Facility Fees Whitepaper

Executive Summary

Section 1: Introduction – Hospital billing is a complex and often confusing system, one component of which is facility fees. Facility fees are more appropriately described as technical fees. The practice of billing facility fees has been a fundamental part of the system since the early days of the Medicare program. As the cost of care continues to shift to patients, there is increased confusion resulting in heightened scrutiny about hospital billing, especially as it relates to facility fees, and subsequently the cost to the patient for their care. Prohibiting facility fees is not a solution to the problem of the high cost of health care. The facility fee ban proposed in House Bill (HB) 23-1215 would have resulted in devastating impacts to the state's community hospitals and access to care for patients. The final bill requires a one-time study on the impact of facility fees in Colorado due to be completed and submitted to the Colorado General Assembly by Oct. 1, 2024.

Section 2: Origin and Purpose of Facility Fees – Charges for care provided in a hospital setting (inpatient or outpatient) are split into two different fees as mandated by Medicare (part of the federal government): 1) a professional fee to cover the cost of the doctor and 2) a facility fee to cover the cost of everyone and everything else involved in patient care. These billing requirements are often replicated by commercial payers. Hospitals would not be able to provide care to patients without this reimbursement. Reimbursement for care provided in a hospital outpatient department (HOPD) differs from those for other sites of service because hospitals have unique requirements and capabilities as dictated by state and federal regulations. HOPDs also serve a different patient population than other sites of care. A facility fee ban, as proposed in HB 23-1215, would have devastating impacts on Colorado's care delivery system because hospital departments would no longer receive sustainable payments to offset the costs a hospital bears to deliver services to its patients.

Section 3: Facility Fees in Context of Health Care Market Trends and Regulations – Over the past two decades, Colorado's health care delivery system has shifted towards an integrated model of care and more care delivery in an outpatient setting, both of which work towards meeting the goal of increasing access, while reducing cost and maintaining quality. Facility fees help support the patient care improvements achieved through an increased investment in an integrated model of care, which leads to better care and lower hospital costs. During this same period, independent physicians facing high administrative burden and inadequate reimbursements have affiliated with hospitals or sold to private equity. Consolidation with health systems can and does facilitate value, integrated care, and continuity of care – all good things for patients. Physician affiliations with health systems have saved access to care in many places by ensuring doctors continue to practice medicine.

Section 4: Impact of Facility Fees on Patients – As a result of changes in insurer policies and insurance plan designs, patients are facing increased cost sharing, driving more scrutiny towards the cost of care. Colorado has a disproportionate number of high deductible health plans, which unfortunately have not achieved their intended goal of appropriate price sensitivity and reducing health care costs. Colorado is better than the United States overall at controlling health care and hospital costs. The rising cost of care is being driven more by rising prescription drug costs than hospital costs. Colorado hospitals provide comprehensive charity care safety net assistance to their patients. A facility fee ban would have significant downstream effects on the state's Medicaid expansion population.

Section 5: Conclusion – Colorado is a leader in terms of health system performance. A facility fee ban would have significant impacts on the system hospitals have built and the patients they serve.

Section 1: Introduction

As patients take on a greater share of their health care costs with high deductibles and copays, they deserve to better understand the costs associated with their care. Due to complex payer requirements, hospital billing is a complex and multifaceted system that is highly regulated by both the state and federal governments. Because hospitals interact with a number of different insurance companies as well as state and federal programs, each with unique requirements, the billing process is highly variable and extremely confusing for patients.

Payment and policy changes at the state and federal levels over the past 10-15 years have resulted in a greater integration of health care services across the continuum of care and population health. Independent physicians have increasingly left traditional, private practice settings and have sought employment or affiliation with hospitals. Increased regulatory complexity and lower reimbursement have often made the delivery of care too complex for a small practice. As a result, hospitals and health systems have expanded into primary and specialty care services to support the changing care delivery model and to ensure access to primary care. In frontier and rural areas, access to care would be non-existent without investment by hospitals. As a result, some care is moving outside the traditional four walls of the hospital and into other hospital-owned facilities to provide alternative access to care for Colorado communities.

Charges for health care services provided in a hospital-owned facility are commonly referred to as facility fees. Separate and distinct from physician services and billing, facility fees were originally created by the federal government and are intended to cover the cost of patient care staff and the broad variety of other staff and services necessary to deliver high-quality care. As hospitals have expanded and shifted from the traditional large hospital facility (on campus) to smaller community based facilities strategically placed to improve access to care (off campus), the distinction of what is and is not a hospital, and the charges for facility fees, has become less obvious and often confusing to patients and stakeholders.

In recognition of the profound impact HB 23-1215 would have had on Colorado's health care delivery system by banning facility fees,[1] stakeholders found common ground requiring a one-time report on the impact of facility fees. CHA has developed this whitepaper to provide additional background on facility fees and help the steering committee answer the seven charges they have been tasked with evaluating in the final report. These seven charges are:

1. Payer reimbursement and payment policies for outpatient facility fees across payer types, as well as provider billing guidelines and practices for outpatient facility fees across provider types.
2. Payments for outpatient facility fees, including insights into the associated care across payer types.
3. Coverage and cost-sharing provisions for outpatient care services associated with facility fees across payers and payer types.
4. Denied facility fee claims by payer type and provider type.
5. The impact of facility fees and payer coverage policies on consumers, small and large employers, and the medical assistance program.
6. The impact of facility fees and payer coverage policies on the charges for health care services rendered by independent health care providers.
7. The charges for health care services rendered by health care providers affiliated with or owned by a hospital or health system.

