Hospital Facility Fee Report

Report on the impact of hospital facility fees in Colorado

PRELIMINARY VERSION September 1, 2024

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

COLORADO
Department of Health Care Policy & Financing

Contents

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Dear Representatives and Senators,

The Hospital Facility Fee Steering Committee is pleased to present this preliminary version of the report, a testament to the committee's diligent work thus far. While this version does not yet include the appendices or the conclusions, we are fully committed to delivering a thorough final report by the October 1, 2024 deadline.

We recognize the critical yet complex nature of the Colorado health care landscape and the various factors that influence health care costs, access, workforce, and equity; however our analysis has remained focused on the specific impact of hospital facility fees.

Throughout our work, we encountered challenges related to data availability, data structure, health care network variations, and the legislative boundaries of our charge. These factors have shaped the scope and depth of our findings and highlight the importance of our collective efforts. We hope this report conveys the complexity of the issues at hand and our dedication to ongoing discussions and further analysis.

We appreciate your understanding and patience as we work towards completing this important task.

Respectfully,

Facility Fee Steering Committee Members

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

Background and Introduction

House Bill (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. See Appendix X for the list of Steering Committee members.

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

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

The Department of Health Care Policy and Financing (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 X for additional definitions related to facility fees.

Key Findings

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

1) Facility fees are a complicated topic due in part to the complexity of health care and the associated billing practices.
2) Billing requirements 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 hospital outpatient clinics 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 amounts[1] for Medicare and Commercial, which is about 22.8% of the total allowed HOPD facility fees. The raw increase in facility fee billing from 2017 to 2022 was 10%, not normalized based on population growth or changes in utilization. Here is the breakdown by market:

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

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

6) The Hospital Outpatient Department (HOPD) facility fees contributed approximately $50.8 million to $53.7 million in health care expected reimbursement as compared to affiliated or independent professional fees for the top 25 codes reviewed across Medicare and Commercial payers.[2],[3]

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

    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.

    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.

[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.

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 resources. This would be in addition to any E&M codes billed as part of the professional fee for an HOPD visit.

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

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

10) The payment rate differential between HOPDs who are able to charge a facility fee and professional fees, combined with stagnant reimbursement rates for professional fees, create, 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]

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

Data Sources and Caveats

The Steering Committee received the majority of the data from the APCD with supplemental data supplied by hospitals, health systems, the Department of Health

[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

Care Policy and Financing (HCPF), commercial payers, and independent providers. Service provider types not specifically listed were excluded. A full listing of data sources and caveats is in Appendix X, and highlights are shown here:

APCD

The APCD is the state's most comprehensive health care claims database representing the majority of payers (49 commercial payers, Medicaid, and Medicare), and 74% of covered lives. APCD supplied data from 2017 through 2022. However, it does not include uninsured and self-pay claims, federal programs such as the Veterans Affairs (VA), Tricare, and Indian Health Services. Medicare and Medicare Advantage data also cover 2017 through 2022 and represent 95% of Colorado members.

Survey and Supplemental Data

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

Several caveats are important to acknowledge:

- The Committee found there is no single data source that contains all of the information required by HB23-1215. Integration of different sources is necessary for complete analysis.
- Emergency departments (on and off campus) were completely excluded from analysis throughout the report.
- The APCD lacks indicators for facility fees and on denied claims for an entire visit. The data does contain partially denied claims - where an individual service for a visit was denied. As noted above, the APCD data covers 74% 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.

- Responses to surveys distributed to providers were used to validate other analyses.

Analysis Methods and Limitations

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

Stakeholder Perspectives

As noted in the introduction, the Steering Committee consists of 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 X, you will find four separate, one-page perspectives with each group's views on facility fees.

Research and Report Requirements

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

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

When a patient receives outpatient health care services in an on-site or off-site HOPD, the patient is considered to be treated within the hospital rather than a physician's office. A patient who receives care at an HOPD will receive two bills: one is the hospital or facility bill, commonly referred to as the facility fee, and the other

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

There were several federal actions in the 1980s and 1990s regarding Medicare reimbursement for hospital outpatient services culminating in federal regulations published in the Federal Register (65 FR 18434) establishing an outpatient PPS for Medicare services in July 2000.

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

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

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 section X 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 payment the facility separate from the professional services.[7]

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

[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*

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 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 Centers for Medicare and Medicaid Services 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 campus. The hospitals also indicate that changes over time reflect changes in billing guidelines or the incorporation of

[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

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

Medicare has an additional and distinct incremental facility fee code (G0463) for hospital outpatient department facilities.[11] Hospital providers also use evaluation and management (E&M) codes to bill for facility resources in Commercial programs. E&M codes were the predecessor to G0463 in Medicare, likely the driver of this policy in Commercial programs. Medicaid does not have a distinct incremental facility fee and reimburses for hospital facility fee claims using a grouping methodology.[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 sections 25.5-4-216(6)(a) to address the payments for HOPD facility fees, including insights across payer types. This report will not analyze Medicaid HOPD from the APCD, focusing this section on payers that cost-share, impacting consumers. Appendices include additional details and summary tables.

