|  |
| --- |
| BILL ANALYSIS |

|  |
| --- |
| C.S.H.B. 2556 |
| By: Frank |
| Public Health |
| Committee Report (Substituted) |

|  |
| --- |
| **BACKGROUND AND PURPOSE**  The bill author has informed the committee that facility fees are often charged by hospitals to account for the higher costs of operating a hospital such as being open 24 hours per day, seven days per week and paying for expensive medical equipment or technology and that when a hospital buys up a physician practice, sometimes the hospital will begin charging facility fees for services provided at the physician practices. However, the bill author has further informed the committee that these facility fee charges can come as a surprise to patients, who may have gone to that physician practice before it started charging facility fees or did not expect a facility fee on certain services such as telehealth services. C.S.H.B. 2556 seeks to protect patients from being surprised with facility fee charges. |
| **CRIMINAL JUSTICE IMPACT**  It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision. |
| **RULEMAKING AUTHORITY**  It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission and the executive head of a state regulatory authority with jurisdiction over a health care provider in SECTION 1 of this bill. |
| **ANALYSIS**  C.S.H.B. 2556 amends the Health and Safety Code to require, on or after January 1, 2031, a health care provider required or eligible to obtain a national provider identifier (NPI) under federal law to apply for and obtain an NPI for the provider and for each provider-based outpatient facility the health care provider owns or manages or with which the health care provider is otherwise affiliated, and if the provider is a hospital, each hospital-owned facility. This requirement expires September 1, 2029.  C.S.H.B. 2556 requires a health care provider to include a valid place of service code for the setting where a health care service was provided on each claim for reimbursement submitted for the health care service provided by the provider.  C.S.H.B. 2556 requires a health care provider, effective January 1, 2026, to provide to a patient, not later than the 10th day before the date scheduled for provision of a health care service or supply or in accordance with statutory provisions relating to facility policies or federal law, as applicable, written notice of a facility fee charged for the service or supply provided to the patient at the following:   * if the provider is a hospital, at a hospital-owned facility; or * at a provider-based facility that: * is at a location other than the health care provider campus; * provides services organizationally and functionally integrated with the provider; and * provides outpatient preventative health services, diagnostic health services, treatment services, or emergency care.   The bill requires the provider to provide the written notice on the date the health care service or supply is provided if the provision of the service or supply is scheduled less than 10 days before that date or in accordance with statutory provisions relating to facility policies or federal law, as applicable. The bill requires the written notice to include the following:   * the amount of the facility fee or, if the exact health care service or supply to be provided is not known, an explanation that the patient may incur a cost-share or coinsurance expense that would not occur if the service or supply is provided by an independent physician or physician group; * the purpose of the facility fee; and * if the third party payor of a patient's health benefit plan provides the information to a health care provider before the date the notice is required, information on whether the health benefit plan covers the fee.   The bill prohibits a health care provider from charging a facility fee for telehealth services or telemedicine medical services.  C.S.H.B. 2556 requires a health care provider, not later than the 90th day before the date the provider begins charging the facility fee, to notify all contracted third party payors of the provider's intent to begin charging facility fees at a facility before the provider may begin charging a facility fee for provision of a health care service or supply as follows:   * at a newly built provider-based outpatient facility; * at a provider-based outpatient facility or hospital-owned facility that did not previously charge a facility fee; or * for a health care service or supply that did not previously include a facility fee charge.   The bill prohibits the provider from charging a patient or third party payor a facility fee at a provider-based outpatient facility or hospital-owned facility unless the provider provides that notice.  C.S.H.B. 2556 authorizes the executive commissioner of the Health and Human Services Commission (HHSC) to adopt rules to implement the bill's provisions and authorizes the executive head of a state regulatory authority with jurisdiction over a health care provider to adopt rules regarding the duties of a health care provider under the bill's provisions and disciplinary action to be taken against a health care provider that violates the bill's provisions. The bill requires HHSC or the appropriate state regulatory authority with jurisdiction over a health care provider to assess an administrative penalty capped at $1,000 for each violation against a health care provider that violates those provisions or such a rule. The bill expressly does not create a private cause of action against a provider for legal or equitable relief.  C.S.H.B. 2556 requires The University of Texas Health Science Center at Houston, using the Texas All Payor Claims Database, and in cooperation with HHSC and the Department of State Health Services (DSHS), to conduct a study on health care facility fees charged in Texas. The bill requires the study to include the following:   * a description by third party payor type of a patient's cost-sharing obligation for health care facility fees; * a comparison, in the aggregate, of the cost of health care services provided by health care professionals affiliated with a health system and independent physicians or physician groups, including a comparison of the charges for professional fees when a health care facility fee is included in a patient's statement of charges; and * a comparison, in the aggregate, of any trends in total spending and a patient's cost-sharing obligation for specific health care services, including those services reported using a Current Procedural Terminology code as performance of an evaluation and management procedure, for claims for reimbursement submitted by an individual health care provider or a health care facility.   The bill requires The University of Texas Health Science Center at Houston, not later than December 1, 2026, to submit to the legislature a written report on the findings of the study. The bill's provisions relating to the study expire September 1, 2027.  C.S.H.B. 2556 defines the following terms for purposes of its provisions:   * "facility fee" means a fee a health care provider charges to compensate the health care provider for operational, administrative, or management expenses that is separate from a fee a health care provider charges in relation to professional medical services provided by a physician, including a membership fee, subscription fee, or other administrative fee, and excluding a direct fee charged by an independent physician or physician group for providing direct primary care; * "health care provider" means a hospital system, hospital, provider-based outpatient facility, or other health care facility, including   + a designee or affiliate of a health care facility;   + an entity that facilitates the provision of or that provides health care services and that is owned or operated by or affiliated with a health insurance company;   + a health care facility that is owned or operated by or affiliated with a private equity fund; or   + a physician or physician group that is owned, operated, or managed by or affiliated with a corporation. * "health care provider campus" means:   + the main buildings of a health care provider;   + the physical area immediately adjacent to the main buildings and other areas or structures not contiguous to the main buildings but located not more than 250 yards from the main buildings; and   + any other area the federal Centers for Medicare and Medicaid Services determine to be a health care provider campus; * "hospital-owned facility" means a clinic or other facility that provides health care services and is owned or operated by, in whole or in part, a hospital and is not located on the hospital's health care provider campus; * "independent physician or physician group" means a physician practice or physician group that is not employed, owned, operated, or managed by or affiliated with a health care provider; * "national provider identifier" by reference means the national provider identifier number required under the federal Social Security Act; * "place of service code" means a two-digit code maintained by the federal Centers for Medicare and Medicaid Services or an alphanumeric indicator that is placed on a health care provider's or independent physician or physician group's claim for reimbursement or payment to indicate the setting in which a health care service was provided; * "provider-based outpatient facility" means a facility a health care provider owns or operates, wholly or partly, where outpatient health care services and supplies are provided; * "telehealth service," by reference to Occupations Code provisions, means a health service, other than a telemedicine medical service or a teledentistry dental service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology; * "telemedicine medical service," by reference to Occupations Code provisions, means a health care service delivered by a physician licensed in Texas, or a health professional acting under the delegation and supervision of a physician licensed in Texas, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology; and * "third party payor" means an insurance company, health benefit plan sponsor, health benefit plan issuer, or entity other than a patient or health care provider that pays for health care services and supplies provided to a patient.   The terms "telehealth service" and "telemedicine medical service" exclude a telehealth service or telemedicine medical service provided by a hospital or provider-based outpatient facility to a patient physically located at the hospital or provider-based outpatient facility at the time the service is provided. |
| **EFFECTIVE DATE**  Except as otherwise provided, September 1, 2025. |
| **COMPARISON OF INTRODUCED AND SUBSTITUTE**  While C.S.H.B. 2556 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.  The substitute includes provisions that were not in the introduced that do the following:   * require a health care provider to include a valid place of service code for the setting where a health care service was provided on each claim for reimbursement submitted for the health care service provided by the provider; * authorize the executive head of a state regulatory authority with jurisdiction over a health care provider to adopt rules regarding the duties of a health care provider under the bill's provisions and disciplinary action to be taken against a health care provider that violates the bill's provisions; * prohibit a provider from charging a third party payor a facility fee at a provider-based outpatient facility or hospital-owned facility unless the provider provides notice of intent to begin charging facility fees at a facility; * with respect to the requirement for an applicable health care provider to apply for and obtain an NPI for the provider and for each provider-based outpatient facility the health care provider owns or manages or with which the health care provider is otherwise affiliated:   + establish a beginning date for the requirement of on or after January 1, 2031;   + extend the requirement to do so to each hospital-owned facility, if the provider is a hospital; and   + set an expiration date of September 1, 2029, for the requirement; * require The University of Texas Health Science Center at Houston, using the Texas All Payor Claims Database, and in cooperation with HHSC and DSHS, to conduct a study on health care facility fees charged in Texas and requires the study to include certain information and for such information to be submitted to the legislature by The University of Texas Health Science Center at Houston, in the form of a written report not later than December 1, 2026; and * set an expiration date of September 1, 2027, for the provisions establishing the study.   The substitute omits the provisions from the introduced that do the following:   * require an applicable health care provider or provider-based facility to include the NPI of the facility where the health care services and supplies were provided on each claim for reimbursement or payment, including certain information and provisions conditioning the health care provider's or provider-based facility's authority to charge a facility fee for the provision of health care services or supplies on the claim for reimbursement or payment for the services or supplies including the NPI of the facility where the services or supplies were provided; * prohibit a health care provider from charging a facility fee for preventative health services; and * prohibit, effective January 1, 2026, a health benefit plan issuer or third party payor from paying a facility fee charge on a health care provider's claim for reimbursement for provided health care services or supplies unless the claim includes the unique NPI for the facility where the services or supplies were provided.   The substitute replaces all of the introduced version's references to a provider-based facility with references to a provider-based outpatient facility.  Whereas the introduced required a health care provider to provide to a patient, not later than certain dates depending on how far in advance the health care service or supply is scheduled, written notice of a facility fee charged for the service or supply provided to the patient, the substitute requires a health care provider to provide to a patient, not later than those dates or in accordance with statutory provisions relating to facility policies or federal law, as applicable, written notice of a facility fee charged for the service or supply provided to the patient. The substitute also includes a provision absent from the introduced requiring the a health care provider to do so for a health care service or supply provided to the patient at a hospital-owned facility, if the provider is a hospital.  Both the introduced and substitute require such written notice to include the amount and purpose of the facility fee and information on whether a patient's health benefit plan covers the fee; however the substitute specifies that the written notice must include the following:   * with respect to the amount of the facility fee, an explanation that the patient may incur a cost-share or coinsurance expense that would not occur if the service or supply is provided by an independent physician or physician group, if the exact health care service or supply to be provided is not known; and * with respect to the information on whether a patient's health benefit plan covers the facility fee, a condition that the patient's health benefit plan provides the information to a health care provider before the date the notice is required.   Whereas the introduced required HHSC to assess an administrative penalty capped at $1,000 against a health care provider that violates the bill's provisions or rules, the substitute requires HHSC or the appropriate state regulatory authority with jurisdiction over a health care provider to assess an administrative penalty capped at $1,000 for each violation against a health care provider that violates the bill's provisions or rules.  With respect to the requirement for a health care provider to notify all contracted third party payors of the provider's intent to begin charging facility fees at a facility or for a service or supply before the provider may begin charging a facility fee for provision of a health care service or supply at certain locations, the introduced and substitute differ as follows:   * the substitute includes a deadline for the requirement absent from the introduced of not later than the 90th day before the date the provider begins charging a facility fee; * the substitute includes a requirement absent from the introduced for a health care provider to do so at a hospital-owned facility that did not previously charge a facility fee; and * the substitute omits the requirement to do so for a service or supply.   The substitute revises the following definitions established by the introduced version:   * "facility fee"; * "health care provider"; * "national provider identifier"; * "provider-based facility"; * "telehealth service" and "telemedicine medical service"; and * "third party payor."   Accordingly, the substitute includes the following definitions absent in the introduced:   * "hospital-owned facility"; * "independent physician or physician group"; and * "place of service code."   The substitute omits the definition of "preventative health services" from the introduced. |