Glossary of Common Terminology Related to Facility Fees

HB23-1215 Steering Committee

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Overview: This document contains DRAFT definitions for common terms related to the Hospital Facility Fee Steering Committee's task. The definitions should serve as a starting point for the discussion between members. This will be a living document—edits and additions are welcome. A final version of this list could be a component of the Steering Committee's report to the legislature.

Here is the initial list:

Ambulatory or outpatient care - Health care services provided without admission to a hospital or when the patient is expected to stay less than 24 hours (even if overnight).*

Ambulatory surgical center - A stand-alone health care facility that provides outpatient surgical services to patients that do not require hospitalization and for whom care is not expected to exceed 24 hours; may be owned by a hospital or health system or operated independently from a hospital.*

Balance bill - A medical bill from a healthcare provider billing a patient for the difference between the total cost of services being charged and the amount the insurance pays. This is sometimes referred to as a 'surprise bill.'

Centers for Medicare and Medicaid Services (CMS) - a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP).

CMS 1500 (aka HCFA 1500) - A federally maintained claims form used for billing purposes by health professionals, often referred to as the individual provider form. The same information is conveyed via the HIPAA X12 837P electronic claims transaction.*

Co-insurance - The percentage that the insured pays after the insurance policy's deductible is exceeded.

Congressional Budget Office (CBO) - a federal agency within the legislative branch of the United States government that provides budget and economic information to Congress.

Co-pay - A fixed amount for a covered service, paid by a patient to the provider of service before receiving the service.

CPT A/M - *[proposed by Karlee, need clarification and definition]*

Critical access hospital (CAH) – a federal designation given to rural hospitals that meet specific size and geographic location requirements. CAHs receive cost-based payments from Medicare.

Current Procedural Terminology (CPT) - a uniform language healthcare professionals use for coding medical services and procedures to streamline reporting, and to increase accuracy and efficiency.

Deductible - The portion of health care expenses the insured must pay before insurance applies.

Differential payment rates -Differential that recognizes a physician's practice expense is generally lower when services are provided in a facility setting. When a procedure is performed in a facility setting the physician uses hospital resources rather than their own therefore reducing the practice expense for the physician.

Emergency Department (ED) – A department located within a hospital that provides emergency care.

Evaluation and Management (E&M) - services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient's health.

Facility fees - Charges institutional health care providers bill that are for facility operational expenses. These charges are distinct from a professional fee.*

Freestanding ED – A stand-alone health care facility that provides emergency care; may be owned by a hospital or health system but is structurally distinct from a hospital.*

Government Accountability Office (GAO) - An independent, nonpartisan government agency within the legislative branch that provides auditing, evaluative, and investigative services for the United States Congress.

Grouper - In the context of health care revenue cycle management, a grouper refers to a software tool or algorithm used to assign diagnosis-related groups (DRGs) or other grouping methodologies to patient encounters or claims. The primary purpose of a grouper is to categorize patients into specific groups based on their diagnoses, procedures, and other relevant factors. This grouping process is crucial for accurate reimbursement, as it helps determine the appropriate payment amount for healthcare services provided.

Healthcare professional - Physicians, nurse practitioners, physician assistants, physical therapists, and other individually licensed or certified health care providers.

Healthcare system - An organization of people, institutions, and resources that delivers health care services to meet the health needs of target populations.

High-acuity services - *[need definition]*

Horizontal integration - When one type of entity in the supply chain purchases another entity of the same type, such as one hospital merging with another hospital.*

Hospital-Based Facility or Setting - A health care setting that is owned or operated, in whole or part, by a hospital or health system.

Hospital Outpatient Department (HOPD) - An outpatient department of a hospital, including outpatient surgery centers, that fall under the same financial and administrative contracts as the hospital; for Medicare purposes, an HOPD must be located within 35 miles of a hospital's main campus.*

Independent provider – A provider that is not affiliated with a hospital.

Inpatient care – When a patient is kept overnight (or more than 24 hours) in a healthcare facility.

Institutional provider - Inpatient hospitals, outpatient departments and clinics, emergency departments, and other facilities.

Low-acuity services – *[need definition]*

Medicare Payment Advisory Commission (MedPAC) – A nonpartisan independent legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program.

National Provider Identifier (NPI) - A federally assigned unique identification number for health care providers to use for administrative and financial transactions.

Non-Excepted HOPD - *[need definition]*

Off-campus outpatient department – A hospital facility location physically separate from a main hospital campus. Medicare and some state laws specify that there must be more than 250 yards between the main campus and an off-campus facility.*

Patient financial liability/cost sharing/out of pocket cost – The portion of a medical bill that patient needs to pay to cover their treatment costs. This may come in the form of co-pays, co-insurance or deductibles.

Place of service - A code that indicates the type of setting where care was provided (e.g., an individual office, ASC, on- or off-campus HOPD, or inpatient hospital); used on the CMS 1500 form.*

Private equity - A privately-held company that does not offer stock to the general public.

Professional service fee - Charges health care professionals, including physicians, nurse practitioners, physician assistants, and physical therapists, bill for their services. For independent providers, these charges typically account for the professional's practice overhead, including costs for rent, equipment and supplies, and clinical and administrative support staff, in addition to the professional's time and malpractice expenses.*

Provider-based status - A regulatory status under Medicare allowing a facility or organization to bill as a hospital.

Rural hospital - Rural hospitals are those hospitals not located within a metropolitan area as defined by the U.S. Office and Management and Budget and the U.S. Census Bureau.

Site-neutral payments - Paying the same amount for the same item or service, regardless of the location or type of setting where care is provided.*

Taxpayer Identification Number (TIN) - An identification number used by the Internal Revenue Service (IRS) in the administration of tax laws.
Note: A TIN is assigned to each practice for tax purposes and NPIs are used to identify individual health care providers. TINs were developed by the IRS and NPIs were developed by CMS.

Technical fees – another term for facility fees.

Vertical integration - When one type of entity in the supply chain purchases another type of entity, such as hospitals acquiring physician practices.*

UB-04 (aka CMS/HCFA 1450) - A federally maintained claims form used for billing purposes by institutional providers, often referred to as the institutional provider form. The same information is conveyed via the HIPAA X12 837I electronic claims transaction.*

*Obtained directly from or paraphrased from the report "Protecting Patients from Unexpected Outpatient Facility Fees: States on the Precipice of Broader Reform" published by Georgetown University's Center on Health Insurance Reforms and Westhealth.