Hospital Facility Fee Report

Report on the impact of hospital facility fees in Colorado

October 1, 2024 DRAFT VERSION 8-20

Submitted to: Senate Health and Human Services Committee and House Health and Human Services Committee

COLORADO
Department of Health Care Policy & Financing

TIPS & TRICKS FOR THIS REPORT

DELETE THIS PAGE BEFORE SUBMITTING:

Desired Outcomes

- Legislators can quickly skim and easily understand the report
- Streamlined, succinct report with key information and effective visualizations that tell the story to legislators effectively

Tips

- Content should be concise and informative so that it can be easily reviewed and understood by reviewers and the external legislative audience.
- Use plain language and limit jargon and legalese.
- Place any detailed data, graphs and analysis in appendices.
- All images, charts, and graphs need alt text. Here's how to write alt text. Add your alt text by right-clicking the image, scroll to 'alt text' and add it to the 'Description' box.
- Use the styles embedded in this document to avoid accessibility issues which will lead to longer remediation time before publishing

Trainings and Resources

Please review the following short articles and videos before starting:

1. How to write executive summary - quick reads article, article and article
2. Be concise: less is more - quick read article
3. How to tell stories with data - 15 min, Cornerstone
4. Plain Language - best practice for writing for all audiences - watch minutes 7:20 to 41:00 min of this training video and/or review the slide deck
5. Tips to make sure your document is accessible

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Dear Representatives and Senators,

The Hospital Facility Fee Steering Committee respectfully submits the attached report in accordance with the requirements of HB23-1215.

Outpatient facility fees are an important topic to all stakeholders in the Colorado health care environment/universe. Facility fees are also an incredibly complex topic. Given the short timeline and the inherent challenge of the legislation, the Steering Committee offer the following caveats to the reader:

- ***Data Availability:*** Some of the data required for the requested analysis is not provided to any central organization. In some cases, the data is proprietary to one or more organizations and was not provided.
- ***Data Structure:*** Claims structure drives data reporting. The way in which data is reported and stored at points limited our ability to make comparisons.
- ***Health Care Network:*** Variations in provider business designs make a full cost-of-care analysis very challenging. Some people are cared for completely by one provider while another consumer with similar health needs may receive services from an imaging vendor and a contract radiologist in addition to their treating provider.
- ***Assignment Boundaries:*** The Colorado General Assembly set specific boundaries on the analysis and requested analysis of impact, not recommendations. The Committee has worked diligently to answer the questions posed in the legislation while remaining within its purview.

Application of these caveats appear throughout the report and are typically called out to assist the reader in understanding the impact of each limitation.

We appreciate the opportunity to serve the State of Colorado on this important task, and, while the work required of the legislation has been completed, we remain committed to helping drive this dialogue forward. Our contact information is available in Appendix X of this document and we welcome any reader to reach out to discuss.

Respectfully,

Facility Fee Steering Committee Members

Isabel Cruz, Policy Director, Colorado Consumer Health Initiative	Diane Kruse, Health Care Consumer	Dr. Omar Mubarak, Managing Partner, Vascular Institute of the Rockies	Dan Rieber, Chief Financial Officer, UCHealth
Bettina Schneider, Chief Financial Officer, Colorado Department of Health Care Policy and Financing (HCPF)	Kevin Stansbury, Chief Executive Officer, Lincoln Health	Karlee Tebbutt, Regional Director, America's Health Insurance Plans	

Background and Introduction

House Bill 23-1215, signed by Governor Polis on May 30, 2023, established the Hospital Facility Fee Steering Committee at § 25.5-4-216, C.R.S., administered by the Department of Health Care Policy and Financing (HCPF). The Committee, comprising seven governor-appointed consumers, advocates, and experts in health care billing and payment policy, was tasked with producing a final report by October 1, 2024. See Appendix X for the list of Steering Committee members.

The Steering Committee confined the scope of work to the requirements of HB23-1215. The Steering Committee is not tasked with developing recommendations but with analyzing the data to identify the impact of facility fees. This report evaluates the following as it relates to facility fees:

- Payer reimbursement and payment policies, provider billing guidelines, and practices.
- Coverage and cost-sharing across payers and payer types and denied claims by payer and provider type.
- Impact on coverage policies for consumers, employers, and the Medicaid program.
- Impact on policies and charges for independent practitioners, including a comparison of professional fee charges and facility fee charges.
- Charges for services rendered by health system affiliated practitioners, including a comparison of professional fee charges and facility fee charges.
- Impact on the Medicaid program and uncompensated and under-compensated care.
- Impact on access to care, health equity, and the health care workforce, and history and legal parameters concerning facility and professional fee billing.

The Department of Health Care Policy and Financing provided administrative support to the Committee. CBIZ Optumas provided actuarial analysis of the data. Government Performance Solutions, Inc. provided facilitation and project management support.

Facility Fees Defined

Facility fees as defined at § 25.5-4-216 (1)(d), C.R.S., are “any fee a hospital or health system bills for outpatient hospital services that is intended to compensate the

hospital or health system for its operational expenses and separate and distinct from a professional fee charged or billed by a health-care provider for professional medical services." Based on the definition, we are considering all amounts charged by a Hospital Outpatient Department (HOPD) as facility fees which is why this report frequently references HOPDs. See Appendix X for additional definitions related to facility fees.

Key Findings

The Steering Committee, created at § 25.5-4-216 (2), C.R.S. through the enactment of HB23-1215, is required to report on the impact of outpatient facility fees on the Colorado health care system. This includes analyzing the effects on consumers, employers, and providers. The following key findings are based on the available data.

1) Facility fees are a complicated topic due in part to the complexity of health care and the associated billing practices.
2) Billing requirements drive complexity, which adds costs and opacity, making next-level analysis challenging. Some rates and reimbursement policies were able to be sourced, but private payor rates are considered trade secrets and not available.
3) Medicare policy is the key driver of separate billing for professional and facility fees.
4) The total amount of facility fees reported in the Colorado All Payers Claims Database (APCD), administered by the Center for Improving Value in Health Care (CIVHC), was $13.4 billion over the 6-year study period from 2017 to 2022 for Commercial and Medicare payers
    a) Seventy-four percent of covered lives in Colorado are included in the APCD. Most of the data in this report is based upon APCD data. This does not imply that the data represents the same percentage of claims activity and/or dollars billed.

5) The top 25 billing codes drive $3.0 billion in facility fee allowed amounts[1] for Medicare and Commercial, which is about 22.8% of the total allowed HOPD facility fees. The raw increase in facility fee billing from 2017 to 2022 was 10%, not normalized based on population growth. Here is the breakdown by market:

    a) Commercial Market: $1.3B for top 25 codes; growing at 6.5% on an average annual basis

    b) Medicare market including Medicare Advantage: $1.7B for top 25 codes; growing at 14.3% on an average annual basis

6) The Hospital Outpatient Department (HOPD) facility fees contributed approximately $50.8 million to $53.7 million in health care expenditures as compared to affiliated or independent professional fees for the top 25 codes reviewed across Medicare and Commercial payers.

    a) **Medicare Fee-for-Service (FFS):** HOPD facility fees were about 95% higher than those of independent and affiliated providers, contributing $11 million in member and payer expenses.

    b) **Medicare Advantage:** HOPD facility fees were about 14% higher than independent providers and 36% higher than affiliated providers, resulting in between $1.6 million and $3.4 million in health care expenses.

    c) **Commercial payers**: HOPD facility fees were 90% higher than independent providers and 95% higher than affiliated providers, contributing between $38.2 million and $39.2 million in health care expenses.

    d) For Commercial payers, HOPD facility fees for evaluation and management (E&M) codes were observed to be lower than professional fees. However, the HOPD fees may be billed in addition to professional fees, increasing overall costs.