Total Facility Fees

In total, there were between 2,200,000 million and 3,235,000 patient visits totaling $1.75 billion to $2.9 billion on an annual basis for which facility fees were charged for Commercial and Medicare payers.

[11] The use of G0463 is described in Appendix X. 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 for which facility fees were charged for Commercial payers. Approximately 95% of those were for in-network providers across the study period. That level was also observed to be consistent for each year within the study period.

For Commercial payers, there were approximately 190,000 to 280,000 annual HOPD visits with a professional component that was in-network on the same day for the same member that an HOPD facility fee was billed.[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 X 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 for which facility fees were charged for Medicare payers (FFS and Advantage combined). Approximately 97% of those were for an in-network provider across the study period. That level was also observed to be consistent for each year within the study period.

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

Appendix X includes additional details and summary tables.

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

[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 X.

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 UCHealth 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.

Appendix X includes additional details and summary tables.

Top Codes

Top Codes by Frequency

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

Commercial Payers

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

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

prior to 2014. The result is that that member has received two bills, one for the HOPD facility fee and one for the professional fee, which could include the same E & M codes.

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

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

Medicare Payers

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

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

Top Codes by Expected ReimbursementAmount

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 (EKG), joint devices, injectable drugs including chemotherapy, arthroplasty, laparoscopy, mammograms, endoscopy, colonoscopy, and MRIs. Outpatient Observation, code G0378, was also included in the top codes by expected reimbursement amount, distinct from the G0463 facility resource code used by Medicare.

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

Medicare Payers

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

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

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

Impact on Coverage & Cost-Sharing

> *25.5-4-216(5)(c): Coverage and cost-sharing provisions for outpatient care services associated with facility fees across payers and payer types*
>
> *25.5-4-216(5)(e): The Impact of facility fees and payer coverage policies on consumers, small and large employers, and the medical assistance program*

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

Top Codes by Cost-Sharing

Commercial Payers

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

Eleven of the codes are also in the list for top 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 X contains a full list of top codes by member sharing amounts by year and in total.

Medicare Payers

The top codes for which a facility fee was charged with the highest member cost-sharing amount were a range of services including: echocardiogram (EKG), laboratory codes, injectable drugs including chemotherapy, physical therapy, arthroplasty, mammograms, and MRIs. Additionally, G0463 (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 X contains a full list of top codes by member sharing amounts by year and in total.

Cost Sharing Proportion by Payer Type

For HOPD related expenses, Commercial members on average paid a lower proportion of cost-sharing at 13.5% than Medicare FFS at 19.9% and Medicare Advantage at 26.2%. As noted in the data limitations section, the Commercial percentage may be understated due to the absence of self-funded or self-insured members. Those members could have a higher percentage of cost-sharing due to potentially selecting high deductible health plans. The Medicare FFS cost-sharing of approx. 20% is consistent with the Medicare benefit package design, while Medicare Advantage

benefit package designs may deviate from that. The results were fairly stable across the study period for Commercial and Medicare FFS, while Medicare Advantage showed about an 8% reduction from 31.4% to 23.2% from 2017 to 2022.

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

Impact on Consumers, Small and Large Employers

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

High-deductible payer coverage plans increase patients' out-of-pocket costs.

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 the 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. Medicaid members

[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 this Premium Impact Scenarios document.

have no or very low co-payment and no other cost sharing. Accordingly, the impact of facility fees on Medicaid members is negligible. On the other hand, facility fees can have an impact on the cost of the program's outpatient expenditures.

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 X.

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

Impact to Health Care Charges for Providers

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

The APCD data was utilized to address the requested analytics in sections 25.5-4-216(5)(g) and 25.5-4-216(5)(g) to address the comparison of payments for HOPD facility fees and professional fees of either an independent or affiliated provider. The Steering Committee interprets the word "charges" as providing a bill to the member and payer. This would reflect the full sum of the 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 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 made by site of service, professional's affiliation, and payer type.[16] More information on the methodology is in Appendix X.

Table X. 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 Table X and Table X below, the overall observation of the comparison of HOPD facility fees to professional fees for the same service, for either affiliated or independent providers, was that HOPD facility fees were higher than the professional fees for the top 25 codes reviewed. An estimated dollar impact can be calculated by applying the difference in HOPD volume and utilization and the mix of services to these comparisons. The HOPD facility fees contributed approximately $50.8 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.[17]

[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.

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

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

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

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

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 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 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.
- 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 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 professional office.

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

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

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

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

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

Table X. Professional Office Visit with a Total Visit 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 X.

