. To ensure that we selected facilities from different types of hospitals we organized these 84 hospitals into three strata based on the number of off-campus provider-based facilities that the hospitals owned. We purposively selected a total of 50 hospitals and facilities from these three strata based on location of the provider-based facility to the hospital and size (i.e., number of beds) of the hospital. We applied this criteria to ensure variability in facility distance from the hospital (i.e., over 250 yards to no more than 35 miles) and hospital size.

See Table B-2 for selection of hospitals in our purposive sample, as well as the number of hospitals in each stratum, the number of hospitals selected from each stratum, and the percentage of hospitals selected out of those in each stratum.

[42] We defined operational MAC jurisdictions as those that reviewed provider-based attestations in 2012.

Table B-2: Selection of Hospitals in Our Purposive Sample, 2013

Stratum	Number of Hospitals Selected in Stratum	Number of Hospitals in Sample	Percentage of Hospitals Selected Out of Stratum
Owns 0-5 Provider-Based Facilities	30	17	57%
Owns 6-10 Provider-Based Facilities	27	17	63%
Owns Greater Than 10 Provider-Based Facilities	27	16	59%
Total	**84**	**50**	**60%***

Source: OIG analysis of 2013 hospital respondent data, 2015.
*Total is weighted by each stratum.

We sent an information request to the 50 hospitals in our sample and asked whether the hospital and the selected off-campus provider-based facilities that they owned met requirements in 42 CFR § 413.65. We requested supporting documentation for these responses. We received responses and documentation from all 50 hospitals and determined whether hospitals and facilities met all provider-based requirements. If the hospital indicated they met a requirement, we asked it to provide supporting documentation. For instance, if a hospital stated that it owned 100-percent of a provider-based facility (one of the requirements for an off-campus facility), we asked for documentation supporting this response. While CMS Transmittal A-03-030 contains examples of documents that indicate compliance with provider-based requirements, CMS has not developed a list of specific documents that must be submitted with attestations to support compliance with these requirements. Therefore, we were conservative in our analysis and if the documentation submitted was not among the types of acceptable example documents listed in CMS Transmittal A-03-030, we reviewed the content of the documentation to determine whether it met requirements.

We determined that hospitals and their provider-based facilities did not meet requirements if the hospitals provided documentation that did not meet requirements (e.g., stating that the hospital and provider-based facility were integrated but providing documentation that did not support this response) or if the hospital reported that it did not have documentation that it met requirements. Additionally, if hospitals and their provider-based facilities did not meet one element of a requirement, we determined that they did not meet the requirement.

Determining the Number of Attestations CMS Reviewed in 2012 and the Results of These Reviews. To determine the number of provider-based attestations that CMS reviewed in 2012, we reviewed CMS's management

information system data that contained the number of attestations received in 2012 and the results of CMS's reviews of these attestations (e.g., approvals and denials). At that time, the database contained observations for 942 attestations; however, CMS had entered decisions (e.g., approval, denial) for only 715 of these 942 attestations. Therefore, we did not include the remaining 227 attestations in our analysis. Of these 715 attestations, we determined the number and percentage that were approved for provider-based status, and whether they were on or off campus. We also calculated the number of attestations that regional offices returned because the attestations lacked documentation or were incomplete in other ways, as well as those the hospital withdrew or cancelled submitting it.

In addition, we collected information from CMS and MACs about the provider-based review process, such as whether CMS or MACs had experienced any challenges during its reviews, and the reason for these challenges. We received responses from all 10 CMS regional offices and 14 MAC jurisdictions.

