HB23-1215
Hospital Facility Fee Steering Committee

Facilitated by:

Government Performance Solutions, Inc. (GPS)

Tuesday, March 12, 2023

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

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, University of Colorado Hospital Authority
5. Bettina Schneider, Chief Financial Officer, Colorado Department of Health Care Policy and Financing (HCPF)
6. Kevin Stansbury, Chief Executive Officer, Lincoln Community Hospital
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?

- Confirm shared purpose, boundaries, requirements, and our behavioral commitments (10 min)
- Discuss progress on data collection and analysis efforts and discuss the proposed outline for the final report; embody edits as available (40 min)
- Review requirements and potential impacts on the Colorado Healthcare Affordability & Sustainability Enterprise (CHASE) (20 min)
- Review proposed edits to the perspectives section of the draft report (20 min)
- Discuss the plan for upcoming meetings (15 min)
- Hear public comment (10 min)
- Engage in Q&A and discuss next steps (5 min)

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 Update

Segment overview

Objectives

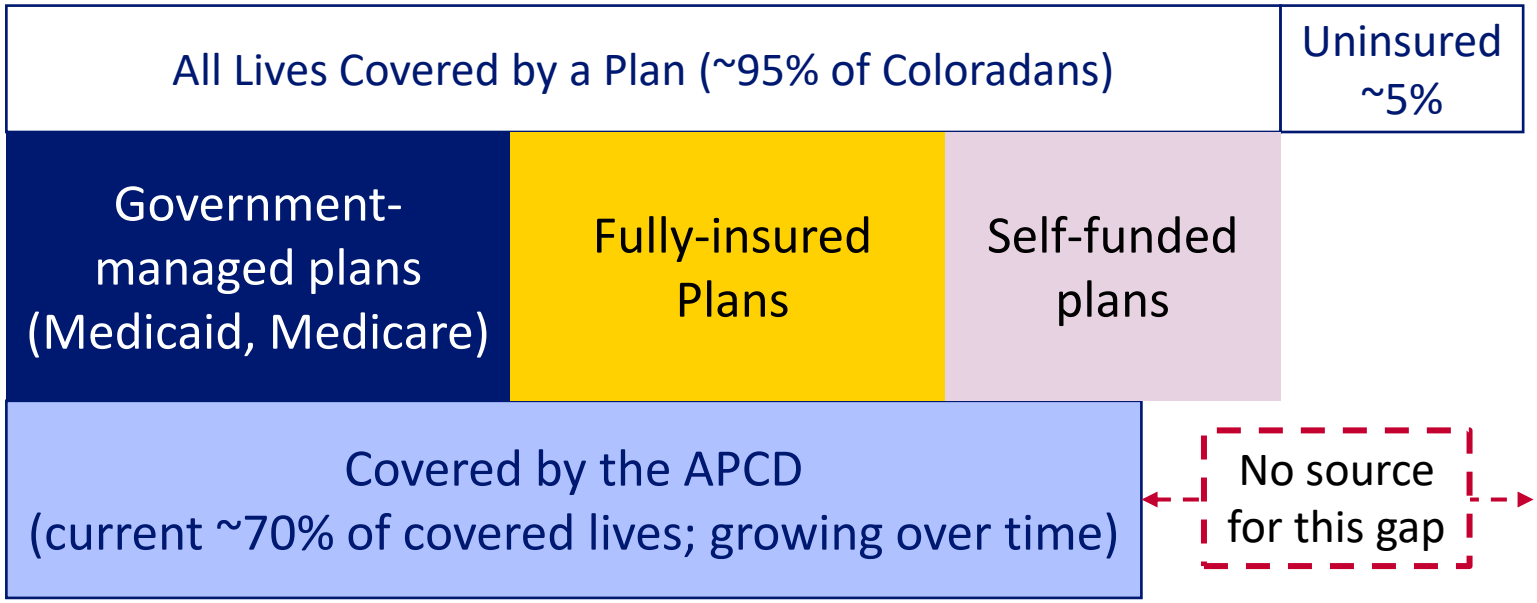
- Remind steering committee what data we have received from CIVHC, including:
- Provide information on data validation activities and findings
- Discuss what information we have and don't have related to denied claims
- Discuss Medicare billing guidelines and what facility fee data we see in the APCD

