

# HB23-1215

## Hospital Facility Fee Steering Committee

Facilitated by:  
Government Performance Solutions, Inc. (GPS)

Tuesday, July 16, 2024  
4:00 – 6:00 p.m.



**COLORADO**  
Department of Health Care  
Policy & Financing



# Virtual meeting guidelines

Here are some ideas to make virtual collaboration easy on us all:



This meeting is being recorded!



If your computer has a camera, please keep it on. Be careful there is nothing revealing in your background. We suggest using the blur feature or virtual background.



Put your computer microphones (or phone) on mute



Use the chat feature to share ideas and ask questions



Click the Live Transcript icon at the bottom of your screen

# Welcome



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# Who's on the steering committee?

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



# Why are we here? HB23-1215

- HCPF must form a steering committee to deliver to the state House of Representatives Health and Insurance Committee, the Senate Health and Human Services Committee, or their successor committees a separate, one-time report by October 1, 2024, that details the impact of facilities fees using data from the past 10 years.
- **The Steering Committee is required to develop a report detailing the impact of facility fees**, defined as “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.”
- The Steering Committee is entitled to receive and request data from the All-Payers Claims Database, hospitals, and health systems, Health Care Policy and Financing (HCPF), Division of Insurance (DOI), commercial payers, and independent providers.



# What will we accomplish today?

1. Agenda, shared purpose, and commitments (5 minutes)
2. Data scorecard recap and action items (5 minutes)
3. Impact on Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) (20 minutes)
4. Comparison of professional and facility fees for independent and affiliated providers (30 minutes)
5. Impact of facility fee & payer coverage policies (30 minutes)
6. Legal and historic reasons for split billing (15 minutes)
7. Public comment 5:45 - 5:55 p.m. (10 minutes)
8. Next steps (5 minutes)



# Recap: Our boundaries

- The steering committee will keep the scope of work confined to HB23-1215's requirements.
- There may be limitations on the data available for actuarial analysis, so the report will be based on what is available.
- The steering committee shall not share publicly any information submitted to the steering committee as “confidential.”

# Procedural norms

- Follow [open meeting laws](#) protocols; communication between 2 or more steering committee members requires public notice
- If we need to vote to confirm consensus on the accuracy and completeness of the language/data that explain the impact, we will
  - Use roll call vote and ask dissenters to draft their opinion
  - If unable to attend a meeting where a vote is occurring, share your vote and opinion in writing before the meeting
- Have public comment at the end of the meeting, unless voting on impact/decision, then prior to the vote

# Shared behavioral commitments

In January, the group adopted these (8) behavioral commitments:

- Engage in candid, honest dialogue while maintaining an open mind about other's positions
- Avoid acronyms and speak up if you require clarification
- Stay on topic and within the boundaries established in [HB23-1215](#)
- Use the raise hand function to signal your desire to speak; allow some grace if there is a topic change
- Be succinct in your engagement to make room for others to ask questions and share their opinions
- Maintain mutual respect, acknowledging that each person has been chosen for a reason and is equally important
- It's okay to disagree, but do so without being disagreeable
- Be on camera by default; notify others if there is a reason you cannot

# Data Scorecard and Upcoming Meetings



# Recap

- Prior to last meeting, Optumas and HCPF developed a spreadsheet that highlights:
  - Requirement
  - Planned analysis
  - Data availability
    - **Green**—data available and the analysis is understood
    - **Yellow**—With Steering Committee support, the data is available and analysis is possible
    - **Red**—There are barriers to data access and/or analysis that may not be surmountable
- We have updated the spreadsheet based on recent progress and the Steering Committee’s request to map topic against future meetings