APPENDIX C

Sample Sizes, Point Estimates, and 95-Percent Confidence Intervals

Estimate Description	Sample Size	Point Estimate	Confidence Interval
Percentage of hospitals that owned at least one on- or off-campus provider-based facility	**272**	**49.7%**	**42.4%–57.0%**
Average number of provider-based facilities that hospitals owned	**168**	**6.0**	**4.8–7.2**
Percentage of hospitals that own provider-based facilities that have not attested for at least one (i.e., some or none) of these facilities	**168**	**60.9%**	**51.2%–70.6%**
Percentage of hospitals that own provider-based facilities that have not attested for any (i.e., none) of their facilities	**168**	**43.1%**	**33.2%–53.1%**
Percentage of hospitals that own provider-based facilities that have attested for some of their facilities	**168**	**18.3%**	**10.5%–26.1%**
Percentage of hospitals that own provider-based facilities that have attested for all of their facilities	**168**	**38.6%**	**28.6%–48.5%**

Source: OIG analysis of 2013 hospital respondent data, 2015

APPENDIX D

Description and Number of Hospitals That Owned Facilities That Did Not Meet Provider-Based Requirements

Thirty-seven of the 50 hospitals in our sample provided information for their off-campus facilities that did not support compliance with at least one provider-based requirement. Twenty-four hospitals that owned off-campus provider-based facilities did not meet requirements to operate their provider-based facility under the control of the hospital. Of these, 14 hospitals owned provider-based facilities that did not meet the requirement that the main provider have final approval or responsibility over the facility for decisions, such as personnel actions and medical staff appointments. The remaining 10 hospitals owned facilities that did not meet other requirements, such as showing that the provider-based facility and main provider operated under the same organizational documents or that these providers were governed by the same body.

Twenty-one hospitals owned off-campus facilities that did not meet requirements related to the administration and supervision of the provider-based facility. All of these hospitals owned facilities that did not meet the requirement that administrative functions (e.g., human resources, billing services) be integrated with those of the main provider.

Eighteen hospitals in our sample owned off-campus facilities that did not meet the clinical services integration requirements, despite this being one potential benefit of provider-based billing. Of these, seven hospitals submitted documentation that indicated beneficiaries treated at the provider-based facility who required further care did not have full access to services at the main provider. The remaining 11 hospitals owned facilities that did not meet other requirements, such as integrating the medical records of the provider-based facility and the main provider or ensuring that professional committees at the main provider were responsible for quality assurance activities and integration of services in the provider-based facility.

Ten hospitals owned off-campus facilities that did not meet requirements to make beneficiaries aware that the facility was a part of the hospital. This noncompliance could lead to beneficiaries being unaware of the additional co-insurance liability incurred when receiving services at these facilities.

Additionally, two hospitals owned off-campus facilities that did not meet requirements to comply with hospital rules. These hospitals owned facilities that did not report compliance related to billing correct place-of-service codes. For instance, one of the hospitals reported that physicians

in the facility billed place-of-service code 11 for provider-based services, while these facilities should have used code 22. Code 11 should be used by facilities that are not under the control of an owning hospital. Using the incorrect service code could result in potential overpayments.[43]

Nineteen of the 50 hospitals in our sample reported that they did not have documentation to support that the off-campus facilities that they owned met provider-based requirements. These 19 hospitals in our sample reported that they owned off-campus facilities that met provider-based requirements but stated that they did not have supporting documentation. Specifically, nine hospitals in our sample did not have documentation supporting that clinical services at the provider-based facility were integrated with those of the main provider. Of these, six hospitals did not have documentation to support that medical records from the provider-based facility were integrated with those of the main hospital. The remaining three hospitals did not have documentation to support other requirements, such as the requirement that medical committees at the main provider are responsible for medical activities in the provider-based facility.

Five hospitals stated that they did not have documentation of a hospital license or regulations stating that off-campus provider-based facilities that they owned do not need to be included on the hospital's license.

Four hospitals in our sample stated that they did not have supporting documentation showing that the off-campus facilities they owned met requirements related to the administration and supervision of the provider-based facility. Nor did these hospitals have documentation showing that the hospital was responsible for certain administration functions, such as human resource and purchasing services, which were integrated with the main provider.

