Summary Notes

HB23-1215 Hospital Facility Fee Steering Committee Meeting

This meeting will be hybrid, available in-person and remote.

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

Location: Health Care Policy and Financing, 303 E. 17th Avenue, 11th floor, conference rooms ABC

Directions for getting to the conference room: from the lobby, please use the elevators to access the 11th floor. The ABC conference rooms are through the double doors (north side).

Information on parking: 1740 Grant St. (303 E 17th Ave. Covered Garage); 1682 Logan St. Lot; or 2-hour metered street parking available on Grant Street and E. 17th Avenue

Remote participants: Register to attend the Zoom meeting

Meeting recording 1 of 2 (pre-breakout)

Meeting recording 2 of 2 (post-breakout)

1. Agenda, shared purpose, and commitments (10 minutes)

a. Introduce steering committee members to the public
   i. Karlee Tebbutt, Regional Director, America's Health Insurance Plans
   ii. Kevin Stansbury, Chief Executive Officer, Lincoln Community Hospital
   iii. Bettina Schneider, Chief Financial Officer, Colorado Department of Health Care Policy and Financing (HCPF)
   iv. Dan Rieber, Chief Financial Officer, University of Colorado Hospital Authority
   v. Dr. Omar Mubarak, Managing Partner, Vascular Institute of the Rockies and President of Colorado Medical Society.

    vi. Isabel Cruz, Policy Director, Colorado Consumer Health Initiative
    vii. Diane Kruse, Health Care Consumer

b. Facilitator recaps the shared purpose, boundaries, and open meeting law, and shared commitments
    i. Shared behavioral commitments (slide 9)
        1. No comments or questions.

2. Final report outline discussion (80 minutes)

a. Share a draft outline of the final report
    i. Overall design, structure, and format
        1. Kevin, the general outline is OK, but question about data collection – specifically the data sources and caveats table within the report. Concerns about the Division of Insurance data and the type of requests that can be made.
            a. Nancy shared this is where the caveats will come into play to share what data we can view, what's missing, and what we were able to evaluate.
        2. Kevin, have we done a preliminary survey with the payers?
            a. No, we have not asked those specific questions yet.
        3. Dan, in terms of the overall design, it is laid out in a format that is easy to follow. I am assuming everything that is required by legislation is in the outline.
        4. Dan, overarching questions:
            a. Who is specifically drafting this report? Who put this first draft outline together?
                i. Health Care Policy and Financing, Government Performance Solutions, and CBIZ Optumas are drafting based on the data and guidance from the steering committee for the steering committee to react and offer edits.

b. What is the process for adding edits and comments? Will it be one big, massive redline review or section by section?
    i. Nancy, this will be an iterative process over the next several months, and we will be flexible in the approach – when it makes sense, we will go section by section.
    ii. Dan, can we color code when there is agreement, so we do not revisit sections where we have an agreement?
    iii. GPS, we will invite you to provide comments, suggestions, edits to us and Health Care Policy & Financing for us to compile and add to the report draft for the steering committee to discuss and review at the upcoming meeting.
    iv. Kevin, what happens when we cannot agree? Will there be space for alternate opinions?
        1. Nancy, we will strive for agreement and work in good faith so we hope there will be a consensus report. However, if at the time there is a disagreement that cannot be overcome, we will, as a group, determine how we want to handle the disagreement; for example, add a footnote.

c. What access will the steering committee have to the raw data CBIZ Optumas is using?
    i. CBIZ Optumas can share more when we talk about the data later in today's meeting.

d. How will we resolve when one of us believes there is bias in the data?

            e. How will we ensure when extrapolate from incomplete data to not arrive at an inaccurate impact?
        5. Karlee, carrier data reporting – request we hear from APCD what is already being reported because carriers are already submitting an extensive amount of data so it would be good to know what APCD already has. Carriers are not the ones charging facility fees so to the extent that data is available would be helpful. Also is the NPI (National Provider Identifier) in Colorado helping identify?
        6. Kevin, hospitals are coding per payer guidelines and based on those codes. There isn't a code for facility fees. Also, technically the fees cover a wide range of issues and not just facilities.
        7. Isabel, I understood the question to be for payers not represented in the APCD. Is there open-source data from payers?
        8. Dan, we learned in past meetings – what claim forms are used, site of service, etc. and it is in our definitions. Payers receive that information and then adjudicate the claims.

    ii. Anything surprising to the steering committee?
        1. Not discussed/no comments.

    iii. Anything critical the steering committee thinks is missing in the format or structure?
        1. Not discussed/no comments.

    iv. Perspective section draft (pages 5 - 7)
        1. Each steering committee member has "comment" access within the document. If you have comments on someone else's comments, use the respond to feature within the comment.
            a. Kevin, each group should include their comments about the other perspectives under their own perspective.
        2. Used 4 Zoom breakout rooms: Payers, Consumers, Hospitals & Health Systems, and Independent Medical Providers

3. Report out from Payers breakout - Karlee spoke on behalf of the Payers breakout group:
    a. Some additional suggestions on the language and hospital costs stats – suggest edits. Percentage of around 42%.
        i. Dan, changing from 30% to 42% we should reference the data source. Let's keep things fact-based and cite sources.
        ii. Karlee agrees we should cite sources. To the extent we stick to our own sections we provide our source.
    b. More transparency on facility fees and how the NPI is being used in Colorado. Hear from APCD about whether it is having the intended impact.
    c. It is broader than transparency. Also, can we provide feedback on other's perspectives?
4. Report out from Consumers breakout – Isabel spoke on behalf of the Consumer breakout:
    a. As a separate note, there were audio issues which made it challenging for Diane and others to engage.
    b. Suggest reframing points around facilities fees not being well understood to instead emphasize that consumers are often surprised.
    c. Should include information about affordability barriers, including impact/relationship to high deductible plans.
5. Report out from Hospitals & Health Systems breakout, Kevin spoke on behalf of:
    a. Complexity of hospital billing and where those practices come from being placed upon them by payers.
    b. Include the impact of a ban of these kinds of fees would have on hospital providers.
    c. Include analysis of the cost structures of services, patients, payer mix, etc.

d. Wondering about how sources/citations will be handled (e.g., inline, footnote, appendix etc.).
e. Karlee, separate out by rural hospitals vs. urban hospitals to show the impact on the different types of hospitals.