As we review, please:

- Remember that no single data source will contain all we need→ sampling is a valid approach if done correctly
- Recall our commitment to educating ourselves and each other → Engage with the data, ask questions, and offer perspectives

Reminder: Data sources

Gathering data on 100% of claims is very challenging. Here's how the sources line up:



Data review & validation

A review of the APCD data on Medicare membership aligns closely with CMS benchmark of Colorado Medicare members

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

https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/

Denied claims data

- APCD data does not contain data on denied claims if the *entire visit* was denied by payer
- APCD does contain instances where an *individual service* during a visit was denied
  - Can identify denials within a paid claim

Medicare billing guidelines (1 of 5)

CMS Federal Register—April 7, 2000

- Created ambulatory payment classification (APC)
- Result is a "grouped" payment across services rather than a service-specific payment
  - Many additional considerations and rules around which services are grouped
  - Some services are still paid separately
- Excludes professional services of physicians and non-physician practitioners paid under the Medicare physician fee schedule

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

Medicare billing guidelines (2 of 5)

CMS Federal Register—April 7, 2000 (continued)

- 31 E/M *[Evaluation/Management]* CPT codes for clinic and emergency visits grouped to the following APC code groups
  - 0600 through 0602: E/M CPT codes for a outpatient department visit
  - 0610 through 0612: E/M codes for an emergency department visit
  - 0620: for critical care E/M code

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

Medicare billing guidelines (3 of 5)

CMS Federal Register—July 19, 2013

- *"Since April 7, 2000, CMS has instructed hospitals to report facility resources for clinic and ED hospital outpatient visits using the CPT E/M [Evaluation/Management] codes..."*
- CMS consolidated from range of E/M code billing for facility resources to one CPT code for hospital outpatient to report facility resources

- https://www.federalregister.gov/documents/2013/07/19/2013-16555/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical
- https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2845cp.pdf

Medicare billing guidelines (4 of 5)

CMS Transmittal Letter, Effective January 1, 2014

- CMS will recognize HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPPS for outpatient hospital clinic visits
- CPT codes 99201-99205 and 99211-99215 will no longer be recognized for payment under the OPPS

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

Medicare billing guidelines (5 of 5)

Telehealth—a CMS rule from November 18, 2022

- CMS also allows for billing for hospital resource and facility fee for telehealth visits
  - Q3014 : "telehealth originating site facility fee"
- Expanded options for billing telehealth services, and corresponding facility fee, during COVID pandemic
- Allowance for telehealth traces back to 2001

https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

A Medicare member's experience (illustrative only)

- A Medicare member secures an appointment with their physician because their back hurts
- The member visits the doctor, who examines them and then orders some imaging in the hospital's outpatient department
- The imaging is completed and the members heads home
- They receive Explanations of Benefits (EOBs) for the visit(s), one from the physician and one from the hospital outpatient department

Claim structure—What we see in the data (illustrative only)

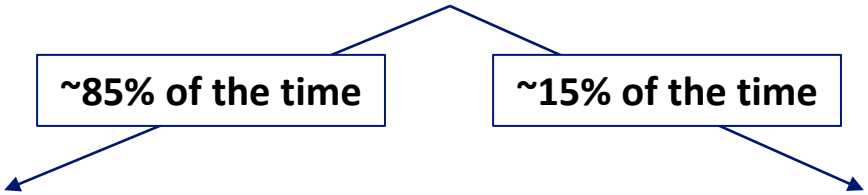
- In this example, we see two claims for a single member with the same service date

Member ID	Claim ID	Service Date	CPT Code	POS	Allowed	Member Share	Plan Paid
ABC123	999999001	6/5/2017	99214	22	$86.24	$0	$86.24
ABC123	999999002	6/5/2017	72100	22	$35.54	$14.00	$21.54
ABC123	999999002	6/5/2017	72070	22	$34.47	$14.00	$20.47
ABC123	999999002	6/5/2017	G0463	22	$102.45	$5.00	$97.45

- *POS is Place of Service, 22 = outpatient department
- 7-series CPT codes are radiology related services

Interpretation of methodology

Identify visit (claim) for a member with either G0463 or Q3014 on an outpatient claim (UB-04)



- Align with physician professional claim (HCFA 1500) with an E/M code(s) for same member and date of service
- E/M codes used:
  - 99202-99499: Professional E/M
  - 92002-92499: Ophthalmology Services (vision)
  - 97010-97799: Physical Medicine and Rehabilitation Evaluations

- Reviewing instances with G0463 or Q3014 on the outpatient claim *without* corresponding professional E&M visit on the same date of service

Claim volumes for code G0463

Analyzing the APCD data for both Medicare FFS and Medicare advantage members from 2017 through 2022 shows over 2 million claims (visits) featuring G0463 at approximately $100/allowed per claim for this code. This is consistent with the Medicare fee schedule for G0463.

