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Facility Fees and Facility Fee Notices

Required by Section 2 of Chapter 142 (2024)

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Executive Summary

The Maryland Health Services Cost Review Commission (HSCRC) presents this legislatively mandated report[1] on hospital outpatient facility fees; their impact on consumers, payers, and hospitals; and the effectiveness of Maryland's facility fee notices. Building on a preliminary report submitted in December 2024,[2] this document incorporates new data, Workgroup input, and consumer testing results to inform policy recommendations for the oversight and administration of facility fee notices in Maryland.

Key Findings

- **Overview of Facility Fees:** Facility fees are charges by institutional providers (such as hospitals) intended to cover costs associated with the operation of health care facilities (e.g., building, utilities, professional staff, and some services). These fees are distinct from professional fees charged by clinicians for their services. HSCRC is required by law to ensure that total hospital costs are reasonable and that aggregate charges are reasonably related to those costs. HSCRC sets global budgets on hospital revenue for all HSCRC-regulated services across inpatient, emergency department (ED), and on-campus outpatient services. Therefore, facility fees cannot be separated from global budgets. If facility fees were to be reduced or eliminated for certain services like outpatient, HSCRC would still be required to ensure that hospitals recover their total costs. As a result, rates for inpatient and/or ED services would need to increase proportionally
- **Regulation of Facility Fee Notices in Maryland:** Maryland hospitals are required to provide facility fee notices to patients for certain HSCRC-regulated outpatient services. Specific notice language and timing requirements are currently written into statute. These notices aim to educate consumers about facility fees, provide an estimate of the hospital charge, and promote consumer choice.
- **Magnitude and Impact of Facility Fees:** In calendar year (CY) 2023, total patient cost-sharing for hospital outpatient services (i.e., facility fees) in Maryland was estimated to be $897 million. Of this, $64.6 million (7.2%) was attributed to clinic rate center services subject to facility fee notice requirements, with Medicare fee-for-service (FFS) accounting for 57% of these costs. Patient cost-sharing as a percentage of total allowed costs varied widely by payer, from 4.6% for large group fully insured commercial plans to 19.9% for Medicare FFS. Clinic services showed even greater disparity, with cost-sharing ranging from 4.7% (large group fully insured) to 22.5% (Medicare FFS).[3]
- **Effectiveness of Facility Fee Notices:** Consumer testing revealed that the current notice language and format are difficult for some consumers to understand, with technical terms and

[1] 2024 MD Laws Ch. 142.
[2] https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/SB1103Ch142(2)(2024)_2024.pdf
[3] Medicare FFS figures do not account for cost-sharing by Medicare supplemental plans.

formatting issues reducing clarity. Many consumers were unclear about the meaning of facility fees and their potential financial liability, and nearly half indicated that the notice might lead them to delay or cancel care. When consumers were shown a revised version of the notice, with changes to the organization, format, and language, they found it easier to read and understand. Consumers indicated greater clarity about the meaning of facility fees in the revised notice, and none of the respondents indicated that the revised notice would lead them to delay or cancel care.

Recommendations

This report provides recommendations for revision of the facility fee notice requirements informed by Workgroup contributions and consumer testing, including: 1) moving detailed notice requirements from statute to regulation for greater flexibility; 2) providing additional options for the cost estimate in the notice; 3) updating notice timing; 4) clarifying the definition of “facility fee” in plain language in the notice; 5) adding key reference information to notices; and 6) improving clarity and accessibility of the notice through the use of text formatting, organization, and digital tools. These recommendations aim to ensure that facility fee notices achieve their intended purpose of educating consumers and promoting consumer choice, while balancing concerns from hospitals about administrative and consumer burden.

Introduction

Maryland law requires the Health Services Cost Review Commission (HSCRC) to submit two reports on the regulation of hospital facility fees, including the requirement that hospitals provide notices to consumers of facility fees.[4] The HSCRC submitted a preliminary report in December 2024.[5] This 2025 report builds on the 2024 report and provides additional qualitative and quantitative analyses; an update per the legislative requirements follows.

1. The nature of costs underlying hospital outpatient facility fees and how similar costs are recovered in other health care settings.

   This information was provided in the 2024 report.

2. The drivers of hospital facility costs that are unique to hospitals and are not reflected in other health care settings.

   This information was provided in the 2024 report.

3. The magnitude and impact of hospital facility fee charges for hospitals, payers, and consumers.

   This information is presented in this report.

4. Industry practices for seeking authority for an outpatient location to be approved as "at the hospital" and thereby subject to rate regulation.

   This information was provided in the 2024 report.

5. Alternative mechanisms or revisions to the billing of the facility fees that would allow hospitals to recover costs while protecting individual consumers from high facility fee bills, maintaining access to health care services, and addressing health equity concerns.

   These analyses are on hold while final terms of the AHEAD Model are pending.

6. The interaction of the alternative mechanisms or revisions studied under item (5) of this subsection with the State's Total Cost of Care model obligations to the federal government, including any impact on Medicare total cost of care savings if outpatient facility fees are eliminated or reduced.

   These analyses are on hold while final terms of the AHEAD Model are pending.

7. The impact of the alternative mechanisms or revisions studied under item (5) of this subsection on Medicaid, Medicare, and commercial insurance, including consumer out-of-pocket costs, with a particular focus on the interaction with high-deductible commercial insurance products.

[4] 2024 MD Laws Ch. 142.
[5] https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/SB1103Ch142(2)(2024)_2024.pdf

These analyses are on hold while final terms of the AHEAD Model are pending.

8. Published material on efforts in other states, by federal Medicare and Medicaid regulatory agencies, and by national advocacy organizations related to the regulation or minimization of facility fees, and the potential effects that similar efforts may have on health care costs in the State, including consumers' out-of-pocket costs.

   This information is presented in this report.