Three hospitals stated that they did not have supporting documentation showing that the off-campus provider-based facilities they owned operated under the control of the main provider. For instance, hospitals did not have documentation showing that the provider-based facility operated under the same organizational documents (e.g., bylaws) as the main provider.

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[43] If a provider-based facility uses the incorrect place of service code when billing for physician services, Medicare and beneficiaries pay for the hospital's facility component of the service under OPPS and for the physician component of the service under the MPFS (i.e., non-facility) rate. This results in an overpayment because the Medicare reimbursement equals the non-facility MPFS rate plus the OPPS rate, rather than the reduced (i.e., facility) MPFS rate plus the OPPS rate.

For the remaining three requirements, hospitals stated that they did not have supporting documentation showing that the facilities they owned met requirements related to financial integration, public awareness, and location of the provider-based facility relative to the main provider. For instance, one hospital did not have documentation showing the provider-based facility's financial status was readily incorporated into the main provider's trial balance. Another hospital stated that it did not have documentation to make beneficiaries aware that the provider-based facility it owned is part of the hospital, which would cause beneficiaries to incur higher copayments. Specifically, this hospital did not have documentation of written notices informing beneficiaries that the facility is provider-based and that a visit to the facility would result in an additional copayment. Finally, one hospital stated that it did not have documentation to support that the provider-based facility it owned was clearly identified as part of the main provider and another hospital did not have documentation to support that its provider-based facility was less than 35 miles from the main provider.

APPENDIX E

Number and Percentage of Attestations that CMS Regional Offices Approved for Provider-Based Status, 2012

Regional Office	Number of Attestations Approved	Number of On-Campus Attestations Approved	Number of Off-Campus Attestations Approved	Number of Attestations for Which Regional Offices Made Decisions	Percentage of Attestations Approved
1 – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	77	23	54	79	97%
2 – New Jersey, New York, Puerto Rico, Virgin Islands	6	1	5	10	60%
3 – Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	6	5	1	29	21%
4 – Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	255	66	189	267	96%
5 – Illinois, Indiana, Ohio, Michigan, Minnesota, Wisconsin	89	28	61	102	87%
6 – Arkansas, Louisiana, New Mexico, Oklahoma, Texas	61	10	51	64	95%
7 – Kansas, Iowa, Missouri, Nebraska	17	5	12	25	68%
8 – Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	53	22	31	55	96%
9 – American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands	25	7	18	26	96%
10 – Alaska, Idaho, Oregon, Washington	57	18	39	58	98%
Total	**646**	**181**	**461**	**715**	**90%**

Source: OIG analysis of CMS management information system database, 2015.

APPENDIX F

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

FEB 2 9 2016

To: Daniel R. Levinson
Inspector General
Office of Inspector General

From: Andrew M. Slavitt /S/
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain (OEI-04-12-00380)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to protecting taxpayer dollars by ensuring proper billing by provider-based facilities.

Medicare payments for physicians' services vary depending on whether they are furnished at a freestanding facility or provider-based facility. A provider-based facility operates under a hospital's ownership and meets the requirements in our regulations while a freestanding facility furnishes services to Medicare beneficiaries but is not integrated with a hospital. Under our regulations, provider-based facilities can either be on-campus (within 250 yards from the main provider) or off-campus (greater than 250 yards). Total Medicare payment for services furnished in provider-based facilities is generally higher than Medicare payment for the same services furnished in freestanding facilities because those services are also paid under the Hospital Outpatient Prospective Payment System (OPPS).

As OIG noted in its report, CMS has taken positive steps to address vulnerabilities in provider-based billing. In 2015, the President's FY 2016 HHS budget included a proposal to equalize payments for services furnished in all off-campus provider-based and freestanding facilities. The amendments made by section 603 of the Bipartisan Budget Act of 2015 partially enacted this proposal by requiring certain off-campus provider-based facilities to be paid under the applicable payment systems other than the OPPS beginning on January 1, 2017. CMS is working to implement this provision.

