COLORADO
Department of Health Care Policy & Financing

303 E. 17th Avenue
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Hospital Facility Fee Data Requests

Committee Consultation

The all-payers claims database (APCD) claims analysis must be supplemented with data from hospitals and health systems, independent practitioners, and commercial payers (as well as HCPF and the Division of Insurance) to complete the requirements of the facility fee report. To meet the data and analysis requirements of the facility fee report as specified in C.R.S. 25.5-4-216(6), HCPF is proposing to survey these three groups to gather information:

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

The legislation specifies the information to be obtained from each of the groups. These requirements, as they appear in the Colorado Revised Statutes, are shown at the end of this document.

HCPF will use an online survey software to facilitate the collection of required information.

In preparing the surveys, HCPF is requesting guidance from the steering committee on request content to ensure:

- adherence to statutory requirements
- questions designed in such a way as to minimize the need for interpretation on the part of the respondents
- responses are consistent in format and content
- responses provide the information necessary for the steering committee to prepare its report meeting the intention of the legislation
- a minimal number of data requests[1]

While the statute does provide some specificity with respect to the information that is to be gathered, **HCPF believes there is ambiguity in some of the requirements that needs to be clarified.**

Listed below are data considerations that need facility fee committee guidance accompanied by subject matter expert feedback, and HCPF recommendations. These HCPF recommendations consider that “every effort must be made to minimize the number of data requests.”[2]

[1] 25.5-4-216(9)
[2] 25.5-4-216(9)

Data Request Specific Considerations

A. Hospital and Health Systems Data Request

Ambiguity to Address

- Sub-sections III and IV regarding Hospital and Health Systems data section require descriptions of services.
    - HCPF suggests the term "description" be defined to ensure consistency in responses and recommends respondents use CPT codes to describe services to alleviate the ambiguity in this request and provide for more consistent responses.
- Sub-section III of the Hospital and Health Systems data section uses the term "most frequent health-care services for which facility fees were charged."
    - HCPF suggests this term requires some definition and recommends that instead of "most frequent," the request should specify a number of CPT codes that provides adequate coverage of the total number of unique services.
- Sub-section IV of the Hospital and Health Systems data section requests the health care services that "generated the greatest amount of gross facility fee revenue and net revenue received."
    - HCPF suggests this question be framed in terms of a specified number of CPT codes that cover adequate percentages of the amount reported under sub-section II (total revenue collected in facility fees) and gross facility fee revenue.

Subject Matter Expert Feedback Received

HCPF reached out to the Colorado Hospital Association (CHA) to solicit feedback on these points. Their responses are as follows:

- Regarding the proposal to use CPT codes in place of "description":

  CHA RESPONSE: In asking each hospital for the most frequent services, it would be most practical to ask for the top 25 count of HCPC/CPT services provided.

  CHA has run data for the entire industry and the top 25 codes represent 37% of all services (more than top quartile). Trying to get to 80/90% would be more than most frequent. That would be nearly all services and not practical for each hospital. CHA is willing to provide top 50 (51% of all services) or top 100 (66% of all services) for the industry if that is necessary.

- Regarding the proposal to further define the term "most frequent":

  CHA RESPONSE: In asking each hospital for the most frequent services, it would be most practical to ask for the top 25 count of HCPC/CPT services provided.

  CHA has run data for the entire industry and the top 25 codes represent 37% of all services (more than top quartile). Trying to get to 80/90% would be more

than most frequent. That would be nearly all services and not practical for each hospital. CHA is willing to provide top 50 (51% of all services) or top 100 (66% of all services) for the industry if that is necessary.

- Regarding the proposal to further define the term "greatest amount":

  CHA RESPONSE: In asking each hospital for the greatest amount of gross revenue and net revenue of services, it would be most practical to ask for the top 25 HCPC/CPT items of total gross charges.

  CHA has run data for the entire industry and the top 25 codes represent nearly 35% of total $ charges for all services (more than top quartile). Trying to get to 80/90% would be more than most frequent. That would be nearly all services and not practical for each hospital. CHA is willing to provide top 50 (41% of all services) or top 100 (46% of all services) for the industry if that is necessary.

  Net revenue at the HCPC/CPT level is not possible. Net revenue at almost any detail level metric is not available and hospitals do not have that data. There are many different types of payment arrangements that are not made at a detail level (DRG, per diems, EAPGs, risk sharing payments, etc). Those are not accumulated at HCPC/CPT (or any level). Other methods could be used, however, to estimate net revenue by 1) taking HCPC/CPT volumes multiplied by average payment rates (perhaps from the APCD) or 2) using gross charges times a payment to charge factor/ratio or 3) obtaining data from the payers.

