North Carolina Healthcare Association

2024 NCHA Legislative Brief

Facility Fees

Facility fees finance the high acuity, 24/7 standby capacity that only hospitals provide for and no payor covers the full cost.

NCHA strongly supports facility fees, which fund the direct and indirect costs that allow hospitals to continue to provide services to patients and serve the needs of their community, allowing specialty care to remain close to home.

Context & Insights

Facility fees are best described as “care-team” fees as they cover the team of nurses, medical assistants, lab and radiology technicians, environmental services, interpreters, front desk personnel, and the many others that help to deliver care within outpatient settings, and technical expenses such as electronic medical records, equipment, and supplies.

Why do facility fees exist?

Unlike independent outpatient clinics, hospital outpatient clinics are required by Medicare, Medicaid, and some private insurance carriers to bill facility fees, better described as “care-team” fees separately from the provider fees. However, non-hospital clinics are allowed to bundle these costs into one fee. Receiving a single bill from non-hospital clinics does not mean you are not paying for these costs; they are just combined as these locations are allowed to submit one global bill. While both sites receive payment for their facility fees, hospital outpatient sites tend to have higher fees due to the additional regulatory requirements and availability of required specialty care. Also, hospitals receive a reduced payment for the professional fee to account for the two separate bills.

BILL EXAMPLE 1

Hospital Outpatient Clinic Visit

Bill for Professional Fee

Covers the cost of the service the doctor or professional staff provides.

Billing for Facility Fee

Covers the cost of nurses, other clinical staff, front desk personnel, environmental services, leasing the clinic space, equipment, supplies, maintaining electronic medical records, etc.

BILL EXAMPLE 2

Private Practice Physician Visit

“Global” Bill

Covers the cost of the service the doctor or professional staff provides and the cost of nurses, other clinical staff, front desk personnel, environmental services, leasing the clinic space, equipment, supplies, maintaining electronic medical records, etc.

In 2023, proposed legislation ("Medical Debt De-Weaponization Act") was introduced to create new legal protections to address medical debt collections. A provision was added to the legislation that would prohibit most non-hospital healthcare facilities from charging facility fees and prohibit hospitals from charging facility fees for specified services identified by NC DHHS regardless of location.

Prohibiting facility fees would eliminate the funds utilized to pay dedicated "care-team" members along with the valuable assets that hospitals provide to their community. North Carolina health systems and hospitals are significant economic engines for the state through job creation and more. These organizations are one of the 10 largest employers in 92 of North Carolina's 100 counties and a top 3 employer in 45 counties (U.S. Bureau of Labor Statistics, 2021).[1]

Over the last decade, legislation has resulted in significant cuts from government payors thereby reducing funding for these dedicated "care-team" members. Section 603 of the Bipartisan Act of 2015 resulted in reduced payments for any outpatient services provided in off-campus provider-based departments, except emergency department services that were established on or after Nov. 2, 2015. These non-grandfathered services began billing at 40% of the previous amount under the outpatient prospective payment system (OPPS).[2] In 2021, this reduced rate was applied to previously grandfathered hospital outpatient departments (HOPDs) as well, a reduction of 60%.[3] Continued cuts from government and non-government payors will threaten access to care, especially in rural communities.

Key Advocacy Messages

North Carolinians depend on the unique benefits of hospitals and eliminating facility fees would significantly jeopardize access to essential care in local communities, particularly our rural communities.

- The elimination of facility fees would cut the funding used to pay for the staff and resources utilized to care for patients beyond the doctor and advanced practice provider who submit a separate bill. The facility fee helps cover the costs of these "care-team" members who play a vital role in patient care.
- Because hospitals have a unique duty to serve all regardless of their ability to pay, hospital outpatient clinics tend to serve a higher proportion of government payors and self-pay and lower rate of commercial payors.[4]

Given Their Unique Role, Hospitals Are Held to Higher Standards than Ambulatory Surgery Centers and Physician Offices

Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✓		
Backup for Complications Occurring in Other Settings	✓		
EMTALA	✓		
Uncompensated Care/ Safety Net	✓		
Teaching/Graduate Medical Education	✓		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✓		
Required Government Cost Reports	✓		
Equipment Redundancy Requirements	✓		
Disaster Preparedness and Response	✓	✓	
Annual Hazard Vulnerability Analysis	✓	✓	
Stringent Ventilation Requirements and Infection Control Codes	✓	✓	
Fire and Life Safety Codes (NFPA 101)	✓	✓	
Essential Electrical System (NFPA 99)	✓	✓	
Evacuation and Relocation and Quarterly Fire Drills	✓	✓	
Infection Control Program	✓	✓	
Quality Assurance Program	✓	✓	
Joint Commission Accreditation	✓	✓	

None of these roles are specifically funded. Instead, hospitals must cover the costs of complying with these requirements through their direct patient care revenue.