9. The regulation of fees charged by out-of-state hospital outpatient facilities located in the State.

   This analysis is on hold while final terms of the AHEAD Model are pending and the above analyses are completed.

10. The effectiveness of the notice of hospital outpatient facility fees that is provided to consumers.

    This information is presented in this report.

Process for Report Development

The HSCRC consulted with national experts on facility fees and with stakeholders through a Workgroup to develop this report. The Facility Fee Workgroup met seven times in 2025. HSCRC staff solicited comments from Workgroup members and the public during each meeting and allowed for a written comment period after each meeting. Prior to finalizing this report, HSCRC staff also solicited feedback from Workgroup members on the report's recommendations. Appendix A contains more information about the Workgroup and stakeholder engagement process. Consensus was not achieved in all Workgroup discussions. The HSCRC drafted the recommendations in this report after considering the viewpoints of stakeholders and experts alongside information gathered from consumer testing. Differing stakeholder perspectives are summarized under each recommendation.

Background

What is a Facility Fee?

For purposes of this report, a "facility fee" is defined as a charge from an institutional provider, such as a hospital, that is intended to cover the costs associated with the operation of health care facilities (e.g., building, utilities, professional staff, and some health care services). This report will focus on facility fees charged by hospitals for outpatient services. Facility fees may also be referred to as "hospital charges." This report does not address hospital charges for emergency department (ED) or inpatient hospital services or facility fees charged by other types of facilities.

Facility fees are distinct from professional fees. Professional fees are charges from physicians or advanced practice providers (such as nurse practitioners) for services the clinician provided during the patient's visit. Professional fees reimburse clinical professionals for the services they provide to the patient.

For services provided at a hospital, there are usually two charges: 1) the facility fee and 2) the professional fee. The patient may receive these charges through a single bill (this is more common if the professional is employed by the hospital) or two bills (this may be more likely if the professional and the hospital are separate legal entities). For example, for an outpatient surgery conducted at a hospital, there will be a hospital charge for the operating room time and professional charges from the surgeon and anesthesiologist. The amount patients pay in facility fees can vary widely depending on their insurance coverage, much like other health care expenses. Patients covered by Maryland Medicaid—or those receiving care related to workers' compensation or auto insurance claims—typically have full coverage for hospital charges with no out-of-pocket costs. In contrast, patients with commercial insurance or Medicare are responsible for cost-sharing based on the specific terms of their individual plans. See the HSCRC's 2024 Facility Fee Report for additional background information on facility fees.

HSCRC is required by law to ensure that total hospital costs are reasonable and that aggregate charges are reasonably related to those costs. HSCRC sets global budgets on hospital revenue for all HSCRC-regulated services across inpatient, ED, and on-campus outpatient services. Therefore, facility fees cannot be separated from global budgets. If facility fees were to be reduced or eliminated for certain services like outpatient, HSCRC would still be required to ensure that hospitals recover their total costs. As a result, rates for inpatient and/or ED services would need to increase proportionally. HSCRC does not have regulatory authority over out-of-state hospitals that have outpatient office locations in Maryland.

Maryland Facility Fee Notice Requirements

Maryland's Facility Fee Right-to-Know Act[6] (FFRTKA) of 2020 established facility fee notice requirements for Maryland hospitals. The intended purpose of facility fee notices is to educate consumers about facility fees and promote consumer choice. Under current law, Maryland hospitals are required to provide a facility fee notice to patients with visits that meet the following criteria:

- The hospital charge for the visit is regulated by the HSCRC;
- The visit is for an outpatient service; and
- The outpatient service is within the HSCRC's clinic rate center.[7]

[6] 2020 MD Laws Ch. 366 (to be codified at MD. CODE. ANN., Health-Gen. § 19-349.2).
[7] Facility fee notices are required for visits related to a "hospital outpatient charge approved by HSCRC for an outpatient clinic service, supply, or equipment, including the service of a non-physician clinician" (MD Code Ann., Health-Gen §19-

If a hospital does not provide the required facility fee notice to a patient, the hospital may not charge, bill, or attempt to collect an outpatient facility fee.[8] Violations of the facility notice requirement may also be a violation of the Maryland Consumer Protection Act.[9] Please see the HSCRC's 2024 Facility Fee Report for more background information on which services require a facility fee notice under current law and the types of services regulated by the HSCRC.

Maryland law specifies the required text for facility fee notices (see Appendix B).[10] Hospitals may use the exact text provided in the law or a "substantially similar form."[11] The notice includes general information about facility fees, the possibility of avoiding them at other locations, an estimate of the amount of the total charge, notice that the consumer may not be liable for the total charge due to their insurance, and instructions for filing complaints about facility fees. It also includes a space for the patient's signature to confirm receipt of the notice.

Hospitals must provide the facility fee notice at the time an appointment is made.[12] The patient is required to acknowledge the notice at the time of the appointment. These notices are not required to be provided after the hospital service is rendered. If a patient makes an appointment in person or over the phone, the notice must be provided orally at the time the appointment is made, and the hospital must follow up with a written electronic notice. If the patient makes the appointment electronically or uses a website, the written notice must be provided at the time the appointment is made and sent to the patient electronically. If the patient does not accept electronic communications from the hospital, the hospital must send the notice to the patient by first class mail.

Study Findings

The HSCRC issued two requests for proposal (RFPs) for consultants to conduct analytics to inform this report. First, the HSCRC awarded a contract to Milliman in the spring of 2025 to conduct analyses and issue a report on the following study requirements:

- The magnitude and impact of hospital facility fee charges for hospitals, payers, and consumers.

349.2). This requirement has been in effect since July 2021. In 2024, the Maryland General Assembly amended the law to change the text of the required facility fee notice. 2024 MD Laws Ch. 142.

[8] MD Code Ann., Health-Gen §19-349.2(g).

