COLORADO
Department of Health Care Policy & Financing

Summary Notes

HB23-1215 Hospital Facility Fee Steering Committee Meeting

Register to attend the Zoom meeting

Tuesday, November 14, 2023
4:00 – 6:00 p.m.

Meeting recording

1. Agenda and recap

a. Facilitator recapped the shared purpose, boundaries (slide 10), group norms (slide 11), and open meeting law
   i. See pages 3 – 11 of the slides.
      1. Kevin requested that the second bullet on slide #4 directly match the language used in HB23-1215.
   ii. No edits to the group norms.

2. Steering committee perspectives

a. Facilitator recaps insights from steering committee interviews
b. Each Steering Committee member shared their point of view (starting at 4:17 p.m.)
   i. 4:18 PM Karlee Tebbutt, Regional Director of America's Health Insurance Plans (AHIP), supports site-neutral payment policies, and a significant driver of insurance premiums is related to hospital care. Concerns through their research and other independent research are that the same services cost more at facilities that charge hospital facility fees than independent offices offering the same services. There is an understanding of the need for facility fees for emergency departments.
   ii. 4:21 PM Kevin Stansbury, Chief Executive Officer, Lincoln Community Hospital, a critical access hospital in Hugo that operates four primary care clinics in a large geographic area

with a small population. From a rural perspective, there is a dramatic decrease in family practice clinics. The hospital facility fees help cover hospitals' extra overhead for maintaining these clinics. Medicare has imposed a split system to split the facility fee from the professional fee. Costs have increased over 10% year-over-year, and there is stagnant or reduced reimbursement from all payers. The system is confusing, but the answer is not to cut hospital facility fees because it will reduce access to care, especially in rural areas.

iii. 4:26 PM Bettina Schneider, Chief Financial Officer, Colorado Department of Health Care Policy and Financing (HCPF), HCPF does not bill or pay separate facility fees. She previously worked at a large safety net hospital (Denver Health). I want to strike a balance to ensure equitable access to medical services, prioritize transparency in billing, and mitigate catastrophic financial billing to patients.

iv. 4:29 PM Dan Rieber, Chief Financial Officer, University of Colorado Hospital Authority, represents Colorado Hospital Association too; hospital billing is extremely complex and highly regulated by state and federal governments. Hospital fees are intended to compensate hospitals for operating expenses (e.g., staff, supplies), not just for infrastructure. It is not an extra fee but a fee for care staff give to patients. Look at what Medicare is doing; in 2015, it began lowering the fee for site neutral. There is a difference between free-standing outpatient locations because not all take Medicaid, Medicare, or all-payers. Still, hospitals are the safety net and must treat patients regardless of the patient's ability to pay. Also, there are teaching/academic hospitals, required governmental reporting, equipment redundancy, and other costs that free-standing clinics do not have. We must understand many billing components and understand the implications of access.

v. Dr. Omar Mubarak, Managing Partner, Vascular Institute of the Rockies

vi. 4:34 PM Diane Kruse, Health Care Consumer – did not attend but provided her introduction in writing for the facilitator to read. The facilitator read her written statement. She shared a story about her husband's cardiac issues. It appeared I was double-billed, and after several calls, I learned I was charged a hospital facility fee. These fees were not disclosed upfront, so I did not have the option to choose not to go to that clinic.

I am interested in learning how hospital fees were able to migrate to outpatient clinics. Some outpatient clinics do not charge hospital facility fees and remain in business, so how can a hospital say they will go out of business if they do not charge the fees? More than 50% of outpatient clinics are now owned by hospitals or large medical centers, so it reduces the choice of consumers. It has increased costs for the same services at the exact location without knowing the cost increase to patients using those facilities. Consumers could make an informed choice if the fees were disclosed before an appointment. Then, there were several questions she asked that the facilitator read.

vii. 4:44 PM Isabel Cruz, Policy Director, Colorado Consumer Health Initiative, a consumer advocacy organization, heard a lot of similar challenges that Diane's statement shared. An ophthalmologist shared a story of a $2,000 facility fee for a procedure he performed. Stories of patients who are now paying significantly more for the exact same services at the exact same locations now that hospitals have purchased those outpatient clinics. Patients are forgoing care because of the cost, which is harming their health. I am interested in learning about the amount of the fees charged to patients for the different services and locations. These mergers and acquisitions are not leading to improved patient care, and there is anecdotal evidence that the quality of care is decreasing and access to care is decreasing.