# Meeting Dates and Topics

July 16	August 13
<ul style="list-style-type: none"> <li>• <a href="#">Impact on CHASE</a></li> <li>• Comparison of professional and facility fees (independent and affiliated providers) - <b>results</b></li> <li>• Impact of facility fees &amp; payer coverage policies</li> <li>• Independent provider survey data on charges and policies</li> <li>• Impact to Access to Care, Health Equity</li> <li>• Facility Fee Legal Review</li> </ul>	<ul style="list-style-type: none"> <li>• Discuss the first draft of the report shared with the SteerCo on August 1</li> <li>• Identify areas of consensus and confirm via vote</li> <li>• Clarify remaining open items and the path to close by October 1</li> </ul> <p><i>HCPF will notify the Legislature to expect the report on September 1</i></p>

**Note: Reference to specific requirements in the legislation available in the scorecard: [CO HB1215 - Data Progress.xlsx - Google Sheets](#)**

# Follow-up Actions and Status

Based on the July 9 Steering Committee meeting, Optumas and HCPF completed the following:

1. Adjust the example in the PowerPoint from 7/9 to be an apples-to-apples comparison (Done, updated version posted)
2. Determine which publicly available information from hospital billing submissions should be included (in process)
3. Develop one or more examples using actual data to illustrate the complexity of billing and difference in total cost of a visit between different sites of service (for steering committee consideration in the draft final report on Aug 1)