G0463	Medicare FFS & Medicare Advantage		
Year	Allowed Amount	Claim Count	Allowed / Claim
2017	$35,652,827	362,739	$98.29
2018	$38,922,806	374,488	$103.94
2019	$40,695,344	416,488	$97.71
2020	$31,390,625	334,043	$93.97
2021	$37,730,455	374,420	$100.77
2022	$40,591,696	417,646	$97.19
Total	**$224,983,754**	**2,279,824**	**$98.68**

Figures above are limited to claims for providers in Colorado.

Claim volumes for Q3014

Analyzing the APCD data for both Medicare FFS and Medicare advantage members from 2017 through 2022 shows limited utilization of this code until 2020 (COVID), when telehealth grew in popularity. Allowed amount per claim for Q3014 is consistent with the Medicare fee schedule.

Q3014	Medicare FFS & Medicare Advantage		
Year	**Allowed Amount**	**Claim Count**	**Allowed / Claim**
2017	$6,545	454	$14.42
2018	$3,850	417	$9.23
2019	$7,459	594	$12.56
2020	$1,651,001	69,365	$23.80
2021	$1,192,189	45,957	$25.94
2022	$1,080,554	45,071	$23.97
Total	**$3,941,597**	**161,858**	**$24.35**

Figures above are limited to claims for providers in Colorado.

Combined claim volumes for G G0463 and Q3014

Combined	Medicare FFS & Medicare Advantage		
Year	Allowed Amount	Claim Count	Allowed / Claim
2017	$35,659,372	363,193	$98.18
2018	$38,926,656	374,905	$103.83
2019	$40,702,803	417,082	$97.59
2020	$33,041,626	403,408	$81.91
2021	$38,922,644	420,377	$92.59
2022	$41,672,250	462,717	$90.06
Total	**$228,925,352**	**2,441,682**	**$93.76**

Figures above are limited to claims for providers in Colorado.

Other data requests

- Hospital data request—Sent 2/29 and responses are due 3/15
- Independent provider data request—Sent 2/29 and responses are due 3/15
- Payor data request—to be discussed on March 12

Data discussion:

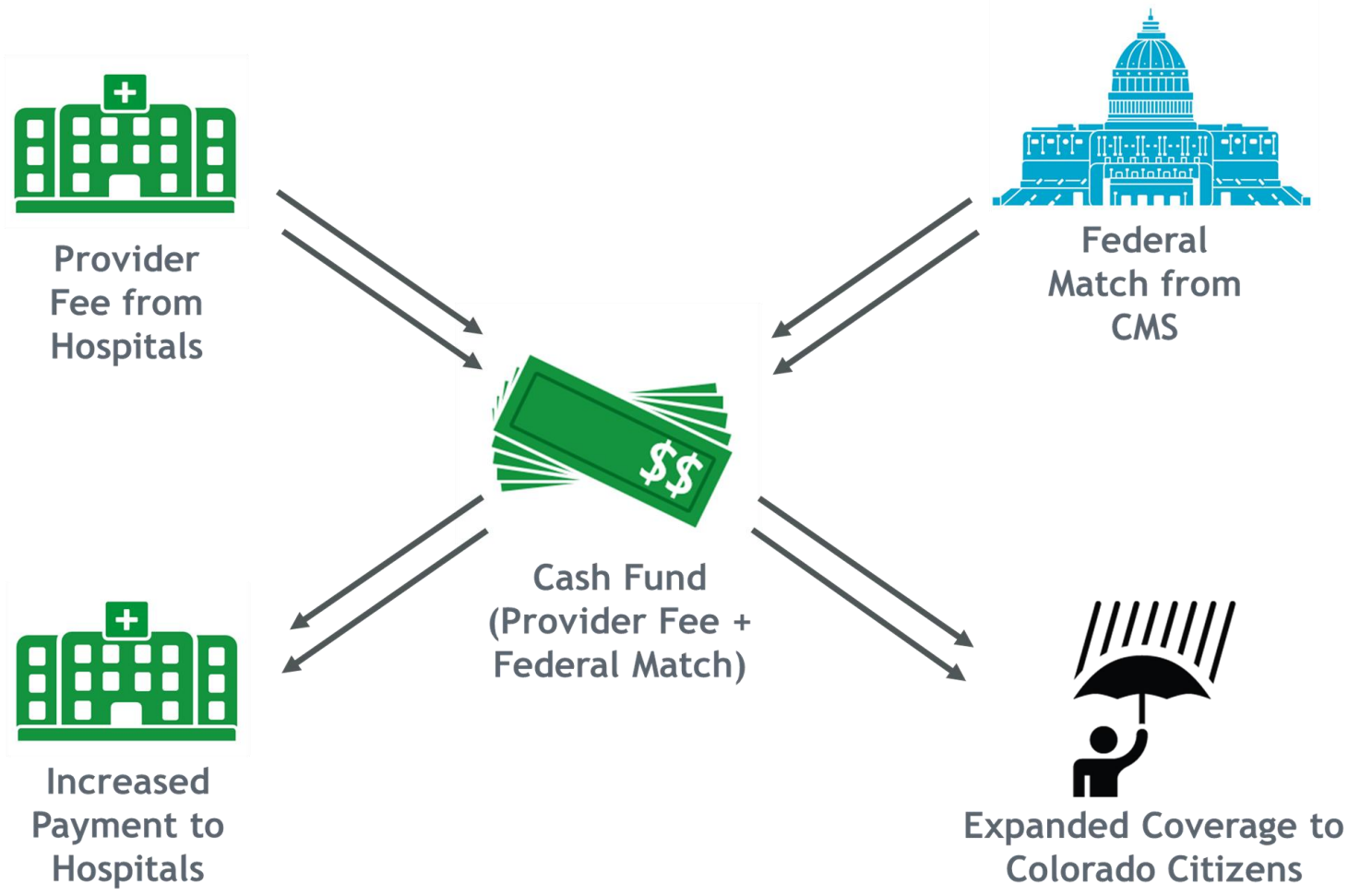
What questions or guidance do you have?

CHASE

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"

CHASE background (1 of 4)



CHASE background (2 of 4)

- Assess hospital provider fee to
  - Increase reimbursement to hospitals for care provided to Medicaid members and through the Colorado Indigent Care Program
  - 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

Colorado's hospital provider fee created under the Colorado Health Care Affordability Act (CHCAA) via House Bill 19-1293, effective July 1, 2009, and repealed effective June 30, 2017. CHASE was enacted July 1, 2017 via Senate Bill 17-267.

CHASE background (3 of 4)

Federal Fiscal Year (FFY) 2022-23

- $1.2 billion hospital fees collected
- $1.7 billion supplemental Medicaid and Disproportionate Share Hospital (DSH) payments
- $464 million net reimbursement increase
- 622,000 Coloradans covered through Medicaid and CHP+
  - 483,000 Medicaid adults without dependent children (up to 133% of the federal poverty level, FPL)
  - 93,000 Medicaid parents (61% to 133% FPL)
  - 27,000 CHP+ children and pregnant people (206% to 250% FPL)
  - 19,000 Medicaid members with disabilities, working adults up to 450% FPL and children up to 300% FPL
- $3.86 billion in federal funds, a 214% return rate

CHASE background (4 of 4

In millions	Net Patient Rev	CHASE Fee	% of Fees	NPR Limit
Inpatient	$9,558	$548	45%	5.73%
Outpatient	$11,891	$682	55%	5.74%
Total	**$21,449**	**$1,230**		**5.73%**

In millions	CHASE Fee	% of Fees	Federal Funds	Total
CHASE Fee	**$1,230**			
Expansion Estimates	$487	40%	$2,779	$3,267
Administration Estimates	$40	3%	$76	$115
General Fund Offset	$16	1%		$16
Supplemental Medicaid Payments	$565	46%	$885	$1,450
DSH Payments	$122	10%	$122	$244
Total Expenses	**$1,230**		**$3,862**	**$5,092**