[1] HB 23-1215: Limits on Hospital Facility Fees. Colorado General Assembly. 2023. https://leg.colorado.gov/bills/hb23-1215

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Section 2: Origin and Purpose of Facility Fees

Patients who receive care at a hospital outpatient setting are generally charged two separate fees – a professional fee (pays for the doctor and/or advanced practice provider) and a facility fee (pays for everyone and everything else). The practice of separately billing hospital and professional fees originated early in the Medicare program – Medicare is the largest payer in the country and has set the industry standards for health care billing that most insurers follow. Medicaid payments for outpatient care include facility fees as part of the state's non-negotiable fee schedule (enhanced ambulatory patient groups or EAPGs) and commercial payers negotiate rates with hospitals that include facility payments for inpatient and outpatient care.

Without reimbursement for facility and staff expenses to cover the high operational cost of care, hospitals would not be able to sustainably provide outpatient care. While there is increased scrutiny by policymakers around the cost of care at different sites of service it is important to note that existing payment policies and those being debated at the federal level recognize the need for the facility component of a hospital bill. There is no federal plan or intention to eliminate facility fees, but there is consideration of re-evaluating facility fee payment rates for hospitals compared to other non-hospital facilities. While Medicare has phased in some "site-neutral" payments in the past six years, hospital reimbursement for outpatient services continues to include facility fees. Notably, CMS considered and rejected a policy in 2016 and 2018 to impose site neutrality reductions to new services.[2]

"Facility fee" is a bit of a misnomer as it has little to do with a facility and instead supports the variety of staff and resources required for outpatient care, including:

- *nurses,*
- *patient care technicians,*
- *registration professionals,*
- *environmental services,*
- *imaging specialists, pharmacists,*
- *equipment specialists,*
- *and more.*

The cost of care delivered by hospitals and health systems is fundamentally different than other sites of care, such as an ambulatory surgical center or independent physician office, and thus their reimbursement structure must take into account the unique requirements and capabilities that they provide to their communities.

- HOPDs see far more under- and uninsured patients than independent physician's offices or other non-hospital sites. HOPDs are also more likely to see older, sicker and more complex patients, needing more specialized clinical personnel and facility capabilities.[3] For example, skilled nursing facilities generally take their patients to HOPDs for necessary outpatient services because freestanding physician offices are not fully prepared to meet the needs of their older, sicker patients. Hospitals are better equipped to handle complications and emergencies, which often require the use of additional resources that other settings do not provide.
- HOPDs are often the only source of care for Medicare beneficiaries in rural areas and for those dually eligible for Medicaid – 36% of physician visits are provided through an HOPD in rural settings and 40% of outpatient visits to an HOPD were by dual-eligible patients.[4] HOPD beneficiaries are also more likely have lower socioeconomic status and more likely to be non-

[2] Coons T. CMS adopts important "site-neutral" changes to payment rules. Baker Donelson. December 18, 2018. https://www.bakerdonelson.com/cms-adopts-important-site-neutral-changes-to-payment-rules.

[3] Koenig L, Sheriff J, Nevo O, et al. Comparison of Medicare Beneficiary Characteristics Between Hospital Outpatient Departments and Other Ambulatory Care Settings. KNG Health Consulting. 2023: https://www.aha.org/system/files/media/file/2023/03/Comparison-of-Medicare-Beneficiary-Characteristics-Between-Hospital-Outpatient-Departments-and-Other-Ambulatory-Care-Settings.pdf

[4] KNG Health Consulting calculation using 5% Outpatient and Carrier Standard Analytic Files, 2019-2021.

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white (1.5 and 1.4 times more likely to be Black and Hispanic, respectively), compared to patients at independent physician offices.[5]

- Hospitals must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements compared to other sites of care. Federal and state regulators place licensure, certification, conditions of participation and other regulatory requirements on HOPDs because of their specialty staffing and capabilities to provide more complex care. None of these additional requirements are specifically funded and must be covered through direct patient care revenue.

Impact of Facility Fee Ban in HB 23-1215: HB 23-1215, which passed through the General Assembly in 2023, started as a bill banning all outpatient facility fees in Colorado. This ban would have had catastrophic consequences for hospitals and the broader health care system by:

- Threatening access and adding 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 department (ED) and inpatient care, driving up health care costs for everyone.
- Disrupting the 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.
- Significantly impacting patients seeking care in rural areas, especially the underserved, thereby imposing unnecessary travel and associated expenses for sick patients seeking care.
- Imposing over $9 billion in cuts to Colorado hospitals at a time when hospitals are already facing significant financial challenges. The proposed changes would make 96% of Colorado hospitals financially unsustainable (based on 2022 Medicare Cost Report data). To put the $9 billion in cuts into perspective – this equates to the salaries of about 120,000 nurses. Colorado has just over 60,000 nurses.

HB 23-1215 as introduced would have put Colorado hospitals in direct conflict with federal law as they would no longer be able to bill as the Medicare program directs them to and would cause many catastrophic downstream effects, including loss of licensure and ability to operate in the state as well as not being able to participate in the Medicare nor 340B Drug Pricing Programs.