[9] The Attorney General's Office has multiple enforcement options under the Consumer Protection Act, including injunctive relief to prohibit future violations of the Act; restitution and damages for injured consumers; civil penalties; and criminal penalties. Md. Code, Com. § 13-401 et seq.

[10] MD Code Ann., Health-Gen §19-349.2.

[11] MD Code Ann., Health-Gen §19-349.2.

[12] MD Code Ann., Health-Gen §19-349.2.

- Alternative mechanisms or revisions to the billing of the facility fees that would allow hospitals to recover costs while protecting individual consumers from high facility fee bills, maintaining access to health care services, and addressing health equity concerns.
- The interaction of these alternative mechanisms or revisions with the State's Total Cost of Care model obligations to the federal government, including any impact on Medicare total cost of care savings if outpatient facility fees are eliminated or reduced.
- The impact of these alternative mechanisms or revisions on Medicaid, Medicare, and commercial insurance, including consumer out-of-pocket costs, with a particular focus on the interaction with high-deductible commercial insurance products.

After work on this contract began, it became clear that proposed federal changes to the hospital rate-setting process under the upcoming AHEAD model would directly impact three of the analyses related to alternative facility fee billing mechanisms. As a result, the HSCRC postponed the analyses of alternative mechanisms until further details about the new rate-setting process are finalized. In addition, the HSCRC staff postponed data collection and analysis of facility fees that may be charged by out-of-state hospitals with outpatient facilities in Maryland until these analyses were conducted.

The HSCRC awarded a second contract to EurekaFacts in the summer of 2025 to test the effectiveness of the current facility fee notice language with consumers in Maryland, test revisions to the notice, and offer recommendations for improvement. Staff solicited Workgroup feedback on methodology and presented findings from both consultant studies.

State and Federal Efforts to Regulate Facility Fees

State Activity

In recent years, several states have pursued reforms that limit hospitals' ability to charge outpatient facility fees. Four states—New York, Indiana, Maine, and Connecticut—have passed laws prohibiting certain kinds of outpatient facility fees. An additional five states—Maryland, Mississippi, Ohio, Texas, and Washington—have narrower prohibitions regarding outpatient facility fees. [13]

- New York prohibits facility fees for preventive care services.
- Maine has the oldest facility fee prohibition law, which prohibits commercial insurance from paying separate facility fees for services provided in an office setting. An office setting under Maine law is defined as "a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is

[13] Georgetown University Center on Health Insurance Reforms. (2025, September 5). *Prohibitions on outpatient facility fee billing in the commercial health insurance market.* https://facilityfeereform.chir.georgetown.edu/facility-fee-prohibitions/

physically located within a facility." In practice, this law means that hospitals are prohibited from charging facility fees for office-based care, even when provided in a hospital-owned practice. Maine's law does not distinguish between off campus and on campus offices.

- Indiana prohibits health care providers owned in whole or part by an Indiana nonprofit hospital system with at least $2 billion in annual patient revenue as of 2021 from billing facility fees for care provided in an off-campus office-based setting. The prohibition does not apply to certain facilities such as critical access hospitals, rural health clinics, federally qualified health centers, and oncology centers.
- Connecticut bars hospital-owned or operated facilities from charging facility fees for outpatient evaluation and management or assessment and management services at on- and off-campus locations, excluding EDs and certain types of observation stays. Connecticut also prohibits facility fee charges for telehealth services.

Table 1 summarizes these facility fee prohibitions in other states.

Table 1. Summary of Facility Fee Prohibitions in Other States[14]

	New York	Maine	Indiana	Connecticut
Effective Date	2023	2005	2025	2017 (off-campus evaluation and management services) 2022 (off-campus assessment and management services) 2024 (on-campus evaluation and assessment and management services)
Type of Prohibition on Facility Fees	Preventive services as defined by the United States Preventive Services Task Force	On- and off-campus office-based settings	Off-campus office settings owned by large non-profit hospitals	Evaluation/assessment and management services on-and off-campus, telehealth
Exclusions	None	None	Certain facilities including critical access hospitals, rural health clinics, FQHCs, oncology centers, and psychiatric services delivered in hospitals or within 35 miles	Emergency rooms and certain observation stays

[14] Georgetown University Center on Health Insurance Reforms.

In addition to Maryland, Connecticut, Ohio, and Washington have prohibited facility fee charges for certain telehealth services. In Maryland, hospitals may only charge a facility fee for telehealth services where there is no professional fee.[15] Texas has prohibited facility fees for drive-through services at freestanding EDs.

Site-Neutral Payments

Medicare's current reimbursement system pays different rates for similar services depending on where care is delivered. Hospital outpatient departments (HOPDs) typically receive higher payments than freestanding physician offices or ambulatory surgical centers (ASCs), largely due to facility fees that cover hospital overhead and compliance costs. Federal policy discussions have focused on "site-neutral payments," a concept in which Medicare payments for select services—particularly those that can safely be provided in physician offices or ASCs—would be standardized across sites of care. Supporters argue that aligning payments could reduce Medicare spending, lower patient out-of-pocket costs, and curb incentives for hospital acquisition of physician practices. Hospital stakeholders, including the American Hospital Association (AHA), warn that payment cuts may threaten access to care, especially in rural or safety-net settings. Medicare has incrementally aligned payments for clinic visits provided at *off-campus* HOPDs and for other services provided at off-campus HOPDs that started billing after November 2, 2015.[16] It is important to note that, in Maryland, the HSCRC's regulatory authority—and therefore covered under FFRTKA—is limited to rates for services provided "at the hospital."