CHASE discussion

- Approach to analysis impact of facility fees and payer coverage policies on CHASE
  - Medicaid (and CHP+) coverage expansions
  - Uncompensated care (DSH)
  - Undercompensated care (supplemental Medicaid payments)

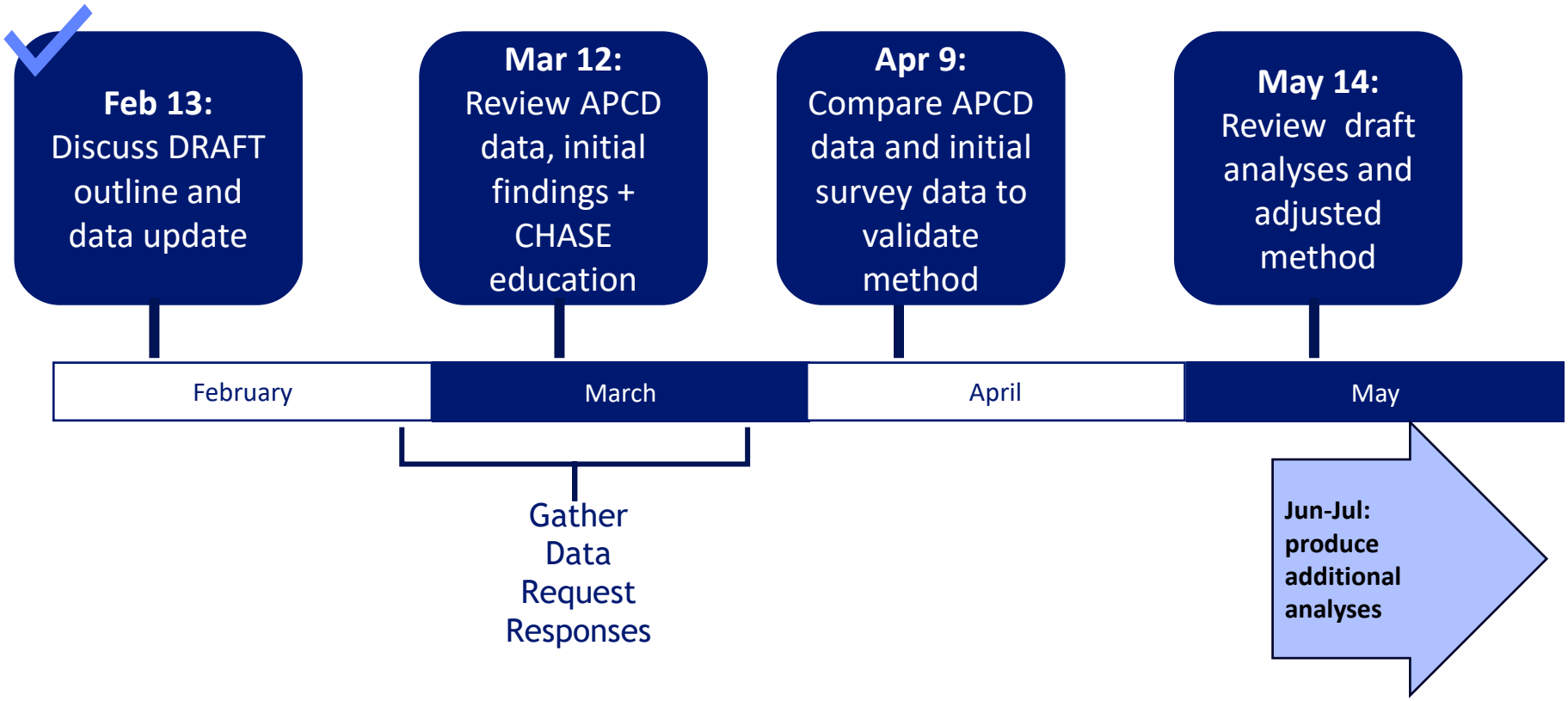
Final Report Outline

Review & discuss proposed edits

- DRAFT Facility Fee Report OUTLINE - Google Docs
- Let's review the new materials (highlighted in light blue) and discuss your feedback