In addition, CMS continues to seek a better understanding of the growing trend toward hospital acquisition of physicians' offices and the impact on beneficiary cost-sharing. In order to better track these trends, on January 1, 2016, CMS began requiring facilities to use a modifier on hospital outpatient claims identifying when a service has been furnished in an off-campus provider-based department. Similarly, CMS requires physicians to use a new place-of-service

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code that distinguishes whether a service was furnished in an off-campus facility or an on-campus facility. CMS is using the data from this new modifier and place-of-service code to analyze the frequency, type, and payment for services furnished in off-campus provider-based hospital departments.

OIG Recommendation

OIG recommends that CMS implement systems and methods to monitor billing by all provider-based facilities.

CMS Response

CMS partially concurs with this recommendation. In the CY 2015 OPPS Final Rule, CMS created a Healthcare Common Procedure Coding System (HCPCS) modifier "PO" for hospital claims that is to be reported for items and services furnished in an off-campus provider-based department of a hospital. In addition, physician and practitioner claims furnished in off-campus provider-based departments are required to use new place-of-service codes. Reporting of this new modifier and place of service codes became mandatory on January 1, 2016, and will allow CMS to better monitor billing by off-campus provider-based facilities. We believe the major policy concerns regarding this issue are with hospitals acquiring physicians' offices that are off-the-campus of the hospital, making such offices into provider-based departments, and billing Medicare under the OPPS for the services furnished in such departments even though nothing has changed about the services being furnished. We do not believe there are the same concerns with on-campus provider-based departments. Further, we note that the distinction between the parts of the main campus of the provider that are part of that provider and those parts of the main campus that are provider-based is much more difficult to parse than the location distinction for off-campus provider-based departments. Finally, we note that concerns regarding patient understanding of whether they are in a provider-based department or a freestanding clinical setting are most acute in off-campus settings. For all of these reasons, we do not believe it is prudent to focus our resources on distinguishing among services provided on the main campus of the hospital.

OIG Recommendation

OIG recommends that CMS require hospitals to submit attestations for all provider-based facilities.

CMS Response

CMS non-concurs with this recommendation. CMS shares the OIG's concerns about possible vulnerabilities in provider-based billing. CMS has taken several steps to address this issue, including implementing a new modifier and place-of-service codes for claims furnished in an off-campus provider-based facility. The amendments made by section 603 of the Bipartisan Budget Act of 2015 also requires certain off-campus provider-based entities to be paid under the applicable payment systems other than the OPPS rate beginning on January 1, 2017, which may

limit the vulnerability identified by the OIG in provider-based billing. After implementing such amendments, CMS will consider whether additional activities are needed to ensure that only those facilities that qualify as provider-based departments are being paid at the OPPS rate.

OIG Recommendation

OIG recommends that CMS clarify the documentation that hospitals must submit to demonstrate that their off-campus provider-based facilities meet requirements.

CMS Response

CMS concurs with this recommendation. CMS has worked with the Medicare Administrative Contractors (MACs) to streamline the attestation review process including developing tools to make sure provider-based facilities meet all requirements. CMS also hosted a training session for CMS staff and MACs to review the provider-based status regulations and the attestation process.

OIG Recommendation

OIG recommends that CMS take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements.

CMS Response

CMS concurs with this recommendation. CMS will work with the MACs to determine if the providers referred by the OIG are out of compliance with the provider-based requirements. If a provider is found to be out of compliance, CMS will work with the MACs to recover any overpayments and revise the provider's prospective payment rates to those for free-standing units.

ACKNOWLEDGMENTS

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David Samchok served as lead analyst for this study. Central office staff who provided support include Clarence Arnold, Evan Godfrey, and Joanne Legomsky.