Top Codes by Frequency - Off-Campus Locations

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

Top Codes by 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 UCHealth hospital system. Within the UCHealth system, the primary off-campus clinic billing was associated with the Poudre Valley Hospital. Review of the top codes for off-campus indicates that may be driven by their off-campus cancer treatment clinic in that area.

The next two highest were National Jewish Health hospital and Colorado West Health Care System (DBA Community Hospital), each with about 6.5% of the total Medicare

off-campus HOPD 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 $1.7M 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 $470k and $830k 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.

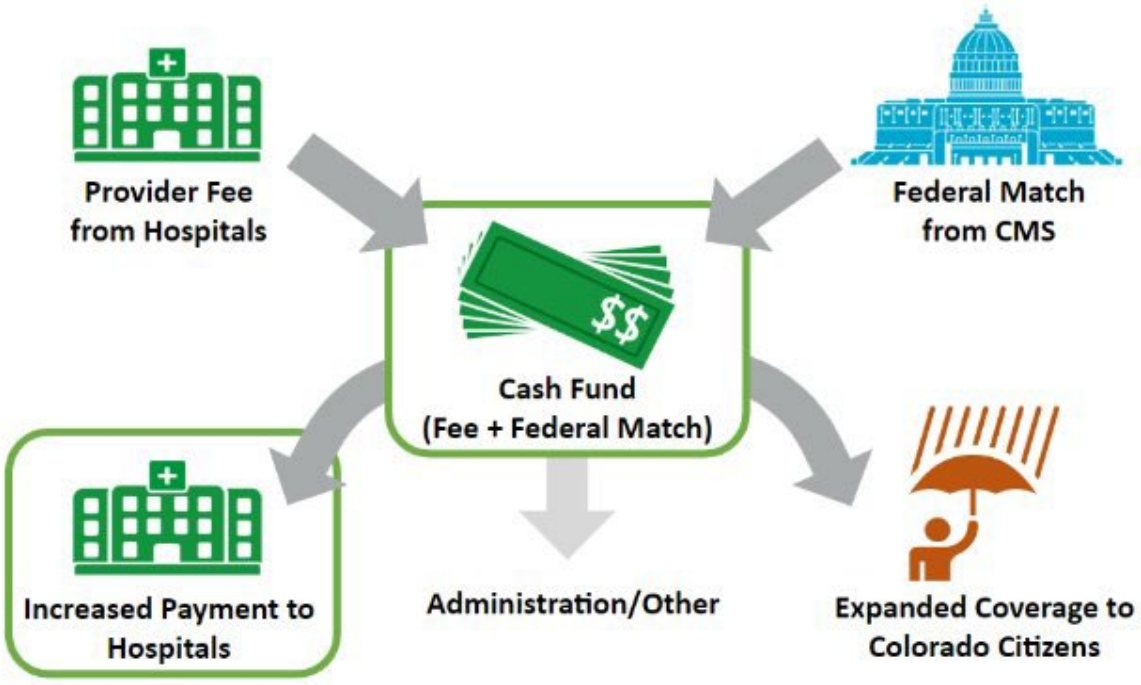
Impact to CHASE, Medicaid Expansion & Uncompensated Care

> *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 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 Medicaid members and uninsured patients, finance the state's expansion of health care coverage for more than 500,000 Coloradans through the Medicaid and Child Health Plan Plus (CHP+) programs, and to pay its related administrative costs. The CHASE hospital provider fee has increased hospital payments by an average of more than $415 million per year, reduced hospitals' uncompensated care costs, and reduced the number of uninsured Coloradans. See the 2024 CHASE Annual Report for more information.

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



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

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

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

- Facility fees reduction between ($24.4 million) at 10% to ($244.5 million) at 100%,
- Federal funds reduction between ($85.4 million) at 10% to ($853.6 million) at 100%, and

- Total spending reduction between ($109.8 million) at 10% to ($1.098 billion) at 100%.

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

Impact to Uncompensated Care

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

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

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

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

hospital/health system, and independent physicians. Perspectives from these groups are available in Appendix X.

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, inducing 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.[18] 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. Hospitals or health systems believe 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.

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

[18] 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

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. For the consumer, vertical integration between physicians and hospitals or health systems increases the cost of care and adversely impacts the adherence for Black, Asian, Hispanic, and Native American patients, patients over 80 years old, and patients with greater comorbidities.[19] Vertical integration has increased significantly, thus reducing lower cost alternatives and hindering some consumers' ability to shop for care.[20]

From the provider perspective, higher costs of care are necessary to help HOPDs serve a broader and more diverse population range and maintain 24/7 emergency care.[21]

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. While the Steering Committee did discuss the general trends impacting independent physicians, the Committee did not review research on this issue at the time of this preliminary draft.

