

Hospital Facility Fee Report

Report on the impact of hospital facility fees in Colorado

October 1, 2024

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



COLORADO

Department of Health Care
Policy & Financing

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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 House Bill 23-1215. On September 17, 2024, the Steering Committee approved the attached report for submission. This report was supported by 6 Committee members with member Dan Rieber dissenting (see Appendix Q for Mr. Rieber’s letter of dissension).

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, for example, 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 A of this document and we welcome any reader to reach out to discuss.

Respectfully,

Facility Fee Steering Committee Members

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Background and Introduction

[House Bill \(HB\) 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 representatives of health care providers and payers, each with relevant expertise in billing and payment policy, was tasked with producing a final report by October 1, 2024. While HCPF is represented on the Committee, this report represents the views of the Committee and not necessarily the views of HCPF or the Governor Polis administration. See Appendix A 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 [HCPF](#) 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 B 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 are both complex and opaque making analysis of facility fees challenging. Some rates and reimbursement policies were able to be sourced, but private payer rates are considered trade secrets and not available.
- 3) Medicare policy is the key driver of separate billing for professional and facility fees and the circumstances of when/whether HOPDs charge facility fees varies. Commercial billing practices and agreements commonly mirror Medicare guidelines.
- 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 expected reimbursement amounts¹ for Medicare and Commercial coverage, which is about 22.8% of the total allowed HOPD facility fees across the study period. The raw increase in facility fee billing from 2017 to 2022 was 10%, not normalized based on population growth or changes in utilization. Here is the breakdown by market:
- a) Commercial market: \$1.3 billion for the top 25 codes, growing on average at 6.5% annually.
 - b) Medicare market including Medicare Advantage: \$1.7 billion for the top 25 codes, growing on average at 14.3% annually.
 - c) Note that Medicaid reimburses for hospital outpatient services claims using a grouping methodology and does not reimburse for distinct incremental facility fees.
- 6) HOPD facility fees contributed approximately \$50.8 million to \$53.7 million more in health care expected reimbursement on an annual basis when compared to professional expected reimbursement for affiliated or independent providers for the top 25 codes reviewed across Medicare and Commercial payers. The results can be interpreted as the incremental impact to expected reimbursement based on the site of service.^{2,3}
- a) **Medicare Fee-for-Service (FFS):** HOPD facility fees were about 95% higher than independent provider fees, and 95% higher than affiliated providers fees. This contributed \$11 million in expected reimbursement on an annual basis for either group when comparing HOPD facility fees to comparable professional fees.
 - b) **Medicare Advantage:** HOPD facility fees were about 14% higher than independent provider fees and 36% higher than affiliated provider fees, resulting in between \$1.6 million and \$3.4 million in expected reimbursement on an annual basis.

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

² This impact is intended to highlight reimbursement differences and does not comment on the feasibility of impacting actual reimbursement due to utilization shifting between sites of service.

³ Note that “affiliated with” means that the provider is employed by a hospital or health system; or under a professional services agreement, faculty agreement, or management agreement with a hospital or health system that permits the hospital or health system to bill on behalf of the affiliated entity.

- c) **Commercial payers:** HOPD facility fees were 90% higher than independent provider fees and 95% higher than affiliated provider fees, contributing between \$38.2 million and \$39.2 million in expected reimbursement on an annual basis.
 - 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 million in health care expected reimbursement 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 be reimbursed for hospital expenses. 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 a 10% reduction to a 100% reduction in Commercial HOPD facility fees on CHASE could be between \$109.8 million to \$1.098 billion in total spending annually.
- 9) 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, according to the preamble to the federal regulations when published in the federal register, an incentive to shift the site of service toward affiliated settings.⁴ Recent publications report additional incentives contribute to the shift from independent practices toward affiliation like improved access to resources and ability to better manage administrative and regulatory requirements.

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

⁴ Prospective Payment System for Hospital Outpatient Services. 65 FR 18434 (2000).
<https://www.federalregister.gov/documents/2000/04/07/00-8215/office-of-inspector-general-medicare-program-prospective-payment-system-for-hospital-outpatient>

Data Sources and Caveats

The Steering Committee received the majority of the data used in this analysis from the APCD with supplemental data supplied by hospitals, health systems, HCPF, commercial payers, and independent providers. Service provider types not specifically listed were excluded. As directed by the legislation, some analyses were completed using existing data from credible sources already subject to rigorous reporting and auditing standards. These sources include Medicaid caseload and expenditure data reported to the Joint Budget Committee pursuant to HCPF's FY 2024-25 Legislative Request For Information #1 and the CHASE Annual Report to the Joint Budget Committee and Senate and House Health and Human Services Committees.

A full listing of data sources and caveats is in Appendix C, and highlights are shown here:

All Payer Claims Database (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% of covered lives. APCD supplied data from 2017 through 2022. However, the data provided does not include uninsured and self-pay claims, comprehensive self-insured employer claims data, 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% of Colorado members.

Survey and Supplemental Data

The Steering Committee requested billing policies and data 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.
- Emergency departments (on and off campus) were completely excluded from analysis throughout the report.

- The APCD data does not include indicators for facility fees for claims that were completely denied for an entire patient visit. The data does include facility fee data for partially denied claims; that is, where only some of the services provided during the patient’s visit were denied. As noted above, the APCD data covers 74% 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 \$209 million in expected reimbursement over the six year study period.
- Responses from provider surveys helped 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 D.

Stakeholder Perspectives

As noted in the introduction, the Steering Committee consists of seven governor-appointed consumers, advocates, and representatives of health care providers and payers. Although this report is data-driven, the Steering Committee felt a balanced understanding of their perspectives is important. Therefore, in Appendix E, you will find 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 beyond the rendering physician's professional services, 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 typically 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.⁵

The practice of separately billing hospital and professional fees is an artifact of Medicare reimbursement practices. Hospitals have billed facility fees since at least 2000 when Medicare set billing standards for facility-based providers. As described in the preamble to 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.

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

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.

The history of federal actions includes:

- In the 1980s, Congress took action to control the escalating costs of outpatient care through across-the-board reductions 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 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.
- The Social Security Act ([Section 1834\(g\)\(1\)](#)) describes how Critical Access Hospitals (CAHs) are paid based on their cost of providing services for Medicare patients. For more information on CAHs, see the Impact on Rural Hospitals section below.

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.⁶ While commercial payers set their rates differently, and based on negotiations with providers, they generally follow the same practice of paying the facility fee separate from the professional services.⁷

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

⁷ Congressional Budget Office, 2022. [The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services](#)

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 be equal whether these visits were provided in an HOPD or in a freestanding physician’s office.⁸
- In the Bipartisan Budget Act (BBA) of 2015, Congress directed the Centers for Medicare and Medicaid Services (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 2015.⁹
- In 2022, MedPAC analyzed and identified services for which payments can be more closely aligned across settings.¹⁰

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 typically receive a bill from the provider and the facility.

Hospitals are required to follow CMS rules and guidelines in their Medicare billing practices and are allowed to charge facility fees when a patient utilizes HOPDs that are on- or off-

⁸ Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2012

⁹ Centers for Medicare & Medicaid Services 2019

¹⁰ Medicare Payment Advisory Commission, 2022. *Medicare and the Health Care Delivery System*, [Chapter 6](#)

campus. The hospitals also indicate that changes over time reflect changes in billing guidelines or the incorporation of acquired facilities into standard practices.

Medicare has an additional and distinct incremental facility fee code (G0463) for HOPD facilities.¹¹ Hospital providers also use 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 reimburses for hospital outpatient claims using a grouping methodology and does not reimburse for distinct incremental facility fees.¹² 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 voluntary, charity care programs in place intended to help low-income individuals with 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 §25.5-4-216(6)(a), C.R.S., to address the payments for HOPD facility fees, including insights across payer types. Because Medicaid reimburses hospital outpatient services using a grouper methodology and does not pay for distinct incremental facility fees, this report does not include analysis of Medicaid HOPD from the APCD. The following sections focus on payers that cost-share, impacting consumers. Appendices include additional details and summary tables.

Total Facility Fees

In total, there were between 2,200,000 and 3,235,000 patient visits totaling \$1.75 billion to \$2.9 billion on an annual basis between 2017 and 2022 for which facility fees were charged for Commercial and Medicare payers. This totaled to \$13.4 billion across the six year study period.

¹¹ The use of G0463 is described in Appendix G. The analysis below reviews the presence of this code within Medicare billing.

¹² For more information see [Colorado Department of Health Care Policy & Financing's Outpatient Hospital Payment](#) website

Commercial Payers

There were between 700,000 to 985,000 patient visits totaling \$1.0 billion to \$1.4 billion on an annual basis between 2017 and 2022 for which facility fees were charged for Commercial payers. This totaled to \$7.1 billion across the six year study period. 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.¹³ 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 F includes additional details and summary tables.

Medicare Payers

There were between 1,500,000 and 2,250,000 patient visits totaling \$750 million to \$1.5 billion on an annual basis between 2017 and 2022 for which facility fees were charged for Medicare payers (FFS and Advantage combined). This totaled to \$6.3 billion across the six year study period. 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 G includes additional details and summary tables.

¹³ 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 F.

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 expected reimbursement amount. That was consistent between Commercial and Medicare across the study period. The volume by hospital and/or health system is driven by the percentage of services they provide and their general market share.

The top hospital/health system for total allowed HOPD facility fees was the UCHHealth hospital system, with approximately 30% of the total for both Medicare and Commercial. The next three highest were HCA HealthONE, Intermountain Health, and CommonSpirit Health, each with 8% to 10% of the total HOPD expected reimbursement amount across Medicare and Commercial. Children's Hospital Colorado, AdventHealth, Banner Health, Valley View, Parkview Medical Center, and Denver Health round out the top 10 hospitals/health systems across Commercial and Medicare. These results are driven by the volume of services provided for each hospital and/or health system, which had similar results.

Appendix H 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 this 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, 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 F contains a list of top codes by frequency by year and in total.

Medicare Payers

For Medicare, the top most frequent codes for which a facility fee was charged were similar to Commercial payers and included laboratory codes, physical therapy, mammogram, injectable drugs, and x-ray. Like Commercial, blood work-related services were the most common services that resulted in a facility fee. Additionally, G0463 (facility fee) was the second most commonly billed code. Appendix G 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 G contains a list of top codes by frequency by year and in total.

Top Codes by Expected Reimbursement Amount

Commercial Payers

The top codes based on the expected reimbursement amount for which a facility fee was charged included a range of services, including echocardiogram, joint devices, injectable drugs including chemotherapy, arthroplasty, laparoscopy, mammograms, endoscopy, colonoscopy, and magnetic resonance imaging (MRI). Outpatient Observation, code G0378, was also included in the top codes by expected reimbursement amount, distinct from the G0463 facility resource code used by Medicare.

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

Medicare Payers

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

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

Total Facility Fee Claim Denials

As noted in Appendix D, 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%.

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 §25.5-4-216(6)(a), C.R.S., 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, computed tomography (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 expected reimbursement amount. When compared to the total expected reimbursement 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 F 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, laboratory codes, injectable drugs including chemotherapy, physical therapy, arthroplasty, mammograms, and MRIs. Additionally, G0463 (facility fee) was the highest code based on expected reimbursement amount totalling \$5.6 million to \$7.2 million a year. As noted in Section IV, Medicare allows this code to reflect facility resources beyond the services provided.

Appendix G 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 approximately 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. Moreover, high deductible payer coverage plans increase patients' out-of-pocket costs. 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 cost site-of-service care at HOPDs, as demonstrated in this report, results in higher health care costs to consumers.

Higher expected reimbursements are driven by site of service, HOPD vs. professional office visit in this case, and may be passed on to employers and consumers as part of the monthly premium they pay to the insurer for health care coverage. Additional research and analysis is needed to examine the impact of facility fees on health coverage premiums. 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 described below find 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 HOPD facility fees contribute 6.2% to the premium paid by the employer and consumer.¹⁴

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. Health First Colorado members have no co-payments except for low co-payments for non-emergency care provided in an emergency department. Health First Colorado members have no other cost sharing. Accordingly, the impact of facility fees on Health First Colorado members is negligible. On the other hand, the trend of shifting the site of care from independent practices to affiliated ones increases the Medicaid program's overall health care expenditures.

¹⁴ 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 is available in Appendix I Premium Impact Scenarios document.

An analysis of hospital outpatient expenditures from the Medicaid program and CHASE, Medicaid caseload, and the total hospital outpatient expenditures per capita using HCPF budget documents is available in Appendix J.

A shortcoming of using HCPF budget documents for analysis 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 the shift from independent provider to HOPD sites of care 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 §25.5-4-216(5)(g), C.R.S., 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 expected reimbursement 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 specific to Medicare and Commercial payers 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.¹⁵ Comparisons are

¹⁵ 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.

made by site of service, professional’s affiliation, and payer type.¹⁶ More information on the methodology is in Appendix K.

Table 1. Service code comparisons are done at the code level and compare CPT codes

| Member ID | Date | Claim No. | CPT Code | Description | Location | Fee Type | Expected Reimbursement 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 Tables 2 and 3 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 \$50.8 million to \$53.7 million in health care expected reimbursement when compared against either affiliated or independent professional fees, respectively, for the top 25 codes reviewed across Medicare and Commercial payers. This effectively shows the incremental impact of the difference in expected reimbursement by site of service.¹⁷

¹⁶ 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.

¹⁷ The aggregate impact calculation is based on using the HOPD volume of utilization and mix of services across those top codes.

Table 2. Average Independent Professional Fee Compared to HOPD Facility Fees for Top 25 Codes

| Payer | Medicare FFS | Medicare Advantage | Commercial | Total |
|------------------------|--------------|--------------------|--------------|--------------|
| Professional Fee Avg. | \$21.11 | \$91.78 | \$71.41 | |
| HOPD Facility Fee Avg. | \$41.14 | \$104.76 | \$135.60 | |
| Percentage Difference | 95% | 14% | 90% | |
| Dollar Difference | \$11,046,858 | \$1,606,978 | \$38,166,482 | \$50,820,319 |

Table 3. Average Affiliated Professional Fee Compared to HOPD Facility Fees for Top 25 Codes

| Payer | Medicare FFS | Medicare Advantage | Commercial | Total |
|------------------------|--------------|--------------------|--------------|--------------|
| Professional Fee Avg. | \$21.22 | \$76.92 | \$69.60 | |
| HOPD Facility Fee Avg. | \$41.14 | \$104.76 | \$135.60 | |
| Percentage Difference | 94% | 36% | 95% | |
| Dollars Difference | \$10,988,667 | \$3,446,198 | \$39,242,048 | \$53,676,913 |

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

For the methodology, accompanying details, and tables for this analysis, see Appendix K, Comparison Methodology and Tables, and Appendix L, Dataset Comparison by Year. Additional insight into observations by payer type is outlined below.

Medicare FFS

For the top codes reviewed for Medicare FFS, HOPD facility fees were about 95% higher than independent and affiliated provider fees (or charges), 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 expected reimbursement 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 \$1.6 million and \$3.4 million in higher health care expected reimbursement relative to independent affiliated or professional fees, respectively.

The difference between affiliated and independent providers is driven by independent providers' higher average professional services 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 \$38.2 million and \$39.2 million in additional health care expected reimbursement relative to independent affiliated or professional fees, respectively.

The difference between affiliated and independent providers is likely driven by different levels of contracted reimbursement rates between the provider and payers/health plans. Independent providers had 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.
 - The following codes in Table 4 illustrate the range of expected reimbursement differences based on site of service.

Table 4. Reimbursement Variation by Site of Service for selected Laboratory CPT codes

| CPT Code | Professional Site of Service Avg. Expected Reimbursement | HOPD Site of Service Avg. Expected Reimbursement | % Difference of HOPD to Professional |
|---------------------|--|--|--------------------------------------|
| 80048 ¹⁸ | \$6.45 | \$63.77 | 889% |
| 88305 ¹⁹ | \$144.07 | \$171.21 | 19% |

- 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 expected reimbursement amount for HOPD facility fees for E&M codes is lower, it should be noted that the E&M codes may be billed twice

¹⁸ Blood Test, Basic Group Of Blood Chemicals

¹⁹ Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity

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 are likely 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 usually 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 expected reimbursement 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 freestanding physician 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 freestanding physician 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 5. HOPD Visit that Results in Two Distinct Invoices for the Visit with a Total Visit Expected Reimbursement Amount Equal to \$390.00

| Member ID | Date | Claim No. | CPT Code | Description | Location | Fee Type | Expected Reimbursement 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 6. Professional Office Visit with a Total Visit Expected Reimbursement Amount Equal to \$196.00

| Member ID | Date | Claim No. | CPT Code | Description | Location | Fee Type | Expected Reimbursement 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 M.

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 echocardiography -related procedures.

Top Codes by Expected Reimbursement 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 expected reimbursement 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 expected reimbursement 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 expected reimbursement amount.

Approximately 73.5% of all Medicare off-campus HOPD facility fees were associated with the UHealth hospital system. Within the UHealth 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 expected reimbursement 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 \$1.7 million in expected reimbursement 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 \$470,000 and \$830,000 in additional health care expected reimbursement 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.

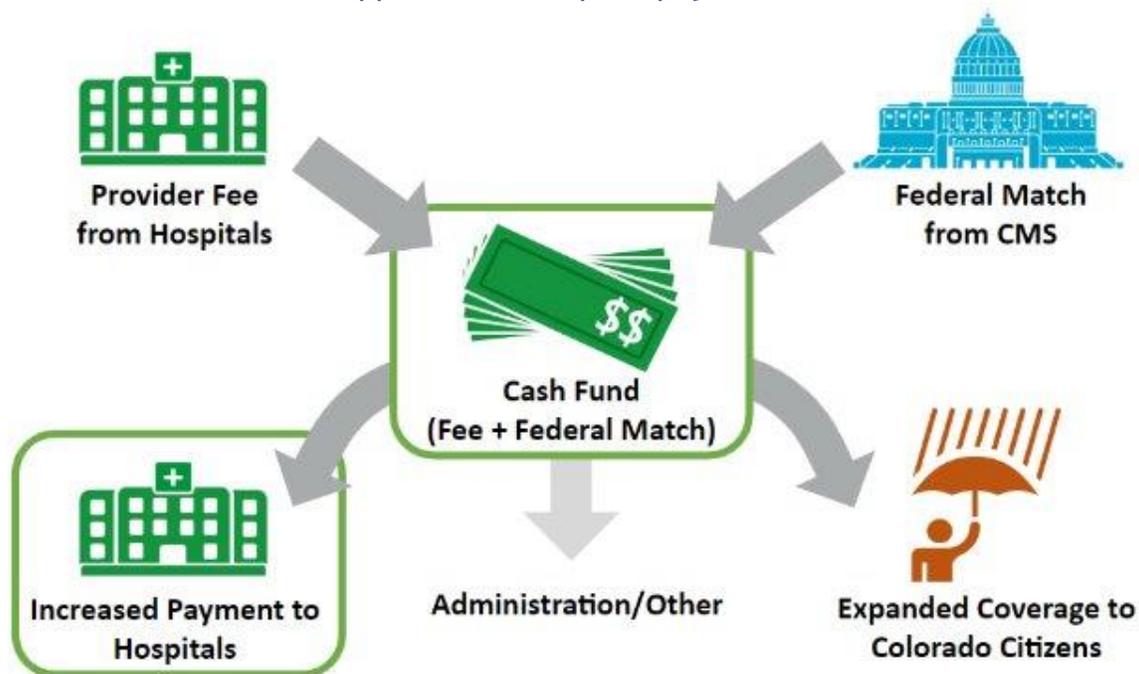
Impact to CHASE, Medicaid Expansion & Uncompensated Care

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 CAHs 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 Health First Colorado members and uninsured patients, finance the state's expansion of health care coverage for a currently estimated more than 500,000 Coloradans through the Health First Colorado 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 1. 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 2022 data and an estimation methodology described in Appendix N.

Based on 2022 data, the estimated annual impact is presented as a range from a reduction of 10% to 100% of HOPD facility fees applied to estimated hospital patient revenue. The total annual estimated impacts to CHASE hospital provider fees, federal funds, and total CHASE spending from the lower range of 10% to higher range of 100% reduction in HOPD facility fees are as follows:

- If HOPD facility fees were reduced by 10%, CHASE hospital provider fees would reduce by (\$24.4 million). If facility fees reduced by 100%, CHASE hospital provider fees would reduce by (\$244.5 million);

- If facility fees were reduced by 10%, federal funds would reduce by (\$85.4 million). If facility fees reduced by 100%, federal funds would reduce by (\$853.6 million); and
- If facility fees were reduced by 10%, total CHASE spending would reduce by (\$109.8 million). If facility fees reduce by 100%, total CHASE spending would reduce by (\$1.098 billion).

The comprehensive breakdown of the range is available in Appendix N. There are other impacts to CHASE that have not been analyzed and are not reflected here, including decreases to hospital reimbursement for care provided to Health First Colorado members due to decreases in the Medicaid payment limit (known as the upper payment limit) and decreases in covered lives if health coverage expansion is affected as discussed below. 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 supplement hospital payments through CHASE 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 may be undertaken by the General Assembly to mitigate such impacts.

Impact to Uncompensated Care

CMS defines uncompensated care as “health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.” 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 HOPDs 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 payers, consumers, hospitals/health systems, and independent physicians. Perspectives from these groups are available in Appendix E.

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, whether between physicians and hospitals or health systems, between physician groups, and/or via acquisition by private equity or payers.

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

Determining the impact of facility fees on access to care, including specialty care, primary care, and behavioral health care, was not possible given the data available to the Steering Committee.

Impact of Facility Fees on an Integrated Care System

As shown in this report, HOPD facility fees are higher than professional fees for the same service, and research shows that facility fees are more prevalent when physicians become vertically integrated with hospitals or health systems.²⁰ 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. From the hospital perspective, facility fees are necessary to cover the higher costs associated with licensing and accreditation requirements, providing more coordinated care, and, in the case of CAHs, at times acquisition of providers helps ensure access to care that may otherwise leave their community. Whether the use of facility fee revenue is appropriate or not is not part of this statutory report.

²⁰ [Study finds vertical integration in medicine is leading to higher costs and worse health outcomes](#) and [The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence - PMC](#)

Impact of Facility Fees on Health Equity

Health equity is a critical and complex topic. Isolating the impact of facility fees on health equity was not possible given the data available to the Steering Committee. However, some research indicates that vertical integration, whether between physicians and hospitals or health systems, between physician groups, and/or via acquisition by private equity or payers, increases the cost of care for consumers.

There are two perspectives to consider in reviewing impacts to health equity: that of the health care consumer and that of the health care provider. According to Levin et al., for the consumer, vertical integration between physicians and hospitals or health systems increases the cost of care and adversely impacts the medication adherence for Black, Asian, Hispanic, and Native American patients, patients over 80 years old, and patients with greater comorbidities. The authors also note that while a common argument supporting hospital-physician vertical integration is improvements in care coordination and quality, they found no measurable improvements of common quality measures with meaningful reductions among vulnerable populations.”²¹ Vertical integration has increased significantly, thus reducing lower cost alternatives and hindering some consumers' ability to shop for care.²²

From the provider perspective, facility fees are necessary to cover the higher costs of to help HOPDs serve a broader and more diverse population range and maintain 24/7 emergency care.²³ These costs include those associated with licensing and accreditation requirements, providing care for underserved and high-acuity patients, maintaining the capability of taking all patients regardless of ability to pay, and providing more coordinated care. Also, in some communities, providing care through HOPDs may help ensure access to care that may otherwise not be available.

Impact of Facility Fees on the Health Care Workforce

Factors influencing the health care workforce are myriad, and isolating the impact of facility fees on this topic was not possible given the data available to the Steering Committee within the allowed timeframe. However, the Steering Committee did discuss the general trends

²¹ Levin, J. S., Komanduri, S., & Whaley, C. (2023). Association between hospital-physician vertical integration and medication adherence rates. *Health services research*, 58(2), 356-364. <https://doi.org/10.1111/1475-6773.14090> or <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10012217/>

²² Chapter 6, Aligning fee-for-service payment rates across ambulatory settings, pp. 166 - 168, https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf

²³ Chapter 6, Aligning fee-for-service payment rates across ambulatory settings, p. 166, https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf

impacting independent physicians and some research is available on this topic. According to Rooke-Key et al, nearly 80% of physicians are now employed by hospitals, health systems, or corporations. The authors note many factors contributing to the shift from independent practices toward affiliation include rising administrative burdens, changing employment preferences, greater capital demands for health information technology, favorable financial incentives, and shifts to value-based payment models.²⁴

In a review of peer-reviewed publications on the risks and benefits of physician practice acquisition and consolidation in the U.S., Tewfik, et al., note that physicians in acquired practices may experience loss of clinical autonomy but also report improved work environments and decreased rates of burnout. Additional benefits of consolidation include centralization of administrative tasks, lower costs, and practice stability, among other benefits. Additional downsides of consolidation include higher costs of care and decreased physician competition, amongst others.²⁵ There are other segments of the workforce, including nurses, aides, technicians, administrative personnel, and others that were not analyzed or researched by the Committee.

Impact on Rural Hospitals

While HB 23-1215 did not direct the Steering Committee to separately evaluate facility fees for CAHs or other rural hospitals, the Committee had regular discussion on the different dynamics at play for rural hospitals versus their urban counterparts.

Market pressures for rural hospitals are often very different from the larger integrated systems found in urban areas. In Colorado, these hospitals are, for the most part, independent free-standing institutions and are almost exclusively governmental or private not-for-profit facilities. In most cases, these facilities serve as safety net providers for their communities. For example, when a physician practice is closing in a rural community, the hospital is often the only entity able to absorb the practice to maintain access to care. The cost of operating this practice is greatly supported by the hospital's ability to bill a "facility fee" for services provided within that practice. This pressure is often exacerbated by the payer mix of rural hospitals where governmental payers often cover more than 50% of the

²⁴ Rooke-Ley H, Song Z, Zhu JM. Value-Based Payment and Vanishing Small Independent Practices. JAMA. Published online August 22, 2024. doi:10.1001/jama.2024.12900. [Value-Based Payment and Vanishing Small Independent Practices](https://doi.org/10.1001/jama.2024.12900)

²⁵ Tewfik, G., Grech, D., Laham, L., Chaudhry, F., & Naftalovich, R. (2024). The Risks and Benefits of Physician Practice Acquisition and Consolidation: A Narrative Review of Peer-Reviewed Publications Between 2009 and 2022 in the United States. *Journal of multidisciplinary healthcare*, 17, 2271-2279. [Physician practice acquisition/consolidation risks/benefits | JMDH](https://doi.org/10.1177/17557441241271279) or <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11102090/>

patient population. This results in relatively small numbers of patients covered by commercial plans, creating a disparate market relationship between Commercial payers and the hospital. Payer mix for CAHs is discussed in more detail below. A review of the Commercial and Medicare HOPD facility fees analyzed for this report shows that CAH represented 6.8% of Commercial, 11.2% of all Medicare, and 8.9% of total allowed facility fees. See Appendix O.

The General Assembly has at times recognized that rural areas have more limited financial resources and access to care than urban areas,²⁶ and HB23-1215 exempted CAHs from the prohibition on collecting a facility fee for preventive health care services directly from a patient for care not covered by the patient's health insurance.

Colorado is largely a rural state, and the Committee believes an overview of all rural hospitals should be included in this report given their importance to providing access to care for rural Coloradans.

According to the Colorado Rural Health Center's 2024 Snapshot of Rural Health in Colorado:²⁷

- 47 of Colorado's 64 counties are rural or frontier.²⁸
- 77% of Colorado's landmass is considered rural or frontier.
- Colorado has 32 CAHs and 11 additional rural hospitals that are not designated as CAHs.²⁹ See Appendix P for a list of Colorado's CAHs and rural and frontier counties and rural.
- 22% of the rural population is aged 65 and older while 17% of the urban population is aged 65 or older.³⁰

²⁶ See legislative declarations of [SB 22-200](#) and [SB 17-267](#), for example.

²⁷ Colorado Rural Health Center. (2024). Snapshot of Rural Health in Colorado 2024. <https://coruralhealth.org/snapshot-of-rural-health#/>

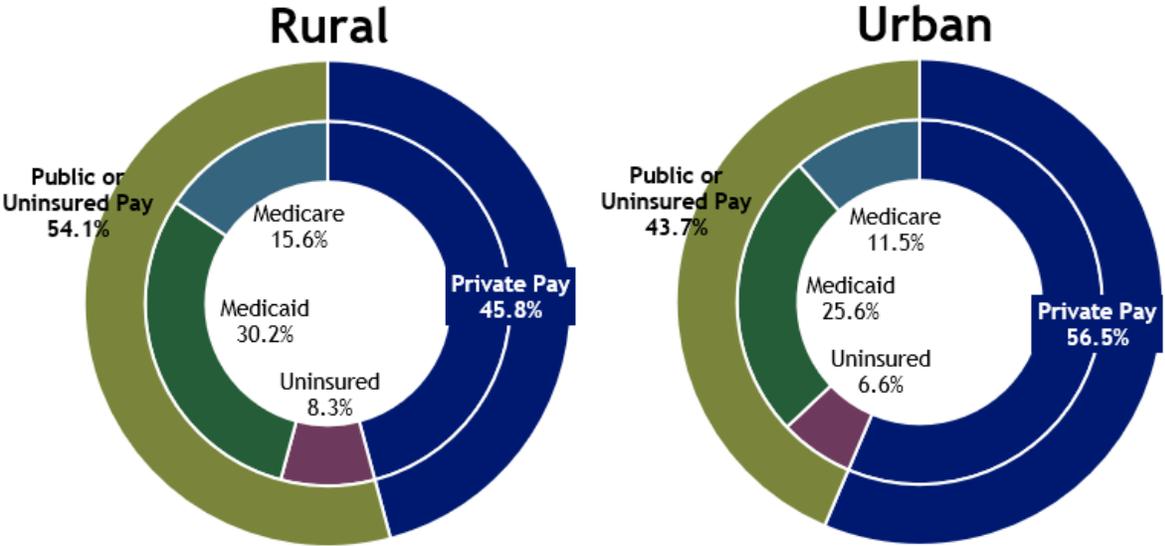
²⁸ Rural county is a non-metropolitan county containing no municipalities over 50,000 residents. A frontier county is a county with a population density of 6 or fewer residents per square mile.

²⁹ Of the rural non-Critical Access Hospitals, Delta County Memorial Hospital is designated as a Sole Community Hospital and is also exempt from HB 23-1215's prohibition on collecting facility fees from patients not covered by their health insurance. See [Reimbursement of Sole Community Hospitals Under Medicare's Prospective Payment System](#) and [Sole Community Hospitals | HRSA](#) for more information on Sole Community Hospitals.

³⁰ Colorado State Demography Office, & Department of Local Affairs. (n.d.). Population by Single Year of Age - County 2023 (Forecasted). Retrieved June 1, 2023. <https://gis.dola.colorado.gov/population/data/sya-county/#county-population-by-single-year-of-age>

- Health coverage in rural Colorado has a higher public payer and uninsured payer mix, and lower commercial payer mix, compared to urban areas.³¹
- 19% of children in rural areas live in poverty compared to 11% in urban areas and 12% statewide.³²

Figure 2. Rural and Urban Payer Mix Compared³³



CAH is a designation given to eligible rural hospitals by CMS. According to the Rural Health Information Hub, Congress created the CAH designation through the Balanced Budget Act of 1997 (Public Law 105-33) in response to over 400 rural hospital closures during the 1980s and early 1990s. This designation is designed to reduce the financial vulnerability of rural hospitals and improve access to health care by keeping essential services in rural communities.

³¹ Colorado Rural Health Center. (2024). Snapshot of Rural Health in Colorado 2024. <https://coruralhealth.org/snapshot-of-rural-health#/> using survey data from Colorado Health Institute. Colorado Health Access Survey - 2021. Retrieved October 16, 2022 <https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2021>

³² Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute. County Health Rankings (2023, April). Colorado County Data: Children Living in Poverty. Retrieved June 1, 2023. <https://www.countyhealthrankings.org/>

³³ Colorado Rural Health Center. (2024). Snapshot of Rural Health in Colorado 2024. <https://coruralhealth.org/snapshot-of-rural-health#/> using survey data from Colorado Health Institute. Colorado Health Access Survey - 2021. Retrieved October 16, 2022 <https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2021>

In addition to other requirements, generally hospitals must meet the following conditions to obtain CAH designation from CMS:³⁴

- Have 25 or fewer acute care inpatient beds.³⁵
- Be located more than 35 miles from another hospital or more than 15 miles in areas with mountainous terrain or only secondary roads.
- Maintain an annual average length of stay of 96 hours or less for acute care patients.
- Provide 24-hour a day emergency care services 7 days a week.

Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on costs. CMS pays CAHs for inpatient, outpatient, lab, therapy, and post-acute services in swing beds³⁶ provided to Medicare patients at 101% of reasonable costs. However, due to sequestration, CAH reimbursement is subject to a 2% reduction through 2032, meaning CAHs are currently paid below cost of care provided to Medicare patients.³⁷ Further, according to the [2024 CHASE Annual Report](#), Medicaid reimburses all hospitals approximately 81% of costs in the aggregate.³⁸

While CAHs represent only a fraction of the Commercial and Medicare facility fees evaluated, CAHs are particularly vulnerable to reimbursement policy changes given that the majority of their payer mix is from Medicare and Medicaid who reimburse below the cost of care and are generally located in areas which face great economic, infrastructure, and access to care challenges than urban areas of the state.

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, which are as diverse as the backgrounds of the Steering Committee members themselves. Detailed one-page

³⁴ See [Critical Access Hospitals | CMS](#) for more information on CMS' criteria for CAH designation.

³⁵ In addition to 25 acute beds, CAHs are allowed to have distinct-part skilled nursing facilities, 10-bed psychiatric units, 10 bed rehabilitation units, and home health agencies. However, these departments of the CAH are paid through Medicare's prospective payment systems and are not eligible for cost-based reimbursement.

³⁶ Swing beds can be used to provide either acute or skilled nursing facility (SNF) care. See [Swing Bed Providers | CMS](#) for more information.

³⁷ For more information on Medicare reimbursement for CAHs and sequestration, see: [Critical access hospitals payment system - MedPAC](#), [Medicare and Budget Sequestration](#), and [2021-12-16-MLNC | CMS](#).

³⁸ Department of Health Care Policy & Financing. (2024, February). 2024 CHASE Annual Report. <https://hcpf.colorado.gov/colorado-healthcare-affordability-and-sustainability-enterprise-chase-board>

perspectives with each group's views on facility fees are available in Appendix E. 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 physicians to become affiliated with hospitals resulting in fewer lower-cost options for patients. From the hospital perspective, facility fees are necessary to cover the costs of providing care for underserved and high-acuity patients 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, C.R.S. 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 expected reimbursement for the same procedures that could otherwise be provided in other settings. These higher expected reimbursements 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 health care system. It is important to note that interviews with employer representatives suggest that facility fees are not a high priority in efforts to control health care costs as the cost of pharmaceuticals and potentially avoidable care are often their focus.

The Committee was not tasked with making recommendations, but notes the following:

- **Further Analysis:** Given the complexity of the topic, more analysis is needed to fully understand the financial impact of facility fees, including to the individual patient. 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.

- **Quality and Access Perspective:** The financial component of facility fees is just one aspect, and further exploration of the non-financial implications of facility fees would be beneficial. These include exploring the effects of practice acquisition and health care consolidation on quality of care, patient access, and the benefits and downsides of consolidation for physicians and other members of the health care workforce. Exploring how these dynamics differ for urban communities compared to rural communities would be beneficial as well.
- **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. Understanding the circumstances where hospital acquisition of independent practices may support access to care in underserved areas while exploring ways to help independent providers remain independent when appropriate would be beneficial.
- **Employer Engagement:** Despite the prominence of facility fees, employer representatives may not be fully engaged in the issue. Employers are among the largest purchasers of health care services 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.

Appendix A. Hospital Facility Fee Steering Committee Members

- [Isabel Cruz](#), Policy Director, Colorado Consumer Health Initiative, representing a health care consumer advocacy organization
- [Diane Kruse](#), Health Care Consumer, representing a consumer of health care
- [Dr. Omar Mubarak](#), Managing Partner, Vascular Institute of the Rockies, representing health care providers not affiliated with or owned by a hospital or health system or who has independent physician billing expertise
- [Dan Rieber](#), Chief Financial Officer, University of Colorado Hospital Authority, representing a statewide association of hospitals
- [Bettina Schneider](#), Chief Financial Officer, Department of Health Care Policy and Financing, designee of the Executive Director of the Department of Health Care Policy and Financing
- [Kevin Stansbury](#), Chief Executive Officer, Lincoln Community Hospital, representing a rural, critical access, or independent hospital
- [Karlee Tebbutt](#), Regional Director, America's Health Insurance, representing a health care payer

Appendix X. Glossary of Terms

Ambulatory care - Ambulatory care refers to medical services performed on an outpatient basis without admission to a hospital or other facility. It is provided in settings such as dialysis clinics, ambulatory surgical centers, hospital outpatient departments, and physicians' offices and other health professionals.

Campus - A hospital's main buildings; the physical area immediately adjacent to a hospital's main buildings and structures owned by the hospital that are not strictly contiguous to the main building but are located within 250 yards of the main building; or any other area that the federal Centers for Medicare and Medicaid Services (CMS) has determined, on an individual-case basis, to be part of a hospital's campus.

Centers for Medicare and Medicaid Services (CMS) - A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare, Medicaid, and Children's Health Insurance Programs and the federally facilitated Marketplace.

CMS 1500 (aka HCFA 1500) - The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.

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

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

Co-payment or co-pay - A fixed amount for a covered service, paid by a patient to the provider of service before receiving the service. The amount can vary by the type of covered healthcare service and is a standard part of many health insurance plans. Insurance companies often charge copays for things such as doctor visits or prescription drugs. (HCG)

Critical access hospital (CAH) - a CMS designation for hospitals that meet the following requirements:

- Be designated by the State as a CAH;
- Be located in a rural area or an area that is treated as rural;
- Be located either more than 35-miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified as a CAH based on State designation as a “necessary provider” of health care services to residents in the area. • Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services;
- Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units);
- Demonstrate compliance with the CAH CoPs found at 42 CFR Part 485 subpart F; and
- Furnish 24-hour emergency care services 7 days a week;

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

Deductible - Health care expenses the beneficiary must pay before insurance applies.

Emergency Department (ED) - A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

Evaluation and Management (E&M) - Services by a physician (or other health care professional) in which the provider evaluates or manages a patient's health.

Facility fees - Any fee a hospital or health system charges or 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 (From HB23-1215)

Grouper - In the context of healthcare revenue cycle management, a grouper refers to a software tool or algorithm used to assign diagnosis-related groups (DRGs) or other

grouping methodologies to patient encounters or claims. The primary purpose of a grouper is to categorize patients into specific groups based on their diagnoses, procedures, and other relevant factors. This grouping process is crucial for accurate reimbursement, as it helps determine the appropriate payment amount for healthcare services provided.

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

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

High-acuity services - Services provided to a high-acuity patient, which is a patient who is severely ill.

Horizontal integration - Horizontal integration occurs when two or more like providers, such as two hospitals, join forces.

Hospital - “General hospital” means a health facility that, under an organized medical staff, offers and provides inpatient services, emergency medical and emergency surgical care, continuous nursing services, and necessary ancillary services to individuals for the diagnosis or treatment of injury, illness, pregnancy, or disability, twenty-four (24) hours per day, seven (7) days per week.

- A. A general hospital may offer and provide, but is not limited to, outpatient, preventive, therapeutic, surgical, diagnostic, rehabilitative, or any other supportive services for periods of less than twenty-four (24) hours per day.
- B. Services provided by a general hospital may be provided directly or by contractual agreement. Direct inpatient services shall be provided on the licensed premises of the general hospital.
- C. A general hospital may provide services on its campus and on off-campus locations.
- D. Non-direct care services (such as billing functions) necessary for the successful operation of the hospital that are not on the hospital campus may be incorporated under the license.

ICD-10-CM Code - Stands for the International Classification of Diseases, Tenth Revision (ICD-10), a standardized coding system used to classify all diagnoses.

Diagnosis codes are required on a medical claim to determine whether the patient's diagnosis(es) are medically necessary to justify the services received. (HCG)

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

Inpatient hospital services - Subject to the conditions, limitations, and exceptions set forth in this subpart, the term "inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

- Bed and board
- Nursing services and other related services
- Use of hospital or CAH facilities
- Medical social services
- Drugs, biologicals, supplies, appliances, and equipment
- Certain other diagnostic or therapeutic services
- Medical or surgical services provided by certain interns or residents-in-training
- Transportation services, including transport by ambulance

Modifier - A two-character alphanumeric value appended to a CPT or HCPCS code to provide additional information about the medical procedure, service, or supply without changing the meaning of the code. Modifiers provide a mechanism to communicate special or specific circumstances related to the performance of a procedure or service. (HCG)

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

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

Off-Campus Location - A facility that meets all of the following criteria: (A) Whose operations are directly or indirectly owned or controlled by, in whole or in part, or affiliated with a hospital, regardless of whether the operations are under the same governing body as the hospital; (B) That is located more than two hundred fifty (250) yards from the hospital's main campus; (C) That provides services that are organizationally and functionally integrated with the hospital; (D) That is an

outpatient facility providing preventative, diagnostic, treatment, or emergency services; and (E) That is not otherwise subject to regulation under 6 CCR 1011-1.

Off-Campus Hospital Services - These are services provided by a hospital entity that are not on campus. Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Outpatient hospital services - Medical or surgical care that does not include an overnight hospital stay. Medical or surgical care received from a clinic or hospital but not admitted as an inpatient. Outpatient care may include emergency department services, observation services, outpatient surgery, lab tests or X-rays.

Outpatient Prospective Payment System (OPPS) - The system for payment used by CMS to reimburse for hospital outpatient services. All items and services paid for under the OPPS are assigned a payment group called Ambulatory Payment Classification (APCs) which group together items and services that are similar clinically and in terms of resource use. (HCG)

Owned by - Owned by a hospital or health system when billed under the hospital's tax identification number.

Cost sharing - The portion of a medical bill that patient needs to pay to cover their treatment costs. This may come in the form of co-pays, co-insurance or deductibles. Sometimes referred to as out-of-pocket.

Payer mix - Payer Mix is a term used in healthcare revenue cycle management to describe the percentage of patients who are covered by different types of payers, such as commercial insurance, Medicare, Medicaid, and self-pay. Payer Mix is calculated by determining the percentage of revenue generated by each payer type. (MDclarity.com)

Payer type - Commercial insurers; Medicare; the Medical Assistance Program established pursuant to Articles 4 to 6 of Title 25.5; Individuals who self-pay; a financial assistance plan; or the "Colorado Indigent Care Program," established in Part 1 of Article 3 of Title 25.5.

Place of Service Codes (POS) - A two-digit code placed on a 1500 claim form to indicate the setting in which the professional healthcare services were provided. The Centers for Medicare and Medicaid Services (CMS) maintains the standardized POS codes used throughout the healthcare industry. (HCG)

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

Professional fee - Charges health care professionals, including physicians, nurse practitioners, physician assistants, and physical therapists, to bill for their services. Any claim submitted using the HIPAA-mandated transaction ASC X12 837 professional claim or the CMS-1500 paper claim form.

Prospective Payment System (PPS) - A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation services, long-term care hospitals, and skilled nursing facilities. (HCG)

Provider-based - Provider-based means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility that complies with the provisions of 42 CFR § 413.65.

Revenue Code - A 4-digit code (including a leading zero) that indicates the type or location of the service or item the patient received. Standard revenue codes are used to group similar types of charges together. For example, Rev Code 0450 is used for Emergency Room (ER) services. Revenue Codes are mandatory for hospital billing and are paired with procedure codes. (HCG)

Rural hospital - Rural hospitals are those hospitals not located within a metropolitan area as defined by the U.S. Office and Management and Budget and the U.S. Census Bureau. The Census does not define “rural.” They consider “rural” to include all people, housing, and territory that are not within an urban area. Any area that is not urban is rural. The Census defines urban as: Urbanized Areas (UAs) of 50,000 or more people and Urban Clusters (UCs) of 2,500 - 49,999 people.

Sole Community Hospital - CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals or it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:

1. The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:
 - i. No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;
 - ii. The hospital has fewer than 50 beds, and the MAC certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or
 - iii. Because of local topography or periods of prolonged severe weather conditions, other facilities, such as hospitals, are inaccessible for at least 30 days in each two out of three years.
2. The hospital is located between 15 and 25 miles from other hospitals, but because of local topography or periods of prolonged severe weather conditions, the other hospitals are inaccessible for at least 30 days each 2 out of 3 years.
3. Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest hospital is at least 45 minutes.
4. For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, combined data from the main campus and its remote location(s) are required to demonstrate that the criteria specified in paragraphs (a)(1)(i) and (ii) of this section are met. For the mileage and rural location criteria in paragraph (a) of this section and the mileage, accessibility, and travel time criteria specified in paragraphs (a)(1) through (3) of this section, the hospital must demonstrate that the main campus and its remote location(s) each independently satisfy those requirements.

Technical component - Another term for facility fees.

Vertical integration - Vertical integration refers to the integration of providers at different points along the continuum of care, such as a hospital partnering with a skilled nursing facility (SNF) or a physician group.

UB-04 (aka CMS/HCFA 1450) - The uniform medical billing form (or UB for short) is the standard claim form used by institutional providers to bill insurers for services rendered. Examples of institutional providers include hospitals, outpatient physical therapy services, skilled nursing facilities (SNF), and hospices. (HCG). The same information is conveyed via the HIPAA X12 837I electronic claims transaction.

HCG = Haugen Consulting Group

CMS glossary available at <https://www.cms.gov/glossary>

Appendix C. Data Sources and Caveats

The primary data source for this report is the All Payers Claims Database (APCD). In addition to the APCD, surveys and supplemental data were required or requested.

Consideration was made before making additional requests for information to adhere to 25.5-4-216(9), which directs the Steering Committee to exhaust existing data sources before making additional requests and minimize the number of requests. As directed by the legislation, some analyses were completed using existing data from credible sources already subject to rigorous reporting and auditing standards. These sources include Medicaid caseload and expenditure data reported to the Joint Budget Committee pursuant to HCPF's FY 2024-25 Legislative Request For Information #1 and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Annual Report to the Joint Budget Committee and Senate and House Health and Human Services Committees.

The following section satisfies 25.5-4-216(9)'s direction to "include a description of which entities were contacted for information and the outcome of each request."

All Payers Claims Database

The Colorado All Payer Claims Database (APCD) provided by the Center for Improving Value in Healthcare (CIVHC) was utilized for the analytics requested. The data provided was for calendar years 2017 to 2022. The APCD contains claim level data from Medicare, Medicaid, and Commercial payers within the State of Colorado. The report focused on the Medicare and Commercial payers for hospital outpatient claims and professional claims. Benchmarks for Medicare membership volume from the Centers for Medicare and Medicaid (CMS) show that APCD includes about 98% of total Medicare members, which includes both Medicare Advantage and Medicare FFS. Benchmarks from CIVHC indicate that about 75% of Commercial members are reflected in the APCD. Additional notes on data caveats and limitations are provided in sections below.

Surveys & Supplemental Data

In addition to the APCD, the report's research and analysis have been guided and supplemented by survey data from hospitals, health systems, independent practitioners, supplementary datasets from the Colorado Hospital Association, and responses from employer and commercial payer representatives.

Survey

The legislation specifies information to be obtained from these specific groups:

- [25.5-4-216\(6\)\(b\) - Hospital & Health System Survey](#)
- [25.5-4-216\(6\)\(c\) - Commercial Payers Survey](#)
- [25.5-4-216\(6\)\(d\) - Independent Health-Care Providers Not Affiliated with or Owned by a Hospital or Health System Survey](#)

HCPF used online survey software to facilitate the surveys.

The statute provides specificity, but some ambiguity needed clarification before surveys were launched. HCPF consulted the Steering Committee during the Jan. 9, 2024, meeting for steerage in the data collection questions.

The resulting surveys are available at:

- [Hospitals and Health Systems Survey Link](#)
- [Independent Providers Survey Link](#)
- [Insurance Carriers Survey Link](#)

The survey and supplemental data were used to verify and understand APCD data, the state's comprehensive source of health care spending information.

The Methodology section of this report includes more information on how survey data was transformed and utilized.

Hospital

On Feb. 29, 2024, HCPF emailed a survey link and instructions to HCPF's list of Chief Financial Officers and known support staff for hospitals, health systems, and the Colorado Hospital Association. Before release, HCPF shared the survey for feedback with the Colorado Hospital Association and asked for assistance in distribution. The initial due date was March 15, 2024.

HCPF received responses from 60 of the 84 hospitals.

- 34 respondents were from health systems and offered nearly complete data submissions.
- Although the AdventHealth health system representatives indicated there would be a submission, HCPF never received a survey submission.
- Hospitals faced major challenges in accessing older data.

To improve data submissions, HCPF worked with hospital representatives selectively.

HCPF organized and shared data with supporting consultants and actuaries for consideration as they performed their analyses.

Commercial Payer

On March 11, 2024, HCPF emailed a survey link and instructions to 19 carrier representatives and organizations, including United Healthcare, Anthem, Elevance Health, Kaiser Permanente, Cigna, CVS Health, Aetna, Colorado Association of Health Plans, and the State of Colorado. The survey requested a due date of March 22, 2024.

Soon after the survey was released, the Colorado Association of Health Plans asked HCPF questions. On March 20, 2024, HCPF received an email response from the Colorado Association of Health Plans expressing their concerns about sensitive information, the complexity of the request, and the timeline for the request. Information was exchanged between the organizations until April 6, 2024.

No carrier representatives or organizations completed the survey.

On April 8, 2024, HCPF received a narrative response from the Colorado Association of Health Plans emphasizing using the APCD dataset. The response included some excerpts from their members' facility fee payment guidelines.

At the April 9, 2024, Steering Committee meeting, the carrier representative requested HCPF utilize the APCD and contact specific carrier representatives as needed to answer questions about the data within the APCD, specifically the billing guidelines.

HCPF representatives contacted carrier organization representatives to clarify billing practices and reported and shared information with HCPF and actuarial consultants.

Independent Health-Care Provider

On Feb. 29, 2024, HCPF sent a survey link and instructions to representatives at the Colorado Academy of Family Physicians and the Colorado Medical Society with a requested due date of March 15, 2024. After a low response rate, HCPF contacted the Colorado Medical Society to have the survey distributed in their monthly newsletter.

As of June 28, 2024, 24 completed responses exist, which is not an appropriate sample size for generalized observations on independent health-care providers.

Despite the low response rate, the providers shared valuable information, bringing anecdotal perspectives to the report.

Although the sample size was too small to make inferences about all independent health-care providers in Colorado, the following insights were gleaned:

- These independent providers suggest that facility fees:
 - Drive up health care costs,
 - Decrease or complicate patient access to care because of the cost of care, specifically mentioning the impact of high deductible plans,
 - Decrease quality of care and care coordination,
- Because hospital outpatient services are paid higher through facility fees, these providers have trouble competing, particularly in staff recruitment.

These providers have challenges negotiating rates to cover their practice's expenses. Many respondents state their commercial carrier contracts are "take it or leave it," they are under-reimbursed for their costs, and that facility fees are unfair. Some provider respondents respond to these challenges by shifting to the direct primary care model of serving patients, by joining accountable care organizations, and through participation in value-based programs.^{1,2,3}

Complete responses to the survey questions are available in spreadsheet format at the following link: [Independent Health-Care Provider Information](#).

Supplementary Datasets

Third Party Affiliation Dataset

HCPF procured a third party dataset from 2017 through 2022 to identify individual providers affiliated with hospitals and health systems at the time of the claim.

Colorado Hospital Association

On Feb. 26, 2024, the Colorado Hospital Association agreed to provide the top 100 billing codes based on the number of records and charges to provide an industry-wide perspective. The association delivered two files on March 15, 2024. After reviewing the dataset in analytical software, HCPF sent an email with questions for the association on March 25, 2024, and the association responded on April 11, 2024.

HCPF organized and shared data with respective parties.

Division of Insurance

HCPF emailed a Division of Insurance representative on Jan. 23, 2024, regarding data collection from or through the agency. The two agencies met to discuss on Feb. 26, 2024. The Division of Insurance informed HCPF that relationships with commercial payers were strained from perceived over-collection of data, that the division has no unique dataset to share with HCPF, and that the carriers believe the APCD is the comprehensive dataset to utilize for claims information. HCPF informed the Division of Insurance that the survey was still essential to the report because of the non-claims billing policy inquiries for the report and asked for the division's assistance in

¹ Direct primary care is a no insurance, subscription-based model of being a primary care practice.

² [Accountable Care and Accountable Care Organizations | Centers for Medicare & Medicaid Services](#)

³ [Value Based Payments | Colorado Department of Health Care Policy & Financing](#)

reviewing survey language and distribution. This discussion resulted in HCPF delaying the commercial payer survey release so that the survey language could be edited.

Health Care Policy & Financing

HCPF has used Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) data to estimate and evaluate the impact on this enterprise.

HCPF analysts have downloaded and joined tables to create datasets similar to those from publicly available resources such as the National Plan and Provider Enumeration System National Provider Identifier registry and Medicare Cost Reports.

Per the direction of the Steering Committee, HCPF has utilized other publicly available literature and datasets, cited directly within the report.

Stakeholder Response

Colorado Hospital Association and Hospital Representatives

On March 12, 2024, the Colorado Hospital Association shared a document titled [CHA Facility Fees White Paper](#) with the Steering Committee, HCPF staff, and contracted consultants.

Steering Committee member Kevin Stansbury, MS, JD, FACHE shared a document titled [Analysis: Hospitals and Health Systems Are Critical to Preserving Access to Care for Rural Communities](#).

Employers

At the April 9, 2024, Steering Committee meeting, a committee member directed HCPF to devise a plan to capture the employer perspective to satisfy 25.5-4-216(5)(e) of the statute. HCPF contacted 11 Chamber of Commerce and Employer Advocacy Organizations with an invitation to share insights from the employer's perspective along with a short explanation of facility fees. The email included six questions to respond to or use in preparation for a semi-formal interview. HCPF received one written response from a chamber and a request for a virtual meeting. Here is [documentation of the response and interview](#).

At the May 14, 2024, Steering Committee meeting, a committee member suggested contacting the state of Colorado's employee benefits administration representatives. HCPF met with the Director of Employee Benefits Contracts at the state's Division of Human Resources on May 28, 2024. Here is [documentation of the interview](#).

Independent Health-Care Providers

On Jan. 18, 2024, the Colorado Academy of Family Physicians shared a letter with feedback on the data request and definitions. [This document](#) was shared with the Steering Committee members on Jan 23, 2024.

Consumers

On April 8, 2024, a group of Colorado health care consumers negatively impacted by facility fees following the Steering Committee's work shared a letter with HCPF. [This document](#) was shared with the Steering Committee members on April 9, 2024.

Limitations & Caveats

APCD

The APCD data has the following limitations and caveats:

Commercial Data Volume

- Optumas also received benchmarks from CIVHC that estimate they have about 74% of all Commercial covered lives within the APCD. Programs that are not included in the data are listed as follows:
 - Uninsured patients and self-pay claims
 - Self-insured employers
 - Veterans Affairs (VA)
 - Tricare
 - Worker’s compensation
 - Medical coverage paid for by a property & casualty insurance company
 - Example - a person has a car accident, and medical bills are paid for by car insurance company

Place of service

- Place of service codes were sparsely populated for hospital outpatient facility claims. This was confirmed by CIVHC that those values are not required to be reported within the APCD. The result was limited ability to identify off-campus facilities for Commercial payers. Alternative methods were available for Medicare that were applied to complete off-campus analytics for that program.

Denials

- Denied claims were not provided if the entire visit was denied by the health plan. This is a data limitation of the APCD as those claims are not required to be submitted as part of the APCD. However, information on partial denials was available. This would involve cases where some services were approved for an individual visit while others were denied.

Survey & Supplementary Data

The report’s statute provides a detailed description of specific expectations of data provided to the Steering Committee, and ambiguities were discussed with the Steering Committee before data was requested.

The Colorado Hospital Association’s supplementary dataset is most comprehensive for 2019 through 2022. Each year of data includes over 60% of hospital outpatient facility fee records and charges billed by billing code. 2017 and 2018 are missing data, and CHA estimates represent 54% and 75% of billing codes, respectively.

Hospitals had challenges with 2017 and 2018 data as well, and hospital and health system surveys were missing that information.

Data sourced from the survey was utilized as needed for analysis and reporting purposes. Despite missing data, the data assisted in confirming and understanding the APCD for the analysis.

As described above, the independent provider survey response rate will only bring person-level perspectives because of the low number and provider types who responded.

Appendix D. Analysis Methods and Limitations

All Payers Claims Database

Outpatient visits can be split into two bills, one for the individual professional's fees, as applicable, and one for the hospital outpatient department (HOPD) facility fee(s) that is intended to compensate the hospital or health system for its operational expenses based on the service(s) provided during the visit. These two bills generate two individual claims, each of which uses their own claim form. The HOPD facility fees are billed on a UB-04 claim form, and professional services are billed using a HCFA-1500 claim form. The result is that the professional fees are on a separate and distinct claim within the dataset, and the HOPD facility fees can be identified independently from the professional fees in most cases. These billing policies were found to be applicable to Medicare, Medicare Advantage, and Commercial. Those payer types were therefore the focus of the analytics within this report.

It should also be noted that not every outpatient visit results in a professional fee and HOPD facility fee. The HOPD facility fee claims identified for reporting were inclusive of all instances of a HOPD facility fee, regardless of the presence of a professional fee for that visit.

The following discusses the identification of the HOPD facility fee portion of the overall outpatient visit.