Office of Inspector General

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Maine Task Force to Evaluate the Impact of Facility Fees on Patients

Development of Connecticut's laws related to facility fees

Vicki Veltri, former Executive Director, CT Office of Health Strategy
December 7, 2023

Facility Fees Restrictions in CT

- **Consumer Notice:** Required facilities to provide notice to consumers of facility fees for evaluation and management services in 2014 (HB 5337)
- **Facility Fee Prohibition:** No hospital, health system or hospital-based facility shall collect a facility fee for:
    1. Outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code or assessment and management (CPT A/M) code and are provided at a hospital-based facility located off-site from a hospital campus, or
    2. Outpatient health care services provided at a hospital-based facility located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate.

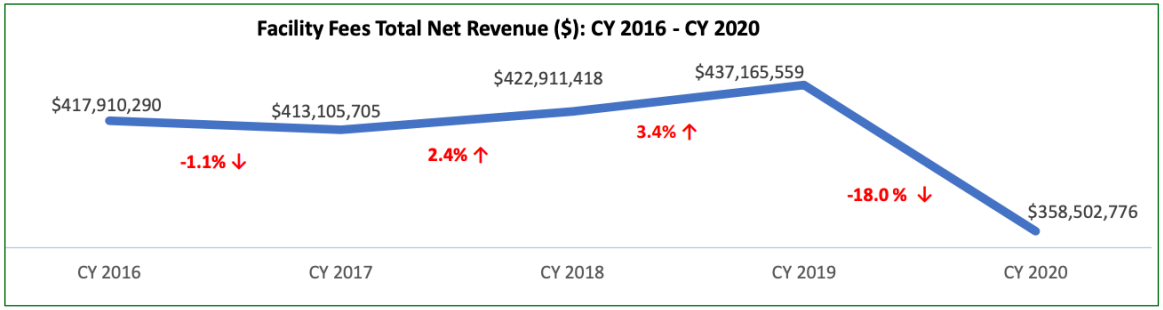
    **First enacted in 2015, effective in 2017 (SB 811)*

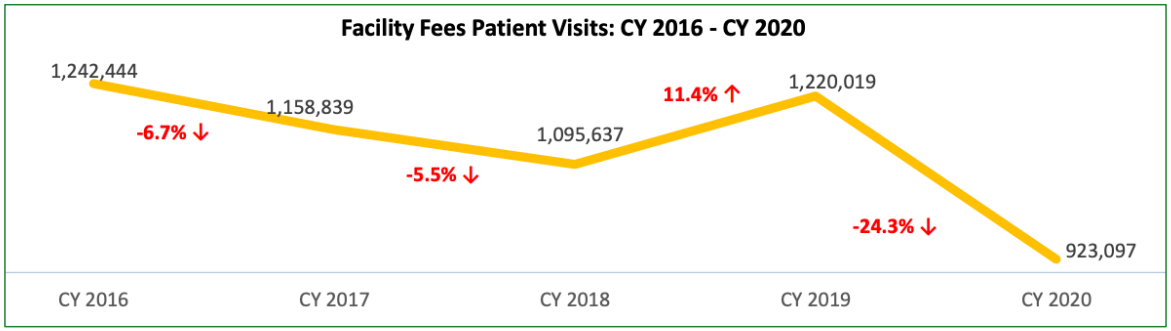
Facility Fee Restrictions in CT

- Connecticut has updated its facility fee regulations several times since 2014
  - Added a prohibition on services that use assessment and management (CPT A/M) codes in response to hospitals assessing facility fees for these codes (2021)
  - Added a prohibition on facility fees for telehealth regardless of the location of services (2022)
  - Added an on campus ban on the same codes except for an emergency department located on a hospital campus, observation stays on a hospital campus, and (CPT E/M) and (CPT A/M) codes on campus when billed for certain services (2023)

Facility Fee Restrictions in CT

- Connecticut also requires hospitals to provide notice to consumers about facility fees and to submit data on facility fee revenue to the Office of Health Strategy (OHS)
  - OHS publishes data annually and makes all filings available to the public
  - Detailed reporting requirements (e.g. fees by payer mix, CPT codes, top ten services with facility fees) were updated in 2021 and 2023