7) Medicare allows for the inclusion of an additional amount for on- and off-campus HOPD visits as code G0463 for hospital resources. This contributed $209

[1] Expected reimbursement amount is reflective of the allowed amount from the APCD.

million in health care allowed amounts over the 6-year study period from 2017 to 2022.

    a) For Commercial payers, hospitals may use the evaluation and management (E&M) codes to capture hospital resources. This would be in addition to any E&M codes billed as part of the professional fee for an HOPD visit.

8) Analysis performed using the most recent Colorado Health Care Affordability and Sustainability Enterprise (CHASE) provider fee revenue shows the potential impact of facility fees on CHASE to be $$109.8 million to $1.098 billion in total spending.

9) All stakeholders contacted are aware of facility fees and have various and valid perspectives on their impact.

10) The payment rate differential between HOPDs who are able to charge a facility fee and professional fees, combined with stagnant reimbursement rates for professional fees, create an incentive to shift the site of service toward affiliated settings.

All Steering Committee members believe this topic is critical to Colorado and continued analysis is required.

Data Sources and Caveats

The Steering Committee received the majority of the data from the APCD with supplemental data supplied by hospitals, health systems, Health Care Policy and Financing, commercial payers, and independent providers. A full listing of data sources and caveats is in Appendix X, and highlights are shown here:

APCD

The APCD is the state's most comprehensive health care claims database representing the majority of payers (49 commercial payers, Medicaid, and Medicare), and 74 percent of covered lives. APCD supplied data from 2017 - 2022. However, it does not include uninsured and self-pay claims, federal programs such as the Veterans Affairs

(VA), Tricare, and Indian Health Services. Medicare and Medicare Advantage data also cover 2017 through 2022 and represent 95 percent of Colorado members.

Survey and Supplemental Data

Using survey-based data requests, billing policies and data were requested from hospitals and health systems, commercial payers, and independent providers. The Colorado Hospital Association (CHA) provided large supplemental data sets for comparison and validation of APCD data. Employers and employer representatives were engaged to understand their perspectives. HCPF engaged with the Division of Insurance to understand what data was available and was directed to use APCD data and provider data.

Several caveats are important to acknowledge:

- The Committee found there is no single data source that contains all of the information required by HB23-1215. Integration of different sources is necessary for complete analysis.
- The APCD lacks indicators for facility fees and on denied claims for an entire visit. The data does contain partially denied claims - where an individual service for a visit was denied. As noted above, the APCD data covers 74 percent of covered lives in Colorado, and while this may not capture every detail, it allows for statistically significant and reliable inferences to be drawn from the available data.
- Medicare allows for the inclusion of an additional amount for on- and off-campus HOPD visits as code G0463 for hospital resources. This contributed $209M in health care expenses.
- Responses to surveys distributed to providers were used to validate other analyses.

Analysis Methods and Limitations

Analysts supporting the committee undertook a comprehensive review of the available data to ensure completeness and validity, focusing on the longitudinal consistency of visit volume and financial fields. Additional details on analysis methods and limitations are available in Appendix X.

Stakeholder Perspectives

As noted in the introduction, the Steering Committee consists of experts from different backgrounds representing various stakeholder perspectives (e.g., consumers, advocates, payers, urban and rural hospitals/health systems, and independent providers). Although this report is data-driven, the Steering Committee felt a balanced understanding of their perspectives is important. Therefore, in Appendix X, you will find four separate, one-page perspectives with each group's views on facility fees.

Research and Report Requirements

Description of Outpatient Health Care Services Payment, Reimbursement, and Facility Fees

> *25.5-4-216(6)(g): A description of the way in which health care providers may be paid or reimbursed by payers for outpatient health care services, with or without facility fees, that explores any legal and historical reasons for split billing between professional and facility fees at*
>
> > *25.5-4-216(6)(g)(I): On-campus locations;*
> >
> > *25.5-4-216(6)(g)(II): Off-campus locations by health care providers affiliated with or owned by a hospital or health system;*
> >
> > *25.5-4-216(6)(g)(III): Locations by independent health care providers not affiliated with or owned by a hospital system;*

When a patient receives outpatient health care services in an on-site or off-site HOPD, the patient is considered to be treated within the hospital rather than a physician's office. A patient who receives care at an HOPD will receive two bills: one is the hospital or facility bill, commonly referred to as the facility fee, and the other is the physician or professional fee. The hospital's facility fee is intended to cover hospital costs that do not apply to independent physician offices, such as costs to maintain standby capacity for handling emergencies and to comply with regulatory requirements that physician offices do not have. When a patient receives care in an independent physician's office, the patient receives one bill.

Reimbursement policies for outpatient health care services for HOPDs and for independent physicians arise from Medicare's policies. The prices paid through the Medicare fee-for-service program are set administratively through laws and regulations. Under Medicare, payment for physician services is set by a fee schedule.[2]

As described in the April 2000 final rule published in the Federal Register (65 FR 18434), the history of Medicare's hospital payment policies is lengthy. When Medicare was established, both inpatient and outpatient hospital services were paid based on hospital-specific reasonable costs (later amended to the lower of customary charges or reasonable costs). At that time, there was little incentive for providers to affiliate with each other to increase Medicare revenue because at that time hospitals were paid retroactively on a cost-of-care basis. There was also little incentive for hospitals to be cost efficient given their reimbursement was based on their costs. In 1983, following revision to federal law, the cost-based reimbursement method for inpatient hospital services was revised and a prospective payment (PPS) for acute hospital inpatient stays was implemented. Medicare outpatient hospital reimbursement continued to be based on hospital-specific costs, however.

There were several federal actions in the 1980s and 1990s regarding Medicare reimbursement for hospital outpatient services culminating in federal regulations published in the Federal Register (65 FR 18434) establishing an outpatient PPS for Medicare services in July 2000. With the change to an outpatient PPS methodology, the incentive for providers to affiliate with each other increased.[3]

The history of federal actions includes:

- In the 1980s, Congress took action to control the escalating costs of outpatient care through across-the-board reduction of 5.8% and 10% for hospital operating costs and capital costs, respectively, that would otherwise be payable by Medicare, as well as establishing fee schedule reimbursement for clinical

[2] Congressional Budget Office, 2022. *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*

[3] A commenter on these regulations when proposed voiced support for a provision to prohibit hospitals from acquiring free-standing physician practices and converting them to hospital-based entities. While the federal agency [Health Care Financing Administration (HCFA) at the time, now the Centers for Medicare and Medicaid Services (CMS)] understood the commenter's concern, they noted they do not have authority under the Medicare law to prohibit this practice.

diagnostic laboratory tests and alternative payment methods for dialysis and other services

- The Omnibus Budget Reconciliation Act (OBRA) of 1986 paved the way for the development of a PPS for hospital outpatient services.
- In March 1995, as required by the OBRA 1986 and the OBRA 1990, the Department of Health and Human Services Secretary recommended to Congress the 3M-Health Information Systems ambulatory patient groups method for outpatient PPS.
- The Balanced Budget Act (BBA) of 1997 and the Balanced Budget Refinement Act (BBRA) of 1999 included changes to the outpatient PPS.

Today, Medicare sets payment rates for clinician services for physicians and other health care professionals through a physician fee schedule and sets payment rates for most HOPD services through outpatient PPS. For services provided in HOPDs, Medicare makes two payments: one for the HOPD facility fee and one for the clinician's professional fee. For services provided in a freestanding, independent clinician's offices, Medicare makes a single payment to the practitioner under the physician fee schedule.[4] While commercial payers set their rates differently, they generally follow the same practice of payment the facility separate from the professional services.[5]

The federal government continues to review and revise Medicare payment policies related to HOPDs.