First, all outpatient related claims for Colorado based-providers were identified in the APCD using a delineation provided by CIVHC. That was validated by reviewing the bill type provided on each claim to confirm they were appropriately identified. Bill type is a nationally standardized set of codes for institutional/facility-based services that provides information on the type of bill the provider is submitting to the payer. We subsetted the data for this comparison to claims that had the following Bill Type to ensure isolation to HOPD claims:

- "131" - Hospital, outpatient, admit through discharge.
- "851" - Critical Access Hospital, outpatient, admit through discharge.

Additionally, the data was limited to non-Emergency Room outpatient claims within the APCD. After discussion with the Hospital Facility Fee Steering Committee, it was determined to exclude all Emergency Room claims from the analytics. The emergency room visits were identified using revenue codes, specifically revenue codes 450-459, which an emergency department will include on the claim to indicate the use of emergency department services. This data set served as the final HOPD data set for identifying the facility fees for Colorado based providers.

Medicare Billing: G0463

Medicare billing research indicated that the federal agency that oversees Medicare, the Centers for Medicare and Medicaid Services (CMS), provided billing guidelines that instructs prospective payment system (PPS) hospitals to report facility resources for HOPD visits using the CPT code G0463 for an in-person visit or Q3014 for a telehealth

visit.¹²³ This CPT code would be billed in addition to the other services provided as part of the outpatient visit, and would be a subset of the overall HOPD facility fee. The Medicare facility fee codes are also separate and distinct from the professional fee(s) billed by the physician during the visit.⁴ These codes were identified within the APCD for the Medicare HOPD data for the PPS hospitals as part of the analytics.

CMS also provided instructions for non-PPS hospitals, which are primarily Critical Access Hospitals (CAH), that they may either use those two codes for billing facility fees, or to bill for facility fees using evaluation and management (E&M) codes.⁵ The APCD was reviewed for CAH HOPD visits and found that some facilities did use the G0463 for billing facility fees while others continued to use E&M codes as part of the overall facility fee.

Hospital/Health System Identification

To identify the specific hospitals providing the HOPD services within the claims data, Optumas utilized a public dataset from CMS, which contains the hospitals' business names cross-walked to the hospitals' billing National Provider Identifier (NPI). To identify the health system the hospitals are associated with, Optumas utilized a secondary dataset provided by HCPF which contains the hospitals and their associated health systems based on the hospitals' billing NPIs.

Off-Campus

On-campus and off-campus analytics were also requested within the statute. Generally off-campus visits can be identified using a place of service code on the claim, specifically code '19'. While the place of service field is provided in the data, unfortunately there is a data limitation due to it not being well populated for facility-related claims within the APCD. The following alternative approaches were explored by payer type. The results are that an alternative option was identified for Medicare, however; the off-campus clinic visits were not able to be delineated within the Commercial data.

Medicare

Medicare requires that off-campus clinics include specific modifiers - PN, PO, ER - on the claim form along with the Current Procedural Terminology (CPT) code that identifies the service that is provided.

- PO - Excepted service provided at an off-campus, outpatient, provider-based department of a hospital.
- PN - Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital.

¹ [Federal Register :: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records \(EHR\) Incentive Program; Provider Reimbursement Determinations and Appeals](#)

² [CMS Transmittal 2845](#)

³ [CMS Manual System - Pub 100-04 Medicare Claims Processing](#)

⁴ [Federal Register :: Office of Inspector General; Medicare Program; Prospective Payment System for Hospital Outpatient Services](#)

⁵ [Clarification of Clinic Billing for Critical Access Hospitals - Baker Newman Noyes](#)

- ER - Items and services furnished by a provider-based off-campus emergency department. This modifier was ultimately not used given that emergency department visits are excluded from the analysis.

Using this information, we identified any instance of either PN or PO modifier on any individual line on a claim. We then identified that entire claim as a HOPD off-campus visit. This approach identified \$60M to \$90M per year in the Medicare data.

Commercial

Commercial billing and payment policies differ from Medicare related to off-campus HOPD billing, and do not require the inclusion of specific modifiers be documented for off-campus payments. Therefore, this approach was not able to be leveraged for Commercial data.

We reviewed an additional method for tracking down the off-campus locations by NPI based on the off-campus clinic NPIs provided via the hospital provider surveys. Despite multiple attempts, data was not available for off-campus vs. on-campus for commercial claims.

There are two provider NPI fields in the APCD:

Billing NPI - this generally reflected the hospital/hospital system that owns the off-campus clinic, and did not get any significant matches to the individual off-campus NPIs that were provided via the hospital provider surveys.

Servicing NPI -this generally reflected the individual physician that was present during the service, and again did not get any significant matches to the individual off-campus NPIs that were provided via the hospital provider surveys.

Given the above, we are limited in using any NPIs from the Medicare off-campus data as those would also flag either the main hospital/hospital system or an individual physician, and not necessarily the specific off-campus clinic.

As a final potential option, we looked at using the Place of Service that was on the professional fee claim component of an outpatient visits, and aligning that with the HOPD facility fee claim.

We limited the professional claims to a Place of Service of '19' (Off-campus clinic), and then looked for any HOPD claims for the same member and date of service.

This approach did result in some data being flagged as off-campus, but it was a much smaller amount than observed in Medicare.

The result is a limited off-campus APCD dataset that may not be credible for accurate analytics.

In-Network (INN) vs. Out-of-Network (OON)

The APCD includes a data field that indicates whether a claim was for an in-network or out-of-network provider. This field was used to identify if the facility fee was for in-network or out of network. In general this field was well populated, but in the instances when it was either blank or unknown, we assumed those claims would be in network. This would be especially true for the Medicare FFS data, as Medicare FFS would generally only pay for in network claims.

Professional Fees

The professional claims to be used for the requested comparison analytics in the statute were also delineated within the APCD by CIVHC for Colorado based-providers. That delineation was validated by reviewing the Place of Service (POS) provided on each claim to confirm they were appropriately identified. We found that the POS were all generally related to a freestanding physician office, however; we further delineated that data for this comparison to claims that had the following POS codes:

- 11 - Office
- 12 - Home
- 81 - Independent Laboratory

Other POS codes were found that identified the professional fee component of an outpatient visit. These were excluded so that the comparison focused on the professional fees provided during a patient visit that was independent of an HOPD visit. This final professional data set services as the basis for identifying the professional fees for Colorado based providers.

Independent/Affiliated Providers

To identify independent and hospital-affiliated providers, we leveraged an additional third party dataset for the same 2017 to 2022 time period. This data set provides information on each individual provider and if they are affiliated with a hospital or health system for each year, including which health system they are affiliated with at that time. This information was aligned with the APCD by the servicing provider NPI, which identifies the individual practitioner present for the visit. The dataset includes physicians that are either Medical Doctors (MDs) or Doctors of Osteopathy (DOs).

Comparison Methodology and Analytics

The comparison of the facility fee and professional fees for the same services is based on using the allowed amount in APCD for the datasets and provider splits identified above. The comparison focuses on the same service provided in either a HOPD setting or a professional setting. It should be noted that the professional fees in this comparison are for services provided in a professional setting only, and do not reflect the professional fee component of an outpatient visit. The allowed amount reflects the contracted rate between the provider and payer, and reflects the total reimbursement for the services provided. The following identifies additional data adjustments and methodology for the comparison.

Grouped Payments

We are aware that some HOPD visits are paid on a grouped basis, which means that all services provided during a visit are grouped together into one overall payment. The result is that the allowed amount listed on a claim for an individual CPT code may not reflect the payment for that individual service, but rather for the entire visits as a whole which may include other services. Inclusion of these grouped payments would skew the HOPD cost per service upward for those individual codes, and would not be appropriate for the comparison. We identified these instances by comparing the overall allowed amount for a visit to the individual allowed amount for each service

(CPT code) during a visit. In the instances where they were the same amount, we removed those from the data prior to performing the comparison analysis.

Zero (\$0) Allowed Amount

If a service (CPT code) had a \$0 allowed amount, in either the HOPD or Professional data, it was excluded from the analysis to avoid skewing the cost per service downward. Excluding services with \$0 allowed amount limits the scope of our analysis to services for which facility fees are charged, but we recognize that some hospitals and health systems may not charge facility fees for certain services or at all.

Modifiers

The comparison is based on the CPT codes that identify each individual service provided during a visit in the claims data, however; we understand that there are also modifiers that can be associated with a CPT code that may further modify the allowed amount for that service. For this comparison, we included any instances of either modifier TC (Technical Component) or 26 (Professional Component) along with the CPT code to ensure that variation driven by these modifiers was controlled for in the calculation of the allowed amount per service comparison.

Allowed per Service

The comparison is done at the individual CPT code level based on the allowed amount per service. The allowed amount per service is based on the allowed amount for each CPT code relative to the detailed units of that individual service that was provided as reported on the claim in APCD. The service units itemize the number of units associated with each individual CPT code (service provided), which indicates how much to reimburse the provider for that service. the majority of cases, the detailed units are one (1) based on providing one instance of that individual service, but in some cases may be greater than one (1) depending on the type of service provided and the billing guidelines for that service. This approach ensures that we are accounting and controlling for those instances for an accurate comparison when calculating the allowed amount per service.

Outliers

Once the above data adjustments were taken into account, the allowed amount per service was reviewed for any outliers. This was done for each unique combination of the following:

- Payer
 - Commercial
 - Medicare
 - Medicare Advantage
- CPT/modifier combination
- For each of the three comparison groups:
 - HOPD
 - Professional affiliated
 - Professional independent

The result allowed us to isolate and remove the top 5% of the allowed amount per service for each of the combinations above. This was done to remove any data anomalies or outlier contracting agreements that could further skew the comparison.

Weighted Average

After outliers were removed, we calculated the average allowed amount per service for each of the unique combinations noted above. The approach reflects the weighted average of the allowed amount per service based on the utilization of each code within the APCD. We also reviewed the use of the median allowed amount per service, which returned similar results for higher utilized services, but had more variability for lower utilized services included in the comparison. The result was the selection of the utilization weighted average allowed amount per service.

Final Code Selection for Comparison

In order to ensure an informative comparison, an initial selection of the top 50 codes were selected based on highest frequency of utilization and also highest allowed amount within the HOPD data between each payer. The result is a list of codes that reflects highly utilized services, along with services that may have lower overall utilization but that reflect a higher proportion of expenses due to the higher cost nature of those services. The list excludes injectable drugs (J-series codes) due to the additional complexity around the pricing of those pharmaceutical related codes.

We then looked for those top HOPD codes within the Professional data, and only included the codes that were in both datasets for the final comparison. Additionally, we set a minimum limit of at least twenty-five (25) individual instances of each code within the either dataset to account for credibility and stability of the contracted amount for those codes. The final list was limited to the top 25 codes that were found in both datasets, by payer, that also met the minimum utilization threshold.

Survey and Supplemental Data

As described in the Data Sources and Caveats section of this report, several additional data sources were pursued for this report. Although not all data requests were generative, what was collected was critical. Billing practices were essential in understanding whether the APCD analysis could utilize a code or identifier for a unique subcomponent of a claim. Hospital and health system data was used to understand and validate APCD findings. Below is a description of how these datasets were transformed and utilized.

HCPF representatives downloaded hospital survey submissions and shared the files with contracted actuaries. HCPF organized the submissions into 3 data sources: affiliated providers, billing policies, and data submissions that include record counts and charges in aggregate and by top CPT codes. HCPF reviewed the dataset using analytical software to ensure its useability and explore distinctions with the APCD analysis. For example:

- Outlier situations like those of certain injectable drugs within the APCD were confirmed at a total gross charges level. Particularly seen in Children's Hospital Colorado, these injections resulted in millions of charges per CPT billed.

- The UHealth health system provided net patient revenue and gross charges in its survey submission, which was helpful in understanding the relationship between gross charges and net revenue.

Because the Colorado Hospital Association provided the percentage of their dataset represented by the total charges and total CPT records (between 45% and 64%), HCPF could calculate total CPT records and total gross charges. The Colorado Hospital Association's top coding is available in [Colorado Hospital Association Top Count of CPTs Billed](#) and [Colorado Hospital Association Top Gross Charges](#).

HCPF representatives downloaded the independent health care provider surveys and reviewed each response to find commonalities. Responses to the survey questions are available in spreadsheet format at the following link: [Independent Health-Care Provider Information](#).

Appendix E. Stakeholder Perspectives

Private Practice Physician Perspective

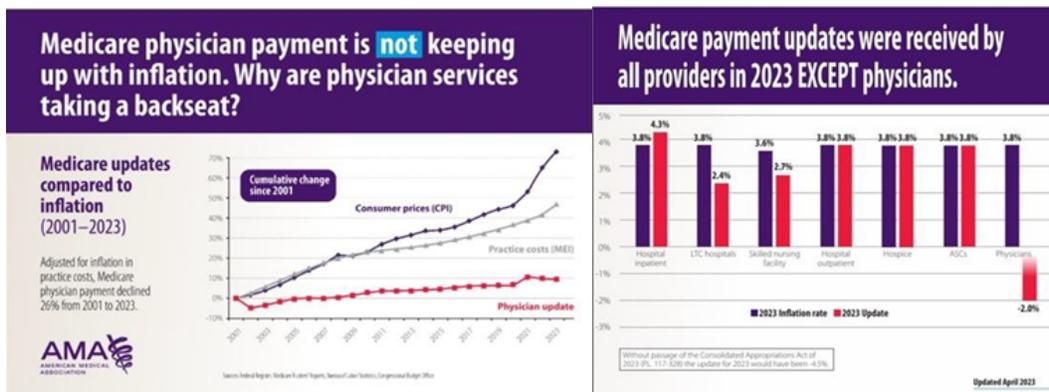
Definitions:

- Professional fee: The billing associated with services provided by individual healthcare providers, i.e. physicians and non-hospital-based practitioners. Professional fees do not account for overhead involved with a clinic.
- Facility fee: Expenses charged by hospitals to cover their overhead. People who receive outpatient care at hospital owned buildings are charged a facility fee, in addition to treatment costs and fees charged individually by doctors. Hospitals do not have to disclose the cost of facility fees in advance of the service and patients are often shocked when they receive a bill that is much higher than expected. There are two main ways patients face facility fees: outpatient treatment at an emergency room or at a hospital-owned doctor's office.

Problem statement:

Medicare sets fee schedules by adjusting a conversion factor per CPT (current procedural terminology) code. Over the past two decades professional fees have stagnated or declined. At the same time the cost of maintaining a private practice clinic (i.e. personnel and equipment) have risen with inflation. The Centers for Medicare and Medicaid Services has made positive updates for hospitals, nursing facilities, hospice care and ambulatory surgery centers - **everyone except physicians**. Hospitals lobby to influence annual changes to their favor. Lobbying is expensive and hospitals have a greater financial advantage than private practices.

Two alarming charts show the degree physicians are being squeezed by the current payment model.



This flawed payment model has led to the demise of private practice over time. According to a report from the American Medical Association (AMA), “the number of

physicians working in private practice decreased 13% from 60.1% to 46.7% between 2012-2022; many of these physicians are opting to join large health systems, private equity groups, or employed settings.”

At this point many physicians who remain in private practice are often in niche practices that have also found the ability to garner facility fees to survive. The specialties would include orthopedic, gastroenterology (GI), rheumatology, cardiovascular, otolaryngology (ENT), and dermatology, all of whom perform procedures outside of the hospital systems in office settings. Often the same procedure in the hospital setting is reimbursed more than in the outpatient setting. Further fees charged in a Hospital Outpatient Department (HOPD) are often more costly than the same procedure billed in a private practice setting. Medicare fee schedules from most to least expensive: Hospital>Hospital Outpatient Department (HOPD)>Ambulatory Surgical Center (ASC)>Office Based Lab (OBL).

Solution statement:

The competitive disadvantage of private physician practices has negative effects on the larger system. I believe measures that would increase the viability of private practice in Colorado will decrease costs and ensure quality. I urge the state government to take steps to support private practice.

Health Care Payer Perspective

Hospital facility fees have emerged as a significant driver of rising health care costs, imposing financial burdens on patients, employers, and commercial and government payers. Hospitals have been billing facility fees since at least 2000,¹ with facility fees only becoming more common as hospitals acquire more physician practices.² Over the next decade, facility fees are expected to cost patients \$70 billion.³ Policies that restrict hospitals' use of facility fees for those with private health insurance could save patients an estimated \$73 billion in cost-sharing over a decade, reduce premiums by \$386 billion, and save taxpayers \$117 billion.⁴

Hospital business strategies are leading to higher health care prices, without commensurate improvements to patient care.⁵ Hospitals have consolidated tremendously over the past 30 years,⁶ increasingly acquiring doctors' offices. Nearly 70% of U.S. physicians were employed by hospitals or other corporate entities in 2021.⁷ Hospitals have an economic incentive to purchase physician offices and convert them to HOPDs to capture higher payments through facility fees, even though there are often no changes to the physical location, services provided, acuity of patients seen,⁸ or improved health outcomes.⁹ On average, payment for ambulatory services was 145% higher in a HOPD than in a physician office and patient out-of-pocket spending was 109% higher.¹⁰ In addition to higher costs at the point of care, hospital

¹ [Hospital 'facility fees boosting medical bills, and not just for hospital care](#), The Center for Public Integrity, December 2012; [Same Service, Same Price: Tackling Hospitals' Add-On Facility Fees](#), Third Way, March 2024.

² [Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform](#), U.S. Government Accountability Office, December 2015; [Cost Trends Report](#), Massachusetts Health Policy Commission, February 2019; [What We Know About Provider Consolidation](#), Kaiser Family Foundation, September 2020.

³ [Same Service, Same Price: Tackling Hospitals' Add-On Facility Fees](#), Third Way, March 2024.

⁴ [Moving to Site Neutrality in Commercial Insurance Payments](#), Committee for a Responsible Federal Budget, February 2023.

⁵ [Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality](#), Sage Journals, August 2017.

⁶ AHIP, [Hospital Acquisition of Physician Practices Drives up Cost](#), August 2021.

⁷ Physicians Advocacy Institute, [COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020](#), June 2021.

⁸ [Hospital Pricing Following Integration with Physician Practices](#), May 2021; [Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform](#), U.S. Government Accountability Office, December 2015.

⁹ [Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices](#), December 2015; [The effect of hospital acquisitions of physician practices on prices and spending](#), April 2018.

¹⁰ [Site-based payment differentials for ambulatory services among individuals with commercial insurance](#), October 2022.

acquisitions increase their market power and ability to demand higher reimbursements from commercial payers.¹¹

Once owned by a hospital, doctors' offices can begin billing facility fees, leading to higher costs for the same care. Under Medicare's payment systems,¹² which many payers follow, overhead and related costs are billed separately as a much higher facility fee for hospital-owned locations but bundled into the professional fee as a "practice expense" value for independent groups. Therefore, despite claims from the hospital industry, eliminating facility fees still permits hospitals to receive payment for the cost of operations under practice expense values,¹³ which are more appropriately matched to outpatient resource use. Existing rules that permit HOPDs to bill two separate claims afford Medicare limited ability to associate professional and facility fees,¹⁴ impeding insight into potential improper billing or overpayments.¹⁵

States should pursue site-neutral policies to address inappropriate billing practices by hospitals, lower costs, and reduce incentives for further hospital consolidation. CMS has recognized the HOPD vs. physician office payment differential is unwarranted in certain cases and has taken steps to address it.¹⁶ Further, MedPAC¹⁷ and a broad group of stakeholders¹⁸ have recommended CMS and federal and state policymakers implement site-neutral payments to lower costs and reduce incentives for further hospital consolidation, while preserving the ability to adjust payments for complex care. This could include increasing transparency around Colorado hospital billing practices, strengthening and enforcing Colorado's national provider identifier law,¹⁹

¹¹ [The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured](#), National Bureau of Economic Research Working Paper, May 2018; [Policy Approaches to Reduce What Commercial Insurers Pay for Hospital' and Physicians' Services](#), September 2022; [The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence](#), January 2021.

¹² [In the Shadow of a Giant: Medicare's Influence on Private Physician Payments](#), December 2016.

¹³ [Impact of Resource-Based Practice Expenses on the Medicare Physician Volume](#)

¹⁴ HHS Office of Inspector General, [CMS Is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain](#), June 2016.

¹⁵ [Environmental Scan on Consolidation Trends and Impacts in Health Care Markets](#), RAND Health Care August 2022.

¹⁶ HHS Office of Inspector General, [CMS Is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain](#), June 2016; [42 CFR Parts 416 and 419](#).

¹⁷ MedPAC, [Using payment to ensure appropriate access to and use of hospital emergency department services](#), June 2018; MedPAC, [Aligning fee-for-service payment rates across ambulatory settings](#), June 2022; MedPAC, [Medicare and the Health Care Delivery System](#), June 2022.

¹⁸ [Consumers First](#), January 23, 2023; [Reducing Overpayments in Medicare through Site-Neutral Reforms](#), Paragon Health Institute, June 7, 2023; [Time for Action to Reverse Hospital Consolidation](#), The Heritage Foundation, January 3, 2023; [Americans for Prosperity](#), April 25, 2023; [Site-neutral Payments](#), American Action Forum, May 4, 2023; [Assessing recent health care proposals from the House Committee on Energy and Commerce](#), USC-Brookings Initiative for Health Policy, May 25, 2023.

¹⁹ https://leg.colorado.gov/sites/default/files/2018a_1282_signed.pdf.

requiring hospitals to bill on the correct forms, including a “place of service code”, and prohibiting the assessment of facility fees for low-acuity services.

Hospital and Health System Perspective

If facility fees were eliminated, patients - especially underserved and high-acuity patients - would lose access to care close to home, and thousands of health care workers, whose livelihoods are supported by facility fees, would lose jobs. **A ban on facility fees is bad for patients, bad for health care workers, and bad for hospitals. Facility fees support greater access to care and pay for tens of thousands of health care workers across the state.**

- **Medicare requires hospitals to distinguish between provider and facility charges.** Medicare is the largest payer in the country and sets industry standards for billing that most insurers follow. Charges for care provided in a hospital setting (inpatient or outpatient) are split into two different fees ***as mandated by Medicare*** - a professional fee that only covers the cost of the doctor and a facility fee, or technical fee, to cover a variety of costs including staffing, supplies, medications, equipment use, rent, IT, and other expenses.
- Due to changes in insurer policies over the past two decades, patients are facing increased cost sharing, driving more scrutiny around the cost of care. Prohibiting facility fees is not a solution to this problem. (1) Hospitals are concerned about the cost of care being borne by patients. Colorado hospitals have provided more than [\\$1.2 billion in charity care](#) since 2019. (2) Colorado has some of the [lowest hospital costs in the country](#) - as a share of household income, Coloradans spent 4.1% on hospital costs, the second lowest amount of all US states, substantially less than the US average of 5.9%. (3) The explosion in high-deductible health plans (HDHPs) leaves patients with higher out of pocket expenses. Colorado has a disproportionate percentage of HDHPs, which have not achieved their goal of appropriate price sensitivity and reducing health care costs.

Contrary to popular belief, facility fees allow more patients to be seen in community settings, disproportionately benefiting underserved patients especially in rural areas.

- Hospital outpatient departments (HOPDs) require greater resources because, unlike other settings such as independent physician practices, HOPDs see a [broader patient population](#) and can accommodate patients with more acute health care needs. HOPDs see patients that are higher acuity, dually eligible for Medicare and Medicaid, in rural areas, lower socio-economic status, non-White. Hospitals, and thus HOPDs, must comply with a more comprehensive scope of licensing, accreditation, and other [regulatory requirements](#).
- Facility fees support the industry shift towards more outpatient, integrated care, driven by continuous quality improvement in patient care. A facility fee ban would starve these settings of needed resources and severely restrict access to outpatient care.

Banning facility fees restricts access by forcing patients into more expensive hospital settings - reversing a trend toward less expensive outpatient care.

- A ban would have devastating impacts on the hospital industry and access to care for patients. It would: **(1)** Threaten access and add expense - removing all payment for outpatient care beyond the physician would force outpatient locations to close and force patients to access care through the emergency room and inpatient care, driving up health care costs for everyone. **(2)** Disrupt patient care improvements made possible by the significant investment in an integrated model of care, which leads to lower per capita hospital costs and patients getting care at the right time and right place. **(3)** Significantly impact patients seeking care in rural areas, especially the underserved, thereby imposing unnecessary travel and associated expenses for sick patients seeking care. **(4)** Impose over \$9 billion in cuts to Colorado hospitals at a time when hospitals are already facing significant financial challenges. Additional information can be found [here](#).

Consumer Perspective

- Facility fees can pose severe challenges to affording care and prevent patients from accessing needed care in the future. While facility fees are commonly understood to compensate hospitals for the “overhead” required to keep a facility running 24/7, as hospital consolidation grows, fees are added to bills for routine, low-intensity care like outpatient office visits at hospital-owned clinics. Consumers, especially those with private insurance and Medicare, are billed these fees, which often exceed the provider fee and the cost of the same service received from independent providers.²⁰ Sometimes facilities that previously did not charge such fees suddenly begin doing so, despite no changes in other facets of care or the facilities. While consumers expect reasonable additional costs for care delivered in an emergency, paying these fees for outpatient services with scheduled daytime appointments comes as a surprise.
- Rising healthcare costs concern Coloradans and fear of cost deters many from seeking the care they need. In 2023, 19.8% of Coloradans reported they could not afford needed general or specialist care or prescriptions, and 26.4% reported receiving a medical bill in the past year that they thought their insurance would cover.²¹
- While some may think these bills come as a surprise due to low health insurance literacy, knowledgeable consumers report calling their carriers, checking network status, and requesting full bill estimates, yet still receiving surprise facility fees.
- Nearly one-third of working-age adults report having medical or dental debt they are paying off and 57% of working-age adults report that 10% or more of their monthly budget goes to health care.²² Nearly 4.4% of all households and 6.2% of Black households have high medical debt.²³
- High-deductible health plans are common due to a variety of market factors, and for many consumers with employer coverage, they may be one of if not the only option.²⁴ Many with these plans must pay the fees out of pocket before the deductible is met.
- Yet, facility fees have proliferated beyond being explainable by a rise in these health plans. Facilities that previously did not charge these fees suddenly begin doing so after an ownership change, leaving consumers on the hook despite their insurance coverage remaining the same.²⁵

²⁰ [wsj.com/health/healthcare/hidden-hospital-fees-cost-patients-hundreds-of-dollars-0024cd95](https://www.wsj.com/health/healthcare/hidden-hospital-fees-cost-patients-hundreds-of-dollars-0024cd95)

²¹ coloradohealthinstitute.org/research/colorado-health-access-survey-2023

²² commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey

²³ brookings.edu/articles/the-racial-implications-of-medical-debt-how-moving-toward-universal-health-care-and-other-reforms-can-address-them/

²⁴ kffhealthnews.org/news/032613-michelle-andrews-on-high-deductible-plans-and-large-employers/

²⁵ [wsj.com/health/healthcare/hidden-hospital-fees-cost-patients-hundreds-of-dollars-0024cd95](https://www.wsj.com/health/healthcare/hidden-hospital-fees-cost-patients-hundreds-of-dollars-0024cd95)

- Increased transparency will help consumers decide where to seek care, but for specialties and in rural areas of the state, the presumption of choice doesn't match reality.²⁶ Furthermore, the onus of researching, repeated calls to confirm the absence of facility fees, and coordinating a shift in medical care falls unfairly on consumers who are simply trying to get or stay healthy and unduly so on rural residents who may have to drive into regional city centers to access care that does not charge these fees.
 - It is also important to note that there has been mixed uptake with transparency requirements at the state and federal levels among hospitals.²⁷

²⁶ healthcarevaluehub.org/advocate-resources/publications/improving-healthcare-value-rural-america

²⁷ gazette.com/premium/colorado-hospitals-pricing/article_f4dd8f24-db1d-11ed-ab2b-778b27f4a589.html

Appendix F. Commercial Outpatient Methodology and Tables



October 1, 2024

Subject: Colorado HB1215 – Commercial Facility Fee Identification Methodology Report

Commercial Facility Fee Identification Methodology

Overview

CBIZ Optumas (Optumas) was contracted by the Colorado Department of Health Care Policy and Financing (HCPF) to explore the policies, practices, and costs to Colorado health payers of facility fees as outlined in HB23-1215. Optumas was tasked with identifying outpatient facility fees within the Colorado All Payer Claims Database (APCD) provided by the Center for Improving Value in Healthcare (CIVHC) for 2017 through 2022. The APCD contains claims data from Medicare, Medicaid, and Commercial payers within the State of Colorado. The purpose of this memo is to detail the methodology used to identify hospital outpatient department (HOPD) facility fees within the Commercial claims portion of the APCD.

Data Validation

Optumas reviewed the data for all the requested fields to ensure they were complete and had the expected valid values. This review indicated that we received appropriate data aligned with our data request that would allow us to continue with the analysis. The exception to this is related to denied claims. The APCD does delineate if an individual service was denied during a visit but does not provide information on visits that were denied in their entirety. Optumas will note below for those analysis how this data limitation was handled.

We then reviewed the visit volume and financial field volume on a monthly longitudinal basis by service type and program. This review indicated that we did not have any major gaps or anomalies in the data. Optumas will note that we did not audit the APCD data and are relying on the accuracy of the data provided.

Optumas also received benchmarks from CIVHC that estimate they have about 75% of all covered lives within the APCD. Programs that are not included in the data are listed as follows:

- Uninsured patients and self-pay claims
- Self-insured employers
- Veterans Affairs (VA)
- Tricare
- Worker's compensation
- Medical coverage paid for by a property & casualty insurance company
 - Example – a person has a car accident, and medical bills are paid for by car insurance company

Billing Guidelines Research

Optumas researched the billing of facility fees within Medicaid, which included provider surveys for Colorado hospitals and hospital systems. The findings from that research were that the professional services and HOPD services are billed on two separate claims using their appropriate claim forms. UB-04 claim forms are used for HOPD, and HCFA-1500 claim forms are used for professional services. The facility fee portion of the visit is therefore identified as just the HOPD portion based on the UB-04 form, exclusive of any professional component. That methodology is consistent with the definition of facility fees as outlined in HB23-1215, as well as how providers reported their facility fees within the provider surveys. This methodology was applied consistently to all hospital types (PPS and Critical Access Hospitals).

Analytics

Optumas identified all non-ER Outpatient claims with a Bill Type of '131' (Hospital Outpatient) or '851' (Critical Access Hospital) charged to Commercial payers within the APCD. After discussion with the Hospital Facility Fee Steering Committee, it was determined to exclude all Emergency Room claims from the analytics. The data consists of total HOPD facility fees, regardless of whether a professional fee was billed in addition to the HOPD facility fee. This subset of data serves as the basis for the analytics to be performed that are outlined below. An initial overall summary of allowed amount and visits was performed to check for volume consistency or variation across the study period. The table below itemizes the initial summary of allowed amount, visits, and cost per visit.



Table 2.A – HOPD Summary of Commercial HOPD Visits and Allowed Amount

| CY | Allowed Amt. | Visit Count | Visit Cost |
|--------------|------------------------|--------------------|-------------------|
| 2017 | \$1,008,237,175 | 760,476 | \$1,325.80 |
| 2018 | \$1,125,884,884 | 802,641 | \$1,402.73 |
| 2019 | \$1,180,206,208 | 733,497 | \$1,609.01 |
| 2020 | \$1,119,921,450 | 708,201 | \$1,581.36 |
| 2021 | \$1,321,160,980 | 984,567 | \$1,341.87 |
| 2022 | \$1,381,627,529 | 864,956 | \$1,597.34 |
| Total | \$7,137,038,226 | 4,854,338 | \$1,470.24 |

As required under 25.5-4-216(6)(a)(I) through (VII) C.R.S., the following analytics and summaries are to be derived from the APCD. Optumas has provided the methodology used to perform each analysis, and reference to the summary table in the appendices as applicable.



25.5-4-216(6)(a)(I)

Description

The number of patient visits for which facility fees were charged, including, to the extent possible, a breakdown of which visits were in-network and which were out-of-network.

Methodology

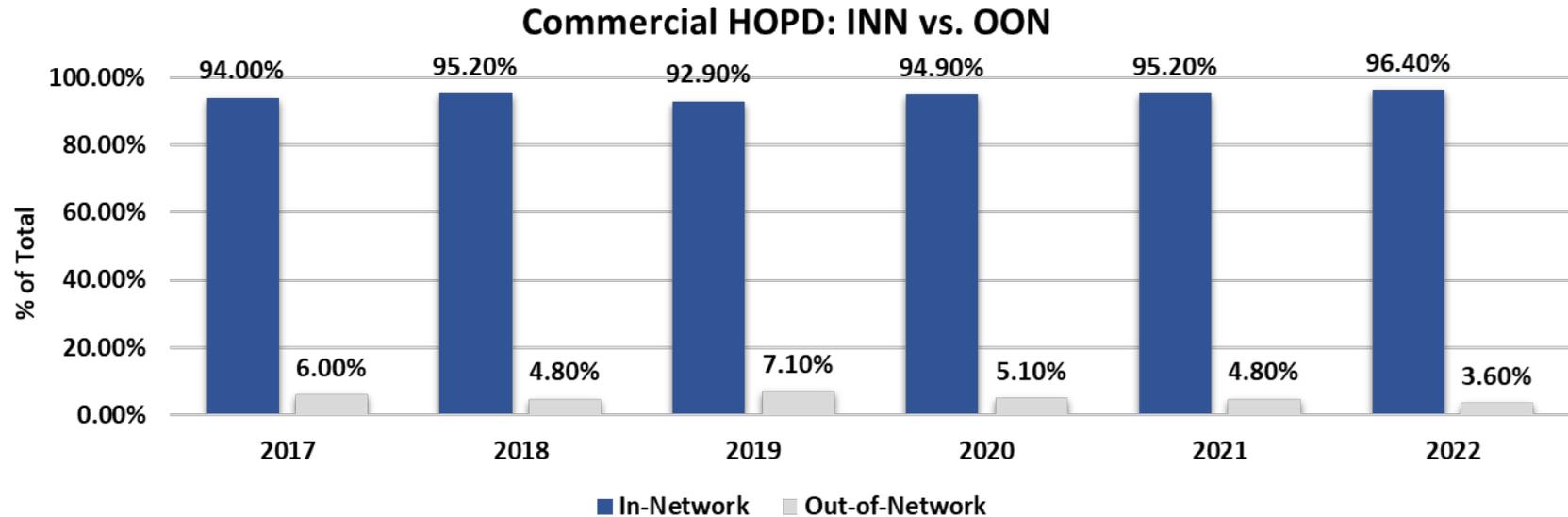
Optumas received a field in the APCD that indicates whether a claim was for an in-network or out-of-network provider. If this field was labeled as “unknown”, Optumas assumed the claim was in-network. Optumas developed this assumption by benchmarking the volume of in-network (INN) and out-of-network (OON) claims by year. In aggregate, 7% of Commercial HOPD claims had an “unknown” network indicator. This field was then used to summarize the volume of visits and allowed amount for non-ER HOPD claims charged to Commercial payers, by in-network or out-of-network.

Results

There were between 708,000 and 984,000 HOPD visits each year for Commercial payers, totaling over 4.8M visits across the study period. Approximately 95% of Commercial related HOPD visits were for an in-network provider each year of the study period. See Exhibit I for the detailed results by year.

Exhibit I - Number of Patient Visits for which Facility Fees were charged in-network and out-of-network.

| CY | HOPD Visits In-Network | HOPD Visits Out-of-Network | HOPD Visits Total | Percentage of Total: In-Network | Percentage of Total: Out-of-Network | Total |
|--------------|------------------------|----------------------------|-------------------|---------------------------------|-------------------------------------|---------------|
| 2017 | 714,705 | 45,771 | 760,476 | 94.0% | 6.0% | 100.0% |
| 2018 | 764,238 | 38,403 | 802,641 | 95.2% | 4.8% | 100.0% |
| 2019 | 681,412 | 52,085 | 733,497 | 92.9% | 7.1% | 100.0% |
| 2020 | 671,963 | 36,238 | 708,201 | 94.9% | 5.1% | 100.0% |
| 2021 | 937,579 | 46,988 | 984,567 | 95.2% | 4.8% | 100.0% |
| 2022 | 833,900 | 31,056 | 864,956 | 96.4% | 3.6% | 100.0% |
| Total | 4,603,797 | 250,541 | 4,854,338 | 94.8% | 5.2% | 100.0% |



25.5-4-216(6)(a)(II)

Description

To the extent possible, the number of patient visits for which the facility fees were charged out-of-network and the professional fees were charged in-network for the same outpatient service.

Methodology

Optumas utilized the analysis from above that identified OON HOPD visits. The member ID and date of service for that visit was used to find a corresponding professional E&M visit for the same date of service for that member. As noted above within the billing guidelines research, the professional fees are separate from the HOPD facility fee. The professional fees are also billed on a separate claim, resulting in the need to use the member ID and date of service methodology to identify the corresponding professional visit when a facility fee was billed. The following CPT codes were utilized to identify the E&M professional visit:

- CPT Codes 99202 – 99499: Professional Evaluation and Management

Table 3 below illustrates an example claim structure for a member that had a professional E&M visit and a HOPD visit on the same date of service. In this example, the member visited their physician and then had imaging done on their lower back at a HOPD. The claim example shows the date of service, the services provided, the place of service (POS) code, and the relevant financial fields. The financial fields reflect:

- *Allowed*: full amount that insurer (Commercial payer) has agreed to reimburse provider for each service.
- *Member Share*: the portion of the allowed amount that the member is responsible for paying. This amount will be dependent upon their deductible, copay, and coinsurance of their benefit package.
- *Paid*: Amount that the insurer (Commercial payer) paid.

Below is a description of the two claim examples:

- *Claim ID 999999001*: represents the E&M professional visit for member ABC123
 - CPT 99214: “Established patient office or other outpatient visit, 30-39 minutes”
 - POS (place of service): 22 indicates the visit took place in the outpatient department
- *Claim ID 999999002*: represents hospital outpatient clinic visit for member ABC123
 - CPT 99214: “Established patient office or other outpatient visit, 30-39 minutes”
 - CPT 72100: “Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Spine and Pelvis”



- “The technician takes 2 or 3 views of the vertebrae in the lumbar region which is the lower part of the spine and the sacrum, the area that connects the spine to the pelvis. Lumbosacral spine X-rays help evaluate back injuries, persistent numbness, and low back pain.”
- CPT 72070: “Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Hospital outpatient clinic visit for assessment and management of a patient’s Spine and Pelvis”
- “A radiologic examination of the thoracic spine is an X-ray of the twelve chest thoracic vertebrae. An AP and lateral are basic projections. The X-rays are used in a controlled way to minimize the radiation exposure. The X-ray helps evaluate bone injuries and diseases, fractures, dislocations, osteoporosis and deformities in the curvature of the spine.”

Table 3 – Claim Structure Example

| Member ID | Claim ID | Service Date | CPT Code | POS | Allowed | Member Share | Plan Paid |
|-----------|-----------|--------------|----------|-----|---------|--------------|-----------|
| ABC123 | 999999001 | 6/5/2017 | 99214 | 22 | \$86.24 | \$0.00 | \$86.24 |
| ABC123 | 999999002 | 6/5/2017 | 72100 | 22 | \$35.54 | \$14.00 | \$21.54 |
| ABC123 | 999999002 | 6/5/2017 | 72070 | 22 | \$34.47 | \$14.00 | \$20.47 |

Results

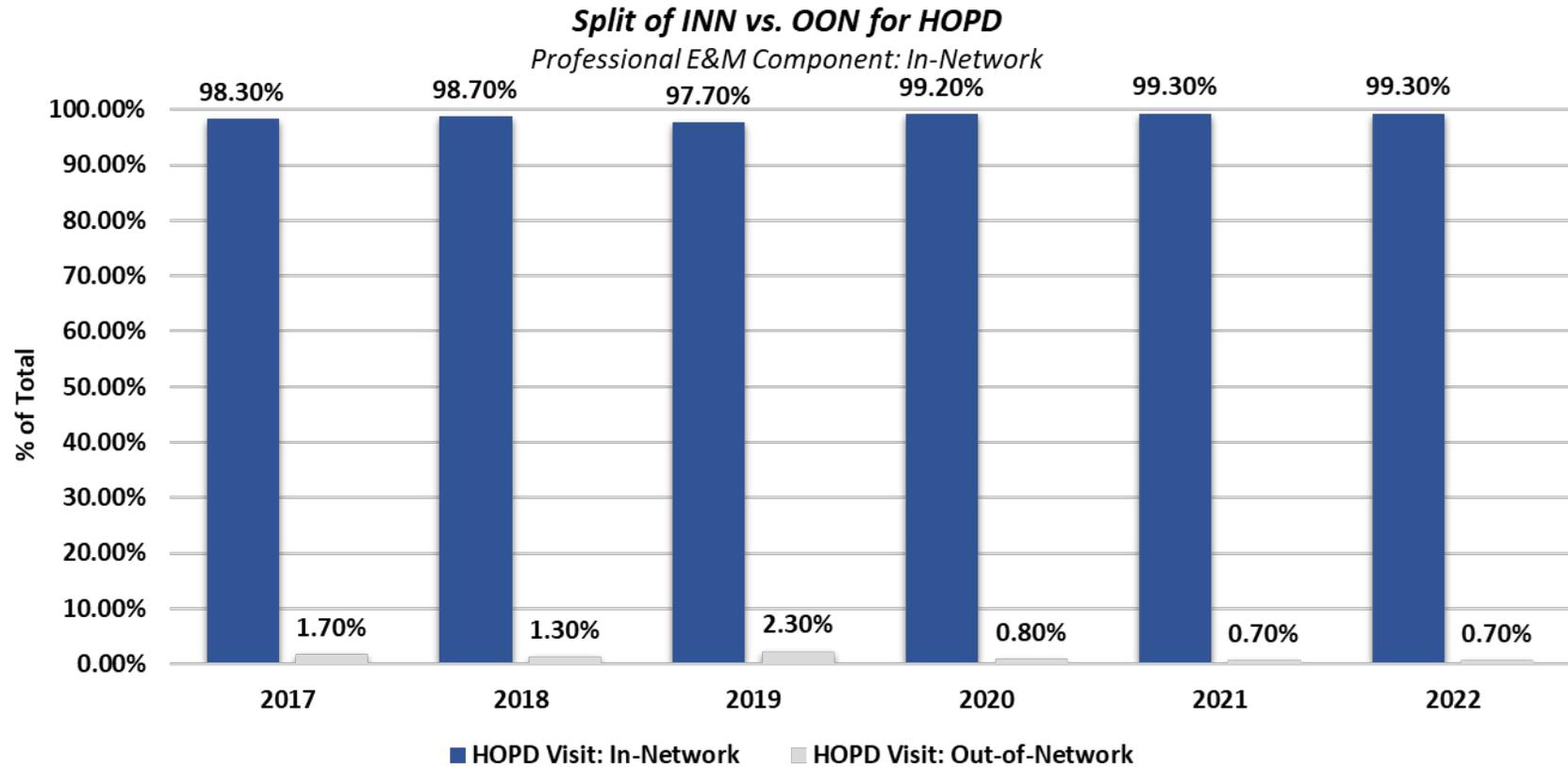
Of the roughly 1,400,000 HOPD visits with a Professional E&M visit on the same day that were charged to Commercial payers from 2017 -2022, 98.8% had a professional fee component that was also charged by an in-network provider. Only 1.2% of Outpatient visits with a Professional E&M visit that was charged by an in-network provider had an Outpatient HOPD visit charged by an out-of-network provider. See Exhibit II for a detailed table of results by year and in-network vs. out-of-network HOPD visits. Note, the total Outpatient visits displayed in this exhibit do not represent all Commercial Outpatient non-ER visits from 2017 – 2022. Only visits from a member that had an in-network Professional E&M visit on the same day as their HOPD visit are displayed.

Exhibit II - Number of Patient Visits for which Facility Fees were charged out-of-network and the professional fees were charged in-network for the same service.

| CY | Professional E&M Visit: In-Network & HOPD Visit: In-Network | Professional E&M Visit: In-Network & HOPD Visit: Out-of-Network | Total |
|--------------|---|---|------------------|
| 2017 | 186,981 | 3,309 | 190,290 |
| 2018 | 209,804 | 2,733 | 212,537 |
| 2019 | 244,352 | 5,715 | 250,067 |
| 2020 | 219,956 | 1,801 | 221,757 |
| 2021 | 274,312 | 2,045 | 276,357 |
| 2022 | 282,128 | 1,929 | 284,057 |
| Total | 1,417,533 | 17,532 | 1,435,065 |

| CY | Percentage HOPD Visit: In-Network | Percentage HOPD Visit: Out-of-Network | Total |
|--------------|-----------------------------------|---------------------------------------|---------------|
| 2017 | 98.3% | 1.7% | 100.0% |
| 2018 | 98.7% | 1.3% | 100.0% |
| 2019 | 97.7% | 2.3% | 100.0% |
| 2020 | 99.2% | 0.8% | 100.0% |
| 2021 | 99.3% | 0.7% | 100.0% |
| 2022 | 99.3% | 0.7% | 100.0% |
| Total | 98.8% | 1.2% | 100.0% |

Exhibit II - Number of Patient Visits for which Facility Fees were charged out-of-network and the professional fees were charged in-network for the same service.



25.5-4-216(6)(a)(III)

Description

The total allowed facility fee amounts billed and denied.

Methodology

As noted in the Data Validation section, there is a data limitation on identifying all denied visits. The APCD includes information on when an individual service billed by the provider, such as the HOPD visit, was denied with the rest of the visit approved and paid. The data does not include information on when the entirety of the visit was denied. As such, Optumas is limited in reporting on the cases when the entire visit was denied but can report on the instances when the HOPD portion of the visit was denied while other services were approved and paid.

The APCD provides a field in the data on each individual claim line that indicates paid or denied status. Optumas summarized the allowed amount and visit count, delineated by paid or denied using the line level information in the data, for all HOPD visits by year in the Commercial data for the study period. Note, the denied indicator was not sufficiently populated for 2017 – 2019. For those three years, Optumas did not consider the data to be credible for the analysis. As such, the data has been removed from the summary tables below.

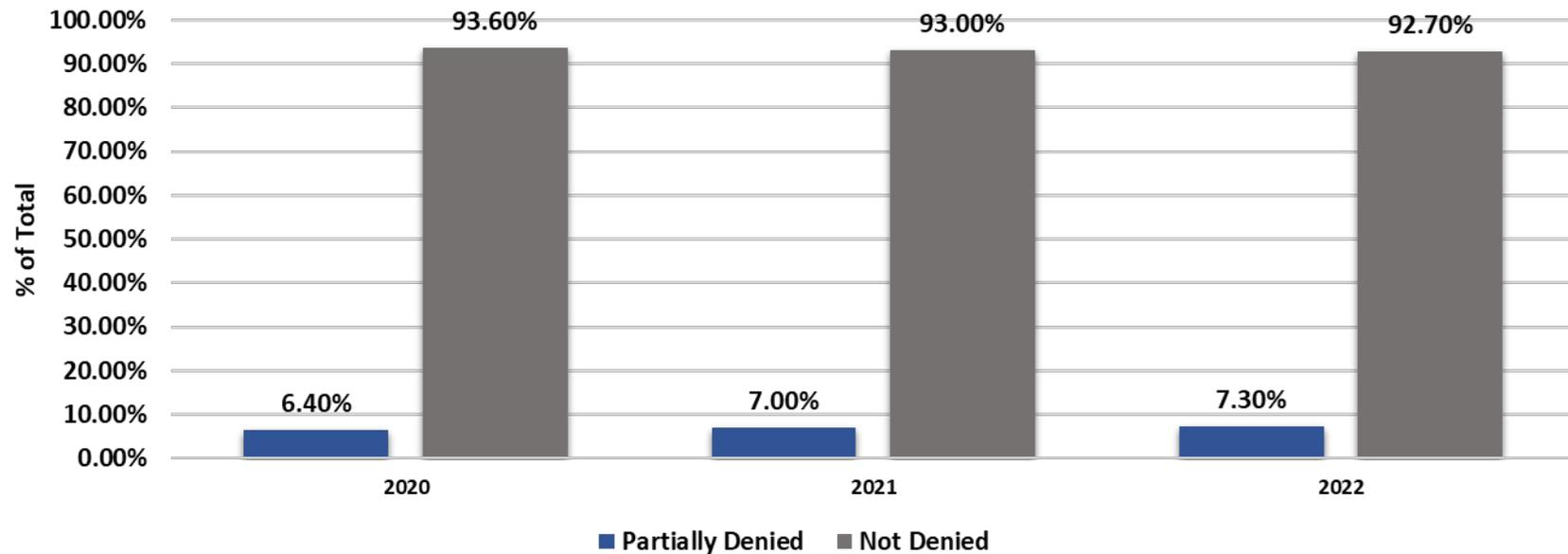
Results

About 93% of allowed dollars for HOPD visits were paid, and approximately 7% were partially denied across 2020 – 2022. As noted above, this does not include instances where the entire visit was denied. See Exhibit III for the detailed table of results by year, paid or denied status, for Commercial HOPD visits.

Exhibit III – The total allowed Facility Fee amounts billed and denied.¹

| CY | Allowed Dollars - Partially Denied | Allowed Dollars - Not Denied | Allowed Dollars - Total | Percentage of Total - Partially Denied | Percentage of Total - Not Denied | Percentage of Total - Total |
|--------------|------------------------------------|------------------------------|-------------------------|--|----------------------------------|-----------------------------|
| 2020 | \$71,875,254 | \$1,048,046,196 | \$1,119,921,450 | 6.4% | 93.6% | 100.0% |
| 2021 | \$92,059,618 | \$1,229,101,362 | \$1,321,160,980 | 7.0% | 93.0% | 100.0% |
| 2022 | \$101,093,649 | \$1,280,533,880 | \$1,381,627,529 | 7.3% | 92.7% | 100.0% |
| Total | \$265,028,521 | \$3,557,681,438 | \$3,822,709,959 | 6.9% | 93.1% | 100.0% |

Percentage of Allowed Dollars: Partially Denied vs. Not Denied



¹ The denied indicator for the 2017 – 2019 data was not sufficiently populated. The data from these three years has been removed from this analysis.

25.5-4-216(6)(a)(IV)

Description

The top ten most frequent CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, for which facility fees were charged.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) most frequent 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.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim.** This data was then used to analyze the most frequently billed services.

Results

The 25 most frequent procedure codes for which facility fees were charged to Commercial payers are displayed in Exhibit IV.a. Laboratory services, which account for over 40% of the top 25 most frequent procedure codes, are the most common services that are performed during a HOPD visit. Appendix 1 contains the detailed descriptions of the top 25 most frequent procedure codes for which HOPD visits were charged to Commercial payers.

The top 25 most frequent revenue codes for which HOPD visits were charged to Commercial payers are displayed in Exhibit IV.b. Revenue code '0301', which designates Laboratory/Chemistry related services, account for over 15% of the top 25 most frequent revenue codes for which HOPD visits are charged.

Exhibit IV.a – Top 25 CPT codes for which Facility Fees were charged by Frequency Count

| CPT Code | Description ² | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|----------|--------------------------|---------|---------|---------|--------|---------|---------|---------|
| 36415 | Laboratory | 144,313 | 147,192 | 124,917 | 96,440 | 121,884 | 127,805 | 762,551 |
| 80053 | Laboratory | 76,227 | 76,576 | 66,136 | 54,902 | 69,885 | 71,352 | 415,078 |
| 85025 | Laboratory | 73,042 | 72,757 | 62,358 | 53,240 | 66,965 | 68,017 | 396,379 |
| 97110 | Physical Therapy | 45,035 | 53,053 | 49,961 | 46,646 | 59,798 | 61,281 | 315,774 |
| 77067 | Mammogram | 23,461 | 56,671 | 52,836 | 45,593 | 52,872 | 54,524 | 285,957 |
| J3490 | Injectables | 9,996 | 13,021 | 16,775 | 43,662 | 69,392 | 131,065 | 283,911 |
| 99213 | Office Visit | 41,399 | 52,612 | 50,808 | 35,940 | 43,408 | 47,863 | 272,030 |
| 77063 | X-Ray | 25,320 | 35,814 | 38,284 | 38,301 | 47,437 | 50,188 | 235,344 |
| 97140 | Therapy | 31,537 | 37,086 | 35,533 | 31,692 | 39,579 | 39,727 | 215,154 |
| 84443 | Laboratory | 40,616 | 39,398 | 34,347 | 26,691 | 37,377 | 36,527 | 214,956 |
| 80061 | Laboratory | 35,315 | 33,926 | 29,521 | 23,282 | 33,743 | 36,599 | 192,386 |
| J2704 | Injectables | 23,811 | 25,691 | 21,636 | 24,081 | 40,941 | 52,910 | 189,070 |
| 99212 | Office Visit | 23,080 | 27,132 | 25,914 | 20,891 | 23,837 | 24,689 | 145,543 |
| J1100 | Injectables | 21,737 | 22,315 | 19,459 | 18,456 | 28,501 | 33,361 | 143,829 |
| J3010 | Injectables | 23,415 | 22,901 | 18,892 | 17,874 | 28,986 | 31,512 | 143,580 |
| J2405 | Injectables | 21,912 | 21,899 | 19,153 | 18,079 | 27,350 | 30,260 | 138,653 |
| 85027 | Laboratory | 24,024 | 25,264 | 22,037 | 18,212 | 22,596 | 24,611 | 136,744 |
| 80048 | Chemical Screen | 24,421 | 24,961 | 20,890 | 17,846 | 21,400 | 22,851 | 132,369 |
| J2250 | Injectables | 21,495 | 21,798 | 18,120 | 20,145 | 24,621 | 25,646 | 131,825 |
| 83036 | Laboratory | 20,645 | 21,411 | 18,577 | 16,077 | 23,679 | 27,069 | 127,458 |
| 99214 | Office Visit | 19,388 | 21,073 | 20,395 | 15,373 | 23,203 | 26,433 | 125,865 |
| J7120 | Injectables | 14,608 | 14,125 | 15,313 | 16,291 | 26,811 | 29,861 | 117,009 |
| 88305 | Pathology | 20,799 | 20,384 | 17,725 | 15,080 | 18,321 | 19,466 | 111,775 |
| 93005 | Cardiography | 16,916 | 17,374 | 14,876 | 13,090 | 16,274 | 17,099 | 95,629 |
| 97530 | Therapeutic Activity | 13,696 | 15,710 | 14,613 | 13,300 | 17,039 | 19,125 | 93,483 |

² For Injectables, counts are based on the frequency of the procedure codes within the APCD.

Exhibit IV.b – Top 25 revenue codes for which Facility Fees were charged by Frequency Count

| Rev. Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|-----------|----------------------------------|---------|---------|---------|---------|---------|---------|-----------|
| 0301 | Laboratory - Chemistry | 350,789 | 377,477 | 342,001 | 282,157 | 381,430 | 408,908 | 2,142,762 |
| 0636 | Pharmacy | 261,476 | 284,389 | 268,099 | 303,946 | 409,456 | 217,091 | 1,744,457 |
| 0300 | Laboratory - General | 289,027 | 234,549 | 193,060 | 195,446 | 253,073 | 239,507 | 1,404,662 |
| 0250 | Pharmacy - General | 114,523 | 171,957 | 160,021 | 156,129 | 172,827 | 83,248 | 858,705 |
| 0305 | Hematology | 130,820 | 147,019 | 128,445 | 107,851 | 131,400 | 133,228 | 778,763 |
| 0510 | Outpatient Hospital | 111,423 | 140,820 | 136,445 | 104,311 | 128,588 | 135,740 | 757,327 |
| 0420 | Physical Therapy | 103,930 | 111,286 | 100,727 | 90,367 | 119,105 | 123,654 | 649,069 |
| 0306 | Bacteriology | 74,742 | 89,257 | 85,351 | 118,162 | 137,870 | 106,970 | 612,352 |
| 0403 | Screening Mammography | 65,398 | 90,364 | 91,011 | 85,307 | 102,724 | 107,114 | 541,918 |
| 0320 | X-Ray | 125,143 | 84,222 | 72,544 | 64,342 | 77,614 | 79,982 | 503,847 |
| 0302 | Immunology | 67,031 | 75,239 | 73,160 | 67,890 | 85,867 | 92,110 | 461,297 |
| 0360 | Operating Room | 49,423 | 55,555 | 57,579 | 51,289 | 61,562 | 64,823 | 340,231 |
| 0402 | Ultrasound | 39,818 | 51,746 | 50,188 | 48,391 | 56,736 | 59,088 | 305,967 |
| 0272 | Sterile Supplies | 51,492 | 47,670 | 40,528 | 39,369 | 51,136 | 53,886 | 284,081 |
| 0771 | Preventive Care | 13,528 | 17,692 | 18,613 | 19,380 | 161,247 | 43,357 | 273,817 |
| 0258 | IV Solutions | 48,246 | 46,178 | 43,097 | 37,083 | 47,364 | 17,547 | 239,515 |
| 0710 | Recovery Room | 33,511 | 37,921 | 38,368 | 34,675 | 43,356 | 45,963 | 233,794 |
| 0370 | Anesthesia | 33,457 | 34,564 | 32,569 | 30,247 | 39,862 | 44,112 | 214,811 |
| 0333 | Home Health | 27,490 | 37,496 | 34,858 | 33,699 | 37,871 | 38,551 | 209,965 |
| 0761 | Treatment Room | 30,675 | 33,102 | 31,082 | 29,176 | 35,611 | 35,361 | 195,007 |
| 0260 | IV Therapy | 23,491 | 25,507 | 27,469 | 27,415 | 34,431 | 36,111 | 174,424 |
| 0307 | Urology | 21,691 | 28,334 | 25,613 | 22,395 | 27,747 | 29,052 | 154,832 |
| 0312 | Laboratory Pathology - Histology | 26,239 | 27,159 | 24,814 | 22,524 | 26,627 | 27,073 | 154,436 |
| 0430 | Occupational Therapy - General | 18,439 | 22,733 | 20,242 | 20,456 | 24,469 | 26,187 | 132,526 |
| 0401 | Imaging - Diagnostic Mammography | 14,550 | 21,077 | 21,671 | 21,715 | 25,878 | 26,801 | 131,692 |

25.5-4-216(6)(a)(V)

Description

The top ten CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, with the highest total allowed amounts from facility fees.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) codes with the highest allowed amount 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.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim.** This data was then used to analyze the codes with the highest allowed amount.

