COLORADO
Department of Health Care Policy & Financing

Notes

HB23-1215 Hospital Facility Fee Steering Committee Meeting

Tuesday, July 9, 2024
4:00 – 6:00 p.m.

Participants register for Zoom meeting.

Meeting resources:

- Updated slides (to correct a typo): HB23-1215_SteerCo_July-9-2024_vUpdated.pdf (colorado.gov)
- Data scorecard: CO HB1215 - Data Progress.xlsx - Google Sheets
- Video recording: video_2024-07-09_HB23-1215-SteerCo.mp4

1. **Agenda, Shared Purpose, and Commitments (10 minutes) -** slides 1 - 9
   a. Introduce steering committee members to the public
   b. The facilitator recaps the shared purpose, boundaries, open meeting law, and shared commitments
      a. Isabel Cruz, Policy Director, Colorado Consumer Health Initiative
      b. Diane Kruse, Health Care Consumer
      c. Dr. Omar Mubarak, Managing Partner, Vascular Institute of the Rockies
      d. Bettina Schneider, Chief Financial Officer, Colorado Department of Health Care Policy and Financing (HCPF)
      e. Kevin Stansbury, Chief Executive Officer, Lincoln Community Hospital
      f. Not in attendance:
         i. Dan Rieber, Chief Financial Officer, UC Health
         ii. Karlee Tebbutt, Regional Director, America's Health Insurance Plans

2. Data Scorecard Recap and Action Items (20 minutes)

slides 10 - 13

a. Optumas shared an overview of the updated data scorecard (CO HB1215 - Data Progress.xlsx - Google Sheets) and status on action items assigned last meeting (slide 12)
b. Facilitator shared upcoming meeting dates and topics (slide 13)
c. Steering committee discussion and questions
    i. Kevin: Where is the Medicare Advantage data from? Answer: All-Payer Claims Database (APCD)
    ii. Kevin: Do people understand what CHASE is? Answer: The March meeting covered CHASE: HB23-1215_SteerCo_Mar12-2024.pdf (colorado.gov) (see slides 28 – 34)
    iii. Kevin: Can I get more clarification on the impact to CHASE? Answer: Nancy offered a quick overview and shared what information will be shared at the July 16 meeting.
    iv. Isabel & Kevin: Grateful for the work being done on the scorecard.

3. Facility Fee vs. Professional Fee Comparison Methodology (35 min) slides 14 - 23

a. Optumas describes the comparison of the methodology for facility fee versus professional fee
b. Steering committee discussion and questions
    i. Isabel: Are we comparing HOPD with on-campus and non-facility fee locations for professional fees? Answer: Correct. For example, we are comparing the average allowed facility fee amount for an x-ray at a hospital-affiliated site and the average allowed amount for an x-ray for a professional fee at a non-facility location. That is based on what is written in the bill.
    ii. Diane: Is the professional component the reading of the X-ray? Answer: Yes.
    iii. Diane: Can you determine if there is a facility fee component? Answer: It may be split out if it is billed as 2 separate codes or has modifiers. There is usually a split for outpatient service, but not always.
    iv. Kevin: If there are 2 scenarios: 1) the patient goes to a hospital-owned practice, the film is transferred to a

radiologist service to be read, and 2) the patient goes to the hospital clinic, and the hospital radiologist reads it. How do those scenarios impact how the data is collected? Answer: We are starting with how the data shows up in the APCD, starting with that as the base, then using modifiers, and then looking for a professional equivalent with the same billing scenario.

v. Kevin: We are all frustrated by the complexity of healthcare billing, and it would be good if an outcome from this committee's work addressed the importance of resolving some of this complexity.

vi. Isabel: Is there a way to tell if a hospital chooses not to charge a facility fee for this type of exclusion? Some hospitals said they do not charge a facility fee, just a professional fee. I think that is important data for us to have (Shared (3) examples from the archive of policies).

vii. Diane: The variations in how hospitals bill or choose to bill are interesting.
    1. We won't have that data if they do not bill for it. However, the data should be representative, with more similarities than not – especially for Medicare.

viii. Kevin: Because of the billing requirements we are subject to, our (treating) professionals document in the record, another set of professionals enter the codes, and those codes get matched to our charge master, and that's what gets billed. We are not saying bill this and not that. The documentation drives the billing.

ix. Isabel: I think the existing variation is important to understand. Can you give us a snapshot of the exclusions? The point of the report is how facility fees impact the system, so the total cost of care is important to understand.
    1. The total cost of care is more complex and challenging, so we are using the same set of services as the starting point. When you see the memo we are publishing tomorrow, it will hopefully start to answer your questions. Also, the scope of our tasks may not answer all of your questions about the total cost of care.

x. Kevin: There is variability in the documentation from the physician, which may impact how things are billed. Also, the variability in how insurers require us to bill impacts what we get reimbursed for.
    1. **ACTION ITEM 1:** Fix slide 19 to show the codes are the same to correct the typo (72070 instead of 77207) and have HCPF post the updated slides (PDF) to the website (COMPLETE AND THE UPDATED DOCUMENT IS POSTED).