Source: https://portal.ct.gov/-/media/OHS/ohca/Facility-Fees/CY-2016-2020-Facility-Fee-Filing-Trend-Report.pdf

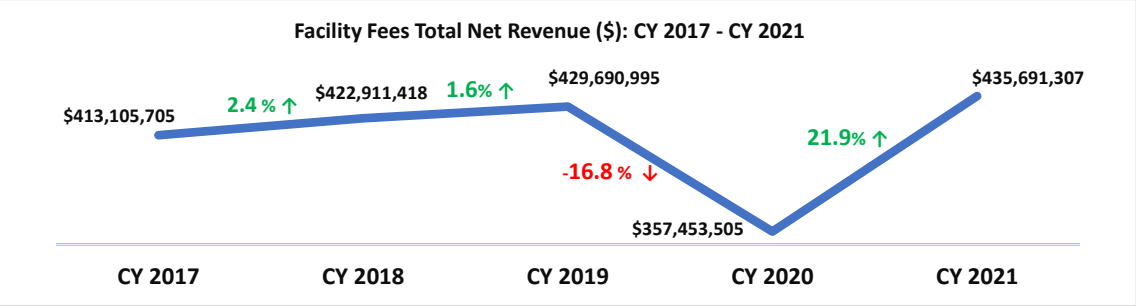
Facility Fee Revenue Trends, 2016 – 2020

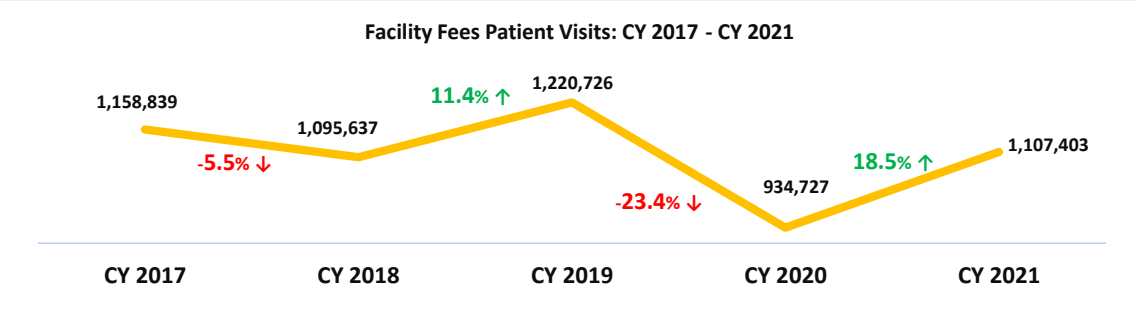
- Facility Fee Total Revenue was increasing before the pandemic
- Total patient visits with facility fees have fluctuated over time but were most recently increasing

Key Findings from CT's 2020 Facility Fee report

- Outpatient facility fees were down 18% to $358.5 million from 2019 to 2020
- Patient visits generating facility fees decreased 24.3%
- In CY2020, cardiovascular procedures generated the most facility fee revenue, nearly $19 million
- 62% of the facility fee revenue was paid by employer and commercial health plans on behalf of policyholders
  - These health plans also paid the highest average facility fees at $620 per visit.

Source: https://portal.ct.gov/OHS/Press-Room/Press-Releases/2021-Press-Releases/Office-of-Health-Strategy-Releases