- The Medicare Payment Advisory Commission (MedPAC, an independent congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program) has maintained that Medicare should strive to base payment rates on the resources needed to treat patients in the most efficient setting. In 2012 and 2014, MedPAC recommended that Medicare reduce payment rates and cost-sharing for office visits provided in HOPDs and that total payment rates and cost-sharing would

[4] Medicare Payment Advisory Commission, 2022. *Medicare and the Health Care Delivery System*, Chapter 6

[5] Congressional Budget Office, 2022. *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*

be equal whether these visits were provided in an HOPD or in a freestanding physician's office.[6]

- In the Bipartisan Budget Act (BBA) of 2015, Congress directed CMS to develop a limited system that closely aligned payment rates between HOPDs and freestanding physician's offices. CMS moved beyond the BBA of 2015 requirements by reducing the outpatient PPS payment rate to more closely align with the physician fee schedule rate for office visits that occur in any off-campus department, not just those specified in the BBA of 2015.[7] However, the effects of these policies were limited.
- In 2022, MedPAC analyzed and identified services for which payments can be more closely aligned across settings.[8]

Payer Reimbursement and Payment Policies

> *25.5-4-216(5)(a): Payer reimbursement and payment policies for outpatient facility fees across payer types, including insights, where available, into changes over time, as well as provider billing guidelines and practices for outpatient facility fees across provider types, including insights, where available, into changes made over time*

As described above, facility fees are the fees for hospital outpatient services distinct from the professional fee. Depending on the location of the visit, a person may receive one or two bills from the provider. If a person goes to an HOPD (on-campus or off-campus), they may receive a bill from the provider and the facility. The bill from the facility is the facility fee.

Hospitals indicate that they follow Centers for Medicare and Medicaid Services guidelines in their billing practices and charge facility fees when a patient utilizes HOPDs that are on or off campus. The hospitals also indicate that changes over time reflect changes in billing guidelines or the incorporation of acquired facilities into

[6] Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2012
[7] Centers for Medicare & Medicaid Services 2019
[8] Medicare Payment Advisory Commission, 2022. *Medicare and the Health Care Delivery System*, Chapter 6

standard practices. Billing policies received from hospitals and health systems are available in Appendix X.

All payers experience facility fees because they are the bill the hospital sends for their services. One payer (Medicare) has an additional and distinct incremental facility fee code (G0463) for hospital outpatient department facilities.[9] Hospital providers also use evaluation and management (E&M) codes to bill for facility resources in Commercial programs. E&M codes were the predecessor to G0463 in Medicare, likely the driver of this policy in Commercial programs. Medicaid does not have a distinct incremental facility fee and reimburses for hospital facility fee claims using a grouping methodology.[10] Self-pay individuals will transact directly with the provider for billing. These individuals are subject to what the provider bills for services. There are several laws and programs in place to protect low-income individuals from high health care costs that providers must account for in their payment policies. Hospitals are also subject to price transparency requirements that should aid these self-pay individuals and can offer self-pay discounts even though not statutorily required.

Payments & Billing Practices

> *25.5-4-216(5)(b): Payments for outpatient facility fees, including insights into the associated care across payer types.*
>
> *25.5-4-216(5)(d): Denied facility fee claims by payer type and provider type;*

The APCD data was utilized to address the requested analytics in sections 25.5-4-216(6)(a) to address the payments for HOPD facility fees, including insights across payer types. This report will not analyze Medicaid HOPD from the APCD, focusing this section on payers that cost-share, impacting consumers. Appendices include additional details and summary tables.

[9] The use of G0463 is described in Appendix X. The analysis below reviews the presence of this code within Medicare billing.

[10] For more information see Colorado Department of Health Care Policy & Financing's Outpatient Hospital Payment website

Total Facility Fees

Commercial Payers

There were between 700,000 to 985,000 patient visits totaling $1.0B to $1.4B on an annual basis for which facility fees were charged for Commercial payers. Approximately 95% of those were for in-network providers across the study period. That level was also observed to be consistent for each year within the study period.

For Commercial payers, there were approximately 190,000 to 280,000 annual HOPD visits with a professional component that was in-network on the same day for the same member that an HOPD facility fee was billed.[11] Of those total HOPD visits, 98% to 99% were in-network when the professional component was also in-network. This was consistent on a yearly basis across the study period.

Appendix X includes additional details and summary tables.

Medicare Payers

There were between 1,500,000 and 2,250,000 patient visits totaling $750M to $1.5B on an annual basis for which facility fees were charged for Medicare payers (FFS and Advantage combined). Approximately 97% of those were for an in-network provider across the study period. That level was also observed to be consistent for each year within the study period.

For Medicare (FFS and Advantage), there were approximately 245,000 to 385,000 annual HOPD visits with a professional component that was in-network, based on the codes above, on the same day for the same member that an HOPD facility fee was billed. Of those total HOPD visits, over 99.7% were in-network when the professional component was also in-network. This was consistent on a yearly basis across the study period.

Appendix X includes additional details and summary tables.

[11] Member ID and date of service for each HOPD visit was matched to a corresponding professional component for the same date of service for that member. Specific 90000 Medicine Services and Procedures and Evaluation and Management CPT codes were used to identify the professional component. More information is available in Appendix X.

Total by Hospital and/or Health System

As a supplement to the provider surveys, the APCD was utilized to summarize total HOPD facility fees by hospital and/or health system. The top 10 hospitals and/or health systems account for approximately 80% of the total HOPD allowed amount. That was consistent between Commercial and Medicare across the study period.

The top hospital/health system for total allowed HOPD facility fees was the UCHealth hospital system, with approximately 30% of the total for both Medicare and Commercial. The next three highest were HCA Health care, Intermountain, and CommonSpirit, each with 8% to 10% of the total HOPD allowed amount across Medicare and Commercial. Colorado Children's, AdventHealth, Banner Health, Valley View, Parkview, and Denver Health round out the top 10 hospitals/health systems across Commercial and Medicare.

Appendix X includes additional details and summary tables.

Top Codes

Top Codes by Frequency

After discussion with the Steering Committee, it was determined that the request for the top ten (10) codes would be expanded to the top twenty-five (25) codes. This is intended to align with the provider surveys and the level of detail requested from providers for other components of the final report.

Commercial Payers

The top most frequent codes for which a facility fee was charged were largely laboratory codes, with physical therapy, mammogram, injectable drugs and x-ray also included in the top codes. Blood work, including blood drawing, comprehensive blood testing, and blood cell counting, is the most common service that results in a facility fee claim, representing 29% of HOPD claims with facility fees.

Additionally, Evaluation and Management (E&M) codes 99212, 99213, and 99214 were included in the top codes by frequency. As noted, the facility fee data is exclusive of any professional fees; however, these codes are reflective of additional billing by the HOPD to reflect hospital resources. This would be comparable to the G0463 billed

under Medicare billing policies. As a note, the predecessor Medicare policy for G0463 allowed for E&M codes to be billed by the facility in addition to the professional fee prior to 2014. The result is that that member has received two bills, one for the HOPD facility fee and one for the professional fee, which could include the same E & M codes.

A year-over-year trend analysis of note is the rise in unclassified injectable drugs billed for with code J3490. This general code is not tied to a specific drug. This code was not frequently billed for in 2017 (9,996 instances) and grew to the most frequent code tied to facility fees in 2022 (131,065 instances). The same growth pattern occurs in Medicare.

Appendix X contains a list of top codes by frequency by year and in total.

Medicare Payers

The top most frequent codes for which a facility fee was charged were similar to Commercial and included laboratory codes, with physical therapy, mammogram, injectable drugs and x-ray also included in the top codes. Like Commercial, blood work-related services were the most common services that resulted in a facility fee. Additionally, G0463 was the second most commonly billed code. Appendix X describes how Medicare allows this code to reflect facility resources above and beyond the services provided. The predecessor codes for G0463 were E&M codes before 2014 and would be an additional amount on the facility fee claim in addition to any professional fees.

Appendix X contains a list of top codes by frequency by year and in total.

Top Codes by Allowed Amount

Commercial Payers

The top codes based on the allowed amount for which a facility fee was charged included a range of services, including echocardiogram (EKG), joint devices, injectable drugs including chemotherapy, arthroplasty, laparoscopy, mammograms, endoscopy, colonoscopy, and MRIs. Outpatient Observation, code G0378, was also

included in the top codes by allowed amount, distinct from the G0463 facility resource code used by Medicare.

Appendix X contains a full list of top codes by expected reimbursement amount by year and in total.

Medicare Payers

The top codes based on the allowed amount for which a facility fee was charged included a range of services, including joint arthroplasty (knee, hip, shoulder), echocardiogram (EKG), injectable drugs, including chemotherapy, coronary angioplasty, physical therapy, pacemakers, mammograms and endoscopies. Additionally, G0463 was the second-highest code based on the allowed amount totaling $28.9M to $38.9M a year. Appendix X describes how Medicare allows this code to reflect facility resources above and beyond the services provided.

Appendix X contains a full list of top codes by allowed amount by year and in total.

Total Facility Fee Claim Denials

As noted in Appendix X. Data Sources and Caveats, the APCD does not include denied claims when the entire visit was denied. This is a data limitation and prevents reporting on total claim denials by site of service.

The APCD does include partial denials, where some services within a visit were approved and others denied by the payer. This information was utilized to address the request for the number of facility fee claim denials. For Commercial, the partial denial information for 2017 to 2019 was not well populated; however, the 2020 to 2022 data indicated a partial denial rate of approximately 6.5% to 7.5%. For Medicare, the partial denial information for 2017 to 2019 was not well populated; however, the 2020 to 2022 data indicated a partial denial rate of approximately 2% to 5%.D.

Impact on Coverage & Cost-Sharing

> *25.5-4-216(5)(c): Coverage and cost-sharing provisions for outpatient care services associated with facility fees across payers and payer types*

25.5-4-216(5)(e): The Impact of facility fees and payer coverage policies on consumers, small and large employers, and the medical assistance program

The APCD data was utilized to address the requested analytics in sections 25.5-4-216(6)(a) to address the cost-sharing portion of payments for HOPD facility fees, including insights across payer types. Appendices include additional details and summary tables.

Top Codes by Cost-Sharing

Commercial Payers

The top codes for which a facility fee was charged with the highest member cost-sharing amount included a range of services, with MRIs, Echocardiography services, Laboratory services, CT scans, and joint repair accounting for the majority of member cost sharing for the top codes.

Eleven of the codes are also in the list for top allowed amount. When compared to the total allowed amount for those same codes, the joint repair services had the lowest cost sharing proportion at 5% to 10%. MRIs, Echocardiography, laboratory, and CT scans had the highest cost sharing percentage at 25% to 30%.

Appendix X contains a full list of top codes by member sharing amounts by year and in total.

Medicare Payers

The top codes for which a facility fee was charged with the highest member cost-sharing amount were a range of services including: echocardiogram (EKG), laboratory codes, injectable drugs including chemotherapy, physical therapy, arthroplasty, mammograms, and MRIs. Additionally, G0463 was the highest code based on allowed amount totalling $5.6M to $7.2M a year. As noted in Section IV, Medicare allows this code to reflect facility resources beyond the services provided.

Appendix X contains a full list of top codes by member sharing amounts by year and in total.

Cost Sharing Proportion by Payer Type

For HOPD related expenses, Commercial members on average paid a lower proportion of cost-sharing at 13.5% than Medicare FFS at 19.9% and Medicare Advantage at 26.2%. As noted in the data limitations section, the Commercial percentage may be understated due to the absence of self-funded or self-insured members. Those members could have a higher percentage of cost-sharing due to potentially selecting high deductible health plans. The Medicare FFS cost-sharing of approx. 20% is consistent with the Medicare benefit package design, while Medicare Advantage benefit package designs may deviate from that. The results were fairly stable across the study period for Commercial and Medicare FFS, while Medicare Advantage showed about an 8% reduction from 31.4% to 23.2% from 2017 to 2022.

Impact of Facility Fees and Payer Coverage Policies on Consumers, Small and Large Employers, and the Medical Assistance Program

Impact on Consumers, Small and Large Employers

Higher Health Care Provider services and goods inevitably result in higher costs to Consumers, Employers, and Carriers through out-of-pocket, negotiated rates, and premiums. As public and commercial coverage is funded by Consumer and Employer taxes and premiums, these stakeholders finance higher health care services and goods. All things being equal, higher site-of-service care at HOPDs, as demonstrated in this report, results in higher health care costs to consumers.

High-deductible payer coverage plans increase patients' out-of-pocket costs. Several stakeholders engaged for this report believe these plans curb patients' motivation to lower out-of-pocket expenses as high-cost procedures and their high-deductible convolutes possible payer cost-savings by shopping for care.

Employers engaged for this report are aware of hospital outpatient facility fees. Still, due to the challenges in analyzing facility fees, they emphasized other priorities in reducing health care costs. Employers are concerned with increasing health care costs due to their perspective that increasing health care costs increases their insurance coverage costs. Employers either absorb or pass on the increased cost, and in either

case, the increase impacts their ability to increase salaries or results in a higher proportion of premiums being paid by employees.

Higher costs of care that are driven by site of service, HOPD vs. professional office visit in this case, are passed on to employers and consumers as part of the monthly premium they pay to the insurer for health care coverage. Using some basic assumptions, a high-level scenario was completed to demonstrate the trickle-down of site-of-service impact on health care costs from facility fees to consumers. Results in the figure below display the impact to premiums assuming that an HOPD visit is approximately twice as expensive as the same service at an independent provider's office. This is based at a high level on the comparison analytics performed. The impact is that the HOPD facility fees contribute 6.2% to the premium paid by the employer and consumer.[12]

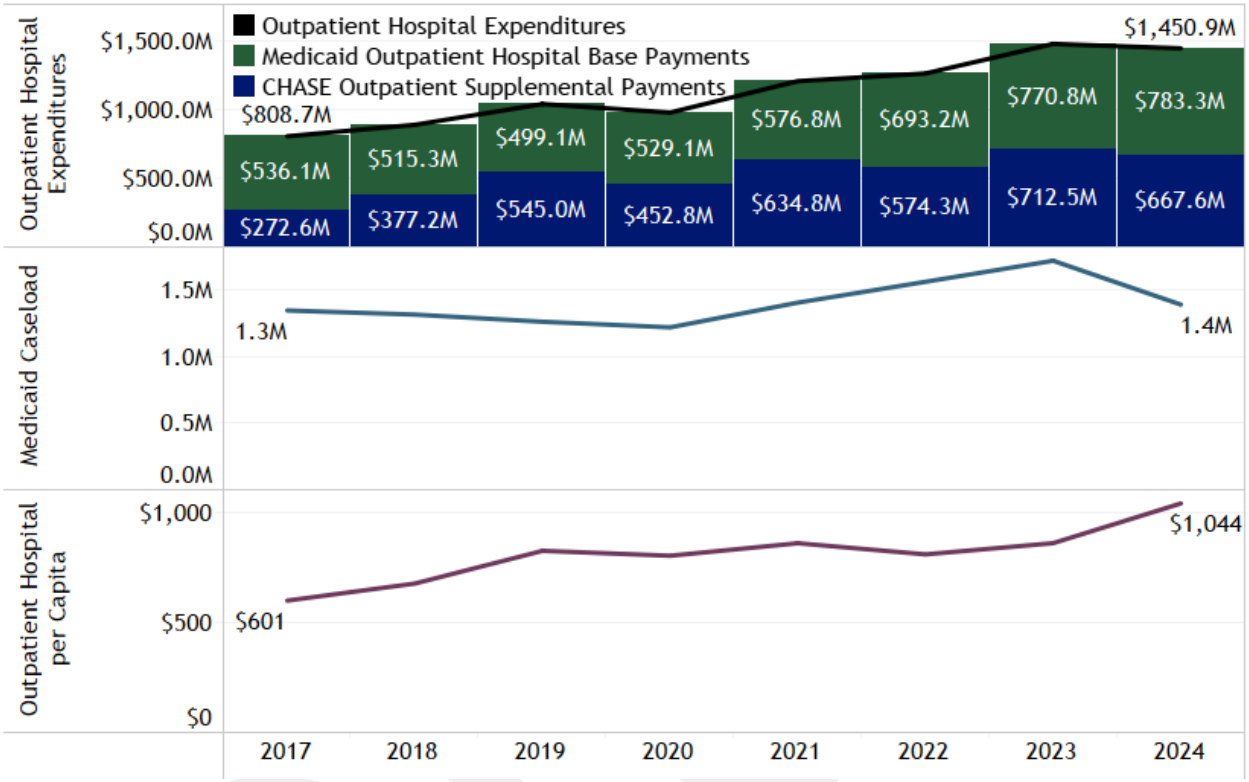
Impact on the Medical Assistance Program

Health First Colorado (Colorado's Medicaid Program) is free or low-cost public health insurance for qualifying Coloradans. The program covers doctor visits, emergency care, preventative care, and other procedures and treatments. Medicaid members have no or very low co-payment and no other cost sharing. Accordingly, the impact of facility fees on Medicaid members is negligible. On the other hand, facility fees can have an impact on the cost of the program's outpatient expenditures. HCPF

The figure below displays hospital outpatient expenditures from the Medicaid program and CHASE, Medicaid caseload and the total hospital outpatient expenditures per capita. HCPF budget documents were used for all these values. A tabular breakdown is available in Appendix X.

[12] Like any scenario analysis, the specific assumptions determine the results. The Steering Committee is using this high-level analysis for demonstrative purposes of the impact on premiums. The analysis for this Premium Impact Scenarios.

Figure X. Colorado Medicaid and CHASE Outpatient Expenditures, Caseload, in Aggregate and Per Capita



Total hospital outpatient expenditures for providing Medicaid services have grown 8.7% annually. Hospital outpatient base payment expenditures grew at 5.6% per year, and supplemental payments through the CHASE program grew at 13.7% per year. Over the same time frame, the Medicaid caseload of eligible members grew at 0.5% per year. Per-capital hospital outpatient expenditures grew by 8.2%.

A shortcoming of using HCPF budget documents is that they utilize gross expenditures for hospital outpatient services. A more accurate review would remove emergency department care and net outpatient hospital provider fees from the gross expenditures. This level of detail was not attainable, given the amount of time required to complete the report. Therefore, HCPF will continue to assess the impact of facility fees on Colorado Medicaid and potential cost-saving opportunities for Coloradans.

Impact to Health Care Charges for Providers

> *25.5-4-216(5)(f): The impact of facility fees and payer coverage policies on the charges for health care services rendered by independent health care providers, including a comparison of professional fee charges and facility fee charges.*
>
> *25.5-4-216(5)(g): The charges for health care services rendered by health care providers affiliated with or owned by a hospital or health system, and including a comparison of professional fee and facility fee charges.*

The APCD data was utilized to address the requested analytics in sections 25.5-4-216(5)(g) and 25.5-4-216(5)(g) to address the comparison of payments for HOPD facility fees and professional fees of either an independent or affiliated provider. The Steering Committee interprets the word "charges" as providing a bill to the member and payer. This would reflect the full sum of the allowed amount in the APCD, which is the payment by the payer and allowed invoice to the member. Appendices include additional details and summary tables.

Service Code Comparison

The following is a comparison of the impact that the site of service for a visit has on reimbursement to the provider and payment from the payer and member and is done at the individual procedure code level.[13] Comparisons are made by site of service, professional's affiliation, and payer type.[14] More information on the methodology is in Appendix X.

Table X. Service code comparisons are done at the code level and compare CPT codes

[13] The comparison was done at the individual procedure code level to ensure the analysis controlled for variation in the number and types of services that could be provided based on any one individual's specific health care needs during either an HOPD or professional office visit.

[14] The comparison was split between professionals who were affiliated with a hospital or health system, and professionals who were identified as being independent of a hospital or health system. Additionally, the comparison was reviewed by payer type - Commercial, Medicare FFS, and Medicare Advantage. The two Medicare programs were delineated since Medicare Advantage health plans may contract at different rates with providers compared to traditional Medicare FFS.

Member ID	Date	Claim No.	CPT Code	Description	Location	Fee Type	Allowed Amount
ABC123	8/6/19	1111	36415	Blood Draw	Office	Professional	$5.00
DEF456	11/9/21	2222	36415	Blood Draw	HOPD	Facility	$10.00

As seen in Table X and Table X below, the overall observation of the comparison of HOPD facility fees to professional fees for the same service, for either affiliated or independent providers, was that HOPD facility fees were higher than the professional fees for the top 25 codes reviewed. An estimated dollar impact can be calculated by applying the difference in HOPD volume and utilization and the mix of services to these comparisons. The HOPD facility fees contributed approximately $50.8M to $53.7M in health care expenditures when compared against either affiliated or independent professional fees, respectively, for the top 25 codes reviewed across Medicare and Commercial payers.[15]

Table X. Independent Professional Fee Compared to HOPD Facility Fees for Top 25 Codes

Table X. Affiliated Professional Fee Compared to HOPD Facility Fees for Top 25 Codes

This impact is intended to highlight reimbursement differences and does not comment on the feasibility of impacting actual expenditures due to utilization shifting between sites of service.

For the methodology, accompanying details, and tables for this analysis, see Appendix X. Additional insight into observations by payer type is outlined below.

[15] The aggregate impact calculation is based on using the HOPD volume of utilization and mix of services across those top codes.

Medicare FFS

For the top codes reviewed for Medicare FFS, HOPD facility fees were about 95% higher than independent and affiliated providers, meaning a consumer would be charged nearly twice as much when billed by an HOPD than the same service billed by a professional. The independent and affiliated providers had comparable reimbursement, driven by consistent Medicare FFS billing guidelines across professional fees. When applied to the same HOPD utilization and mix of services, the resulting impact indicates that the HOPD facility fees contributed $11.0M in higher member and payer expenses relative to the same professional fees for either independent or affiliated providers.

At the more detailed service level, it was observed that:

- Laboratory: reimbursed 30% to 150% higher for HOPD facility fees than professional fees based on the site of service.
- Radiology: mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees.
- Chemotherapy and other infusion/injection: 90% to 270% higher for HOPD facility fees than professional fees.