4. Hospital and Health System Survey Summary (25 minutes)

slides 24 - 28

a. HCPF shares the survey summary and limitations
b. Steering committee discussion
    i. HCPF has been asked to review the survey information to ensure it does not contain proprietary information so that data has been removed from public view until such a review is completed.
        1. **ACTION ITEM 2:** Follow-up to see if the submitted information can be re-posted.
    ii. Kevin: No one is happy with the widening gap between gross charges and payments. I urge you to be careful about making broad statements about that because it is a complicated issue that deserves further discussion. Also, under the uninsured protections, programs like Hospital Discounted Care are important, but many of us have robust charity care programs. I want some credit given to safety net hospitals and others that provide robust charity care programs without requirements by government regulations.
    iii. Dr. Mubarak: It's good to know there are protections in place for consumers who feel like they are getting surprised billing. For example, if a consumer goes to urgent care and receives a higher bill than if they went to their primary care provider.
        1. Information for consumers and providers: https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/federal-no-surprises-act/colorado

2. https://hcpf.colorado.gov/colorado-hospital-discounted-care

iv. Dr. Mubarak: I've had some hospital CFOs dig in on the charges, and others have said, "Yes, they were overcharged." It is helpful to have websites to share with patients.

v. Kevin: It is also about the appropriate site of care. You don't go to the emergency room for a sore throat. You schedule an appointment with your primary care physician. There are times to go to urgent care, but it is a higher cost of care. More must be done to educate patients on the appropriate care center.

vi. Bettina: Health plans and employers provide part of the education. When I had a head wound, I drove to 3 different urgent cares because the first two couldn't tell me what I would be charged. It is not easy for patients to navigate the health care system.

vii. Isabel: I think there are a lot of sides to the coins. We are getting down some interesting rabbit holes but are off track regarding what the legislation requires us to examine. I want to dive back into the data analysis.

viii. Kevin: I think these conversations are important. Also, facilities shouldn't tell the cost until the patient is assessed—we do not refuse care. We should look at more than just facility fees because the system's complexity is the problem.

ix. Diane: If gross charges are 2 to 3 times the payments, and hospitals still make profits, I have trouble understanding what the gross charges are really for.

1. Kevin: Most hospitals in Colorado are tax-free charitable organizations. There is no incentive to create big charges, and some of them are related to insurer contracts. Most rural hospitals don't make a profit. It depends on the location. As I interpret EMTALA, if the location is within 250 yards of the main campus, the facility is subject to those rules.

x. Dr. Mubarak: I look at for-profit companies like HealthOne; their decisions are based on profit. I can see how the billing could devastate a family.

5. Final Report (15 minutes) slides 29 - 33

a. Support team shares the updated final report structure and rationale
b. Support team shares process for review (2 options)
c. Steering committee discusses and chooses to have items added to the folder rather than a single document.
    i. Diane: As materials are added to the folder, can steering committee members be alerted or notified somehow? Answer: Yes, we will email the steering committee.
    ii. Isabel: Ditto to what Diane requested.

6. Public Comment (10 minutes; 5:45 – 5:55 p.m.) slide 35

a. Time is divided equally between the people who ask to speak,
    i. Erica Pike from Colorado Academy of Family Physicians (CAFP): I want to return to the methods comparing independent providers with hospital-affiliated providers and suggest a note to be included in the legislative letter that it is still not an apples-to-apples comparison because independent practices cannot charge a facility fee. Reimbursement allowed comparison should consist of the facility fee and professional fee. Our more considerable payment reform efforts are trying to move away from a fee-for-service model to a more holistic payment model. I encourage the committee to consider how prospective, alternative payment models could shift this conversation so we are covering the actual cost of care. My takeaway is that no one is making it in the fee-for-service model. Broad payment reform is needed.
    ii. Adeline Ewing with Colorado Hospital Association (CHA): I wanted to provide data on hospital financial assistance policies. Hospitals have taken meaningful steps to assist patients through charity care and financial assistance programs. In 2022, Colorado hospitals provided more than $296 million in charity care and more than $1.2 billion since 2019. Charity care by Colorado hospitals has

increased by more than 40% since 2019. Hospital Discounted Care went into effect in September 2022, codified charity care laws, and established rules for how Colorado hospitals screen, bill, and collect payments from low-income patients at 250% of the federal poverty level (FPL) and below. Data from the program's first year show Colorado hospitals provided financial assistance to more than 200,000 Coloradans just through Hospital Discounted Care. Regarding gross charges and increases over time, it is important to look at insurance company plan designs. CHA's position is that insurance companies have shifted the cost burden to individuals and employees through different plans like high-deductible plans. According to the Kaiser Health Foundation, between 2006 – 2022, the average insurance deductible has increased by roughly 250%

b. Written comments are also welcome at hcpf_facilityfee@state.co.us

7. Next Steps (5 minutes) slide 37

a. Next meeting: July 16, 2024, from 4:00 – 6:00 p.m.
b. Agenda and slides posted on Hospital Facility Fee Steering Committee | Colorado Department of Health Care Policy & Financing by close of business on Wednesday, July 10

Reasonable accommodation will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-4764 or Shay.Lyon@state.co.us or the 504/ADA Coordinator at hcpf504ada@state.co.us at least one week before the meeting to make arrangements.