Results

The top 25 procedure codes for which HOPD visits were charged to Commercial payers, based on allowed amount by code, are displayed in Exhibit V.a. Medical Devices/Supplies, Chemotherapy Drugs, Injectables and Radiation Treatment services account for over 40% of the allowed amount for the top 25 codes. Appendix 2 contains the detailed descriptions of the top 25 procedure codes for which facility fees were charged to Commercial payers, based on allowed amount by code.

The top 25 most frequent revenue codes for which HOPD visits were charged to Commercial payers are displayed in Exhibit V.b. Revenue code '0360' is related to Operating Room services, which aligns with the observation that the top procedure codes are related to Dialysis, Medical Devices/Supplies, Arthroplasty, and Colonoscopy services.

Exhibit V.a – Top 25 procedure codes with the highest total allowed amounts on same visit as a facility fees.

| CPT Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|----------|------------------------------|--------------|--------------|--------------|--------------|--------------|--------------|---------------|
| 93306 | Echocardiography | \$14,622,766 | \$15,177,954 | \$15,348,468 | \$15,149,076 | \$19,765,505 | \$21,404,624 | \$101,468,394 |
| C1776 | Devices/Supplies | \$1,237,049 | \$4,738,399 | \$9,833,348 | \$15,367,068 | \$23,070,468 | \$25,419,785 | \$79,666,117 |
| C1713 | Devices/Supplies | \$9,984,913 | \$10,906,603 | \$10,817,483 | \$11,247,454 | \$16,768,245 | \$18,320,108 | \$78,044,807 |
| 77386 | Radiation Treatment | \$9,192,113 | \$10,755,100 | \$12,427,393 | \$12,163,322 | \$12,812,247 | \$12,930,531 | \$70,280,706 |
| J2350 | Injectables | \$0 | \$17,541,652 | \$16,177,211 | \$10,117,123 | \$12,395,986 | \$11,044,823 | \$67,276,795 |
| J9271 | Chemotherapy Drug | \$4,426,605 | \$4,962,097 | \$8,636,873 | \$12,837,951 | \$14,113,087 | \$20,720,469 | \$65,697,082 |
| 27447 | Arthroplasty | \$87,732 | \$4,022,876 | \$8,711,292 | \$10,650,050 | \$17,010,071 | \$21,820,765 | \$62,302,787 |
| 77067 | Mammogram | \$5,544,498 | \$11,613,582 | \$11,722,798 | \$10,004,706 | \$11,606,995 | \$11,721,798 | \$62,214,377 |
| 58571 | Laparoscopy | \$8,106,885 | \$9,509,503 | \$8,539,130 | \$8,265,768 | \$10,799,938 | \$11,659,570 | \$56,880,794 |
| 43239 | Endoscopy | \$6,952,477 | \$7,941,050 | \$8,637,077 | \$7,122,505 | \$9,151,899 | \$9,810,778 | \$49,615,787 |
| 97110 | Physical Therapy | \$5,708,827 | \$7,787,794 | \$8,476,304 | \$7,687,545 | \$9,410,586 | \$10,057,323 | \$49,128,380 |
| G0378 | Outpatient Observation | \$6,831,672 | \$5,972,705 | \$9,720,301 | \$8,262,527 | \$8,529,233 | \$8,834,022 | \$48,150,462 |
| 96413 | Chemotherapy Drug | \$6,787,163 | \$7,774,158 | \$7,460,047 | \$8,157,872 | \$8,544,054 | \$8,524,220 | \$47,247,514 |
| J1745 | Injectables | \$9,499,561 | \$9,076,980 | \$7,986,056 | \$7,649,411 | \$6,507,006 | \$4,081,166 | \$44,800,182 |
| 45380 | Colonoscopy | \$6,751,361 | \$7,288,331 | \$7,551,745 | \$5,875,859 | \$7,959,252 | \$8,905,699 | \$44,332,247 |
| J2505 | Immunostimulant | \$7,639,432 | \$10,016,811 | \$9,877,808 | \$10,075,395 | \$6,074,197 | \$0 | \$43,683,644 |
| J9299 | Chemotherapy Drug | \$2,713,192 | \$6,058,322 | \$8,935,221 | \$7,393,128 | \$8,955,433 | \$9,353,028 | \$43,408,325 |
| 80053 | Laboratory | \$6,338,965 | \$6,562,295 | \$7,030,785 | \$6,869,498 | \$7,859,878 | \$7,780,116 | \$42,441,536 |
| 74177 | CT Scan | \$7,244,036 | \$6,825,976 | \$6,773,543 | \$6,474,441 | \$6,629,204 | \$6,847,889 | \$40,795,089 |
| 27130 | Arthroplasty | \$107,036 | \$667,402 | \$1,727,275 | \$8,935,332 | \$12,086,928 | \$17,061,574 | \$40,585,546 |
| 77412 | Radiation Treatment | \$5,223,937 | \$6,767,807 | \$7,001,565 | \$7,224,780 | \$6,623,981 | \$7,524,384 | \$40,366,454 |
| 36415 | Laboratory | \$4,956,334 | \$6,515,753 | \$7,208,226 | \$5,820,119 | \$6,507,733 | \$7,179,720 | \$38,187,884 |
| 70553 | MRI | \$6,968,588 | \$6,090,281 | \$5,769,052 | \$4,947,443 | \$5,489,708 | \$5,656,002 | \$34,921,074 |
| 45378 | Colonoscopy | \$5,062,235 | \$5,296,357 | \$5,632,973 | \$3,859,866 | \$5,883,830 | \$8,096,401 | \$33,831,662 |
| 47562 | Laparoscopic Cholecystectomy | \$5,154,054 | \$5,357,713 | \$5,666,827 | \$5,451,457 | \$6,308,821 | \$5,752,645 | \$33,691,516 |

Exhibit V.b – Top 25 revenue codes with the highest total allowed amounts on same visit as a facility fee.

| Rev. Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|-----------|-----------------------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| 0360 | Operating Room | \$145,732,879 | \$191,470,387 | \$234,706,827 | \$222,617,508 | \$271,578,989 | \$292,663,719 | \$1,358,770,308 |
| 0636 | Pharmacy | \$95,550,270 | \$146,205,844 | \$177,528,564 | \$182,905,050 | \$211,735,757 | \$70,591,239 | \$884,516,725 |
| 0278 | Medical Supplies - Implants | \$42,090,164 | \$48,552,619 | \$54,774,213 | \$56,378,914 | \$76,574,784 | \$74,022,640 | \$352,393,335 |
| 0333 | Home Health | \$33,302,219 | \$41,949,588 | \$48,048,053 | \$48,870,291 | \$49,914,346 | \$55,282,922 | \$277,367,420 |
| 0250 | Pharmacy - General | \$49,165,495 | \$42,600,846 | \$39,998,841 | \$36,486,512 | \$37,720,613 | \$24,538,243 | \$230,510,551 |
| 0710 | Recovery Room | \$26,104,277 | \$31,473,902 | \$37,055,018 | \$33,170,627 | \$38,843,964 | \$40,342,122 | \$206,989,909 |
| 0481 | Cardiology | \$18,931,942 | \$23,079,968 | \$33,969,395 | \$30,237,872 | \$35,861,229 | \$37,432,480 | \$179,512,886 |
| 0320 | X-Ray | \$41,858,270 | \$25,003,267 | \$24,905,919 | \$20,606,290 | \$24,688,925 | \$25,584,158 | \$162,646,830 |
| 0750 | Gastrointestinal Services | \$16,683,356 | \$22,462,854 | \$28,258,087 | \$23,074,259 | \$31,956,767 | \$38,933,938 | \$161,369,262 |
| 0272 | Sterile Supplies | \$30,260,537 | \$26,992,334 | \$27,508,374 | \$22,456,049 | \$26,237,579 | \$26,201,586 | \$159,656,460 |
| 0301 | Laboratory - Chemistry | \$22,530,828 | \$24,811,372 | \$25,800,298 | \$24,027,881 | \$29,196,031 | \$31,184,420 | \$157,550,829 |
| 0490 | Ambulatory Surgical Care | \$92,891,808 | \$56,595,335 | \$529,145 | \$426,022 | \$484,165 | \$168,751 | \$151,095,226 |
| 0370 | Anesthesia | \$20,233,361 | \$21,601,292 | \$22,364,107 | \$20,031,024 | \$26,176,982 | \$27,282,571 | \$137,689,336 |
| 0361 | Operating Room | \$14,222,036 | \$21,061,941 | \$23,260,182 | \$20,299,906 | \$21,954,549 | \$24,981,390 | \$125,780,003 |
| 0483 | Echocardiology | \$14,347,141 | \$18,410,757 | \$18,677,488 | \$18,268,385 | \$24,018,485 | \$25,482,864 | \$119,205,121 |
| 0402 | Ultrasound | \$13,581,127 | \$18,555,701 | \$19,577,855 | \$18,640,213 | \$21,549,297 | \$22,933,401 | \$114,837,594 |
| 0761 | Treatment Room | \$15,912,922 | \$17,418,851 | \$18,651,691 | \$17,221,235 | \$21,109,281 | \$20,600,659 | \$110,914,640 |
| 0352 | CT Scan | \$14,699,436 | \$16,674,251 | \$17,517,486 | \$16,571,516 | \$18,298,139 | \$18,934,107 | \$102,694,935 |
| 0480 | Cardiology | \$21,353,926 | \$13,707,609 | \$13,100,386 | \$11,862,445 | \$14,995,421 | \$13,210,915 | \$88,230,701 |
| 0420 | Physical Therapy | \$13,249,146 | \$12,905,147 | \$13,963,241 | \$12,488,103 | \$15,342,440 | \$16,238,292 | \$84,186,369 |
| 0403 | Screening Mammography | \$10,471,579 | \$13,603,618 | \$14,562,275 | \$13,050,275 | \$15,516,663 | \$15,977,966 | \$83,182,375 |
| 0610 | Magnetic Resonance Tech | \$11,851,201 | \$13,134,089 | \$12,448,278 | \$11,127,976 | \$13,304,313 | \$13,892,021 | \$75,757,877 |
| 0300 | Laboratory - General | \$16,351,926 | \$9,987,620 | \$9,569,755 | \$11,558,635 | \$13,276,816 | \$13,131,295 | \$73,876,047 |
| 0240 | Ancillary | \$37,884,341 | \$26,483,851 | \$308,486 | \$1,143,086 | \$1,254,699 | \$4,539,925 | \$71,614,388 |
| 0306 | Bacteriology | \$6,875,255 | \$9,764,095 | \$10,602,724 | \$13,979,734 | \$14,236,703 | \$12,078,516 | \$67,537,027 |

25.5-4-216(6)(a)(VI)

Description

The top ten CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, for which facility fees are charged with the highest member cost sharing.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) codes with the highest member cost sharing 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.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim.** This data was then used to analyze the codes with the highest member cost sharing.

Results

Exhibit VI.a represents the top 25 procedure codes for which HOPD visits were charged to Commercial payers with the highest member cost sharing amounts. MRIs, Echocardiography services, Laboratory services, and CT scans account for the greatest member cost sharing. This will be partially driven by the individual cost of those services, and the timing of a member meeting their deductible which contributes to how much the member owes. If the member is below their deductible, and the service is not covered under a fixed copay, the member will pay 100% of the service cost up to their deductible. After they meet their deductible, the member will pay their responsible portion based on their benefit package design, and the Commercial payer will cover the remainder. The member portion may continue to be reflective of copay levels or may reflect co-insurance which is reflective of a percentage of the total service allowed amount. Appendix 3 contains the detailed descriptions of the top 25 procedure codes for which HOPD visits were charged with the highest member cost sharing amounts.

Exhibit VI.b displays the top 25 revenue codes for which HOPD visits were charged to Commercial payers with the highest member cost sharing. Revenue codes '0360' (Operating Room), '0320' (X-Rays), and '0402' (Ultrasound) represent nearly 40% of the top 25 revenue codes with the highest member cost sharing.

Exhibit VI.a – Top 25 procedure codes for which Facility Fees are charged with the highest member cost sharing.

| CPT Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|----------|------------------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------|
| 93306 | Echocardiography | \$4,247,975 | \$4,371,668 | \$4,423,239 | \$4,649,441 | \$5,592,440 | \$6,206,457 | \$29,491,220 |
| 43239 | Endoscopy | \$1,737,853 | \$1,874,781 | \$2,021,982 | \$1,611,159 | \$1,998,961 | \$2,070,725 | \$11,315,462 |
| 73721 | MRI | \$2,040,771 | \$1,885,293 | \$1,794,899 | \$1,560,489 | \$1,957,839 | \$1,825,990 | \$11,065,281 |
| 36415 | Laboratory | \$1,494,512 | \$1,823,532 | \$2,058,306 | \$1,665,009 | \$1,861,960 | \$2,136,248 | \$11,039,568 |
| 74177 | CT Scan | \$1,876,207 | \$1,816,231 | \$1,788,167 | \$1,654,698 | \$1,766,385 | \$1,771,167 | \$10,672,855 |
| 70553 | MRI | \$1,909,587 | \$1,679,024 | \$1,703,199 | \$1,476,890 | \$1,690,026 | \$1,598,779 | \$10,057,504 |
| 97110 | Physical Therapy | \$1,137,757 | \$1,464,874 | \$1,669,513 | \$1,530,209 | \$1,916,873 | \$1,930,442 | \$9,649,669 |
| 80053 | Laboratory | \$1,459,387 | \$1,469,927 | \$1,551,937 | \$1,437,252 | \$1,703,842 | \$1,767,313 | \$9,389,656 |
| 76642 | Ultrasound | \$1,207,230 | \$1,368,613 | \$1,369,749 | \$1,483,282 | \$1,579,257 | \$1,566,065 | \$8,574,196 |
| C1713 | Devices/Supplies | \$1,071,865 | \$1,200,917 | \$1,158,543 | \$1,124,634 | \$1,646,242 | \$1,912,651 | \$8,114,852 |
| 78452 | CT Scan | \$1,305,064 | \$1,461,962 | \$1,523,350 | \$1,166,771 | \$1,353,535 | \$1,246,333 | \$8,057,013 |
| 58571 | Laparoscopy | \$871,315 | \$1,129,035 | \$1,038,173 | \$980,484 | \$1,288,044 | \$1,372,040 | \$6,679,091 |
| 19083 | Percutaneous Biopsy | \$1,024,366 | \$1,104,451 | \$1,109,100 | \$1,077,765 | \$1,031,618 | \$1,159,869 | \$6,507,169 |
| 88305 | Pathology | \$1,185,235 | \$1,075,153 | \$1,015,053 | \$870,368 | \$1,077,465 | \$1,168,058 | \$6,391,332 |
| 72148 | MRI | \$1,213,370 | \$1,071,193 | \$988,756 | \$938,571 | \$1,125,363 | \$985,082 | \$6,322,335 |
| G0378 | Outpatient Observation | \$901,112 | \$891,113 | \$1,139,271 | \$1,147,918 | \$1,060,713 | \$1,035,572 | \$6,175,699 |
| 71046 | X-Ray | \$0 | \$1,258,047 | \$1,244,852 | \$1,085,117 | \$1,082,839 | \$1,249,833 | \$5,920,689 |
| 93005 | Cardiography | \$720,571 | \$863,626 | \$891,933 | \$865,484 | \$1,098,113 | \$1,210,706 | \$5,650,433 |
| 70551 | MRI | \$884,770 | \$919,940 | \$926,095 | \$840,673 | \$960,223 | \$1,020,347 | \$5,552,049 |
| 93017 | Cardiovascular Testing | \$990,632 | \$996,715 | \$937,190 | \$687,893 | \$826,794 | \$889,167 | \$5,328,391 |
| 58558 | Hysteroscopy | \$826,028 | \$896,185 | \$797,951 | \$754,326 | \$966,777 | \$920,250 | \$5,161,518 |
| 97140 | Therapy | \$653,382 | \$847,297 | \$887,634 | \$825,872 | \$1,020,676 | \$859,583 | \$5,094,443 |
| C1776 | Devices/Supplies | \$88,776 | \$292,492 | \$473,968 | \$883,136 | \$1,469,391 | \$1,791,751 | \$4,999,515 |
| 95811 | Polysomnography | \$849,575 | \$875,685 | \$859,128 | \$609,403 | \$850,981 | \$867,902 | \$4,912,675 |
| 73221 | MRI | \$854,797 | \$790,580 | \$792,327 | \$700,225 | \$896,308 | \$825,287 | \$4,859,523 |

Exhibit VI.b – Top 25 revenue codes for which Facility Fees are charged with the highest member cost sharing.

| Rev. Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|-----------|-----------------------------|--------------|--------------|--------------|--------------|--------------|--------------|---------------|
| 0360 | Operating Room | \$19,210,553 | \$24,179,775 | \$29,487,260 | \$27,353,318 | \$31,992,445 | \$33,582,577 | \$165,805,930 |
| 0320 | X-Ray | \$13,080,013 | \$8,803,555 | \$8,928,137 | \$7,707,610 | \$9,180,321 | \$9,375,665 | \$57,075,302 |
| 0402 | Ultrasound | \$5,558,763 | \$7,477,597 | \$7,896,928 | \$7,876,374 | \$8,677,549 | \$8,842,086 | \$46,329,296 |
| 0301 | Laboratory - Chemistry | \$5,565,910 | \$6,076,555 | \$6,543,236 | \$5,931,173 | \$7,489,319 | \$8,078,799 | \$39,684,992 |
| 0636 | Pharmacy | \$3,589,350 | \$5,260,671 | \$7,848,651 | \$7,435,244 | \$8,750,691 | \$5,533,694 | \$38,418,301 |
| 0483 | Echocardiology | \$4,127,154 | \$5,077,547 | \$5,166,926 | \$5,206,922 | \$6,164,610 | \$7,155,115 | \$32,898,276 |
| 0352 | CT Scan | \$3,877,541 | \$4,676,213 | \$4,868,051 | \$4,772,030 | \$5,388,265 | \$5,565,587 | \$29,147,687 |
| 0278 | Medical Supplies - Implants | \$3,379,689 | \$3,659,497 | \$4,016,312 | \$4,351,663 | \$6,133,714 | \$6,632,238 | \$28,173,114 |
| 0250 | Pharmacy - General | \$5,369,797 | \$4,613,802 | \$4,918,898 | \$3,779,203 | \$3,899,676 | \$3,768,224 | \$26,349,601 |
| 0610 | Magnetic Resonance Tech | \$3,965,719 | \$4,440,097 | \$4,230,303 | \$3,737,263 | \$4,715,282 | \$4,781,137 | \$25,869,802 |
| 0361 | Operating Room | \$2,200,625 | \$2,847,592 | \$3,925,442 | \$3,788,606 | \$4,268,686 | \$4,490,604 | \$21,521,556 |
| 0750 | Gastrointestinal Services | \$1,933,711 | \$2,549,785 | \$3,679,579 | \$3,115,202 | \$3,831,530 | \$3,957,305 | \$19,067,112 |
| 0272 | Sterile Supplies | \$3,302,605 | \$3,083,435 | \$3,069,415 | \$2,454,435 | \$2,935,931 | \$3,921,262 | \$18,767,083 |
| 0300 | Laboratory - General | \$4,251,426 | \$2,692,330 | \$2,612,875 | \$2,472,089 | \$2,955,328 | \$3,259,875 | \$18,243,923 |
| 0761 | Treatment Room | \$2,273,675 | \$2,437,547 | \$3,007,556 | \$3,062,856 | \$3,360,353 | \$3,466,694 | \$17,608,680 |
| 0420 | Physical Therapy | \$2,413,352 | \$2,453,262 | \$2,748,983 | \$2,481,902 | \$3,139,780 | \$3,091,532 | \$16,328,811 |
| 0710 | Recovery Room | \$1,949,166 | \$2,265,369 | \$2,744,153 | \$2,523,332 | \$3,151,435 | \$3,043,851 | \$15,677,306 |
| 0341 | Nuclear Medicine | \$2,040,915 | \$2,739,388 | \$2,892,599 | \$2,354,538 | \$2,688,997 | \$2,545,521 | \$15,261,959 |
| 0611 | MRI - Brain | \$1,965,870 | \$2,345,515 | \$2,504,479 | \$2,300,981 | \$2,608,586 | \$2,583,876 | \$14,309,307 |
| 0305 | Hematology | \$986,106 | \$2,148,426 | \$2,796,816 | \$2,378,935 | \$2,677,904 | \$2,837,978 | \$13,826,165 |
| 0306 | Bacteriology | \$1,390,764 | \$2,227,672 | \$2,473,268 | \$2,083,327 | \$2,064,043 | \$2,328,512 | \$12,567,587 |
| 0920 | Diagnostic Services | \$1,293,310 | \$1,820,578 | \$2,236,966 | \$1,893,803 | \$2,492,134 | \$2,830,132 | \$12,566,922 |
| 0480 | Cardiology | \$3,784,927 | \$1,435,641 | \$1,412,846 | \$1,452,189 | \$1,885,209 | \$1,638,768 | \$11,609,580 |
| 0612 | MRI - Spinal Cord | \$1,517,020 | \$1,857,466 | \$1,879,356 | \$1,772,963 | \$2,116,588 | \$2,030,552 | \$11,173,945 |
| 0481 | Cardiology | \$1,094,357 | \$1,117,895 | \$1,965,652 | \$1,776,530 | \$2,003,367 | \$1,990,967 | \$9,948,767 |

25.5-4-216(6)(a)(VII)

Description

The total number of facility fee claim denials, by site of service.

Methodology

As noted above, the APCD does not include denied claims when the entire visit was denied. This data limitation prevents Optumas from reporting on claim denials by site of service. Optumas can report on instances when the facility fee line was denied during a visit that was otherwise approved. This has been captured in the analytics above under 25.5-4-216(6)(a)(III), and the corresponding Appendix III.

Appendices

Appendix 1

| CPT Code | Description ³ |
|----------|--|
| 36415 | Collection of venous blood by venipuncture. |
| 80053 | Comprehensive metabolic panel. |
| 85025 | Complete blood count with automated differential white blood cell count. |
| 97110 | Therapeutic exercise that helps patients develop or maintain strength, endurance, flexibility, or range of motion. |
| 77067 | Bilateral screening mammogram that includes computer-aided detection. |
| J3490 | Meloxicam injection. |
| 99213 | Level three office visit with an established patient, 20-29 minutes. |
| 77063 | Bilateral screening digital breast tomosynthesis. |
| 97140 | Manual therapy techniques used for 15 minutes or more in one or more body regions. |
| 84443 | Blood test measuring thyroid stimulating hormone level. |
| 80061 | Lipid panel test to measure the level of triglycerides in blood. |
| J2704 | 10 mg injection of propofol, an anesthetic and sedative used to help patients relax or sleep. |
| 99212 | Office visit, other outpatient visits, evaluation and management. |
| J1100 | 1 mg injection of dexamethasone sodium phosphate |
| J3010 | 0.1 mg injection of fentanyl citrate. |
| J2405 | 1 mg injection of ondansetron hydrochloride, used for chemotherapy drugs. |
| 85027 | Blood count on the red and white blood cells and platelets and hemoglobin test. |
| 80048 | Basic metabolic panel. |
| J2250 | Injection up to 50 mg of promethazine HCl, to treat nausea and vomiting caused by motion sickness. |
| 83036 | Glycated hemoglobin/Glycated protein. |
| 99214 | Office or outpatient visit that evaluates and manages an established patient, 30-39 minutes. |
| J7120 | Ringers lactate infusion, up to 1000 cc. |
| 88305 | Level 4 surgical pathology and microscopic examination. |
| 93005 | Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report. |
| 97530 | Physical Medicine and Rehabilitation Therapeutic Procedures |

Appendix 2

| CPT Code | Description ³ |
|----------|--|
| 93306 | Transthoracic echocardiography, complete study. |
| C1776 | Implantable joint device, such as an artificial joint in a patient's ankle, knee, hip, or shoulder. |
| C1713 | Implantable anchor or screw that opposes bone-to-bone or soft tissue-to-bone. |
| 77386 | Radiation therapy to deliver radiation doses to a malignant tumor. |
| J2350 | 1 mg injection of ocrelizumab. |
| J9271 | Injection, pembrolizumab - Chemotherapy Drugs. |
| 27447 | Total knee arthroplasty, replacing the condyle and plateau of the knee as well as the medial and lateral compartments. |
| 77067 | Bilateral screening mammogram that includes computer-aided detection. |
| 58571 | Surgical laparoscopy with a total hysterectomy, for uterus weighing 250 grams or less. |
| 43239 | Esophagogastroduodenoscopy with biopsy. |
| 97110 | Therapeutic exercise that helps patients develop or maintain strength, endurance, flexibility, or range of motion. |
| G0378 | Hospital observation used by facilities to report hospital outpatient observation. |
| 96413 | Injection and intravenous infusion chemotherapy. |
| J1745 | 10 mg injection of infliximab, excluding biosimilars. |
| 45380 | Examination of the entire colon. |
| J2505 | Injection, pegfilgrastim - Chemotherapy Drugs. |
| J9299 | Injection, nivolumab - Chemotherapy Drugs. |
| 80053 | Comprehensive metabolic panel. |
| 74177 | CT Scan of the abdomen and pelvis with contrast material. |
| 27130 | Total hip arthroplasty, or acetabular and proximal femoral prosthetic replacement. |
| 77412 | Technical component of radiation treatment using greater than or equal to 1 MeV energy level. |
| 36415 | Collection of venous blood by venipuncture. |
| 70553 | MRI of the brain. |
| 45378 | Flexible diagnostic colonoscopy that involves collecting specimens by brushing or washing. |
| 47562 | Laparoscopic cholecystectomy. |

Appendix 3

| CPT Code | Description ³ |
|----------|---|
| 93306 | Transthoracic echocardiography, complete study. |
| 43239 | Esophagogastroduodenoscopy with biopsy. |
| 73721 | Magnetic Resonance Imaging of any joint in the lower extremity. |
| 36415 | Collection of venous blood by venipuncture. |
| 74177 | CT Scan of the abdomen and pelvis with contrast material. |
| 70553 | MRI of the brain. |
| 97110 | Therapeutic exercise that helps patients develop or maintain strength, endurance, flexibility, or range of motion. |
| 80053 | Comprehensive metabolic panel. |
| 76642 | Limited unilateral breast ultrasound examination. |
| C1713 | Implantable anchor or screw that opposes bone-to-bone or soft tissue-to-bone. |
| 78452 | 3D imaging of the heart by using a high-energy CT scanner. |
| 58571 | Surgical laparoscopy with a total hysterectomy, for uterus weighing 250 grams or less. |
| 19083 | Percutaneous biopsy of the first breast lesion using ultrasound guidance. |
| 88305 | Level 4 surgical pathology and microscopic examination. |
| 72148 | Magnetic Resonance Imaging of the lumbar spinal canal and contents. |
| G0378 | Hospital observation used by facilities to report hospital outpatient observation. |
| 71046 | Chest X-Ray with at least two views. |
| 93005 | Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report. |
| 70551 | Magnetic Resonance Imaging of the brain and brain stem. |
| 93017 | Cardiovascular stress test that involves tracing the heart's electrical activity. |
| 58558 | Surgical hysteroscopy procedure that may include a biopsy of the endometrium, polypectomy, or dilation and curettage. |
| 97140 | Manual therapy techniques used for 15 minutes or more in one or more body regions. |
| C1776 | Implantable joint device, such as an artificial joint in a patient's ankle, knee, hip, or shoulder. |
| 95811 | Polysomnography to evaluate a patient's response to therapies. |
| 73221 | Magnetic Resonance Imaging of any joint in the upper extremity. |

³ Procedure Code Definitions: <https://www.aapc.com/>

Appendix G. Medicare Facility Fee Methodology and Tables



October 1, 2024

Subject: Colorado HB1215 – Medicare Facility Fee Identification Methodology Report

Medicare Facility Fee Identification Methodology

Overview

CBIZ Optumas (Optumas) was contracted by the Colorado Department of Health Care Policy and Financing (HCPF) to explore the policies, practices, and costs to Colorado health payers of facility fees as outlined in HB23-1215. Optumas was tasked with identifying outpatient facility fees within the Colorado All Payer Claims Database (APCD) provided by the Center for Improving Value in Healthcare (CIVHC) for 2017 through 2022. The APCD contains claims data from Medicare, Medicaid, and Commercial payers within the State of Colorado. The purpose of this memo is to detail the methodology used to identify hospital outpatient department (HOPD) facility fees within the Medicare claims portion of the APCD. This covers both Medicare Fee-for-service (FFS) and Medicare Advantage.

Data Validation

Optumas reviewed the data for all the requested fields to ensure they were complete and had the expected valid values. This review indicated that we received appropriate data aligned with our data request that would allow us to continue with the analysis. The exception to this is related to denied claims. The APCD does delineate if an individual service was denied during a visit but does not provide information on visits that were denied in their entirety. Optumas will note below for those analysis how this data limitation was handled.

We then reviewed the visit volume and financial field volume on a monthly longitudinal basis by service type and program. This review indicated that we did not have any major gaps or anomalies in the data. Optumas will note that we did not audit the APCD data and are relying on the accuracy of the data provided.

Optumas also compared the Medicare-specific data within APCD to determine what proportion of Medicare members were reflected within the dataset. That analysis indicated that for the 2017-2022 time period, the APCD reflects 95% of both Medicare and Medicare Advantage members. See Table 1 below.

Table 1. Medicare Membership Benchmark. Total Medicare Membership

| Period | CMS Reported Medicare Enrollment | APCD | % of Benchmark |
|--------|----------------------------------|---------|----------------|
| 2017 | 847,702 | 807,492 | 95% |
| 2018 | 881,043 | 834,766 | 95% |
| 2019 | 911,545 | 860,660 | 94% |
| 2020 | 938,949 | 886,492 | 94% |
| 2021 | 961,592 | 921,281 | 96% |
| 2022 | 983,947 | 946,661 | 96% |

Billing Guidelines Research

Optumas researched the billing of facility fees within Medicaid, which included provider surveys for Colorado hospitals and hospital systems. The findings from that research were that the professional services and HOPD services are billed on two separate claims using their appropriate claim forms. UB-04 claim forms are used for HOPD, and HCFA-1500 claim forms are used for professional services. The facility fee portion of the visit is therefore identified as just the HOPD portion based on the UB-04 form, exclusive of any professional component. That methodology is consistent with the definition of facility fees as outlined in HB23-1215, as well as how providers reported their facility fees within the provider surveys. This methodology was applied consistently to all hospital types (PPS and Critical Access Hospitals).

Optumas identified all HOPD claims within the APCD using a delineation provided by CIVHC to identify hospital outpatient claims. Optumas validated that delineation by reviewing the Bill Type provided on each claim to confirm they were appropriately identified. Bill Type is a nationally standardized set of codes for institutional/facility-based services that provides information on the type of bill the provider is submitting to the payer. Optumas found that the Bill Types were all generally related to an outpatient-type setting, however; we further delineated that data for this comparison to claims that had the following Bill Type:

- “131” - Hospital, outpatient, admit through discharge¹.
- “851” – Critical Access Hospital, outpatient, admit through discharge¹.

Additionally, Optumas limited the data to non-Emergency Room outpatient claims within the APCD. After discussion with the Hospital Facility Fee Steering Committee, it was determined to exclude all Emergency Room claims from the analytics. This final HOPD data set services as the basis for identifying the facility fees for Colorado based providers.

¹ <https://med.noridianmedicare.com/web/jea/topics/claim-submission/bill-types>

Billing Guidelines Research: G0463

The federal agency that oversees Medicare, the Centers for Medicare and Medicaid Services (CMS), provided billing guidelines^{2,3} that instructed prospective payment system (PPS) hospitals to report facility resources for HOPD visits using the CPT code G0463 for an in-person visit or Q3014⁴ for a telehealth visit. As a note, PPS hospitals represent a large majority of hospitals and hospital visits in the state. Depending on the visit type, one of these CPT codes are included on the claim billed to the member, along with the other services provided during the visit, to delineate and reimburse the hospital for their resources during the visit. The Medicare facility fee codes are also separate and distinct from the professional fee(s) billed by the physician during the visit⁵. Optumas was able to identify these CPT codes within the APCD for the Medicare HOPD data for the PPS hospitals.

CMS also provided instruction for non-PPS hospitals, which are primarily Critical Access Hospitals (CAH), that they may either use those two codes for billing facility fees, or to bill for facility fees using evaluation and management (E&M) codes⁶. Optumas reviewed the APCD for CAH HOPD visits and found that some facilities did use the G0463 for billing facility fees.

The billing of G0463 or Q3014 is a subset of the overall facility fee, which captures hospital resources in addition to the services provided as part of the total claim billed to the member.

Analytics

Optumas identified all non-ER Outpatient claims with a Bill Type of '131' (Hospital Outpatient) or '851' (Critical Access Hospital) charged to Medicare. This subset of data serves as the basis for the analytics to be performed that are outlined below. An initial overall summary of allowed amount and visits was performed to check for volume consistency or variation across the study period. The table below itemizes that initial summary of allowed amount, visits, and cost per visit. The cost per visit serves as an additional validation point, as the amount observed in the data aligns with the Medicare fee schedule for those codes during that time period.

Table 2 – HOPD Summary. All Medicare HOPD

| CY | Allowed Amount | Visit Count | Allowed/Visit |
|--------------|------------------------|-------------------|-----------------|
| 2017 | \$744,114,004 | 1,449,574 | \$513.33 |
| 2018 | \$804,985,821 | 1,406,391 | \$572.38 |
| 2019 | \$1,012,109,890 | 1,682,003 | \$601.73 |
| 2020 | \$1,046,365,677 | 1,691,453 | \$618.62 |
| 2021 | \$1,224,278,400 | 1,962,235 | \$623.92 |
| 2022 | \$1,453,497,345 | 2,250,621 | \$645.82 |
| Total | \$6,285,351,137 | 10,442,277 | \$601.91 |

² <https://www.federalregister.gov/documents/2013/07/19/2013-16555/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical>

³ <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2845cp.pdf>

⁴ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1026CP.pdf>

⁵ <https://www.federalregister.gov/documents/2000/04/07/00-8215/office-of-inspector-general-medicare-program-prospective-payment-system-for-hospital-outpatient>

⁶ <https://www.bnncpa.com/resources/clarification-of-clinic-billing-for-critical-access-hospitals/>

As required under 25.5-4-216(6)(a)(I) through (VII) C.R.S., the following analytics and summaries are to be derived from the APCD. Optumas has provided the methodology used to perform each analysis, and reference to the summary table in the appendices as applicable.

25.5-4-216(6)(a)(I)

Description

The number of patient visits for which facility fees were charged, including, to the extent possible, a breakdown of which visits were in-network and which were out-of-network.

Methodology

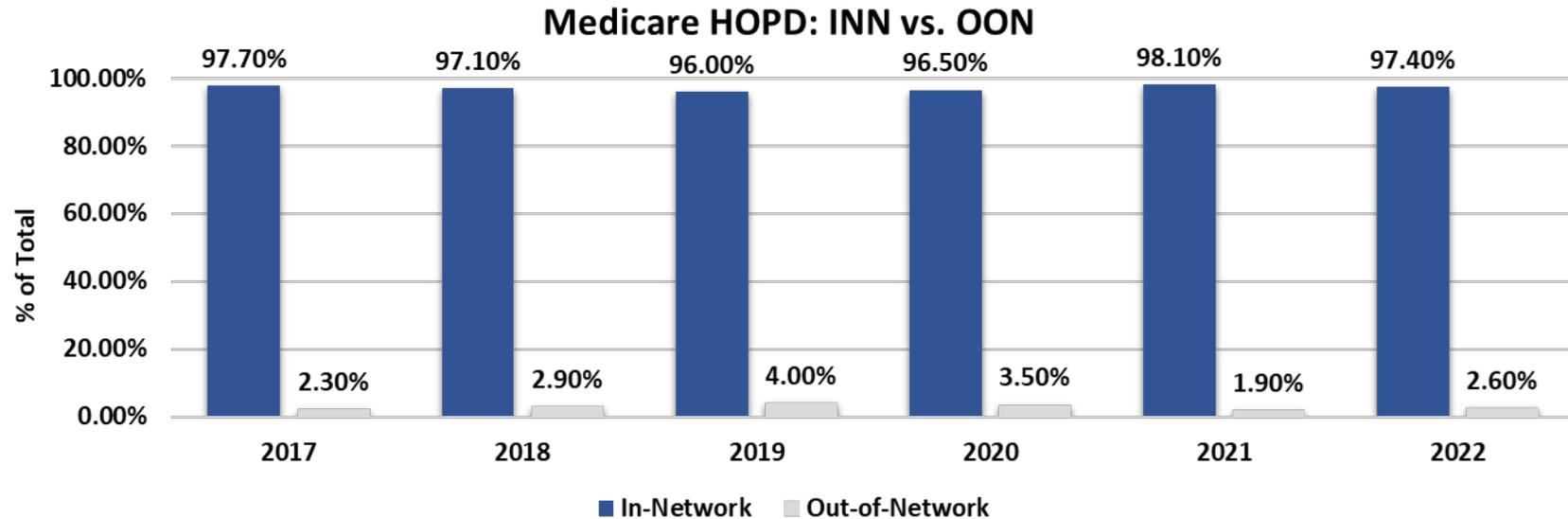
Optumas received a field in the APCD that indicates whether a claim was for an in-network or out-of-network provider. For Medicare FFS, if this field was not populated, Optumas assumed it was in-network as Medicare FFS would only pay for claims that were with an approved Medicare provider. This field was then used to summarize the volume of visits and allowed amounts for facility fees by in-network (INN) or out-of-network (OON).

Results

There were between 1,406,000 and 2,250,000 HOPD visits each year for Medicare, totaling over 10.4M visits across the study period. Over 96% of Medicare HOPD visits were for an in-network provider each year of the study period. See Exhibit I for table of detailed results by year.

Exhibit I - Number of Patient Visits for which Facility Fees were charged in-network and out-of-network.

| CY | HOPD Visits - In-Network | HOPD Visits - Out-of-Network | HOPD Visits - Total | Percentage of Total - In-Network | Percentage of Total - Out-of-Network | Percentage of Total - Total |
|--------------|--------------------------|------------------------------|---------------------|----------------------------------|--------------------------------------|-----------------------------|
| 2017 | 1,415,590 | 33,984 | 1,449,574 | 97.7% | 2.3% | 100.0% |
| 2018 | 1,365,331 | 41,059 | 1,406,390 | 97.1% | 2.9% | 100.0% |
| 2019 | 1,615,297 | 66,706 | 1,682,003 | 96.0% | 4.0% | 100.0% |
| 2020 | 1,632,470 | 58,983 | 1,691,453 | 96.5% | 3.5% | 100.0% |
| 2021 | 1,924,163 | 38,072 | 1,962,235 | 98.1% | 1.9% | 100.0% |
| 2022 | 2,192,106 | 58,515 | 2,250,621 | 97.4% | 2.6% | 100.0% |
| Total | 10,144,957 | 297,319 | 10,442,276 | 97.2% | 2.8% | 100.0% |



25.5-4-216(6)(a)(II)

Description

To the extent possible, the number of patient visits for which the facility fees were charged out-of-network and the professional fees were charged in-network for the same outpatient service.

Methodology

Optumas utilized the analysis from above that identified OON HOPD visits that had a facility fee. The member ID and date of service for that visit was used to find a corresponding professional E&M visit for the same date of service for that member. As noted above within the billing guidelines research, the professional fees are separate from the facility fee. The professional fees are also billed on a separate claim, resulting in the need to use the member ID and date of service methodology to identify the corresponding professional visit when a facility fee was billed. The following CPT codes were utilized to identify the E&M professional visit:

- CPT Codes 99202 – 99499: Professional Evaluation and Management
- CPT Codes 92002 – 92499: Ophthalmology Services
- CPT Codes 97010 – 97799: Physical Medicine and Rehabilitation Evaluations

Table 3 below illustrates an example claim structure for a member that had a professional visit and a HOPD visit with a facility fee on the same date of service. In this example, the member visited their physician and then had imaging done on their lower back at a HOPD that also included a facility fee. The claim example shows the date of service, the services provided, the place of service (POS) code, and the relevant financial fields. The financial fields reflect:

- Allowed: full amount that insurer (Medicare) has agreed to reimburse provider for each service.
- Member Share: the portion of the allowed amount that the member is responsible for paying. This amount will be dependent upon their deductible, copay, and coinsurance of their benefit package.
- Paid: Amount that the insurer (Medicare) paid.

Below is a description of the two claim examples:

- Claim ID 999999001: represents the E&M professional visit for member ABC123
 - CPT 99214: “Established patient office or other outpatient visit, 30-39 minutes”
 - POS (place of service): 22 indicates the visit took place in the outpatient department
- Claim ID 999999002: represents hospital outpatient clinic visit for member ABC123
 - CPT 99214: “Established patient office or other outpatient visit, 30-39 minutes”

- CPT 72100: “Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Spine and Pelvis”
 - “The technician takes 2 or 3 views of the vertebrae in the lumbar region which is the lower part of the spine and the sacrum, the area that connects the spine to the pelvis. Lumbosacral spine X-rays help evaluate back injuries, persistent numbness, and low back pain.”⁷
 - CPT 72070: ““Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Hospital outpatient clinic visit for assessment and management of a patient G0463 Spine and Pelvis””
 - “A radiologic examination of the thoracic spine is an X-ray of the twelve chest thoracic vertebrae. An AP and lateral are basic projections. The X-rays are used in a controlled way to minimize the radiation exposure. The X-ray helps evaluate bone injuries and diseases, fractures, dislocations, osteoporosis and deformities in the curvature of the spine.”⁸
 - CPT G0463: “Hospital outpatient clinic visit for assessment and management of a patient G0463”

Table 3 – Claim Structure Example

| Member ID | Claim ID | Service Date | CPT Code | POS | Allowed | Member Share | Plan Paid |
|-----------|-----------|--------------|----------|-----|----------|--------------|-----------|
| ABC123 | 999999001 | 6/5/2017 | 99214 | 22 | \$86.24 | \$0.00 | \$86.24 |
| ABC123 | 999999002 | 6/5/2017 | 72100 | 22 | \$35.54 | \$14.00 | \$21.54 |
| ABC123 | 999999002 | 6/5/2017 | 72070 | 22 | \$34.47 | \$14.00 | \$20.47 |
| ABC123 | 999999002 | 6/5/2017 | G0463 | 22 | \$102.45 | \$5.00 | \$97.45 |

⁷ <https://www.aapc.com/codes/cpt-codes/72100>

⁸ <https://www.aapc.com/codes/cpt-codes/72070>

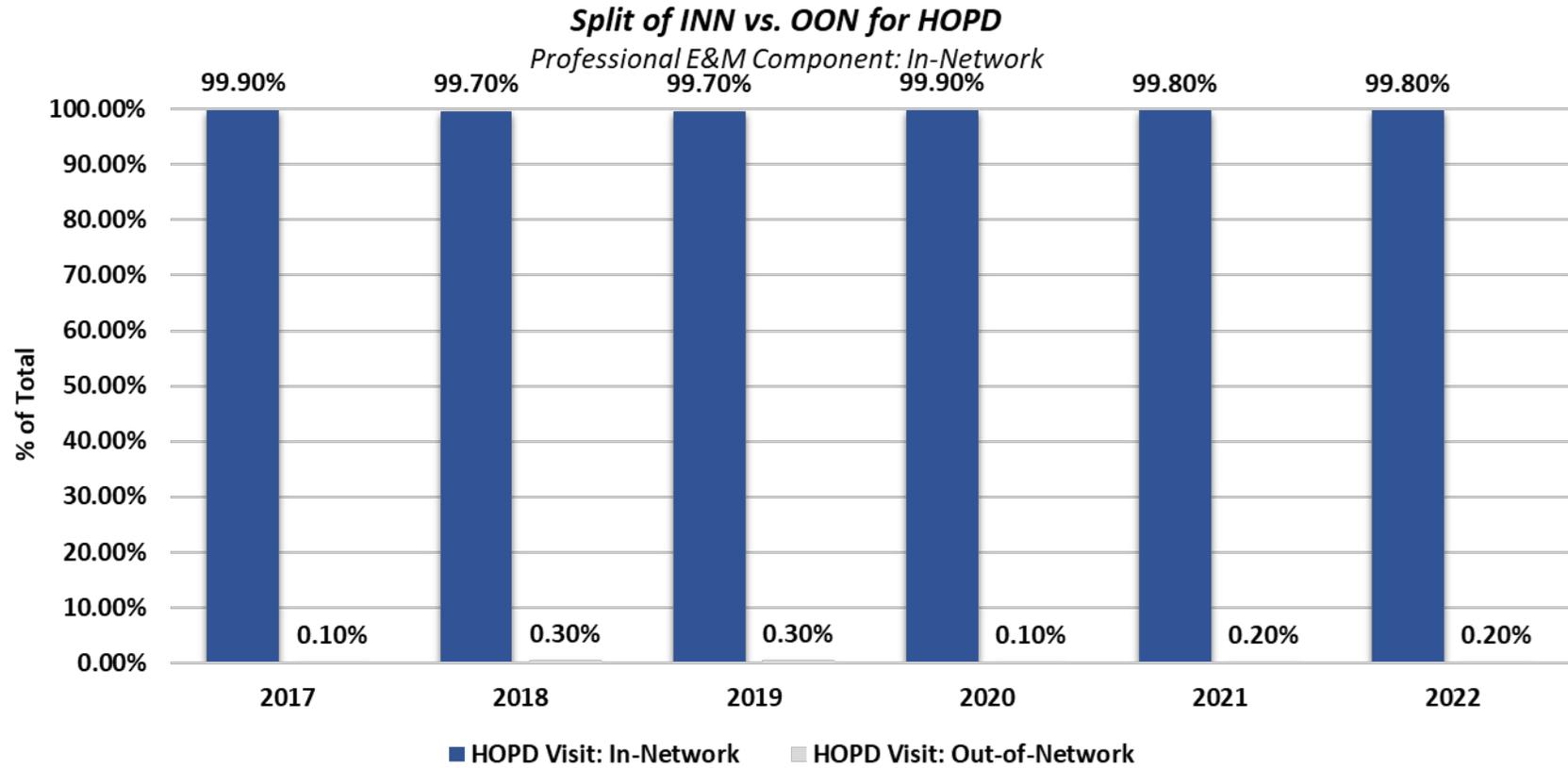
Results

Of the roughly 1,800,000 HOPD visits with a Professional E&M visit on the same day that were charged to Commercial payers from 2017-2022, 99.8% had a professional fee component that was also charged by an in-network provider. Only 0.2% of Outpatient visits with a Professional E&M visit that was charged by an in-network provider had an Outpatient HOPD visit charged by an out-of-network provider. See Exhibit II for detailed table of results by year and in-network vs. out-of-network professional component. Note, the total Outpatient visits displayed in this exhibit do not represent all Medicare Outpatient non-ER visits from 2017 – 2022. Only visits for a member that had an in-network Professional E&M visit on the same day as their HOPD visit are displayed.

Exhibit II - Number of Patient Visits for which Facility Fees were charged out-of-network and the professional fees were charged in-network for the same service. Professional E&M Visit In-Network

| CY | HOPD Visit: In-Network | HOPD Visit: Out-of-Network | HOPD Visit: Total | Percentage of Total - HOPD Visit: In-Network | Percentage of Total - HOPD Visit: Out-of-Network | Percentage of Total In - HOPD Visit: Total |
|--------------|------------------------|----------------------------|-------------------|--|--|--|
| 2017 | 245,212 | 235 | 245,447 | 99.90% | 0.10% | 100.00% |
| | | | | | | |
| Total | 1,802,174 | 3,624 | 1,805,798 | 99.80% | 0.20% | 100.00% |

Exhibit II - Number of Patient Visits for which Facility Fees were charged out-of-network and the professional fees were charged in-network for the same service.



25.5-4-216(6)(a)(III)

Description

The total allowed facility fee amounts billed and denied.

Methodology

As noted in the Data Validation section, there is a data limitation on identifying all denied visits. The APCD includes information on when an individual service billed by the provider, such as the facility fee, was denied with the rest of the visit approved and paid. The data does not include information on when the entirety of the visit was denied. As such, Optumas is limited in reporting on the cases when the entire visit was denied, but can report on the instances when the facility fee portion of the visit was denied while other services were approved and paid.

The APCD provides a field in the data on each individual claim line that indicates paid or denied status. Optumas summarized the allowed amount and visit count, delineated by paid or denied using the line level information in the data, for all instances of HOPD visits by year in the Medicare data for the study period.

Results

About 96.4% of allowed dollars for HOPD visits were paid, and approximately 3.6% were partially denied across 2020 – 2022. As noted above, this does not include instances where the entire visit was denied. See Exhibit III for the detailed table of results by year, paid or denied status, for Medicare HOPD visits.

Exhibit III – The total allowed Facility Fee amounts billed and denied.⁹

| CY | Allowed Dollars - Partially Denied | Allowed Dollars - Not Denied | Allowed Dollars - Total | Percentage of Total - Partially Denied | Percentage of Total - Not Denied | Percentage of Total - Total |
|--------------|------------------------------------|------------------------------|-------------------------|--|----------------------------------|-----------------------------|
| 2020 | \$56,402,274 | \$989,963,403 | \$1,046,365,677 | 5.4% | 94.6% | 100.0% |
| 2021 | \$47,974,925 | \$1,176,303,476 | \$1,224,278,400 | 3.9% | 96.1% | 100.0% |
| 2022 | \$30,706,308 | \$1,422,791,037 | \$1,453,497,345 | 2.1% | 97.9% | 100.0% |
| Total | \$135,083,507 | \$3,589,057,916 | \$3,724,141,423 | 3.6% | 96.4% | 100.0% |

⁹ The denied indicator for the 2017 – 2019 data was not sufficiently populated. The data from these three years has been removed from this analysis.

25.5-4-216(6)(a)(IV)

Description

The top ten most frequent CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, for which facility fees were charged.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) most frequent 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.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim.** This data was then used to analyze the most frequently billed services.

Results

The 25 most frequent procedure codes for which HOPD visits were charged to Medicare are displayed in Exhibit IV.a. Laboratory services, which account for over 46% of the top 25 most frequent procedure codes, are the most common services that are performed during an HOPD visit. Appendix 1 contains the detailed descriptions of the top 25 most frequent procedure codes for which facility fees were charged to Medicare.

The top 25 most frequent revenue codes for which HOPD visits were charged to Medicare are displayed in Exhibit IV.b. Revenue code '0301', which designates a Laboratory/Chemistry service, account for nearly 20% of the top 25 most frequent revenue codes for which HOPD visits are charged.

Exhibit IV.a – Top 25 CPT codes for which Facility Fees were charged. Procedure Code: Counts

| CPT Code | Description ¹⁰ | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|----------|---------------------------|---------|---------|---------|---------|---------|---------|-----------|
| 36415 | Laboratory | 361,414 | 314,198 | 385,827 | 365,756 | 415,861 | 438,972 | 2,282,028 |
| G0463 | HOPD Clinic Visit | 323,658 | 336,707 | 371,324 | 309,905 | 366,844 | 412,696 | 2,121,134 |
| 80053 | Laboratory | 194,057 | 172,663 | 229,516 | 237,938 | 275,344 | 300,117 | 1,409,635 |
| 85025 | Laboratory | 186,791 | 171,586 | 230,808 | 222,814 | 255,047 | 275,196 | 1,342,242 |
| 97110 | Physical Therapy | 97,400 | 112,007 | 138,392 | 116,651 | 144,319 | 166,952 | 775,721 |
| 80048 | Chemical Screen | 86,500 | 80,448 | 119,327 | 101,302 | 111,487 | 119,373 | 618,437 |
| 84443 | Laboratory | 89,283 | 73,268 | 97,106 | 102,231 | 119,076 | 128,669 | 609,633 |
| 80061 | Laboratory | 87,560 | 70,218 | 92,259 | 102,262 | 120,607 | 133,518 | 606,424 |
| 85610 | Prothrombin Time | 106,797 | 101,517 | 111,030 | 95,309 | 92,554 | 88,431 | 595,638 |
| J3490 | Injectables | 9,179 | 15,586 | 24,732 | 82,202 | 130,995 | 318,915 | 581,609 |
| 97140 | Therapy | 59,746 | 72,776 | 92,049 | 76,205 | 91,967 | 102,399 | 495,142 |
| 83036 | Laboratory | 61,047 | 48,825 | 63,695 | 70,626 | 84,934 | 98,446 | 427,573 |
| 85027 | Laboratory | 53,415 | 53,767 | 78,093 | 72,407 | 78,208 | 86,745 | 422,635 |
| A9270 | Misc. Supplies | 37,970 | 53,393 | 78,754 | 68,406 | 75,991 | 71,913 | 386,427 |
| 77067 | Mammogram | 75 | 64,806 | 76,513 | 70,292 | 76,774 | 83,331 | 371,791 |
| J2704 | Injectables | 26,675 | 34,656 | 45,202 | 51,908 | 78,495 | 112,498 | 349,434 |
| 77063 | X-Ray | 33,196 | 41,873 | 56,269 | 58,758 | 68,647 | 77,230 | 335,973 |
| J3010 | Injectables | 43,185 | 46,759 | 58,192 | 55,551 | 59,297 | 70,040 | 333,024 |
| 93005 | Cardiography | 40,559 | 41,244 | 67,649 | 47,441 | 51,784 | 64,063 | 312,740 |
| Q9967 | Low Osmolar Contrast | 35,568 | 37,427 | 54,317 | 49,087 | 49,218 | 53,439 | 279,056 |
| 93306 | Echocardiography | 38,342 | 38,682 | 45,835 | 43,311 | 49,094 | 61,153 | 276,417 |
| J1100 | Injectables | 28,609 | 33,598 | 43,293 | 46,703 | 53,959 | 66,977 | 273,139 |
| J2250 | Injectables | 35,992 | 39,690 | 47,049 | 45,849 | 46,967 | 53,430 | 268,977 |
| 83735 | Laboratory | 28,190 | 27,193 | 39,144 | 41,091 | 49,868 | 56,423 | 241,909 |
| J2405 | Injectables | 26,102 | 29,380 | 43,272 | 39,849 | 44,116 | 54,481 | 237,200 |

¹⁰ For Injectable services, counts are based on the frequency of the procedure codes within the APCD.

Exhibit IV.b – Top 25 revenue codes for which Facility Fees were charged. Revenue Code: Counts

| Rev. Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|-----------|----------------------------------|---------|---------|---------|-----------|-----------|-----------|-----------|
| 0301 | Laboratory - Chemistry | 746,811 | 754,966 | 924,708 | 1,112,505 | 1,338,852 | 1,474,258 | 6,352,100 |
| 0636 | Pharmacy | 488,994 | 560,176 | 613,444 | 802,650 | 875,637 | 1,007,875 | 4,348,776 |
| 0300 | Laboratory - General | 825,388 | 612,014 | 673,387 | 622,624 | 765,627 | 795,527 | 4,294,567 |
| 0305 | Hematology | 322,480 | 324,190 | 358,379 | 408,620 | 462,541 | 482,798 | 2,359,008 |
| 0510 | Outpatient Hospital | 355,660 | 362,104 | 361,893 | 324,528 | 394,414 | 429,727 | 2,228,326 |
| 0250 | Pharmacy - General | 148,978 | 230,902 | 225,156 | 293,211 | 374,386 | 560,057 | 1,832,690 |
| 0420 | Physical Therapy | 250,741 | 293,353 | 268,299 | 235,727 | 294,862 | 334,363 | 1,677,345 |
| 0320 | X-Ray | 143,935 | 143,565 | 147,736 | 151,631 | 176,240 | 191,010 | 954,117 |
| 0306 | Bacteriology | 103,730 | 104,424 | 115,040 | 171,225 | 187,175 | 171,888 | 853,482 |
| 0302 | Immunology | 84,336 | 90,773 | 102,747 | 164,161 | 185,828 | 171,357 | 799,202 |
| 0403 | Screening Mammography | 98,446 | 105,929 | 112,990 | 125,794 | 144,407 | 158,865 | 746,431 |
| 0272 | Sterile Supplies | 94,895 | 101,365 | 107,846 | 122,130 | 133,709 | 155,885 | 715,830 |
| 0761 | Treatment Room | 91,190 | 95,131 | 100,538 | 102,226 | 111,609 | 124,757 | 625,451 |
| 0333 | Home Health | 48,707 | 69,322 | 74,389 | 83,171 | 93,795 | 99,507 | 468,891 |
| 0360 | Operating Room | 65,129 | 67,121 | 67,821 | 76,241 | 87,129 | 104,764 | 468,205 |
| 0260 | IV Therapy | 59,006 | 62,671 | 68,491 | 78,738 | 89,876 | 95,555 | 454,337 |
| 0352 | CT Scan | 51,738 | 49,797 | 55,520 | 79,200 | 90,839 | 98,562 | 425,656 |
| 0258 | IV Solutions | 62,579 | 69,954 | 74,975 | 71,682 | 74,871 | 70,196 | 424,257 |
| 0637 | Self-administered Drugs | 41,722 | 57,723 | 82,301 | 74,999 | 84,196 | 78,560 | 419,501 |
| 0370 | Anesthesia | 46,204 | 52,463 | 60,771 | 73,055 | 82,973 | 102,388 | 417,854 |
| 0710 | Recovery Room | 44,721 | 49,509 | 52,969 | 61,166 | 71,906 | 88,474 | 368,745 |
| 0460 | Pulmonary Function | 58,239 | 53,649 | 56,194 | 48,323 | 56,823 | 62,255 | 335,483 |
| 0483 | Echocardiology | 45,170 | 47,238 | 46,575 | 52,136 | 60,726 | 68,123 | 319,968 |
| 0402 | Ultrasound | 46,380 | 46,411 | 47,848 | 49,968 | 55,712 | 58,147 | 304,466 |
| 0312 | Laboratory Pathology - Histology | 41,103 | 43,364 | 46,623 | 51,060 | 54,408 | 58,909 | 295,467 |



25.5-4-216(6)(a)(V)

Description

The top ten CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, with the highest total allowed amounts from facility fees.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) codes with the highest allowed amount 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.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim.** This data was then used to analyze the codes with the highest allowed amount.