3. HB23-1215 report and data requirements

a. Revisited the requirements of the Steering Committee's final report
b. Actuary shared a summary of the data requirements from HB23-1215 - Dan Skinner from CBIZ Optumas shared the following:
   i. Report requirements as laid out in HB23-1215 (slide 14)
   ii. Explained acronyms of the three primary data sources to be used in their analysis (slide 15)
   iii. Shared more information on the data sources (slide 16)
      1. 95% of Coloradans are covered by a health plan (Medicare, Medicaid, commercial: fully-insured, and self-funded plans)
         a. Self-funded plans cannot be compelled to turn over their data to a state database, so only about half have shared their data with the All-Payers Claims Database

2. QUESTION: Will the data allow for identifying the difference in high-deductible health plans? Answer: I believe so.
3. QUESTION: Will other data sources be used? Answer: We will talk about that a little bit later.

iv. Seth Adamson from CBIZ Optumas shared some information about data availability or lack of (slides 17 – 20):
1. IQVIA Historical OneKey data will supplement the APCD data to conduct different views of hospital-affiliated, non-affiliated, and other splits.
2. They have a request for APCD data and expect to receive data in January or February 2024.
3. Due to contractual data use agreements, other data sets they have used in the past cannot be used for this.
4. The APCD has no flag or indicator to identify hospital facility fees.
5. APCD does not have data on denied claims.
    a. The state will send out a provider survey, which may be able to help supplement information on this.
6. COMMENT: Facility fee is a reimbursement for a hospital. The UBO4 form indicates inpatient vs. outpatient. There should be an indicator for room/board or revenue codes for inpatient care; the other services would be outpatient.
    a. Seth – we want to make sure we can identify affiliated and non-affiliated and reliably attribute the difference in reimbursement to the hospital facility fee and not other causes.
7. QUESTION: What is IQVIA's role in supporting the understanding and bridging the gap?
    a. The IQVIA will get us down the path to identifying and segmenting the data.
8. QUESTION: What does the provider survey look like for affiliated and non-affiliated clinics?
    a. Answer: We are in the process of putting that together now, so we are making sure it is structured in a way that is easy to respond to and calls out the required data listed in HB23-1215.
9. COMMENT: Not having the slides in advance puts us at a disadvantage.

    a. RESPONSE: In the future, we will try our best to get the steering committee the slides and information a week before the meetings.
10. COMMENT: We should be able to quantify the match percentages with the drop in revenue.
11. COMMENT: I think HCPF can share the nuances of the formula regarding CHASE. The revenue conversation will be meaningful when we get to that point. The significant look should be on access to care and affordability.
    a. RESPONSE: I recommend that the people who model the CHASE at HCPF perform this calculation.
12. COMMENT: On denied claims, it seems the only source that there would be comprehensive data is on the payers (Medicaid, Medicare, and Commercial Payers), and whether they will disclose that will be the bigger question.
13. COMMENT: There is a lot in bullet #4 on slide 19. Could there be a sampling of health care marketplaces across the state to understand why hospitals enter the clinic business? Health equity speaks to access. In the healthcare workforce, we may be able to get quantitative data, and the workforce tends to be the largest expense for hospitals. You will get different answers for different health care communities/markets. It is very important for us to understand the different markets.
    a. RESPONSE: It is big, and we will need to talk about how we address this with the data and time limits we have.
14. COMMENT: We need to get this information ahead of these meetings if you want better comments and feedback.
    a. RESPONSE: This is meant to lay the groundwork for what we will discuss in the future and wasn't meant to have you provide comments and feedback at this meeting.

4. Components of an emerging roadmap

a. Discussed the timing of key tasks aligned with upcoming meetings

5. Public Comment (5:45 – 5:55 p.m.)

a. Two-minute limit per person

i. Public comment from chat:
    1. Erica Pike from the Colorado Academy of Family Physicians. Will provider surveys be distributed to non-hospital affiliated providers, too?
        a. To Kevin's point, if the steering committee is given an education example for hospital billing, can this also be done for independent practices as well? So that there is equal explanation of how billing and management of overhead costs is adapted based on different settings?
        b. We have heard both sides of the facility fee issue amongst our membership. There is one voice for independent practices. Wondering how we can expand on the independent practice voice because Dr. Mubarak was not in attendance today. We will be present and paying attention and are happy to provide support through our membership.
    2. Adeline Ewing with Colorado Hospital Association, facility fees pay for patient care staff. Examples include nurses, environmental and spiritual care staff, technicians, etc. Patients have more options through primary care vs. seeking care through the emergency room and can receive diagnostics and services. Hospital facility fees are needed for the next pandemic, disaster, etc. What has changed is how insurers are using high-deductible health plans, not facility fees.

6. Steering committee Q&A

a. Steering Committee asked its final questions
    i. COMMENT: There is no flag for facility fees; it is the labor costs, supply costs, etc.
    ii. QUESTION: Is there any value to the steering committee in doing a walk-through of hospital billing? Would that help members of this team?
        1. One member agrees. Understanding what site neutral and facility fee band, the UB04 and 1500 forms are important to understand. We should go back in time to understand why hospital facility fees were created and CMS's path.

2. One member agrees. I think understanding where the gap exists, how things play out on the ground, and why consumers find these fees concerning.
3. One member said it would be important to understand how billing looks outside of the hospital context for free-standing medical clinics. Also, looking into trends in consolidations and the resulting changes in the market and costs to consumers.
4. One member said learning about the complexity of billing for health care – separate processes depending on who the payers are (e.g., Medicare, Medicaid, private insurers, etc.). Explaining how patients are billed, and sometimes, we don't know about it until after the bill has been submitted. It would be great if we could simplify all billing.
5. QUESTION: Who will do this education? Would it be best to have a third party do the education since there is much to learn here? Also, to understand all the requirements to notify patients of billing.
6. COMMENT: Defining what "baseline" information upfront is needed vs. information to be shared further down the line. We want to learn more about how facility fees are negotiated and set and how those are related to physician fees. It has been identified as a concern by consumers. How price relates to cost will be helpful in level setting.

b. Heard about the next steps
   i. Slide 22 develops a shared understanding of facility fees and how these work (e.g., terminology, codes, billing mechanisms, etc.) AND
   ii. Slide 22 continues to define the gaps in what data is available and design data requests or accommodation methodologies to close those gaps.
   iii. Slide 23 lists a starter roadmap of the topics for the December 12, January 9, and February 13 meetings.

1. March–May will be when the steering committee will begin comparing the CBIZ Optumas data analysis and provider survey.

7. Next meeting: December 12, 2023, from 4:00 – 6:00 p.m.

a. **Please visit: [Hospital Facility Fee Steering Committee | Colorado Department of Health Care Policy & Financing]**

Topics will include:

i. Learning about key terminology
ii. Laying out the data requirements and data sources → continued discussion on closing gaps
iii. Having the actuary answer high-level questions

Educational materials will be provided to the steering committee one week before December 12.

REQUEST: Send meeting materials, notes, and recordings to the steering committee after the meeting and/or alert them once those materials are posted on the website: https://hcpf.colorado.gov/hospitalfacilityfeesteeringcommittee

Reasonable accommodations 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 hcpf504ada@state.co.us at least one week before the meeting to make arrangements.