COLORADO
Department of Health Care Policy & Financing

Notes

HB23-1215 Hospital Facility Fee Steering Committee Meeting

Tuesday, August 13, 2024
4:00 – 6:00 p.m.

Participants register for Zoom meeting

Resources:

- Slides: HB23-1215_SteerCo_Aug_13_2024.pdf (colorado.gov)
- Meeting recording

1. Agenda, shared purpose, and commitments

a. Introduce steering committee members to the public
b. Facilitator recaps the shared purpose, boundaries, open meeting law, and shared commitments
   i. Isabel Cruz, Policy Director, Colorado Consumer Health Initiative
   ii. Diane Kruse, Health Care Consumer
   iii. Dr. Omar Mubarak, Managing Partner, Vascular Institute of the Rockies
   iv. Dan Rieber, Chief Financial Officer, UCHealth
   v. Bettina Schneider, Chief Financial Officer, Colorado Department of Health Care Policy and Financing (HCPF)
   vi. Kevin Stansbury, Chief Executive Officer, Lincoln Health
   vii. Karlee Tebbutt, Regional Director, America's Health Insurance Plans

2. Review comments and embody agreed-upon edits

a. Facilitator shares proposed edit list
   i. Notes and resolutions were captured within the proposed edit list document
   ii. At the start of the meeting:
      1. 18% of rows were "green" agreement across all steering committee members regarding the edit

2. 23% of rows were "yellow." One steering committee member disagreed with the proposed edit.
3. 59% of rows were "red," where 2 or more steering committee members disagreed with the proposed edit.

iii. Index 2 discussion: disagreement with "expertise" and with "billing and payment policy"
1. Suggestion to replace "expertise" with "experience"
2. Comment that HB23-1215 "THE STEERING COMMITTEE CONSISTS OF THE FOLLOWING SEVEN MEMBERS APPOINTED BY THE GOVERNOR WITH **RELEVANT EXPERTISE IN HEALTH-CARE BILLING AND PAYMENT POLICY**"
3. Important to align with the statute language
4. In the overall scheme, it is not important
5. The majority of the steering committee agreed with one objection that steering committee members are not experts in billing.

iv. Index 4 discussion: new proposal: Billing requirements are both complex and opaque, making analysis of facility fees challenging.
1. The majority of the steering committee agreed with the new proposal

v. Index 5, 6, and 8: the majority of the steering committee supported for the proposed edits
1. Row 6 – suggested "commonly mirror"
2. Row 8 – accept the edit as proposed "changes in utilization" and remove the content in the parenthesis

vi. Index 9: Optumas based its analysis on the *allowed amount* (the contracted amount between the payer and provider), and the actual paid amount is the allowed amount (the agreed-upon contractual amount). Allowed amounts reflected throughout, and be careful about the terms "charges" and "billed" because providers and hospitals internally use those. Suggest using the allowed amount *due* vs. the allowed amount *billed*.

1. *Allowed* amounts and *contract* amounts are being used interchangeably, and that is not the case for all providers and hospitals.
2. *Billed* is used as a verb – the action of billing/invoicing.
3. It is important that we are consistent and that the report is understandable. Leading with the *allowed amount* makes the report less accessible.
4. It sounds like these are basically payments by the payer or the patient. So, suggestion to use *reimbursements*.
    a. *Reimbursement* is a good middle ground.
5. I do not love "reimbursement," but if it is the word closest to its meaning, I can live with it.
6. *Reimbursement* implies more payment than a provider may actually receive.
7. Suggestion: use "*expected reimbursement*."
8. Clarified Optumas used the All-Payers Claims Database, then if use "expected reimbursement" doesn't make sense.
    a. Optumas said they used "allowed amounts."
9. Suggestion to use the original form of the sentence and use "expected reimbursement."
10. *The Hospital Outpatient Department (HOPD) facility fees contributed approximately $50.8 million to $53.7 million in expected reimbursement as compared*. The steering committee agreed to this version.

vii. Index 10 and 11, the way it reads is that independent providers and affiliated providers are combined vs. compared.