Results

The 25 procedure codes for which HOPD visits were charged to Medicare, based on allowed amount by code, are displayed in Exhibit V.a. Blood collection and blood testing services account for nearly 25% of the allowed amount for the top 25 codes. Procedure code 'G0463', which designates additional hospital resources being billed as part of the facility fee component of a HOPD visit, accounts for approximately 12% of the allowed amount for the top 25 codes. Appendix 2 contains the detailed descriptions of the top 25 procedure codes for which HOPD visits were charged to Medicare, based on allowed amount by code.

The top 25 most frequent revenue codes for which HOPD visits were charged to Medicare are displayed in Exhibit V.b. Revenue code '0360' is related to Operating Room services.

Exhibit V.a – Top 25 procedure codes with the highest total allowed amounts on same visit as a facility fees. Procedure Code: Allowed Amounts

| CPT Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|----------|-------------------------------|--------------|--------------|--------------|--------------|--------------|--------------|---------------|
| 27447 | Knee Arthroplasty | \$36,854 | \$16,988,420 | \$35,230,798 | \$48,361,832 | \$57,142,739 | \$82,480,562 | \$240,241,205 |
| G0463 | HOPD Clinic Visit | \$32,485,010 | \$35,746,351 | \$37,185,074 | \$28,956,988 | \$35,750,632 | \$38,910,801 | \$209,034,856 |
| 93306 | Echocardiography | \$18,365,276 | \$19,015,710 | \$21,924,740 | \$20,576,462 | \$23,954,899 | \$27,176,147 | \$131,013,233 |
| J9271 | Chemotherapy Drug | \$8,158,424 | \$10,519,290 | \$13,772,739 | \$22,369,406 | \$27,330,203 | \$26,911,033 | \$109,061,095 |
| 27130 | Hip Arthroplasty | \$10,767 | \$23,110 | \$21,474 | \$24,864,276 | \$32,797,620 | \$44,604,323 | \$102,321,570 |
| 93656 | Electrophysiologic Evaluation | \$7,300,539 | \$8,324,753 | \$15,609,939 | \$16,168,355 | \$20,373,344 | \$26,793,164 | \$94,570,095 |
| 78452 | Nuclear Medicine | \$12,622,667 | \$12,584,378 | \$15,176,814 | \$12,981,469 | \$14,332,813 | \$15,613,951 | \$83,312,092 |
| 93653 | Electrophysiologic Procedures | \$8,915,220 | \$8,695,161 | \$10,438,725 | \$10,929,257 | \$9,985,898 | \$13,782,901 | \$62,747,161 |
| C9600 | Coronary Angioplasty | \$8,211,297 | \$7,384,817 | \$9,669,137 | \$9,910,833 | \$11,055,772 | \$12,853,737 | \$59,085,594 |
| J9299 | Chemotherapy Drug | \$6,506,450 | \$7,204,130 | \$9,744,556 | \$9,697,977 | \$8,925,559 | \$8,711,546 | \$50,790,219 |
| 66984 | Vision | \$8,010,596 | \$8,058,991 | \$7,761,569 | \$7,193,537 | \$8,564,460 | \$10,722,938 | \$50,312,092 |
| 77386 | Radiation Treatment | \$4,345,201 | \$6,898,454 | \$7,863,961 | \$9,516,416 | \$9,450,540 | \$10,475,601 | \$48,550,172 |
| J1561 | Chemotherapy Drug | \$5,399,310 | \$5,370,113 | \$7,952,640 | \$9,263,558 | \$11,156,984 | \$7,160,104 | \$46,302,710 |
| 23472 | Shoulder Arthroplasty | \$62,743 | \$28,392 | \$26,458 | \$150,592 | \$14,502,507 | \$26,728,420 | \$41,499,114 |
| 96413 | Chemotherapy Drug | \$5,123,432 | \$5,976,415 | \$6,311,938 | \$8,104,248 | \$8,073,943 | \$7,837,764 | \$41,427,739 |
| J0897 | Osteoporosis Drug | \$5,455,804 | \$5,942,828 | \$6,763,802 | \$6,670,848 | \$7,924,410 | \$7,939,712 | \$40,697,404 |
| 78815 | Nuclear Medicine | \$5,245,762 | \$5,595,772 | \$6,281,362 | \$6,822,095 | \$7,482,706 | \$8,810,895 | \$40,238,592 |
| 97110 | Physical Therapy | \$5,200,383 | \$5,805,515 | \$7,072,221 | \$5,853,016 | \$7,274,345 | \$8,468,814 | \$39,674,294 |
| 33249 | Pacemaker | \$6,255,942 | \$5,501,237 | \$6,952,483 | \$7,026,613 | \$7,034,321 | \$6,882,362 | \$39,652,958 |
| 33208 | Pacemaker Insertion | \$5,268,723 | \$4,569,545 | \$5,887,186 | \$7,469,824 | \$6,780,368 | \$7,186,503 | \$37,162,150 |
| 77067 | Mammogram | \$4,745 | \$6,704,466 | \$7,480,668 | \$7,091,687 | \$7,698,337 | \$8,103,363 | \$37,083,266 |
| J9312 | Chemotherapy Drug | \$0 | \$0 | \$12,788,431 | \$11,032,911 | \$7,123,500 | \$4,288,579 | \$35,233,422 |
| J2350 | Injectables | \$0 | \$5,347,396 | \$7,157,522 | \$8,024,294 | \$7,981,724 | \$6,585,770 | \$35,096,706 |
| 45380 | Endoscopy Procedures | \$5,145,567 | \$5,209,464 | \$6,078,786 | \$5,198,544 | \$6,247,283 | \$6,765,232 | \$34,644,876 |
| J2505 | Immunostimulant | \$7,873,866 | \$7,481,406 | \$8,366,363 | \$6,527,661 | \$3,839,007 | \$0 | \$34,088,302 |

Exhibit V.b – Top 25 revenue codes with the highest total allowed amounts on same visit as a facility fees. Revenue Code: Allowed Amounts

| Rev. Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|-----------|---------------------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| 0360 | Operating Room | \$125,334,663 | \$149,639,053 | \$162,819,771 | \$223,743,274 | \$286,596,902 | \$367,378,245 | \$1,315,511,907 |
| 0636 | Pharmacy | \$141,056,277 | \$147,746,892 | \$163,818,759 | \$204,999,500 | \$231,014,630 | \$225,388,781 | \$1,114,024,839 |
| 0481 | Cardiology | \$46,784,064 | \$46,884,789 | \$51,676,697 | \$63,889,082 | \$67,857,498 | \$82,374,719 | \$359,466,849 |
| 0361 | Operating Room | \$31,221,522 | \$33,437,537 | \$34,724,850 | \$40,589,178 | \$40,809,982 | \$45,900,104 | \$226,683,173 |
| 0761 | Treatment Room | \$28,693,370 | \$30,674,927 | \$31,470,235 | \$35,290,672 | \$40,958,875 | \$46,736,613 | \$213,824,692 |
| 0510 | Outpatient Hospital | \$33,867,983 | \$36,702,409 | \$35,170,596 | \$29,373,815 | \$37,034,741 | \$40,013,222 | \$212,162,766 |
| 0333 | Home Health | \$17,030,267 | \$24,923,537 | \$27,512,418 | \$33,764,664 | \$37,608,276 | \$41,103,172 | \$181,942,335 |
| 0480 | Cardiology | \$17,829,324 | \$18,161,147 | \$22,798,989 | \$23,506,493 | \$28,086,369 | \$31,715,498 | \$142,097,820 |
| 0483 | Echocardiology | \$18,273,844 | \$19,641,728 | \$18,892,589 | \$20,730,027 | \$24,467,419 | \$28,003,072 | \$130,008,679 |
| 0750 | Gastrointestinal Services | \$16,974,546 | \$18,664,609 | \$19,283,313 | \$20,093,915 | \$23,730,388 | \$30,061,259 | \$128,808,030 |
| 0341 | Nuclear Medicine | \$14,831,038 | \$14,833,857 | \$15,317,393 | \$15,410,048 | \$17,413,373 | \$18,211,635 | \$96,017,344 |
| 0352 | CT Scan | \$13,693,322 | \$12,549,328 | \$14,960,526 | \$16,515,977 | \$18,140,004 | \$19,622,020 | \$95,481,177 |
| 0301 | Laboratory - Chemistry | \$10,884,455 | \$10,431,512 | \$12,276,011 | \$14,630,113 | \$17,203,701 | \$20,081,932 | \$85,507,723 |
| 0320 | X-Ray | \$11,686,020 | \$11,880,990 | \$12,163,946 | \$12,639,185 | \$15,026,261 | \$16,829,869 | \$80,226,271 |
| 0420 | Physical Therapy | \$9,090,677 | \$10,405,064 | \$11,939,170 | \$10,461,349 | \$13,078,742 | \$15,585,438 | \$70,560,440 |
| 0300 | Laboratory - General | \$10,909,273 | \$8,094,433 | \$8,849,706 | \$9,920,530 | \$12,205,896 | \$12,630,668 | \$62,610,506 |
| 0278 | Medical Supplies | \$6,811,538 | \$6,499,426 | \$9,647,541 | \$8,496,269 | \$11,866,234 | \$18,418,635 | \$61,739,643 |
| 0260 | IV Therapy | \$6,716,733 | \$6,988,461 | \$7,655,122 | \$8,724,480 | \$10,680,499 | \$11,615,668 | \$52,380,961 |
| 0403 | Screening Mammography | \$7,295,616 | \$7,721,682 | \$7,567,813 | \$8,418,269 | \$9,493,479 | \$10,093,313 | \$50,590,172 |
| 0335 | Chemotherapy | \$6,220,309 | \$7,255,513 | \$7,177,104 | \$9,762,471 | \$10,000,806 | \$9,733,810 | \$50,150,013 |
| 0404 | Tomography | \$6,030,226 | \$6,473,205 | \$6,556,091 | \$8,154,614 | \$9,414,346 | \$11,261,628 | \$47,890,110 |
| 0250 | Pharmacy - General | \$5,092,065 | \$5,693,032 | \$3,657,905 | \$9,336,194 | \$6,471,974 | \$11,775,355 | \$42,026,525 |
| 0610 | Magnetic Resonance Tech | \$6,644,252 | \$6,243,162 | \$6,345,225 | \$6,113,660 | \$7,447,377 | \$8,299,787 | \$41,093,463 |
| 0612 | MRI - Spine | \$4,751,547 | \$4,647,013 | \$5,069,431 | \$5,457,404 | \$6,700,360 | \$7,088,490 | \$33,714,245 |
| 0611 | MRI - Brain | \$4,743,194 | \$4,912,354 | \$4,859,625 | \$5,236,007 | \$5,989,712 | \$6,450,966 | \$32,191,858 |

25.5-4-216(6)(a)(VI)

Description

The top ten CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, for which facility fees are charged with the highest member cost sharing.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) codes with the highest member cost sharing 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.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim.** This data was then used to analyze the codes with the highest member cost sharing.

Results

Exhibit VI.a represents the top 25 procedure codes for which HOPD visits were charged to Medicare with the highest member cost sharing amounts. Chemotherapy drugs provided via injection or infusion, Laboratory services, Echocardiography services, and procedure code 'G0463' account for the greatest member cost sharing. This will be partially driven by the individual cost of those services, and the timing of a member meeting their Medicare deductible which contributes to how much the member owes. If the member is below their deductible, and the service is not covered under a fixed copay, the member will pay 100% of the service cost up to their deductible. After they meet their deductible, the member will pay 20% of the remainder and Medicare will pay 80%. This is referred to as co-insurance coverage. Appendix 3 contains the detailed descriptions of the top 25 procedure codes for which HOPD visits were charged with the highest member cost sharing amounts.

Exhibit VI.b displays the top 25 revenue codes for which HOPD visits were charged to Medicare with the highest member cost sharing. Revenue codes '0636' (Pharmacy) and '0360' (Operating Room) represent nearly 46% of the top 25 revenue codes with the highest member cost sharing.

Exhibit VI.a – Top 25 procedure codes for which Facility Fees are charged with the highest member cost sharing. Procedure Code: Member Cost Sharing Amounts

| CPT Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|----------|----------------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------|
| G0463 | HOPD Clinic Visit | \$7,124,993 | \$6,663,149 | \$7,169,841 | \$5,595,487 | \$6,128,818 | \$7,154,539 | \$39,836,828 |
| 93306 | Echocardiography | \$3,826,743 | \$4,155,787 | \$4,693,914 | \$4,453,523 | \$5,054,759 | \$5,494,485 | \$27,679,211 |
| 27447 | Arthroplasty | \$19,304 | \$1,602,980 | \$2,891,345 | \$3,743,643 | \$4,877,341 | \$6,789,894 | \$19,924,506 |
| 78452 | Nuclear Medicine | \$2,736,557 | \$2,694,516 | \$3,029,904 | \$2,394,448 | \$2,518,079 | \$2,621,675 | \$15,995,179 |
| J9271 | Chemotherapy Drug | \$1,156,312 | \$1,588,160 | \$1,893,167 | \$2,814,500 | \$3,152,392 | \$2,451,209 | \$13,055,740 |
| 97110 | Physical Therapy | \$1,720,172 | \$1,903,860 | \$2,188,046 | \$1,730,093 | \$2,132,433 | \$2,449,826 | \$12,124,430 |
| 66984 | Vision | \$2,081,740 | \$2,015,332 | \$1,659,733 | \$1,549,596 | \$1,763,650 | \$2,042,355 | \$11,112,405 |
| J0897 | Osteoporosis Drug | \$1,236,038 | \$1,354,497 | \$1,534,457 | \$1,480,133 | \$1,681,350 | \$1,624,397 | \$8,910,872 |
| J1561 | Chemotherapy Drug | \$1,068,467 | \$1,056,204 | \$1,475,072 | \$1,767,129 | \$2,073,248 | \$1,366,700 | \$8,806,820 |
| 27130 | Hip Arthroplasty | \$6,577 | \$13,937 | \$6,918 | \$1,986,245 | \$2,864,864 | \$3,728,172 | \$8,606,713 |
| 74177 | CT Scan | \$1,042,864 | \$1,032,358 | \$1,416,496 | \$1,385,258 | \$1,596,362 | \$1,593,516 | \$8,066,853 |
| 96413 | Chemotherapy Drug | \$1,064,159 | \$1,196,383 | \$1,211,782 | \$1,510,831 | \$1,472,368 | \$1,308,314 | \$7,763,835 |
| 95811 | Sleep Medicine | \$1,568,409 | \$1,552,385 | \$1,536,738 | \$870,356 | \$941,579 | \$994,822 | \$7,464,288 |
| 96365 | Intravenous Infusion | \$995,588 | \$1,051,301 | \$1,201,321 | \$1,155,295 | \$1,398,522 | \$1,426,584 | \$7,228,612 |
| 78815 | Nuclear Medicine | \$1,077,124 | \$1,136,172 | \$1,172,139 | \$1,140,656 | \$1,259,122 | \$1,390,861 | \$7,176,074 |
| J1745 | Injectables | \$1,274,608 | \$1,224,507 | \$1,314,311 | \$1,369,940 | \$1,092,703 | \$693,345 | \$6,969,414 |
| 77386 | Radiation Treatment | \$706,647 | \$1,071,313 | \$1,164,766 | \$1,341,118 | \$1,337,288 | \$1,287,104 | \$6,908,236 |
| J9312 | Chemotherapy Drug | \$0 | \$0 | \$2,220,506 | \$2,155,868 | \$1,604,579 | \$919,345 | \$6,900,299 |
| 72148 | Radiology | \$992,651 | \$926,997 | \$1,117,294 | \$1,080,390 | \$1,331,263 | \$1,377,756 | \$6,826,351 |
| 70553 | MRI of the Brain | \$1,172,243 | \$1,130,286 | \$1,037,971 | \$1,028,418 | \$1,143,429 | \$1,194,354 | \$6,706,701 |
| 43239 | Endoscopy | \$1,035,611 | \$1,080,221 | \$1,165,792 | \$1,063,363 | \$1,089,354 | \$1,245,351 | \$6,679,690 |
| J9299 | Chemotherapy Drug | \$1,158,578 | \$1,038,179 | \$1,196,816 | \$1,137,922 | \$1,018,959 | \$935,844 | \$6,486,298 |
| 93458 | Catheter Placement | \$999,200 | \$954,438 | \$1,044,768 | \$941,474 | \$1,002,021 | \$1,073,059 | \$6,014,959 |
| 71260 | Radiology | \$919,638 | \$889,846 | \$961,965 | \$1,015,198 | \$1,047,953 | \$1,110,042 | \$5,944,641 |
| 45380 | Endoscopy Procedures | \$1,017,238 | \$956,896 | \$1,057,097 | \$854,954 | \$1,020,081 | \$1,004,559 | \$5,910,824 |

Exhibit VI.b – Top 25 revenue codes for which Facility Fees are charged with the highest member cost sharing. Revenue Code: Member Cost Sharing Amounts

| Rev. Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|-----------|---------------------------|--------------|--------------|--------------|--------------|--------------|--------------|---------------|
| 0636 | Pharmacy | \$26,763,406 | \$27,165,374 | \$29,466,162 | \$35,512,708 | \$39,031,555 | \$35,275,960 | \$193,215,164 |
| 0360 | Operating Room | \$21,613,754 | \$23,023,499 | \$24,783,799 | \$27,871,613 | \$34,663,579 | \$41,790,392 | \$173,746,635 |
| 0510 | Outpatient Hospital | \$7,648,740 | \$7,081,346 | \$7,503,967 | \$5,897,587 | \$6,662,794 | \$7,758,878 | \$42,553,311 |
| 0761 | Treatment Room | \$4,960,761 | \$5,658,504 | \$5,905,602 | \$6,350,693 | \$7,112,520 | \$8,095,792 | \$38,083,872 |
| 0361 | Operating Room | \$5,453,157 | \$5,543,031 | \$6,057,463 | \$6,711,126 | \$6,782,894 | \$7,277,267 | \$37,824,939 |
| 0481 | Cardiology | \$5,269,771 | \$5,110,520 | \$5,700,028 | \$5,804,263 | \$6,428,968 | \$7,173,605 | \$35,487,155 |
| 0352 | CT Scan | \$4,219,054 | \$3,882,930 | \$4,693,756 | \$4,944,755 | \$5,487,139 | \$5,783,663 | \$29,011,297 |
| 0333 | Home Health | \$3,134,607 | \$4,168,045 | \$4,423,920 | \$4,804,830 | \$5,340,948 | \$5,282,813 | \$27,155,163 |
| 0483 | Echocardiology | \$3,503,427 | \$4,017,485 | \$3,956,756 | \$4,179,579 | \$4,774,947 | \$5,427,120 | \$25,859,313 |
| 0420 | Physical Therapy | \$2,962,282 | \$3,251,365 | \$3,512,947 | \$2,975,499 | \$3,671,566 | \$4,193,249 | \$20,566,907 |
| 0750 | Gastrointestinal Services | \$2,979,572 | \$3,239,202 | \$3,299,705 | \$3,177,793 | \$3,352,323 | \$4,286,799 | \$20,335,394 |
| 0341 | Nuclear Medicine | \$3,303,928 | \$3,264,366 | \$3,271,895 | \$3,015,931 | \$3,240,869 | \$3,341,691 | \$19,438,680 |
| 0320 | X-Ray | \$2,936,324 | \$2,724,473 | \$3,043,996 | \$3,040,620 | \$3,442,033 | \$3,594,386 | \$18,781,832 |
| 0480 | Cardiology | \$2,467,862 | \$2,340,203 | \$2,690,449 | \$2,593,306 | \$3,156,154 | \$3,458,090 | \$16,706,063 |
| 0610 | Magnetic Resonance Tech | \$2,314,294 | \$2,101,145 | \$2,113,137 | \$2,015,668 | \$2,367,984 | \$2,548,525 | \$13,460,753 |
| 0260 | IV Therapy | \$1,662,670 | \$1,715,973 | \$1,727,067 | \$1,963,007 | \$2,395,089 | \$2,628,276 | \$12,092,082 |
| 0612 | MRT - Spine | \$1,524,117 | \$1,459,226 | \$1,653,026 | \$1,717,363 | \$2,106,916 | \$2,194,238 | \$10,654,885 |
| 0402 | Ultrasound | \$1,408,152 | \$1,283,473 | \$1,512,681 | \$1,754,234 | \$1,913,956 | \$1,930,580 | \$9,803,076 |
| 0335 | Chemotherapy | \$1,288,472 | \$1,445,700 | \$1,450,471 | \$1,844,454 | \$1,841,352 | \$1,653,903 | \$9,524,352 |
| 0611 | MRI - Brain | \$1,442,474 | \$1,449,225 | \$1,379,083 | \$1,417,942 | \$1,617,057 | \$1,709,248 | \$9,015,030 |
| 0278 | Medical Supplies | \$774,039 | \$718,448 | \$1,082,998 | \$1,549,243 | \$2,227,453 | \$2,610,320 | \$8,962,502 |
| 0404 | Tomography | \$1,243,770 | \$1,312,973 | \$1,250,235 | \$1,372,772 | \$1,568,530 | \$1,808,106 | \$8,556,385 |
| 0350 | CT Scan | \$1,050,224 | \$1,040,936 | \$1,124,276 | \$1,150,260 | \$1,387,008 | \$1,557,426 | \$7,310,128 |
| 0921 | Diagnostic Services | \$1,051,274 | \$952,059 | \$1,028,043 | \$1,181,083 | \$1,273,949 | \$1,272,665 | \$6,759,072 |
| 0740 | Electroencephalogram | \$1,591,816 | \$1,409,002 | \$1,193,828 | \$798,715 | \$788,399 | \$895,046 | \$6,676,806 |

25.5-4-216(6)(a)(VII)

Description

The total number of facility fee claim denials, by site of service.

Methodology

As noted above, the APCD does not include denied claims when the entire visit was denied. This is a data limitation and prevents Optumas from reporting on claim denials by site of service. Optumas can report on instances when the HOPD line was denied during a visit that was otherwise approved. This has been captured in the analytics above under 25.5-4-216(6)(a)(III), and the corresponding Appendix III.

Appendices

Appendix 1

| CPT Code | Description ¹¹ |
|----------|--|
| 36415 | Collection of venous blood by venipuncture. |
| G0463 | Hospital outpatient clinic visits. Assessment and management of patients in the hospital setting. |
| 80053 | Comprehensive metabolic panel. |
| 85025 | Complete blood count with automated differential white blood cell count. |
| 97110 | Fundamental occupational therapy exercise. |
| 80048 | Basic metabolic panel. |
| 84443 | Blood test measuring thyroid stimulating hormone level. |
| 80061 | Lipid panel test to measure the level of triglycerides in blood. |
| 85610 | Prothrombin Time. |
| J3490 | Meloxicam injection. |
| 97140 | Manual therapy techniques used for 15 minutes or more in one or more body regions. |
| 83036 | Glycated hemoglobin/Glycated protein. |
| 85027 | Blood count on the red and white blood cells and platelets and hemoglobin test. |
| A9270 | Miscellaneous supplies and equipment - non-covered items or services. |
| 77067 | Bilateral screening mammogram that includes computer-aided detection. |
| J2704 | 10 mg injection of propofol, an anesthetic and sedative used to help patients relax or sleep. |
| 77063 | Bilateral screening digital breast tomosynthesis. |
| J3010 | 0.1 mg injection of fentanyl citrate. |
| 93005 | Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report. |
| Q9967 | Low osmolar contrast material, 300-399 mg/ml iodine concentration. |
| 93306 | Echocardiography, ultrasonic examination of the heart. |
| J1100 | 1 mg injection of dexamethasone sodium phosphate |
| J2250 | Injection up to 50 mg of promethazine HCl, to treat nausea and vomiting caused by motion sickness. |
| 83735 | Blood test measuring magnesium level. |
| 92134 | Analysis of computerized imaging of the retina to evaluate for disease. |

¹¹ Procedure Code Definitions: <https://www.aapc.com/>



Appendix 2

| CPT Code | Description ¹¹ |
|----------|---|
| 27447 | Collection of venous blood by venipuncture. |
| G0463 | Hospital outpatient clinic visits. Assessment and management of patients in the hospital setting. |
| 93306 | Echocardiography, ultrasonic examination of the heart. |
| J9271 | Injection, pembrolizumab - Chemotherapy Drugs. |
| 27130 | Total hip arthroplasty. |
| 93656 | Basic metabolic panel. |
| 78452 | Blood test measuring thyroid stimulating hormone level. |
| 93653 | Lipid panel test to measure the level of triglycerides in blood. |
| C9600 | Prothrombin Time. |
| J9299 | Injection, nivolumab - Chemotherapy Drugs. |
| 66984 | Manual therapy techniques used for 15 minutes or more in one or more body regions. |
| 77386 | Glycated hemoglobin/Glycated protein. |
| J1561 | Injection, immune globulin, non-lyophilized. |
| 23472 | Total shoulder arthroplasty. |
| 96413 | Bilateral screening mammogram that includes computer-aided detection. |
| J0897 | Injection, denosumab. |
| 78815 | Bilateral screening digital breast tomosynthesis. |
| 97110 | Fundamental occupational therapy exercise. |
| 33249 | Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report. |
| 33208 | Insertion or replacement of a permanent pacemaker. |
| 77067 | Transthoracic echocardiography, complete study. |
| J9312 | Injection, rituximab - Chemotherapy Drugs. |
| J2350 | 1 mg injection of ocrelizumab. |
| 45380 | Colonoscopy, with biopsy, single or multiple. |
| J2505 | Injection, pegfilgrastim - Chemotherapy Drugs. |



Appendix 3

| CPT Code | Description ¹¹ |
|----------|---|
| G0463 | Hospital outpatient clinic visits. Assessment and management of patients in the hospital setting. |
| 93306 | Echocardiography, ultrasonic examination of the heart. |
| 27447 | Comprehensive metabolic panel. |
| 78452 | Diagnostic Nuclear Medicine Procedures on the Cardiovascular System |
| J9271 | Injection, pembrolizumab - Chemotherapy Drugs. |
| 97110 | Fundamental occupational therapy exercise. |
| 66984 | Blood test measuring thyroid stimulating hormone level. |
| J0897 | Injection, denosumab. |
| J1561 | Injection, immune globulin, non-lyophilized. |
| 27130 | Total hip arthroplasty. |
| 74177 | Manual therapy techniques used for 15 minutes or more in one or more body regions. |
| 96413 | Glycated hemoglobin/Glycated protein. |
| 95811 | Under Sleep Medicine Testing Procedures |
| 96365 | Intravenous infusion, for therapy, prophylaxis, or diagnosis. |
| 78815 | Diagnostic Nuclear Medicine Procedure |
| J1745 | 10 mg injection of infliximab, excluding biosimilars. |
| 77386 | Bilateral screening digital breast tomosynthesis. |
| J9312 | Injection, rituximab - Chemotherapy Drugs. |
| 72148 | Diagnostic Radiology (Diagnostic Imaging) Procedures of the Spine and Pelvis |
| 70553 | MRI of the brain, including brain stem. |
| 43239 | Transthoracic echocardiography, complete study. |
| J9299 | Injection, nivolumab - Chemotherapy Drugs. |
| 93458 | Catheter placement in coronary artery for coronary angiography. |
| 71260 | Diagnostic Radiology (Diagnostic Imaging) Procedures of the Chest |
| 45380 | Colonoscopy, with biopsy, single or multiple. |



Appendix H. Hospital Outpatient Department (HOPD) Supplemental Summaries



October 1, 2024

Subject: Colorado Facility Fee – Medicare HOPD – Off-Campus Analytics

Medicare HOPD Off-Campus and Other Supplemental Analytics

Overview

CBIZ Optumas (Optumas) was contracted by the Colorado Department of Health Care Policy and Financing (HCPF) to explore the policies, practices, and costs to Colorado health payers of facility fees as outlined in HB23-1215. Optumas was tasked with comparing professional fees and hospital outpatient department (HOPD) facility fees at off-campus locations for the same services. The Colorado All Payer Claims Database (APCD) provided by the Center for Improving Value in Healthcare (CIVHC) was utilized for this analysis across the 2017 to 2022 calendar years. The APCD contains claims data from Medicare, Medicaid, and Commercial payers within the State of Colorado. The purpose of this memo is to detail the methodology used to identify hospital outpatient department (HOPD) facility fees at off-campus locations. The off-campus analysis will focus on Medicare data due to data limitations on identifying off-campus providers within the Commercial data. We are also providing supplemental summaries related to total HOPD by hospital and high-level review of member cost sharing provisions.

Data Validation

Optumas reviewed the data for all the requested fields to ensure they were complete and had the expected valid values. This review indicated that we received appropriate data aligned with our data request that would allow us to continue with the analysis. We then reviewed the visit volume and financial field volume on a monthly longitudinal basis by service type and program. This review indicated that we did not have any major gaps or anomalies in the data. Optumas will note that we did not audit the APCD data and are relying on the accuracy of the data provided.

Optumas also compared the Medicare-specific data within APCD to determine what proportion of Medicare members were reflected within the dataset. That analysis indicated that for the 2017-2022 time period, the APCD reflects 95% of both Medicare and Medicare Advantage members. See Table 1 below.

Table 1. Medicare Membership Benchmark

| Period | CMS Reported Medicare Enrollment | APCD | % of Benchmark |
|--------|----------------------------------|---------|----------------|
| 2017 | 847,702 | 807,492 | 95% |
| 2018 | 881,043 | 834,766 | 95% |
| 2019 | 911,545 | 860,660 | 94% |
| 2020 | 938,949 | 886,492 | 94% |
| 2021 | 961,592 | 921,281 | 96% |
| 2022 | 983,947 | 946,661 | 96% |

HOPD Facility Fee Identification

HOPD Facility Fee Data

Each outpatient visit at a HOPD will generate a facility fee billed to the patient, and in many cases an additional bill for the individual physician’s professional fees. The following discusses the identification of the HOPD facility fee portion of the HOPD related outpatient visits.

Optumas first identified all HOPD claims within the APCD using a delineation provided by CIVHC to identify hospital outpatient claims. Optumas validated that delineation by reviewing the Bill Type provided on each claim to confirm they were appropriately identified. Bill Type is a nationally standardized set of codes for institutional/facility-based services that provides information on the type of bill the provider is submitting to the payer. We created a subset of the data for this comparison to claims that had the following Bill Type to ensure isolation to HOPD claims:

- “131” - Hospital, outpatient, admit through discharge¹.
- “851” – Critical Access Hospital, outpatient, admit through discharge¹.

Additionally, Optumas limited the data to non-Emergency Room outpatient claims within the APCD. After discussion with the Hospital Facility Fee Steering Committee, it was determined to exclude all Emergency Room claims from the analytics. Optumas also removed any services that had been denied by the payer. This final HOPD data set services as the basis for identifying the facility fees for Colorado based providers.

On-campus/Off-campus

To identify the on-campus and off-campus visits, Optumas first looked to the Place of Service on each claim. Place of Service is a nationally standardized set of codes that provides information on the location of the visit between the patient and provider. While this field is provided in the data, unfortunately there is a data limitation due to it not being populated for facility-related claims within the APCD. Optumas explored the following alternative approaches by payer type. The results are that an alternative option was identified for Medicare, however; the off-campus clinic visits were not able to be delineated within the Commercial data.

Medicare

¹ <https://med.noridianmedicare.com/web/jea/topics/claim-submission/bill-types>



1. Modifiers

- a. Medicare requires that off-campus clinics include specific modifiers – PN, PO, ER – on the claim form along with the Current Procedural Terminology (CPT) code that identifies the service that is provided.
 - i. PO – Excepted service provided at an off-campus, outpatient, provider-based department of a hospital.
 - ii. PN – Non-expected service provided at an off-campus, outpatient, provider-based department of a hospital.
 - iii. ER – Items and services furnished by a provider-based off-campus emergency department.
 1. This modifier was ultimately not used given that emergency department visits are excluded from the analysis.
- b. Using this information, we identified any instance of either PN or PO modifier on any individual line on a claim. We then identified that entire claim as a HOPD off-campus visit. This approach identified \$60M to \$90M per year in the Medicare data.

Commercial

1. Modifiers

- a. Commercial billing and payment policies differ from Medicare related to off-campus HOPD billing, and do not require the inclusion of specific modifiers be documented for off-campus payments.
- b. Therefore, this approach was not able to be leveraged for Commercial data.

2. National Payer Identification (NPI)

- a. We reviewed a third method in trying to track down the off-campus locations by NPI based on the off-campus clinic NPIs provided via the hospital provider surveys. However; we ran into data limitations here as well.
- b. There are two provider NPI fields in the APCD:
 - i. Billing NPI – this generally reflected the hospital/hospital system that owns the off-campus clinic, and did not get any significant matches to the individual off-campus NPIs that were provided via the hospital provider surveys.
 - ii. Servicing NPI –this generally reflected the individual physician that was present during the service, and again did not get any significant matches to the individual off-campus NPIs that were provided via the hospital provider surveys.
- c. Given the above, we are also limited in using any NPIs from the Medicare off-campus data as those would also flag either the main hospital/hospital system, or an individual physician, and not necessarily the specific off-campus clinic.

3. Place of Service (professional component)

- a. As a final potential option, we looked at using the Place of Service that was on the professional fee claim component of an outpatient visits, and aligning that with the HOPD facility fee claim.
- b. We limited the professional claims to a Place of Service of '19' (Off-campus clinic), and then looked for any HOPD claims for the same member and date of service.
- c. This approach did result in some data being able to be flagged as off-campus, but it was a much smaller amount than we observed in Medicare.
- d. The result is a limited dataset that may not be credible for accurate professional and facility fee comparison.

Hospital/Health System Identification

To identify the specific hospitals providing the HOPD services within the claims data, Optumas utilized a public dataset from CMS, which contains the hospitals' business names cross-walked to the hospitals' billing National Provider Identifier (NPI). To identify the health system the hospitals are associated with, Optumas utilized a secondary dataset provided by HCPF which contains the hospitals and their associated health systems based on the hospitals' billing NPIs. Note, the hospitals that are not affiliated with a health system are excluded from the analysis.

Professional Fee Data

The professional claims to be used for the comparison were also delineated within the APCD by CIVHC. Optumas validated that delineation by reviewing the Place of Service (POS) provided on each claim to confirm they were appropriately identified. Optumas found that the POS were all generally related to a professional setting, however; we further delineated that data for this comparison to claims that had the following Place of Service² codes:

- 11 – Office
- 12 – Home
- 81 – Independent Laboratory

Optumas also found Places of Service for the professional fee component of a HOPD outpatient visit. These were excluded so that the comparison focused on the professional fees provided during a patient visit that was independent of an outpatient visit. Finally, Optumas removed any services that had been denied by the payer. This final professional data set services as the basis for identifying the professional fees for Colorado based providers.

² <https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>



Off Campus Summaries

25.5-4-216(6)(a)(IV)

Description

The total Allowed dollars for Off-Campus HOPD visits billed to Medicare, by Health System.

Methodology

Once the Off-Campus HOPD visit was identified, Optumas used the secondary dataset from HCPF referenced above to identify the Health System the billing hospital was associated with. Optumas then summarize the total allowed dollars by year and Health System, in the State of Colorado for HOPD Off-Campus visits that were billed to Medicare.

Results

The total Allowed dollars billed to Medicare for Off-Campus HOPD visits, by Health System, are displayed in *Exhibit I.A*. The Health Systems' yearly shares of Allowed dollars billed to Medicare for Off-Campus HOPD visits are displayed in *Exhibit I.B*. Over 70% of all Medicare Off-Campus HOPD facility fees were associated with the UC Health hospital system. Within UC Health system, the primary off-campus clinic locations were located in Fort Collins, associated with the Poudre Valley Hospital. Aligned with the next summary that identifies top codes, this may be driven by their off-campus cancer treatment clinic in that area.

Exhibit I.A – Total Off-Campus HOPD Allowed Dollars billed to Medicare by year and Health System.

| Health System | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|--------------------------------------|--------------|--------------|--------------|--------------|--------------|--------------|---------------|
| UC Health | \$63,326,822 | \$63,828,737 | \$64,390,580 | \$63,720,489 | \$75,565,232 | \$70,768,108 | \$401,599,967 |
| National Jewish Health | \$5,671,751 | \$4,752,243 | \$6,247,020 | \$5,667,722 | \$6,986,088 | \$6,678,949 | \$36,003,773 |
| Colorado West Healthcare System | \$2,463,864 | \$5,088,368 | \$5,011,078 | \$5,823,304 | \$8,467,102 | \$7,294,844 | \$34,148,561 |
| AdventHealth | \$2,954,897 | \$3,863,598 | \$5,528,584 | \$4,720,961 | \$4,417,615 | \$4,928,575 | \$26,414,230 |
| Banner Health | \$3,433 | \$1,246,339 | \$2,046,861 | \$1,667,927 | \$17,957 | \$4,207,559 | \$9,190,074 |
| Boulder Community Health | \$1,442,383 | \$1,040,941 | \$1,109,411 | \$338,159 | \$842,456 | \$777,152 | \$5,550,502 |
| Parkview Medical Center, Inc. | \$969,974 | \$1,235,663 | \$980,714 | \$619,615 | \$1,092,754 | \$601,648 | \$5,500,367 |
| HCA Healthcare | \$1,374,382 | \$1,005,003 | \$743,780 | \$546,717 | \$1,304,215 | \$314,329 | \$5,288,425 |
| Vail Clinic, Inc. | \$427,031 | \$576,495 | \$725,296 | \$502,440 | \$775,803 | \$1,052,081 | \$4,059,145 |
| CommonSpirit | \$1,731,508 | \$1,009,023 | \$785,664 | \$96,731 | \$107,544 | \$134,935 | \$3,865,405 |
| Animas Surgical Hospital, LLC | \$148,736 | \$64,386 | \$109,254 | \$447,396 | \$815,507 | \$1,519,288 | \$3,104,567 |
| Intermountain | \$40,302 | \$146,621 | \$200,202 | \$174,582 | \$118,787 | \$1,668,670 | \$2,349,165 |
| Denver Health And Hospital Authority | \$33,510 | \$28,259 | \$102,037 | \$345,694 | \$349,911 | \$369,619 | \$1,229,030 |
| All Other | \$270,111 | \$922,109 | \$520,632 | \$1,393,053 | \$1,424,334 | \$2,863,108 | \$7,393,348 |

Exhibit I.B – Health System Distribution of Off-Campus HOPD Allowed Dollars billed to Medicare by year.

| Health System | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|--------------------------------------|-------|-------|-------|-------|-------|-------|-------|
| UC Health | 78.3% | 75.3% | 72.8% | 74.0% | 73.9% | 68.6% | 73.6% |
| National Jewish Health | 7.0% | 5.6% | 7.1% | 6.6% | 6.8% | 6.5% | 6.6% |
| Colorado West Healthcare System | 3.0% | 6.0% | 5.7% | 6.8% | 8.3% | 7.1% | 6.3% |
| AdventHealth | 3.7% | 4.6% | 6.2% | 5.5% | 4.3% | 4.8% | 4.8% |
| Banner Health | 0.0% | 1.5% | 2.3% | 1.9% | 0.0% | 4.1% | 1.7% |
| Boulder Community Health | 1.8% | 1.2% | 1.3% | 0.4% | 0.8% | 0.8% | 1.0% |
| Parkview Medical Center, Inc. | 1.2% | 1.5% | 1.1% | 0.7% | 1.1% | 0.6% | 1.0% |
| HCA Healthcare | 1.7% | 1.2% | 0.8% | 0.6% | 1.3% | 0.3% | 1.0% |
| Vail Clinic, Inc. | 0.5% | 0.7% | 0.8% | 0.6% | 0.8% | 1.0% | 0.7% |
| CommonSpirit | 2.1% | 1.2% | 0.9% | 0.1% | 0.1% | 0.1% | 0.7% |
| Animas Surgical Hospital, LLC | 0.2% | 0.1% | 0.1% | 0.5% | 0.8% | 1.5% | 0.6% |
| Intermountain | 0.0% | 0.2% | 0.2% | 0.2% | 0.1% | 1.6% | 0.4% |
| Denver Health And Hospital Authority | 0.0% | 0.0% | 0.1% | 0.4% | 0.3% | 0.4% | 0.2% |
| All Other | 0.3% | 1.1% | 0.6% | 1.6% | 1.4% | 2.8% | 1.4% |

25.5-4-216(6)(a)(IV)

Description

The top 25 procedure codes for which Off-Campus HOPD visits were charged to Medicare in the State of Colorado, with the highest total allowed amounts.

Methodology

Once the Off-Campus HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. This data was then used to analyze the codes with the highest allowed amount.

Results

The top 25 procedure codes for which Off-Campus HOPD visits were charged to Medicare, based on allowed amount by code, are displayed in *Exhibit II.A*. Chemotherapy drugs represent over 50% of the allowed dollars for the top 25 procedure codes. Procedure code 'G0463' (hospital outpatient clinic visits for the assessment and management of patients), represents nearly 15% of the allowed dollars for the top 25 procedure codes. Detailed descriptions for the procedure codes contained in this summary are located in *Appendix 1*.

Exhibit II.A – Top 25 procedure codes with the highest total allowed amounts from Medicare HOPD Off-Campus visits.

| CPT Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|----------|---------------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------|
| G0463 | HOPD Clinic Visit | \$8,586,941 | \$9,119,950 | \$7,563,039 | \$3,976,687 | \$4,304,957 | \$4,879,314 | \$38,430,888 |
| J9271 | Chemotherapy Drug | \$2,112,520 | \$2,984,742 | \$3,176,248 | \$6,096,802 | \$7,627,775 | \$8,126,169 | \$30,124,255 |
| J9299 | Chemotherapy Drug | \$2,567,032 | \$2,232,922 | \$3,371,527 | \$4,041,874 | \$3,775,729 | \$3,040,490 | \$19,029,574 |
| 93306 | Echocardiography | \$2,238,258 | \$2,690,099 | \$3,327,815 | \$2,793,367 | \$3,397,210 | \$3,297,264 | \$17,744,014 |
| 78452 | CT scan | \$1,970,847 | \$1,985,341 | \$2,558,311 | \$2,101,022 | \$2,363,470 | \$2,420,308 | \$13,399,299 |
| J2505 | Immunostimulant | \$3,309,861 | \$2,988,974 | \$2,829,655 | \$2,201,319 | \$1,177,571 | \$0 | \$12,507,380 |
| 77385 | Radiation Treatment | \$1,370,795 | \$1,355,613 | \$1,786,888 | \$1,976,904 | \$2,116,822 | \$2,243,461 | \$10,850,482 |
| 96413 | Chemotherapy Drug | \$1,547,931 | \$1,646,016 | \$1,508,324 | \$1,827,299 | \$1,966,662 | \$1,949,173 | \$10,445,405 |
| J9144 | Chemotherapy Drug | \$0 | \$0 | \$0 | \$0 | \$4,304,424 | \$6,064,647 | \$10,369,071 |
| 77386 | Radiation Treatment | \$1,078,775 | \$1,696,145 | \$1,552,484 | \$1,803,259 | \$1,819,136 | \$2,360,868 | \$10,310,667 |
| J0897 | Osteoporosis Drug | \$1,643,977 | \$1,684,158 | \$1,494,944 | \$1,352,346 | \$1,517,517 | \$1,542,014 | \$9,234,955 |
| J1561 | Chemotherapy Drug | \$854,396 | \$1,215,164 | \$1,377,496 | \$1,683,576 | \$2,247,423 | \$1,438,161 | \$8,816,216 |
| J9355 | Chemotherapy Drug | \$2,337,629 | \$2,497,895 | \$1,913,738 | \$1,033,817 | \$485,210 | \$48,038 | \$8,316,327 |
| J9145 | Chemotherapy Drug | \$887,520 | \$1,188,081 | \$2,255,444 | \$1,914,047 | \$1,351,640 | \$669,616 | \$8,266,347 |
| J9310 | Chemotherapy Drug | \$3,863,558 | \$3,241,571 | \$0 | \$0 | \$0 | \$0 | \$7,105,129 |
| J9312 | Chemotherapy Drug | \$0 | \$0 | \$2,953,610 | \$2,259,741 | \$1,280,695 | \$592,405 | \$7,086,450 |
| J9305 | Chemotherapy Drug | \$974,502 | \$1,255,045 | \$1,017,207 | \$928,766 | \$1,071,464 | \$964,059 | \$6,211,044 |
| 77067 | Mammogram | \$0 | \$1,088,589 | \$1,217,421 | \$1,041,859 | \$1,363,044 | \$1,382,717 | \$6,093,630 |
| J2353 | Hormonal Therapy | \$1,553,863 | \$1,092,439 | \$1,013,697 | \$805,422 | \$743,381 | \$818,112 | \$6,026,914 |
| 93798 | Cardiac Rehab | \$637,659 | \$649,467 | \$1,108,259 | \$812,177 | \$1,209,731 | \$1,221,600 | \$5,638,893 |
| J9035 | Chemotherapy Drug | \$1,927,541 | \$1,493,969 | \$974,628 | \$771,824 | \$399,620 | \$62,457 | \$5,630,039 |
| 77373 | Radiation Treatment | \$430,643 | \$538,297 | \$936,261 | \$967,731 | \$1,075,877 | \$1,270,004 | \$5,218,812 |
| J1930 | Hormonal Therapy | \$458,831 | \$570,548 | \$623,646 | \$893,193 | \$1,275,418 | \$1,057,174 | \$4,878,812 |
| 97110 | Physical Therapy | \$595,636 | \$649,974 | \$803,287 | \$652,382 | \$881,110 | \$491,680 | \$4,074,068 |
| J2350 | Injectables | \$0 | \$639,803 | \$742,893 | \$841,986 | \$886,234 | \$862,912 | \$3,973,829 |

Notes:

- Mammogram code was new as of 2018
- J-code injectables can change year to year as new drugs come out that replace prior treatments.

25.5-4-216(6)(a)(IV)

Description

The top 25 most frequent procedure codes for which Off-Campus HOPD visits were charged to Medicare in the State of Colorado.

Methodology

Once the Off-Campus HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. This data was then used to analyze the most frequently billed procedure codes.

Results

The top 25 most frequent procedure codes for which Off-Campus HOPD visits were charged to Medicare are displayed in *Exhibit III.A*. Laboratory services, which account for over 40% of the top 25 most frequent procedure codes, are the most common services performed during an Off-Campus HOPD visit. Detailed descriptions for the procedure codes contained in this summary are located in *Appendix 2*.

Exhibit III.A – Top 25 procedure codes for which HOPD Off-Campus visits were charged to Medicare by code frequency.

| CPT Code | Description | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|----------|----------------------|--------|--------|---------|--------|--------|---------|---------|
| G0463 | OP E&M Visit | 87,533 | 91,919 | 101,125 | 81,073 | 87,898 | 101,924 | 551,472 |
| 36415 | Laboratory | 77,349 | 78,752 | 71,935 | 81,833 | 97,318 | 107,006 | 514,193 |
| 80053 | Laboratory | 41,300 | 39,921 | 37,889 | 44,982 | 53,145 | 60,697 | 277,934 |
| 85025 | Laboratory | 32,934 | 35,385 | 34,364 | 39,743 | 47,215 | 54,441 | 244,082 |
| 80061 | Laboratory | 21,699 | 20,823 | 20,291 | 23,666 | 27,896 | 31,161 | 145,536 |
| 84443 | Laboratory | 20,643 | 20,469 | 19,731 | 22,749 | 26,960 | 29,863 | 140,415 |
| 85610 | Prothrombin Time | 22,343 | 26,921 | 25,369 | 22,647 | 17,587 | 17,206 | 132,073 |
| 83036 | Laboratory | 14,967 | 14,090 | 14,530 | 17,532 | 20,907 | 24,365 | 106,391 |
| 80048 | Chemical Screen | 13,626 | 13,960 | 12,524 | 14,287 | 17,025 | 18,387 | 89,809 |
| 97110 | Physical Therapy | 11,936 | 13,939 | 17,211 | 14,074 | 19,579 | 12,031 | 88,770 |
| 85027 | Laboratory | 13,906 | 12,488 | 11,078 | 13,399 | 15,348 | 16,830 | 83,049 |
| 97140 | Therapy | 6,718 | 9,512 | 12,497 | 11,214 | 15,029 | 10,428 | 65,398 |
| 77063 | X-Ray | 5,351 | 9,529 | 10,961 | 9,421 | 12,976 | 13,699 | 61,937 |
| 77067 | Mammogram | - | 10,586 | 12,277 | 10,162 | 13,537 | 14,088 | 60,650 |
| 93798 | Cardiac Rehab | 6,202 | 7,368 | 11,338 | 8,370 | 11,388 | 11,687 | 56,353 |
| J1642 | Injectables | 8,329 | 8,960 | 7,481 | 7,320 | 8,630 | 11,200 | 51,920 |
| 81001 | Urinalysis | 6,839 | 6,369 | 6,227 | 7,541 | 8,179 | 8,308 | 43,463 |
| 83735 | Laboratory | 4,760 | 5,304 | 5,188 | 6,718 | 8,438 | 10,425 | 40,833 |
| 96413 | Chemotherapy Drug | 5,880 | 6,012 | 6,056 | 6,808 | 7,403 | 7,378 | 39,537 |
| 93306 | Echocardiography | 5,167 | 5,747 | 6,996 | 6,074 | 7,456 | 7,836 | 39,276 |
| 82306 | Blood Test | 5,895 | 5,571 | 5,263 | 6,367 | 7,629 | 7,884 | 38,609 |
| 84439 | Laboratory | 5,138 | 5,349 | 5,363 | 6,298 | 7,223 | 8,124 | 37,495 |
| J3490 | Injectables | 214 | 839 | 1,492 | 6,630 | 8,203 | 14,278 | 31,656 |
| 84100 | Laboratory | 3,760 | 3,925 | 3,717 | 5,282 | 6,435 | 7,473 | 30,592 |
| 82728 | Chemistry Procedures | 3,573 | 3,612 | 3,766 | 4,332 | 6,169 | 7,832 | 29,284 |

Supplemental Analytics

Total HOPD by Hospital and Health System

In addition to the analytics detailed above, Optumas quantified the total allowed dollars for HOPD visits, both On-Campus and Off-Campus, that were charged to Medicare and Commercial payers in the state of Colorado.

Methodology

Once the HOPD visit was identified, Optumas used the secondary dataset from HCPF referenced above to identify the Health System the billing hospital was associated with. Optumas then summarize the total allowed dollars by year and Health System, in the State of Colorado for all HOPD visits that were billed to Medicare and Commercial payers.

The total Allowed dollars billed to Medicare for HOPD visits, by Health System, are displayed in *Exhibit IV.A*.

The Health Systems' yearly distributions of total Allowed dollars billed to Medicare for HOPD visits are displayed in *Exhibit IV.B*.

The total Allowed dollars billed to Commercial payers for HOPD visits, by Health System, are displayed in *Exhibit IV.C*.

The Health Systems' yearly distributions of total Allowed dollars billed to Commercial payers for HOPD visits are displayed in *Exhibit IV.D*.

The total allowed dollars billed to both Medicare and Commercial payers for HOPD visits, by Health System, are displayed in *Exhibit IV.E*.

The Health Systems' yearly distributions of total Allowed dollars billed to both Medicare and Commercial payers for HOPD visits are displayed in *Exhibit IV.F*.

Results

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 UHealth hospital system with approximately 30% of the total for both Medicare and Commercial. The next three highest were HCA Healthcare, 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.

