FINAL BILL REPORT
ESHB 2582

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Synopsis as Enacted

Brief Description: Requiring notice to patients for certain charges at a health care facility.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Johnson, Cody, Ross, Jinkins, Green, Walsh, Hinkle, Clibborn, Liias, Kenney, Klippert, Smith, Alexander, Warnick, Fagan, Bailey, Ahern, Asay, Dahlquist, Kretz, DeBolt, Angel, Kelley, Hunt, Dickerson, Ladenburg, Orcutt, Zeiger, Wilcox, Finn, Wylie, Probst, Darneille, Moscoso, Kagi and Tharinger).

House Committee on Health Care & Wellness
Senate Committee on Health & Long-Term Care

Background:

Under the Medicare program, charges for hospital outpatient department visits may be comprised of two components: a professional fee and a facility fee. The facility fee may be charged if the location of the service is considered a provider-based department. Many factors affect the determination of provider-based status, including whether or not the hospital and the outpatient facility operate under the same license, the integration of clinical services of the hospital and the outpatient facility, the financial integration of the outpatient facility and the hospital, and the public's awareness of the relationship of the facility with the hospital.

To maintain provider-based status under the Medicare program, a hospital outpatient department must meet several obligations. One of these requirements is that, if the Medicare patient will be responsible for a coinsurance requirement for the facility fee, the hospital-based entity must provide the Medicare patient with:

- notice of the amount of the potential cost to the patient, prior to the delivery of services; and
- an explanation to the patient that he or she will be responsible for coinsurance costs to the hospital because of the facility's provider-based status.

Summary:

A "provider-based clinic" is defined as a clinic or provider office that either (1) is 250 yards or more from the main campus of a hospital or (2) has been determined to be a provider-

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based clinic by the federal Centers for Medicare and Medicaid Services. In addition, to meet the definition, "provider-based clinics" must be (1) owned by a hospital or health system that operates hospitals, (2) licensed as part of the hospital, and (3) primarily engaged in providing diagnostic and therapeutic care. The definition excludes clinics that are rural health clinics or that exclusively provide laboratory, x-ray, testing, therapy, pharmacy, or educational services.

A "facility fee" is defined as any separate charge, in addition to professional fees, by a provider-based clinic that is intended to cover building, electronic medical records, billing, and other administrative and operational expenses.

Prior to delivering nonemergency services, a provider-based clinic must notify the patient that the clinic is licensed as part of the hospital and the patient may receive a separate billing for a facility fee which may result in greater out-of-pocket expenses for the patient. A provider-based clinic must also post a statement, in a place that is accessible and visible to patients, that the clinic is licensed as a part of the hospital and that a separate facility fee may be charged to the patient.

Hospitals that own or operate provider-based clinics that charge facility fees must report specified information to the Department of Health about their facility fees. The report must include: (1) the total number of provider-based clinics owned or operated by the hospital that charge a facility fee; (2) the number of visits at each provider-based clinic for which a facility fee was charged; (3) the revenue received by the hospital through facility fees at each provider-based clinic; and (4) the range of allowable facility fees charged at each provider-based clinic.

Votes on Final Passage:

House	81	16	
Senate	49	0	(Senate amended)
House	95	1	(House concurred)

Effective: January 1, 2013