Medicare Advantage

For the top codes reviewed for Medicare Advantage, HOPD facility fees were about 14% higher than independent providers and 36% higher than affiliated providers. The resulting impact indicates that the HOPD facility fees contributed between $1.6M and $3.4M in higher health care expenses relative to independent affiliated or professional fees, respectively.

The difference between affiliated and independent providers is driven by independent providers' higher average reimbursement than affiliated providers under Medicare Advantage. Medicare Advantage allows for payers to contract at varying rates among their provider network, which may explain the difference between results compared to Medicare FFS.

At the more detailed service level, it was observed that:

- Laboratory: higher HOPD facility fees than affiliated provider professional fees, but lower HOPD facility fees compared to independent professional fees.
    - The laboratory related HOPD facility fees for Medicare Advantage were comparable to Medicare FFS.
- Radiology: mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees.
- Chemotherapy and other infusion/injection: 10% to 115% higher for HOPD facility fees than professional fees.

Commercial

For the top codes reviewed for Commercial, HOPD facility fees were 90% higher than independent providers and 95% higher than affiliated providers. The resulting impact indicates that the HOPD facility fees contributed between $38.2M and $39.2M in additional health care expenses relative to independent affiliated or professional fees, respectively.

The difference between affiliated and independent providers is driven by independent providers having slightly higher average reimbursement than affiliated providers for the top codes, although the results were mixed at the code level. For evaluation and management codes, which are the primary professional fees billed by those providers, affiliated providers had higher average contracting.

At the more detailed service level, it was observed that:

- Laboratory: on average, 200% higher for HOPD facility fees than professional fees for both groups across all laboratory codes reviewed.
    - The variation at the code level was much higher for affiliated providers ranging from 20% to 880% higher for HOPD facility fees.
- Radiology: mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees.
    - The highest utilized radiology services for mammograms had lower HOPD facility fees than professional fees.

- Chemotherapy and other infusion/injection: 115% to 225% higher for HOPD facility fees than professional fees.
- Physical Therapy: HOPD facility fees were 150% to 250% higher than professional fees for both comparison groups.
- Evaluation and management (E&M): lower HOPD facility fees compared to professional fees.
    - The E&M codes on the HOPD claim portion of the visit are in addition to and separate from any E&M codes billed as part of the professional fees portion of an outpatient visit.
        - This is comparable to the use of G0463 in Medicare, which allows for HOPD to bill for hospital resources in addition to the services provided. As a note, Medicare allowed the use of E&M codes for billing for hospital resources prior to the implementation of G0463 in 2014.
    - While the average allowed amount for HOPD facility fees for E&M codes is lower, it should be noted that the E&M codes may be billed twice to the member: once for the physician's professional fees and again on a second bill for the HOPD facility fees for their hospital resources.

Total Cost of Service

The top codes listed for Medicare FFS and Medicare Advantage are those that may also be associated with a visit that also had a G0463 code billed, which identifies hospital facility resources per Medicare billing guidelines. The result is that in addition to the individual service generally being higher in an HOPD setting compared to a professional setting, the final total amount the consumer and payer are responsible for could be higher in an HOPD setting due to the inclusion of G0463 for the overall visit reimbursement.

Similarly, for Commercial, an E&M code on an HOPD claim may be similar to the G0463 billing guidelines for Medicare, given that E&M codes were the predecessor for G0463 for hospitals to bill for facility resources. So while the E&M fees for HOPD are

lower than professional based on the comparison results, those HOPD E&M fees would be in addition to any professional E&M fees for that same HOPD visit, which would generally increase the overall cost of the visit for the consumer. This applies to both on- and off-campus locations.

Total Cost of Service - Examples

Below are examples of two visits, one at an HOPD and one in a professional office setting, covering the same services. The examples are intended to highlight the different billing structures between each site of service, as well as how the reimbursement comparison analysis at the code level translates into the impact on a total cost of service basis. Both examples are based on real claims within the APCD. The allowed amounts shown are based on the results of the comparison analytics, as well as the amounts on the real claims identified for the example.

These are examples and are intended to highlight the general findings of the research into facility fees and professional fees. They do not encompass every type of scenario that may occur when visiting either an HOPD or professional office.

The HOPD visit results in two claims, one from the provider for their time spent with the member as a professional fee and one from the facility for the other services provided. In addition to the services provided, the facility may also bill for hospital resources via the E&M code for Commercial coverage. This is in addition to the E&M billed by the professional for their time. For Medicare, this would be reflected as G0463. It should be noted that this does not occur on every HOPD visit.

The professional office visit results in one claim for both the provider's time with the member and the services received. It also only has one E&M code billed to the member.

In this example, the amount for the E&M portion of the visit is higher in the office setting than the professional fee portion of the HOPD setting. This is consistent with observations in Medicare that pay for professional fees in a non-facility setting at a higher rate than comparable professional fees in a facility setting. The intent is to reimburse the provider in a non-facility setting for additional overhead and administrative costs that may be covered by the hospital in a facility setting.

Table X. HOPD Visit that results in Two Distinct Invoices for the Visit with a Total visit allowed amount = $390.00

Member ID	Date	Claim No.	CPT Code	Description	Location	Fee Type	Allowed Amount
DEF456	11/9/21	2222	36415	Blood Draw	HOPD	Facility	$25.00
DEF456	11/9/21	2222	80048	Blood Test	HOPD	Facility	$64.00
DEF456	11/9/21	2222	84443	Blood Test	HOPD	Facility	$65.00
DEF456	11/9/21	2222	85025	Blood Test	HOPD	Facility	$40.00
DEF456	11/9/21	2222	99214	E&M	HOPD	Facility	$93.00
DEF456	11/9/21	3333	99214	E&M	HOPD	**Professional**	$103.00

Table X. Professional Office Visit with a Total visit allowed amount equal to $196.00

Member ID	Date	Claim No.	CPT Code	Description	Location	Fee Type	Allowed Amount
ABC123	8/6/19	1111	36415	Blood Draw	Office	Professional	$5.00
ABC123	8/6/19	1111	80048	Blood Test	Office	Professional	$13.00
ABC123	8/6/19	1111	84443	Blood Test	Office	Professional	$26.00
ABC123	8/6/19	1111	85025	Blood Test	Office	Professional	$12.00
ABC123	8/6/19	1111	99214	E&M	Office	Professional	$140.00

Off-Campus Hospital Outpatient Department Locations

In addition to the analytics above, additional analytics for off-campus HOPD locations are included below. Only Medicare off-campus locations could be identified in the APCD for the analysis.

For the methodology, accompanying details, and tables for this analysis, see Appendix X.

Top Codes by Frequency - Off-Campus Locations

Procedure code 'G0463', which represents hospital resources allowed to be billed in addition to the services provided, was the top code based on frequency and represents 18% of the total codes billed for the top 25 procedure codes. Laboratory services were the next most common, followed by physical therapy, x-rays, mammograms, and cardiac rehab and EKG-related procedures.

Top Codes by Allowed Amount - Off-Campus Locations

Procedure code 'G0463', which represents hospital resources that are allowed to be billed in addition to the services provided, was the top code based on allowed amount and represents nearly 15% of the allowed dollars for the top 25 procedure codes. Chemotherapy drugs and radiation treatment were the majority of services provided based on allowed amount, representing 55% of the allowed dollars for the top 25 procedure codes across the study period.

Total by Hospital and/or Health System - Off-Campus

The APCD was utilized to summarize total HOPD facility fees by hospital and/or health system. The top 5 hospitals and/or health systems account for 93.0% of total Medicare HOPD off-campus HOPD allowed amount.