Exhibit IV.A – Total Medicare HOPD Allowed Dollars, by year and Health System & Hospital.

| Health System | Classification | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|--|----------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| UC Health | Health System | \$251,801,854 | \$266,470,252 | \$317,443,235 | \$350,140,612 | \$405,329,049 | \$456,049,333 | \$2,047,234,336 |
| Intermountain | Health System | \$69,470,731 | \$87,884,911 | \$108,638,329 | \$116,930,399 | \$131,091,734 | \$158,771,972 | \$672,788,076 |
| CommonSpirit | Health System | \$72,304,212 | \$69,965,807 | \$97,526,431 | \$99,382,176 | \$114,893,013 | \$163,782,855 | \$617,854,494 |
| HCA Healthcare | Health System | \$71,764,480 | \$82,802,065 | \$112,565,022 | \$102,578,101 | \$111,128,942 | \$124,787,339 | \$605,625,949 |
| AdventHealth | Health System | \$36,631,266 | \$39,597,483 | \$56,390,261 | \$53,496,776 | \$60,087,397 | \$88,469,244 | \$334,672,427 |
| Banner Health | Health System | \$34,710,854 | \$36,911,226 | \$49,976,422 | \$45,038,572 | \$53,533,535 | \$52,938,822 | \$273,109,431 |
| National Jewish Health | Hospital | \$22,430,222 | \$21,626,267 | \$28,445,024 | \$26,280,669 | \$28,348,183 | \$28,716,193 | \$155,846,558 |
| Parkview Medical Center, Inc. | Hospital | \$18,299,519 | \$21,106,341 | \$30,090,820 | \$25,280,181 | \$27,571,575 | \$29,156,209 | \$151,504,643 |
| Boulder Community Health | Hospital | \$16,031,979 | \$17,423,302 | \$22,033,990 | \$22,679,553 | \$28,809,570 | \$32,768,749 | \$139,747,143 |
| Denver Health And Hospital Authority | Hospital | \$14,685,761 | \$19,135,760 | \$22,065,002 | \$19,878,321 | \$24,264,716 | \$23,919,910 | \$123,949,470 |
| Colorado West Healthcare System | Hospital | \$10,326,232 | \$11,957,530 | \$15,441,318 | \$17,627,319 | \$26,963,640 | \$30,847,738 | \$113,163,777 |
| Salida Hospital District | Hospital | \$13,729,161 | \$14,340,639 | \$12,379,799 | \$14,190,228 | \$20,136,758 | \$25,246,923 | \$100,023,509 |
| Valley View Hospital Association | Hospital | \$10,332,940 | \$11,555,398 | \$14,641,680 | \$16,404,254 | \$20,093,636 | \$24,770,572 | \$97,798,479 |
| Aspen Valley Hospital District | Hospital | \$9,726,174 | \$9,673,643 | \$10,250,316 | \$11,535,914 | \$14,639,673 | \$16,317,081 | \$72,142,802 |
| Lower Valley Hospital Association | Hospital | \$4,738,271 | \$5,510,290 | \$10,407,970 | \$13,668,774 | \$16,328,959 | \$18,543,813 | \$69,198,076 |
| Delta County Memorial Hospital | Hospital | \$6,543,973 | \$7,014,873 | \$10,115,359 | \$9,863,463 | \$15,192,422 | \$17,805,449 | \$66,535,540 |
| Vail Clinic, Inc. | Hospital | \$2,951,088 | \$5,702,880 | \$8,383,228 | \$11,087,066 | \$14,493,026 | \$18,249,249 | \$60,866,537 |
| Montrose Memorial Hospital, Inc. | Hospital | \$5,628,324 | \$5,474,352 | \$7,750,550 | \$8,920,757 | \$10,987,148 | \$13,205,909 | \$51,967,040 |
| Park Hospital District | Hospital | \$6,322,289 | \$5,539,976 | \$6,698,126 | \$7,396,895 | \$8,372,951 | \$9,187,614 | \$43,517,852 |
| Grand River Hospital District | Hospital | \$5,186,934 | \$5,033,233 | \$5,485,856 | \$6,093,956 | \$8,956,896 | \$11,459,133 | \$42,216,007 |
| Southwest Health System, Inc. | Hospital | \$3,635,459 | \$3,518,443 | \$5,110,711 | \$5,009,074 | \$6,916,045 | \$8,795,624 | \$32,985,356 |
| The Memorial Hospital | Hospital | \$4,438,007 | \$3,716,773 | \$3,533,245 | \$4,390,456 | \$5,428,427 | \$8,296,440 | \$29,803,349 |
| Animas Surgical Hospital, LLC | Hospital | \$3,416,507 | \$3,141,339 | \$4,304,587 | \$3,942,418 | \$5,393,149 | \$7,891,400 | \$28,089,400 |
| San Luis Valley | Health System | \$3,852,863 | \$3,955,472 | \$4,837,717 | \$4,236,514 | \$4,791,009 | \$5,926,757 | \$27,600,333 |
| Gunnison Valley Hospital | Hospital | \$3,239,594 | \$3,319,470 | \$2,849,701 | \$4,287,164 | \$6,530,582 | \$6,570,581 | \$26,797,093 |
| Upper San Juan Health Service District | Hospital | \$2,752,059 | \$3,205,769 | \$3,873,531 | \$4,983,726 | \$5,193,454 | \$6,634,485 | \$26,643,024 |
| Prowers County Hospital District | Hospital | \$3,173,883 | \$3,148,191 | \$3,642,327 | \$3,569,264 | \$3,687,713 | \$4,717,965 | \$21,939,342 |
| Yuma District Hospital | Hospital | \$3,767,833 | \$3,726,954 | \$3,845,326 | \$3,032,297 | \$3,653,993 | \$3,895,137 | \$21,921,541 |
| Wray Community District Hospital | Hospital | \$3,039,991 | \$2,520,735 | \$3,209,085 | \$3,107,911 | \$4,235,794 | \$3,966,022 | \$20,079,537 |
| Lincoln Community Hospital | Hospital | \$3,084,859 | \$3,063,081 | \$2,745,229 | \$2,228,609 | \$2,874,712 | \$3,540,274 | \$17,536,764 |
| All Other Hospitals/Health Systems | Both | \$26,096,683 | \$26,943,366 | \$27,429,694 | \$29,104,257 | \$34,350,699 | \$48,268,554 | \$192,193,253 |



Exhibit IV.B – Health System & Hospital distribution of Medicare HOPD Allowed Dollars by year.

| Health System | Classification | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|--|----------------|-------|-------|-------|-------|-------|-------|-------|
| UC Health | Health System | 33.8% | 33.1% | 31.4% | 33.5% | 33.1% | 31.4% | 32.6% |
| Intermountain | Health System | 9.3% | 10.9% | 10.7% | 11.2% | 10.7% | 10.9% | 10.7% |
| CommonSpirit | Health System | 9.7% | 8.7% | 9.6% | 9.5% | 9.4% | 11.3% | 9.8% |
| HCA Healthcare | Health System | 9.6% | 10.3% | 11.1% | 9.8% | 9.1% | 8.6% | 9.6% |
| AdventHealth | Health System | 4.9% | 4.9% | 5.6% | 5.1% | 4.9% | 6.1% | 5.3% |
| Banner Health | Health System | 4.7% | 4.6% | 4.9% | 4.3% | 4.4% | 3.6% | 4.3% |
| National Jewish Health | Hospital | 3.0% | 2.7% | 2.8% | 2.5% | 2.3% | 2.0% | 2.5% |
| Parkview Medical Center, Inc. | Hospital | 2.5% | 2.6% | 3.0% | 2.4% | 2.3% | 2.0% | 2.4% |
| Boulder Community Health | Hospital | 2.2% | 2.2% | 2.2% | 2.2% | 2.4% | 2.3% | 2.2% |
| Denver Health And Hospital Authority | Hospital | 2.0% | 2.4% | 2.2% | 1.9% | 2.0% | 1.6% | 2.0% |
| Colorado West Healthcare System | Hospital | 1.4% | 1.5% | 1.5% | 1.7% | 2.2% | 2.1% | 1.8% |
| Salida Hospital District | Hospital | 1.8% | 1.8% | 1.2% | 1.4% | 1.6% | 1.7% | 1.6% |
| Valley View Hospital Association | Hospital | 1.4% | 1.4% | 1.4% | 1.6% | 1.6% | 1.7% | 1.6% |
| Aspen Valley Hospital District | Hospital | 1.3% | 1.2% | 1.0% | 1.1% | 1.2% | 1.1% | 1.1% |
| Lower Valley Hospital Association | Hospital | 0.6% | 0.7% | 1.0% | 1.3% | 1.3% | 1.3% | 1.1% |
| Delta County Memorial Hospital | Hospital | 0.9% | 0.9% | 1.0% | 0.9% | 1.2% | 1.2% | 1.1% |
| Vail Clinic, Inc. | Hospital | 0.4% | 0.7% | 0.8% | 1.1% | 1.2% | 1.3% | 1.0% |
| Montrose Memorial Hospital, Inc. | Hospital | 0.8% | 0.7% | 0.8% | 0.9% | 0.9% | 0.9% | 0.8% |
| Park Hospital District | Hospital | 0.8% | 0.7% | 0.7% | 0.7% | 0.7% | 0.6% | 0.7% |
| Grand River Hospital District | Hospital | 0.7% | 0.6% | 0.5% | 0.6% | 0.7% | 0.8% | 0.7% |
| Southwest Health System, Inc. | Hospital | 0.5% | 0.4% | 0.5% | 0.5% | 0.6% | 0.6% | 0.5% |
| The Memorial Hospital | Hospital | 0.6% | 0.5% | 0.3% | 0.4% | 0.4% | 0.6% | 0.5% |
| Animas Surgical Hospital, LLC | Hospital | 0.5% | 0.4% | 0.4% | 0.4% | 0.4% | 0.5% | 0.4% |
| San Luis Valley | Health System | 0.5% | 0.5% | 0.5% | 0.4% | 0.4% | 0.4% | 0.4% |
| Gunnison Valley Hospital | Hospital | 0.4% | 0.4% | 0.3% | 0.4% | 0.5% | 0.5% | 0.4% |
| Upper San Juan Health Service District | Hospital | 0.4% | 0.4% | 0.4% | 0.5% | 0.4% | 0.5% | 0.4% |
| Prowers County Hospital District | Hospital | 0.4% | 0.4% | 0.4% | 0.3% | 0.3% | 0.3% | 0.3% |
| Yuma District Hospital | Hospital | 0.5% | 0.5% | 0.4% | 0.3% | 0.3% | 0.3% | 0.3% |
| Wray Community District Hospital | Hospital | 0.4% | 0.3% | 0.3% | 0.3% | 0.3% | 0.3% | 0.3% |
| Lincoln Community Hospital | Hospital | 0.4% | 0.4% | 0.3% | 0.2% | 0.2% | 0.2% | 0.3% |
| All Other Hospitals/Health Systems | Both | 3.5% | 3.3% | 2.7% | 2.8% | 2.8% | 3.3% | 3.1% |

Exhibit IV.C – Total Commercial HOPD Allowed Dollars, by year and Health System & Hospital.

| Health System | Classification | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|---|----------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| UC Health | Health System | \$258,502,156 | \$296,680,351 | \$341,083,093 | \$324,745,826 | \$418,824,731 | \$439,258,776 | \$2,079,094,933 |
| HCA Healthcare | Health System | \$129,689,144 | \$144,339,497 | \$154,089,321 | \$140,123,190 | \$139,121,163 | \$137,174,975 | \$844,537,291 |
| Intermountain Childrens' | Health System | \$105,654,993 | \$128,473,747 | \$125,582,335 | \$113,908,141 | \$133,608,164 | \$129,599,781 | \$736,827,162 |
| CommonSpirit | Health System | \$77,092,448 | \$93,597,869 | \$98,164,787 | \$104,334,949 | \$129,426,058 | \$133,592,877 | \$636,208,988 |
| Banner Health | Health System | \$75,888,162 | \$74,516,480 | \$79,974,217 | \$73,363,421 | \$90,282,566 | \$99,203,189 | \$493,228,035 |
| AdventHealth | Health System | \$56,489,893 | \$52,292,577 | \$54,891,780 | \$49,234,728 | \$43,067,812 | \$46,400,639 | \$302,377,431 |
| Valley View Hospital Association | Hospital | \$32,566,506 | \$37,848,708 | \$41,767,727 | \$38,881,115 | \$54,133,602 | \$63,368,225 | \$268,565,884 |
| Denver Health And Hospital Authority | Hospital | \$44,916,309 | \$33,212,162 | \$37,218,957 | \$34,465,993 | \$39,608,436 | \$43,086,784 | \$232,508,640 |
| Parkview Medical Center, Inc. | Hospital | \$19,457,570 | \$24,472,706 | \$26,595,094 | \$25,801,574 | \$31,825,988 | \$34,069,786 | \$162,222,718 |
| Colorado West Healthcare System | Hospital | \$20,135,944 | \$21,668,573 | \$22,055,190 | \$20,724,821 | \$26,367,453 | \$26,526,587 | \$137,478,569 |
| Boulder Community Health | Hospital | \$16,393,069 | \$17,355,164 | \$21,277,835 | \$21,211,280 | \$20,706,122 | \$22,060,972 | \$119,004,442 |
| Aspen Valley Hospital District | Hospital | \$15,880,306 | \$17,306,790 | \$18,781,020 | \$17,783,417 | \$20,729,264 | \$21,646,532 | \$112,127,329 |
| National Jewish Health | Hospital | \$13,935,691 | \$12,655,035 | \$12,473,708 | \$13,130,568 | \$16,720,023 | \$20,921,611 | \$89,836,635 |
| Vail Clinic, Inc. | Hospital | \$14,301,520 | \$14,501,855 | \$15,629,653 | \$15,779,464 | \$14,336,864 | \$13,344,115 | \$87,893,471 |
| Montrose Memorial Hospital, Inc. | Hospital | \$9,828,434 | \$10,936,360 | \$13,890,682 | \$14,172,776 | \$16,166,572 | \$17,604,540 | \$82,599,365 |
| Delta County Memorial Hospital | Hospital | \$9,454,903 | \$9,170,892 | \$12,453,294 | \$13,234,816 | \$15,681,954 | \$15,177,628 | \$75,173,487 |
| Salida Hospital District | Hospital | \$9,500,616 | \$9,556,069 | \$10,796,248 | \$10,855,930 | \$13,039,489 | \$11,643,378 | \$65,391,730 |
| Grand River Hospital District | Hospital | \$9,429,906 | \$9,199,659 | \$9,350,379 | \$9,016,522 | \$10,971,133 | \$12,563,965 | \$60,531,565 |
| Gunnison Valley Hospital | Hospital | \$8,763,009 | \$9,874,781 | \$9,820,279 | \$8,804,727 | \$9,248,755 | \$11,317,499 | \$57,829,051 |
| San Luis Valley | Health System | \$7,114,281 | \$8,616,918 | \$9,336,981 | \$9,347,018 | \$9,359,854 | \$9,151,279 | \$52,926,332 |
| Animas Surgical Hospital, LLC | Hospital | \$6,820,214 | \$5,545,266 | \$5,377,877 | \$4,170,622 | \$4,276,502 | \$4,628,379 | \$30,818,860 |
| HCA - HealthOne, LLC | Hospital | \$5,215,290 | \$4,401,131 | \$4,244,346 | \$4,025,089 | \$4,485,962 | \$5,627,687 | \$27,999,504 |
| Lower Valley Hospital Association | Hospital | \$3,131,804 | \$6,602,101 | \$5,062,447 | \$5,241,677 | \$3,112,774 | \$4,789,440 | \$27,940,243 |
| Denver VAMC | Hospital | \$3,776,069 | \$4,768,944 | \$4,812,397 | \$3,750,685 | \$4,972,247 | \$5,142,227 | \$27,222,568 |
| Prowers County Hospital District | Hospital | \$3,488,571 | \$4,213,226 | \$4,369,240 | \$2,887,513 | \$3,733,114 | \$3,571,258 | \$22,262,922 |
| Southwest Health System, Inc. | Hospital | \$2,299,720 | \$2,820,569 | \$2,848,319 | \$3,367,404 | \$4,427,219 | \$3,627,001 | \$19,390,230 |
| Wray Community District Hospital | Hospital | \$2,902,855 | \$3,517,550 | \$3,103,440 | \$3,191,743 | \$2,960,097 | \$3,170,877 | \$18,846,561 |
| Kremmling Memorial Hospital District | Hospital | \$1,780,746 | \$1,760,161 | \$2,012,126 | \$2,530,213 | \$3,787,392 | \$4,034,740 | \$15,905,378 |
| The Memorial Hospital | Hospital | \$1,405,843 | \$2,066,858 | \$2,699,359 | \$2,497,183 | \$2,902,358 | \$3,760,639 | \$15,332,239 |
| All Other Hospitals/Health Systems | Both | \$2,176,639 | \$2,483,816 | \$2,783,062 | \$2,362,615 | \$2,101,315 | \$2,758,105 | \$14,665,551 |
| | | \$40,244,564 | \$61,429,070 | \$27,661,013 | \$26,976,431 | \$31,175,996 | \$32,804,038 | \$220,291,111 |



Exhibit IV.D – Health System & Hospital distribution of Commercial HOPD Allowed Dollars by year.

| Health System | Classification | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|--------------------------------------|----------------|-------|-------|-------|-------|-------|-------|-------|
| UC Health | Health System | 25.6% | 26.4% | 28.9% | 29.0% | 31.7% | 31.8% | 29.1% |
| HCA Healthcare | Health System | 12.9% | 12.8% | 13.1% | 12.5% | 10.5% | 9.9% | 11.8% |
| Intermountain | Health System | 10.5% | 11.4% | 10.6% | 10.2% | 10.1% | 9.4% | 10.3% |
| Childrens' | Health System | 7.6% | 8.3% | 8.3% | 9.3% | 9.8% | 9.7% | 8.9% |
| CommonSpirit | Health System | 7.5% | 6.6% | 6.8% | 6.6% | 6.8% | 7.2% | 6.9% |
| Banner Health | Health System | 5.6% | 4.6% | 4.7% | 4.4% | 3.3% | 3.4% | 4.2% |
| AdventHealth | Health System | 3.2% | 3.4% | 3.5% | 3.5% | 4.1% | 4.6% | 3.8% |
| Valley View Hospital Association | Hospital | 4.5% | 2.9% | 3.2% | 3.1% | 3.0% | 3.1% | 3.3% |
| Denver Health And Hospital Authority | Hospital | 1.9% | 2.2% | 2.3% | 2.3% | 2.4% | 2.5% | 2.3% |
| Parkview Medical Center, Inc. | Hospital | 2.0% | 1.9% | 1.9% | 1.9% | 2.0% | 1.9% | 1.9% |
| Colorado West Healthcare System | Hospital | 1.6% | 1.5% | 1.8% | 1.9% | 1.6% | 1.6% | 1.7% |
| Boulder Community Health | Hospital | 1.6% | 1.5% | 1.6% | 1.6% | 1.6% | 1.6% | 1.6% |
| Aspen Valley Hospital District | Hospital | 1.4% | 1.1% | 1.1% | 1.2% | 1.3% | 1.5% | 1.3% |
| National Jewish Health | Hospital | 1.4% | 1.3% | 1.3% | 1.4% | 1.1% | 1.0% | 1.2% |
| Vail Clinic, Inc. | Hospital | 1.0% | 1.0% | 1.2% | 1.3% | 1.2% | 1.3% | 1.2% |
| Montrose Memorial Hospital, Inc. | Hospital | 0.9% | 0.8% | 1.1% | 1.2% | 1.2% | 1.1% | 1.1% |
| Delta County Memorial Hospital | Hospital | 0.9% | 0.8% | 0.9% | 1.0% | 1.0% | 0.8% | 0.9% |
| Salida Hospital District | Hospital | 0.9% | 0.8% | 0.8% | 0.8% | 0.8% | 0.9% | 0.8% |
| Grand River Hospital District | Hospital | 0.9% | 0.9% | 0.8% | 0.8% | 0.7% | 0.8% | 0.8% |
| Gunnison Valley Hospital | Hospital | 0.7% | 0.8% | 0.8% | 0.8% | 0.7% | 0.7% | 0.7% |
| San Luis Valley | Health System | 0.7% | 0.5% | 0.5% | 0.4% | 0.3% | 0.3% | 0.4% |
| Animas Surgical Hospital, LLC | Hospital | 0.5% | 0.4% | 0.4% | 0.4% | 0.3% | 0.4% | 0.4% |
| HCA - HealthOne, LLC | Hospital | 0.3% | 0.6% | 0.4% | 0.5% | 0.2% | 0.3% | 0.4% |
| Lower Valley Hospital Association | Hospital | 0.4% | 0.4% | 0.4% | 0.3% | 0.4% | 0.4% | 0.4% |
| Denver VAMC | Hospital | 0.3% | 0.4% | 0.4% | 0.3% | 0.3% | 0.3% | 0.3% |
| Prowers County Hospital District | Hospital | 0.2% | 0.3% | 0.2% | 0.3% | 0.3% | 0.3% | 0.3% |
| Southwest Health System, Inc. | Hospital | 0.3% | 0.3% | 0.3% | 0.3% | 0.2% | 0.2% | 0.3% |
| Wray Community District Hospital | Hospital | 0.2% | 0.2% | 0.2% | 0.2% | 0.3% | 0.3% | 0.2% |
| Kremmling Memorial Hospital District | Hospital | 0.1% | 0.2% | 0.2% | 0.2% | 0.2% | 0.3% | 0.2% |
| The Memorial Hospital | Hospital | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% |
| All Other Hospitals/Health Systems | Both | 4.0% | 5.5% | 2.3% | 2.4% | 2.4% | 2.4% | 3.1% |



Exhibit IV.E – Total HOPD Allowed Dollars charged to Medicare and Commercial payers, by year and Health System & Hospital.

| Health System | Classification | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|--|----------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| UC Health | Health System | \$510,304,010 | \$563,150,603 | \$658,526,329 | \$674,886,438 | \$824,153,780 | \$895,308,110 | \$4,126,329,269 |
| HCA Healthcare | Health System | \$201,453,624 | \$227,141,562 | \$266,654,343 | \$242,701,291 | \$250,250,106 | \$261,962,314 | \$1,450,163,240 |
| Intermountain | Health System | \$175,125,724 | \$216,358,658 | \$234,220,665 | \$230,838,540 | \$264,699,898 | \$288,371,753 | \$1,409,615,238 |
| CommonSpirit | Health System | \$148,192,374 | \$144,482,288 | \$177,500,648 | \$172,745,597 | \$205,175,579 | \$262,986,044 | \$1,111,082,529 |
| Childrens' | Health System | \$77,338,246 | \$93,838,159 | \$98,456,460 | \$104,659,188 | \$129,836,524 | \$134,124,919 | \$638,253,496 |
| AdventHealth | Health System | \$69,197,773 | \$77,446,191 | \$98,157,988 | \$92,377,891 | \$114,220,999 | \$151,837,469 | \$603,238,311 |
| Banner Health | Health System | \$91,200,748 | \$89,203,803 | \$104,868,202 | \$94,273,300 | \$96,601,347 | \$99,339,462 | \$575,486,862 |
| Valley View Hospital Association | Hospital | \$55,249,248 | \$44,767,560 | \$51,860,637 | \$50,870,247 | \$59,702,072 | \$67,857,356 | \$330,307,119 |
| Parkview Medical Center, Inc. | Hospital | \$38,435,462 | \$42,774,914 | \$52,146,010 | \$46,005,002 | \$53,939,028 | \$55,682,796 | \$288,983,212 |
| Denver Health And Hospital Authority | Hospital | \$34,143,331 | \$43,608,465 | \$48,660,096 | \$45,679,895 | \$56,090,704 | \$57,989,697 | \$286,172,188 |
| Boulder Community Health | Hospital | \$31,912,285 | \$34,730,092 | \$40,815,010 | \$40,462,970 | \$49,538,834 | \$54,415,280 | \$251,874,472 |
| National Jewish Health | Hospital | \$36,731,742 | \$36,128,122 | \$44,074,677 | \$42,060,133 | \$42,685,048 | \$42,060,308 | \$243,740,029 |
| Colorado West Healthcare System | Hospital | \$26,719,300 | \$29,312,694 | \$36,719,153 | \$38,838,599 | \$47,669,762 | \$52,908,710 | \$232,168,219 |
| Aspen Valley Hospital District | Hospital | \$23,661,866 | \$22,328,678 | \$22,724,025 | \$24,666,482 | \$31,359,696 | \$37,238,691 | \$161,979,438 |
| Salida Hospital District | Hospital | \$23,159,067 | \$23,540,298 | \$21,730,179 | \$23,206,751 | \$31,107,891 | \$37,810,888 | \$160,555,074 |
| Vail Clinic, Inc. | Hospital | \$12,779,523 | \$16,639,239 | \$22,273,910 | \$25,259,843 | \$30,659,598 | \$35,853,789 | \$143,465,902 |
| Delta County Memorial Hospital | Hospital | \$16,044,588 | \$16,570,942 | \$20,911,607 | \$20,719,394 | \$28,231,912 | \$29,448,826 | \$131,927,269 |
| Montrose Memorial Hospital, Inc. | Hospital | \$15,083,227 | \$14,645,244 | \$20,203,845 | \$22,155,572 | \$26,669,102 | \$28,383,537 | \$127,140,527 |
| Grand River Hospital District | Hospital | \$13,949,943 | \$14,908,014 | \$15,306,135 | \$14,898,683 | \$18,205,651 | \$22,776,632 | \$100,045,058 |
| Lower Valley Hospital Association | Hospital | \$8,514,340 | \$10,279,233 | \$15,220,367 | \$17,419,458 | \$21,301,206 | \$23,686,041 | \$96,420,645 |
| Gunnison Valley Hospital | Hospital | \$10,353,876 | \$11,936,388 | \$12,186,682 | \$13,634,182 | \$15,890,436 | \$15,721,860 | \$79,723,424 |
| San Luis Valley | Health System | \$10,673,077 | \$9,500,739 | \$10,215,594 | \$8,407,136 | \$9,067,511 | \$10,555,136 | \$58,419,192 |
| Park Hospital District | Hospital | \$8,375,357 | \$7,599,093 | \$8,521,401 | \$9,616,282 | \$10,470,853 | \$11,712,316 | \$56,295,303 |
| Animas Surgical Hospital, LLC | Hospital | \$8,631,797 | \$7,542,470 | \$8,548,932 | \$7,967,507 | \$9,879,111 | \$13,519,088 | \$56,088,904 |
| Southwest Health System, Inc. | Hospital | \$6,538,314 | \$7,035,994 | \$8,214,151 | \$8,200,817 | \$9,876,142 | \$11,966,500 | \$51,831,917 |
| The Memorial Hospital | Hospital | \$6,614,646 | \$6,200,589 | \$6,316,307 | \$6,753,071 | \$7,529,742 | \$11,054,545 | \$44,468,900 |
| Prowers County Hospital District | Hospital | \$5,473,603 | \$5,968,760 | \$6,490,645 | \$6,936,667 | \$8,114,932 | \$8,344,966 | \$41,329,573 |
| Upper San Juan Health Service District | Hospital | \$3,840,303 | \$4,652,282 | \$5,966,562 | \$7,392,248 | \$7,435,356 | \$8,464,094 | \$37,750,846 |
| Wray Community District Hospital | Hospital | \$4,820,737 | \$4,280,896 | \$5,221,211 | \$5,638,124 | \$8,023,186 | \$8,000,761 | \$35,984,915 |
| HCA - HealthOne, LLC | Hospital | \$3,407,642 | \$6,898,057 | \$5,386,401 | \$5,643,243 | \$3,594,755 | \$6,216,509 | \$31,146,606 |
| All Other Hospitals/Health Systems | Both | \$74,425,405 | \$97,400,679 | \$64,217,928 | \$61,372,578 | \$73,458,621 | \$89,526,477 | \$460,401,687 |



Exhibit IV.F – Health System & Hospital distribution of HOPD Allowed Dollars charged to Medicare and Commercial payers, by year.

| Health System | Classification | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Total |
|--|----------------|-------|-------|-------|-------|-------|-------|-------|
| UC Health | Health System | 29.1% | 29.2% | 30.0% | 31.2% | 32.4% | 31.6% | 30.7% |
| HCA Healthcare | Health System | 11.5% | 11.8% | 12.2% | 11.2% | 9.8% | 9.2% | 10.8% |
| Intermountain | Health System | 10.0% | 11.2% | 10.7% | 10.7% | 10.4% | 10.2% | 10.5% |
| CommonSpirit | Health System | 8.5% | 7.5% | 8.1% | 8.0% | 8.1% | 9.3% | 8.3% |
| Childrens' | Health System | 4.4% | 4.9% | 4.5% | 4.8% | 5.1% | 4.7% | 4.8% |
| AdventHealth | Health System | 3.9% | 4.0% | 4.5% | 4.3% | 4.5% | 5.4% | 4.5% |
| Banner Health | Health System | 5.2% | 4.6% | 4.8% | 4.4% | 3.8% | 3.5% | 4.3% |
| Valley View Hospital Association | Hospital | 3.2% | 2.3% | 2.4% | 2.3% | 2.3% | 2.4% | 2.5% |
| Parkview Medical Center, Inc. | Hospital | 2.2% | 2.2% | 2.4% | 2.1% | 2.1% | 2.0% | 2.2% |
| Denver Health And Hospital Authority | Hospital | 1.9% | 2.3% | 2.2% | 2.1% | 2.2% | 2.0% | 2.1% |
| Boulder Community Health | Hospital | 1.8% | 1.8% | 1.9% | 1.9% | 1.9% | 1.9% | 1.9% |
| National Jewish Health | Hospital | 2.1% | 1.9% | 2.0% | 1.9% | 1.7% | 1.5% | 1.8% |
| Colorado West Healthcare System | Hospital | 1.5% | 1.5% | 1.7% | 1.8% | 1.9% | 1.9% | 1.7% |
| Aspen Valley Hospital District | Hospital | 1.4% | 1.2% | 1.0% | 1.1% | 1.2% | 1.3% | 1.2% |
| Salida Hospital District | Hospital | 1.3% | 1.2% | 1.0% | 1.1% | 1.2% | 1.3% | 1.2% |
| Vail Clinic, Inc. | Hospital | 0.7% | 0.9% | 1.0% | 1.2% | 1.2% | 1.3% | 1.1% |
| Delta County Memorial Hospital | Hospital | 0.9% | 0.9% | 1.0% | 1.0% | 1.1% | 1.0% | 1.0% |
| Montrose Memorial Hospital, Inc. | Hospital | 0.9% | 0.8% | 0.9% | 1.0% | 1.0% | 1.0% | 0.9% |
| Grand River Hospital District | Hospital | 0.8% | 0.8% | 0.7% | 0.7% | 0.7% | 0.8% | 0.7% |
| Lower Valley Hospital Association | Hospital | 0.5% | 0.5% | 0.7% | 0.8% | 0.8% | 0.8% | 0.7% |
| Gunnison Valley Hospital | Hospital | 0.6% | 0.6% | 0.6% | 0.6% | 0.6% | 0.6% | 0.6% |
| San Luis Valley | Health System | 0.6% | 0.5% | 0.5% | 0.4% | 0.4% | 0.4% | 0.4% |
| Park Hospital District | Hospital | 0.5% | 0.4% | 0.4% | 0.4% | 0.4% | 0.4% | 0.4% |
| Animas Surgical Hospital, LLC | Hospital | 0.5% | 0.4% | 0.4% | 0.4% | 0.4% | 0.5% | 0.4% |
| Southwest Health System, Inc. | Hospital | 0.4% | 0.4% | 0.4% | 0.4% | 0.4% | 0.4% | 0.4% |
| The Memorial Hospital | Hospital | 0.4% | 0.3% | 0.3% | 0.3% | 0.3% | 0.4% | 0.3% |
| Prowers County Hospital District | Hospital | 0.3% | 0.3% | 0.3% | 0.3% | 0.3% | 0.3% | 0.3% |
| Upper San Juan Health Service District | Hospital | 0.2% | 0.2% | 0.3% | 0.3% | 0.3% | 0.3% | 0.3% |
| Wray Community District Hospital | Hospital | 0.3% | 0.2% | 0.2% | 0.3% | 0.3% | 0.3% | 0.3% |
| HCA - HealthOne, LLC | Hospital | 0.2% | 0.4% | 0.2% | 0.3% | 0.1% | 0.2% | 0.2% |
| All Other Hospitals/Health Systems | Both | 4.2% | 5.0% | 2.9% | 2.8% | 2.9% | 3.2% | 3.4% |



Cost Sharing Proportion by Payer Type

Optumas quantified the total allowed dollars and member cost sharing for both HOPD visits and professional visits to analyze the proportion of total reimbursement that the member contributes to the provide via cost sharing. The professional visits are exclusive of any professional fees related to an outpatient visit.

Methodology

The APCD includes both allowed and cost sharing financial fields in the claims data. The HOPD and professional data sets identified were used to summarize the allowed dollars and member cost sharing dollars by year and by payer type for each of the service types. As an important data limitation note – the commercial data does not include self-funded or self-insured members. These members may enroll in high deductible health plans at a proportion than other types of payer coverage. The result is that those members would pay a higher percentage of the overall reimbursement, which is not reflected in this analysis.

Results

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 above, the Commercial percentage may be understated due to the absence of self-funded or self-insured members, which could have a higher percentage of cost sharing due to tending to select high deductible health plans. The Medicare FFS cost sharing of approx. 20% is consistent with the Medicare benefit package design, though 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.

Exhibit V.A – Cost Sharing Proportion by Payer Type for HOPD

| Year | Medicare FFS: Allowed Amount | Medicare FFS: Member Cost Sharing | Medicare FFS: % Cost Sharing |
|--------------|------------------------------|-----------------------------------|------------------------------|
| 2017 | \$525,894,442 | \$109,678,122 | 20.9% |
| 2018 | \$523,241,211 | \$106,461,477 | 20.3% |
| 2019 | \$596,336,788 | \$120,312,472 | 20.2% |
| 2020 | \$620,195,995 | \$122,656,259 | 19.8% |
| 2021 | \$708,016,923 | \$139,693,258 | 19.7% |
| 2022 | \$750,393,503 | \$141,384,369 | 18.8% |
| Total | \$3,724,078,863 | \$740,185,958 | 19.9% |

| Year | Medicare Advantage: Allowed Amount | Medicare Advantage: Member Cost Sharing | Medicare Advantage: % Cost Sharing |
|--------------|------------------------------------|---|------------------------------------|
| 2017 | \$218,219,561 | \$68,448,988 | 31.4% |
| 2018 | \$281,744,610 | \$86,194,047 | 30.6% |
| 2019 | \$415,773,102 | \$104,930,137 | 25.2% |
| 2020 | \$426,169,682 | \$109,692,211 | 25.7% |
| 2021 | \$516,261,478 | \$139,841,953 | 27.1% |
| 2022 | \$703,103,842 | \$163,163,503 | 23.2% |
| Total | \$2,561,272,275 | \$672,270,839 | 26.2% |

| Year | Commercial: Allowed Amount | Commercial: Member Cost Sharing | Commercial: % Cost Sharing |
|--------------|----------------------------|---------------------------------|----------------------------|
| 2017 | \$1,008,237,175 | \$142,241,073 | 14.1% |
| 2018 | \$1,125,884,884 | \$153,284,541 | 13.6% |
| 2019 | \$1,180,206,208 | \$162,182,222 | 13.7% |
| 2020 | \$1,119,921,450 | \$148,260,518 | 13.2% |
| 2021 | \$1,321,160,980 | \$175,890,578 | 13.3% |
| 2022 | \$1,381,627,529 | \$184,793,352 | 13.4% |
| Total | \$7,137,038,226 | \$966,652,285 | 13.5% |

Appendices

Appendix 1

| CPT Code | Description ² |
|----------|--|
| G0463 | Hospital outpatient clinic visit for assessment and management of a patient. |
| J9271 | Injection, pembrolizumab - Chemotherapy Drugs. |
| J9299 | Injection, nivolumab - Chemotherapy Drugs. |
| 93306 | Transthoracic echocardiography, complete study. |
| 78452 | 3D imaging of the heart by using a high-energy CT scanner. |
| J2505 | Injection, pegfilgrastim - Chemotherapy Drugs. |
| 77385 | Radiation therapy to deliver radiation doses to a malignant tumor, using computer designed mapping. |
| 96413 | Injection and intravenous infusion chemotherapy. |
| J9144 | Injection, daratumumab and hyaluronidase - Chemotherapy Drugs. |
| 77386 | Radiation therapy to deliver radiation doses to a malignant tumor. |
| J0897 | Injection, denosumab. |
| J1561 | Injection, immune globulin, non-lyophilized. |
| J9355 | Injection, trastuzumab, excludes biosimilar - Chemotherapy Drugs. |
| J9145 | Injection, daratumumab - Chemotherapy Drugs. |
| J9310 | Injection, rituximab - Chemotherapy Drugs. |
| J9312 | Injection, rituximab - Chemotherapy Drugs. |
| J9305 | Injection, pemetrexed - Chemotherapy Drugs. |
| 77067 | Bilateral screening mammogram that includes computer-aided detection. |
| J2353 | Injection, octreotide, depot form for intramuscular injection. |
| 93798 | Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring. |
| J9035 | Injection, bevacizumab - Chemotherapy Drugs. |
| 77373 | Technical component of stereotactic body radiation therapy. |
| J1930 | Injection, lanreotide. |
| 97110 | Therapeutic exercise that helps patients develop or maintain strength, endurance, flexibility, or range of motion. |
| J2350 | 1 mg injection of ocrelizumab. |



Appendix 2

| CPT Code | Description ³ |
|----------|--|
| G0463 | Hospital outpatient clinic visit for assessment and management of a patient. |
| 36415 | Collection of venous blood by venipuncture. |
| 80053 | Comprehensive metabolic panel. |
| 85025 | Complete blood count with automated differential white blood cell count. |
| 80061 | Lipid panel test to measure the level of triglycerides in blood. |
| 84443 | Blood test measuring thyroid stimulating hormone level. |
| 85610 | Prothrombin Time. |
| 83036 | Glycated hemoglobin/Glycated protein. |
| 80048 | Basic metabolic panel. |
| 97110 | Therapeutic exercise that helps patients develop or maintain strength, endurance, flexibility, or range of motion. |
| 85027 | Blood count on the red and white blood cells and platelets and hemoglobin test. |
| 97140 | Manual therapy techniques used for 15 minutes or more in one or more body regions. |
| 77063 | Bilateral screening digital breast tomosynthesis. |
| 77067 | Bilateral screening mammogram that includes computer-aided detection. |
| 93798 | Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring. |
| J1642 | Injection, heparin sodium. |
| 81001 | Urinalysis to detect substances or cellular material associated with different metabolic kidney disorders. |
| 83735 | Blood test measuring magnesium level. |
| 96413 | Injection and intravenous infusion chemotherapy. |
| 93306 | Transthoracic echocardiography, complete study. |
| 82306 | Vitamin D blood test. |
| 84439 | Laboratory test that measures the levels of free thyroxine in a patient's blood. |
| J3490 | Meloxicam injection. |
| 84100 | Blood test to evaluate the level of phosphate in the patient specimen. |
| 82728 | Serum Iron studies. |

³ Procedure Code Definitions: <https://www.aapc.com/>



Appendix I. Premium Impact Scenarios

Scenario 1

| | Value | Assumption | |
|---|-----------------|------------|---|
| Employer & Employee Premium | \$450.00 | | |
| Medical (paid to providers) | \$382.50 | 85% | <i>Estimated percentage of premium for medical expenses paid for by payer</i> |
| Non-medical (health plan overhead) | \$67.50 | 15% | <i>Estimated percentage of premium for non-medical expenses</i> |
| HOPD Facility Fees | | | |
| Proportion of total expenses (payer and | \$57.38 | 15% | <i>See below</i> |
| Site Neutral Pricing Assumption | \$29.42 | 95% | <i>See below</i> |
| Site Neutral Impact | -\$27.95 | | |
| Impact to Premium | | | |
| Adjusted Premium | \$422.05 | | |
| Impact | -6.2% | | |

Scenario 2

| | Value | Assumption | |
|---|-----------------|------------|---|
| Employer & Employee Premium | \$450.00 | | |
| Medical (paid to providers) | \$382.50 | 85% | <i>Estimated percentage of premium for medical expenses paid for by payer</i> |
| Non-medical (health plan overhead) | \$67.50 | 15% | <i>Estimated percentage of premium for non-medical expenses</i> |
| HOPD Facility Fees | | | |
| Proportion of total expenses (payer and | \$57.38 | 15% | <i>See below</i> |
| Site Neutral Pricing Assumption | \$32.79 | 75% | <i>See below</i> |
| Site Neutral Impact | -\$24.59 | | |
| Impact to Premium | | | |
| Adjusted Premium | \$425.41 | | |
| Impact | -5.5% | | |

Assumption Notes

- HOPD portion estimated based on assumption that Hospital (inpatient + outpatient) is about 40% of total medical expenses. Outpatient is estimated to be about 50% of total hospital net patient revenue, resulting in an initial 20% estimate for HOPD of total expenditures. This was then lowered to an assumption of 15% due to the exclusion of emergency department
- Site neutral pricing assumption is based on results of comparison analysis that indicated that HOPD reimbursement was about 95% higher than professional site of service reimbursement for the same services. A range was put around this to show potential varying impacts for other scenarios

Appendix J. Impact to Colorado’s Medical Assistance Program (Colorado Medicaid)

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. Health First Colorado members have no co-payments except for low co-payments for non-emergency care provided in an emergency department. Health First Colorado members have no other cost sharing. Accordingly, the impact of facility fees on Health First Colorado members is negligible. On the other hand, the trend of shifting the site of care from independent practices to affiliated ones increases the Medicaid program’s overall health care expenditures. Hospitals receive a base payment tied to a claim when it is submitted for outpatient hospital services provided to an eligible Health First Colorado Medicaid member. The hospital claims include charges for services and the facility fee, but Medicaid does not pay for a distinct incremental facility fee.

The table on the following page reviews the Colorado Medicaid program’s outpatient hospital expenditure over time, including the caseload numbers of Medicaid’s members. As directed by the legislation, analyses were completed using existing data from credible sources already subject to rigorous reporting and auditing standards. The data source on the following page is the Medicaid caseload and expenditure data reported to the Joint Budget Committee (JBC) pursuant to HCPF’s FY 2024-25 Legislative Request For Information #1.¹ Data is reported by state fiscal year (SFY), which begins on July 1 and runs through June 30. There are two types of reimbursements to hospitals for outpatient services, base payments paid when a claim is submitted for an eligible Medicaid member and supplemental payments paid through the CHASE.

¹ See [Premiums, Expenditures and Caseload Reports | Colorado Department of Health Care Policy & Financing](#).

Table 1. Total Outpatient Hospital Expenditures

| Field | SFY 2016 - 2017 | SFY 2017 - 2018 | SFY 2018 - 2019 | SFY 2019 - 2020 | SFY 2020 - 2021 | SFY 2021 - 2022 | SFY 2022 - 2023 | SFY 2023 - 2024 | Compound Annual Growth Rate |
|--|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------------------|
| Medicaid Outpatient Hospital Base Payments | \$536,125,165 | \$515,329,319 | \$499,081,828 | \$529,148,233 | \$576,836,402 | \$693,185,242 | \$770,779,792 | \$783,306,589 | 5.6% |
| CHASE Total Supplemental Payments - Outpatient | \$272,604,531 | \$377,239,934 | \$545,016,968 | \$452,812,126 | \$634,801,130 | \$574,264,679 | \$712,501,885 | \$667,614,622 | 13.7% |
| Total Outpatient Hospital Expenditure | \$808,729,696 | \$892,569,253 | 1,044,098,796 | \$981,960,359 | \$1,211,637,532 | 1,267,449,921 | 1,483,281,677 | 1,450,921,211 | 8.7% |

Expenditures sourced from the JBC Report available at <https://hcpf.colorado.gov/budget>

Table 2. Total Outpatient Hospital Per Capita

| Field | SFY 2016 - 2017 | SFY 2017 - 2018 | SFY 2018 - 2019 | SFY 2019 - 2020 | SFY 2020 - 2021 | SFY 2021 - 2022 | SFY 2022 - 2023 | SFY 2023 - 2024 | Compound Annual Growth Rate |
|---------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------------------|
| Total Outpatient Hospital Expenditure | \$808,729,696 | \$892,569,253 | 1,044,098,796 | \$981,960,359 | 1,211,637,532 | \$1,267,449,921 | \$1,483,281,677 | 1,450,921,211 | 8.7% |
| Medicaid Caseload | 1,346,174 | 1,315,217 | 1,261,366 | 1,219,245 | 1,404,955 | 1,561,560 | 1,719,393 | 1,390,186 | 0.5% |
| Total Outpatient Hospital Per Capita | \$601 | \$679 | \$828 | \$805 | \$862 | \$812 | \$863 | \$1,044 | 8.2% |

Caseload sourced from July's 2017 thru 2024 Monthly Premiums/Caseload Report to the JBC available at <https://hcpf.colorado.gov/budget>



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-capita hospital outpatient expenditures grew by 8.2%.

However, the relatively low caseload growth rate does not reflect a temporary increase in Medicaid caseload during state fiscal years (SFY) 2020 through 2023 due to the federal government's COVID-19 public health emergency mandate. The mandate did not allow states to disenroll members who were found to be no longer eligible for Medicaid. Across the country, Medicaid members were 'locked in' to Medicaid eligibility. When the health emergency ended on May 11, 2023, Colorado Medicaid began disenrolling members who were no longer eligible for the program bringing caseload numbers closer to pre-pandemic levels. As a result, the per capita growth rate of hospital outpatient revenues grew by 8.2%. The annual per capita growth rate exceeds the rate at which Medicaid reimbursement grew and exceeds the effects of acuity changes. Therefore, the annual per capita growth rate may include the impact of increasing facility fees.

Additional data and analyses are warranted.

Appendix K. Comparison Methodology and Tables



October 1, 2024

Subject: Colorado HB1215 – Professional and Facility Fee Comparison Methodology Report

Professional and Facility Fee Comparison Methodology Report

Overview

CBIZ Optumas (Optumas) was contracted by the Colorado Department of Health Care Policy and Financing (HCPF) to explore the policies, practices, and costs to Colorado health payers of facility fees as outlined in HB23-1215. Optumas was tasked with comparing professional fees and hospital outpatient department (HOPD) facility fees for the same services. The Colorado All Payer Claims Database (APCD) provided by the Center for Improving Value in Healthcare (CIVHC) was utilized for this analysis across the 2017 to 2022 calendar years. The APCD contains claims data from Medicare, Medicaid, and Commercial payers within the State of Colorado. The purpose of this memo is to detail the methodology used to identify hospital outpatient department (HOPD) facility fees and compare against the comparable professional fees for the same services. The comparison focuses on Medicare Fee-for-service (FFS), Medicare Advantage, and Commercial payers for HOPD services that also can be provided in a professional setting. The HOPD facility fees will be compared to the professional fees for the same services, and professional fees will be split between independent providers and hospital affiliated providers.

Data Validation

Optumas reviewed the data for all the requested fields to ensure they were complete and had the expected valid values. This review indicated that we received appropriate data aligned with our data request that would allow us to continue with the analysis. We then reviewed the visit volume and financial field volume on a monthly longitudinal basis by service type and payer. This review indicated that we did not have any major gaps or anomalies in the data. Optumas will note that we did not audit the APCD data and are relying on the accuracy of the data provided.

Optumas also received benchmarks from CIVHC that estimate they have about 75% of all Commercial covered lives within the APCD. Programs that are not included in the data are listed as follows:

- Uninsured patients and self-pay claims
- Self-insured employers
- Veterans Affairs (VA)
- Tricare
- Worker’s compensation
- Medical coverage paid for by a property & casualty insurance company
 - Example – a person has a car accident, and medical bills are paid for by car insurance company

Optumas also compared the Medicare-specific data within APCD to determine what proportion of Medicare members were reflected within the dataset. That analysis indicated that for the 2017-2022 time period, the APCD reflects 95% of both Medicare and Medicare Advantage members. See Table 1 below.

Table 1. Medicare Membership Benchmark

| Period | CMS Reported Medicare Enrollment | APCD | % of Benchmark |
|---------------|---|-------------|-----------------------|
| 2017 | 847,702 | 807,492 | 95% |
| 2018 | 881,043 | 834,766 | 95% |
| 2019 | 911,545 | 860,660 | 94% |
| 2020 | 938,949 | 886,492 | 94% |
| 2021 | 961,592 | 921,281 | 96% |
| 2022 | 983,947 | 946,661 | 96% |

HOPD Facility Fee and Professional Fee Identification

HOPD Facility Fee Data

Each outpatient visit at a HOPD will generate a facility fee billed to the patient, and in many cases an additional bill for the individual physicians professional fees. The following discusses the identification of the HOPD facility fee portion of the HOPD related outpatient visits.

Optumas first identified all HOPD claims within the APCD using a delineation provided by CIVHC to identify hospital outpatient claims. Optumas validated that delineation by reviewing the Bill Type provided on each claim to confirm they were appropriately identified. Bill Type is a nationally standardized set of codes for institutional/facility-based services that provides information on the type of bill the provider is submitting to the payer. Optumas found that the Bill Types were all generally related to an outpatient-type setting, however; we further delineated that data for this comparison to claims that had the following Bill Type:

- “131” - Hospital, outpatient, admit through discharge¹.
- “851” – Critical Access Hospital, outpatient, admit through discharge¹.

Additionally, Optumas limited the data to non-Emergency Room outpatient claims within the APCD. After discussion with the Hospital Facility Fee Steering Committee, it was determined to exclude all Emergency Room claims from the analytics. Optumas also removed any services that had been denied by the payer. This final HOPD data set services as the basis for identifying the facility fees for Colorado based providers.

On-campus/Off-campus

To identify the on-campus and off-campus visits, Optumas first looked to the Place of Service on each claim. Place of Service is a nationally standardized set of codes for that provides information on the location of the visit between the patient and provider. While this field is provided in the data, unfortunately there is a data limitation due to it being sparsely populated for facility-related claims within the APCD. Optumas explored the following alternative approaches by payer type. The results are that an alternative option was identified for Medicare, however; the off-campus clinic visits were not able to be delineated within the Commercial data. Optumas will delineate on-campus HOPD for the Medicare comparison, and look at a combination of on and off campus HOPD for the Commercial payer comparison. Additional analytics will be provided regarding off-campus locations for hospital systems for the final Steering Committee report.

Professional Fee Data

The professional claims to be used for the comparison were also delineated within the APCD by CIVHC. Optumas validated that delineation by reviewing the Place of Service (POS) provided on each claim to confirm they were appropriately identified. Optumas found that the POS were all generally related to a

¹ <https://med.noridianmedicare.com/web/jea/topics/claim-submission/bill-types>

professional setting, however; we further delineated that data for this comparison to claims that had the following Place of Service² codes:

- 11 – Office
- 12 – Home
- 81 – Independent Laboratory

Optumas also found Places of Service for the professional fee component of a HOPD outpatient visit. These were excluded so that the comparison focused on the professional fees provided during a patient visit that was independent of an outpatient visit. Finally, Optumas removed any services that had been denied by the payer. This final professional data set services as the basis for identifying the professional fees for Colorado based providers.

Independent/Affiliated Providers

To identify independent and hospital-affiliated providers, Optumas leveraged an additional third-party dataset that provides information on each individual provider and if they are affiliated with a hospital or health system for each year, including which health system they are affiliated with at that time. This information was aligned with the APCD by the servicing provider NPI, which identifies the individual practitioner present for the visit. The additional third-party dataset includes physicians that are either Medical Doctors (MDs) or Doctors of Osteopathy (DOs).

² <https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>

Comparison Methodology and Analytics

The comparison of the facility fee and professional fees for the same services is based on using the allowed amount in APCD for the datasets and provider splits identified above. The comparison focuses on the same service provided in either a HOPD setting or a professional setting. It should be noted that the professional fees in this comparison are for services provided in a professional setting only, and do not reflect the professional fee component of an outpatient visit. The allowed amount reflects the contracted rate between the provider and payer, and reflects the total reimbursement for the services provided. The following identifies additional data adjustments and methodology for the comparison.

Grouped Payments

Optumas is aware that some HOPD visits are paid on a grouped basis, which means that all services provided during a visit are grouped together into one overall payment. The result is that the allowed amount listed on a claim for an individual CPT code may not reflect the payment for that individual service, but rather for the entire visits as a whole which may include other services. Inclusion of these grouped payments would skew the HOPD cost per service upward for those individual codes, and would not be appropriate for the comparison. Optumas identified these instances by comparing the overall allowed amount for a visit to the individual allowed amount for each service (CPT code) during a visit. In the instances where they were the same amount, we removed those from the data prior to performing the comparison analysis.

Zero (\$0) Allowed Amount

If a service (CPT code) had a \$0 allowed amount, in either the HOPD or Professional data, it was excluded from the analysis to avoid skewing the cost per service downward.

Modifiers

The comparison is based on the CPT codes that identify each individual service provided during a visit in the claims data, however; Optumas understands that there are also modifiers that can be associated with a CPT code that may further modify the allowed amount for that service. For this comparison, Optumas included any instances of either modifier TC (Technical Component) or 26 (Professional Component) along with the CPT code to ensure that variation driven by these modifiers was controlled for in the calculation of the allowed amount per service comparison.

Allowed per Service

The comparison is done at the individual CPT code level based on the allowed amount per service. The allowed amount per service is based on the allowed amount for each CPT code relative to the detailed units of that individual service that was provided as reported on the claim in APCD. The service units itemize the number of units associated with each individual CPT code (service provided), which indicates how much to reimburse the provider for that service. the majority of cases, the detailed units are one (1) based on providing one instance of that individual service, but in some cases may be greater than one (1) depending on the type of service provided and the billing guidelines for that service. This

approach ensures that we are accounting and controlling for those instances for an accurate comparison when calculating the allowed amount per service.

Outliers

Once the above data adjustments were taken into account, the allowed amount per service was reviewed for any outliers. This was done for each unique combination of the following:

- Payer
 - Commercial
 - Medicare
 - Medicare Advantage
- CPT and modifier combination
- For each of the three comparison groups:
 - HOPD
 - Professional (affiliated)
 - Professional (independent)

The result allowed Optumas to isolate and remove the top 5% of the allowed amount per service for each of the combinations above. This was done to remove any data anomalies or outlier contracting agreements that could further skew the comparison.

Weighted Average

After outliers were removed, Optumas calculated the average allowed amount per service for each of the unique combinations noted above. The approach reflects the weighted average of the allowed amount per service based on the utilization of each code within the APCD. Optumas also reviewed the use of the median allowed amount per service, which returned similar results for higher utilized services, but had more variability for lower utilized services included in the comparison. The result was the selection of the utilization weighted average allowed amount per service.

Final Code Selection

In order to ensure an informative comparison, an initial selection of the top 50 codes were selected based on highest frequency of utilization and also highest allowed amount within the HOPD data between each payer. The result is a list of codes that reflects highly utilized services, along with services that may have lower overall utilization but that reflect a higher proportion of expenses due to the higher cost nature of those services. The list excludes injectable drugs (J-series codes) due to the additional complexity around the pricing of those codes.

We then looked for those top HOPD codes within the Professional data, and only included the codes that were in both datasets for the final comparison. Additionally, Optumas set a minimum limit of at least twenty-five (25) individual instances of each code within the either dataset to account for credibility and stability of the contracted amount for those codes. The final list was limited to the top 25 codes that were found in both datasets, by payer, that also met the minimum utilization threshold.

Appendices I.A.i to I.C.ii include the list of the final top 25 codes for Medicare FFS, Medicare Advantage, and Commercial comparison aggregated across the six years of data. The codes are in numerical order.

Appendices II.A.i to II.C.ii include the list of the final top 25 codes for Medicare FFS, Medicare Advantage, and Commercial comparison for each year. The codes are in numerical order. These are provided in a separate Excel appendix.

Appendices III.A to III.C include the full definition of each code used for the comparison by payer type.

Results & Key Findings

Overall

The overall observation was that HOPD facility fees were higher than the professional fees for the same services when provided in a professional site of service. This was the case for both hospital affiliated and independent providers. The resulting impact indicates that 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. This is based on using the HOPD volume of utilization and mix of services. This impact is intended to highlight reimbursement differences, and does not comment on feasibility of impacting actual expenditures due to utilization shifting between sites of service.

Hospital Resource Billing Note

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 codes being compared, the final total amount the patient and payer are responsible for could be higher in a HOPD setting due to the inclusion of G0463 for the overall visit reimbursement.

Similarly for Commercial, the presence of an E&M code on a 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.

Medicare FFS

For the top codes reviewed for Medicare FFS, HOPD facility fees were about 95% higher than both independent and affiliated providers. The independent and affiliated providers had comparable reimbursement, driven by Medicare FFS billing guidelines that are consistent across professional fees. The resulting impact indicates that the HOPD facility fees contributed \$11.0M in member and payer expenses relative to the same professional fees for both types of providers, based on using the HOPD volume of utilization and mix of services.

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

- Laboratory - were reimbursed 30% to 150% higher for HOPD than and professional settings.
- Radiology - had mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees.
- Chemotherapy and other infusion/injection - were 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 health care expenses relative to independent affiliated or professional fees, respectively. This is based on using the HOPD volume of utilization and mix of services for both comparisons.

The difference between affiliated and independent providers is driven by independent providers having higher average reimbursement than affiliated providers under Medicare Advantage. 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 - had higher HOPD 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 - had mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees.
- Chemotherapy and other infusion/injection - were 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 health care expenses relative to independent affiliated or professional fees, respectively. This is based on using the HOPD volume of utilization and mix of services for both comparisons.

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, we observed that affiliated providers had higher average contracting.

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

- Laboratory - were on average 200% higher for HOPD facility fees than professional fees for both groups, however; the variation at the code level was much higher for affiliated providers ranging from 20% to 880% higher for HOPD facility fees.
- Radiology - had mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees. The highest utilized radiology services had lower HOPD facility fees than professional fees.
- Chemotherapy and other infusion/injection - were 115% to 225% higher for HOPD facility fees than professional fees.
- Physical Therapy - showed that HOPD facility fees were 150% to 250% higher than professional fees for both comparison groups.
- Evaluation and management (E&M) - observed to have 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 is lower for HOPD facility fees for E&M codes, it should be noted that the E&M codes may be being billed twice to the member: once for the physicians professional fees, and again on a second bill for the HOPD facility fees for their hospital resources.

Changes over Time

Overall, Medicare Advantage had the most volatility in average reimbursement over time for both HOPD and professional sites of service for the top codes, while Medicare FFS and Commercial were slightly more stable. The result is that it is challenging for consumers to understand potential future health care expenditures because of the changes in contracting between provider and payer from year to year.

The results from the HOPD by year comparison indicate the following by payer type based on the top codes reviewed:

- Medicare FFS
 - The average HOPD facility fees increased by about 3.4% on average annually.
 - The average professional fees had a slight reduction of -0.5% to -1.1% on average annually for affiliated and independent providers, respectively.
 - These are driven by reductions to laboratory services implemented in 2018 and 2019 by the Centers for Medicaid and Medicare (CMS) that oversee the Medicare program and billing policies.
- Medicare Advantage
 - The average HOPD facility fees decreased by about -6.0% on average annually, driven by reductions in 2018 and 2019.
 - The average professional fees had a slight reduction of -2.2% to -2.9% on average annually for affiliated and independent providers, respectively.
- Commercial
 - The average HOPD facility fees increased by about 2.5% on average annually.
 - The average professional fees had a similar increase of 2.8% on average annually for both affiliated and independent providers, respectively.
 - This is driven by a larger increase in 2021 for professional providers, potentially in response to the COVID-19 pandemic.

