Senate Bill 899

Sponsored by Senators MONNES ANDERSON, FAGAN

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires hospitals or health systems that own or operate, in whole or in part, health care facilities that charge facility fees to report specified information to Oregon Health Authority regarding facilities and to notify patients individually and through public displays of specified information regarding facility fees and costs to patients. Requires billing statements that include facility fees to include certain information. Prohibits facility fees for outpatient services located off of hospital's campus under certain conditions.

Permits authority to impose civil penalty for failure of hospital or health system to report required information to authority.

A BILL FOR AN ACT

Relating to fees charged for services provided in hospital-based facilities; creating new provisions; and amending ORS 442.015 and 442.445.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 and 3 of this 2019 Act are added to and made a part of ORS chapter 442.

SECTION 2. (1) A hospital licensed in this state or the hospital's health system shall report to the Oregon Health Authority, in the form and manner prescribed by the authority, the name and location of each hospital-based facility, or facility owned or operated by the hospital or health system, that provides services for which a facility fee is charged or billed, and, for the prior calendar year, the following information regarding each facility:

(a) The number of patient visits at the facility:

(b) The number, total amount and range of facility fees paid by Medicare, Medicaid or insurers to the facility;

(c) The amount of revenue from facility fees received by the hospital or health system from the facility;

(d) The total amount of revenue from facility fees received by the hospital or health system;

(e) A description of the 10 procedures or services that generated the greatest amount of revenue from facility fees and the total amount of facility fees received for each of the procedures or services; and

(f) The top 10 procedures or services, for which facility fees are charged, based on patient volume.

(2) The authority shall post the information reported under subsection (1) of this section on its website in a location that is easily accessible by the public.

SECTION 3. (1) As used in this section and section 2 of this 2019 Act:

(a) "Campus" means:

(A) The physical area immediately adjacent to a hospital's main buildings and other areas

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings; or

(B) Any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus.

(b) "Facility fee" means any fee charged or billed by a hospital or health system for outpatient hospital services provided at 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.

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

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

(2) If a hospital or health system charges a facility fee for outpatient services provided at a hospital-based facility that is located on or off of the hospital's campus, the hospital or health system shall provide to a patient presenting at the hospital-based facility a notice that includes the following information, written in plain language and in a form that may be understood by a patient who does not possess special knowledge regarding hospital or health system facility fees:

(a) A statement that the hospital-based facility charges a facility fee that is in addition to and separate from the professional fee charged by providers at the hospital-based facility;

(b) The amount of the patient's potential financial liability, including any facility fee likely to be charged and any professional fee likely to be charged, or, if the exact type and extent of the medical services to be provided are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for services provided at the hospital-based facility, including the facility fee;

(c) An explanation that the patient may incur financial liability that is greater than the patient would incur if the medical services were not provided at a hospital-based facility; and

(d) If the patient is covered by health insurance, a statement that the patient should contact the insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any.

(3) If services are to be provided at a hospital-based facility that is located off of the hospital's campus, the written notice described in subsection (2) of this section must also include a statement that the hospital-based facility is wholly or partially owned or operated by a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by providers at the hospital-based facility.

(4) A billing statement from a hospital or health system that charges a facility fee must:

(a) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider;

(b) State the Medicare facility fee reimbursement rate for the same service, as a comparison;

(c) Explain what expenses the facility fee is intended to cover;

(d) State that the patient's financial liability may have been less if the services had been

provided at a facility not owned or operated by the hospital or health system; and

(e) Include notice of the patient's right to request a reduction in the facility fee and instructions to the patient on how to request a reduction.

(5) A hospital-based facility that charges a facility fee shall prominently display written notices in locations that are readily accessible to and visible by patients, including patient waiting areas, stating that:

(a) The hospital-based facility is wholly or partially owned or operated by a hospital or health system; and

(b) The patient may incur financial liability greater than the patient would incur if the hospital-based facility were not wholly or partially owned or operated by the hospital or health system.

(6)(a) If a hospital or health system acquires or purchases a health care facility at which facility fees will likely be billed, not later than 30 days after the acquisition or purchase, the hospital or health system shall provide written notice of the transaction, by first class mail, to each patient served within the previous three years by the health care facility.