Section 3: Facility Fees in Context of Health Care Market Trends and Regulations

Shift Towards Integrated Care: Facility fees play an integral role in the structure of the current health care delivery system and industry shift towards more outpatient, integrated care, driven by continuous quality improvement in patient care. A facility fee ban would threaten access to outpatient care as the provision of such care would no longer be financially viable without reimbursement for the many different inputs that go into running a hospital outpatient department.

Following passage of the Affordable Care Act, policymakers have invested a lot of time imposing payment and policy changes to the health care system to incentivize an integrated care model and value-based payment arrangements, which requires line of sight into the patient across the continuum of care. Integrated care leads to improved health and lower costs. Care integration improves patient outcomes, bolsters care coordination, amplifies health system productivity, reduces fragmentation and

[5] Koenig L, Sheriff J, Nevo O, et al. Comparison of Medicare Beneficiary Characteristics Between Hospital Outpatient Departments and Other Ambulatory Care Settings. KNG Health Consulting. 2023: https://www.aha.org/system/files/media/file/2023/03/Comparison-of-Medicare-Beneficiary-Characteristics-Between-Hospital-Outpatient-Departments-and-Other-Ambulatory-Care-Settings.pdf

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duplication, and is associated with lower overall costs.[6] Care integration promotes the use of interprofessional, multidisciplinary, and team-based care. Integrated care is designed to be collaborative, comprehensive, coordinated, transparent, and empowering.[7] This work plays a vital role in the provision of excellent patient care. Care provided in an outpatient setting is an important part of integrated care. Examples include:

- **Cancer care** – Multidisciplinary teams help create more streamlined care at the time of diagnosis. Patients engaged in such team-based care experience shorter wait times for diagnostic procedures including CT scans and endoscopies resulting in a faster and better diagnosis, and higher degree of patient satisfaction.[8, 9, 10, 11]
- **Cardiac care** – For the 5+ million patients in the nation with atrial fibrillation, integrated care improves access to diagnostic testing, pharmacologic or procedural treatment, and patient education. These systems of care reduce all-cause mortality and significantly reduce cardiovascular-related acute hospitalizations.[12]
- **Mental health care** – There is overwhelming evidence in support of integrated care for behavioral health and substance use disorder diagnoses. This includes screening and diagnoses of psychosis, depression, anxiety, post-traumatic stress disorder, and obsessive-compulsive disorders and incorporates occupation therapists, speech language pathologists, physiotherapists, among others.[13]
- **Gastrointestinal care** – Patients with functional and inflammatory gastrointestinal issues achieve greater improvement of symptoms, wellbeing, and quality of life while decreasing overall health care utilization. Such care models include dieticians, physiotherapy, and hypnotherapy. [14] [15]

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[6] Rocks S, Berntson D, Gil-Salmerón A, et al. Cost and effects of integrated care: a systematic literature review and meta-analysis. Eur J Health Econ. 2020;21(8):1211-1221. doi:10.1007/s10198-020-01217-5

[7] Zonneveld N, Driessen N, Stüssgen RAJ, Minkman MMN. Values of Integrated Care: A Systematic Review. Int J Integr Care. 2018;18(4):9. doi:10.5334/ijic.4172

[8] Lucarini A, Garbarino GM, Orlandi P, et al. From "Cure" to "Care": The Role of the MultiDisciplinary Team on Colorectal Cancer Patients' Satisfaction and Oncological Outcomes. JMDH. 2022;Volume 15:1415-1426. doi:10.2147/JMDH.S362550

[9] Prabhu Das I, Baker M, Altice C, Castro KM, Brandys B, Mitchell SA. Outcomes of multidisciplinary treatment planning in US cancer care settings: Multidisciplinary Treatment Planning. Cancer. 2018;124(18):3656-3667. doi:10.1002/cncr.31394

[10] Richardson B, Preskitt J, Lichliter W, et al. The effect of multidisciplinary teams for rectal cancer on delivery of care and patient outcome: has the use of multidisciplinary teams for rectal cancer affected the utilization of available resources, proportion of patients meeting the standard of care, and does this translate into changes in patient outcome? The American Journal of Surgery. 2016;211(1):46-52. doi:10.1016/j.amjsurg.2015.08.015

[11] Conron M, Denton E. Improving outcomes in lung cancer: the value of the multidisciplinary health care team. JMDH. Published online March 2016:137. doi:10.2147/JMDH.S76762

[12] Khan A, Cereda A, Walther C, Aslam A. Multidisciplinary Integrated Care in Atrial Fibrillation (MICAF): A Systematic Review and Meta-Analysis. Clin Med Res. 2022;20(4):219-230. doi:10.3121/cmr.2022.1702

[13] Chan V, Toccalino D, Omar S, Shah R, Colantonio A. A systematic review on integrated care for traumatic brain injury, mental health, and substance use. Fani N, ed. PLoS ONE. 2022;17(3):e0264116. doi:10.1371/journal.pone.0264116

[14] Basnayake C, Kamm MA, Stanley A, et al. Long-Term Outcome of Multidisciplinary Versus Standard Gastroenterologist Care for Functional Gastrointestinal Disorders: A Randomized Trial. Clinical Gastroenterology and Hepatology. 2022;20(9):2102-2111.e9. doi:10.1016/j.cgh.2021.12.005

[15] Christian K, Cross RK. Improving Outcomes in Patients With Inflammatory Bowel Disease Through Integrated Multi-Disciplinary Care—the Future of IBD Care. Clinical Gastroenterology and Hepatology. 2018;16(11):1708-1709. doi:10.1016/j.cgh.2018.07.021