# CHASE Impact



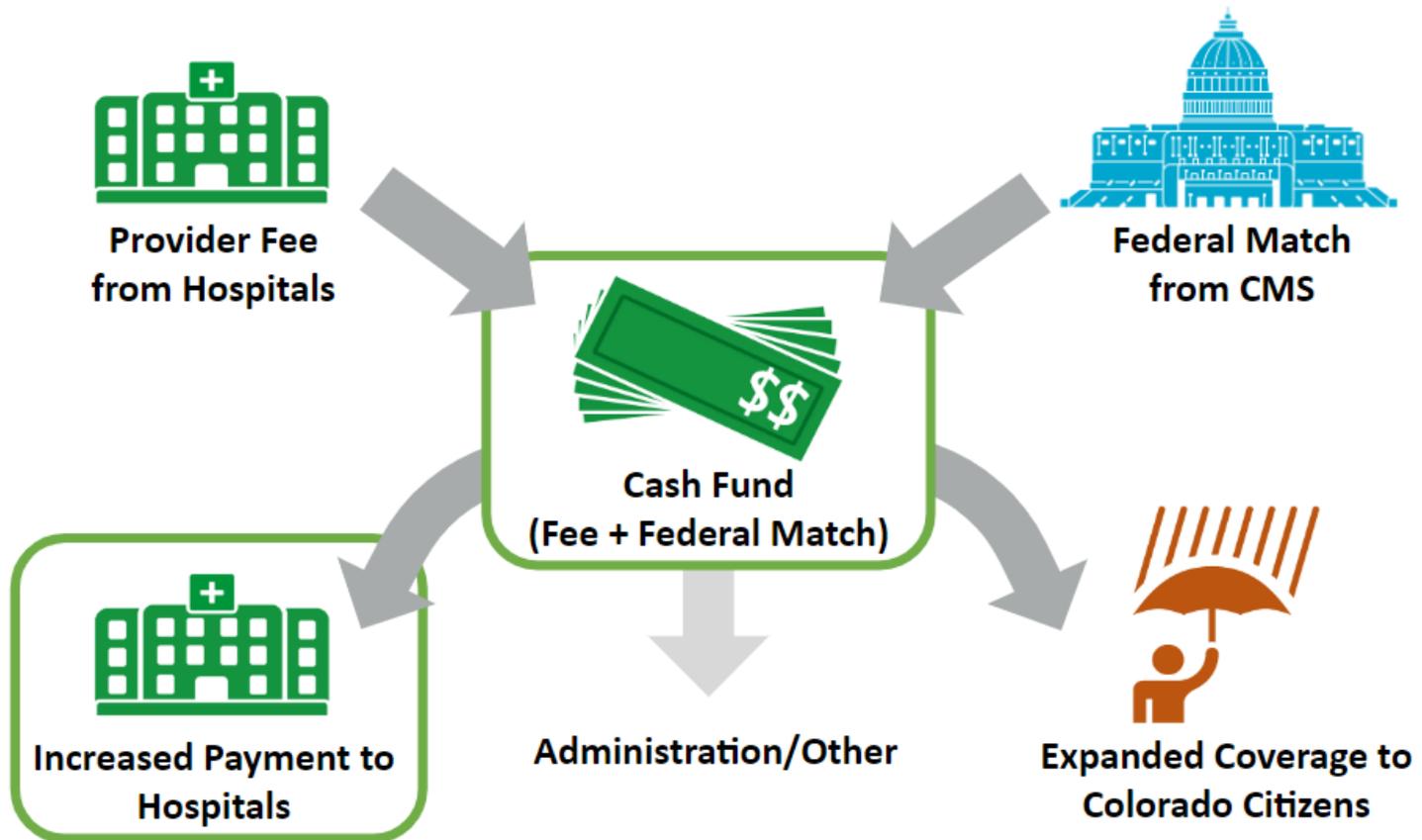
# CHASE Requirement

- Colorado Healthcare Affordability and Sustainability Enterprise (CHASE)
- Section 25.5-4-216(6)(e), C.R.S., requires that the report include an analysis of “the impact of facility fees and payer coverage policies on the Colorado Healthcare Affordability and Sustainability enterprise, created in section 25.5-4-402.4, the Medicaid expansion, uncompensated care, and undercompensated care”

Row 47 on the [data scorecard](#) summary tab



# CHASE Background



# CHASE Background

- Assess hospital provider fee to
  - Increase reimbursement to hospitals for care provided to Medicaid members and uninsured patients
  - Fund Hospital Quality Incentive Payments
  - Fund and implement the Hospital Transformation Program
  - Increase Medicaid and Child Health Plan *Plus* (CHP+) coverage to reduce uncompensated care
  - Pay administrative costs limited to 3% of expenditures
- Federal limits
  - Fees collected limited to 6% of hospitals' net patient revenues (NPR)
  - Medicaid supplemental payments limited to upper payment limits (UPLs) and Disproportionate Share Hospital (DSH) allotment



# CHASE Impact

- Compute the current CHASE revenue that is due to facility fees, utilizing an estimation method for markets where data is not available
- Identify the potential impact on CHASE

# CHASE Impact Available Data

- 2022 allowed commercial facility fees  
([Exhibit III, Commercial Methodology Memo](#))
- Net Patient Revenue (NPR) inpatient and outpatient breakout, CHASE fee NPR %, CHASE fee uses  
(2023-24 CHASE fees and payments model)
- 2022 NPR by major payer group  
([Hospital Financial Transparency](#) dataset)

# CHASE Impact Available Data (1 of 3)

- 2022 allowed commercial facility fees

*Exhibit III – The total allowed Facility Fee amounts billed and denied.<sup>1</sup>*

CY	Allowed Dollars		
	Denied	Not Denied	Total
2020	\$88,256,555	\$1,279,759,827	\$1,368,016,382
2021	\$115,093,371	\$1,498,463,813	\$1,613,557,184
2022	\$127,876,219	\$1,550,983,945	\$1,678,860,164
<b>Total</b>	<b>\$331,226,145</b>	<b>\$4,329,207,584</b>	<b>\$4,660,433,730</b>

# CHASE Impact Available Data (2 of 3)

- NPR inpatient and outpatient breakout, CHASE fee NPR %, CHASE fee uses

NPR by Service Type	%
Inpatient (IP)	43.2%
Outpatient (OP)	56.8%

CHASE Fee NPR	%
CHASE Fee NPR	5.6%

CHASE Fee Uses	% of Fees
Expansion Estimates	40%
Administration Estimates	3%
General Fund Offset	1%
Supplemental Medicaid Payments	46%
DSH Payments	10%

# CHASE Impact Available Data (3 of 3)

- 2022 NPR by major payer group

Payer	Total NPR (in millions)
Champus/Tricare	\$382.1
Colorado Indigent Care Program (CICP)	\$44.2
Commercial	\$10,397.5
Medicaid	\$3,709.5
Medicare	\$5,792.5
Other	\$723.3
Self Pay	\$206.8
Total	\$21,255.9