Approximately 73.5% of all Medicare Off-Campus HOPD facility fees were associated with the UCHealth hospital system. Within the UCHealth system, the primary off-campus clinic billing was associated with the Poudre Valley Hospital. Review of the top codes for off-campus indicates that may be driven by their off-campus cancer treatment clinic in that area.

The next two highest were National Jewish Health hospital and Colorado West Health Care System (DBA Community Hospital), each with about 6.5% of the total Medicare off-campus HOPD allowed amount. AdventHealth and Banner Health round out the top 5 hospitals/health systems with 4.8% and 1.7%, respectively.

Service Code Comparison for Off-Campus Locations

Medicare FFS

For the top codes reviewed for Medicare FFS, HOPD off-campus facility fees were about 62% higher than both independent and affiliated providers. The independent and affiliated providers had comparable reimbursements, driven by Medicare FFS billing guidelines that are consistent across professional fees. The resulting impact indicates that the HOPD facility fees contributed an additional $1.7M in member and payer expenses relative to the same professional fees for both types of providers, based on using the HOPD off-campus volume of utilization and mix of services.

At the more detailed service level, it was observed that:

- Laboratory: reimbursed at a similar level between HOPD and professional settings.
- Radiology: mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees, but were overall higher for HOPD off-campus locations.
- Chemotherapy and other infusion/injection: the highest contributing factor based on the top codes, driving over 50% of the total increase observed for the top codes reviewed.

Medicare Advantage

For the top codes reviewed for Medicare Advantage, HOPD off-campus facility fees were about 23% higher than independent providers and 50% higher than affiliated providers. The resulting impact indicates that the HOPD facility fees contributed between $470k and $830k in additional health care expenses relative to independent affiliated or professional fees, respectively.

The difference between affiliated and independent providers is driven by independent providers having higher average reimbursement than affiliated providers under Medicare Advantage. This analysis only viewed affiliation relative to a hospital system, and does not consider affiliation with a health plan. Medicare Advantage allows for payers to contract at varying rates among their provider network, which would explain the difference between results compared to Medicare FFS.

At the more detailed service level, it was observed that:

- Laboratory: higher HOPD off-campus facility fees than affiliated provider professional fees, but lower HOPD facility fees when compared to independent professional fees.
    - The HOPD facility fees for Medicare Advantage were comparable to Medicare FFS, so the variation is driven by varying contracting rates for professional fees.
- Radiology: mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees, but were overall higher for HOPD off-campus locations.
- Evaluation of Wheezing (CPT 94060): the highest contributing service at about 40% of the overall increased reimbursement for the top codes reviewed.

Impact to CHASE, Medicaid Expansion & Uncompensated Care

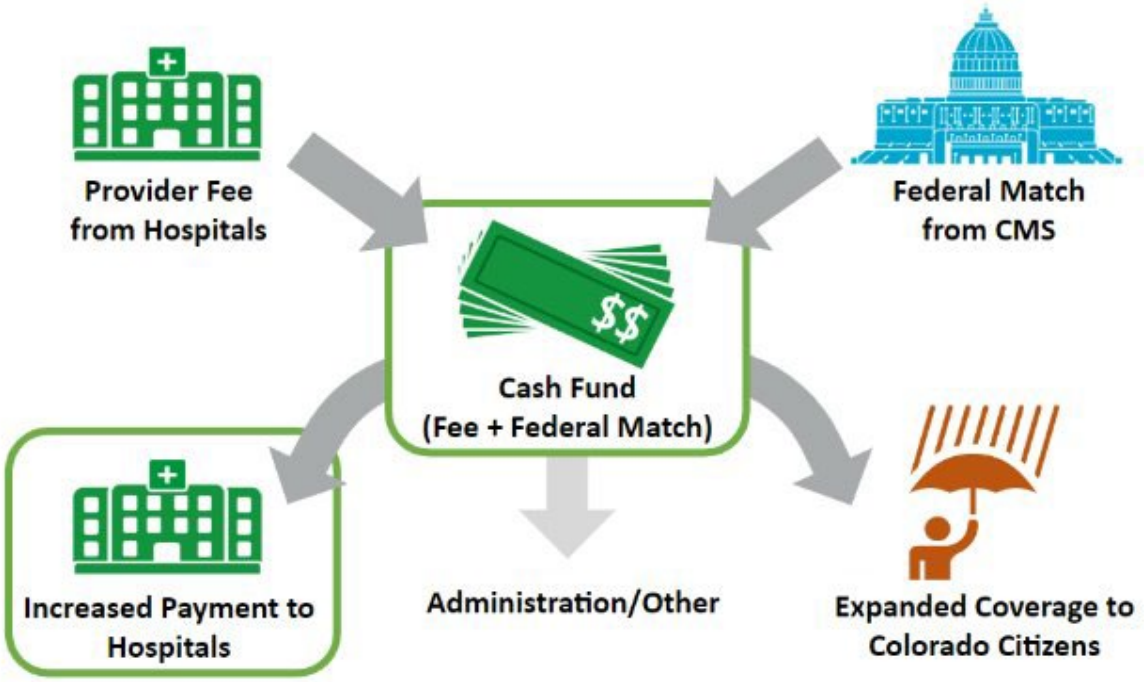
> *25.5-4-216(6)(e): The impact of facility fees and payer coverage policies on the Colorado health care affordability and sustainability enterprise, created in section 25.5-4-402.4, the Medicaid expansion, uncompensated care, and under-compensated care*

Impact to CHASE and Medicaid Expansion

Through CHASE, HCPF assesses a hospital provider fee on acute care and critical access hospitals throughout the state to draw federal Medicaid matching funds. These fees and federal matching funds are used exclusively to increase payments to hospitals for care provided to Medicaid members and uninsured patients, finance the state's expansion of health care coverage for more than 500,000 Coloradans through

the Medicaid and Child Health Plan Plus (CHP+) programs, and to pay its related administrative costs. The CHASE hospital provider fee has increased hospital payments by an average of more than $415 million per year, reduced hospitals' uncompensated care costs, and reduced the number of uninsured Coloradans. See the 2024 CHASE Annual Report for more information.

Figure X. CHASE is financed through hospital provider fees and federal matching from CMS. CHASE then expends its cash fund by funding expansion populations and paying supplemental hospital payments.



Under federal Medicaid regulations, the hospital provider fee cannot exceed 6% of hospitals' net patient revenues. This means if there is a decline in hospital patient revenue, such as through reductions in HOPD facility fees, the amount of hospital provider fees that could be collected may decline.

To assess the impact of HOPD facility fees on CHASE hospital reimbursement and expansion coverage, one year of impact on CHASE hospital provider fee revenue due to facility fees was computed utilizing an estimation methodology described in Appendix X.

The estimated impact is presented as a range of 10%, 50%, and 100% of HOPD patient revenue applied to estimated facility fee hospital patient revenue. The total estimated impacts are as follows:

- Facility fees between ($24.4 million) to ($244.5 million),
- Federal funds between ($85.4 million) to ($853.6 million), and
- Total spending between ($109.8 million) to ($1.098 billion).

The comprehensive breakdown of the range is available in Appendix X.There are other impacts to CHASE that have not been analyzed and are not reflected here, including decreases to the hospital payment limit (known as the upper payment limit). In addition, scenarios have not been analyzed where, under the CHASE statute, if fee revenue is insufficient to fund all uses of the CHASE hospital fee, reductions in expansion population coverage or benefits would be made before hospital payments would be reduced. The CHASE fee could first be increased to the federal maximum of 6% of net patient revenue and other actions may be recommended by the CHASE Board or undertaken by the General Assembly to mitigate such impacts.