Moreover, there are two barriers to billing off-campus facility fees in Maryland that do not exist in other states.[17] First, to bill a facility fee, a service would need to meet the HSCRC's definition of "at the hospital." As a result, off-campus HOPDs in Maryland cannot bill facility fees. Second, Maryland's hospital payment model ensures that aggregate costs for regulated services are accounted for within each hospital's global budget revenue (GBR). For this reason, new facility fees would not generate new revenue. In this way, global budgets are an inherently site-neutral policy while also addressing the need to fund vital hospital services.

The Medicare Payment Advisory Commission (MedPAC) has long supported partial site-neutral payment reforms, arguing that Medicare should not pay more for a service in one setting if it can be safely performed elsewhere. MedPAC's June 2023 report to Congress[18] identified 66 ambulatory payment classifications (APCs) that may be appropriate for site-neutral payment adjustments in Medicare based on the fact that

[15] COMAR 10.37.10.07-1(K).
[16] Kaiser Family Foundation. (2024, June 14). *Five things to know about Medicare site-neutral payments*. https://www.kff.org/medicare/five-things-to-know-about-medicare-site-neutral-payment-reforms/
[17] HSCRC has no authority over out-of-state hospitals that own outpatient facilities in Maryland.
[18] Medicare Payment and Advisory Commission. *Report to Congress. Chapter 8: Aligning fee-for-service payment rates across ambulatory settings.* https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

they are most commonly performed outside HOPDs, in either a physician's office or an ASC. These services include clinic visits, drug administration, imaging services, and minor surgical procedures, among others. MedPAC acknowledges that hospitals have higher fixed costs than independent providers. However, they suggest that Medicare should pay rates based on the lowest cost setting where a service can be provided without a reduction in safety or quality. Discussed later in this report, the HSCRC used these 66 codes identified by MedPAC for modeling of potential alternative scenarios to the billing of facility fees.

No Surprises Act

The federal No Surprises Act[19] (NSA) primarily seeks to protect patients from unexpected bills arising from out-of-network care, especially in emergency scenarios. For uninsured and self-paying patients, the NSA also requires health care providers and facilities to deliver a good faith estimate (GFE) prior to scheduled, non-emergency services. The GFE must itemize expected charges from the provider or facility and, when reasonably expected, include charges from co-providers or co-facilities involved in the care. The NSA further mandates that all providers and facilities publicly post information about patients' rights under the Act and the availability of GFEs. While both the NSA and Maryland's FFRTKA promote transparency in health care billing, Maryland hospitals have expressed concern that the GFE requirements of the NSA and the requirements of the FFRTKA both overlap and vary in scope, applicability, and administrative requirements.

Table 2 compares the requirements in the FFRTKA and NSA. The NSA's GFE requirement currently applies to uninsured and self-pay patients; final rules that will require them for *insured* patients are still pending. In contrast, Maryland's facility fee law applies to all patients receiving outpatient care by HSCRC-regulated facilities, regardless of insurance status, but only requires disclosure of the facility fee itself, not professional fees. Timing requirements for the notices also differ.

There are also procedural differences. While both laws reference financial assistance, the language differs slightly. The NSA requires a disclaimer that the GFE is only an estimate and includes an explanation of the federal dispute resolution process if billed charges exceed the estimate by a significant margin. Maryland law requires the notice to include a statement that financial help may be available to assist with the facility fee. Finally, compliance responsibilities vary: the HSCRC and the Health Education and Advocacy Unit (HEAU) oversee FFRTKA compliance, while the NSA is enforced federally by the Centers for Medicare & Medicaid Services (CMS), with support from state agencies such as the Maryland Insurance Administration (MIA) and the Consumer Protection Division of the Office of the Attorney General.

[19] No Surprises Act of the 2021 Consolidated Appropriations Act, Pub. L. No. 116-260, 134 Stat. 1182 (2021).

Table 2. Comparison of NSA and FFRTKA Notice Requirements

Written Notice Requirements	Maryland Law - FFRTKA	Federal Law - NSA GFE
Written notice required	Yes – Notice of facility fee and actual cost or estimate required for all patients in the outpatient clinic rate center of HSCRC regulated facilities	Yes – Providers must give a GFE of costs to uninsured/self-pay patients before receiving non-emergency services
How to submit a complaint	Included in notice	Included in the notice
Estimate of costs includes both professional and facility charges	No – Facility fee only	Yes, when applicable, both professional and facility charges are included in the estimate
Information on financial assistance	Included in notice	Not specifically included in notice, but the GFE must reflect expected charges, including any expected discounts, including financial assistance.
Information about seeking care at an alternative location	Included in notice	Not included in notice
Information about role of insurance coverage on cost	Included in notice	N/A as the GFE is currently for uninsured/self-pay patients
Timing of Notice	-When appointment is scheduled -Before patient sees provider	-For services scheduled at least 3 days in advance, no later than 1 business day after scheduling -For services scheduled at least 10 business days in advance, or if cost information is requested, no later than 3 business days after scheduling or requesting
Patient acknowledgement of notice required	Yes	No
Who handles complaints	1. Hospital 2. HSCRC and/or HEAU	1. HEAU- bills 2. MIA- insurance claims
Facility required to post information in building and online	No	Yes

Alternative Mechanisms to the Billing of Facility Fees

The statute requires the HSCRC to study alternative mechanisms or revisions to the billing of facility fees that would allow hospitals to recover costs while protecting individual consumers from high facility fee bills. While this work was later paused due to uncertainties with the final terms of the AHEAD Model, the HSCRC

worked with Milliman and the Workgroup to develop alternative scenarios for modeling. These alternative scenarios included the following:

- Capping facility fees at a specified dollar amount for services billed under the HSCRC's clinic rate center;[20]
- Disallowing facility fees for services billed under the HSCRC's clinic rate center;
- Limiting facility fees to a specified percentage of the Medicare Physician Fee Schedule (PFS) using codes identified by MedPAC as candidates for site-neutral payments (discussed above in the Site-Neutral Payment section of this report)[21]; and
- Capping patient payments for services with codes identified by MedPAC as candidates for site-neutral payment at a specific amount.