# CHASE Impact Methodology

1. Using 2022 allowed HOPD commercial facility fees, calculate the percentage of commercial OP NPR due to HOPD commercial facility fees, then
2. Multiple that percentage by OP NPR for all payers to estimate the total amount of HOPD facility fee revenue across all payers, then
3. Subtract the estimated HOPD total facilities fee revenue from total NPR and estimate a range of potential NPR amounts, then
4. Given federal 6% NPR limit, compare current fees to this cap across the range of potential NPR amounts

# CHASE Impact Estimate in Millions (1 of 5)

Allowed Commercial HOPD Facility Fees	\$1,551.0
Divided by APCD % of covered lives	74%
Equals Adjusted Commercial HOPD Facility Fees	\$2,095.9

# CHASE Impact Estimate in Millions (2 of 5)

NPR by Service Type	%
Inpatient (IP)	43.2%
Outpatient (OP)	56.8%

Payer	Total NPR	Est. IP NPR	Est. OP NPR
Champus/Tricare	\$382.1	\$165.0	\$217.0
Colorado Indigent Care Program (CICP)	\$44.2	\$19.1	\$25.1
<b>Commercial</b>	\$10,397.5	\$4,490.9	<b>\$5,906.6</b>
Medicaid	\$3,709.5	\$1,602.2	\$2,107.3
Medicare	\$5,792.5	\$2,501.9	\$3,290.6
Other	\$723.3	\$312.4	\$410.9
Self Pay	\$206.8	\$89.3	\$117.5
<b>Total</b>	<b>\$21,255.9</b>	<b>\$9,180.9</b>	<b>\$12,075.0</b>

# CHASE Impact Estimate in Millions (3 of 5)

Commercial OP NPR	\$5,906.6
Divided by Adj. Commercial HOPD Facility Fees	\$2,095.9
Equals HOPD Facility Fees % of Commercial OP NPR	35%

OP NPR	\$12,075.0
Multiplied by HOPD Facility Fees % of OP NPR	35%
Equals HOPD Facility Fees Amount of Total OP NPR	\$4,284.7

# CHASE Impact Estimate in Millions (4 of 5)

Estimate the range of Adjusted NPR at (3) scenarios: 10%, 50%, 100%)

Total NPR	Fac Fees OP NPR	% Effect	Adj Fac Fees OP NPR	Adj Total NPR
\$21,255.9	\$4,284.7	10%	\$428.5	\$20,827.4
\$21,255.9	\$4,284.7	50%	\$2,142.4	\$19,113.5
\$21,255.9	\$4,284.7	100%	\$4,284.7	\$16,971.2

Net dollar impact at (3) scenarios within the 6% cap

Scenario	NPR	Federal NPR Limit	Maximum Fees	Difference from Status Quo
CHASE NPR % Status Quo	\$21,255.9	5.6%	\$1,186.2	\$0.0
Fac Fee Impact 10%	\$20,827.4	6%	\$1,249.6	\$63.5
Fac Fee Impact 50%	\$19,113.5	6%	\$1,146.8	-\$39.4
Fac Fee Impact 100%	\$16,971.2	6%	\$1,018.3	-\$167.9

# CHASE Impact Estimate in Millions (5 of 5)

CHASE Fee Uses	% of Fees
Expansion Estimates	40%
Supplemental Medicaid Payments	46%

	Difference from Status Quo	Supp. Payments	Expansion
CHASE Status Quo	\$0.0	\$0.0	\$0.0
Fac Fee Impact 10%	\$63.5	\$0.0	\$0.0
Fac Fee Impact 50%	-\$39.4	-\$18.1	-\$15.8
Fac Fee Impact 100%	-\$167.9	-\$77.2	-\$67.3

\*\*There are other impacts to the CHASE model that have not been analyzed and are therefore not reflected here