1. Index 10, agreement to consistently use "expected reimbursement"
2. Proposal to use statute language for index 11:
   (a) "AFFILIATED WITH" MEANS:
   (I) EMPLOYED BY A HOSPITAL OR HEALTH SYSTEM; OR
   (II) UNDER A PROFESSIONAL SERVICES AGREEMENT, FACULTY AGREEMENT, OR MANAGEMENT

AGREEMENT WITH A HOSPITAL OR HEALTH SYSTEM THAT PERMITS THE HOSPITAL OR HEALTH SYSTEM TO BILL ON BEHALF OF THE AFFILIATED ENTITY.

3. Index 11, Optumas will clarify the language that these are comparisons and not combined.
    a. suggestion: The payment rate differential between HOPDs who are able to charge a facility fee and professional fees, combined with stagnant reimbursement rates for professional fees, ACCORDING TO FEDERAL REGULATIONS create an incentive to shift the site of service toward affiliated settings.
    b. Suggestion: HOPD facility fees were about 95% higher than fees for…
        i. Agreement to this suggestion.
4. Index 14 &15: A steering committee member disagrees with the word "incentive," and two other members said this was not analyzed, so they support deleting the sentence.
    a. Suggestion to use the word "aligned"
    b. Suggest clarifying that this is based on federal regulations and citing the preamble of those regulations because it is an important part of history.
    c. Steering committee member agrees to modify the statement to clarify this is the history.
    d. Can HCPF clarify what sources can be used in the report, because it seems we can include citations other than Optumas data reports?
        i. This part of the report is under the research and report requirements. The statute directs you to write a description of how healthcare providers may be paid or reimbursed by payers. Outpatient healthcare services with and without facility that explores any legal or historical reasons for split

billing between professional facility fees.

e. Does this segment reference why private practices are dying off?
    i. Answer: Yes, we discussed this in a meeting.
    ii. A Steering Committee member disagrees that this was ever discussed in a meeting, and we did not come to this conclusion as a steering committee. It is not that hospitals are overpaid but that independent physicians are underpaid. This implies a conspiracy that hospitals are buying up private practices so if you make this comment, you have to make it clear this is not a hard and fast conclusion.
    iii. Another steering committee said that relying on these sources needs a disclaimer, saying that the steering committee did not fully review these documents and does not agree with the conclusion as stated.
    iv. Suggestion to ascribe the content to the citation and not the steering committee.
    v. Page 11 of the report are links to the fed register
    vi. Steering Committee tasked support team to rewrite this segment based on today's feedback.

5. Index 16, Agreement to include a bullet "Emergency departments (on and off campus) were completely excluded from analysis throughout the report.
6. Index 17: why is this different than the introduction on page 5 of the report? Suggestions to make this consistent within the report:

   a. Agreement to make this language consistent with page 5 of the report.
7. Index 18, agreement on proposed edit as written.
8. Index 19: Hospital outpatient departments are generally used for more complex patients, and hospitals incur additional costs to maintain 24/7 services. Also, hospitals (who are safety net providers) take patients who don't have a payer source. These are the reasons costs get driven up in a hospital setting.
   a. Some of the nuances is mentioned from the stakeholders' perspectives, so it does not seem necessary to detail this in this section.
   b. Not including the nuance whitewashes the difference between independent providers and hospitals, especially for complex patients, because it is the reality of hospitals.
   c. Many of these things are accurate, particularly when comparing rural and urban settings.
   d. HOPDs, especially off-campus, do not have the same patient loads, and this is not the section to discuss since there is research to support different perspectives.
   e. Suggest keeping in patients who do not have a payer source but leaving out the complex and acutely ill.
   f. Private practice is also stuck with indigent and patients without payer sources.
   g. Facility fee for rural primary care is different than the affiliate fee in an urban environment.
   h. There is no analysis or comparison between rural and urban hospitals in the report. Nor is there any discussion of the impact of facility fees on rural hospitals and rural providers.