(b) The notice under paragraph (a) of this subsection must include the following information:

(A) A statement that the health care facility is now a hospital-based facility and is wholly or partially owned or operated by a hospital or health system;

(B) The name, business address and phone number of the hospital or health system that acquired or purchased the health care facility;

(C) A statement that the hospital-based facility bills patients or is likely to bill patients a facility fee that is in addition to any professional fee billed by a health care provider at the hospital-based facility;

(D) A statement that the patient's actual financial liability will depend on the medical services actually provided to the patient;

(E) An explanation that the patient may incur financial liability that is greater than the patient would incur if the facility were not a hospital-based facility;

(F) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at the hospital-based facility for the most common services provided at the hospital-based facility; and

(G) A statement that prior to seeking services at the hospital-based facility, a patient covered by health insurance should contact the patient's insurer for additional information regarding the hospital-based facility fees, including the patient's potential financial liability, if any.

(7) For outpatient health care services that are provided at a hospital-based facility, other than a hospital emergency department, that is not located on the hospital's campus, the hospital, health system or hospital-based facility may not collect a facility fee:

(a) For services billed using a current procedural terminology evaluation and management code or similar code; or

(b) That is more than the Medicare rate if the patient is uninsured.

(8) Notwithstanding subsection (7) of this section, if a hospital or health system has a contract with an insurer that is in effect on January 1, 2020, and that requires reimbursement for facility fees prohibited by subsection (7) of this section, a hospital or health system may continue to collect reimbursement from the insurer for the facility fees until the expi-

ration or renewal of the contract.

SECTION 4. ORS 442.015, as amended by section 22, chapter 608, Oregon Laws 2013, and section 6, chapter 50, Oregon Laws 2018, is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, for the purpose of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

(4) "Delegated credentialing agreement" means a written agreement between an originating-site hospital and a distant-site hospital that provides that the medical staff of the originating-site hospital will rely upon the credentialing and privileging decisions of the distant-site hospital in making recommendations to the governing body of the originating-site hospital as to whether to credential a telemedicine provider, practicing at the distant-site hospital either as an employee or under contract, to provide telemedicine services to patients in the originating-site hospital.

(5) "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

(6) "Distant-site hospital" means the hospital where a telemedicine provider, at the time the telemedicine provider is providing telemedicine services, is practicing as an employee or under contract.

(7) "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

(8) "Extended stay center" means a facility licensed in accordance with section 2, chapter 50, Oregon Laws 2018.

(9) "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

(10) "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

(11) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

(12)(a) "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center;

(E) An outpatient renal dialysis facility; or

(F) An extended stay center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

(13) "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310(d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(14) "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

(15) "Health system" means:

(a) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means; or

(b) A hospital and any entity affiliated with such hospital through ownership, governance, membership or other means.

[*(15)*] **(16)** "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the authority by rule.

[*(16)*] **(17)** "Institutional health services" means health services provided in or through health care facilities and the entities in or through which such services are provided.

[*(17)*] **(18)** "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

[*(18)(a)*] **(19)(a)** "Long term care facility" means a permanent facility with inpatient beds, providing:

(A) Medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services; and

(B) Treatment for two or more unrelated patients.

(b) "Long term care facility" includes skilled nursing facilities and intermediate care facilities but does not include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

[*(19)*] **(20)** "New hospital" means:

(a) A facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services; or

(b) Any replacement of an existing hospital that involves a substantial increase or change in the services offered.

[*(20)*] **(21)** "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period.

[*(21)*] **(22)** "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

[*(22)*] **(23)** "Originating-site hospital" means a hospital in which a patient is located while receiving telemedicine services.

[*(23)*] **(24)** "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

[*(24)*] **(25)** "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

[*(25)*] **(26)** "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

[*(26)*] **(27)** "Telemedicine" means the provision of health services to patients by physicians and

health care practitioners from a distance using electronic communications.

SECTION 5. ORS 442.445 is amended to read:

442.445. (1) Any health care facility that fails to perform as required in ORS 442.205**,** [*and*] 442.400 to 442.463 or 442.855 **or section 2 or 3 of this 2019 Act**[*, and*] **or** rules of the Oregon Health Authority may be subject to a civil penalty.

(2) The Oregon Health Authority shall adopt a schedule of penalties not to exceed $500 per day of violation, determined by the severity of the violation.

(3) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and conditions as the authority considers proper and consistent with the public health and safety.

(5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose of rate determination or for reimbursement by a third-party payer.

SECTION 6. Section 3 of this 2019 Act applies to services provided at hospital-based facilities on or after the effective date of this 2019 Act.