# Comparison of professional and facility fees for independent and affiliated providers



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# Overall Approach

- Code level comparison for top HOPD codes
  - Independent and affiliated professional fees compared to HOPD facility fees
- Payers
  - Commercial, Medicare FFS, Medicare advantage
- Methodology
  - Average allowed amount per code (unit cost)
  - Removed outliers and grouped payments

Rows 9-10 on the [data scorecard](#) summary tab



# Comparison Memo

- Optumas has created a memo for Steering Committee review.
- Optumas will cover the high-points and result and then we can dig into the details



July 8, 2024

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

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## **Professional and Facility Fee Comparison Methodology Report - DRAFT**

### **Overview**

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

# Results (1 of 2)

- Generally, HOPD allowed amount higher than professional allowed amount for the same service
  - \$50.8M to \$53.7M higher for top 25 HOPD codes compared to professional fees (affiliated and independent, respectively)
    - Commercial: \$38.2M to \$39.2M
    - Medicare FFS: \$11.0M for both prof. provider types
    - Medicare Advantage: \$1.6M to \$3.4M

# Results (2 of 2)

- 90% to 95% higher for Medicare FFS and Commercial in aggregate across top codes
  - 15% to 35% higher for Medicare Advantage
  - Based on HOPD utilization volume by CPT code
- Range of variation across CPT codes
  - A few codes were noted to have lower facility fees than professional fees

# The impact of facility fees and payer coverage policies to...



# Consumers, small and large employers, and the medical assistance program

- Consumers pay more, in general, for hospital outpatient services than the same service in a non-hospital setting
- High-deductible plans increase out-of-pocket cost and motivation to shop for care, and potentially foregoing care
- Employers are concerned with increasing health care costs. Employers absorb the increased cost of premiums, and the increase impacts payroll
- May contribute to higher premiums (a high-level scenario analysis is forthcoming)

## Billing Policies

- [Hospital and Health System Billing Policies](#) - *determining which publicly available information to include*
- [Carrier Response](#)

Row 8 on the [data scorecard](#) summary tab



# Independent health-care provider charges

- APCD analysis indicates
  - Charges vary broadly across providers and are not consistently related to payments
  - Payments (“allowed amounts”) to, independent providers are typically less for the same billing codes
- Survey responses indicate
  - Frustration with inequity— independent providers report being frustrated with being paid less for the same/similar service
  - [Independent Health-Care Provider Survey Responses with Respondent Information Removed](#)

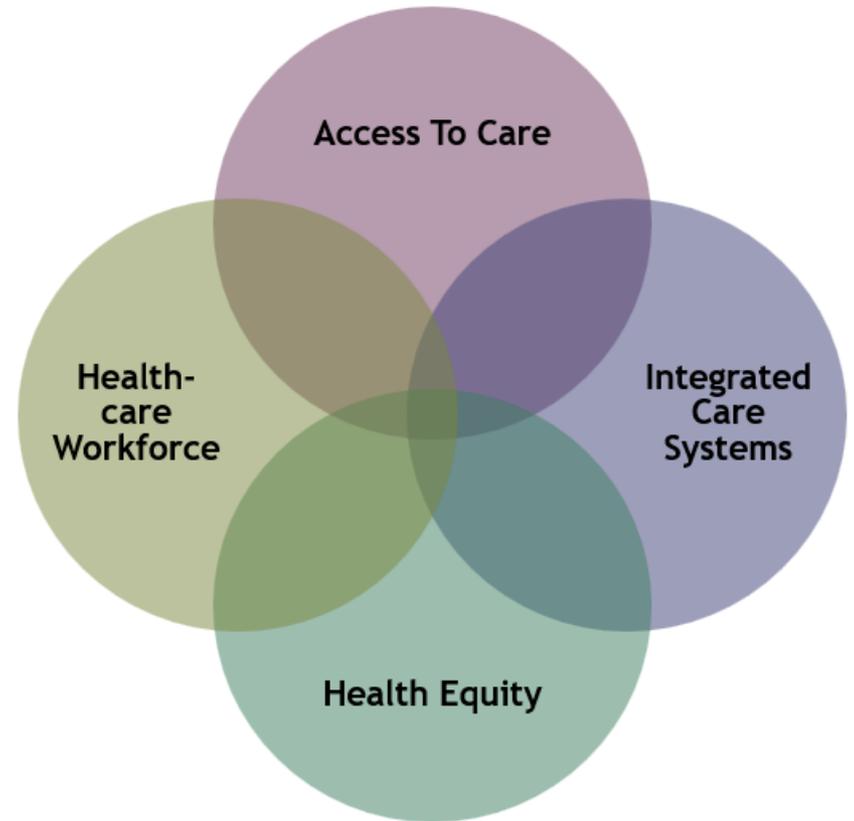
Row 9 on the [data scorecard](#) summary tab