   i. Suggestion: strike this and add an area where steering committee can add more content and their sources.
   j. Suggestion: have the department and Optumas come up with a rural hospital section of the report.
      i. Steering Committee agreed.
9. Index 20, full text from the report: When a patient receives outpatient health care services in an on-site or off-site HOPD, the patient is considered to be treated within the hospital rather than a physicians office. A patient receiving care at an HOPD will receive two bills: the hospital or facility bill, commonly referred to as the facility fee, and the physician or professional fee. The hospitals facility fee is intended to cover hospital costs that do not apply to independent physician offices, such as costs to maintain standby capacity for handling emergencies and to comply with regulatory requirements that physician offices do not have. When a patient receives care in an independent physicians office, the patient receives one bill.
   a. Steering Committee member said there are instances where someone may not receive a facility fee.
   b. Proposal: add “typically” to the description
      i. The Steering Committee agreed.
10. Index 22, there is not agreement to delete this segment.
   a. Include the issue of reimbursement for rural hospitals but add context that this is not the only thing that drives this phenomenon.
   b. It does not say anything about split billing. I struggled with this and recommend removing it.
   c. Moving to the PPS, away from cost-based reimbursement, is what resulted in split billing.

d. Suggestion: For the Department to revise this segment to clarify based on (moving to PPS…)

11. Index 26,

viii. Other: The Facilitator asked if the steering committee could meet to finish reviewing the proposed edits.
1. Diane is out and cannot meet between now and the September meeting.
2. Dan also is out for part of the time.
3. Potential for meeting early next week.

ix. Other: Discussion on impact of facility fees on the Colorado Health Care Affordability Enterprise (CHASE) including the Medicaid expansion.
1. Dan Rieber inquired about follow up on the CHASE analysis from a recent meeting. Nancy Dolson had walked the committee through an analysis and presentation. The committee had follow-up requests, including reflecting the impact on the federal matching funds. Mr. Rieber asks if there will be a follow-up presentation and walk-through of the revisions. Committee member Kevin Stansbury also asked if the analysis shows the impact to Medicaid expansion coverage.
2. Nancy Dolson with HCPF responded that the additional analysis requested by the committee was completed and included in the draft report about 2 weeks ago, which the committee can access. This analysis now includes the impact on federal funds and includes the impact on funding for coverage expansions and hospital reimbursement as it had originally. The details of the methodology are included in an appendix. HCPF and/or the committee facilitators will follow up with the committee to direct them to that analysis specifically. If there are questions about the analysis, we can discuss them at the next committee meeting as part of the draft report review.

3. Public comment request—Approx 5:35p.m.

a. Time was offered form members of the public to speak and comments are also welcome at hcpf_facilityfee@state.co.us
b. No members of the public requested to address the steering committee, but Katherine Mulready, requested via chat "can I ask that the post-meeting version of this document (with notes/decisions) be posted to the HCPF site? The version made available publicly prior to this meeting is dramatically different to the current working version (and this version is not downloadable for offline analysis). Thank you!

4. Request a vote to approve the preliminary draft report without appendices for submission to the General Assembly on September 3 (original agenda topic-- NO VOTE TAKEN)

5. Next steps

a. Plan to resolve the additional edits
   - The steering committee agreed to meet virtually on Tuesday, August 20, from 4:00 to 6:00 PM, which works for most. Isabel joins at 4:30 p.m., and Bettina leaves at 5:30 p.m.
   - Also, a reminder to the steering committee to submit specific objections to appendices (to be resolved at the September meeting).
b. Preliminary version of the report is to be sent on Tuesday, September 3
c. The next regular meeting is scheduled for **September 10**, from 4:00 – 6:00 p.m.
d. Please visit: Hospital Facility Fee Steering Committee | Colorado Department of Health Care Policy & Financing

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.