- **Neurological care** – Examples of integrated care models can be found in neurovascular, spine, trauma, and neurosurgical practices and functional/medical neurology and improve patient satisfaction and quality of life and reduce hospital readmissions.[16,17]
- **Rheumatologic care** – For patients with lupus, enrollment in a primary care-based integrated care management program resulted in decreased rates of ED visits and avoidable hospitalizations.[18]
- **Orthopedic care** – Specific for geriatric patients who have experienced a hip fracture, team-based care leads to decreased time to surgery, shorter length of stay, improved postoperative clinical outcomes, decreased mortality, and lower costs.[19,20]
- **Diabetic and wound care** – Integrated care has a positive impact on clinical outcomes as a result of vigorous interventions that include self-monitoring of blood glucose, diet tracking, exercise planning, and closer follow-ups. Collaborative approaches lead to improved ability to meet the educational, behavioral, and psychosocial needs of patients and improve clinical outcomes including reduced blood glucose and blood pressure.[21] In addition, outpatient wound care is associated with greater limb preservation.

As part of this shift towards better quality, integrated care, the health system has been changing over time to shift procedures from the more complex inpatient setting towards a lower cost outpatient setting, as clinically appropriate. CMS and other payers have been primarily driving this change, which can be seen through the significant shortening of the inpatient only list (IPO). The IPO list is a list of services that, due to their medical complexity, Medicare will only pay for when performed in the inpatient setting. CMS has been slowly whittling down the IPO list, allowing more services to be provided on an outpatient basis, to the point where they proposed eliminating the IPO list all together in

[16] Lee KS, Yordanov S, Stubbs D, Edlmann E, Joannides A, Davies B. Integrated care pathways in neurosurgery: A systematic review. Farag E, ed. PLoS ONE. 2021;16(8):e0255628. doi:10.1371/journal.pone.0255628

[17] Eggers C, Dano R, Schill J, Fink GR, Hellmich M, Timmermann L. Patient-centered integrated healthcare improves quality of life in Parkinson's disease patients: a randomized controlled trial. J Neurol. 2018;265(4):764-773. doi:10.1007/s00415-018-8761-7

[18] Williams JN, Taber K, Huang W, et al. The Impact of an Integrated Care Management Program on Acute Care Use and Outpatient Appointment Attendance Among High-Risk Patients With Lupus. ACR Open Rheumatology. 2022;4(4):338-344. doi:10.1002/acr2.11391

[19] Patel JN, Klein DS, Sreekumar S, Liporace FA, Yoon RS. Outcomes in Multidisciplinary Team-based Approach in Geriatric Hip Fracture Care: A Systematic Review. J Am Acad Orthop Surg. 2020;28(3):128-133. doi:10.5435/JAAOS-D-18-00425

[20] Wallace R, Angus LDG, Munnangi S, Shukry S, DiGiacomo JC, Ruotolo C. Improved outcomes following implementation of a multidisciplinary care pathway for elderly hip fractures. Aging Clin Exp Res. 2019;31(2):273-278. doi:10.1007/s40520-018-0952-7

[21] Siaw MYL, Lee JYC. Multidisciplinary collaborative care in the management of patients with uncontrolled diabetes: A systematic review and meta-analysis. Int J Clin Pract. 2019;73(2):e13288. doi:10.1111/ijcp.13288

2020.[22] This proposal was ultimately not finalized due to stakeholder comments primarily centered around patient safety concerns, but this action from CMS indicates an industry trend, which was accelerated by the COVID-19 pandemic, to move as much care as possible to a lower cost outpatient setting that can provide high quality care to the patient. According to an analysis performed by Deloitte (Figure 1), the share of outpatient services in hospital revenue has almost doubled between 1994 and 2016.[23]

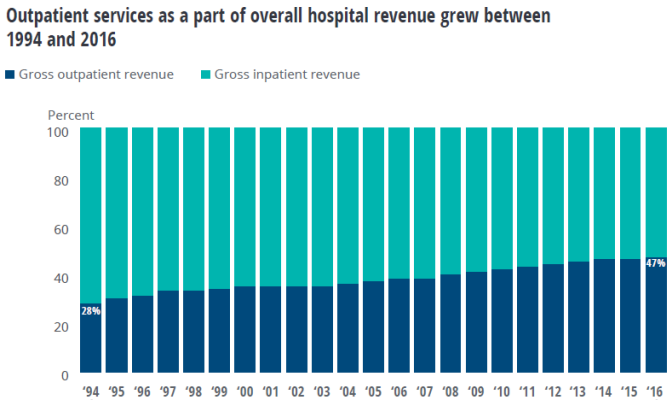

Figure 1. Outpatient vs Inpatient Revenue, 1994-2016.