Impact to Uncompensated Care

The American Hospital Association defines uncompensated care as "an overall measure of hospital care provided for which no payment was received from the patient or insurer." Uncompensated care is measured based on the hospital's cost of care provided rather than the amount billed but not collected. Uncompensated care is usually calculated at the organization level. Isolating the impact on uncompensated care to an individual facet of the hospital's operations, such as facility fees, depends heavily on the hospital's cost allocation methodology, which can vary greatly from hospital to hospital. To the extent there is a direct, positive correlation between facility fees and hospital costs, a change in facility fees will likely result in a change in uncompensated care costs, assuming no change in patients' ability to pay. A shift in care from less expensive sites of service to hospital clinics will not by itself cause an increase in uncompensated care, but if this shift also results in increased hospital costs, uncompensated care will likely increase.

Impact of Facility Fees to Access to Care, Integrated Care Systems, Health Equity, and the Health Care Workforce

> *25.5-4-216(6)(f): The impact of facility fees on access to care, including specialty care, primary care, and behavioral health care; integrated care systems; health equity; and the health care workforce.*

There is a complex relationship between access to care, integrated care systems, health equity, and the health care workforce. It is helpful to address the impact by looking at the issue from multiple perspectives, including the consumer, hospital/health system and independent physicians.

The impact of facility fees on these subjects is not easily quantifiable, and it is also difficult to evaluate the impact of facility fees without considering the overarching impacts of vertical integration.

Impact of Facility Fees on Access to Care, including Specialty Care, Primary Care, and Behavioral Health Care

The impact on access to primary, behavioral, and specialty care from a consumer perspective may all be quite similar. Consumers may only notice that care for the same service has become more expensive if their physician becomes affiliated with a hospital or health system when they are under the physician's care. If the physician and hospital or health system are already affiliated at the time of the consumer's first visit to the physician, then care may just appear to be more expensive with little explanation. In either case, due to the higher cost of care, the consumer may skip certain preventive care, which can ultimately result in more severe illness and additional costs.

Impact of Facility Fees on an Integrated Care System

Facility fees are more prevalent when physicians become vertically integrated with hospitals or health systems. From a consumer perspective, such integration can cause confusion since the consumer may not be aware of the affiliation status of the physician they are seeing and could be surprised by higher costs only after they have received services. The trend of increasing vertical integration also decreases the number of lower-cost alternatives for consumers. Hospitals or health systems believe

facility fees are necessary to cover the higher costs associated with their 24/7/365 operations and providing more coordinated care. Whether the use of facility fee revenue is appropriate or not is not part of this statutory report. Hospitals also believe integration provides more access to coordinated care for those who may otherwise find it difficult to find physician services elsewhere.

Impact of Facility Fees on Health Equity

Vertical integration between physicians and hospitals or health systems increases the cost of care for consumers. This effect adversely affects lower-income populations and may hinder some consumers' ability to shop for care. Conversely, this action may help hospital outpatient departments serve a broader and more diverse population range.

Impact of Facility Fees on the Health Care Workforce

Independent physicians are finding it more difficult to compete with hospitals and health systems due to a relative lack of negotiating power and stagnant payment rates. Independent physicians also incur overhead but without the benefit of economies of scale. Competing with hospitals and health systems for quality staff is an additional challenge for independent physicians and limits employment opportunities for those who do not wish to work for larger organizations. For reasons such as these, independent physicians are experiencing burnout, and many turn to becoming affiliated with larger organizations, including hospitals or health systems. Hospitals and health systems, on the other hand, generally have the capacity to provide more generous compensation packages to clinic staff and offer more opportunities for career advancement.

Conclusion

The Committee was tasked with developing a report on the impact of hospital facility fees in Colorado. There are a variety of perspectives regarding facility fees diverse as the backgrounds of the steering committee members. From the consumer's perspective, facility fees result in surprise bills and more expensive care. From the payer's perspective, hospital strategies with respect to physician acquisition have broadened the hospital's ability to charge facility fees leading to higher costs for the

same care. From the independent physician perspective, payment rates for professional services have remained stagnant forcing more and more physicians to become affiliated with hospitals resulting in fewer and fewer lower-cost options for patients. Hospitals feel facility fees are necessary to cover the costs of providing 24/7 care and the capability of taking all patients regardless of ability to pay. **Regardless of these varying perspectives, there is a consensus that medical billing is complex.** There is a lack of billing practice standardization across the various payers making analysis of facility fees a challenging endeavor. The structure of health claims and how data is reported differently between payers makes it difficult to conduct a comprehensive impact of facility fees and perform a full cost-of-care analysis comparison across all providers and payers in Colorado.

The steering committee utilized data from the APCD, surveys and supplemental data to respond to the requirements of 25.5-4-216. As described in this report and related appendices, there are several caveats with respect to the data sources primarily centering around missing data and low survey response rates. However, the data did confirm that **HOPD facility fees result in higher costs for the same procedures that could otherwise be provided in other settings**. These higher costs have a direct impact on employers and consumers. This report begins the important process of analyzing the overall financial impact on the health care system; there are additional opportunities to continue to quantify the financial impact across the breadth of the healthcare system. It is important to note that interviews with employer representatives suggest that facility fees are not a high priority in efforts to control healthcare costs.

The committee was not tasked with making recommendations, but it is clear that more needs to be done:

- Given the complexity of the topic, more analysis is needed to fully comprehend the financial impact of facility fees. Statutorily, the committee was charged with comparing the cost of individual procedures across sites of service. Since many episodes of care involve multiple procedures, often performed by several different providers, an analysis of the total episodic cost of care is warranted.

- The financial component of facility fees is but one perspective. A deeper dive into the value-based aspect of facility fees is needed. Quality and patient access are key components of value-based care.

- Further exploration into billing standardization and transparency is warranted. The current situation results in data gaps for some payers and considerable confusion and frustration for consumers making shopping for care difficult, even for savvy consumers.

- With the trend of hospital and physician affiliation, outpatient care has migrated to the HOPD setting resulting in fewer options for patients, which is more costly to consumers. An exploration of how to help independent providers remain independent would be beneficial.

- It is disconcerting that, despite the high profile of facility fees, employer representatives are not more engaged in the topic. Employers make the largest purchases of healthcare services, and ways to get them more connected to the issue should be explored.

—------ Alternative options for the bullets:

- **Further Analysis:** Given the complexity of the topic, more analysis is needed to fully understand the financial impact of facility fees. Statutorily, the committee was charged with comparing the cost of individual procedures across different sites of service. Since many episodes of care involve multiple procedures performed by several providers, a thorough analysis of the total episodic cost of care is warranted.

- **Value-Based Perspective:** The financial component of facility fees is just one aspect. It is necessary to explore the value-based implications of facility fees, including quality and patient access.

- **Billing Standardization and Transparency:** There is a need for further exploration into billing standardization and transparency. The current situation leads to data gaps for some payers and significant confusion for consumers, making it difficult for even savvy shoppers to navigate care options.

- **Support for Independent Providers:** With the trend of hospital and physician affiliation, outpatient care has increasingly shifted to the HOPD setting, reducing patients' options and increasing costs. Exploring ways to help independent providers remain independent would be beneficial.
- **Employer Engagement:** It is concerning that, despite the prominence of facility fees, employer representatives are not more engaged in the issue. Employers, among the largest purchasers of healthcare services, should be more connected to this topic, and strategies to increase their involvement should be explored.

The steering committee appreciates the opportunity to shed light on the impact of facility fees in Colorado and exposing the myriad of related issues. Committee members are committed to the continuation of dialogue and study of these issues and encouraging informed, positive change.