There is a complex relationship between access to care, integrated care systems, health equity, and the health-care workforce

Let's explore from 2 perspectives:

- 1) Consumer
- 2) Hospital & Health System



# Access to care, integrated care systems, health equity, and the health-care workforce (1 of 3)

- Impact on access to care: primary, behavioral, and specialty care
  - Consumer perspective:
    - Health care becomes more expensive for the same service, leading to
      - Medical debt
      - People skipping needed care
    - Facility fees are more prevalent as hospital/health systems acquire physician practices, which limits
      - Patient's ability to shop for care
      - Patient's choice on referrals
  - Hospital/Health System perspective:
    - Facility fees help support costs, allowing facilities to remain open and available
    - HOPDs also serve a different patient population than other sites of care, including those with more complex needs

Row 50 on the [data scorecard](#) summary tab

# Access to care, integrated care systems, health equity, and the health-care workforce (2 of 3)

- Impact on Integrated Care Systems:
  - Consumer perspective:
    - Consumer is often unaware as to the affiliation status of the physician and the existence of facility fees
  - Hospital/Health System perspective:
    - Better care coordination
- Impact on Health Equity
  - Consumer perspective:
    - Facility fees adversely affect lower income populations and less savvy purchasers
  - Hospital/Health System perspective:
    - HOPDs serve a different patient population than other sites of care and help ensure high quality care for people with complex health needs

Row 50 on the [data scorecard](#) summary tab

# Access to care, integrated care systems, health equity, and the health-care workforce (3 of 3)

- Impact on Health-care Workforce
  - Burnout of independent providers
    - inequity in reimbursement
    - less negotiating power
    - loss of employees
    - loss of market share
  - Consolidation with health systems
    - Can facilitate value, integrated care, and continuity of care
    - Can result in wage increases as hospitals/health systems often pay more

Row 50 on the [data scorecard](#) summary tab



# Description: Legal and historic reasons for split billing



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# Description Legal and Historic Reasons for Split Billing

- The report requires 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;
- HCPF will include this description in the draft version of the report to be shared on August 1 for Steering Committee Review, edit and adoption

Rows 53-55 on the [data scorecard](#) summary tab





# Public Comment

# Public comment

Please...

1. Indicate you wish to offer public comment:
  - Speak to the facilitator if in person
  - Use the “raise your hand” icon if online
  - Hit \*9 to raise your hand if you are on the phone.
2. Wait to speak until the facilitator calls your name.
3. Make your comments within the request time limit to allow other time to speak.
4. Written comments are also welcome at [hcpf\\_facilityfee@state.co.us](mailto:hcpf_facilityfee@state.co.us)

Thank you!

# Next Steps



# Next steps

- The analysis and facilitation team (HCPF, Optumas, and GPS) will create a first draft of the full report by August 1
  - Per agreement on 7/9, we will send sections to steering committee members as they are ready and post the sections in the [Steering Committee Members Shared Materials](#) folder
- Steering Committee meeting is August 13, from 4:00 - 6:00 PM
  - Identify areas of consensus and confirm via vote
  - Clarify remaining open items and the path to close by October 1

*HCPF will notify the Legislature to expect the report on September 1*

# Thank you!