Hospitals have responded to changes in state and federal policy by investing in infrastructure for outpatient care in areas that traditionally haven't had access to health care services. Clinically integrated networks have been set up in response to this shift towards more integrated care provided through an outpatient setting. Clinically integrated networks have emerged as models to help smaller hospitals and independent physicians retain their independence while enabling them to build capabilities. According to the definitions that CHA provided to the Steering Committee, clinical integration is defined as enabling greater collaboration on care delivery within and across settings of care, which in turn improves the patient experience. Clinically integrated hospitals and other providers work together across settings of care to establish consistent practices in areas such as quality assurance, utilization review, guidelines and protocols, as well as coordination of patient services and shared access to medical records.[24]

Colorado has multiple clinically integrated networks, including Community Care Alliance led by Western Healthcare Alliance,[25] Colorado Care Partners led by HealthONE,[26] and Trinsic jointly led by Intermountain Health and UCHealth.[27] These clinically integrated networks cover a significant number of Coloradans and have performed very well in lowering the cost of care while increasing quality of care. In addition to these formal integrated networks, many rural hospitals operate as de-facto integrated networks as they often offer a range of services from primary and specialty care, a range of inpatient and outpatient services, home health and hospital care, and long term care.

[22] Fact sheets CY 2022 Medicare hospital outpatient prospective payment system and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC). CMS.gov Centers for Medicare & Medicaid Services. November 2, 2021. https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0.

[23] Growth in outpatient care: The role of quality and value incentives. Deloitte Center for Health Solutions. https://www2.deloitte.com/content/dam/insights/us/articles/4170_Outpatient-growth-patterns/DI_Patterns-of-outpatient-growth.pdf

[24] Trendwatch - American Hospital Association. The Value of Provider Integration. March 2014. https://www.aha.org/system/files/2017-11/14mar-provintegration.pdf.

[25] Community Care Alliance. Western Healthcare Alliance. https://www.wha1.org/community-care-alliance/.

[26] Colorado Care Partners. HealthONE Colorado Care Partners. https://h1ccp.com/about/.

[27] Select health: Healthcare in Colorado: Individual & Family and Medicare plans. SelectHealth.org. https://selecthealth.org/colorado.

While a facility fee ban would threaten all outpatient care, certain types of outpatient care already run at a financial deficit and would be the first to close if hospitals could no longer charge facility fees for outpatient care. There are certain service lines that provide care in outpatient settings that struggle to self-sustain, even within the current billing model. This includes cancer infusion centers, behavioral health clinics, and multidisciplinary specialty clinics used to treat cancer and complex, chronic conditions such as long-COVID and brain injury. Multidisciplinary specialty clinics are extremely important to the patients who utilize them but are especially vulnerable to closure given the high administrative costs associated with running them.

***Case Study**: A health system in the state built a freestanding ED in a small town of 30,000 people that previously did not have any health care services in their community, forcing them to travel to get necessary care. That freestanding ED quickly became the busiest in the state, demonstrating the dire need for health services in that community. The facility was eventually switched over to an HOPD to better reflect the services they were providing (mostly imaging). Without facility fees, the HOPD wouldn't have a sustainable financial model and the health system would have to close it with a detrimental impact on access to care in the community.*

Consolidation in Physician Market: Along with the shift towards integrated care, the past decades have seen a significant increase in consolidation within the physician market and, as a result, more scrutiny around changes in the cost of care through transition to a provider fee/facility fee billing process when a hospital acquires an independent physician practice.

According to the American Medical Association, consolidation within the physician market is being driven by administrative burden, inadequate reimbursement rates, and physician practice owners growing interest in joining a hospital system. Ninety-four percent of physicians think it has become more financially and administratively difficult to operate a practice. One such example of administrative burden is interaction with commercial policies – 81% of physicians report that commercial insurer policies and practices interfere with their ability to practice medicine.[28] In addition to the high administrative burden, independent physicians receive a reimbursement rate (intended to cover both professional services and overhead facility costs) that is generally not enough to cover the cost of providing care. Independent physician reimbursement rate has effectively been cut 26%, adjusted for inflation, from 2001 to 2023.[29]

More than one hundred thousand (108,700) physicians shifted to employment since January 2019. 2021 alone saw a marked increase in employed physicians from 69.3% to 73.9% of all physicians. As of January 2022, approximately 50% of physician practices are owned by hospital or corporate-owned entities – hospitals own about 26% and non-hospital corporate entities own about 27% (an 86% increase since January 2019).[30] Non-hospital corporate entities include health insurers, private equity firms, and

[28] Report: Examining the real factors driving physician practice acquisition: AHA. American Hospital Association. June 2023. https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition.

[29] Advocacy in action: Leading the charge to reform Medicare pay. American Medical Association. August 18, 2023. https://www.ama-assn.org/practice-management/medicare-medicaid/advocacy-action-leading-charge-reform-medicare-pay.

[30] Physician Employment Trends- PAI-Avalere Health Report on Trends in Physician Employment and Acquisitions of Medical Practices: 2019-2021. Physicians Advocacy Institute. April 2022. https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21.

physician medical groups. Contrary to popular belief, most of the physician acquisitions over the last five years have been driven by non-hospital corporate entities such as private equity, physician groups, and health insurers. 65% of acquired physicians between 2019 and 2023 were by private equity while only 4% was by hospitals and health systems (Figure 2).[31] According to a different study, hospital and health system acquisitions have grown at a steady rate (9% growth), while the sharpest increase in medical practice acquisitions (86% growth) between 2019 and 2021 was by corporate entities.[32] Furthermore, hospitals are not the largest employer of doctors. UnitedHealth and its subsidiary Optum are the largest employers of physicians nationwide, with over 70,000 employed or affiliated physicians.[33] Hospitals are largely acquiring physician practices in rural areas to maintain access to care – hospitals are two and a half times more likely to acquire rural physician practices than other entities, such as commercial insurers.[34]

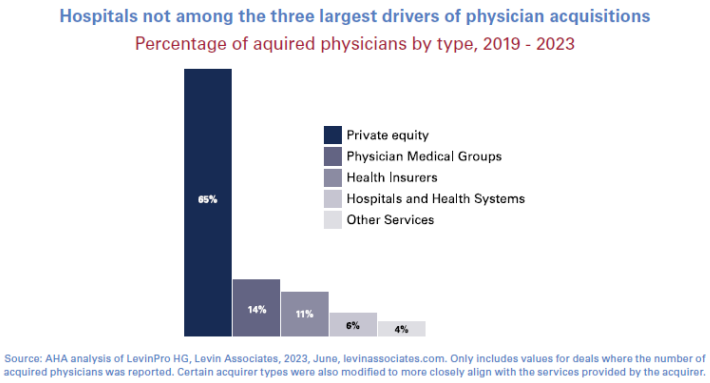

Figure 2. Percentage of acquired physicians by type, 2019-2023.

Unlike physician acquisition by non-hospital entities, the reimbursement structure for a physician practice changes, as mandated by CMS and often adopted by commercial payers, when a practice is acquired by a hospital or health system and practices in an HOPD. Under Medicare requirements, which generally set the industry standard, independent physicians go from receiving reimbursement through one fee that is intended to reimburse for both professional and overhead facility costs to receiving a smaller reimbursement just for the professional services they provide, while the hospital receives the reimbursement portion to cover overhead facility costs. When a practice is acquired by a hospital and providers deliver care in an HOPD, the facility will be required to comply with a much more comprehensive scope of licensing, accreditation, and other regulatory requirements that take funding to meet and maintain. Additionally, the practice will become open to the broader patient mix associated with the hospital, which tend to be older, sicker, more complex, and thus have a higher cost as discussed above. Therefore, the reimbursement structure is set up to account for these changes that occur when a hospital (versus a non-hospital corporate entity) takes ownership of an independent physician practice.

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[31] Setting the record straight: Private equity and health insurers acquire more physicians than Hospitals infographic: AHA. American Hospital Association. June 2023. https://www.aha.org/infographics/2023-06-26-setting-record-straight-private-equity-and-health-insurers-acquire-more-physicians-hospitals?mkt_tok=NzEwLVpMTC02NTEAAAGQiaqPenrGl94qm6qt1ObtY6XIVDJbPdXFOkR3GO_g420LyCSHFMlvU2WQMjL_Ce7BRa682BHlecBrTJCHWoRl3_uexhm_7D2lmEbcs5rjs9FfbA.

[32] Physician Employment Trends- PAI-Avalere Health Report on Trends in Physician Employment and Acquisitions of Medical Practices: 2019-2021. Physicians Advocacy Institute. April 2022. https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21.

[33] Emerson J. Meet America's largest employer of Physicians: Unitedhealth Group. Becker's Payer Issues. February 16, 2023. https://www.beckerspayer.com/payer/meet-americas-largest-employer-of-physicians-unitedhealth-group.html.

[34] Analysis: Hospitals and Health Systems are Critical to Preserving Access to Care for Rural Communities. American Hospital Association. January 2024. https://www.aha.org/system/files/media/file/2024/01/analysis-hospitals-health-systems-are-critical-to-preserving-access-to-care-for-rural-communities-report.pdf

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Consolidation can be positive, especially when there is competition in the market, a metric in which Colorado is highly ranked. According to the Herfindahl-Hirschman Index (HHI), a commonly accepted measure of market concentration, Colorado metro markets are measured as some of the lowest concentration in the U.S., which means there is more competition. Five front range markets were analyzed for hospital market competitiveness and are all in the top 10% most favorable in the United States, out of 186 markets measured.[35] Consolidation can and does facilitate value, integrated care, and continuity of care – all good for patients. Physician affiliations with health systems have saved access to care in many places by ensuring doctors continue to practice medicine.

Section 4: Impact of Facility Fees on Patients

While split billing (i.e. billing for professional and facility fees separately) has been standard practice for a long time, there has been an increased focus on facility fees over the past two decades as plan designs crafted by insurance companies and employers has shifted the cost burden to individuals and employees. According to the Kaiser Family Foundation, the average health insurance deductible for coverage has increased by roughly 250% from 2006 to 2022.[36] Furthermore, the cumulative growth in premiums and out-of-pocket spending for families with large employer insurance between 2008 and 2018 has increased significantly faster than workers' wages – 67% increase in worker share compared to 26% increase in wages.[37]

High Deductible Health Plans (HDHPs): Hand in hand with rising patient cost sharing, the past two decades have also seen an increase in the number of HDHPs. Nationally, enrollment in HDHPs has increased from 34.3% of private sector workers in 2012 to 55.7% of private sector workers in 2021. Colorado is higher than the national rate – 66% of private sector workers were enrolled in HDHPs in 2022, creating a high out-of-pocket cost burden for individuals and families.[38]

The goals of HDHPs were two-fold – drive down unnecessary utilization of health care and thus decrease costs while making patients more invested and informed about their care. However, neither goal has been achieved. The intended behavior change did not occur, and consumers are finding themselves increasingly responsible for more out-of-pocket charges. Individuals with HDHPs are less likely to seek medical care[39] and more likely to be hit with bills they cannot afford,[40] making it a big driver of medical

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[35] Hospital Concentration Index: An Analysis of U.S. Hospital Market Concentration, See how your area stacks up: Denver- Aurora-Lakewood, CO. HMI Interactive Report. June 2023. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-Index.

[36] 2022 employer health benefits survey. KFF. June 5, 2023.https://www.kff.org/mental-health/report/2022-employer-health-benefits-survey/.

[37] Rae M, Copeland R, Cox C. Tracking the rise in premium contributions and cost-sharing for families with large employer coverage. Peterson-KFF Health System Tracker. August 14, 2019. https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/#Cumulative%20growth%20in%20premiums%20and%20out-of-pocket%20spending,%202008-2018.

[38] DeMarco J. High-deductible health plan enrollment falls for first time since 2013. Value Penguin. January 22, 2024. https://www.valuepenguin.com/high-deductible-health-plan-study.

[39] Analysis of high deductible health plans. Rand. https://www.rand.org/pubs/technical_reports/TR562z4/analysis-of-high-deductible-health-plans.html.

[40] Shryock T. Half of the patients with high-deductible health plans have received surprise medical bills. Medical Economics. January 31, 2023. https://www.medicaleconomics.com/view/half-of-patients-with-high-deductible-health-plans-have-received-a-surprise-medical-bill.

debt for patients and uncompensated care for hospitals.[41] Studies have found that patient cost sharing is a blunt instrument that places too high a financial burden on vulnerable patients rather than a finely tuned instrument designed to promote efficient health care use.[42] To add a finer point, cost sharing is effective in reducing costs but doesn't successfully target low-value care, as was the intention.[43] The goal to make patients more informed about their care has also not panned out. A significant amount of effort has been made to increase transparency on behalf of both hospitals and insurers through cost comparison and transparency tools; however, it is unclear the extent to which patients use these tools to effectively shop around for care. Finally, these HDHPs put rural hospitals at a disadvantage as the higher deductible is often consumed at a local level for lower acuity services such as primary and routine care. However, when a significant acute event occurs the patient is very often sent to an urban system where the deductible has been met in the rural area and the urban system is able to bill the insurance company.

Facility Fee Denials: Insurance companies typically reimburse providers and provide coverage to enrollees for facility fees in hospital inpatient and outpatient settings. Increasingly, however, insurance carriers are requiring prior authorization and site of service approvals. These requirements may place restrictions on the type and location of where services can be obtained. If all the approvals and authorizations are not obtained, coverage and payment is denied by the insurance carrier, leaving the patient responsible for the total cost of the services. Recent studies have indicated an increase in prior authorization requirements and denials,[44] leading to delayed care which can increase morbidity and mortality risks for patients.[45]

Cost of Care: It is important to note that while this increase in patient spending would seem to indicate an increase in the underlying cost of care, spending on hospital care has grown at a slower rate (3.4%) since 2020 compared to the growth rate for spending on physicians and clinics (4.0%), and prescription drugs (7.6%), and at a significantly lower rate than patient out of pocket costs, as discussed above.[46] More specifically, Colorado hospitals have much lower costs than the rest of the country. In the most recent release of health expenditures by state, hospital costs in Colorado were $692 lower for each person compared to the U.S. average. For a household of three, that is $2,076 lower than households

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[41] KFF Health News. High-deductible plans jeopardize financial health of patients and rural hospitals in Colorado and beyond. The Colorado Sun. January 12, 2020. https://coloradosun.com/2020/01/11/high-deductible-health-insurance-colorado/.

[42] Remler DK, Greene J. Cost-sharing: A blunt instrument. Annual Reviews: Annual Review of Public Health. April 21, 2009. https://www.annualreviews.org/doi/10.1146/annurev.publhealth.29.020907.090804.

[43] Brot-Goldberg ZC, Chandra A, Handel BR, Kolstad JT. What does a deductible do? the impact of cost-sharing on health care prices, quantities, and spending dynamics*. The Quarterly Journal of Economics. 2017;132(3):1261-1318. doi:10.1093/qje/qjx013

[44] Addressing Commercial Health Plan Challenges to Ensure Fair Coverage for Patients and Providers. American Hospital Association. November 2022. https://www.aha.org/guidesreports/2022-11-01-addressing-commercial-health-plan-challenges-ensure-fair-coverage-patients-and-providers

[45] Gertz AH, Pollack CC, Schultheiss MD, Brownstein JS. Delayed medical care and underlying health in the United States during the COVID-19 pandemic: A cross-sectional study. Prev Med Rep. 2022;28:101882. doi:10.1016/j.pmedr.2022.101882

[46] McGough M, McGough M, Winger A, Rakshit S, Twitter KA. How has U.S. spending on healthcare changed over time? Peterson-KFF Health System Tracker. December 15, 2023. https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Average%20annual%20expenditures%20growth%20rate%20for%20select%20service%20types,%201970-2022.

would be paying compared to the U.S. average.[47] As a share of household income, Coloradans spent 4.1% on hospital costs, the second lowest amount in of all states, substantially less than the U.S. average of 5.9% (Figure 3).[48] Cost trends for Colorado hospitals are less than the national average. From 2015-2020, hospital expense trends in Colorado averaged 3.5% per year compared to the U.S. average of 4.6%.[49]