Upcoming meetings

We are continually refining our meeting roadmap. Here is what is emerging, subject to discussion:



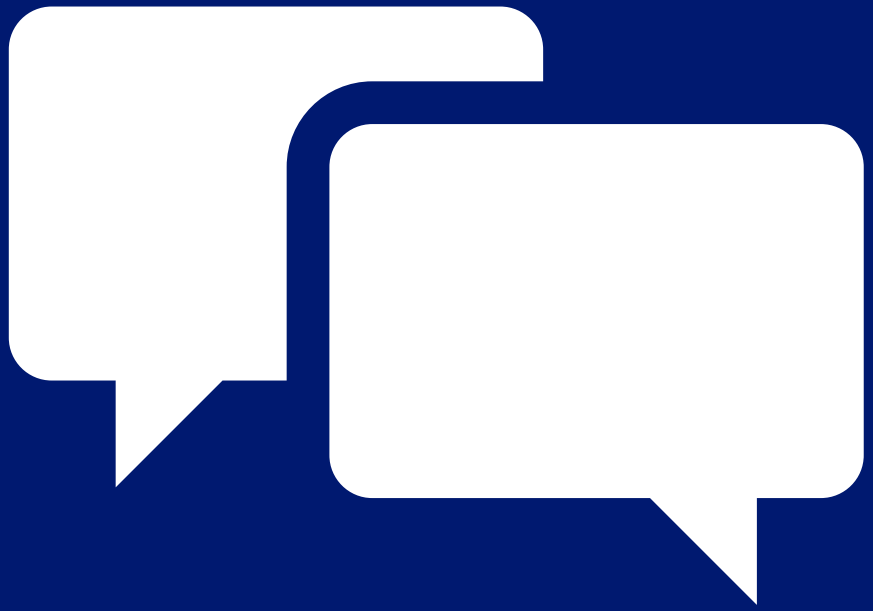
Public comment

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

Thank you!

5 minutes



Steering Committee Questions & Next Steps

Government Performance Solutions, Inc.

Your Partner for:

Strategic Planning	**Stakeholder Engagement**	**Operational Excellence**	**Organizational Effectiveness**

Thank you!

Who are your facilitators?

- Greg & Kate work for Colorado-based Government Performance Solutions, Inc. (GPS)
- GPS partners with public and social sector organizations to navigate change by:
  - Using deep listening & a collaborative approach,
  - Engaging agency staff, their partners, & and the community to co-create solutions that drive sustainable transformations.

Learn more about GPS at governmentperformance.us

Who are your actuaries?

- CBIZ Optumas (Optumas) is Colorado's actuary of record since 2012
- Set actuarially sound capitated rates for all managed care programs:
  - Physical health (DHMC and PRIME), behavioral health (RAEs), CHP+ (HMO & Dental), and PACE
- Provided actuarial analytics and development for alternate payment models for the State:
  - APM 2, Maternity Bundled Payment, Hospital Transformation Program
- Conducted rate review and access to care studies

Who are your actuaries?

- Currently lead the vertical integration analysis for HCPF
  - Studies the effect of hospital systems acquiring independent physician practices
- Optumas will provide the actuarial analysis for the HB23-1215 project
  - Study the financial impact of facility fees on Colorado payers

What are the roles and responsibilities?

Steering Committee:

- Read all required materials to prepare for meetings
- Participate actively in all steering committee meetings
- Understand implication and evaluate options, recognizing constraints and limitations of data
- Debate proposals to consensus

GPS Facilitators:

- Provide a structured approach
- Ensure meetings are productive with balanced participation
- Act as a liaison between the steering committee and actuarial vendor

HCPF & Actuarial Vendor:

- Conduct research
- Perform analysis based on available data
- Share analysis in a user-friendly format
- Answer questions as timely as feasible

Reminder: Open Meetings Law

Statutorily defined as:

- A gathering of 2 or more members
- Discussing public business or taking formal action
- Communicating in-person, by phone, electronically (e.g., email, text, instant message), or other means (e.g., chat, Google documents, etc.)

Open-meeting-requirements-of-the-colorado-sunshine-law.pdf

FAQ on § 24-6-402(2)(a), C.R.S.

Upcoming meetings

We are continually refining our meeting roadmap. Here is what is emerging, subject to discussion: