**FACILITY FEE FILINGS - LIST OF QUESTIONS RECEIVED AND OHS RESPONSES**

**Questions Pertaining to Both TABLES:**

**Question**:

- *Offsite campus Lab drawing stations/centers and Physical Therapy do not have a separate professional fee. Do these locations need to be reported? What if only a professional component is charged?*
- *Is whether something is reportable determined by whether both a technical and professional component service is performed?*

**HSP Response**: Because the definition of Facility Fee means any fee charged or billed 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, it appears that the law was written to intend that the reported fees should be for services/procedures for which a professional fee(s) is also charged. So, it appears that if a procedure/service does not also include a professional fee, the procedure/service does not need to be reported. Regarding the 2nd question, as indicated above, Section 19a-508c (a)(3) of the Connecticut General Statutes does not differentiate the terms "technical fee" vs. "facility fee".

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**Question**:

- *X Hospital is recognized by Medicare as a multi campus provider inclusive of a Hospital and a separate Campus of that Hospital under a single provider number. The separate Campus does not have any offsite provider based locations. Clarify that the separate Campus is exempt from this filing?*

**HSP Response**: It is up to the Hospital to determine if that separate Campus is considered part of the main campus of the hospital per Section 19a-508c(a)(2) of the Statutes or whether it is considered by this statutory definition as a Hospital-Based Facility that is located outside or off of a hospital campus. If the separate Campus is considered by this definition (which refers to CMS determinations) as the main campus or part of the main campus, it is not reportable. If it is located "outside a hospital campus" and is a hospital-based facility, the outpatient services for which Facility Fees are charged would be reportable. In filing the information with OHS, a clarification of this situation should be included by the Hospital.

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**Question:**

- *What is the criteria for determining whether an off campus location should be included in the report?*

**HSP Response**: All parameters for the determination of what needs to be included in the reporting are laid out in Sections 19a-508c(a) of the Connecticut General Statutes and Section 19a-508c(m) of the Connecticut General Statutes. HSP has no other criteria. The Hospital/System should determine what locations they have that are considered located *off-campus* as the term *Campus* is defined in the 19a-508c(a)(2). The Hospital/System should determine what off-campus locations are Hospital-Based Facilities as defined in Section 19a-508c(a)(6).

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## Questions Pertaining to TABLE #1

**Question**:

- *XYZ Health System has only one hospital within its system but has different off campus hospital based facilities. On table 1 do they list the top 10 procedures/services overall or the top 10 of each off campus hospital based facility*?
- *When reporting the top 10 procedures, should the top 10 procedures for each individual off campus location be reported or the top 10 procedures in aggregate at all off campus facilities?*

**HSP Response**: A Hospital-Based Facility is defined as a facility that is *owned or operated, in whole or in part*, by a hospital or health system where *hospital or professional medical services* are provided. First, make sure that the facilities that you are considering for this report meet that description. Table 1 refers to Section 19a-508c(m)(F) and (G) of the Connecticut General Statutes, for each hospital or health system – HSP interprets the language to require that the hospital be reported separately from the System it is in. In the Table 1 template, Column A is for identification of the Reporting Health System and each of its affiliated hospitals (whether one or more). It assumes that there is information to report for both the System and the Hospital, but that may not be the case for all scenarios. Note that Columns C, D, E, F, G and H relate to the System name and Hospital(s) names listed in Column A. The top ten information in Columns C, D, E, F, G and H for each Hospital listed will be for Facility Fees charged/billed by that Hospital for *outpatient off-campus procedures/services* (so billed as hospital services by the hospital). The top ten information in Columns C, D, E, F, G and H, for each System will be for any Facility Fees charged/billed by other entities in that System (so not the Hospital(s)). These would still follow the same definitions, but would be for any procedures/services that are billed by the System Parent or another affiliate in the System. But again, this is for a Hospital-Based Facility. Since, the statutory definition of Hospital-Based Facility includes facilities that are either "owned or operated" and can be owned "in whole or in part", it doesn't include only wholly owned facilities. If an entity's ownership crosses different systems, one system can supply the information, but inform HSP in its response that the responder is providing for the facility owned by multiple systems (such as a cancer center owned by multiple systems).