Health Care Cost Trends (Five Year)	Colorado	U.S.
Hospital Care	3.5%	4.6%
Physician/Professional	4.6%	5.1%
Prescription Drugs/Other Medical	3.3%	2.6%
Nursing Home Care	4.4%	4.7%
Dental Services	3.1%	3.5%
Home Health Care	8.7%	6.7%
Medical Durables	1.2%	2.4%
Other Health	3.3%	2.6%
Total	**3.9%**	**4.1%**

Figure 3. Health care cost trends as a share of household income, 2015-2020

Financial Assistance Policies: While Colorado is a national leader in keeping health care and hospital costs low, patients continue to be challenged with the cost of medical bills. Through programs like Medicaid expansion and Hospital Discounted Care (HDC) requirements, hospitals have taken meaningful steps to absorb the cost of care for patients. For low-income patients, hospitals provide substantial financial support through charity care and financial assistance programs. In 2022, Colorado hospitals provided more than $296.1 million in charity care (more than $1.2 billion since 2019). Charity care provided by Colorado hospitals has increased by nearly 40% since 2019.[50] HB 21-1198, Hospital Discounted Care, which went into effect Sept. 1, 2022, codifies charity care laws, and establishes requirements for how hospitals screen, bill, and collect payments from low-income patients (250% of Federal Poverty Level and below). HDC covers any medically necessary services provided in acute care and critical access hospitals, as well as freestanding EDs. According to the first year of program data, Colorado hospitals provided financial assistance to 212,913 Coloradans through HDC.[51] Since HDC started, the amount of charity care that hospitals provide has increased 14.5% between December 2022 and December 2023.[52]

Downstream Impacts of Facility Fee Ban – Medicaid Expansion: Significant cuts to hospitals lead to significant cuts to the "CHASE" Fee (also known as the Hospital Provider Fee), which funds hospital-based care for Medicaid patients and covers the state's share of expanded Medicaid coverage for

[47] State (residence): Health Expenditures by State of Residence, 1991-2020. Centers for Medicare & Medicaid Services. September 6, 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence.
[48] State (residence): Health Expenditures by State of Residence, 1991-2020. Centers for Medicare & Medicaid Services. September 6, 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence.
[49] State (residence): Health Expenditures by State of Residence, 1991-2020. Centers for Medicare & Medicaid Services. September 6, 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence.
[50] Colorado Healthcare Affordability and Sustainability Enterprise Annual Report. January 16, 2024. https://hcpf.colorado.gov/sites/hcpf/files/DRAFT%202024%20CHASE%20Annual%20Report.pdf
[51] HB21-1198: Hospital Discounted Care Data Reporting Handout. January 19, 2024. https://leg.colorado.gov/sites/default/files/images/hospital_discounted_care_smart_act_handout_presentation_extension.pdf.
[52] CHA DATABANK reporting program.

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622,000 Coloradans in 2023.[53] Without the fees hospitals pay, access for all Medicaid beneficiaries (1.6 million) would worsen, and the state would either need to find **$487 million** per year in the General Fund to cover the state's share, or eliminate coverage for 622,000 Coloradans, also **sacrificing $2.8 billion** per year in federal matching funds.

Section 5: Conclusion

Facility fees and the practice of split billing originated with the inception of the Medicare program to appropriately reimburse facilities for all of the costs associated with running and maintaining a hospital. National experts acknowledge the need for the facility component in hospital reimbursement and preserve facility fees in policy proposals around reimbursement for different sites of care. There has been an increased focus on facility fees with the dramatic increase in patient cost sharing over the last two decades as a result of carrier and employer practices to shift more costs onto the patient and not necessarily due to a corresponding rate of increase in the cost of care. Imposing a ban on facility fees would have dramatic downstream impacts on the safety net system set up for patients with the greatest health care needs.

While there is always room for improvement, Colorado has a highly functioning health care market with some of the best outcomes for patients in the country. Colorado hospitals have answered policymaker calls to create an integrated system of care that has resulted in higher quality care for patients. Patients have access to some of the top hospitals in the country for providing clinical excellence according to 2023 Healthgrades with seven Colorado hospitals in the top 5% of all U.S. hospitals.[54]

Colorado's system of care extends beyond the large urban systems out to the small communities in the state. The partnership between Colorado's frontier and rural hospitals and their urban counterparts has resulted in increased access to care for some of our most vulnerable populations living in remote areas of the state. Colorado is the second best of all states in avoidable ED visits and 30-day hospital readmission rates and Colorado is ranked 12th best for health system performance including measures of quality, access, affordability, and treatment.[55] Finally, Colorado residents are rated the healthiest in the country and the state as a whole is considered the 4th healthiest state.[56] Facility fees are an integral part of Colorado's high performing health system and prohibiting hospitals from charging them would have profound implications on the health system and, most importantly, the patients hospitals serve.

[53] Colorado Healthcare Affordability and Sustainability Enterprise Annual Report. January 16, 2024. https://hcpf.colorado.gov/sites/hcpf/files/DRAFT%202024%20CHASE%20Annual%20Report.pdf

[54] Quality Awards for Quality Care. Healthgrades. 2024. https://www.healthgrades.com/quality/hospital-ratings-awards.

[55] 2022 scorecard on state health system performance. COVID-19 | Commonwealth Fund. June 16, 2022. https://www.commonwealthfund.org/publications/scorecard/2022/jun/2022-scorecard-state-health-system-performance.

[56] Healthiest states 2024. HubScore. 2024. https://hubscore.co/ranking/healthiest-states.

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