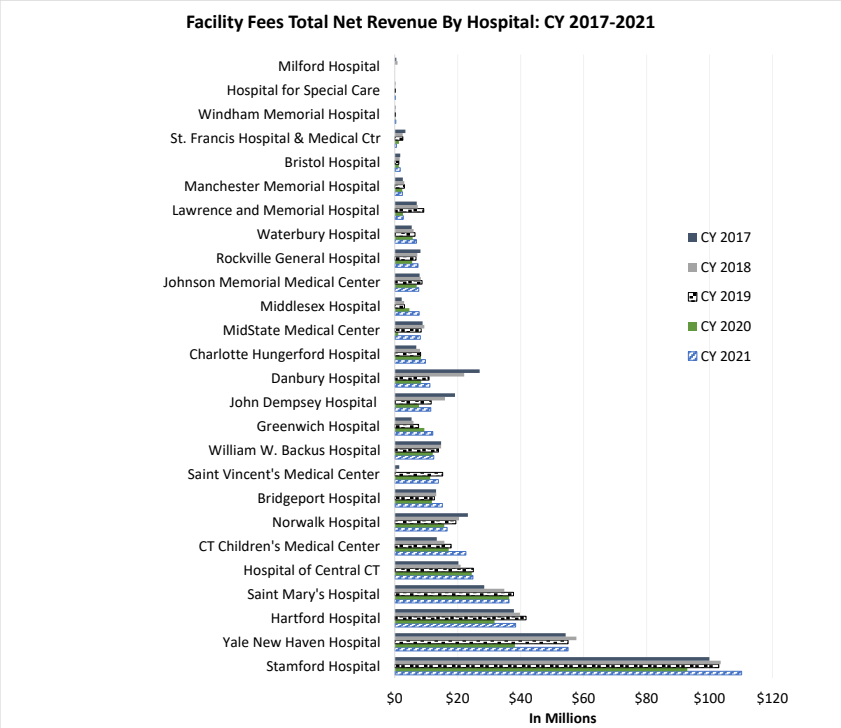


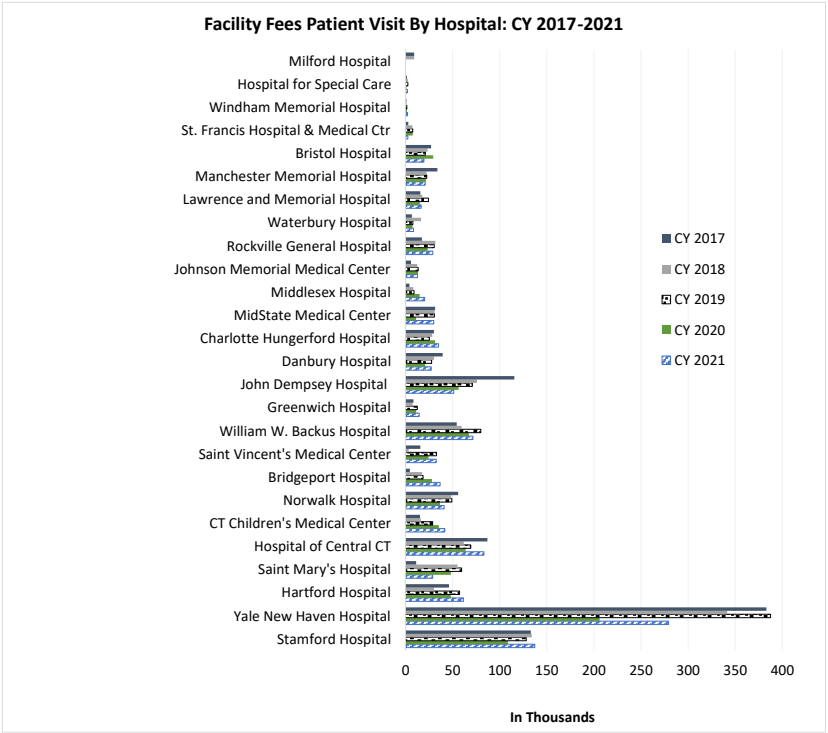
Source: https://portal.ct.gov/-/media/OHS/ohca/Facility-Fees/CY-2017-2021-Facility-Fee-Filing-Trend-Report.pdf

Facility Fee Revenue Trends, 2017-2021

- Facility Fee Total Revenue rebounded in 2021
- Total patient visits with facility fees have fluctuated over time but were most recently increasing and rebounded in 2021

Hospital-Specific Data Example





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