HCPF Recommendations:

Based on CHA's responses, HCPF recommends CPT codes be used to describe the services requested in the statute. HCPF proposes respondents provide a sufficient number of CPT codes to provide adequate coverage of the total number of unique services (frequency). HCPF recommends a minimum of 100 CPT codes should be required.

HCPF also recommends respondents provide a sufficient number of CPT codes to provide adequate coverage of facility fee revenue. HCPF recommends a minimum number of CPT codes that represent X% of net facility fee revenue.

B. Commercial Payer Data Request

Ambiguity to Address

- Sub-section II of the Commercial Payers data section requests a list of common procedures associated with facility fees.
  - HCPF suggests the request should be defined to ensure consistency in responses and recommends that respondents use CPT codes to describe common procedures to provide for consistent information.
  - HCPF suggests the request specifies a number of CPT codes.

HCPF Recommendation: To provide clarity to the respondents and to provide consistency in responses, HCPF proposes that respondents provide a sufficient number of CPT codes to provide adequate coverage of the total number of unique

services. HCPF recommends a minimum of 100 CPT codes should be required, consistent with the request to the hospitals.

C. Independent Health-Care Providers Data Request

Ambiguity to address

- Sub-sections III and IV of this data request information about facility fee policies and volume.
- Statutory language in question:
    - (d) DATA FROM INDEPENDENT HEALTH-CARE PROVIDERS THAT ARE NOT AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM, INCLUDING:
        - (I) HISTORIC AND CURRENT BUSINESS NAMES AND ADDRESSES;
        - (II) HISTORIC AND CURRENT TAX IDENTIFICATION NUMBERS AND NATIONAL PROVIDER IDENTIFIERS;
        - (III) FACILITY FEE BILLING POLICIES, INCLUDING WHETHER ANY CHANGES WERE MADE TO SUCH POLICIES IN THE PAST FIVE YEARS; AND
        - (IV) WHERE APPLICABLE, THE TOP TEN CPT CODES, REVENUE CODES, OR COMBINATION THEREOF, AT THE STEERING COMMITTEE'S DISCRETION, FOR WHICH A FACILITY FEE IS BILLED AND THE PROFESSIONAL FEE AMOUNT FOR THE SAME SERVICE;
- HCPF understands that hospital outpatient facility fee policies and volume are not applicable to independent practitioners. HCPF requests guidance from the Steering Committee regarding these questions.

HCPF Recommendations:

HCPF has one suggested question below. HCPF requests that committee members recommend any additional questions to ask independent providers.

Suggested questions for independent providers:

- How do you ensure your practice expense is covered when negotiating rates with commercial payers?
- To Be Determined

Other Considerations

A. For All Data Requests, No Time-period Described in Statute

Ambiguity to Address

- The statute is silent on the time-period to be covered by the responses. The APCD claims analysis will cover claims from calendar year 2017 through 2022.

Subject Matter Expert Feedback Received

CHA RESPONSE: We would also suggest using a 'standard' reporting period. CHA suggests using a full and complete year of data from 2022 dates of service.

HCPF Recommendation: HCPF recommends that the data gathered covers dates of service calendar year 2022

B. For All Data Requests, Specify the Location of services

Ambiguity to Address

- While outpatient facility fees can be generated at both on-campus and off-campus location, consistent with 25.5-4-216(6)(b)(V) and HCPF's understanding of the intent of the legislation, HCPF suggests the statute is concerned primarily with off-campus facility fees.

HCPF Recommendation: HCPF recommends that the data request requires separate on and off-campus responses.