Appendices

Appendix I.A.i Medicare FFS HOPD Comparison to Professional (Affiliated)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Affiliated) | HOPD | HOPD/ Affiliated % Diff | Dollar Difference |
|-----------------|----------------------------|----------------|-------------------------|---------------------------|----------------|-------------------------|---------------------|
| Combined | | Average | 551,748 | \$21.22 | \$41.14 | 93.9% | \$10,988,667 |
| 20610 | Injection into large joint | Average | 2,905 | \$67.97 | \$165.51 | 143.5% | \$283,311 |
| 36415 | Routine Venipuncture | Average | 155,073 | \$2.96 | \$5.02 | 69.7% | \$319,816 |
| 67028 | Injection Of Drug Into Eye | Average | 2,417 | \$117.38 | \$331.82 | 182.7% | \$518,302 |
| 70553 | Radiology | Average | 838 | \$353.50 | \$785.40 | 122.2% | \$361,796 |
| 71250 | Radiology | Average | 2,383 | \$150.29 | \$161.89 | 7.7% | \$27,660 |
| 77300 | Radiology | Average | 2,166 | \$68.44 | \$125.29 | 83.1% | \$123,121 |
| 77301 | Radiology | Average | 363 | \$1,957.43 | \$1,253.96 | -35.9% | -\$255,126 |
| 77334 | Radiology | Average | 2,169 | \$130.89 | \$327.74 | 150.4% | \$427,040 |
| 78815 | Radiology | Average | 475 | \$1,644.41 | \$1,473.06 | -10.4% | -\$81,420 |
| 80048 | Laboratory | Average | 28,887 | \$9.10 | \$18.77 | 106.3% | \$279,365 |
| 80053 | Laboratory | Average | 88,254 | \$10.94 | \$27.06 | 147.4% | \$1,422,715 |
| 80061 | Laboratory | Average | 49,337 | \$14.00 | \$22.61 | 61.4% | \$424,358 |
| 82306 | Laboratory | Average | 12,365 | \$32.23 | \$41.58 | 29.0% | \$115,562 |
| 83036 | Laboratory | Average | 24,352 | \$10.40 | \$20.04 | 92.7% | \$234,715 |
| 84443 | Laboratory | Average | 42,367 | \$18.12 | \$27.60 | 52.3% | \$401,567 |
| 85025 | Laboratory | Average | 75,765 | \$8.49 | \$15.43 | 81.7% | \$525,862 |
| 93306 | Ultrasound | Average | 4,113 | \$209.84 | \$507.94 | 142.1% | \$1,225,920 |
| 94060 | Evaluation Of Wheezing | Average | 2,117 | \$54.06 | \$234.63 | 334.1% | \$382,189 |
| 96365 | Infusion and injection | Average | 12,589 | \$73.37 | \$189.25 | 158.0% | \$1,458,864 |
| 96367 | Infusion and injection | Average | 3,847 | \$31.15 | \$59.10 | 89.7% | \$107,503 |
| 96372 | Infusion and injection | Average | 6,688 | \$17.24 | \$48.86 | 183.4% | \$211,477 |
| 96374 | Infusion and injection | Average | 2,661 | \$44.44 | \$164.62 | 270.4% | \$319,796 |
| 96375 | Infusion and injection | Average | 12,953 | \$17.58 | \$38.38 | 118.3% | \$269,325 |
| 96413 | Chemotherapy Infusion | Average | 11,123 | \$139.97 | \$295.02 | 110.8% | \$1,724,627 |
| 96415 | Chemotherapy Infusion | Average | 5,546 | \$30.55 | \$59.46 | 94.6% | \$160,322 |

Appendix I.A.ii Medicare FFS HOPD Comparison to Professional (Independent)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Independent) | HOPD | HOPD/ Independent % Diff | Dollar Difference |
|-----------------|----------------------------|----------------|-------------------------|-----------------------------|----------------|--------------------------|---------------------|
| Combined | | Average | 551,748 | \$21.11 | \$41.14 | 94.8% | \$11,046,858 |
| 20610 | Injection into large joint | Average | 2,905 | \$64.91 | \$165.51 | 155.0% | \$292,199 |
| 36415 | Routine Venipuncture | Average | 155,073 | \$2.96 | \$5.02 | 69.8% | \$320,063 |
| 67028 | Injection Of Drug Into Eye | Average | 2,417 | \$115.83 | \$331.82 | 186.5% | \$522,055 |
| 70553 | Radiology | Average | 838 | \$347.69 | \$785.40 | 125.9% | \$366,659 |
| 71250 | Radiology | Average | 2,383 | \$148.98 | \$161.89 | 8.7% | \$30,761 |
| 77300 | Radiology | Average | 2,166 | \$67.43 | \$125.29 | 85.8% | \$125,321 |
| 77301 | Radiology | Average | 363 | \$1,918.52 | \$1,253.96 | -34.6% | -\$241,014 |
| 77334 | Radiology | Average | 2,169 | \$128.16 | \$327.74 | 155.7% | \$432,968 |
| 78815 | Radiology | Average | 475 | \$1,579.65 | \$1,473.06 | -6.7% | -\$50,646 |
| 80048 | Laboratory | Average | 28,887 | \$9.33 | \$18.77 | 101.1% | \$272,547 |
| 80053 | Laboratory | Average | 88,254 | \$11.26 | \$27.06 | 140.4% | \$1,394,739 |
| 80061 | Laboratory | Average | 49,337 | \$14.35 | \$22.61 | 57.5% | \$407,220 |
| 82306 | Laboratory | Average | 12,365 | \$32.52 | \$41.58 | 27.9% | \$111,996 |
| 83036 | Laboratory | Average | 24,352 | \$10.69 | \$20.04 | 87.4% | \$227,568 |
| 84443 | Laboratory | Average | 42,367 | \$18.57 | \$27.60 | 48.6% | \$382,308 |
| 85025 | Laboratory | Average | 75,765 | \$8.43 | \$15.43 | 83.0% | \$530,366 |
| 93306 | Ultrasound | Average | 4,113 | \$206.07 | \$507.94 | 146.5% | \$1,241,429 |
| 94060 | Evaluation Of Wheezing | Average | 2,117 | \$53.99 | \$234.63 | 334.6% | \$382,328 |
| 96365 | Infusion and injection | Average | 12,589 | \$70.28 | \$189.25 | 169.3% | \$1,497,673 |
| 96367 | Infusion and injection | Average | 3,847 | \$31.27 | \$59.10 | 89.0% | \$107,064 |
| 96372 | Infusion and injection | Average | 6,688 | \$16.60 | \$48.86 | 194.4% | \$215,778 |
| 96374 | Infusion and injection | Average | 2,661 | \$43.38 | \$164.62 | 279.5% | \$322,626 |
| 96375 | Infusion and injection | Average | 12,953 | \$17.69 | \$38.38 | 116.9% | \$267,910 |
| 96413 | Chemotherapy Infusion | Average | 11,123 | \$140.07 | \$295.02 | 110.6% | \$1,723,560 |
| 96415 | Chemotherapy Infusion | Average | 5,546 | \$30.00 | \$59.46 | 98.2% | \$163,382 |



Appendix I.B.i Medicare Advantage HOPD Comparison to Professional (Affiliated)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Affiliated) | HOPD | HOPD/ Affiliated % Diff | Dollar Difference |
|-----------------|----------------------------|----------------|-------------------------|---------------------------|-----------------|-------------------------|--------------------|
| Combined | | Average | 123,774 | \$76.92 | \$104.76 | 36.2% | \$3,446,198 |
| 20610 | Injection into large joint | Average | 1,052 | \$85.26 | \$249.67 | 192.8% | \$172,878 |
| 36430 | Blood Transfusion Service | Average | 1,000 | \$72.70 | \$387.76 | 433.3% | \$315,003 |
| 67028 | Injection Of Drug Into Eye | Average | 649 | \$194.20 | \$328.24 | 69.0% | \$86,928 |
| 70553 | Radiology | Average | 586 | \$814.23 | \$443.94 | -45.5% | -\$217,057 |
| 71250 | Radiology | Average | 3,203 | \$295.53 | \$130.61 | -55.8% | -\$528,270 |
| 77300 | Radiology | Average | 2,001 | \$70.14 | \$124.65 | 77.7% | \$109,072 |
| 77301 | Radiology | Average | 464 | \$2,049.08 | \$1,268.24 | -38.1% | -\$362,440 |
| 77334 | Radiology | Average | 2,188 | \$134.58 | \$293.91 | 118.4% | \$348,620 |
| 78815 | Radiology | Average | 419 | \$2,489.20 | \$1,201.49 | -51.7% | -\$539,123 |
| 80048 | Laboratory | Average | 8,901 | \$7.51 | \$19.87 | 164.7% | \$110,054 |
| 80053 | Laboratory | Average | 21,186 | \$9.94 | \$23.10 | 132.5% | \$278,869 |
| 80061 | Laboratory | Average | 11,906 | \$12.13 | \$21.11 | 74.1% | \$106,942 |
| 82306 | Laboratory | Average | 2,907 | \$25.12 | \$39.03 | 55.4% | \$40,435 |
| 83036 | Laboratory | Average | 6,039 | \$7.56 | \$14.67 | 94.1% | \$42,943 |
| 84443 | Laboratory | Average | 9,592 | \$15.19 | \$24.06 | 58.4% | \$85,072 |
| 85025 | Laboratory | Average | 18,063 | \$6.43 | \$12.66 | 97.0% | \$112,586 |
| 93306 | Ultrasound | Average | 8,579 | \$261.01 | \$531.08 | 103.5% | \$2,317,069 |
| 94060 | Evaluation Of Wheezing | Average | 1,215 | \$65.18 | \$218.86 | 235.8% | \$186,639 |
| 96365 | Infusion and injection | Average | 4,210 | \$117.41 | \$181.44 | 54.5% | \$269,548 |
| 96367 | Infusion and injection | Average | 1,471 | \$31.20 | \$59.74 | 91.5% | \$41,979 |
| 96372 | Infusion and injection | Average | 2,162 | \$21.45 | \$46.28 | 115.8% | \$53,679 |
| 96374 | Infusion and injection | Average | 2,850 | \$88.18 | \$168.79 | 91.4% | \$229,742 |
| 96375 | Infusion and injection | Average | 6,687 | \$31.89 | \$38.38 | 20.4% | \$43,408 |
| 96413 | Chemotherapy Infusion | Average | 4,141 | \$262.49 | \$292.35 | 11.4% | \$123,632 |
| 96415 | Chemotherapy Infusion | Average | 2,305 | \$52.62 | \$60.42 | 14.8% | \$17,989 |



Appendix I.B.ii Medicare Advantage HOPD Comparison to Professional (Independent)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Independent) | HOPD | HOPD/ Independent % Diff | Dollar Difference |
|-----------------|----------------------------|----------------|-------------------------|-----------------------------|-----------------|--------------------------|--------------------|
| Combined | | Average | 123,774 | \$91.78 | \$104.76 | 14.1% | \$1,606,978 |
| 20610 | Injection into large joint | Average | 1,052 | \$104.91 | \$249.67 | 138.0% | \$152,219 |
| 36430 | Blood Transfusion Service | Average | 1,000 | \$70.06 | \$387.76 | 453.4% | \$317,644 |
| 67028 | Injection Of Drug Into Eye | Average | 649 | \$173.99 | \$328.24 | 88.7% | \$100,030 |
| 70553 | Radiology | Average | 586 | \$714.86 | \$443.94 | -37.9% | -\$158,805 |
| 71250 | Radiology | Average | 3,203 | \$382.54 | \$130.61 | -65.9% | -\$806,960 |
| 77300 | Radiology | Average | 2,001 | \$88.95 | \$124.65 | 40.1% | \$71,443 |
| 77301 | Radiology | Average | 464 | \$2,679.37 | \$1,268.24 | -52.7% | -\$655,000 |
| 77334 | Radiology | Average | 2,188 | \$174.06 | \$293.91 | 68.9% | \$262,249 |
| 78815 | Radiology | Average | 419 | \$2,590.79 | \$1,201.49 | -53.6% | -\$581,652 |
| 80048 | Laboratory | Average | 8,901 | \$15.11 | \$19.87 | 31.5% | \$42,408 |
| 80053 | Laboratory | Average | 21,186 | \$14.10 | \$23.10 | 63.8% | \$190,681 |
| 80061 | Laboratory | Average | 11,906 | \$21.82 | \$21.11 | -3.3% | -\$8,465 |
| 82306 | Laboratory | Average | 2,907 | \$47.56 | \$39.03 | -17.9% | -\$24,803 |
| 83036 | Laboratory | Average | 6,039 | \$16.34 | \$14.67 | -10.2% | -\$10,066 |
| 84443 | Laboratory | Average | 9,592 | \$27.42 | \$24.06 | -12.3% | -\$32,220 |
| 85025 | Laboratory | Average | 18,063 | \$12.47 | \$12.66 | 1.5% | \$3,442 |
| 93306 | Ultrasound | Average | 8,579 | \$357.62 | \$531.08 | 48.5% | \$1,488,172 |
| 94060 | Evaluation Of Wheezing | Average | 1,215 | \$91.63 | \$218.86 | 138.8% | \$154,514 |
| 96365 | Infusion and injection | Average | 4,210 | \$97.87 | \$181.44 | 85.4% | \$351,816 |
| 96367 | Infusion and injection | Average | 1,471 | \$36.93 | \$59.74 | 61.8% | \$33,552 |
| 96372 | Infusion and injection | Average | 2,162 | \$25.57 | \$46.28 | 81.0% | \$44,769 |
| 96374 | Infusion and injection | Average | 2,850 | \$85.14 | \$168.79 | 98.3% | \$238,414 |
| 96375 | Infusion and injection | Average | 6,687 | \$25.06 | \$38.38 | 53.2% | \$89,076 |
| 96413 | Chemotherapy Infusion | Average | 4,141 | \$217.97 | \$292.35 | 34.1% | \$308,011 |
| 96415 | Chemotherapy Infusion | Average | 2,305 | \$44.59 | \$60.42 | 35.5% | \$36,509 |

Appendix I.C.i Commercial HOPD Comparison to Professional (Affiliated)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Affiliated) | HOPD | HOPD/ Affiliated % Diff | Dollar Difference |
|-----------------|---------------------------|----------------|----------------------------|------------------------------|-----------------|-------------------------------|----------------------|
| Combined | | Average | 594,589 | \$69.60 | \$135.60 | 94.8% | \$39,242,048 |
| 19083 | Breast Biopsy | Average | 1,089 | \$904.75 | \$1,868.15 | 106.5% | \$1,048,656 |
| 36415 | Routine Venipuncture | Average | 110,724 | \$3.23 | \$24.96 | 672.5% | \$2,405,900 |
| 45380 | Colonoscopy And Biopsy | Average | 2,990 | \$915.55 | \$1,649.46 | 80.2% | \$2,194,256 |
| 73721 | Radiology | Average | 2,523 | \$604.28 | \$1,220.60 | 102.0% | \$1,554,872 |
| 74177 | Radiology | Average | 3,459 | \$825.67 | \$1,122.45 | 35.9% | \$1,026,410 |
| 77063 | Radiology | Average | 22,392 | \$97.23 | \$48.24 | -50.4% | -\$1,096,970 |
| 77067 | Radiology | Average | 29,395 | \$255.62 | \$232.24 | -9.1% | -\$687,275 |
| 78452 | Radiology | Average | 1,505 | \$563.73 | \$2,109.81 | 274.3% | \$2,326,085 |
| 78815 | Radiology | Average | 744 | \$2,958.25 | \$3,313.93 | 12.0% | \$264,450 |
| 80048 | Laboratory | Average | 18,752 | \$6.45 | \$63.77 | 888.6% | \$1,074,823 |
| 80053 | Laboratory | Average | 58,843 | \$13.50 | \$80.73 | 498.1% | \$3,956,334 |
| 84443 | Laboratory | Average | 29,446 | \$12.25 | \$64.35 | 425.2% | \$1,533,983 |
| 85025 | Laboratory | Average | 53,972 | \$6.82 | \$40.24 | 489.9% | \$1,803,505 |
| 88305 | Laboratory | Average | 18,309 | \$144.07 | \$171.21 | 18.8% | \$496,791 |
| 93005 | Electrocardiogram Tracing | Average | 12,789 | \$13.77 | \$188.06 | 1265.7% | \$2,228,907 |
| 93306 | Ultrasound | Average | 8,766 | \$346.09 | \$1,151.50 | 232.7% | \$7,060,062 |
| 96365 | Infusion and injection | Average | 6,545 | \$138.20 | \$319.14 | 130.9% | \$1,184,236 |
| 96375 | Infusion and injection | Average | 12,248 | \$34.69 | \$105.90 | 205.3% | \$872,242 |
| 96413 | Chemotherapy Infusion | Average | 9,550 | \$278.23 | \$599.78 | 115.6% | \$3,070,878 |
| 97110 | Physical Therapy | Average | 72,342 | \$24.03 | \$81.86 | 240.6% | \$4,183,106 |
| 97140 | Physical Therapy | Average | 43,443 | \$23.45 | \$81.52 | 247.6% | \$2,522,836 |
| 97530 | Physical Therapy | Average | 24,644 | \$28.36 | \$77.33 | 172.7% | \$1,206,991 |
| 99212 | Evaluation & Management | Average | 14,005 | \$66.83 | \$91.73 | 37.3% | \$348,783 |
| 99213 | Evaluation & Management | Average | 25,272 | \$105.25 | \$77.95 | -25.9% | -\$689,915 |
| 99214 | Evaluation & Management | Average | 10,846 | \$152.73 | \$93.00 | -39.1% | -\$647,897 |



Appendix I.C.ii Commercial HOPD Comparison to Professional (Independent)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Independent) | HOPD | HOPD/ Independent % Diff | Dollar Difference |
|-----------------|---------------------------|----------------|----------------------------|-------------------------------|-----------------|--------------------------------|----------------------|
| Combined | | Average | 594,589 | \$71.41 | \$135.60 | 89.9% | \$38,166,482 |
| 19083 | Breast Biopsy | Average | 1,089 | \$1,106.65 | \$1,868.15 | 68.8% | \$828,893 |
| 36415 | Routine Venipuncture | Average | 110,724 | \$4.18 | \$24.96 | 497.6% | \$2,301,164 |
| 45380 | Colonoscopy And Biopsy | Average | 2,990 | \$833.06 | \$1,649.46 | 98.0% | \$2,440,888 |
| 73721 | Radiology | Average | 2,523 | \$644.15 | \$1,220.60 | 89.5% | \$1,454,309 |
| 74177 | Radiology | Average | 3,459 | \$938.21 | \$1,122.45 | 19.6% | \$637,203 |
| 77063 | Radiology | Average | 22,392 | \$91.48 | \$48.24 | -47.3% | -\$968,155 |
| 77067 | Radiology | Average | 29,395 | \$252.66 | \$232.24 | -8.1% | -\$600,152 |
| 78452 | Radiology | Average | 1,505 | \$862.89 | \$2,109.81 | 144.5% | \$1,875,999 |
| 78815 | Radiology | Average | 744 | \$2,890.43 | \$3,313.93 | 14.7% | \$314,871 |
| 80048 | Laboratory | Average | 18,752 | \$14.90 | \$63.77 | 327.9% | \$916,355 |
| 80053 | Laboratory | Average | 58,843 | \$12.15 | \$80.73 | 564.7% | \$4,035,974 |
| 84443 | Laboratory | Average | 29,446 | \$25.70 | \$64.35 | 150.4% | \$1,138,004 |
| 85025 | Laboratory | Average | 53,972 | \$11.63 | \$40.24 | 246.1% | \$1,544,258 |
| 88305 | Laboratory | Average | 18,309 | \$110.83 | \$171.21 | 54.5% | \$1,105,501 |
| 93005 | Electrocardiogram Tracing | Average | 12,789 | \$13.62 | \$188.06 | 1280.3% | \$2,230,774 |
| 93306 | Ultrasound | Average | 8,766 | \$396.43 | \$1,151.50 | 190.5% | \$6,618,814 |
| 96365 | Infusion and injection | Average | 6,545 | \$123.64 | \$319.14 | 158.1% | \$1,279,470 |
| 96375 | Infusion and injection | Average | 12,248 | \$32.78 | \$105.90 | 223.1% | \$895,609 |
| 96413 | Chemotherapy Infusion | Average | 9,550 | \$243.03 | \$599.78 | 146.8% | \$3,407,101 |
| 97110 | Physical Therapy | Average | 72,342 | \$31.80 | \$81.86 | 157.4% | \$3,621,163 |
| 97140 | Physical Therapy | Average | 43,443 | \$25.35 | \$81.52 | 221.5% | \$2,440,252 |
| 97530 | Physical Therapy | Average | 24,644 | \$30.72 | \$77.33 | 151.7% | \$1,148,684 |
| 99212 | Evaluation & Management | Average | 14,005 | \$58.66 | \$91.73 | 56.4% | \$463,109 |
| 99213 | Evaluation & Management | Average | 25,272 | \$96.28 | \$77.95 | -19.0% | -\$463,215 |
| 99214 | Evaluation & Management | Average | 10,846 | \$139.13 | \$93.00 | -33.2% | -\$500,391 |

Appendices II.A.i to II.C.ii
HOPD Comparison to Professional by year

Please see attached Excel file CO HB1215 - Comparison by Year 2024.07.08_Top Codes.xlsx.

Appendix III.A Medicare FFS Code Definitions

| Code | Long Description |
|-------|---|
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample |
| 67028 | Injection Of Drug Into Eye |
| 70553 | Mri Scan Of Brain Before And After Contrast |
| 71250 | Ct Scan Chest |
| 77300 | Calculation Of Radiation Therapy Dose |
| 77301 | Management Of Modulation Radiotherapy Planning |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh |
| 80048 | Blood Test, Basic Group Of Blood Chemicals |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) |
| 82306 | Vitamin D-3 Level |
| 83036 | Hemoglobin A1C Level |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour |
| 96415 | Infusion Of Chemotherapy Into A Vein |

Appendix III.B Medicare Advantage Code Definitions

| Code | Description |
|-------|---|
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule |
| 36430 | Transfusion Of Blood Or Blood Products |
| 67028 | Injection Of Drug Into Eye |
| 70553 | Mri Scan Of Brain Before And After Contrast |
| 71250 | Ct Scan Chest |
| 77300 | Calculation Of Radiation Therapy Dose |
| 77301 | Management Of Modulation Radiotherapy Planning |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh |
| 80048 | Blood Test, Basic Group Of Blood Chemicals |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) |
| 82306 | Vitamin D-3 Level |
| 83036 | Hemoglobin A1C Level |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour |
| 96415 | Infusion Of Chemotherapy Into A Vein |

Appendix III.C Commercial Code Definitions

| Code | Description |
|-------|---|
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample |
| 45380 | Biopsy Of Large Bowel Using An Endoscope |
| 73721 | Mri Scan Of Leg Joint |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast |
| 77063 | Screening Digital Tomography Of Both Breasts |
| 77067 | Mammography Of Both Breasts |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh |
| 80048 | Blood Test, Basic Group Of Blood Chemicals |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes |

Appendix L. Dataset Comparison by Year

Appendix II.A.i - Medicare FFS HOPD Comparison to Professional (Affiliated) by Year

| Code | Description | Year | HOPD Units | Professional (Affiliated) | HOPD | OP/Affiliated % Diff |
|----------|-------------|------|------------|---------------------------|---------|----------------------|
| Combined | | 2017 | 617,084 | \$21.60 | \$38.06 | 76.2% |
| Combined | | 2018 | 449,682 | \$21.91 | \$41.42 | 89.1% |
| Combined | | 2019 | 558,338 | \$21.05 | \$40.00 | 90.0% |
| Combined | | 2020 | 533,850 | \$20.31 | \$41.12 | 102.5% |
| Combined | | 2021 | 571,208 | \$20.91 | \$42.87 | 105.0% |
| Combined | | 2022 | 580,328 | \$21.10 | \$44.89 | 112.8% |

| Code | Description | Year | HOPD Units | Professional (Affiliated) | HOPD | OP/Affiliated % Diff |
|-------|---|------|------------|---------------------------|------------|----------------------|
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2017 | 4,409 | \$64.54 | \$146.61 | 127.1% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2018 | 3,526 | \$65.87 | \$160.21 | 143.2% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2019 | 2,505 | \$65.14 | \$188.85 | 189.9% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2020 | 2,174 | \$66.67 | \$163.71 | 145.5% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2021 | 2,451 | \$70.64 | \$165.74 | 134.6% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2022 | 2,362 | \$74.17 | \$185.39 | 150.0% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2017 | 186,515 | \$2.94 | \$4.56 | 55.4% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2018 | 129,829 | \$2.94 | \$5.26 | 79.1% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2019 | 165,025 | \$2.94 | \$4.86 | 65.5% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2020 | 144,568 | \$2.98 | \$5.09 | 70.7% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2021 | 150,921 | \$3.00 | \$5.35 | 78.4% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2022 | 153,580 | \$2.96 | \$5.17 | 74.6% |
| 67028 | Injection Of Drug Into Eye | 2017 | 3,298 | \$97.64 | \$298.53 | 205.8% |
| 67028 | Injection Of Drug Into Eye | 2018 | 2,818 | \$111.10 | \$325.71 | 193.2% |
| 67028 | Injection Of Drug Into Eye | 2019 | 2,389 | \$111.01 | \$311.26 | 180.4% |
| 67028 | Injection Of Drug Into Eye | 2020 | 2,609 | \$107.50 | \$348.91 | 224.6% |
| 67028 | Injection Of Drug Into Eye | 2021 | 2,203 | \$123.48 | \$360.37 | 191.8% |
| 67028 | Injection Of Drug Into Eye | 2022 | 1,185 | \$128.71 | \$389.73 | 202.8% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2017 | 1,174 | \$356.30 | \$649.05 | 82.2% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2018 | 1,254 | \$358.18 | \$602.21 | 68.1% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2019 | 707 | \$353.37 | \$902.93 | 155.5% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2020 | 657 | \$349.81 | \$817.46 | 133.7% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2021 | 642 | \$354.20 | \$980.36 | 176.8% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2022 | 592 | \$352.75 | \$1,056.51 | 199.5% |
| 71250 | Ct Scan Chest | 2017 | 2,738 | \$152.66 | \$144.12 | -5.6% |
| 71250 | Ct Scan Chest | 2018 | 2,566 | \$157.28 | \$145.23 | -7.7% |
| 71250 | Ct Scan Chest | 2019 | 2,439 | \$153.28 | \$149.26 | -2.6% |
| 71250 | Ct Scan Chest | 2020 | 2,111 | \$150.25 | \$161.26 | 7.3% |
| 71250 | Ct Scan Chest | 2021 | 2,269 | \$139.69 | \$152.90 | 9.5% |
| 71250 | Ct Scan Chest | 2022 | 2,173 | \$148.95 | \$228.17 | 53.2% |
| 77300 | Calculation Of Radiation Therapy Dose | 2017 | 2,009 | \$67.15 | \$117.53 | 75.0% |
| 77300 | Calculation Of Radiation Therapy Dose | 2018 | 2,505 | \$65.47 | \$125.16 | 91.2% |
| 77300 | Calculation Of Radiation Therapy Dose | 2019 | 2,672 | \$68.16 | \$123.22 | 80.8% |
| 77300 | Calculation Of Radiation Therapy Dose | 2020 | 2,164 | \$68.39 | \$128.37 | 87.7% |
| 77300 | Calculation Of Radiation Therapy Dose | 2021 | 1,926 | \$70.56 | \$128.69 | 82.4% |
| 77300 | Calculation Of Radiation Therapy Dose | 2022 | 1,718 | \$70.60 | \$130.10 | 84.3% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2017 | 302 | \$1,969.99 | \$1,062.23 | -46.1% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2018 | 341 | \$1,931.90 | \$1,182.81 | -38.8% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2019 | 408 | \$1,988.05 | \$1,187.66 | -40.3% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2020 | 367 | \$1,904.75 | \$1,266.80 | -33.5% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2021 | 374 | \$1,966.71 | \$1,283.14 | -34.8% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2022 | 384 | \$1,988.61 | \$1,497.69 | -24.7% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2017 | 2,263 | \$131.53 | \$311.46 | 136.8% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2018 | 2,755 | \$128.24 | \$320.67 | 150.1% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2019 | 2,863 | \$131.57 | \$318.51 | 142.1% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2020 | 2,037 | \$128.27 | \$336.58 | 162.4% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2021 | 1,746 | \$130.93 | \$343.41 | 162.3% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2022 | 1,352 | \$134.03 | \$355.41 | 165.2% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2017 | 419 | \$1,417.74 | \$1,260.13 | -11.1% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2018 | 519 | \$1,432.40 | \$1,330.88 | -7.1% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2019 | 349 | \$1,502.77 | \$1,465.65 | -2.5% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2020 | 283 | \$1,559.79 | \$1,374.92 | -11.9% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2021 | 524 | \$1,681.26 | \$1,475.73 | -12.2% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2022 | 757 | \$1,744.30 | \$1,726.67 | -1.0% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2017 | 34,168 | \$10.77 | \$18.95 | 75.9% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2018 | 24,098 | \$10.22 | \$21.10 | 106.5% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2019 | 31,327 | \$9.20 | \$17.70 | 92.3% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2020 | 26,645 | \$8.41 | \$18.50 | 120.0% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2021 | 28,253 | \$8.46 | \$18.98 | 124.5% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2022 | 28,828 | \$8.34 | \$17.81 | 113.4% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2017 | 91,422 | \$9.06 | \$25.10 | 177.2% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2018 | 65,343 | \$12.75 | \$30.11 | 136.3% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2019 | 85,552 | \$11.49 | \$25.90 | 125.4% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2020 | 87,386 | \$10.48 | \$27.98 | 167.1% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2021 | 97,478 | \$10.56 | \$28.04 | 165.6% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2022 | 102,342 | \$10.41 | \$26.11 | 150.7% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2017 | 52,879 | \$14.07 | \$21.23 | 51.0% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2018 | 36,444 | \$16.19 | \$25.17 | 55.5% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2019 | 47,720 | \$14.57 | \$21.98 | 50.9% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2020 | 48,452 | \$13.30 | \$22.19 | 66.8% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2021 | 53,624 | \$13.38 | \$23.35 | 74.5% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2022 | 56,904 | \$13.20 | \$22.42 | 69.7% |
| 82306 | Vitamin D-3 Level | 2017 | 13,875 | \$39.71 | \$43.30 | 9.0% |
| 82306 | Vitamin D-3 Level | 2018 | 8,826 | \$35.82 | \$44.46 | 24.1% |
| 82306 | Vitamin D-3 Level | 2019 | 12,108 | \$32.16 | \$39.72 | 23.5% |
| 82306 | Vitamin D-3 Level | 2020 | 11,615 | \$29.45 | \$40.37 | 37.1% |
| 82306 | Vitamin D-3 Level | 2021 | 13,514 | \$29.58 | \$41.30 | 39.7% |
| 82306 | Vitamin D-3 Level | 2022 | 14,253 | \$29.23 | \$40.93 | 40.0% |
| 83036 | Hemoglobin A1C Level | 2017 | 28,856 | \$13.01 | \$18.83 | 44.8% |
| 83036 | Hemoglobin A1C Level | 2018 | 17,575 | \$11.73 | \$22.44 | 91.4% |
| 83036 | Hemoglobin A1C Level | 2019 | 23,038 | \$10.54 | \$19.52 | 85.2% |
| 83036 | Hemoglobin A1C Level | 2020 | 23,185 | \$9.63 | \$20.13 | 108.9% |
| 83036 | Hemoglobin A1C Level | 2021 | 25,756 | \$9.69 | \$20.47 | 111.2% |
| 83036 | Hemoglobin A1C Level | 2022 | 27,700 | \$9.56 | \$19.73 | 106.3% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2017 | 47,918 | \$22.57 | \$28.74 | 27.3% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2018 | 32,025 | \$20.32 | \$29.87 | 46.9% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2019 | 42,256 | \$18.29 | \$26.69 | 45.9% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2020 | 41,082 | \$16.70 | \$26.24 | 57.1% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2021 | 44,594 | \$16.82 | \$27.63 | 64.3% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2022 | 46,324 | \$16.56 | \$26.86 | 62.1% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2017 | 82,026 | \$9.49 | \$14.70 | 55.0% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2018 | 59,325 | \$9.38 | \$16.85 | 79.6% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2019 | 74,684 | \$8.45 | \$15.08 | 78.4% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2020 | 72,999 | \$7.71 | \$15.30 | 98.5% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2021 | 80,912 | \$7.76 | \$15.94 | 105.4% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2022 | 84,645 | \$7.66 | \$15.09 | 97.0% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2017 | 5,209 | \$224.55 | \$447.20 | 99.2% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2018 | 5,011 | \$207.76 | \$474.06 | 128.2% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2019 | 4,052 | \$204.32 | \$476.37 | 133.1% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2020 | 3,653 | \$205.62 | \$489.57 | 138.1% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2021 | 3,368 | \$205.61 | \$550.01 | 167.5% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2022 | 3,382 | \$216.74 | \$667.43 | 207.9% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2017 | 2,337 | \$60.07 | \$212.43 | 253.6% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2018 | 2,047 | \$60.88 | \$226.49 | 272.0% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2019 | 2,396 | \$59.49 | \$228.68 | 284.4% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2020 | 1,731 | \$56.92 | \$233.34 | 309.9% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2021 | 2,112 | \$48.60 | \$243.95 | 401.9% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2022 | 2,076 | \$43.04 | \$266.11 | 518.3% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2017 | 12,693 | \$67.67 | \$173.74 | 156.7% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2018 | 12,084 | \$71.26 | \$183.48 | 157.5% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2019 | 13,248 | \$71.98 | \$185.21 | 157.3% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2020 | 12,433 | \$70.22 | \$183.09 | 160.7% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2021 | 13,542 | \$74.79 | \$200.02 | 167.4% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2022 | 11,534 | \$75.13 | \$211.01 | 180.9% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2017 | 3,522 | \$30.62 | \$52.96 | 72.9% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2018 | 3,783 | \$30.57 | \$57.36 | 87.6% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2019 | 4,194 | \$31.17 | \$58.97 | 89.2% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2020 | 4,372 | \$29.61 | \$61.43 | 107.4% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2021 | 3,919 | \$31.07 | \$60.53 | 94.8% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2022 | 3,289 | \$33.47 | \$63.05 | 88.4% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2017 | 8,886 | \$25.41 | \$46.90 | 84.6% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2018 | 5,461 | \$20.57 | \$47.19 | 129.4% |

| | | | | | | |
|-------|--|------|--------|----------|----------|--------|
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2019 | 5,940 | \$16.72 | \$47.78 | 185.8% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2020 | 6,257 | \$14.17 | \$48.27 | 240.6% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2021 | 6,533 | \$14.60 | \$49.22 | 237.2% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2022 | 7,048 | \$15.30 | \$53.74 | 251.2% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 2,540 | \$56.13 | \$152.87 | 172.3% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 2,749 | \$46.29 | \$159.27 | 244.0% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 2,695 | \$39.29 | \$161.52 | 311.0% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 2,885 | \$39.15 | \$165.08 | 321.7% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 2,701 | \$44.13 | \$174.28 | 294.9% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 2,396 | \$44.93 | \$175.25 | 290.0% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 12,336 | \$21.45 | \$34.55 | 61.1% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 12,456 | \$17.72 | \$37.19 | 109.9% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 12,153 | \$16.72 | \$37.54 | 124.5% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 14,324 | \$16.28 | \$38.77 | 138.1% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 14,148 | \$17.41 | \$40.36 | 131.8% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 12,298 | \$17.67 | \$41.51 | 135.0% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2017 | 9,893 | \$135.14 | \$275.63 | 104.0% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2018 | 10,941 | \$136.61 | \$293.11 | 114.6% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2019 | 11,685 | \$135.72 | \$281.33 | 107.3% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2020 | 13,283 | \$137.31 | \$304.01 | 121.4% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2021 | 12,110 | \$145.67 | \$299.90 | 105.9% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2022 | 8,825 | \$147.05 | \$317.05 | 115.6% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2017 | 5,397 | \$27.51 | \$52.77 | 91.8% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2018 | 5,401 | \$30.40 | \$57.53 | 89.2% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2019 | 5,933 | \$30.17 | \$59.34 | 96.7% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2020 | 6,578 | \$29.72 | \$60.90 | 104.9% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2021 | 5,588 | \$32.88 | \$63.32 | 92.5% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2022 | 4,381 | \$32.20 | \$63.15 | 96.2% |

Appendix II.A.ii - Medicare FFS HOPD Comparison to Professional (Independent) by Year

| Code | Description | Year | HOPD Units | Professional (Independent) | HOPD | OP/Independent t % Diff | Professional (Affiliated) | Professional (Independent) | HOPD | Total Units for Mix Adj. |
|----------------|-------------|------|------------|----------------------------|---------|-------------------------|---------------------------|----------------------------|-------|--------------------------|
| Combined | | 2017 | 617,084 | \$21.93 | \$38.06 | 73.6% | | | | 3,310,490 |
| Combined | | 2018 | 449,682 | \$21.79 | \$41.42 | 90.1% | 1.4% | -0.6% | 8.8% | 3,310,490 |
| Combined | | 2019 | 558,338 | \$20.77 | \$40.00 | 92.6% | -3.9% | -4.7% | -3.4% | 3,310,490 |
| Combined | | 2020 | 533,850 | \$20.18 | \$41.12 | 103.8% | -3.5% | -2.9% | 2.8% | 3,310,490 |
| Combined | | 2021 | 571,208 | \$20.87 | \$42.87 | 105.4% | 3.0% | 3.4% | 4.2% | 3,310,490 |
| Combined | | 2022 | 580,328 | \$20.70 | \$44.89 | 116.9% | 0.9% | -0.8% | 4.7% | 3,310,490 |
| Average Annual | | | | | | | -0.5% | -1.1% | 3.4% | |

| Code | Description | Year | HOPD Units | Professional (Independent) | HOPD | OP/Independent t % Diff | Change over Time | | | Total Units for Mix Adj. |
|-------|--|------|------------|----------------------------|------------|-------------------------|---------------------------|----------------------------|--------|--------------------------|
| | | | | | | | Professional (Affiliated) | Professional (Independent) | HOPD | |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2017 | 4,409 | \$62.91 | \$146.61 | 133.1% | | | | 17,427 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2018 | 3,526 | \$63.97 | \$160.21 | 150.4% | 2.1% | 1.7% | 9.3% | 17,427 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2019 | 2,505 | \$62.82 | \$188.85 | 200.6% | -1.1% | -1.8% | 17.9% | 17,427 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2020 | 2,174 | \$63.66 | \$163.71 | 157.2% | 2.4% | 1.3% | -13.3% | 17,427 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2021 | 2,451 | \$67.18 | \$165.74 | 146.7% | 6.0% | 5.5% | 1.2% | 17,427 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2022 | 2,362 | \$70.24 | \$185.39 | 163.9% | 5.0% | 4.6% | 11.9% | 17,427 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2017 | 186,515 | \$2.94 | \$4.56 | 55.4% | | | | 930,438 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2018 | 129,829 | \$2.94 | \$5.26 | 79.0% | 0.0% | 0.0% | 15.3% | 930,438 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2019 | 165,025 | \$2.94 | \$4.86 | 65.5% | 0.0% | 0.0% | -7.6% | 930,438 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2020 | 144,568 | \$2.98 | \$5.09 | 70.8% | 1.5% | 1.4% | 4.7% | 930,438 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2021 | 150,921 | \$3.00 | \$5.35 | 78.4% | 0.6% | 0.6% | 5.1% | 930,438 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2022 | 153,580 | \$2.96 | \$5.17 | 74.6% | -1.3% | -1.3% | -3.4% | 930,438 |
| 67028 | Injection Of Drug Into Eye | 2017 | 3,298 | \$108.06 | \$298.53 | 176.3% | | | | 14,502 |
| 67028 | Injection Of Drug Into Eye | 2018 | 2,818 | \$109.11 | \$325.71 | 198.5% | 13.8% | 1.0% | 9.1% | 14,502 |
| 67028 | Injection Of Drug Into Eye | 2019 | 2,389 | \$110.47 | \$311.26 | 181.8% | -0.1% | 1.3% | -4.4% | 14,502 |
| 67028 | Injection Of Drug Into Eye | 2020 | 2,609 | \$110.07 | \$348.91 | 217.0% | -3.2% | -0.4% | 12.1% | 14,502 |
| 67028 | Injection Of Drug Into Eye | 2021 | 2,203 | \$125.02 | \$360.37 | 188.3% | 14.9% | 13.6% | 3.3% | 14,502 |
| 67028 | Injection Of Drug Into Eye | 2022 | 1,185 | \$131.17 | \$389.73 | 197.1% | 4.2% | 4.9% | 8.1% | 14,502 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2017 | 1,174 | \$351.13 | \$649.05 | 84.8% | | | | 5,026 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2018 | 1,254 | \$353.17 | \$602.21 | 70.5% | 0.5% | 0.6% | -7.2% | 5,026 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2019 | 707 | \$345.27 | \$902.93 | 161.5% | -1.3% | -2.2% | 49.9% | 5,026 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2020 | 657 | \$341.25 | \$817.46 | 139.6% | -1.0% | -1.2% | -9.5% | 5,026 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2021 | 642 | \$350.35 | \$980.36 | 179.8% | 1.3% | 2.7% | 19.9% | 5,026 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2022 | 592 | \$344.16 | \$1,056.51 | 207.0% | -0.4% | -1.8% | 7.8% | 5,026 |
| 71250 | Ct Scan Chest | 2017 | 2,738 | \$157.17 | \$144.12 | -8.3% | | | | 14,296 |
| 71250 | Ct Scan Chest | 2018 | 2,566 | \$156.19 | \$145.23 | -7.0% | 3.0% | -0.6% | 0.8% | 14,296 |
| 71250 | Ct Scan Chest | 2019 | 2,439 | \$150.85 | \$149.26 | -1.1% | -2.5% | -3.4% | 2.8% | 14,296 |
| 71250 | Ct Scan Chest | 2020 | 2,111 | \$149.83 | \$161.26 | 7.6% | -2.0% | -0.7% | 8.0% | 14,296 |
| 71250 | Ct Scan Chest | 2021 | 2,269 | \$141.61 | \$152.90 | 8.0% | -7.0% | -5.5% | -5.2% | 14,296 |
| 71250 | Ct Scan Chest | 2022 | 2,173 | \$141.13 | \$228.17 | 61.7% | 6.6% | -0.3% | 49.2% | 14,296 |
| 77300 | Calculation Of Radiation Therapy Dose | 2017 | 2,009 | \$65.14 | \$117.53 | 80.4% | | | | 12,994 |
| 77300 | Calculation Of Radiation Therapy Dose | 2018 | 2,505 | \$66.13 | \$125.16 | 89.3% | -2.5% | 1.5% | 6.5% | 12,994 |
| 77300 | Calculation Of Radiation Therapy Dose | 2019 | 2,672 | \$66.68 | \$123.22 | 84.8% | 4.1% | 0.8% | -1.6% | 12,994 |
| 77300 | Calculation Of Radiation Therapy Dose | 2020 | 2,164 | \$67.64 | \$128.37 | 89.8% | 0.3% | 1.4% | 4.2% | 12,994 |
| 77300 | Calculation Of Radiation Therapy Dose | 2021 | 1,926 | \$71.82 | \$128.69 | 79.2% | 3.2% | 6.2% | 0.2% | 12,994 |
| 77300 | Calculation Of Radiation Therapy Dose | 2022 | 1,718 | \$68.39 | \$130.10 | 90.2% | 0.1% | -4.8% | 1.1% | 12,994 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2017 | 302 | \$1,862.41 | \$1,062.23 | -43.0% | | | | 2,176 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2018 | 341 | \$1,884.77 | \$1,182.81 | -37.2% | -1.9% | 1.2% | 11.4% | 2,176 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2019 | 408 | \$1,955.97 | \$1,187.66 | -39.3% | 2.9% | 3.8% | 0.4% | 2,176 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2020 | 367 | \$1,881.34 | \$1,266.80 | -32.7% | -4.2% | -3.8% | 6.7% | 2,176 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2021 | 374 | \$1,984.73 | \$1,283.14 | -35.3% | 3.3% | 5.5% | 1.3% | 2,176 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2022 | 384 | \$1,933.80 | \$1,497.69 | -22.6% | 1.1% | -2.6% | 16.7% | 2,176 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2017 | 2,263 | \$125.68 | \$311.46 | 147.8% | | | | 13,016 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2018 | 2,755 | \$126.06 | \$320.67 | 154.4% | -2.5% | 0.3% | 3.0% | 13,016 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2019 | 2,863 | \$129.46 | \$318.51 | 146.0% | 2.6% | 2.7% | -0.7% | 13,016 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2020 | 2,037 | \$130.22 | \$336.58 | 158.5% | -2.5% | 0.6% | 5.7% | 13,016 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2021 | 1,746 | \$134.56 | \$343.41 | 155.2% | 2.1% | 3.3% | 2.0% | 13,016 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2022 | 1,352 | \$129.66 | \$355.41 | 174.1% | 2.4% | -3.6% | 3.5% | 13,016 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2017 | 419 | \$1,351.17 | \$1,260.13 | -6.7% | | | | 2,851 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2018 | 519 | \$1,425.93 | \$1,330.88 | -6.7% | 1.0% | 5.5% | 5.6% | 2,851 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2019 | 349 | \$1,408.99 | \$1,465.65 | 4.0% | 4.9% | -1.2% | 10.1% | 2,851 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2020 | 283 | \$1,514.98 | \$1,374.92 | -9.2% | 3.8% | 7.5% | -6.2% | 2,851 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2021 | 524 | \$1,660.29 | \$1,475.73 | -11.1% | 7.8% | 9.6% | 7.3% | 2,851 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2022 | 757 | \$1,726.20 | \$1,726.67 | 0.0% | 3.7% | 4.0% | 17.0% | 2,851 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2017 | 34,168 | \$10.61 | \$18.95 | 78.6% | | | | 173,319 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2018 | 24,098 | \$10.22 | \$21.10 | 106.4% | -5.1% | -3.7% | 11.4% | 173,319 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2019 | 31,327 | \$9.20 | \$17.70 | 92.3% | -10.0% | -10.0% | -16.1% | 173,319 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2020 | 26,645 | \$8.40 | \$18.50 | 120.2% | -8.6% | -8.7% | 4.6% | 173,319 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2021 | 28,253 | \$8.46 | \$18.98 | 124.5% | 0.6% | 0.6% | 2.6% | 173,319 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2022 | 28,828 | \$8.35 | \$17.81 | 113.4% | -1.3% | -1.3% | -6.2% | 173,319 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2017 | 91,422 | \$11.69 | \$25.10 | 114.8% | | | | 529,523 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2018 | 65,343 | \$12.76 | \$30.11 | 136.0% | 40.7% | 9.2% | 20.0% | 529,523 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2019 | 85,552 | \$11.49 | \$25.90 | 125.4% | -9.8% | -9.9% | -14.0% | 529,523 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2020 | 87,386 | \$10.48 | \$27.98 | 167.0% | -8.8% | -8.8% | 8.0% | 529,523 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2021 | 97,478 | \$10.54 | \$28.04 | 166.0% | 0.8% | 0.6% | 0.2% | 529,523 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2022 | 102,342 | \$10.41 | \$26.11 | 150.9% | -1.4% | -1.3% | -6.9% | 529,523 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2017 | 52,879 | \$15.52 | \$21.23 | 36.9% | | | | 296,023 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2018 | 36,444 | \$16.17 | \$25.17 | 55.7% | 15.1% | 4.2% | 18.5% | 296,023 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2019 | 47,720 | \$14.56 | \$21.98 | 50.9% | -10.0% | -9.9% | -12.7% | 296,023 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2020 | 48,452 | \$13.30 | \$22.19 | 66.8% | -8.7% | -8.6% | 1.0% | 296,023 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2021 | 53,624 | \$13.39 | \$23.35 | 74.4% | 0.6% | 0.6% | 5.2% | 296,023 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2022 | 56,904 | \$13.22 | \$22.42 | 69.6% | -1.3% | -1.3% | -4.0% | 296,023 |
| 82306 | Vitamin D-3 Level | 2017 | 13,875 | \$39.74 | \$43.30 | 9.0% | | | | 74,191 |

| | | | | | | | | | | |
|-------|---|------|--------|----------|----------|--------|--------|--------|--------|---------|
| 82306 | Vitamin D-3 Level | 2018 | 8,826 | \$35.77 | \$44.46 | 24.3% | -9.8% | -10.0% | 2.7% | 74,191 |
| 82306 | Vitamin D-3 Level | 2019 | 12,108 | \$32.19 | \$39.72 | 23.4% | -10.2% | -10.0% | -10.7% | 74,191 |
| 82306 | Vitamin D-3 Level | 2020 | 11,615 | \$29.40 | \$40.37 | 37.3% | -8.4% | -8.7% | 1.6% | 74,191 |
| 82306 | Vitamin D-3 Level | 2021 | 13,514 | \$29.57 | \$41.30 | 39.7% | 0.4% | 0.6% | 2.3% | 74,191 |
| 82306 | Vitamin D-3 Level | 2022 | 14,253 | \$29.20 | \$40.93 | 40.2% | -1.2% | -1.3% | -0.9% | 74,191 |
| 83036 | Hemoglobin A1C Level | 2017 | 28,856 | \$13.03 | \$18.83 | 44.5% | | | | 146,110 |
| 83036 | Hemoglobin A1C Level | 2018 | 17,575 | \$11.74 | \$22.44 | 91.2% | -9.9% | -10.0% | 19.1% | 146,110 |
| 83036 | Hemoglobin A1C Level | 2019 | 23,038 | \$10.55 | \$19.52 | 85.0% | -10.1% | -10.1% | -13.0% | 146,110 |
| 83036 | Hemoglobin A1C Level | 2020 | 23,185 | \$9.64 | \$20.13 | 108.7% | -8.6% | -8.6% | 3.1% | 146,110 |
| 83036 | Hemoglobin A1C Level | 2021 | 25,756 | \$9.70 | \$20.47 | 111.0% | 0.6% | 0.6% | 1.7% | 146,110 |
| 83036 | Hemoglobin A1C Level | 2022 | 27,700 | \$9.58 | \$19.73 | 106.0% | -1.3% | -1.2% | -3.6% | 146,110 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2017 | 47,918 | \$22.57 | \$28.74 | 27.3% | | | | 254,199 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2018 | 32,025 | \$20.32 | \$29.87 | 47.0% | -10.0% | -10.0% | 3.9% | 254,199 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2019 | 42,256 | \$18.29 | \$26.69 | 45.9% | -10.0% | -10.0% | -10.6% | 254,199 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2020 | 41,082 | \$16.70 | \$26.24 | 57.1% | -8.6% | -8.7% | -1.7% | 254,199 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2021 | 44,594 | \$16.80 | \$27.63 | 64.5% | 0.7% | 0.6% | 5.3% | 254,199 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2022 | 46,324 | \$16.58 | \$26.86 | 62.0% | -1.5% | -1.3% | -2.8% | 254,199 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2017 | 82,026 | \$9.49 | \$14.70 | 54.9% | | | | 454,591 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2018 | 59,325 | \$9.38 | \$16.85 | 79.5% | -1.1% | -1.1% | 14.6% | 454,591 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2019 | 74,684 | \$8.45 | \$15.08 | 78.4% | -9.9% | -10.0% | -10.5% | 454,591 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2020 | 72,999 | \$7.71 | \$15.30 | 98.4% | -8.8% | -8.7% | 1.5% | 454,591 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2021 | 80,912 | \$7.76 | \$15.94 | 105.4% | 0.7% | 0.6% | 4.2% | 454,591 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2022 | 84,645 | \$7.66 | \$15.09 | 97.1% | -1.3% | -1.3% | -5.3% | 454,591 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2017 | 5,209 | \$219.26 | \$447.20 | 104.0% | | | | 24,675 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2018 | 5,011 | \$199.88 | \$474.06 | 137.2% | -7.5% | -8.8% | 6.0% | 24,675 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2019 | 4,052 | \$198.98 | \$476.37 | 139.4% | -1.7% | -0.4% | 0.5% | 24,675 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2020 | 3,653 | \$202.08 | \$489.57 | 142.3% | 0.6% | 1.6% | 2.8% | 24,675 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2021 | 3,368 | \$205.69 | \$550.01 | 167.4% | 0.0% | 1.8% | 12.3% | 24,675 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2022 | 3,382 | \$205.09 | \$667.43 | 225.4% | 5.4% | -0.3% | 21.3% | 24,675 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2017 | 2,337 | \$56.46 | \$212.43 | 276.3% | | | | 12,699 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2018 | 2,047 | \$58.22 | \$226.49 | 289.0% | 1.3% | 3.1% | 6.6% | 12,699 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2019 | 2,396 | \$56.53 | \$228.68 | 304.6% | -2.3% | -2.9% | 1.0% | 12,699 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2020 | 1,731 | \$57.25 | \$233.34 | 307.6% | -4.3% | 1.3% | 2.0% | 12,699 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2021 | 2,112 | \$46.08 | \$243.95 | 429.4% | -14.6% | -19.5% | 4.5% | 12,699 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2022 | 2,076 | \$39.62 | \$266.11 | 571.7% | -11.4% | -14.0% | 9.1% | 12,699 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2017 | 12,693 | \$67.02 | \$173.74 | 159.2% | | | | 75,534 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2018 | 12,084 | \$70.64 | \$183.48 | 159.7% | 5.3% | 5.4% | 5.6% | 75,534 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2019 | 13,248 | \$68.68 | \$185.21 | 169.7% | 1.0% | -2.8% | 0.9% | 75,534 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2020 | 12,433 | \$69.76 | \$183.09 | 162.4% | -2.4% | 1.6% | -1.1% | 75,534 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2021 | 13,542 | \$73.71 | \$200.02 | 171.4% | 6.5% | 5.7% | 9.2% | 75,534 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2022 | 11,534 | \$71.44 | \$211.01 | 195.4% | 0.5% | -3.1% | 5.5% | 75,534 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2017 | 3,522 | \$30.34 | \$52.96 | 74.6% | | | | 23,079 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2018 | 3,783 | \$31.33 | \$57.36 | 83.1% | -0.2% | 3.3% | 8.3% | 23,079 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2019 | 4,194 | \$30.75 | \$58.97 | 91.8% | 2.0% | -1.9% | 2.8% | 23,079 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2020 | 4,372 | \$30.77 | \$61.43 | 99.6% | -5.0% | 0.1% | 4.2% | 23,079 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2021 | 3,919 | \$32.58 | \$60.53 | 85.8% | 4.9% | 5.9% | -1.5% | 23,079 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2022 | 3,289 | \$32.03 | \$63.05 | 96.8% | 7.7% | -1.7% | 4.2% | 23,079 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2017 | 8,886 | \$24.24 | \$46.90 | 93.5% | | | | 40,125 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2018 | 5,461 | \$19.66 | \$47.19 | 140.1% | -19.1% | -18.9% | 0.6% | 40,125 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2019 | 5,940 | \$16.03 | \$47.78 | 198.1% | -18.7% | -18.5% | 1.3% | 40,125 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2020 | 6,257 | \$13.30 | \$48.27 | 262.9% | -15.2% | -17.0% | 1.0% | 40,125 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2021 | 6,533 | \$13.45 | \$49.22 | 265.9% | 3.0% | 1.1% | 2.0% | 40,125 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2022 | 7,048 | \$13.65 | \$53.74 | 293.7% | 4.8% | 1.5% | 9.2% | 40,125 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 2,540 | \$54.51 | \$152.87 | 180.4% | | | | 15,966 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 2,749 | \$44.69 | \$159.27 | 256.4% | -17.5% | -18.0% | 4.2% | 15,966 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 2,695 | \$37.01 | \$161.52 | 336.4% | -15.1% | -17.2% | 1.4% | 15,966 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 2,885 | \$37.65 | \$165.08 | 338.5% | -0.4% | 1.7% | 2.2% | 15,966 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 2,701 | \$40.58 | \$174.28 | 329.5% | 12.7% | 7.8% | 5.6% | 15,966 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 2,396 | \$41.81 | \$175.25 | 319.2% | 1.8% | 3.0% | 0.6% | 15,966 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 12,336 | \$21.82 | \$34.55 | 58.3% | | | | 77,715 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 12,456 | \$17.81 | \$37.19 | 108.8% | -17.4% | -18.4% | 7.6% | 77,715 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 12,153 | \$16.39 | \$37.54 | 129.1% | -5.7% | -8.0% | 1.0% | 77,715 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 14,324 | \$16.06 | \$38.77 | 141.3% | -2.6% | -2.0% | 3.3% | 77,715 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 14,148 | \$17.28 | \$40.36 | 133.5% | 6.9% | 7.6% | 4.1% | 77,715 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 12,298 | \$16.97 | \$41.51 | 144.6% | 1.5% | -1.8% | 2.9% | 77,715 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2017 | 9,893 | \$133.65 | \$275.63 | 106.2% | | | | 66,737 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2018 | 10,941 | \$138.90 | \$293.11 | 111.0% | 1.1% | 3.9% | 6.3% | 66,737 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2019 | 11,685 | \$137.41 | \$281.33 | 104.7% | -0.7% | -1.1% | -4.0% | 66,737 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2020 | 13,283 | \$136.75 | \$304.01 | 122.3% | 1.2% | -0.5% | 8.1% | 66,737 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2021 | 12,110 | \$146.81 | \$299.90 | 104.3% | 6.1% | 7.4% | -1.4% | 66,737 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2022 | 8,825 | \$146.65 | \$317.05 | 116.2% | 0.9% | -0.1% | 5.7% | 66,737 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2017 | 5,397 | \$27.61 | \$52.77 | 91.1% | | | | 33,278 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2018 | 5,401 | \$30.54 | \$57.53 | 88.4% | 10.5% | 10.6% | 9.0% | 33,278 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2019 | 5,933 | \$30.00 | \$59.34 | 97.8% | -0.8% | -1.8% | 3.1% | 33,278 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2020 | 6,578 | \$29.58 | \$60.90 | 105.9% | -1.5% | -1.4% | 2.6% | 33,278 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2021 | 5,588 | \$31.67 | \$63.32 | 99.9% | 10.6% | 7.1% | 4.0% | 33,278 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2022 | 4,381 | \$31.15 | \$63.15 | 102.7% | -2.1% | -1.6% | -0.3% | 33,278 |