North Carolina has the 2nd largest rural population in the country[9] and eliminating facility fees would jeopardize access to care in rural communities.

- Our hospital and health systems ensure access to care and establish access points to provide primary and specialty care closer to homes.
- Patients residing in rural communities rely on these access points, particularly HOPDs, for their care. The more rural the county, the more likely they are to seek care in HOPDs than in a physician office. For patients in counties where 90% or more of the population live in a rural area, 36% of the physician visits occur in an HOPD. It drops to 32% for counties where less than 90%, but more than 25% reside in a rural area.[5]
- Hospitals invest in rural communities despite the economics. As a result, hospitals are 2.5 times more likely to acquire practices in rural communities than insurance companies, which are typically focused on the larger more profitable markets. The county-level population was 61.4% larger where commercial insurers acquired physician practices and the median household income was 18.4% higher than it was for hospitals.[5]

Independent clinics and hospital-owned clinics are not the same.

- The cost of care delivered by hospitals and health systems reflects the distinct benefits they provide to the communities they serve, distinguishing them from other sites of care. These differentiating assets include standby capability and capacity for disaster response and public health emergencies, as well as 24/7 emergency care to all regardless of ability to pay or insurance status.
- Additionally, hospital outpatient clinics are required to follow the same strict guidelines for hospitals that independent outpatient care settings do not. For example, stricter accreditations and credentialling/certification requirements of clinical staff.
- Findings from a recent study demonstrated that Medicare patients who receive care in a hospital outpatient department were more likely to come from medically underserved populations, be sicker, and require more complex care than Medicare patients treated in an independent physician clinic and ambulatory surgery center.[6]
- North Carolina is unique in having five health systems with academic affiliations. This is a tremendous benefit to North Carolina as many other states have far fewer university affiliated outpatient facilities. As a result, patients have access to participate in innovative clinical research opportunities they would otherwise miss if treated in a traditional physician practice.

Eliminating facility fees charged by hospital-based outpatient clinics will likely not lower out of pocket costs for consumers or lower healthcare spending.

- As mentioned previously, CMS requires outpatient clinics affiliated with hospitals to bill facility fees separately. These fees do not substantially impact cost of care for beneficiaries unless the insurer decides to pass that fee onto the patient.
- Some have argued that hospital facility fees have led to the consolidation of independent physician practices. In actuality, insurance companies and private equity firms have driven most of the physician practice acquisition in the last five years.[7]
  - Between 2019 and 2023, private equity entities accounted for 65% of the physician practice acquisition deals, followed by physician medical groups at 14% and insurers at 11%. Hospitals and health systems made up just 6% of these deals.[7]
  - Overall, research has shown that private equity investments have resulted in increased costs among other harmful impacts.[8]

Sources

1. NCHA Economic Impact Report, December 2022. Accessed online April 2024.
2. American Hospital Association, Fact Sheet: Site-neutral Payment Provisions, September 2019. Assessed online May 1, 2024.
3. Proposals to Reduce Medicare Payments Would Jeopardize Access to Essential Care and Services for Patients, June 2023. Accessed online May 1, 2024.
4. Patient Data System (PDS), 2021
5. American Hospital Association, Analysis: Hospitals and Health Systems Are Critical to Preserving Access to Care for Rural Communities, January 2024. Accessed online April 2024.
6. Comparison of Medicare Beneficiary Characteristics Between Hospital Outpatient Departments and Other Ambulatory Care Settings, King Health Consulting, LLC, March 22, 2023. Accessed online April 2024.
7. Setting the Record Straight: Private Equity and Health Insurers Acquire More Physicians than Hospital, American Hospital Association, June 2023. Accessed online April 2024.
8. The Growth of Private Equity in US Health Care: Impact and Outlook National Institute for Healthcare Management (NIHCM), Expert Voices. Accessed online May 1, 2024.
9. NC Office of State Management and Budget. 15 Things We Learned from the New 2020 Census Data. May 25, 2023.

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