Magnitude and Impact of Hospital Facility Fees

Milliman conducted an analysis of calendar year (CY) 2023 outpatient hospital claims to estimate the magnitude and impact of hospital facility fee charges for hospitals, payers, and consumers. Data sources included the following:

- Maryland's All-Payer Claims Database (APCD) for the Medicare Advantage, individual, commercial small group, and commercial large group fully insured markets.
- Milliman's Consolidated Health Sources Database (CHSD) for the commercial large group self-insured market.
- The CMS 5 Percent Research Identifiable File for Medicare fee-for-service (FFS), adjusted to estimate the total Medicare FFS market.
- Due to limited data availability for the large group fully insured commercial market, HSCRC staff further extrapolated large group membership using health insurance coverage data from the Kaiser Family Foundation.[22]

Medicaid was excluded from the analysis because participants do not have cost-sharing for facility fees and therefore fall outside of the scope of the analysis. Milliman grouped the outpatient hospital claims into the following mutually exclusive categories:

- Outpatient clinic services as defined by the HSCRC's clinic rate center.

[20] Rate centers are a specific unit of service the HSCRC uses to set regulated prices. Clinic services generally provide organized diagnostic, preventive, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients. See the HSCRC's Accounting and Budget Manual for more information: https://hscrc.maryland.gov/Pages/hdr_compliance.aspx

[21] MedPAC used Medicare claims to identify the codes of interest; an all-payer methodology could be applied for Maryland.

[22] https://www.kff.org/state-health-policy-data/state-indicator/total-population/

- The codes identified by MedPAC as candidates for site-neutral payments (as described earlier in this report).
- Other outpatient categories as classified by Milliman's Health Cost Guidelines (HCG) grouper.[23]

Milliman analyzed the following costs:

- Patient cost-sharing - Total payments made by patients for covered services, including copayments, coinsurance, and deductibles.[24]
- Allowed claims - The total amount paid for covered services, including payments from health plans, patients, and other payers.

See Milliman's report for more detail on the methodology and assumptions. Milliman analyzed patient cost-sharing and allowed amounts by payer and outpatient service category.

To estimate patient liability for outpatient facility fees, Table 3 presents patient cost-sharing for hospital outpatient services by payer for CY 2023, which was $897.1 million. Of this, $64.6 million was attributed to services billed under the clinic rate center, which are subject to the facility fee notice requirement. Medicare FFS accounted for 57% of the clinic rate center cost-sharing.

Table 3. Patient Cost-Sharing for Outpatient Hospital Services by Payer, CY 2023

Service Category	Medicare Advantage (APCD)**	Individual (APCD)	Commercial Small Group (APCD)	Commercial Large Group Fully Insured (APCD)	Commercial Large Group Self Insured (CHSD***)	Medicare FFS (5% LDS)	Estimated Total
Outpatient Surgery	$11.3M	$9.0M	$6.1M	$8.1M	$40.8M	$80.9M	$156.2M
Outpatient Clinic	$2.3M	$3.3M	$2.8M	$4.1M	$15.4M	$36.7M	$64.6M
Outpatient Radiology	$2.4M	$2.6M	$2.3M	$4.2M	$15.8M	$55.8M	$83.0M
Outpatient Other	$22.5M	$26.9M	$19.8M	$37.0M	$121.6M	$365.6M	$593.4M
Total Outpatient	**$38.5M**	**$41.8M**	**$30.9M**	**$53.3M**	**$193.6M**	**$539.0M**	**$897.1M**
MedPAC-Identified Services	***$8.8M***	***$13.3M***	***$11.1M***	***$18.7M***	***$56.1M***	***$109.9M***	***$217.9M***

*Amounts reflect patient responsibility according to insurance coverage and do not include any charity care provisions.
**Based on APCD and extrapolated into the estimated Medicare Advantage membership.
***Based on Milliman's CHSD database and extrapolated into the estimated large group market membership based on Health Insurance Coverage Data from the Kaiser Family Foundation.

[23] For more information, see https://www.milliman.com/en/products/health-cost-guidelines-grouper
[24] Medicare FFS cost-sharing data do not account for Medicare supplemental plans.

Table 4 presents the estimated allowed amounts for hospital outpatient services by payer in CY 2023, which totaled $7.2 billion. Total costs for clinic services were estimated at $476.8 million.

Table 4. Allowed Amounts for Outpatient Hospital Services by Payer, CY 2023

Service Category	Medicare Advantage (APCD)**	Individual (APCD)	Commercial Small Group (APCD)	Commercial Large Group Fully Insured (APCD)	Commercial Large Group Self Insured (CHSD***)	Medicare FFS (5% LDS)	Estimated Total
Outpatient Surgery	$154.4M	$80.4M	$77.0M	$400.2M	$788.5M	$382.0M	$1,882.5M
Outpatient Clinic	27.4M	16.4M	14.6M	86.5M	168.7M	163.1M	476.8M
Outpatient Radiology	$31.4M	$16.7M	$14.3M	$90.3M	$188.3M	$252.4M	$593.4M
Outpatient Other	$373.5M	$156.1M	$101.2M	$584.1M	$1,140.4M	$1,908.9M	$4,264.2M
Total Outpatient	**$586.8M**	**$269.6M**	**$207.1M**	**$1,161.1M**	**$2,285.9M**	**$2,706.5M**	**$7,217.0M**
MedPAC-Identified Services	***$99.7M***	***$46.8M***	***$45.0M***	***$271.9M***	***$510.0M***	***$527.6M***	***$1,501.0M***

*Amounts reflect the amount covered according to insurance coverage.
**Based on APCD and extrapolated into the estimated Medicare Advantage membership.
*** Based on Milliman's CHSD database and extrapolated into the estimated large group market membership based on Health Insurance Coverage Data from the Kaiser Family Foundation.