Impact on Rural Hospitals

While HB 23-1215 did not direct the Steering Committee to separately evaluate facility fees for Critical Access Hospitals (CAH) 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

[19] **Association Between Hospital-Physician Vertical Integration and Medication Adherence Rates,** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10012217/

[20] **Chapter 6, Aligning fee-for-service payment rates across ambulatory settings, Pages 166 – 168,** https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf

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

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 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 X)

The General Assembly has at times recognized that rural areas have more limited financial resources and access to care than urban areas[22], and HB 23-1215 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:[23]

- 47 of Colorado's 64 counties are rural or frontier[24]
- 77% of Colorado's landmass is considered rural or frontier

[22] See legislative declarations of SB 22-200 and SB 17-267, for example.
[23] Colorado Rural Health Center. (2024). Snapshot of Rural Health in Colorado 2024. https://coruralhealth.org/snapshot-of-rural-health#/
[24] 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.

- Colorado has 32 CAHs and 11 additional rural hospitals that are not designated as CAHs.[25] See Appendix X 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[26]
- Health coverage in rural Colorado has a higher public payer and uninsured payer mix, and lower commercial payer mix, compared to urban areas.[27]
- 19% of children in rural areas live in poverty compared to 11% in urban areas and 12% statewide[28]

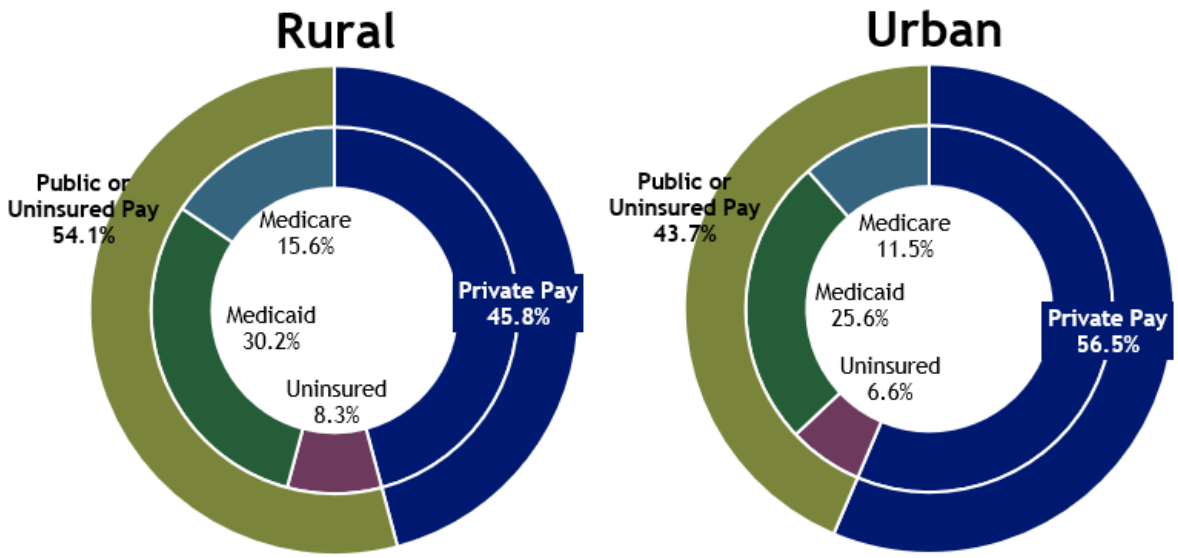
[25] Of the rural non-Critical Access Hospitals, Delta County Memorial Hospital is designated as a Sole Community Hospital and is also exempt from HB 23-1215's prohibition on collecting facility fees from patients not covered by their health insurance. See Reimbursement of Sole Community Hospitals Under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

[26] 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

[27] 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

[28] 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/

Figure X. Rural and Urban Payer Mix Compared[29]



CAH is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (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.

Eligible hospitals must meet the following conditions to obtain CAH designation:

- Have 25 or fewer acute care inpatient beds[30]
- Be located more than 35 miles from another hospital or more than 15 miles in areas with mountainous terrain or only secondary roads

[29] 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

[30] 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

- 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 beds[31] 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.[32] Further, according to the 2024 CHASE Annual Report, Medicaid reimburses all hospitals approximately 81% of costs in the aggregate.[33]

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 they are generally located in areas which face great economic, infrastructure, and access to care challenges than urban areas of the state.

Conclusion

To Be Added with delivery of final report on October 1, 2024.

[31] Swing beds can be used to provide either acute or skilled nursing facility (SNF) care. See Swing Bed Providers | CMS for more information.
[32] 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.
[33] Department of Health Care Policy & Financing. (2024, February). 2024 CHASE Annual Report. https://hcpf.colorado.gov/colorado-healthcare-affordability-and-sustainability-enterprise-chase-board