Appendix II.B.i - Medicare Advantage HOPD Comparison to Professional (Affiliated) by Year

| Code | Description | Year | HOPD Units | Professional (Affiliated) | HOPD | OP/Affiliated % Diff |
|----------|-------------|------|------------|---------------------------|----------|----------------------|
| Combined | | 2017 | 44,142 | \$80.21 | \$136.29 | 69.9% |
| Combined | | 2018 | 63,362 | \$92.62 | \$116.23 | 25.5% |
| Combined | | 2019 | 149,121 | \$85.45 | \$94.27 | 10.3% |
| Combined | | 2020 | 121,516 | \$76.94 | \$95.69 | 24.4% |
| Combined | | 2021 | 160,908 | \$71.82 | \$102.29 | 42.4% |
| Combined | | 2022 | 203,595 | \$71.88 | \$99.92 | 39.0% |

| Code | Description | Year | HOPD Units | Professional (Affiliated) | HOPD | OP/Affiliated % Diff |
|-------|---|------|------------|---------------------------|------------|----------------------|
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2017 | 915 | \$80.43 | \$262.64 | 226.5% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2018 | 1,039 | \$100.27 | \$245.01 | 144.4% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2019 | 1,321 | \$83.68 | \$227.39 | 171.7% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2020 | 831 | \$82.31 | \$246.61 | 199.6% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2021 | 946 | \$86.55 | \$263.70 | 204.7% |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2022 | 1,257 | \$82.63 | \$258.96 | 213.4% |
| 36430 | Transfusion Of Blood Or Blood Products | 2017 | 650 | \$64.30 | \$452.27 | 603.4% |
| 36430 | Transfusion Of Blood Or Blood Products | 2018 | 804 | \$64.09 | \$435.73 | 579.9% |
| 36430 | Transfusion Of Blood Or Blood Products | 2019 | 1,294 | \$68.34 | \$351.99 | 415.0% |
| 36430 | Transfusion Of Blood Or Blood Products | 2020 | 870 | \$66.53 | \$366.23 | 450.5% |
| 36430 | Transfusion Of Blood Or Blood Products | 2021 | 1,026 | \$77.83 | \$384.99 | 394.7% |
| 36430 | Transfusion Of Blood Or Blood Products | 2022 | 1,355 | \$79.81 | \$378.43 | 374.2% |
| 67028 | Injection Of Drug Into Eye | 2017 | 322 | \$200.52 | \$244.99 | 22.2% |
| 67028 | Injection Of Drug Into Eye | 2018 | 481 | \$203.83 | \$301.47 | 47.9% |
| 67028 | Injection Of Drug Into Eye | 2019 | 682 | \$177.75 | \$311.05 | 75.0% |
| 67028 | Injection Of Drug Into Eye | 2020 | 693 | \$175.48 | \$356.72 | 103.3% |
| 67028 | Injection Of Drug Into Eye | 2021 | 841 | \$193.83 | \$356.84 | 84.1% |
| 67028 | Injection Of Drug Into Eye | 2022 | 872 | \$204.60 | \$336.98 | 64.7% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2017 | 486 | \$403.09 | \$535.71 | 32.9% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2018 | 483 | \$994.05 | \$416.91 | -58.1% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2019 | 590 | \$1,014.10 | \$385.25 | -62.0% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2020 | 452 | \$849.24 | \$415.00 | -51.1% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2021 | 623 | \$828.90 | \$495.09 | -40.3% |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2022 | 883 | \$606.00 | \$426.14 | -29.7% |
| 71250 | Ct Scan Chest | 2017 | 1,711 | \$437.66 | \$159.94 | -63.5% |
| 71250 | Ct Scan Chest | 2018 | 2,356 | \$344.86 | \$147.74 | -57.2% |
| 71250 | Ct Scan Chest | 2019 | 3,984 | \$318.77 | \$121.98 | -61.7% |
| 71250 | Ct Scan Chest | 2020 | 3,152 | \$334.57 | \$122.45 | -63.4% |
| 71250 | Ct Scan Chest | 2021 | 3,665 | \$305.98 | \$126.62 | -58.6% |
| 71250 | Ct Scan Chest | 2022 | 4,350 | \$208.50 | \$126.95 | -39.1% |
| 77300 | Calculation Of Radiation Therapy Dose | 2017 | 705 | \$66.84 | \$124.33 | 86.0% |
| 77300 | Calculation Of Radiation Therapy Dose | 2018 | 1,230 | \$118.02 | \$119.98 | 1.7% |
| 77300 | Calculation Of Radiation Therapy Dose | 2019 | 1,730 | \$98.79 | \$114.16 | 15.6% |
| 77300 | Calculation Of Radiation Therapy Dose | 2020 | 1,766 | \$68.63 | \$122.81 | 78.9% |
| 77300 | Calculation Of Radiation Therapy Dose | 2021 | 2,966 | \$52.73 | \$125.86 | 138.7% |
| 77300 | Calculation Of Radiation Therapy Dose | 2022 | 3,609 | \$61.51 | \$131.24 | 113.4% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2017 | 126 | \$1,999.40 | \$1,221.30 | -38.9% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2018 | 328 | \$2,526.38 | \$1,288.99 | -49.0% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2019 | 465 | \$2,167.11 | \$1,225.23 | -43.5% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2020 | 537 | \$1,898.60 | \$1,254.73 | -33.9% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2021 | 632 | \$1,969.72 | \$1,314.06 | -33.3% |
| 77301 | Management Of Modulation Radiotherapy Planning | 2022 | 697 | \$2,031.81 | \$1,264.53 | -37.8% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2017 | 867 | \$134.00 | \$300.84 | 124.5% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2018 | 2,276 | \$213.89 | \$261.59 | 22.3% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2019 | 2,681 | \$203.31 | \$264.26 | 30.0% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2020 | 2,137 | \$132.27 | \$306.03 | 131.4% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2021 | 2,382 | \$99.63 | \$312.91 | 214.1% |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2022 | 2,786 | \$123.78 | \$321.12 | 159.4% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2017 | 363 | \$2,809.16 | \$1,391.41 | -50.5% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2018 | 318 | \$3,033.69 | \$976.96 | -67.8% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2019 | 326 | \$3,144.82 | \$948.64 | -69.8% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2020 | 211 | \$2,779.46 | \$1,108.69 | -60.1% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2021 | 342 | \$1,784.69 | \$1,477.73 | -17.2% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2022 | 952 | \$2,156.44 | \$1,211.99 | -43.8% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2017 | 3,167 | \$10.27 | \$33.39 | 225.0% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2018 | 4,568 | \$9.94 | \$29.79 | 199.8% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2019 | 11,110 | \$9.01 | \$21.79 | 141.9% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2020 | 8,442 | \$8.47 | \$17.41 | 105.7% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2021 | 11,605 | \$6.17 | \$17.35 | 181.1% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2022 | 14,511 | \$5.69 | \$15.79 | 177.6% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2017 | 5,589 | \$13.56 | \$36.90 | 172.2% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2018 | 8,271 | \$12.57 | \$29.59 | 135.4% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2019 | 22,796 | \$10.99 | \$20.39 | 85.5% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2020 | 21,116 | \$9.57 | \$20.05 | 109.5% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2021 | 31,033 | \$8.46 | \$21.47 | 153.7% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2022 | 38,310 | \$7.04 | \$24.30 | 245.4% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2017 | 2,770 | \$18.31 | \$32.40 | 76.9% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2018 | 4,406 | \$18.22 | \$27.59 | 51.4% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2019 | 12,836 | \$14.14 | \$17.83 | 26.1% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2020 | 12,150 | \$12.46 | \$18.39 | 47.6% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2021 | 17,363 | \$10.91 | \$20.88 | 91.4% |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2022 | 21,913 | \$8.98 | \$21.99 | 144.8% |
| 82306 | Vitamin D-3 Level | 2017 | 563 | \$33.13 | \$69.97 | 111.2% |
| 82306 | Vitamin D-3 Level | 2018 | 994 | \$31.89 | \$49.71 | 55.9% |
| 82306 | Vitamin D-3 Level | 2019 | 2,859 | \$29.95 | \$36.22 | 20.9% |
| 82306 | Vitamin D-3 Level | 2020 | 2,744 | \$25.59 | \$35.92 | 40.3% |
| 82306 | Vitamin D-3 Level | 2021 | 4,431 | \$23.06 | \$36.53 | 58.4% |
| 82306 | Vitamin D-3 Level | 2022 | 5,850 | \$20.36 | \$38.96 | 91.4% |
| 83036 | Hemoglobin A1C Level | 2017 | 1,354 | \$11.21 | \$25.61 | 128.4% |
| 83036 | Hemoglobin A1C Level | 2018 | 2,000 | \$9.96 | \$17.89 | 79.5% |
| 83036 | Hemoglobin A1C Level | 2019 | 5,908 | \$8.59 | \$12.92 | 50.4% |
| 83036 | Hemoglobin A1C Level | 2020 | 6,044 | \$7.56 | \$13.03 | 72.3% |
| 83036 | Hemoglobin A1C Level | 2021 | 8,569 | \$7.10 | \$14.13 | 99.0% |
| 83036 | Hemoglobin A1C Level | 2022 | 12,359 | \$6.32 | \$14.97 | 136.9% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2017 | 2,056 | \$23.50 | \$42.33 | 80.1% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2018 | 3,170 | \$24.14 | \$32.35 | 34.0% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2019 | 10,376 | \$18.50 | \$21.56 | 16.5% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2020 | 10,136 | \$15.69 | \$21.49 | 37.0% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2021 | 14,075 | \$13.40 | \$22.87 | 70.6% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2022 | 17,736 | \$10.78 | \$24.33 | 125.8% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2017 | 5,063 | \$6.63 | \$19.30 | 191.4% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2018 | 7,662 | \$8.24 | \$15.55 | 88.7% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2019 | 19,841 | \$7.35 | \$11.69 | 59.1% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2020 | 17,626 | \$6.30 | \$11.07 | 75.7% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2021 | 25,288 | \$5.75 | \$11.70 | 103.5% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2022 | 32,900 | \$4.86 | \$13.15 | 170.5% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2017 | 6,424 | \$248.98 | \$836.20 | 235.9% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2018 | 8,108 | \$341.99 | \$655.40 | 91.6% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2019 | 9,193 | \$294.88 | \$471.46 | 59.9% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2020 | 7,982 | \$254.56 | \$449.14 | 76.4% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2021 | 9,058 | \$228.56 | \$463.06 | 102.6% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2022 | 10,711 | \$271.34 | \$423.75 | 56.2% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2017 | 1,022 | \$68.32 | \$260.40 | 281.1% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2018 | 1,262 | \$89.31 | \$213.49 | 139.0% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2019 | 1,632 | \$73.98 | \$189.58 | 156.3% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2020 | 747 | \$66.56 | \$217.75 | 227.2% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2021 | 1,101 | \$61.09 | \$242.82 | 297.5% |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2022 | 1,523 | \$56.75 | \$210.03 | 270.1% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2017 | 1,927 | \$119.98 | \$198.52 | 65.5% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2018 | 2,953 | \$113.73 | \$174.92 | 53.8% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2019 | 5,978 | \$123.62 | \$159.70 | 29.2% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2020 | 3,917 | \$124.39 | \$167.81 | 34.9% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2021 | 4,542 | \$125.94 | \$192.82 | 53.1% |

| | | | | | | |
|-------|--|------|--------|----------|----------|--------|
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2022 | 5,942 | \$106.34 | \$201.28 | 89.3% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2017 | 771 | \$29.23 | \$63.07 | 115.8% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2018 | 966 | \$51.66 | \$61.75 | 19.5% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2019 | 1,797 | \$45.16 | \$55.10 | 22.0% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2020 | 1,613 | \$38.98 | \$55.04 | 41.2% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2021 | 1,547 | \$44.19 | \$61.19 | 38.5% |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2022 | 2,132 | \$19.24 | \$64.04 | 232.8% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2017 | 1,660 | \$28.95 | \$45.24 | 56.3% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2018 | 1,185 | \$32.08 | \$42.67 | 33.0% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2019 | 2,354 | \$22.89 | \$37.75 | 64.9% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2020 | 1,817 | \$20.44 | \$44.06 | 115.5% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2021 | 2,425 | \$18.25 | \$47.63 | 161.0% |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2022 | 3,530 | \$18.26 | \$53.87 | 195.0% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 587 | \$106.05 | \$169.71 | 60.0% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 889 | \$93.70 | \$162.18 | 73.1% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 10,230 | \$82.49 | \$169.54 | 105.5% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 2,126 | \$71.85 | \$160.30 | 123.1% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 1,437 | \$87.84 | \$174.18 | 98.3% |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 1,831 | \$90.91 | \$173.15 | 90.5% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 2,160 | \$38.29 | \$37.42 | -2.3% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 3,279 | \$35.63 | \$37.57 | 5.5% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 12,237 | \$30.00 | \$36.73 | 22.4% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 6,969 | \$29.01 | \$36.79 | 26.8% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 7,009 | \$31.69 | \$39.80 | 25.6% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 8,470 | \$30.60 | \$41.46 | 35.5% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2017 | 1,908 | \$213.65 | \$276.89 | 29.6% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2018 | 2,669 | \$227.55 | \$300.85 | 32.2% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2019 | 4,357 | \$239.18 | \$260.87 | 9.1% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2020 | 4,817 | \$241.62 | \$282.74 | 17.0% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2021 | 5,212 | \$282.90 | \$300.63 | 6.3% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2022 | 5,881 | \$297.52 | \$317.38 | 6.7% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2017 | 976 | \$43.78 | \$54.15 | 23.7% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2018 | 1,665 | \$47.31 | \$58.59 | 23.8% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2019 | 2,544 | \$48.77 | \$55.68 | 14.2% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2020 | 2,621 | \$49.92 | \$55.64 | 11.5% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2021 | 2,790 | \$58.22 | \$63.48 | 9.0% |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2022 | 3,235 | \$56.82 | \$68.22 | 20.1% |

Appendix II.B.ii - Medicare Advantage HOPD Comparison to Professional (Independent) by Year

| Code | Description | Year | HOPD Units | Professional (Independent) | HOPD | OP/Independent % Diff | Professional (Affiliated) | Professional (Independent) | HOPD | Total Units for Mix Adj. |
|----------------|-------------|------|------------|----------------------------|----------|-----------------------|---------------------------|----------------------------|--------|--------------------------|
| Combined | | 2017 | 44,142 | \$93.04 | \$136.29 | 46.5% | | | | 742,644 |
| Combined | | 2018 | 63,362 | \$106.89 | \$116.23 | 8.7% | 15.5% | 14.9% | -14.7% | 742,644 |
| Combined | | 2019 | 149,121 | \$134.24 | \$94.27 | -29.8% | -7.7% | -25.6% | -18.9% | 742,644 |
| Combined | | 2020 | 121,516 | \$83.59 | \$95.69 | 14.5% | -10.0% | -37.7% | 1.5% | 742,644 |
| Combined | | 2021 | 160,908 | \$73.32 | \$102.29 | 39.5% | -6.7% | -12.3% | 6.9% | 742,644 |
| Combined | | 2022 | 203,595 | \$80.39 | \$99.92 | 24.3% | 0.1% | 9.6% | -2.3% | 742,644 |
| Average Annual | | | | | | | -2.2% | -2.9% | -6.0% | |

| Code | Description | Year | HOPD Units | Professional (Independent) | HOPD | OP/Independent % Diff | Change over Time | | | Total Units for Mix Adj. |
|-------|--|------|------------|----------------------------|------------|-----------------------|---------------------------|----------------------------|--------|--------------------------|
| | | | | | | | Professional (Affiliated) | Professional (Independent) | HOPD | |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2017 | 915 | \$95.53 | \$262.64 | 174.9% | | | | 6,309 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2018 | 1,039 | \$112.58 | \$245.01 | 117.6% | 24.7% | 17.8% | -6.7% | 6,309 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2019 | 1,321 | \$122.34 | \$227.39 | 85.9% | -16.5% | 8.7% | -7.2% | 6,309 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2020 | 831 | \$101.64 | \$246.61 | 142.6% | -1.6% | -16.9% | 8.5% | 6,309 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2021 | 946 | \$99.67 | \$263.70 | 164.6% | 5.1% | -1.9% | 6.9% | 6,309 |
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule | 2022 | 1,257 | \$99.66 | \$258.96 | 159.8% | -4.5% | 0.0% | -1.8% | 6,309 |
| 36430 | Transfusion Of Blood Or Blood Products | 2017 | 650 | \$64.30 | \$452.27 | 603.4% | | | | 5,999 |
| 36430 | Transfusion Of Blood Or Blood Products | 2018 | 804 | \$64.09 | \$435.73 | 579.9% | -0.3% | -0.3% | -3.7% | 5,999 |
| 36430 | Transfusion Of Blood Or Blood Products | 2019 | 1,294 | \$68.33 | \$351.99 | 415.1% | 6.6% | 6.6% | -19.2% | 5,999 |
| 36430 | Transfusion Of Blood Or Blood Products | 2020 | 870 | \$67.00 | \$366.23 | 446.6% | -2.7% | -1.9% | 4.0% | 5,999 |
| 36430 | Transfusion Of Blood Or Blood Products | 2021 | 1,026 | \$77.90 | \$384.99 | 394.2% | 17.0% | 16.3% | 5.1% | 5,999 |
| 36430 | Transfusion Of Blood Or Blood Products | 2022 | 1,355 | \$79.91 | \$378.43 | 373.5% | 2.5% | 2.6% | -1.7% | 5,999 |
| 67028 | Injection Of Drug Into Eye | 2017 | 322 | \$159.85 | \$244.99 | 53.3% | | | | 3,891 |
| 67028 | Injection Of Drug Into Eye | 2018 | 481 | \$183.50 | \$301.47 | 64.3% | 1.7% | 14.8% | 23.1% | 3,891 |
| 67028 | Injection Of Drug Into Eye | 2019 | 682 | \$199.68 | \$311.05 | 55.8% | -12.8% | 8.8% | 3.2% | 3,891 |
| 67028 | Injection Of Drug Into Eye | 2020 | 693 | \$161.29 | \$356.72 | 121.2% | -1.3% | -19.2% | 14.7% | 3,891 |
| 67028 | Injection Of Drug Into Eye | 2021 | 841 | \$171.40 | \$356.84 | 108.2% | 10.5% | 6.3% | 0.0% | 3,891 |
| 67028 | Injection Of Drug Into Eye | 2022 | 872 | \$170.33 | \$336.98 | 97.8% | 5.6% | -0.6% | -5.6% | 3,891 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2017 | 486 | \$910.95 | \$535.71 | -41.2% | | | | 3,517 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2018 | 483 | \$1,003.99 | \$416.91 | -58.5% | 146.6% | 10.2% | -22.2% | 3,517 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2019 | 590 | \$1,154.19 | \$385.25 | -66.6% | 2.0% | 15.0% | -7.6% | 3,517 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2020 | 452 | \$667.05 | \$415.00 | -37.8% | -16.3% | -42.2% | 7.7% | 3,517 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2021 | 623 | \$455.28 | \$495.09 | 8.7% | -2.4% | -31.7% | 19.3% | 3,517 |
| 70553 | Mri Scan Of Brain Before And After Contrast | 2022 | 883 | \$555.13 | \$26.14 | -23.2% | -26.9% | 21.9% | -13.9% | 3,517 |
| 71250 | Ct Scan Chest | 2017 | 1,711 | \$432.45 | \$159.94 | -63.0% | | | | 19,218 |
| 71250 | Ct Scan Chest | 2018 | 2,356 | \$484.35 | \$147.74 | -69.5% | -21.2% | 12.0% | -7.6% | 19,218 |
| 71250 | Ct Scan Chest | 2019 | 3,984 | \$544.16 | \$121.98 | -77.6% | -7.6% | 12.3% | -17.4% | 19,218 |
| 71250 | Ct Scan Chest | 2020 | 3,152 | \$358.26 | \$122.45 | -65.8% | 5.0% | -34.2% | 0.4% | 19,218 |
| 71250 | Ct Scan Chest | 2021 | 3,665 | \$255.47 | \$126.62 | -50.4% | -8.5% | -28.7% | 3.4% | 19,218 |
| 71250 | Ct Scan Chest | 2022 | 4,350 | \$254.79 | \$126.95 | -50.2% | -31.9% | -0.3% | 0.3% | 19,218 |
| 77300 | Calculation Of Radiation Therapy Dose | 2017 | 705 | \$65.60 | \$124.33 | 89.5% | | | | 12,006 |
| 77300 | Calculation Of Radiation Therapy Dose | 2018 | 1,230 | \$129.95 | \$119.98 | -7.7% | 76.6% | 98.1% | -3.5% | 12,006 |
| 77300 | Calculation Of Radiation Therapy Dose | 2019 | 1,730 | \$204.75 | \$114.16 | -44.2% | -16.3% | 57.6% | -4.9% | 12,006 |
| 77300 | Calculation Of Radiation Therapy Dose | 2020 | 1,766 | \$75.88 | \$122.81 | 61.9% | -30.5% | -62.9% | 7.6% | 12,006 |
| 77300 | Calculation Of Radiation Therapy Dose | 2021 | 2,966 | \$54.39 | \$125.86 | 131.4% | -23.2% | -28.3% | 2.5% | 12,006 |
| 77300 | Calculation Of Radiation Therapy Dose | 2022 | 3,609 | \$56.30 | \$131.24 | 133.1% | 16.7% | 3.5% | 4.3% | 12,006 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2017 | 126 | \$1,930.47 | \$1,221.30 | -36.7% | | | | 2,785 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2018 | 328 | \$3,648.28 | \$1,288.99 | -64.7% | 26.4% | 89.0% | 5.5% | 2,785 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2019 | 465 | \$6,936.21 | \$1,225.23 | -82.3% | -14.2% | 90.1% | -4.9% | 2,785 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2020 | 537 | \$2,222.78 | \$1,254.73 | -43.6% | -12.4% | -68.0% | 2.4% | 2,785 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2021 | 632 | \$1,775.77 | \$1,314.06 | -26.0% | 3.7% | -20.1% | 4.7% | 2,785 |
| 77301 | Management Of Modulation Radiotherapy Planning | 2022 | 697 | \$1,663.55 | \$1,264.53 | -24.0% | 3.2% | -6.3% | -3.8% | 2,785 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2017 | 867 | \$131.68 | \$300.84 | 128.5% | | | | 13,129 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2018 | 2,276 | \$281.21 | \$261.59 | -7.0% | 59.6% | 113.5% | -13.0% | 13,129 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2019 | 2,681 | \$387.03 | \$264.26 | -31.7% | -4.9% | 37.6% | 1.0% | 13,129 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2020 | 2,137 | \$148.85 | \$306.03 | 105.6% | -34.9% | -61.5% | 15.8% | 13,129 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2021 | 2,382 | \$88.68 | \$312.91 | 252.9% | -24.7% | -40.4% | 2.2% | 13,129 |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex | 2022 | 2,786 | \$100.95 | \$321.12 | 218.1% | 24.2% | 13.8% | 2.6% | 13,129 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2017 | 363 | \$2,491.47 | \$1,391.41 | -44.2% | | | | 2,512 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2018 | 318 | \$2,916.50 | \$976.96 | -66.5% | 8.0% | 17.1% | -29.8% | 2,512 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2019 | 326 | \$3,312.16 | \$948.64 | -71.4% | 3.7% | 13.6% | -2.9% | 2,512 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2020 | 211 | \$2,540.48 | \$1,108.69 | -56.4% | -11.6% | -23.3% | 16.9% | 2,512 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2021 | 342 | \$2,262.56 | \$1,477.73 | -34.7% | -35.8% | -10.9% | 33.3% | 2,512 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2022 | 952 | \$2,395.30 | \$1,211.99 | -49.4% | 20.8% | 5.9% | -18.0% | 2,512 |

| | | | | | | | | | | |
|-------|---|------|--------|----------|----------|--------|--------|--------|--------|---------|
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2017 | 3,167 | \$18.33 | \$33.39 | 82.2% | | | | 53,403 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2018 | 4,568 | \$15.99 | \$29.79 | 86.3% | -3.3% | -12.8% | -10.8% | 53,403 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2019 | 11,110 | \$15.44 | \$21.79 | 41.1% | -9.3% | -3.5% | -26.8% | 53,403 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2020 | 8,442 | \$13.60 | \$17.41 | 28.0% | -6.0% | -11.9% | -20.1% | 53,403 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2021 | 11,605 | \$14.00 | \$17.35 | 23.9% | -27.1% | 2.9% | -0.4% | 53,403 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2022 | 14,511 | \$13.91 | \$15.79 | 13.5% | -7.9% | -0.6% | -9.0% | 53,403 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2017 | 5,589 | \$18.28 | \$36.90 | 101.9% | | | | 127,115 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2018 | 8,271 | \$15.98 | \$29.59 | 85.2% | -7.3% | -12.6% | -19.8% | 127,115 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2019 | 22,796 | \$17.53 | \$20.39 | 16.3% | -12.6% | 9.7% | -31.1% | 127,115 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2020 | 21,116 | \$12.90 | \$20.05 | 55.4% | -12.9% | -26.4% | -1.7% | 127,115 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2021 | 31,033 | \$11.90 | \$21.47 | 80.5% | -11.6% | -7.8% | 7.1% | 127,115 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2022 | 38,310 | \$11.44 | \$24.30 | 112.4% | -16.8% | -3.8% | 13.2% | 127,115 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2017 | 2,770 | \$28.28 | \$32.40 | 14.5% | | | | 71,438 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2018 | 4,406 | \$24.71 | \$27.59 | 11.6% | -0.5% | -12.6% | -14.8% | 71,438 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2019 | 12,836 | \$23.42 | \$17.83 | -23.9% | -22.4% | -5.2% | -35.4% | 71,438 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2020 | 12,150 | \$19.09 | \$18.39 | -3.7% | -11.9% | -18.5% | 3.1% | 71,438 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2021 | 17,363 | \$19.62 | \$20.88 | 6.4% | -12.5% | 2.7% | 13.5% | 71,438 |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) | 2022 | 21,913 | \$18.57 | \$21.99 | 18.4% | -17.6% | -5.3% | 5.3% | 71,438 |
| 82306 | Vitamin D-3 Level | 2017 | 563 | \$59.75 | \$69.97 | 17.1% | | | | 17,441 |
| 82306 | Vitamin D-3 Level | 2018 | 994 | \$52.41 | \$49.71 | -5.2% | -3.8% | -12.3% | -29.0% | 17,441 |
| 82306 | Vitamin D-3 Level | 2019 | 2,859 | \$51.31 | \$36.22 | -29.4% | -6.1% | -2.1% | -27.1% | 17,441 |
| 82306 | Vitamin D-3 Level | 2020 | 2,744 | \$42.49 | \$35.92 | -15.5% | -14.6% | -17.2% | -0.8% | 17,441 |
| 82306 | Vitamin D-3 Level | 2021 | 4,431 | \$43.77 | \$36.53 | -16.6% | -9.9% | 3.0% | 1.7% | 17,441 |
| 82306 | Vitamin D-3 Level | 2022 | 5,850 | \$42.52 | \$38.96 | -8.4% | -11.7% | -2.9% | 6.7% | 17,441 |
| 83036 | Hemoglobin A1C Level | 2017 | 1,354 | \$21.19 | \$25.61 | 20.9% | | | | 36,234 |
| 83036 | Hemoglobin A1C Level | 2018 | 2,000 | \$18.16 | \$17.89 | -1.5% | -11.1% | -14.3% | -30.2% | 36,234 |
| 83036 | Hemoglobin A1C Level | 2019 | 5,908 | \$17.32 | \$12.92 | -25.4% | -13.8% | -4.6% | -27.8% | 36,234 |
| 83036 | Hemoglobin A1C Level | 2020 | 6,044 | \$14.28 | \$13.03 | -8.8% | -12.0% | -17.5% | 0.8% | 36,234 |
| 83036 | Hemoglobin A1C Level | 2021 | 8,569 | \$14.90 | \$14.13 | -5.1% | -6.1% | 4.3% | 8.5% | 36,234 |
| 83036 | Hemoglobin A1C Level | 2022 | 12,359 | \$13.79 | \$14.97 | 8.6% | -11.0% | -7.5% | 5.9% | 36,234 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2017 | 2,056 | \$35.47 | \$42.33 | 19.3% | | | | 57,549 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2018 | 3,170 | \$30.44 | \$32.35 | 6.3% | 2.7% | -14.2% | -23.6% | 57,549 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2019 | 10,376 | \$30.77 | \$21.56 | -29.9% | -23.4% | 1.1% | -33.4% | 57,549 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2020 | 10,136 | \$24.65 | \$21.49 | -12.8% | -15.2% | -19.9% | -0.3% | 57,549 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2021 | 14,075 | \$24.06 | \$22.87 | -4.9% | -14.6% | -2.4% | 6.4% | 57,549 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2022 | 17,736 | \$22.50 | \$24.33 | 8.2% | -19.6% | -6.5% | 6.4% | 57,549 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2017 | 5,063 | \$14.54 | \$19.30 | 32.8% | | | | 108,380 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2018 | 7,662 | \$13.23 | \$15.55 | 17.5% | 24.4% | -9.0% | -19.4% | 108,380 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2019 | 19,841 | \$14.01 | \$11.69 | -16.6% | -10.9% | 5.9% | -24.8% | 108,380 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2020 | 17,626 | \$11.67 | \$11.07 | -5.2% | -14.2% | -16.7% | -5.3% | 108,380 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2021 | 25,288 | \$11.48 | \$11.70 | 1.9% | -8.7% | -1.6% | 5.7% | 108,380 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2022 | 32,900 | \$10.61 | \$13.15 | 23.9% | -15.5% | -7.6% | 12.4% | 108,380 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2017 | 6,424 | \$364.33 | \$836.20 | 129.5% | | | | 51,476 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2018 | 8,108 | \$374.42 | \$655.40 | 75.0% | 37.4% | 2.8% | -21.6% | 51,476 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2019 | 9,193 | \$447.42 | \$471.46 | 5.4% | -13.8% | 19.5% | -28.1% | 51,476 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2020 | 7,982 | \$328.36 | \$449.14 | 36.8% | -13.7% | -26.6% | -4.7% | 51,476 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2021 | 9,058 | \$292.75 | \$463.06 | 58.2% | -10.2% | -10.8% | 3.1% | 51,476 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2022 | 10,711 | \$384.04 | \$423.75 | 10.3% | 18.7% | 31.2% | -8.5% | 51,476 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2017 | 1,022 | \$88.67 | \$260.40 | 193.7% | | | | 7,287 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2018 | 1,262 | \$98.03 | \$213.49 | 117.8% | 30.7% | 10.6% | -18.0% | 7,287 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2019 | 1,632 | \$122.23 | \$189.58 | 55.1% | -17.2% | 24.7% | -11.2% | 7,287 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2020 | 747 | \$84.16 | \$217.75 | 158.7% | -10.0% | -31.2% | 14.9% | 7,287 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2021 | 1,101 | \$81.57 | \$242.82 | 197.7% | -8.2% | -3.1% | 11.5% | 7,287 |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration | 2022 | 1,523 | \$75.29 | \$210.03 | 179.0% | -7.1% | -7.7% | -13.5% | 7,287 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2017 | 1,927 | \$96.55 | \$198.52 | 105.6% | | | | 25,259 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2018 | 2,953 | \$103.01 | \$174.92 | 69.8% | -5.2% | 6.7% | -11.9% | 25,259 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2019 | 5,978 | \$120.25 | \$159.70 | 32.8% | 8.7% | 16.7% | -8.7% | 25,259 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2020 | 3,917 | \$98.01 | \$167.81 | 71.2% | 0.6% | -18.5% | 5.1% | 25,259 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2021 | 4,542 | \$86.96 | \$192.82 | 121.7% | 1.2% | -11.3% | 14.9% | 25,259 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2022 | 5,942 | \$91.43 | \$201.28 | 120.1% | -15.6% | 5.1% | 4.4% | 25,259 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2017 | 771 | \$32.71 | \$63.07 | 92.8% | | | | 8,826 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2018 | 966 | \$50.24 | \$61.75 | 22.9% | 76.8% | 53.6% | -2.1% | 8,826 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2019 | 1,797 | \$64.48 | \$55.10 | -14.6% | -12.6% | 28.3% | -10.8% | 8,826 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2020 | 1,613 | \$35.21 | \$55.04 | 56.3% | -13.7% | -45.4% | -0.1% | 8,826 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2021 | 1,547 | \$28.92 | \$61.19 | 111.6% | 13.4% | -17.9% | 11.2% | 8,826 |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour | 2022 | 2,132 | \$27.17 | \$64.04 | 135.7% | -56.5% | -6.0% | 4.6% | 8,826 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2017 | 1,660 | \$33.20 | \$45.24 | 36.3% | | | | 12,971 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2018 | 1,185 | \$35.03 | \$42.67 | 21.8% | 10.8% | 5.5% | -5.7% | 12,971 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2019 | 2,354 | \$33.19 | \$37.75 | 13.7% | -28.6% | -5.3% | -11.5% | 12,971 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2020 | 1,817 | \$23.90 | \$44.06 | 84.4% | -10.7% | -28.0% | 16.7% | 12,971 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2021 | 2,425 | \$18.56 | \$47.63 | 156.6% | -10.7% | -22.3% | 8.1% | 12,971 |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention | 2022 | 3,530 | \$18.03 | \$53.87 | 198.8% | 0.0% | -2.9% | 13.1% | 12,971 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 587 | \$98.57 | \$169.71 | 72.2% | | | | 17,100 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 889 | \$89.04 | \$162.18 | 82.1% | -11.6% | -9.7% | -4.4% | 17,100 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 10,230 | \$83.74 | \$169.54 | 102.5% | -12.0% | -5.9% | 4.5% | 17,100 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 2,126 | \$66.94 | \$160.30 | 139.5% | -12.9% | -20.1% | -5.4% | 17,100 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 1,437 | \$87.08 | \$174.18 | 100.0% | 22.3% | 30.1% | 8.7% | 17,100 |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 1,831 | \$82.10 | \$173.15 | 110.9% | 3.5% | -5.7% | -0.6% | 17,100 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 2,160 | \$30.60 | \$37.42 | 22.3% | | | | 40,124 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 3,279 | \$29.54 | \$37.57 | 27.2% | -6.9% | -3.5% | 0.4% | 40,124 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 12,237 | \$33.93 | \$36.73 | 8.3% | -15.8% | 14.8% | -2.2% | 40,124 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 6,969 | \$21.14 | \$36.79 | 74.0% | -3.3% | -37.7% | 0.2% | 40,124 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 7,009 | \$19.37 | \$39.80 | 105.5% | 9.2% | -8.4% | 8.2% | 40,124 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 8,470 | \$20.68 | \$41.46 | 100.5% | -3.4% | 6.8% | 4.2% | 40,124 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2017 | 1,908 | \$201.89 | \$276.89 | 37.1% | | | | 24,844 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2018 | 2,669 | \$230.94 | \$300.85 | 30.3% | 6.5% | 14.4% | 8.7% | 24,844 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2019 | 4,357 | \$280.35 | \$260.87 | -6.9% | 5.1% | 21.4% | -13.3% | 24,844 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2020 | 4,817 | \$197.22 | \$282.74 | 43.4% | 1.0% | -29.7% | 8.4% | 24,844 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2021 | 5,212 | \$199.25 | \$300.63 | 50.9% | 17.1% | 1.0% | 6.3% | 24,844 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2022 | 5,881 | \$212.67 | \$317.38 | 49.2% | 5.2% | 6.7% | 5.6% | 24,844 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2017 | 976 | \$41.84 | \$54.15 | 29.4% | | | | 13,831 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2018 | 1,665 | \$47.18 | \$58.59 | 24.2% | 8.1% | 12.8% | 8.2% | 13,831 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2019 | 2,544 | \$56.88 | \$55.68 | -2.1% | 3.1% | 20.5% | -5.0% | 13,831 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2020 | 2,621 | \$40.80 | \$55.64 | 36.4% | 2.4% | -28.3% | -0.1% | 13,831 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2021 | 2,790 | \$40.61 | \$63.48 | 56.3% | 16.6% | -0.5% | 14.1% | 13,831 |
| 96415 | Infusion Of Chemotherapy Into A Vein | 2022 | 3,235 | \$43.59 | \$68.22 | 56.5% | -2.4% | 7.3% | 7.5% | 13,831 |

Appendix II.C.i - Commercial HOPD Comparison to Professional (Affiliated) by Year

| Code | Description | Year | HOPD Units | Professional (Affiliated) | HOPD | OP/Affiliated % Diff |
|----------|-------------|------|------------|---------------------------|----------|----------------------|
| Combined | | 2017 | 598,584 | \$63.75 | \$125.36 | 96.6% |
| Combined | | 2018 | 651,837 | \$65.01 | \$128.05 | 97.0% |
| Combined | | 2019 | 622,842 | \$69.10 | \$140.36 | 103.1% |
| Combined | | 2020 | 489,240 | \$68.81 | \$141.87 | 106.2% |
| Combined | | 2021 | 578,415 | \$75.32 | \$140.32 | 86.3% |
| Combined | | 2022 | 626,617 | \$73.28 | \$141.96 | 93.7% |

| Code | Description | Year | HOPD Units | Professional (Affiliated) | HOPD | OP/Affiliated % Diff |
|-------|---|------|------------|---------------------------|------------|----------------------|
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2017 | 1,058 | \$722.88 | \$1,981.53 | 174.1% |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2018 | 1,190 | \$940.89 | \$1,852.94 | 96.9% |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2019 | 948 | \$959.82 | \$2,000.35 | 108.4% |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2020 | 981 | \$941.84 | \$2,011.51 | 113.6% |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2021 | 1,127 | \$907.55 | \$1,723.59 | 89.9% |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2022 | 1,227 | \$885.23 | \$1,701.16 | 92.2% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2017 | 108,925 | \$5.03 | \$19.78 | 292.8% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2018 | 111,753 | \$3.29 | \$22.82 | 593.2% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2019 | 112,322 | \$3.09 | \$26.38 | 753.2% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2020 | 85,169 | \$3.28 | \$30.12 | 818.6% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2021 | 105,721 | \$3.08 | \$25.77 | 737.1% |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2022 | 140,452 | \$2.48 | \$25.81 | 939.3% |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2017 | 3,271 | \$744.33 | \$1,406.42 | 89.0% |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2018 | 3,214 | \$997.18 | \$1,515.71 | 52.0% |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2019 | 2,952 | \$967.15 | \$1,644.29 | 70.0% |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2020 | 2,236 | \$775.93 | \$1,711.65 | 120.6% |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2021 | 3,001 | \$939.42 | \$1,753.20 | 86.6% |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2022 | 3,265 | \$954.77 | \$1,891.31 | 98.1% |
| 73721 | Mri Scan Of Leg Joint | 2017 | 3,462 | \$629.09 | \$1,179.90 | 87.6% |
| 73721 | Mri Scan Of Leg Joint | 2018 | 3,312 | \$573.21 | \$1,086.07 | 89.5% |
| 73721 | Mri Scan Of Leg Joint | 2019 | 2,300 | \$609.70 | \$1,298.29 | 112.9% |
| 73721 | Mri Scan Of Leg Joint | 2020 | 1,833 | \$593.17 | \$1,270.68 | 114.2% |
| 73721 | Mri Scan Of Leg Joint | 2021 | 2,196 | \$615.90 | \$1,324.75 | 115.1% |
| 73721 | Mri Scan Of Leg Joint | 2022 | 2,034 | \$608.49 | \$1,263.52 | 107.7% |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2017 | 4,576 | \$809.80 | \$1,200.02 | 48.2% |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2018 | 4,648 | \$749.78 | \$1,099.51 | 46.6% |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2019 | 2,824 | \$786.30 | \$1,360.67 | 73.0% |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2020 | 2,843 | \$770.67 | \$1,075.26 | 39.5% |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2021 | 3,460 | \$960.91 | \$879.43 | -8.5% |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2022 | 2,400 | \$818.36 | \$1,144.92 | 39.9% |
| 77063 | Screening Digital Tomography Of Both Breasts | 2017 | 17,012 | \$76.01 | \$40.12 | -47.2% |
| 77063 | Screening Digital Tomography Of Both Breasts | 2018 | 24,281 | \$88.33 | \$44.66 | -49.4% |
| 77063 | Screening Digital Tomography Of Both Breasts | 2019 | 22,995 | \$92.94 | \$50.61 | -45.5% |
| 77063 | Screening Digital Tomography Of Both Breasts | 2020 | 21,134 | \$97.58 | \$51.73 | -47.0% |
| 77063 | Screening Digital Tomography Of Both Breasts | 2021 | 24,761 | \$100.66 | \$53.20 | -47.2% |
| 77063 | Screening Digital Tomography Of Both Breasts | 2022 | 24,170 | \$104.49 | \$47.16 | -54.9% |
| 77067 | Mammography Of Both Breasts | 2017 | 20,354 | \$231.89 | \$231.81 | 0.0% |
| 77067 | Mammography Of Both Breasts | 2018 | 41,835 | \$249.42 | \$238.02 | -4.6% |
| 77067 | Mammography Of Both Breasts | 2019 | 34,495 | \$258.66 | \$237.98 | -8.0% |
| 77067 | Mammography Of Both Breasts | 2020 | 25,999 | \$255.44 | \$229.73 | -10.1% |
| 77067 | Mammography Of Both Breasts | 2021 | 27,579 | \$260.18 | \$227.46 | -12.6% |
| 77067 | Mammography Of Both Breasts | 2022 | 26,106 | \$254.71 | \$223.29 | -12.3% |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2017 | 2,182 | \$487.95 | \$2,144.95 | 339.6% |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2018 | 2,330 | \$495.99 | \$2,024.87 | 308.3% |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2019 | 1,738 | \$629.03 | \$2,018.66 | 220.9% |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2020 | 946 | \$643.13 | \$2,135.27 | 232.0% |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2021 | 1,009 | \$649.41 | \$2,329.26 | 258.7% |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2022 | 822 | \$625.64 | \$2,151.39 | 243.9% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2017 | 960 | \$3,066.53 | \$3,059.63 | -0.2% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2018 | 954 | \$2,922.04 | \$3,232.63 | 10.6% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2019 | 609 | \$3,268.49 | \$3,971.58 | 21.5% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2020 | 552 | \$3,075.42 | \$3,537.59 | 15.0% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2021 | 645 | \$2,889.10 | \$3,322.71 | 15.0% |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2022 | 741 | \$2,560.81 | \$3,033.29 | 18.5% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2017 | 18,870 | \$10.41 | \$61.62 | 492.1% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2018 | 19,366 | \$6.82 | \$63.00 | 823.8% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2019 | 19,081 | \$6.81 | \$66.60 | 878.7% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2020 | 15,914 | \$6.47 | \$70.94 | 997.0% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2021 | 18,938 | \$5.96 | \$62.34 | 945.3% |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2022 | 20,344 | \$5.51 | \$59.56 | 980.4% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2017 | 58,626 | \$9.67 | \$78.48 | 711.2% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2018 | 59,505 | \$8.77 | \$78.37 | 793.4% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2019 | 60,693 | \$9.14 | \$79.57 | 770.4% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2020 | 47,090 | \$9.44 | \$94.19 | 898.3% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2021 | 57,128 | \$21.07 | \$83.62 | 296.8% |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2022 | 70,017 | \$20.91 | \$74.24 | 255.1% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2017 | 32,435 | \$15.55 | \$64.14 | 312.5% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2018 | 31,482 | \$12.79 | \$63.07 | 393.3% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2019 | 31,695 | \$12.83 | \$60.36 | 370.3% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2020 | 23,208 | \$12.49 | \$68.69 | 449.9% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2021 | 29,207 | \$11.66 | \$64.58 | 453.8% |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2022 | 28,646 | \$11.00 | \$66.65 | 506.2% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2017 | 58,372 | \$7.97 | \$38.02 | 377.1% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2018 | 57,489 | \$7.67 | \$37.84 | 393.5% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2019 | 56,841 | \$7.57 | \$38.66 | 411.0% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2020 | 44,813 | \$6.57 | \$42.64 | 549.0% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2021 | 53,216 | \$6.24 | \$41.62 | 566.7% |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2022 | 53,099 | \$5.38 | \$43.55 | 710.1% |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2017 | 24,155 | \$126.95 | \$160.69 | 26.6% |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2018 | 21,879 | \$141.73 | \$164.86 | 16.3% |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2019 | 18,202 | \$146.28 | \$181.96 | 24.4% |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2020 | 13,579 | \$143.02 | \$172.34 | 20.5% |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2021 | 16,232 | \$146.65 | \$165.99 | 13.2% |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2022 | 15,808 | \$147.29 | \$188.07 | 27.7% |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2017 | 13,449 | \$12.29 | \$158.34 | 1188.8% |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2018 | 14,110 | \$13.89 | \$173.50 | 1149.1% |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2019 | 12,822 | \$15.07 | \$189.75 | 1159.3% |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2020 | 10,442 | \$14.33 | \$202.83 | 1315.8% |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2021 | 13,223 | \$13.53 | \$199.88 | 1377.5% |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2022 | 12,685 | \$13.20 | \$209.58 | 1488.0% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2017 | 11,803 | \$279.27 | \$1,080.32 | 286.8% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2018 | 11,960 | \$279.11 | \$1,059.31 | 279.5% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2019 | 7,908 | \$342.76 | \$1,228.20 | 258.3% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2020 | 6,306 | \$362.52 | \$1,211.64 | 234.2% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2021 | 7,296 | \$390.72 | \$1,235.80 | 216.3% |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2022 | 7,322 | \$374.36 | \$1,198.17 | 220.1% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2017 | 6,354 | \$122.68 | \$278.55 | 127.1% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2018 | 6,295 | \$140.44 | \$304.34 | 116.7% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2019 | 6,861 | \$128.74 | \$305.44 | 137.3% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2020 | 6,289 | \$126.33 | \$302.05 | 139.1% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2021 | 6,883 | \$151.56 | \$353.19 | 133.0% |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2022 | 6,586 | \$143.59 | \$367.46 | 155.9% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 16,113 | \$40.06 | \$83.23 | 107.7% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 11,492 | \$35.35 | \$98.32 | 178.1% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 11,054 | \$32.01 | \$110.48 | 245.1% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 11,235 | \$30.45 | \$115.37 | 278.9% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 11,739 | \$36.29 | \$118.12 | 225.4% |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 11,855 | \$35.12 | \$118.73 | 238.1% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2017 | 9,334 | \$222.33 | \$481.76 | 116.7% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2018 | 10,335 | \$213.50 | \$497.01 | 132.8% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2019 | 9,161 | \$254.40 | \$588.04 | 131.1% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2020 | 9,335 | \$266.18 | \$640.60 | 140.7% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2021 | 9,505 | \$325.35 | \$697.49 | 114.4% |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2022 | 9,632 | \$323.03 | \$699.60 | 116.6% |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2017 | 68,023 | \$27.50 | \$67.08 | 143.9% |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2018 | 78,463 | \$22.53 | \$78.29 | 247.5% |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2019 | 75,924 | \$22.95 | \$84.97 | 270.2% |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2020 | 62,580 | \$25.11 | \$84.44 | 236.3% |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2021 | 74,792 | \$28.94 | \$83.15 | 187.3% |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2022 | 74,271 | \$26.76 | \$92.49 | 245.6% |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2017 | 42,496 | \$28.28 | \$71.95 | 154.4% |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2018 | 49,921 | \$20.51 | \$73.34 | 257.6% |

| | | | | | | |
|-------|---|------|--------|----------|---------|--------|
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2019 | 49,859 | \$20.65 | \$82.54 | 299.7% |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2020 | 37,640 | \$23.89 | \$83.92 | 251.3% |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2021 | 41,890 | \$32.77 | \$85.96 | 162.4% |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2022 | 38,853 | \$32.83 | \$94.11 | 186.6% |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2017 | 24,403 | \$28.10 | \$74.53 | 165.3% |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2018 | 26,878 | \$24.73 | \$75.41 | 204.9% |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2019 | 25,869 | \$26.61 | \$76.47 | 187.4% |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2020 | 21,702 | \$32.60 | \$76.13 | 133.5% |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2021 | 25,207 | \$32.93 | \$78.59 | 138.6% |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2022 | 23,805 | \$33.08 | \$83.08 | 151.2% |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2017 | 13,982 | \$55.67 | \$95.12 | 70.9% |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2018 | 15,297 | \$61.44 | \$92.53 | 50.6% |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2019 | 15,004 | \$66.34 | \$94.74 | 42.8% |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2020 | 10,740 | \$65.67 | \$95.40 | 45.3% |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2021 | 12,492 | \$71.56 | \$98.80 | 38.1% |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2022 | 16,513 | \$73.99 | \$77.65 | 4.9% |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2017 | 26,091 | \$91.28 | \$76.23 | -16.5% |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2018 | 31,394 | \$96.94 | \$76.59 | -21.0% |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2019 | 29,282 | \$105.45 | \$81.34 | -22.9% |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2020 | 19,052 | \$106.35 | \$77.65 | -27.0% |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2021 | 21,394 | \$112.00 | \$80.54 | -28.1% |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2022 | 24,420 | \$114.45 | \$75.46 | -34.1% |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2017 | 12,278 | \$130.84 | \$89.99 | -31.2% |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2018 | 12,454 | \$140.93 | \$90.08 | -36.1% |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2019 | 11,403 | \$155.84 | \$97.27 | -37.6% |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2020 | 7,622 | \$157.57 | \$95.12 | -39.6% |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2021 | 9,774 | \$158.86 | \$95.22 | -40.1% |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2022 | 11,544 | \$164.64 | \$91.84 | -44.2% |

Appendix II.C.ii - Commercial HOPD Comparison to Professional (Independent) by Year

| Code | Description | Year | HOPD Units | Professional (Independent) | HOPD | OP/Independent % Diff | Professional (Affiliated) | Professional (Independent) | HOPD | Total Units for Mix Adj. |
|----------------|-------------|------|------------|----------------------------|----------|-----------------------|---------------------------|----------------------------|-------|--------------------------|
| Combined | | 2017 | 598,584 | \$66.50 | \$125.36 | 88.5% | | | | 3,567,535 |
| Combined | | 2018 | 651,837 | \$66.69 | \$128.94 | 92.0% | 2.0% | 0.3% | 2.1% | 3,567,535 |
| Combined | | 2019 | 622,842 | \$69.60 | \$140.36 | 101.7% | 6.3% | 4.4% | 9.6% | 3,567,535 |
| Combined | | 2020 | 489,240 | \$69.07 | \$141.87 | 105.4% | -0.4% | -0.8% | 1.1% | 3,567,535 |
| Combined | | 2021 | 578,415 | \$77.12 | \$140.32 | 81.9% | 9.5% | 11.6% | -1.1% | 3,567,535 |
| Combined | | 2022 | 626,617 | \$76.36 | \$141.96 | 85.9% | -2.7% | -1.0% | 1.2% | 3,567,535 |
| Average Annual | | | | | | | 2.8% | 2.8% | 2.5% | |

| Code | Description | Year | HOPD Units | Professional (Independent) | HOPD | OP/Independent % Diff | Change over Time | | | Total Units for Mix Adj. |
|-------|---|------|------------|----------------------------|------------|-----------------------|---------------------------|----------------------------|--------|--------------------------|
| | | | | | | | Professional (Affiliated) | Professional (Independent) | HOPD | |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2017 | 1,058 | \$1,068.56 | \$1,981.53 | 85.4% | | | | 6,531 |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2018 | 1,190 | \$1,077.94 | \$1,852.94 | 71.9% | 30.2% | 0.9% | -6.5% | 6,531 |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2019 | 948 | \$1,114.59 | \$2,000.35 | 79.5% | 2.0% | 3.4% | 8.0% | 6,531 |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2020 | 981 | \$1,085.97 | \$2,011.51 | 85.2% | -1.9% | -2.6% | 0.6% | 6,531 |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2021 | 1,127 | \$1,191.20 | \$1,723.59 | 44.7% | -3.6% | 9.7% | -14.3% | 6,531 |
| 19083 | Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance | 2022 | 1,227 | \$1,110.70 | \$1,701.16 | 53.2% | -2.5% | -6.8% | -1.3% | 6,531 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2017 | 108,925 | \$4.12 | \$19.78 | 380.5% | | | | 664,342 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2018 | 111,753 | \$4.06 | \$22.82 | 462.6% | -34.6% | -1.4% | 15.4% | 664,342 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2019 | 112,322 | \$4.14 | \$26.38 | 537.4% | -6.1% | 2.0% | 15.6% | 664,342 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2020 | 85,169 | \$3.97 | \$30.12 | 659.3% | 6.0% | -4.2% | 14.2% | 664,342 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2021 | 105,721 | \$4.43 | \$25.77 | 482.0% | -6.1% | 11.6% | -14.4% | 664,342 |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample | 2022 | 140,452 | \$4.36 | \$25.81 | 491.3% | -19.3% | -1.4% | 0.1% | 664,342 |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2017 | 3,271 | \$858.66 | \$1,406.42 | 63.8% | | | | 17,939 |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2018 | 3,214 | \$735.46 | \$1,515.71 | 106.1% | 34.0% | -14.3% | 7.8% | 17,939 |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2019 | 2,952 | \$775.27 | \$1,644.29 | 112.1% | -3.0% | 5.4% | 8.5% | 17,939 |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2020 | 2,236 | \$789.41 | \$1,711.65 | 116.8% | -19.8% | 1.8% | 4.1% | 17,939 |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2021 | 3,001 | \$928.30 | \$1,753.20 | 88.9% | 21.1% | 17.6% | 2.4% | 17,939 |
| 45380 | Biopsy Of Large Bowel Using An Endoscope | 2022 | 3,265 | \$942.96 | \$1,891.31 | 100.6% | 1.6% | 1.6% | 7.9% | 17,939 |
| 73721 | Mri Scan Of Leg Joint | 2017 | 3,462 | \$648.74 | \$1,179.90 | 81.9% | | | | 15,137 |
| 73721 | Mri Scan Of Leg Joint | 2018 | 3,312 | \$617.92 | \$1,086.07 | 75.8% | -8.9% | -4.8% | -8.0% | 15,137 |
| 73721 | Mri Scan Of Leg Joint | 2019 | 2,300 | \$670.76 | \$1,298.29 | 93.6% | 6.4% | 8.6% | 19.5% | 15,137 |
| 73721 | Mri Scan Of Leg Joint | 2020 | 1,833 | \$651.52 | \$1,270.68 | 95.0% | -2.7% | -2.9% | -2.1% | 15,137 |
| 73721 | Mri Scan Of Leg Joint | 2021 | 2,196 | \$648.54 | \$1,324.75 | 104.3% | 3.8% | -0.5% | 4.3% | 15,137 |
| 73721 | Mri Scan Of Leg Joint | 2022 | 2,034 | \$627.06 | \$1,263.52 | 101.5% | -1.2% | -3.3% | -4.6% | 15,137 |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2017 | 4,576 | \$846.38 | \$1,200.02 | 41.8% | | | | 20,751 |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2018 | 4,648 | \$845.27 | \$1,099.51 | 30.1% | -7.4% | -0.1% | -8.4% | 20,751 |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2019 | 2,824 | \$937.30 | \$1,360.67 | 45.2% | 4.9% | 10.9% | 23.8% | 20,751 |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2020 | 2,843 | \$930.81 | \$1,075.26 | 15.5% | -2.0% | -0.7% | -21.0% | 20,751 |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2021 | 3,460 | \$1,079.43 | \$879.43 | -18.5% | 24.7% | 16.0% | -18.2% | 20,751 |
| 74177 | Ct Scan Of Abdomen And Pelvis With Contrast | 2022 | 2,400 | \$1,014.72 | \$1,144.92 | 12.8% | -14.8% | -6.0% | 30.2% | 20,751 |
| 77063 | Screening Digital Tomography Of Both Breasts | 2017 | 17,012 | \$82.77 | \$40.12 | -51.5% | | | | 134,353 |
| 77063 | Screening Digital Tomography Of Both Breasts | 2018 | 24,281 | \$74.77 | \$44.66 | -40.3% | 16.2% | -9.7% | 11.3% | 134,353 |
| 77063 | Screening Digital Tomography Of Both Breasts | 2019 | 22,995 | \$72.61 | \$50.61 | -30.3% | 5.2% | -2.9% | 13.3% | 134,353 |
| 77063 | Screening Digital Tomography Of Both Breasts | 2020 | 21,134 | \$80.95 | \$51.73 | -36.1% | 5.0% | 11.5% | 2.2% | 134,353 |
| 77063 | Screening Digital Tomography Of Both Breasts | 2021 | 24,761 | \$98.85 | \$53.20 | -46.2% | 3.2% | 22.1% | 2.8% | 134,353 |
| 77063 | Screening Digital Tomography Of Both Breasts | 2022 | 24,170 | \$102.33 | \$47.16 | -53.9% | 3.8% | 3.5% | -11.3% | 134,353 |
| 77067 | Mammography Of Both Breasts | 2017 | 20,354 | \$204.45 | \$231.81 | 13.4% | | | | 176,368 |
| 77067 | Mammography Of Both Breasts | 2018 | 41,835 | \$241.10 | \$238.02 | -1.3% | 7.6% | 17.9% | 2.7% | 176,368 |
| 77067 | Mammography Of Both Breasts | 2019 | 34,495 | \$247.74 | \$237.98 | -3.9% | 3.7% | 2.8% | 0.0% | 176,368 |
| 77067 | Mammography Of Both Breasts | 2020 | 25,999 | \$239.75 | \$229.73 | -4.2% | -1.2% | -3.2% | -3.5% | 176,368 |
| 77067 | Mammography Of Both Breasts | 2021 | 27,579 | \$275.24 | \$227.46 | -17.4% | 1.9% | 14.8% | -1.0% | 176,368 |
| 77067 | Mammography Of Both Breasts | 2022 | 26,106 | \$260.97 | \$223.29 | -14.4% | -2.1% | -5.2% | -1.8% | 176,368 |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2017 | 2,182 | \$796.46 | \$2,144.95 | 169.3% | | | | 9,027 |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2018 | 2,330 | \$806.77 | \$2,024.87 | 151.0% | 1.6% | 1.3% | -5.6% | 9,027 |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2019 | 1,738 | \$864.80 | \$2,018.66 | 133.4% | 26.8% | 7.2% | -0.3% | 9,027 |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2020 | 946 | \$841.29 | \$2,135.27 | 153.8% | 2.2% | -2.7% | 5.8% | 9,027 |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2021 | 1,009 | \$966.60 | \$2,329.26 | 141.0% | 1.0% | 14.9% | 9.1% | 9,027 |
| 78452 | Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies | 2022 | 822 | \$974.59 | \$2,151.39 | 120.7% | -3.7% | 0.8% | -7.6% | 9,027 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2017 | 960 | \$2,710.13 | \$3,059.63 | 12.9% | | | | 4,461 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2018 | 954 | \$2,726.66 | \$3,232.63 | 18.6% | -4.7% | 0.6% | 5.7% | 4,461 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2019 | 609 | \$2,925.51 | \$3,971.58 | 35.8% | 11.9% | 7.3% | 22.9% | 4,461 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2020 | 552 | \$2,904.16 | \$3,537.59 | 21.8% | -5.9% | -0.7% | -10.9% | 4,461 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2021 | 645 | \$3,135.32 | \$3,322.71 | 6.0% | -6.1% | 8.0% | -6.1% | 4,461 |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh | 2022 | 741 | \$2,921.62 | \$3,033.29 | 3.8% | -11.4% | -6.8% | -8.7% | 4,461 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2017 | 18,870 | \$17.05 | \$61.62 | 261.4% | | | | 112,513 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2018 | 19,366 | \$15.69 | \$63.00 | 301.6% | -34.5% | -8.0% | 2.2% | 112,513 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2019 | 19,081 | \$14.53 | \$66.60 | 358.5% | -0.2% | -7.4% | 5.7% | 112,513 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2020 | 15,914 | \$13.45 | \$70.94 | 427.4% | -5.0% | -7.4% | 6.5% | 112,513 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2021 | 18,938 | \$14.19 | \$62.34 | 339.2% | -7.8% | 5.5% | -12.1% | 112,513 |
| 80048 | Blood Test, Basic Group Of Blood Chemicals | 2022 | 20,344 | \$14.55 | \$59.56 | 309.3% | -7.6% | 2.5% | -4.5% | 112,513 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2017 | 58,626 | \$13.50 | \$78.48 | 481.5% | | | | 353,059 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2018 | 59,505 | \$12.87 | \$78.37 | 509.1% | -9.3% | -4.7% | -0.1% | 353,059 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2019 | 60,693 | \$12.05 | \$79.57 | 560.6% | 4.2% | -6.4% | 1.5% | 353,059 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2020 | 47,090 | \$11.39 | \$94.19 | 726.6% | 3.2% | -5.4% | 18.4% | 353,059 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2021 | 57,128 | \$11.48 | \$83.62 | 628.6% | 123.3% | 0.7% | -11.2% | 353,059 |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals | 2022 | 70,017 | \$11.63 | \$74.24 | 538.1% | -0.8% | 1.4% | -11.2% | 353,059 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2017 | 32,435 | \$29.81 | \$64.14 | 115.2% | | | | 176,673 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2018 | 31,482 | \$26.84 | \$63.07 | 135.0% | -17.8% | -10.0% | -1.7% | 176,673 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2019 | 31,695 | \$25.12 | \$60.36 | 140.3% | 0.4% | -6.4% | -4.3% | 176,673 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2020 | 23,208 | \$23.34 | \$68.69 | 194.3% | -2.7% | -7.1% | 13.8% | 176,673 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2021 | 29,207 | \$24.40 | \$64.58 | 164.7% | -6.6% | 4.5% | -6.0% | 176,673 |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) | 2022 | 28,646 | \$23.86 | \$66.65 | 179.4% | -5.7% | -2.2% | 3.2% | 176,673 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2017 | 58,372 | \$12.95 | \$38.02 | 193.6% | | | | 323,830 |