Table 5 presents estimated patient cost-sharing as a percentage of total allowed costs for hospital outpatient services by payer. The data show substantial variation in cost-sharing by payer, ranging from 4.7% for the large group fully insured market to 19.9% for Medicare FFS. For clinic services specifically, cost-sharing ranges from 4.7% for the large group fully insured market to 22.5% for Medicare FFS.

Table 5. Patient Cost-Sharing as a Percentage of Total Allowed Costs for Outpatient Hospital Services by Payer, CY 2023

Service Category	Medicare Advantage (APCD)**	Individual (APCD)	Commercial Small Group (APCD)	Commercial Large Group Fully Insured (APCD)	Commercial Large Group Self Insured (CHSD***)	Medicare FFS (5% LDS)	Estimated Total
Outpatient Surgery	7.3%	11.2%	7.9%	2.0%	5.2%	21.2%	8.3%
Outpatient Clinic	8.5%	20.2%	18.8%	4.7%	9.1%	22.5%	13.5%
Outpatient Radiology	7.5%	15.5%	15.7%	4.7%	8.4%	22.1%	14.0%
Outpatient Other	6.0%	17.2%	19.5%	6.3%	10.7%	19.2%	13.9%
Total Outpatient	**6.6%**	**15.5%**	**14.9%**	**4.6%**	**8.5%**	**19.9%**	**12.4%**
MedPAC-Identified Services	***8.8%***	***28.4%***	***24.7%***	***6.9%***	***11.0%***	***20.8%***	***14.5%***

*Amounts reflect patient responsibility according to insurance coverage and do not include any charity care provisions.
**Based on APCD and extrapolated into the estimated Medicare Advantage membership.
*** Based on Milliman's CHSD database and extrapolated into the estimated large group market membership based on Health Insurance Coverage Data from the Kaiser Family Foundation.

Effectiveness of the Notice

EurekaFacts conducted a two-phased study to test the effectiveness of the current notice language; determine whether the notice provides clear, actionable information that helps patients anticipate costs and make informed decisions about their care; and to test revisions that may improve notice clarity. In the first phase, they conducted in-depth one-on-one interviews with Maryland consumers to explore how they interpreted the current notice language and format, and to identify areas of confusion or opportunities for improvement.

The interviews demonstrated that consumers frequently struggled to read and interpret the **current** notice language and format.

- **Only about half were able to understand the content on their first attempt, and many described the formatting as crowded and visually overwhelming.**
- **Technical language such as "if unknown" or "if applicable" further reduced clarity. Confusion was especially pronounced regarding the concept of facility fees. More than half of respondents did not understand the term, and many were uncertain about what they would ultimately owe.**
- **Nearly half reported that the notice might lead them to delay or cancel treatment altogether.**
- **Accessibility was also a challenge, as several respondents had difficulty locating instructions for alternate languages or formats**.

For the second phase of the study, EurekaFacts revised the notice based on the findings described above, including changes to the notice layout, organization, and language, and then tested the revision in two focus groups. The findings using the **revised notice** reflected considerable improvements in clarity and consumer understanding, including the following:

- **All consumers were able to describe what a facility fee was based on the revised definition.**
- **Most consumers reported that the revised notice clearly communicated the expectation of two separate bills.**
- **Compared to phase one, a larger proportion of consumers were able to identify actions they could take to obtain more information (e.g., contact insurance or a provider).**
- **None of the consumers reported that the notice would cause them to delay or cancel care.**

Phase two respondents identified additional opportunities to further strengthen the notice. They recommended positioning critical details—such as language access and alternate format instructions—at the beginning of the document and requested plainer language for cost information. Respondents also noted the value of digital tools such as QR codes, hyperlinks, and patient portal integration, which could support accessibility and provide personalized cost information.

EurekaFacts' final recommendations for improving the notice included the following:

- **Simplify language and layout to improve readability.**
- **Provide plain-language definitions and clearer cost information.**
- **Move language access and alternate format instructions to the beginning.**
- **Incorporate digital tools (QR codes, patient portals) to enhance usability.**
- **Include context and sources for cost ranges to build transparency.**

More detail on their study and findings are available in the September 12, 2025 Workgroup Meeting slides, available here.

Recommendations

Recommendation 1: Move Some Requirements from Statute to Regulation

The study of the effectiveness of notices outlined a set of potential updates to the facility fee notice language. Currently, the statute requires the notice language to be used as written or in a substantially similar form. Consumer testing revealed that individuals struggled to read and interpret this statutory language. Transferring the notice language and timing requirements from statute to regulation would allow the State to more easily make changes to maintain compliance with plain-language standards and respond to issues raised by consumers and other trends while still maintaining public comment opportunities. This approach would also allow for better alignment with forthcoming federal changes to the NSA's good faith estimate requirements, addressing concerns from hospitals about duplicative notices. Additionally, this proposal is consistent with typical state practice, where statute sets minimum requirements, while specific policy details are addressed through regulation.

Workgroup members agreed that, if the specific notice language is moved from statute to regulation, the underlying statute should clearly define minimum notice requirements to preserve the intent of the FFRTKA and ensure that consumers continue to receive adequate notice. For example, stakeholders identified the following minimum necessary elements:

- An estimated facility fee amount, personalized for the expected services, on the first page/in prominent position on the notice.
- A clear, plain-language definition of facility fees.
- Information on how consumers may seek financial assistance.
- Information on alternative locations that may not charge a facility fee.
- Information on consumer complaint processes.