Data Request Statutory Language

25.5-4-216(6)(b) Hospital & Health Systems Data

(b) DATA FROM HOSPITALS AND HEALTH SYSTEMS, WHICH DATA SHALL BE PROVIDED TO THE STEERING COMMITTEE, INCLUDING:
(I) THE NUMBER OF PATIENT VISITS FOR WHICH FACILITY FEES WERE CHARGED;
(II) THE TOTAL REVENUE COLLECTED IN FACILITY FEES;
(III) A DESCRIPTION OF THE MOST FREQUENT HEALTH-CARE SERVICES FOR WHICH FACILITY FEES WERE CHARGED AND NET REVENUE RECEIVED FOR EACH SUCH SERVICE;
(IV) A DESCRIPTION OF HEALTH-CARE SERVICES THAT GENERATED THE GREATEST AMOUNT OF GROSS FACILITY FEE REVENUE AND NET REVENUE RECEIVED FOR EACH SUCH SERVICE; AND
(V) DATA FROM OFF-CAMPUS HEALTH-CARE PROVIDERS THAT ARE AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM, INCLUDING:
(A) HISTORIC AND CURRENT BUSINESS NAMES AND ADDRESSES;
(B) HISTORIC AND CURRENT TAX IDENTIFICATION NUMBERS AND NATIONAL PROVIDER IDENTIFIERS;
(C) HEALTH-CARE PROVIDER ACQUISITION OR AFFILIATION DATE;
(D) FACILITY FEE BILLING POLICIES, INCLUDING WHETHER ANY CHANGES WERE MADE TO SUCH POLICIES BEFORE OR AFTER THE ACQUISITION OR AFFILIATION DATE; AND
(E) THE TOP TEN CPT CODES, REVENUE CODES, OR COMBINATION THEREOF, AT THE STATE DEPARTMENT'S DISCRETION, FOR WHICH A FACILITY FEE IS BILLED AND THE PROFESSIONAL FEE AMOUNT FOR THE SAME SERVICE;

25.5-4-216(10) Regarding Colorado Hospital Association

(10) A STATEWIDE ASSOCIATION OF HOSPITALS MAY ALSO PROVIDE DATA SPECIFIED IN SUBSECTION (6)(b) OF THIS SECTION TO THE STEERING COMMITTEE.

25.5-4-216(6)(c) Commercial Payers Data

(c) DATA, IF AVAILABLE, FROM THE STATE DEPARTMENT, THE DIVISION OF INSURANCE, AND COMMERCIAL PAYERS, INCLUDING:
(I) THE PAYMENT POLICY EACH PAYER USES FOR PAYMENT OF FACILITY FEES FOR NETWORK PRODUCTS, INCLUDING ANY CHANGES THAT WERE MADE TO SUCH POLICIES WITHIN THE LAST FIVE YEARS;
(II) A LIST OF COMMON PROCEDURES ASSOCIATED WITH FACILITY FEES;

(III) EACH PAYER'S NETWORK PRODUCT NAMES;
(IV) PAID AGGREGATE FACILITY FEE BILLINGS FROM OUTPATIENT PROVIDERS AND THE ASSOCIATED NUMBER OF FACILITY FEE CLAIMS, BROKEN DOWN BY HOSPITAL OR HEALTH SYSTEM; AND
(V) A DESCRIPTION OF THE ESTIMATED IMPACT OF FACILITY FEES ON PREMIUM RATES, OUT-OF-NETWORK CLAIMS, MEMBER COST SHARING, AND EMPLOYER COSTS;

25.5-4-216(6)(d) Independent Health-Care Providers Data

(d) DATA FROM INDEPENDENT HEALTH-CARE PROVIDERS THAT ARE NOT AFFILIATED WITH OR OWNED BY A HOSPITAL OR HEALTH SYSTEM, INCLUDING:
(I) HISTORIC AND CURRENT BUSINESS NAMES AND ADDRESSES;
(II) HISTORIC AND CURRENT TAX IDENTIFICATION NUMBERS AND NATIONAL PROVIDER IDENTIFIERS;
(III) FACILITY FEE BILLING POLICIES, INCLUDING WHETHER ANY CHANGES WERE MADE TO SUCH POLICIES IN THE PAST FIVE YEARS; AND
(IV) WHERE APPLICABLE, THE TOP TEN CPT CODES, REVENUE CODES, OR COMBINATION THEREOF, AT THE STEERING COMMITTEE'S DISCRETION, FOR WHICH A FACILITY FEE IS BILLED AND THE PROFESSIONAL FEE AMOUNT FOR THE SAME SERVICE;

25.5-4-216(9) Additional Information Regarding Data Requests

(9) THE DATA DESCRIBED IN THIS SECTION MUST BE SOUGHT IN A FORM AND MANNER DETERMINED BY THE STEERING COMMITTEE, STATE DEPARTMENT, OR THIRD-PARTY CONTRACTORS TO FACILITATE SUBMISSION OF INFORMATION. THE STEERING COMMITTEE SHALL SEEK TO EXHAUST EXISTING DATA SOURCES BEFORE MAKING ADDITIONAL REQUESTS FOR INFORMATION FOR PURPOSES OF THE REPORT, AND EVERY EFFORT MUST BE MADE TO MINIMIZE THE NUMBER OF DATA REQUESTS. THE REPORT MUST INCLUDE A DESCRIPTION OF WHICH ENTITIES WERE CONTACTED FOR INFORMATION AND THE OUTCOME OF EACH REQUEST.