| | | | | | | | | | | |
|-------|---|------|--------|----------|------------|---------|--------|-------|--------|---------|
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2018 | 57,489 | \$11.76 | \$37.84 | 221.8% | -3.8% | -9.2% | -0.5% | 323,830 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2019 | 56,841 | \$11.62 | \$38.66 | 232.7% | -1.3% | -1.2% | 2.2% | 323,830 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2020 | 44,813 | \$11.03 | \$42.64 | 286.7% | -13.2% | -5.1% | 10.3% | 323,830 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2021 | 53,216 | \$11.25 | \$41.62 | 269.8% | -5.0% | 2.1% | -2.4% | 323,830 |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test | 2022 | 53,099 | \$10.97 | \$43.55 | 296.9% | -13.9% | -2.5% | 4.6% | 323,830 |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2017 | 24,155 | \$106.01 | \$160.69 | 51.6% | | | | 109,855 |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2018 | 21,879 | \$99.96 | \$164.86 | 64.9% | 11.6% | -5.7% | 2.6% | 109,855 |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2019 | 18,202 | \$94.14 | \$181.96 | 93.3% | 3.2% | -5.8% | 10.4% | 109,855 |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2020 | 13,579 | \$93.80 | \$172.34 | 83.7% | -2.2% | -0.4% | -5.3% | 109,855 |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2021 | 16,232 | \$110.13 | \$165.99 | 50.7% | 2.5% | 17.4% | -3.7% | 109,855 |
| 88305 | Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity | 2022 | 15,808 | \$141.18 | \$188.07 | 33.2% | 0.4% | 28.2% | 13.3% | 109,855 |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2017 | 13,449 | \$12.92 | \$158.34 | 1125.8% | | | | 76,731 |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2018 | 14,110 | \$13.78 | \$173.50 | 1159.1% | 13.0% | 6.7% | 9.6% | 76,731 |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2019 | 12,822 | \$14.23 | \$189.75 | 1233.1% | 8.5% | 3.3% | 9.4% | 76,731 |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2020 | 10,442 | \$13.31 | \$202.83 | 1423.3% | -4.9% | -6.5% | 6.9% | 76,731 |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2021 | 13,223 | \$13.54 | \$199.88 | 1375.8% | -5.6% | 1.7% | -1.5% | 76,731 |
| 93005 | Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads | 2022 | 12,685 | \$13.72 | \$209.58 | 1427.4% | -2.4% | 1.3% | 4.9% | 76,731 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2017 | 11,803 | \$359.19 | \$1,080.32 | 200.8% | | | | 52,595 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2018 | 11,960 | \$351.62 | \$1,059.31 | 201.3% | -0.1% | -2.1% | -1.9% | 52,595 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2019 | 7,908 | \$360.85 | \$1,228.20 | 240.4% | 22.8% | 2.6% | 15.9% | 52,595 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2020 | 6,306 | \$379.44 | \$1,211.64 | 219.3% | 5.8% | 5.2% | -1.3% | 52,595 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2021 | 7,296 | \$477.21 | \$1,235.80 | 159.0% | 7.8% | 25.8% | 2.0% | 52,595 |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function | 2022 | 7,322 | \$471.67 | \$1,198.17 | 154.0% | -4.2% | -1.2% | -3.0% | 52,595 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2017 | 6,354 | \$118.40 | \$278.55 | 135.3% | | | | 39,268 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2018 | 6,295 | \$114.55 | \$304.34 | 165.7% | 14.5% | -3.3% | 9.3% | 39,268 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2019 | 6,861 | \$124.54 | \$305.44 | 145.3% | -8.3% | 8.7% | 0.4% | 39,268 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2020 | 6,289 | \$128.57 | \$302.05 | 134.9% | -1.9% | 3.2% | -1.1% | 39,268 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2021 | 6,883 | \$134.32 | \$353.19 | 162.9% | 20.0% | 4.5% | 16.9% | 39,268 |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour | 2022 | 6,586 | \$124.09 | \$367.46 | 196.1% | -5.3% | -7.6% | 4.0% | 39,268 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2017 | 16,113 | \$35.03 | \$83.23 | 137.6% | | | | 73,488 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2018 | 11,492 | \$33.21 | \$98.32 | 196.0% | -11.8% | -5.2% | 18.1% | 73,488 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2019 | 11,054 | \$32.90 | \$110.48 | 235.8% | -9.4% | -1.0% | 12.4% | 73,488 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2020 | 11,235 | \$32.34 | \$115.37 | 256.7% | -4.9% | -1.7% | 4.4% | 73,488 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2021 | 11,739 | \$31.17 | \$118.12 | 279.0% | 19.2% | -3.6% | 2.4% | 73,488 |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention | 2022 | 11,855 | \$32.08 | \$118.73 | 270.2% | -3.2% | 2.9% | 0.5% | 73,488 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2017 | 9,334 | \$225.92 | \$481.76 | 113.2% | | | | 57,302 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2018 | 10,335 | \$219.84 | \$497.01 | 126.1% | -4.0% | -2.7% | 3.2% | 57,302 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2019 | 9,161 | \$240.08 | \$588.04 | 144.9% | 19.2% | 9.2% | 18.3% | 57,302 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2020 | 9,335 | \$246.37 | \$640.60 | 160.0% | 4.6% | 2.6% | 8.9% | 57,302 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2021 | 9,505 | \$269.98 | \$697.49 | 158.3% | 22.2% | 9.6% | 8.9% | 57,302 |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour | 2022 | 9,632 | \$261.96 | \$699.60 | 167.1% | -0.7% | -3.0% | 0.3% | 57,302 |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2017 | 68,023 | \$30.02 | \$67.08 | 123.5% | | | | 434,053 |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2018 | 78,463 | \$30.27 | \$78.29 | 158.6% | -18.1% | 0.8% | 16.7% | 434,053 |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2019 | 75,924 | \$33.42 | \$84.97 | 154.3% | 1.9% | 10.4% | 8.5% | 434,053 |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2020 | 62,580 | \$32.32 | \$84.44 | 161.3% | 9.4% | -3.3% | -0.6% | 434,053 |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2021 | 74,792 | \$33.03 | \$83.15 | 151.7% | 15.3% | 2.2% | -1.5% | 434,053 |
| 97110 | Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes | 2022 | 74,271 | \$32.08 | \$92.49 | 188.3% | -7.6% | -2.9% | 11.2% | 434,053 |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2017 | 42,496 | \$24.06 | \$71.95 | 199.1% | | | | 260,659 |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2018 | 49,921 | \$23.40 | \$73.34 | 213.4% | -27.5% | -2.7% | 1.9% | 260,659 |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2019 | 49,859 | \$25.58 | \$82.54 | 222.7% | 0.7% | 9.3% | 12.6% | 260,659 |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2020 | 37,640 | \$26.29 | \$83.92 | 219.2% | 15.7% | 2.8% | 1.7% | 260,659 |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2021 | 41,890 | \$27.15 | \$85.96 | 216.6% | 37.2% | 3.3% | 2.4% | 260,659 |
| 97140 | Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes | 2022 | 38,853 | \$26.40 | \$94.11 | 256.5% | 0.2% | -2.8% | 9.5% | 260,659 |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2017 | 24,403 | \$27.41 | \$74.53 | 171.9% | | | | 147,864 |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2018 | 26,878 | \$29.79 | \$75.41 | 153.1% | -12.0% | 8.7% | 1.2% | 147,864 |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2019 | 25,869 | \$30.88 | \$76.47 | 147.6% | 7.6% | 3.7% | 1.4% | 147,864 |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2020 | 21,702 | \$32.02 | \$76.13 | 137.8% | 22.5% | 3.7% | -0.4% | 147,864 |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2021 | 25,207 | \$31.18 | \$78.59 | 152.0% | 1.0% | -2.6% | 3.2% | 147,864 |
| 97530 | Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes | 2022 | 23,805 | \$31.48 | \$83.08 | 164.0% | 0.4% | 0.9% | 5.7% | 147,864 |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2017 | 13,982 | \$54.40 | \$95.12 | 74.9% | | | | 84,028 |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2018 | 15,297 | \$54.71 | \$92.53 | 69.1% | 10.4% | 0.6% | -2.7% | 84,028 |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2019 | 15,004 | \$58.70 | \$94.74 | 61.4% | 8.0% | 7.3% | 2.4% | 84,028 |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2020 | 10,740 | \$56.89 | \$95.40 | 67.7% | -1.0% | -3.1% | 0.7% | 84,028 |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2021 | 12,492 | \$63.51 | \$98.80 | 55.6% | 9.0% | 11.6% | 3.6% | 84,028 |
| 99212 | Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes | 2022 | 16,513 | \$66.17 | \$77.65 | 17.3% | 3.4% | 4.2% | -21.4% | 84,028 |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2017 | 26,091 | \$91.78 | \$76.23 | -16.9% | | | | 151,633 |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2018 | 31,394 | \$93.25 | \$76.59 | -17.9% | 6.2% | 1.6% | 0.5% | 151,633 |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2019 | 29,282 | \$98.34 | \$81.34 | -17.3% | 8.8% | 5.5% | 6.2% | 151,633 |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2020 | 19,052 | \$94.15 | \$77.65 | -17.5% | 0.9% | -4.3% | -4.5% | 151,633 |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2021 | 21,394 | \$101.07 | \$80.54 | -20.3% | 5.3% | 7.3% | 3.7% | 151,633 |
| 99213 | Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes | 2022 | 24,420 | \$102.68 | \$75.46 | -26.5% | 2.2% | 1.6% | -6.3% | 151,633 |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2017 | 12,278 | \$132.29 | \$89.99 | -32.0% | | | | 65,075 |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2018 | 12,454 | \$134.62 | \$90.08 | -33.1% | 7.7% | 1.8% | 0.1% | 65,075 |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2019 | 11,403 | \$142.94 | \$97.27 | -32.0% | 10.6% | 6.2% | 8.0% | 65,075 |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2020 | 7,622 | \$137.12 | \$95.12 | -30.6% | 1.1% | -4.1% | -2.2% | 65,075 |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2021 | 9,774 | \$145.06 | \$95.22 | -34.4% | 0.8% | 5.8% | 0.1% | 65,075 |
| 99214 | Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes | 2022 | 11,544 | \$145.99 | \$91.84 | -37.1% | 3.6% | 0.6% | -3.5% | 65,075 |

Appendix M. Medicare Hospital Outpatient Department Off Campus Comparison



October 1, 2024

Subject: Colorado Facility Fee – Medicare HOPD – Off-Campus Analytics

Medicare HOPD Off-Campus Comparison

Overview

CBIZ Optumas (Optumas) was contracted by the Colorado Department of Health Care Policy and Financing (HCPF) to explore the policies, practices, and costs to Colorado health payers of facility fees as outlined in HB23-1215. Optumas was tasked with comparing professional fees and hospital outpatient department (HOPD) facility fees at off-campus locations for the same services. The Colorado All Payer Claims Database (APCD) provided by the Center for Improving Value in Healthcare (CIVHC) was utilized for this analysis across the 2017 to 2022 calendar years. The APCD contains claims data from Medicare, Medicaid, and Commercial payers within the State of Colorado. The purpose of this memo is to detail the methodology used to identify hospital outpatient department (HOPD) facility fees at off-campus locations and compare against the comparable professional fees for the same services. The comparison focuses on Medicare data for off-campus providers due to data limitations on identifying off-campus providers within the Commercial data.

Additionally, Optumas is providing the following Supplemental summaries for off-campus HOPD services:

- Top codes based on frequency
- Top codes based on allowed amount
- Total HOPD off-campus allowed amount by hospital and health system
- Total HOPD combined on- and off-campus allowed amount by hospital and health system

Data Validation

Optumas reviewed the data for all the requested fields to ensure they were complete and had the expected valid values. This review indicated that we received appropriate data aligned with our data request that would allow us to continue with the analysis. We then reviewed the visit volume and financial field volume on a monthly longitudinal basis by service type and program. This review indicated that we did not have any major gaps or anomalies in the data. Optumas will note that we did not audit the APCD data and are relying on the accuracy of the data provided.

Optumas also compared the Medicare-specific data within APCD to determine what proportion of Medicare members were reflected within the dataset. That analysis indicated that for the 2017-2022 time period, the APCD reflects 95% of both Medicare and Medicare Advantage members. See Table 1 below.

Table 1. Medicare Membership Benchmark. Total Medicare Membership

| Period | CMS Reported Medicare Enrollment | APCD | % of Benchmark |
|--------|----------------------------------|---------|----------------|
| 2017 | 847,702 | 807,492 | 95% |
| 2018 | 881,043 | 834,766 | 95% |
| 2019 | 911,545 | 860,660 | 94% |
| 2020 | 938,949 | 886,492 | 94% |
| 2021 | 961,592 | 921,281 | 96% |
| 2022 | 983,947 | 946,661 | 96% |

HOPD Facility Fee Identification

HOPD Facility Fee Data

Each outpatient visit at a HOPD will generate a facility fee billed to the patient, and in many cases an additional bill for the individual physician’s professional fees. The following discusses the identification of the HOPD facility fee portion of the HOPD related outpatient visits.

Optumas first identified all HOPD claims within the APCD using a delineation provided by CIVHC to identify hospital outpatient claims. Optumas validated that delineation by reviewing the Bill Type provided on each claim to confirm they were appropriately identified. Bill Type is a nationally standardized set of codes for institutional/facility-based services that provides information on the type of bill the provider is submitting to the payer. We created a subset of the data for this comparison to claims that had the following Bill Type to ensure isolation to HOPD claims:

- “131” – Hospital, outpatient, admit through discharge¹.
- “851” – Critical Access Hospital, outpatient, admit through discharge¹.

Additionally, Optumas limited the data to non-Emergency Room outpatient claims within the APCD. After discussion with the Hospital Facility Fee Steering Committee, it was determined to exclude all Emergency Room claims from the analytics. Optumas also removed any services that had been denied by the payer. This final HOPD data set serves as the basis for identifying the facility fees for Colorado based providers.

On-campus/Off-campus

To identify the on-campus and off-campus visits, Optumas first looked to the Place of Service on each claim. Place of Service is a nationally standardized set of codes that provides information on the location of the visit between the patient and provider. While this field is provided in the data, unfortunately there is a data limitation due to it not being populated for facility-related claims within the APCD. Optumas explored the following alternative approaches by payer type. The results are that an alternative option was identified for Medicare, however; the off-campus clinic visits were not able to be delineated within the Commercial data.

¹ <https://med.noridianmedicare.com/web/jea/topics/claim-submission/bill-types>

Medicare

1. Modifiers

- a. Medicare requires that off-campus clinics include specific modifiers – PN, PO, ER – on the claim form along with the Current Procedural Terminology (CPT) code that identifies the service that is provided.
 - i. PO – Excepted service provided at an off-campus, outpatient, provider-based department of a hospital.
 - ii. PN – Non-expected service provided at an off-campus, outpatient, provider-based department of a hospital.
 - iii. ER – Items and services furnished by a provider-based off-campus emergency department.
 1. This modifier was ultimately not used given that emergency department visits are excluded from the analysis.
- b. Using this information, we identified any instance of either PN or PO modifier on any individual line on a claim. We then identified that entire claim as a HOPD off-campus visit. This approach identified \$60M to \$90M per year in the Medicare data.

Commercial

1. Modifiers

- a. Commercial billing and payment policies differ from Medicare related to off-campus HOPD billing, and do not require the inclusion of specific modifiers be documented for off-campus payments.
- b. Therefore, this approach was not able to be leveraged for Commercial data.

2. National Payer Identification (NPI)

- a. We reviewed a third method in trying to track down the off-campus locations by NPI based on the off-campus clinic NPIs provided via the hospital provider surveys. However; we ran into data limitations here as well.
- b. There are two provider NPI fields in the APCD:
 - i. Billing NPI – this generally reflected the hospital/hospital system that owns the off-campus clinic, and did not get any significant matches to the individual off-campus NPIs that were provided via the hospital provider surveys.
 - ii. Servicing NPI –this generally reflected the individual physician that was present during the service, and again did not get any significant matches to the individual off-campus NPIs that were provided via the hospital provider surveys.
- c. Given the above, we are also limited in using any NPIs from the Medicare off-campus data as those would also flag either the main hospital/hospital system, or an individual physician, and not necessarily the specific off-campus clinic.

3. Place of Service (professional component)

- a. As a final potential option, we looked at using the Place of Service that was on the professional fee claim component of an outpatient visits, and aligning that with the HOPD facility fee claim.
- b. We limited the professional claims to a Place of Service of '19' (Off-campus clinic), and then looked for any HOPD claims for the same member and date of service.
- c. This approach did result in some data being able to be flagged as off-campus, but it was a much smaller amount than we observed in Medicare.

- d. The result is a limited dataset that may not be credible for accurate professional and facility fee comparison.

Professional Fee Data

The professional claims to be used for the comparison were also delineated within the APCD by CIVHC. Optumas validated that delineation by reviewing the Place of Service (POS) provided on each claim to confirm they were appropriately identified. Optumas found that the POS were all generally related to a professional setting, however; we further delineated that data for this comparison to claims that had the following Place of Service² codes:

- 11 – Office
- 12 – Home
- 81 – Independent Laboratory

Optumas also found Places of Service for the professional fee component of a HOPD outpatient visit. These were excluded so that the comparison focused on the professional fees provided during a patient visit that was independent of an outpatient visit. Finally, Optumas removed any services that had been denied by the payer. This final professional data set services as the basis for identifying the professional fees for Colorado based providers.

Independent/Affiliated Providers

To identify independent and hospital-affiliated providers, Optumas leveraged an additional third-party dataset that provides information on each individual provider and if they are affiliated with a hospital or health system for each year, including which health system they are affiliated with at that time. This information was aligned with the APCD by the servicing provider NPI, which identifies the individual practitioner present for the visit. The additional third-party dataset includes physicians that are either Medical Doctors (MDs) or Doctors of Osteopathy (DOs).

² <https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>

Comparison Methodology and Analytics

The comparison of the facility fee and professional fees for the same services is based on using the allowed amount in APCD for the datasets and provider splits identified above. The comparison focuses on the same service provided in either a HOPD setting or a professional setting. It should be noted that the professional fees in this comparison are for services provided in a professional setting only, and do not reflect the professional fee component of an outpatient visit. The allowed amount reflects the contracted rate between the provider and payer, and reflects the total reimbursement for the services provided. The following identifies additional data adjustments and methodology for the comparison.

Grouped Payments

Optumas is aware that some HOPD visits are paid on a grouped basis, which means that all services provided during a visit are grouped together into one overall payment. The result is that the allowed amount listed on a claim for an individual CPT code may not reflect the payment for that individual service, but rather for the entire visits as a whole which may include other services. Inclusion of these grouped payments would skew the HOPD cost per service upward for those individual codes, and would not be appropriate for the comparison. Optumas identified these instances by comparing the overall allowed amount for a visit to the individual allowed amount for each service (CPT code) during a visit. In the instances where they were the same amount, we removed those from the data prior to performing the comparison analysis.

Zero (\$0) Allowed Amount

If a service (CPT code) had a \$0 allowed amount, in either the HOPD or Professional data, it was excluded from the analysis to avoid skewing the cost per service downward.

Modifiers

The comparison is based on the CPT codes that identify each individual service provided during a visit in the claims data, however; Optumas understands that there are also modifiers that can be associated with a CPT code that may further modify the allowed amount for that service. For this comparison, Optumas included any instances of either modifier TC (Technical Component) or 26 (Professional Component) along with the CPT code to ensure that variation driven by these modifiers was controlled for in the calculation of the allowed amount per service comparison.

Allowed per Service

The comparison is done at the individual CPT code level based on the allowed amount per service. The allowed amount per service is based on the allowed amount for each CPT code relative to the detailed units of that individual service that was provided as reported on the claim in APCD. The service units itemize the number of units associated with each individual CPT code (service provided), which indicates how much to reimburse the provider for that service. In the majority of cases, the detailed units are one (1) based on providing one instance of that individual service, but in some cases may be greater than one (1) depending on the type of service provided and the billing guidelines for that service. This

approach ensures that we are accounting and controlling for those instances for an accurate comparison when calculating the allowed amount per service.

Outliers

Once the above data adjustments were taken into account, the allowed amount per service reviewed for any outliers. This was done for each unique combination of the following:

- Payer
 - Medicare
 - Medicare Advantage
- CPT/modifier combination
- For each of the three comparison groups:
 - HOPD
 - Professional affiliated
 - Professional independent

The result allowed Optumas to isolate and remove the top 5% of the allowed amount per service for each of the combinations above. This was done to remove any data anomalies or outlier contracting agreements that could further skew the comparison.

Weighted Average

After outliers were removed, Optumas calculated the average allowed amount per service for each of the unique combinations noted above. The approach reflects the weighted average of the allowed amount per service based on the utilization of each code within the APCD. Optumas also reviewed the use of the median allowed amount per service, which returned similar results for higher utilized services, but had more variability for lower utilized services included in the comparison. The result was the selection of the utilization weighted average allowed amount per service.

Final Code Selection

In order to ensure an informative comparison, an initial selection of the top 50 codes were selected based on highest frequency of utilization and also highest allowed amount within the HOPD data between each payer. The result is a list of codes that reflects highly utilized services, along with services that may have lower overall utilization but that reflect a higher proportion of allowed amounts due to the higher cost nature of those services. The list excludes injectable drugs (J-series codes) due to the additional complexity around the pricing of those codes.

We then looked for those top HOPD codes within the Professional data, and only included the codes that were in both datasets for the final comparison. Additionally, Optumas set a minimum limit of at least twenty-five (25) individual instances of each code within the either dataset to account for credibility and stability of the contracted amount for those codes. The final list was limited to the top 25 codes that were found in both datasets, by payer, that also met the minimum utilization threshold.

Appendices I.A.i to I.A.ii include the list of the final top 25 codes for Medicare Off-Campus comparison aggregated across the six years of data. The codes are in numerical order.

Appendices II.A.i to II.A.ii include the list of the final top 25 codes for Medicare Off-Campus comparison for each year. The codes are in numerical order. These are provided in a separate Excel appendix.

Appendices III.A includes the full definition of each code used for the comparison.

Results & Key Findings

Overall

The overall observation was that HOPD off-campus facility fees were higher than the professional fees for the same services when provided in a professional site of service. This was the case for both hospital affiliated and independent providers. The resulting impact indicates that the HOPD off-campus facility fees contributed approximately \$2.5M in allowed health care amounts when compared against affiliated professional fees for the top codes reviewed, and approximately \$2.2M in allowed health care amounts when compared against independent professional fees for the top codes reviewed. This is based on using the HOPD off-campus volume of utilization and mix of services. This impact is intended to highlight reimbursement differences, and does not comment on feasibility of impacting actual allowed amounts due to utilization shifting between sites of service.

Hospital Resource Billing Note

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 codes being compared, the final total amount the patient and payer are responsible for could be higher in a HOPD setting due to the inclusion of G0463 for the overall visit reimbursement.

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 reimbursement, driven by Medicare FFS billing guidelines that are consistent across professional fees. The resulting impact indicates that the HOPD facility fees contributed \$1.7M in allowed health care amounts 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 - were reimbursed at a similar level between HOPD and professional settings.
- Radiology - had 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 - were 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 provider fees and 50% higher than affiliated providers. The resulting impact indicates that the HOPD facility fees contributed between \$470k and \$830k in allowed health care amounts relative to independent affiliated or professional fees, respectively. This is based on using the HOPD off-campus volume of utilization and mix of services for both comparisons.

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 view 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 - had 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 - had 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 - was the highest contributing service at about 40% of the overall increased reimbursement for the top codes reviewed.

Appendix I.A.i Medicare FFS Off-campus HOPD Comparison to Professional (Affiliated)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Affiliated) | HOPD | HOPD/Affiliated % Diff | Dollar Difference |
|-----------------|----------------------------|----------------|-------------------------|---------------------------|----------------|------------------------|--------------------|
| Combined | | Average | 165,142 | \$16.80 | \$27.18 | 61.8% | \$1,714,413 |
| 20610 | Injection into large joint | Average | 1,024 | \$67.97 | \$263.29 | 287.4% | \$200,040 |
| 36415 | Routine Venipuncture | Average | 48,617 | \$2.96 | \$2.96 | 0.1% | \$77 |
| 67028 | Injection Of Drug Into Eye | Average | 547 | \$117.38 | \$198.87 | 69.4% | \$44,587 |
| 70553 | Radiology | Average | 3,008 | \$55.33 | \$25.55 | -53.8% | -\$89,606 |
| 71250 | Radiology | Average | 275 | \$40.65 | \$110.99 | 173.0% | \$19,343 |
| 77300 | Radiology | Average | 1,088 | \$83.13 | \$109.03 | 31.2% | \$28,185 |
| 77301 | Radiology | Average | 575 | \$487.66 | \$1,248.58 | 156.0% | \$437,405 |
| 77334 | Radiology | Average | 8,330 | \$9.10 | \$9.26 | 1.8% | \$1,398 |
| 78815 | Radiology | Average | 23,468 | \$10.94 | \$11.32 | 3.5% | \$8,942 |
| 80048 | Laboratory | Average | 16,917 | \$14.00 | \$14.24 | 1.7% | \$3,986 |
| 80053 | Laboratory | Average | 4,184 | \$3.49 | \$3.52 | 0.9% | \$126 |
| 80061 | Laboratory | Average | 2,040 | \$6.11 | \$6.45 | 5.6% | \$697 |
| 82306 | Laboratory | Average | 8,097 | \$10.40 | \$10.79 | 3.7% | \$3,154 |
| 83036 | Laboratory | Average | 18,849 | \$8.49 | \$8.41 | -1.0% | -\$1,613 |
| 84443 | Laboratory | Average | 4,792 | \$6.89 | \$6.83 | -0.9% | -\$287 |
| 85025 | Laboratory | Average | 3,362 | \$4.67 | \$4.56 | -2.4% | -\$371 |
| 93306 | Ultrasound | Average | 2,569 | \$2.96 | \$3.01 | 1.8% | \$138 |
| 94060 | Evaluation Of Wheezing | Average | 328 | \$209.84 | \$447.32 | 113.2% | \$77,932 |
| 96365 | Infusion and injection | Average | 99 | \$200.93 | \$224.49 | 11.7% | \$2,325 |
| 96367 | Infusion and injection | Average | 1,762 | \$73.37 | \$176.47 | 140.5% | \$181,676 |
| 96372 | Infusion and injection | Average | 487 | \$44.44 | \$174.33 | 292.3% | \$63,189 |
| 96374 | Infusion and injection | Average | 5,940 | \$17.58 | \$34.01 | 93.4% | \$97,553 |
| 96375 | Infusion and injection | Average | 4,408 | \$139.97 | \$274.72 | 96.3% | \$593,938 |
| 96413 | Chemotherapy Infusion | Average | 2,475 | \$20.85 | \$37.33 | 79.0% | \$40,776 |
| 96415 | Chemotherapy Infusion | Average | 1,904 | \$20.15 | \$20.58 | 2.2% | \$825 |

Appendix I.A.ii Medicare FFS Off-campus HOPD Comparison to Professional (Independent)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Independent) | HOPD | HOPD/ Independent % Diff | Dollar Difference |
|-----------------|----------------------------|----------------|-------------------------|-----------------------------|----------------|--------------------------|--------------------|
| Combined | | Average | 165,142 | \$16.79 | \$27.18 | 61.9% | \$1,716,046 |
| 20610 | Injection into large joint | Average | 1,024 | \$64.91 | \$263.29 | 305.6% | \$203,173 |
| 36415 | Routine Venipuncture | Average | 48,617 | \$2.96 | \$2.96 | 0.1% | \$155 |
| 67028 | Injection Of Drug Into Eye | Average | 547 | \$115.83 | \$198.87 | 71.7% | \$45,436 |
| 70553 | Radiology | Average | 3,008 | \$55.60 | \$25.55 | -54.1% | -\$90,392 |
| 71250 | Radiology | Average | 275 | \$39.93 | \$110.99 | 178.0% | \$19,542 |
| 77300 | Radiology | Average | 1,088 | \$80.66 | \$109.03 | 35.2% | \$30,870 |
| 77301 | Radiology | Average | 575 | \$476.20 | \$1,248.58 | 162.2% | \$443,995 |
| 77334 | Radiology | Average | 8,330 | \$9.33 | \$9.26 | -0.7% | -\$569 |
| 78815 | Radiology | Average | 23,468 | \$11.26 | \$11.32 | 0.6% | \$1,503 |
| 80048 | Laboratory | Average | 16,917 | \$14.35 | \$14.24 | -0.8% | -\$1,890 |
| 80053 | Laboratory | Average | 4,184 | \$3.52 | \$3.52 | 0.2% | \$28 |
| 80061 | Laboratory | Average | 2,040 | \$6.36 | \$6.45 | 1.4% | \$185 |
| 82306 | Laboratory | Average | 8,097 | \$10.69 | \$10.79 | 0.9% | \$778 |
| 83036 | Laboratory | Average | 18,849 | \$8.43 | \$8.41 | -0.3% | -\$493 |
| 84443 | Laboratory | Average | 4,792 | \$6.81 | \$6.83 | 0.3% | \$91 |
| 85025 | Laboratory | Average | 3,362 | \$4.65 | \$4.56 | -2.0% | -\$314 |
| 93306 | Ultrasound | Average | 2,569 | \$2.98 | \$3.01 | 1.2% | \$88 |
| 94060 | Evaluation Of Wheezing | Average | 328 | \$206.07 | \$447.32 | 117.1% | \$79,169 |
| 96365 | Infusion and injection | Average | 99 | \$196.05 | \$224.49 | 14.5% | \$2,807 |
| 96367 | Infusion and injection | Average | 1,762 | \$70.28 | \$176.47 | 151.1% | \$187,109 |
| 96372 | Infusion and injection | Average | 487 | \$43.38 | \$174.33 | 301.9% | \$63,706 |
| 96374 | Infusion and injection | Average | 5,940 | \$17.69 | \$34.01 | 92.2% | \$96,905 |
| 96375 | Infusion and injection | Average | 4,408 | \$140.07 | \$274.72 | 96.1% | \$593,515 |
| 96413 | Chemotherapy Infusion | Average | 2,475 | \$20.93 | \$37.33 | 78.3% | \$40,572 |
| 96415 | Chemotherapy Infusion | Average | 1,904 | \$20.54 | \$20.58 | 0.2% | \$78 |

Appendix I.B.i Medicare Advantage Off-campus HOPD Comparison to Professional (Affiliated)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Affiliated) | HOPD | HOPD/ Affiliated % Diff | Dollar Difference |
|-----------------|----------------------------|----------------|-------------------------|---------------------------|----------------|-------------------------|-------------------|
| Combined | | Average | 52,421 | \$31.81 | \$47.68 | 49.9% | \$831,887 |
| 20610 | Injection into large joint | Average | 260 | \$85.26 | \$260.95 | 206.1% | \$45,651 |
| 36430 | Blood Transfusion Service | Average | 11,233 | \$3.20 | \$3.08 | -3.9% | -\$1,388 |
| 67028 | Injection Of Drug Into Eye | Average | 154 | \$72.70 | \$346.48 | 376.6% | \$42,253 |
| 70553 | Radiology | Average | 115 | \$194.20 | \$235.90 | 21.5% | \$4,810 |
| 71250 | Radiology | Average | 566 | \$54.17 | \$30.06 | -44.5% | -\$13,651 |
| 77300 | Radiology | Average | 315 | \$39.16 | \$118.61 | 202.9% | \$25,027 |
| 77301 | Radiology | Average | 366 | \$84.20 | \$111.86 | 32.9% | \$10,129 |
| 77334 | Radiology | Average | 374 | \$516.36 | \$1,228.11 | 137.8% | \$265,957 |
| 78815 | Radiology | Average | 1,998 | \$7.51 | \$9.03 | 20.2% | \$3,035 |
| 80048 | Laboratory | Average | 5,347 | \$9.94 | \$11.06 | 11.3% | \$6,007 |
| 80053 | Laboratory | Average | 3,741 | \$12.13 | \$14.15 | 16.7% | \$7,564 |
| 80061 | Laboratory | Average | 953 | \$2.60 | \$3.38 | 29.9% | \$742 |
| 82306 | Laboratory | Average | 2,319 | \$7.56 | \$10.29 | 36.1% | \$6,327 |
| 83036 | Laboratory | Average | 4,569 | \$6.43 | \$8.26 | 28.5% | \$8,365 |
| 84443 | Laboratory | Average | 1,228 | \$4.80 | \$6.99 | 45.7% | \$2,689 |
| 85025 | Laboratory | Average | 1,209 | \$3.72 | \$4.59 | 23.5% | \$1,054 |
| 93306 | Ultrasound | Average | 494 | \$2.07 | \$2.82 | 36.6% | \$374 |
| 94060 | Evaluation Of Wheezing | Average | 1,289 | \$261.01 | \$514.33 | 97.1% | \$326,451 |
| 96365 | Infusion and injection | Average | 607 | \$117.41 | \$168.80 | 43.8% | \$31,185 |
| 96367 | Infusion and injection | Average | 166 | \$88.18 | \$163.01 | 84.9% | \$12,446 |
| 96372 | Infusion and injection | Average | 1,924 | \$31.89 | \$33.72 | 5.8% | \$3,528 |
| 96374 | Infusion and injection | Average | 1,531 | \$262.49 | \$259.18 | -1.3% | -\$5,077 |
| 96375 | Infusion and injection | Average | 7,121 | \$21.52 | \$26.31 | 22.3% | \$34,115 |
| 96413 | Chemotherapy Infusion | Average | 3,991 | \$20.48 | \$22.24 | 8.6% | \$7,001 |
| 96415 | Chemotherapy Infusion | Average | 551 | \$25.66 | \$38.91 | 51.7% | \$7,295 |

Appendix I.B.ii Medicare Advantage Off-campus HOPD Comparison to Professional (Independent)

| Code | Category | Year | HOPD Units (avg annual) | Professional (Independent) | HOPD | HOPD/ Independent % Diff | Dollar Difference |
|-----------------|----------------------------|----------------|----------------------------|-----------------------------------|----------------|--------------------------------|----------------------|
| Combined | | Average | 52,421 | \$38.68 | \$47.68 | 23.3% | \$471,505 |
| 20610 | Injection into large joint | Average | 260 | \$104.91 | \$260.95 | 148.7% | \$40,546 |
| 36430 | Blood Transfusion Service | Average | 11,233 | \$4.80 | \$3.08 | -35.9% | -\$19,347 |
| 67028 | Injection Of Drug Into Eye | Average | 154 | \$70.06 | \$346.48 | 394.5% | \$42,661 |
| 70553 | Radiology | Average | 115 | \$173.99 | \$235.90 | 35.6% | \$7,140 |
| 71250 | Radiology | Average | 566 | \$106.64 | \$30.06 | -71.8% | -\$43,355 |
| 77300 | Radiology | Average | 315 | \$70.28 | \$118.61 | 68.8% | \$15,224 |
| 77301 | Radiology | Average | 366 | \$118.35 | \$111.86 | -5.5% | -\$2,374 |
| 77334 | Radiology | Average | 374 | \$804.59 | \$1,228.11 | 52.6% | \$158,254 |
| 78815 | Radiology | Average | 1,998 | \$15.11 | \$9.03 | -40.2% | -\$12,149 |
| 80048 | Laboratory | Average | 5,347 | \$14.10 | \$11.06 | -21.6% | -\$16,252 |
| 80053 | Laboratory | Average | 3,741 | \$21.82 | \$14.15 | -35.2% | -\$28,698 |
| 80061 | Laboratory | Average | 953 | \$4.98 | \$3.38 | -32.2% | -\$1,529 |
| 82306 | Laboratory | Average | 2,319 | \$16.34 | \$10.29 | -37.0% | -\$14,028 |
| 83036 | Laboratory | Average | 4,569 | \$12.47 | \$8.26 | -33.8% | -\$19,243 |
| 84443 | Laboratory | Average | 1,228 | \$5.59 | \$6.99 | 24.9% | \$1,710 |
| 85025 | Laboratory | Average | 1,209 | \$7.84 | \$4.59 | -41.5% | -\$3,931 |
| 93306 | Ultrasound | Average | 494 | \$3.37 | \$2.82 | -16.2% | -\$271 |
| 94060 | Evaluation Of Wheezing | Average | 1,289 | \$357.62 | \$514.33 | 43.8% | \$201,945 |
| 96365 | Infusion and injection | Average | 607 | \$97.87 | \$168.80 | 72.5% | \$43,043 |
| 96367 | Infusion and injection | Average | 166 | \$85.14 | \$163.01 | 91.5% | \$12,952 |
| 96372 | Infusion and injection | Average | 1,924 | \$25.06 | \$33.72 | 34.6% | \$16,665 |
| 96374 | Infusion and injection | Average | 1,531 | \$217.97 | \$259.18 | 18.9% | \$63,089 |
| 96375 | Infusion and injection | Average | 7,121 | \$23.71 | \$26.31 | 11.0% | \$18,501 |
| 96413 | Chemotherapy Infusion | Average | 3,991 | \$20.51 | \$22.24 | 8.4% | \$6,894 |
| 96415 | Chemotherapy Infusion | Average | 551 | \$31.54 | \$38.91 | 23.4% | \$4,058 |

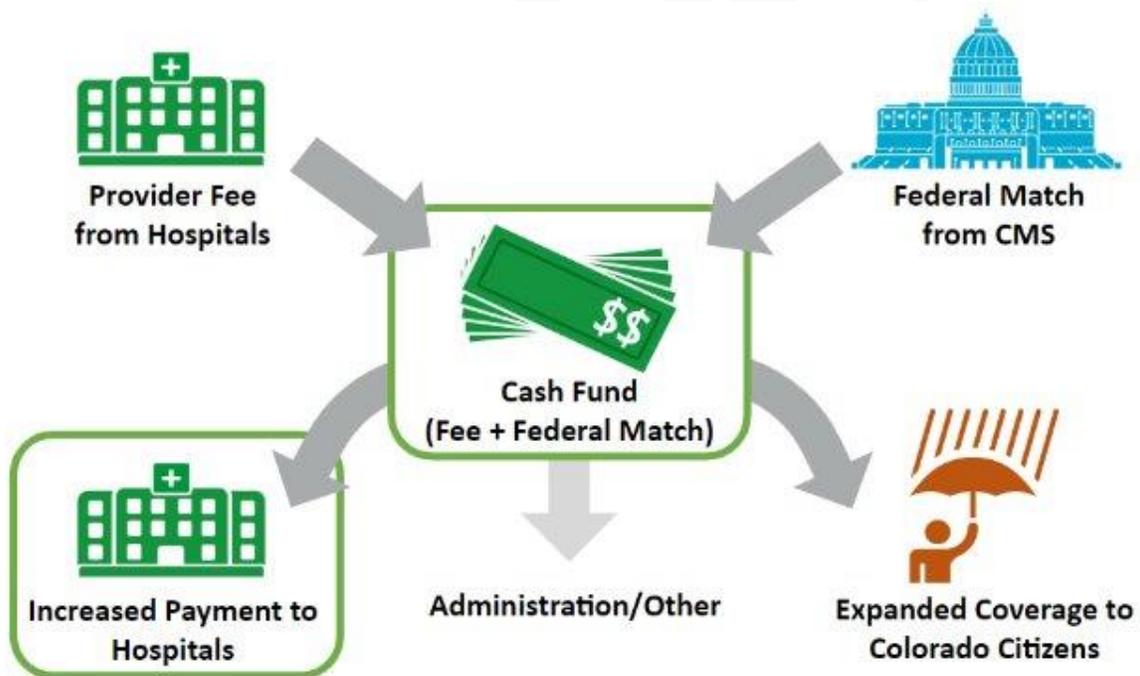
Appendix II.A Medicare Off-Campus HOPD Code Definitions

| Code | Long Description |
|--------------|---|
| 20610 | Aspiration And/Or Injection Of Large Joint Or Joint Capsule |
| 36415 | Insertion Of Needle Into Vein For Collection Of Blood Sample |
| 67028 | Injection Of Drug Into Eye |
| 70553 | Mri Scan Of Brain Before And After Contrast |
| 71250 | Ct Scan Chest |
| 77300 | Calculation Of Radiation Therapy Dose |
| 77301 | Management Of Modulation Radiotherapy Planning |
| 77334 | Radiation Treatment Devices, Design And Construction, Complex |
| 78815 | Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh |
| 80048 | Blood Test, Basic Group Of Blood Chemicals |
| 80053 | Blood Test, Comprehensive Group Of Blood Chemicals |
| 80061 | Blood Test, Lipids (Cholesterol And Triglycerides) |
| 82306 | Vitamin D-3 Level |
| 83036 | Hemoglobin A1C Level |
| 84443 | Blood Test, Thyroid Stimulating Hormone (Tsh) |
| 85025 | Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test |
| 93306 | Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function |
| 94060 | Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration |
| 96365 | Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour |
| 96367 | Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour |
| 96372 | Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention |
| 96374 | Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention |
| 96375 | Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention |
| 96413 | Infusion Of Chemotherapy Into A Vein Up To 1 Hour |
| 96415 | Infusion Of Chemotherapy Into A Vein |

Appendix N. Impact to CHASE Analysis

Through the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), HCPF assesses a hospital provider fee on acute care and Critical Access Hospitals (CAHs) 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 Health First Colorado (Colorado’s Medicaid Program) members and uninsured patients, finance the state’s expansion of health care coverage for more than 500,000 Coloradans through the Health First Colorado 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 1. 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 payments to hospitals.



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, the impact to CHASE hospital provider fee revenue due to facility fees was computed utilizing 2022 data and an estimation methodology for markets where data was not available. Specifically:

- Using allowed commercial facility fees, the percentage of commercial Hospital Outpatient Department (HOPD) patient revenue due to facility fees was calculated to be 35% and applied to total outpatient patient revenue.
- With this information, a range of 10%, 50%, and 100% reduction in HOPD facility fees was applied to total hospital patient revenue.
- With a three-year average of CHASE hospital fees at 5.71% of net patient revenues, the potential impact over the 10%, 50%, and 100% range of reduction was calculated.
- Knowing that 46.6% and 53.4% of an impact to CHASE hospital fees would apply to expansion populations and hospital payments, respectively, the estimated impact to expansion coverage and hospital reimbursement was calculated.
- Finally, the effective federal match rates of 85% and 61% for expansion populations and hospital payments, respectively, allowed for calculation of estimated impacts to fee revenue, federal matching funds, and total spending.

The annual estimated impacts are as follows:

- If HOPD facility fees were reduced by 10%, CHASE hospital provider fees would reduce by (\$24.4 million). If facility fees reduced by 100%, CHASE hospital provider fees would reduce by (\$244.5 million);
- If facility fees were reduced by 10%, federal funds would reduce by (\$85.4 million). If facility fees reduced by 100%, federal funds would reduce by (\$853.6 million); and
- If facility fees were reduced by 10%, total CHASE spending would reduce by (\$109.8 million). If facility fees reduced by 100%, total CHASE spending would reduce by to (\$1.098 billion).

The range of impact on an annual basis to expansion coverage and hospital payment funding are shown in the tables below.

Table 1. 10% Reduction of HOPD Facility Fees (in millions)

| | Expansion Coverage | Hospital Payments | Total |
|---------------|--------------------|-------------------|----------|
| Hospital Fees | -\$11.4 | -\$13.1 | -\$24.4 |
| Federal Funds | -\$64.9 | -\$20.5 | -\$85.4 |
| Total Funds | -\$76.3 | -\$33.5 | -\$109.8 |

Table 2. 50% Reduction of HOPD Facility Fees (in millions)

| | Expansion Coverage | Hospital Payments | Total |
|---------------|--------------------|-------------------|----------|
| Hospital Fees | -\$56.9 | -\$65.3 | -\$122.2 |
| Federal Funds | -\$324.6 | -\$102.3 | -\$426.8 |
| Total Funds | -\$381.5 | -\$167.6 | -\$549.0 |

Table 3. 100% Reduction of HOPD Facility Fees (in millions)

| | Expansion Coverage | Hospital Payments | Total |
|---------------|--------------------|-------------------|------------|
| Hospital Fees | -\$113.8 | -\$130.6 | -\$244.5 |
| Federal Funds | -\$649.1 | -\$204.5 | -\$853.6 |
| Total Funds | -\$762.9 | -\$335.2 | -\$1,098.1 |

There are other impacts to CHASE that have not been analyzed and not reflected here, including decreases to hospital reimbursement for care provided to Health First Colorado members due to decreases in the Medicaid hospital payment limit (known as the upper payment limit) and decreases in covered lives if health coverage expansion is affected as discussed below. 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 (i.e., increases in the number of uninsured Coloradans) or benefits would be made before supplemental hospital payments through CHASE would be reduced. The CHASE fee could first be increased to the federal maximum of 6% net patient revenue and other actions may be recommended by the CHASE Board or may be undertaken by the General Assembly to mitigate such impacts, although the extent to which the impacts could be mitigated has not been studied.

Appendix O. Critical Access Hospital HOPD Facility Fee Splits

| Payer | Year | HOPD Facility Fees - Allowed Amount | | | % Critical Access |
|--|------|-------------------------------------|--------------------------|--------------------------|-------------------|
| | | Critical Access | Non-CAH | Total | |
| Medicare FFS | 2017 | \$ 78,557,688 | \$ 447,336,754 | \$ 525,894,442 | 14.9% |
| Medicare FFS | 2018 | \$ 74,278,721 | \$ 448,962,490 | \$ 523,241,211 | 14.2% |
| Medicare FFS | 2019 | \$ 77,194,334 | \$ 519,142,454 | \$ 596,336,788 | 12.9% |
| Medicare FFS | 2020 | \$ 86,429,762 | \$ 533,766,233 | \$ 620,195,995 | 13.9% |
| Medicare FFS | 2021 | \$ 106,818,582 | \$ 601,198,341 | \$ 708,016,923 | 15.1% |
| Medicare FFS | 2022 | \$ 121,953,362 | \$ 628,440,141 | \$ 750,393,503 | 16.3% |
| Total - Medicare FFS | | \$ 545,232,450 | \$ 3,178,846,413 | \$ 3,724,078,863 | 14.6% |
| Medicare Advantage | 2017 | \$ 12,912,720 | \$ 205,306,842 | \$ 218,219,561 | 5.9% |
| Medicare Advantage | 2018 | \$ 15,223,696 | \$ 266,520,914 | \$ 281,744,610 | 5.4% |
| Medicare Advantage | 2019 | \$ 23,775,790 | \$ 391,997,312 | \$ 415,773,102 | 5.7% |
| Medicare Advantage | 2020 | \$ 25,196,105 | \$ 400,973,577 | \$ 426,169,682 | 5.9% |
| Medicare Advantage | 2021 | \$ 34,666,470 | \$ 481,595,008 | \$ 516,261,478 | 6.7% |
| Medicare Advantage | 2022 | \$ 47,877,444 | \$ 655,226,398 | \$ 703,103,842 | 6.8% |
| Total - Medicare Advantage | | \$ 159,652,225 | \$ 2,401,620,050 | \$ 2,561,272,275 | 6.2% |
| All Medicare | 2017 | \$ 91,470,408 | \$ 652,643,595 | \$ 744,114,004 | 12.3% |
| All Medicare | 2018 | \$ 89,502,418 | \$ 715,483,403 | \$ 804,985,821 | 11.1% |
| All Medicare | 2019 | \$ 100,970,124 | \$ 911,139,766 | \$ 1,012,109,890 | 10.0% |
| All Medicare | 2020 | \$ 111,625,868 | \$ 934,739,810 | \$ 1,046,365,677 | 10.7% |
| All Medicare | 2021 | \$ 141,485,051 | \$ 1,082,793,349 | \$ 1,224,278,400 | 11.6% |
| All Medicare | 2022 | \$ 169,830,806 | \$ 1,283,666,539 | \$ 1,453,497,345 | 11.7% |
| Total - All Medicare | | \$ 704,884,675 | \$ 5,580,466,463 | \$ 6,285,351,137 | 11.2% |
| Commercial | 2017 | \$ 68,761,012 | \$ 939,476,163 | \$ 1,008,237,175 | 6.8% |
| Commercial | 2018 | \$ 71,560,307 | \$ 1,054,324,577 | \$ 1,125,884,884 | 6.4% |
| Commercial | 2019 | \$ 77,884,060 | \$ 1,102,322,148 | \$ 1,180,206,208 | 6.6% |
| Commercial | 2020 | \$ 77,179,830 | \$ 1,042,741,619 | \$ 1,119,921,450 | 6.9% |
| Commercial | 2021 | \$ 90,148,213 | \$ 1,231,012,767 | \$ 1,321,160,980 | 6.8% |
| Commercial | 2022 | \$ 102,830,723 | \$ 1,278,796,806 | \$ 1,381,627,529 | 7.4% |
| Total - Commercial | | \$ 488,364,145 | \$ 6,648,674,081 | \$ 7,137,038,226 | 6.8% |
| Commercial and Medicare | 2017 | \$ 160,231,420 | \$ 1,592,119,759 | \$ 1,752,351,178 | 9.1% |
| Commercial and Medicare | 2018 | \$ 161,062,725 | \$ 1,769,807,981 | \$ 1,930,870,705 | 8.3% |
| Commercial and Medicare | 2019 | \$ 178,854,184 | \$ 2,013,461,914 | \$ 2,192,316,098 | 8.2% |
| Commercial and Medicare | 2020 | \$ 188,805,698 | \$ 1,977,481,429 | \$ 2,166,287,127 | 8.7% |
| Commercial and Medicare | 2021 | \$ 231,633,265 | \$ 2,313,806,116 | \$ 2,545,439,380 | 9.1% |
| Commercial and Medicare | 2022 | \$ 272,661,529 | \$ 2,562,463,345 | \$ 2,835,124,874 | 9.6% |
| Total - Commercial and Medicare | | \$ 1,193,248,820 | \$ 12,229,140,543 | \$ 13,422,389,364 | 8.9% |

Appendix P. Colorado Rural Hospitals

Rural county definitions:

- Frontier county is a county with a population density of six or fewer individuals per one square mile.
 - Colorado's frontier counties are: Baca, Bent, Cheyenne, Costilla, Custer, Dolores, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Las Animas, Lincoln, Mineral, Moffat, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington, Yuma
- Rural county is a county located in a non-metropolitan area in the state that either has no municipality within its territorial boundaries with 50,000 or more permanent residents based upon the most recent population estimates published by the United States Census Bureau or that satisfies alternate criteria for the designation of a rural area as may be promulgated by the federal Office of Management and Budget.
 - Colorado's rural counties are: Alamosa, Archuleta, Chaffee, Conejos, Crowley, Delta, Eagle, Fremont, Garfield, Grand, La Plata, Lake, Logan, Montezuma, Montrose, Morgan, Otero, Ouray, Phillips, Pitkin, Prowers, Rio Grande, Routt, Summit

Table 1. Colorado Rural Hospital Designations

| Index | Rural | Frontier | CAH | County | Hospital Name | System |
|-------|-------------------------------------|-------------------------------------|-------------------------------------|------------|--|-----------------|
| 1 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Otero | Arkansas Valley Regional Medical Center | |
| 2 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Pitkin | Aspen Valley Hospital | |
| 3 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Morgan | East Morgan County Hospital | Banner Health |
| 4 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Garfield | Grand River Hospital District | |
| 5 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Phillips | Haxtun Hospital District | |
| 6 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Chaffee | Heart of the Rockies Regional Medical Center | |
| 7 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Phillips | Melissa Memorial Hospital | |
| 8 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Grand | Middle Park Medical Center | |
| 9 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Archuleta | Pagosa Springs Medical Center | |
| 10 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Prowers | Prowers Medical Center | |
| 11 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Rio Grande | Rio Grande Hospital | |
| 12 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Conejos | San Luis Valley Health Conejos County Hospital | San Luis Valley |
| 13 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Montezuma | Southwest Health System, Inc. | |
| 14 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Fremont | St. Thomas More Hospital | CommonSpirit |
| 15 | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | Lake | St. Vincent General Hospital District | |
| 16 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Gunnison | Gunnison Valley Health | |
| 17 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Cheyenne | Keefe Memorial Health Service District | |
| 18 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Kit Carson | Kit Carson County Health Service District | |
| 19 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Lincoln | Lincoln Community Hospital | |
| 20 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Las Animas | Mt. San Rafael Hospital | |
| 21 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rio Blanco | Pioneers Medical Center | |
| 22 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rio Blanco | Rangely District Hospital | |
| 23 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sedgwick | Sedgwick County Health Center | |
| 24 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Baca | Southeast Colorado Hospital District | |
| 25 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Huerfano | Spanish Peaks Regional Health Center | |
| 26 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Moffat | Memorial Regional Hospital | |
| 27 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Kiowa | Weisbrod Memorial County Hospital | |
| 28 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Yuma | Wray Community District Hospital | |
| 29 | | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Yuma | Yuma District Hospital | |
| 30 | | | <input checked="" type="checkbox"/> | Mesa | Colorado Canyons Hospital and Medical Center | |
| 31 | | | <input checked="" type="checkbox"/> | Larimer | Estes Park Health | |
| 32 | | | <input checked="" type="checkbox"/> | Teller | Pikes Peak Regional Hospital | UCHealth |
| 33 | <input checked="" type="checkbox"/> | | | La Plata | Animas Surgical Hospital | |
| 34 | <input checked="" type="checkbox"/> | | | Morgan | St. Elizabeth | CommonSpirit |
| 35 | <input checked="" type="checkbox"/> | | | Delta | Delta County Memorial Hospital | |
| 36 | <input checked="" type="checkbox"/> | | | La Plata | Mercy Regional Medical Center | CommonSpirit |
| 37 | <input checked="" type="checkbox"/> | | | Montrose | Montrose Memorial Hospital | |
| 38 | <input checked="" type="checkbox"/> | | | Alamosa | San Luis Valley Health Regional Medical Center | San Luis Valley |
| 39 | <input checked="" type="checkbox"/> | | | Summit | St. Anthony Summit Medical Center | CommonSpirit |
| 40 | <input checked="" type="checkbox"/> | | | Logan | Sterling Regional MedCenter | Banner Health |
| 41 | <input checked="" type="checkbox"/> | | | Eagle | Vail Health Hospital | |
| 42 | <input checked="" type="checkbox"/> | | | Garfield | Valley View Hospital | |



| Index | Rural | Frontier | CAH | County | Hospital Name | System |
|-------|-------------------------------------|----------|-----|--------|-----------------------------|----------|
| 43 | <input checked="" type="checkbox"/> | | | Routt | Yampa Valley Medical Center | UCHealth |



September 17, 2024

Dear Representatives and Senators,

I deeply appreciate the dedicated and important work of my fellow Hospital Facility Fee Steering Committee members and the staff at HCPF, GPS, and Optumas CBIZ; however, I believe it would be inappropriate to base any public policy decisions or legislation on the findings included in Committee's report as submitted to you. As the Colorado Hospital Association representative on the Committee, I must dissent and urge you to seek further analysis to address the shortcomings identified below.

As you know, facility fees are charges for all health care services provided by a hospital except for those provided by a physician. The fees are the only reimbursement a hospital-based clinic receives to cover its nurses, nursing assistants, housekeepers, security staff, social workers, supplies, operations and much more. These funds make quality health care accessible in our communities, especially for those who are uninsured or covered by Medicaid.

The report simply is not a reliable or comprehensive analysis of facility fees as it does not provide a thorough, accurate, or balanced picture. Many of the report's limitations - the lack of data, the inadequate time to prepare it, and the lack of participation from key stakeholders - are cited in the report itself. I agree with these points, but because this report could be used to inform important public policy decisions, I believe it is necessary to explain in more detail how these issues impact the overall reliability of the report and, consequently, my decision to dissent. My most fundamental concerns include:

1. **Inadequate Time.** The process was rushed, and there was too little time for true analysis of data, reference materials, or draft reports. Although the Committee had a year to work, most of that time was consumed trying to collect data and information rather than on serious analysis. Although the Committee had access to outside consultants, the complexity of the subject matter and the time constraints prevented the Committee from adequately engaging with consultants to produce a comprehensive report that could serve as the basis for public policy decisions.
2. **Inadequate Data.** As outlined in the report, the Committee was unable to collect complete or comprehensive data, including from key stakeholders like payers, employers and independent providers. Committee members were also not given access to the underlying data to understand or test the conclusions drawn in the report. As a result, policymakers should be cautious in accepting any conclusions based on these incomplete data sources and analyses.
3. **Insufficient Evaluation of Critical Issues.** The report draws conclusions that are not adequately supported, in particular on the questions of how facility fees affect equity, health care employees, access to care, and quality of care. Despite concerns from Committee members, the report omits important sources that could have provided context on the impact that changes to facility fees could have on access to care. The report would be more useful to policymakers if it included a comprehensive and balanced review of literature related to these complex issues.
4. **Conclusions.** The report finds that changes or reductions in facility fees could drastically reduce CHASE funding and the federal dollars that flow to our state to support Medicaid expansion and provide crucial support for hospitals that serve a disproportionate share of Medicaid patients. Committee members and I agree with this finding. The report omits, however, other potential impacts of facility fee legislation such as impacts to the 340B Drug Pricing Program, workforce reductions, and access to community-based facilities.

Based on these factors, I believe additional analysis is vital before the Legislature considers any action.

Sincerely,



Dan Rieber
Chief Financial Officer, UCHealth