Recommendation 2: Revise Notice's Content - Cost Estimate

The challenge of effectively communicating cost estimates generated significant discussion among Workgroup members and stakeholders, as well as during consumer testing. During consumer testing, respondents expressed a strong desire to know as precisely as possible the cost that they would be personally responsible for paying, including considerations related to their insurance coverage (e.g., copays, deductibles, etc.) Providers acknowledged the value of this information, but also noted that because the specific services that will be needed are not always known before a visit, and because individual insurance coverage can vary, a precise advance cost estimate is not always known. Based on these findings, it is recommended to continue the requirement for hospitals to provide a personalized cost estimate based on the known information about the patients' anticipated services and needs when known, and to also require that the notice include language encouraging patients to contact their insurance carrier to determine their estimated financial responsibility.

Consumer testing explored alternatives for communicating cost ranges or estimates when a personalized estimate is unavailable. In the revised notice tested, estimated cost ranges were presented in table format. Consumer response to this format was mixed, with some improvement in overall understanding of expected fees, but also some confusion related to the ranges used in the tested example. Consumers consistently indicated a preference for clear, concrete, personalized, and specific cost information, ideally including information on out-of-pocket costs tailored to their specific insurance coverage. Given these findings, *if a personalized cost estimate is not known*, hospitals should provide one or more of the following options:

- An online cost estimator or calculator that enables patients to enter their anticipated service or appointment details using plain language to receive a personalized estimate. The notice must provide the information necessary for the patient to use the online estimator. Spreadsheets or tools that require specialized knowledge, such as procedure codes or medical terminology, would not be sufficient for this requirement. The online estimator must also contain language that insured patients should contact their carrier to determine estimated financial responsibility for the facility fee.
- A table of estimated costs based on the anticipated services with clearly labeled minimum, maximum, and typical charges. Broad tables, spreadsheets, or tools requiring specialized knowledge would not be sufficient for this requirement.

The Workgroup did not reach consensus on the utility of cost estimators or online calculators. Some stakeholders expressed strong concern that such tools can be difficult for consumers to use with accuracy and may inadvertently lead to erroneous estimates.

Recommendation 3: Update Timing of the Notice

During consumer testing, respondents expressed a strong preference to receive the facility fee notice prior to their appointment and with sufficient time to allow them to explore alternatives to receive lower-cost care. This feedback resulted in a recommendation to consider updating the timing requirements for facility fee notices as follows:

- Notices should be provided at the time of scheduling the appointment or within 72 hours of scheduling.
- Appointment reminders that reference patient financial responsibility and/or cost-sharing (e.g., copays) should also contain information about facility fees.

In response to this recommendation some hospital stakeholders indicated that the current requirement to provide notice at the time of the appointment can result in lengthy telephone calls, as staff may need time to generate personalized cost estimates while consumers are on hold. Staff believe that allowing up to 72 hours to provide the notice strikes a balance between operational feasibility and adequate consumer protection, and that it aligns with current NSA requirements. Additionally, hospitals noted the administrative burden of sending additional notices not already within their billing workstreams. However, consumers indicated a preference for receiving the notice with sufficient time to contact their insurance company or consider alternative sites for their visit. To balance these competing concerns, the recommendation was adjusted to require that facility fee information be included in any existing or future reminders that reference patient financial responsibility or cost-sharing.

Recommendation 4: Revise Notice's Content - Definition of Facility Fee

Consumer testing revealed that the current notice language resulted in a mixed or unclear understanding of the term "facility fee." A revised definition that meets plain-language standards resulted in improved understanding in the second phase of consumer testing. Based on these findings, a revision to the notice language is recommended to include an accurate, clear, and plain-language definition of the term "facility fee(s)."

Recommendation 5: Revise Notice's Content - Additional Language

To enhance clarity and consumer understanding, certain information should be prioritized at the top of the notice, including the following:

- The purpose of the appointment and anticipated services.
- A statement that financial responsibility may vary by insurance coverage, and some patients may have no financial responsibility, including those covered by Medicaid and workers' compensation.

- Cost estimate information should also be in the top half of the first page of the notice.

In testing, consumers requested information at the top of the notice about the reason for the appointment and their likely costs/cost estimates.

The 2024 report included a recommendation that outpatient facility fee notices should not be required for Medicaid patients, and that hospitals should not have to provide a notice to other patients with no cost-sharing, such as those covered by workers' compensation. Several Workgroup members expressed continued support for this recommendation. However, due to recent changes in federal regulation, as well as anticipated future changes, Medicaid eligibility is likely to become more vulnerable to change over shorter periods of time. Given these adjustments, the related potential impacts on patient financial responsibility, and the purpose of facility fee notices to provide patient education, it is recommended that all patients receive the notice with the supplemental information indicated.

Recommendation 6: Improve Accessibility of the Notice

During consumer testing, several respondents described the current format of the notice as difficult to read and navigate, dense, and/or "cluttered." Consumers expressed a preference for improved organization and formatting, including the use of headers and bold text, consistent font sizing, and improved spacing to allow more efficient visual scanning. It is recommended that the notice format and organization be improved in the following ways:

- Placing information about alternate languages and formats prominently at the top of the notice.
- Ensuring that the notice is accessible and readable across various formats and technologies, such as mobile devices and screen readers.
- Using clear, plain language throughout, consistent with plain-language standards established in Maryland law[25] and with recommendations for public-facing health information offered by the American Medical Association[26] and the National Institutes of Health.[27]
- Maintaining consistent font styles and accessible font sizes across the document.
- Highlighting key information with bolding or underlining and using spacing and headers to clearly separate sections.
- Organizing content so that related information is grouped together for easier navigation.

[25] University of Maryland School of Public Health Consumer Health Information Hub
[26] Weiss, B. D. (2003). *Health literacy: A manual for clinicians*. American Medical Association Foundation and American Medical Association.
[27] National Institutes of Health Clear and Simple Guide

Stakeholders generally supported these recommendations, though some cautioned that the notice should not become overly lengthy and emphasized the importance of balancing these recommendations with keeping critical information—such as the cost estimate—on the first page.