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**Question:**

- *Am I correct in assuming that Column C of Table 1 relates to facility fee NET revenue and not Gross revenue? I believe you are seeking what has been received by the hospital.*
- *On table one, Column C, are we selecting the top ten procedures/services by gross or net revenue?*

**HSP Response**: Yes, this would need to be Net Revenue as the basis as it relates to "generated" facility fee revenue (collected, not charged).

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## Questions Pertaining to TABLE #2

**Question**:

- *On Table two, Column C – What is considered the number of patients in the following scenario- 1 Patient who had 2 monthly recurring accounts set up (2 Unique Account numbers) and they had*

*services 4 times during the first month and 3 times (but one of these visits there was not a "facility fee" charged) during the second month.*

- *Are you looking for how many of the total # of patient visits reported in Col. B are Medicare, Medicaid, and private insurance?*

**HSP Response**: The statute does not specify the definition of the term "visits". Since it does not specifically include "patients," and only specifies the number of patient "visits", HSP interprets the statute as amended to require the Hospitals to utilize their standard determinations of a "visit" is for its various reporting requirements to HSP, such as HRS and CON. However, in general terms and for these purposes only, HSP believes a reasonable interpretation is that a visit is a separate, billable encounter. Further, Column C is a total # for patient visits for which the Hospital/System billed a Facility Fee. It does require for a breakdown of patient visits by payer category.

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**Question**:

- *Should only payments from primary insurance payers be included in columns G, H and I?*

**HSP Response**: The statute does not provide specific clarification in this regard. As such, the total amount of allowable facility fees should include all billed payers.

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**Question**:

- *Columns D, E, and F, descriptions are confusing. Please explain further what is needed. Are you looking for the $$ amount of charges associated with the technical/facility component of a patient service/visit for Medicare, Medicaid, and private insurance?*
- *In columns D-F, we want to confirm if this means the number of payments associated with the facility fees that were charged (we received 100 facility payments for facility fee charges) or does it mean the number of gross facility fee charges (i.e. – we charged 100 patients a facility fee)*

**HSP Response**: Columns D, E, and F reflect the specific wording in the statute as amended. The footnote indicates that the term "allowable" refers to what state or federal laws allow as Facility Fee charges. For example, under the heading "Fees allowed to be charged or billed", the statute as amended requires reporting of the "number of allowable fees paid" by the various payers listed therein. It is a numerical reference, not a monetary reference and it is not the number charged but paid ("paid" means payments received for these purposes). If a Hospital has 50 total facility fees for which it can bill at X facility site and Medicare pays only 15 of them (allowable by Medicare), then the # in the cell is 15 for Medicare.

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**Question:**

- *In columns G-I , we want to confirm if this means the number of charges (we charged 100 patients a facility fee) or if it means the number of payments (we received 100 payments related to facility fee charges)*

**HSP Response**: Columns *G-I* should be a dollar amount, such as *Medicaid payments of $300,000 were received by the Hospital for its Facility X, Medicare payments of $275,000 were received by the Hospital*

*for its Facility X …* Also, note that "*we charged 100 patients a facility fee" is what would be in Column C, but for patient visits.*

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**Question:**

- *In columns J-O, we want confirm if this means the highest (maximum) and lowest (minimum) amounts charged or the highest and lowest amounts paid*

**HSP Response**: The wording in the statute as amended is "facility fees paid."

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**Question:**

- In column P, it refers to revenue received. Does this differ from what is being asked in Column G-I as "allowable facility fees paid"

**HSP Response**: We will respond to the difference between Column P and Columns G – I. Columns D - F will be a number instead of a dollar amount. Please note the footnote for Column P which provides clarification: [e]*Total amount of revenue received can differ from the sum of columns G through I for the facility due to the inclusion of revenues from Self-Pay activity and other payer sources*.