Appendix A: Workgroup and Stakeholder Engagement

Maryland law requires that, throughout the study on facility fees, the HSCRC must consult with the Maryland Department of Health, the Maryland Insurance Administration, the Health Education and Advocacy Unit within the Office of the Attorney General, and representatives of hospitals (including out-of-state hospitals providing services to patients who are staying in facilities in the state), physician practices that provide services in hospital outpatient settings, health care payers, consumer advocacy groups, and employer groups. The HSCRC convened a Workgroup that includes these stakeholders to provide advice to the HSCRC on policies related to facility fee notices and facility fees themselves.

The Workgroup was charged with informing the HSCRC's report development on the following topics:

- The nature of costs underlying hospital outpatient facility fees and how similar costs are recovered in other health care settings.
- The drivers of hospital facility costs that are unique to hospitals and are not reflected in other health care settings.
- The magnitude and impact of hospital facility fee charges for hospitals, payers, and consumers.
- Industry practices for seeking authority for an outpatient location to be approved as "at the hospital" and thereby subject to rate regulation.
- Alternative mechanisms or revisions to the billing of the facility fees that would allow hospitals to recover costs while protecting individual consumers from high facility fee bills, maintaining access to health care services, and addressing health equity concerns.
- The interaction of the alternative mechanisms or revisions studied under item (5) of this subsection with the State's Total Cost of Care model obligations to the federal government, including any impact on Medicare total cost of care savings if outpatient facility fees are eliminated or reduced.
- The impact of the alternative mechanisms or revisions studied under item (5) of this subsection on Medicaid, Medicare, and commercial insurance, including consumer out-of-pocket costs, with a particular focus on the interaction with high-deductible commercial insurance products.
- Published material on efforts in other states, by federal Medicare and Medicaid regulatory agencies, and by national advocacy organizations related to the regulation or minimization of facility fees, and the potential effects that similar efforts may have on health care costs in the State, including consumers' out-of-pocket costs.
- The regulation of fees charged by out-of-state hospital outpatient facilities located in the State.
- The effectiveness of the notice about hospital outpatient facility fees that is provided to consumers.

The Workgroup met seven times in 2025. These meetings were initially focused on developing alternative scenarios to the billing of facility fees and then focused on the effectiveness of the notice. HSCRC staff solicited comments from Workgroup members and the public during each meeting and allowed for a written comment period after each meeting. HSCRC staff also solicited oral and written comments from Workgroup members on the report's recommendations. All Workgroup meetings were open to the public. Information about Workgroup meetings and presentation materials are available on the HSCRC's website.[28]

[28] https://hscrc.maryland.gov/Pages/facility-fee-workgroup.aspx

Appendix B: Current Statutory Text of Facility Fee Notice

IMPORTANT FINANCIAL INFORMATION

(Patient Name) _____ Appointment Date: _____

Notice Of Hospital Outpatient Facility Fee And Billing Disclosure

a. Your appointment with (provider, practice, or outpatient facility name) will take place in an outpatient department of (hospital name).b. (Hospital name) will charge an outpatient facility fee that is separate from and in addition to the bill you will receive from (provider).c. You will receive two charges for your visit:1. a provider services bill from (provider); and2. a hospital facility bill from (hospital name).

Expected Fee

(if known) The amount of the facility fee that will be charged by (hospital name) for your appointment is $ _____. or

(if unknown) (Hospital name's) facility fee is likely to range from $ _____ to $ _____. AND

(if unknown) Based on appointments like the one you are scheduled for, we estimate the facility fee to be $ _____. AND

(if unknown) We are providing you with a range of fees and an estimate because the actual amount of the facility fee will depend on the hospital services that are actually provided. The fee could be higher if you require services during your appointment that we cannot reasonably predict today.

Financial help for your portion of the outpatient facility fee bill may be available. If you need financial help with the outpatient facility bill, please contact (hospital financial assistance office, with telephone number and direct website address).

Receiving services here may result in greater financial liability than receiving services at a location where a facility fee may not be charged.

(if applicable) No Facility Fee Location

You can see (provider) at another location that does not charge a facility fee.

(address and contact information)

Contact your insurance carrier to see if (provider) is a participating provider and in-network at the (address of alternative location) location.

Insurance Information

(1) The amount of the facility fee that you will be responsible for paying will depend on your insurance coverage.(2) Insurance companies could impose deductibles or higher copayment or coinsurance amounts for services provided in hospital outpatient departments.(3) If you have insurance, you should contact your carrier to determine your insurance coverage and your estimated financial responsibility for the facility fee, including copayments, coinsurance, and deductible amounts for the outpatient facility fee.

Facility Fee Complaints

If you have a complaint about an outpatient facility fee charge, please first contact the hospital, (hospital billing office contact information).

If the complaint is unresolved, you may then file the complaint with the Health Services Cost Review Commission, (contact information).

If you need additional information regarding your facility fee charges or if you need assistance mediating a facility fee complaint against a hospital, contact the Health Education and Advocacy Unit of the Office of the Attorney General, 1-877-261-8807 | Heau@oag.state.md.us | www.MarylandCares.org.

Acknowledgment

(1) I understand that I will be billed a hospital facility fee and a provider fee.(2) (Hospital name) provided me with information on the facility fees that will be billed for my appointment.(3) I understand that the fee could vary based on conditions and services provided to me that the hospital cannot reasonably predict today.(4) I understand that my out-of-pocket costs will depend on my insurance coverage.

_____ (initial here) - by initialing here, I confirm that I received the facility fee information at the time I made my appointment with (provider).

By signing this form, I acknowledge that I have received this information before receiving services today.

_____ _____

Signature Date

To request this notice in an alternative format, please call (contact information) or e-mail (contact information).

(Same sentence in Spanish).