6. Report out from Independent Medical Providers breakout, Dr. Mubarak spoke on behalf of:
    a. Statement overall by independent medical providers is fairly good. We want to add a statement about the severe decrease in privately employed physicians. Professional fees are stagnant and facility fees have increased.
    b. Also, the quality of outpatient procedures is as-good, or better, with lower costs for consumers.
    c. Dr. Mubarak will share sources on this information.
        i. Kevin, I think more people would like to see more independent physicians, and I think it comes back to payer practices. I support more independent providers.

b. Review/edit suggestions in support of comprehensive, accurate, fact-based language
    i. N/A
c. Discuss feedback received on draft definitions
    i. Reminder: the definitions are for the purpose of running the committee, and we will include only definitions used in the final report. With that said, edits were embodied from the last meeting.
    ii. Do any of the steering committee members have additional edits or questions?
        1. Dan, the free-standing ED definition is a little misleading. I'm not sure why primary and urgent care is embedded in the definition.

2. Dan, Hospital outpatient services needs something added to the definition. It is missing a lot of the therapies (e.g., chemo, behavioral health, physical therapy, etc.). There is a lot more than just x-rays.
3. Dan, add definition for 340-B pricing program, I don't want us to lose site of the connection to outpatient billing.
4. Isabel, it is a very robust definition list. If there are still words that don't have a definition, recommend that we strike the word.
5. Isabel, I would hope for a more neutral differential rate definition.
6. Isabel, the benefits and detriments of vertical integration should not be part of the definitions.
7. Karlee, some of the definitions have a bias and need to be tweaked, but I think we should pause on the definitions and do the tweaking of the words and definitions we actually use in the report and then source the definitions.
8. Kevin, generally the rule should be the defined terms should be referenced in the report or inform the context of the report.
9. Kevin, I think the vertical integration focuses too much on provider integration and not the integration of payers which impacts the cost of care.
10. Dr. Mubarak, facility fee, there are facilities that are owned by independent practices that also charge a facility fee, for example office-based lab or an ambulatory surgical center owned by a group of physicians, but I believe it depends on what location that occurs in.
11. Nancy, we will add the sources back in. We used the definition in legislation for facility fees and we will list the sources.

d. Provide a brief update on the status of data-gathering activities

i. CBIZ Optumas (actuarial vendor) – Seth Adamson speaking
    1. Received APCD data and are looking through to validate the data for accuracy.
    2. Looking at volume, year, date, line of business, member eligibility indicating if they are commercial.
    3. So far, the data is looking good. We have a few questions out to CIVHC.
    4. We are wrapping up our validation.
    5. We're also looking at financial fields, charge amount, allowed amounts. We are confirming the allowed amounts and member paid amounts are validated.
    6. Slide 18 is total allowed dollars across all claims received and the four lines of business. A lot of the data from payer is reflected in the APCD, and acknowledge it is not perfect. Information we have received from CIVHC is it covers 70 – 75% of all lives in Colorado. Gaps are uninsured, and self-insured, but there is sufficient amount of data for us to get a reasonable start on our analytics.
        a. Kevin, when you talk about charges vs. what is allowed. Does your report distinguish between contractual allowance and insurance company denials?
            i. Seth, the legislation does call out denied claims. There is an indicator in the data of denied claims. We are confirming whether that is a reliable field with CIVHC. The allowed amount is assumed to be the contractual rate or negotiated payment between payer and provider.
        b. Kevin, can you distinguish between partial denial vs. full denial?
            i. Seth, that is a question we have out to CIVHC to ensure we are interpreting our line level interpretation is correct.

c. Dan, does the data report out by plan types like high deductible vs. standard?
d. Dan, where does the large military, workers compensation, and out of state Medicaid data fit?
    i. Seth, that is one of the questions to CIVHC.
e. Dan, we need to denote the impact of loss of service and confirm the right number.
f. Isabel, does the data show the place of service?
    i. Seth, there is an indicator that allows us to get fairly granular.
g. Dan, will the encounters show up as separate visits or one visit based on how billing occurs?
    i. Seth, it depends on the billing, we have a claim ID that tells us if all claims are together. We can track individual members, data service provider, and number of visits as we roll up multiple procedure codes.
    ii. Seth, if the claim was submitted as one claim it will make it more difficult to say they were multiple visits.

3. Discuss the plan for upcoming meetings (15 min)

a. Discuss the timing of key tasks aligned with upcoming meetings
    i. CBIZ Optumas is working on data validation, then switching gears to various methodologies and we will bring our methodologies to the steering committee to share that information. We hope to have early indicators for how we will approach the data analysis for the March meeting, and then at the April meeting start sharing some of the results.
b. Gather 'plus/minus' feedback from steering committee on the hybrid meeting format

   i. The sound was challenging. Difficult to hear people in the conference room. Not always clear who was speaking in the conference room.
   ii. The poll showed only 2 steering committee members will attend the March meeting in person.
   iii. The poll showed only 2 steering committee members will attend the April meeting in person.

4. Public Comment (10 minutes; 5:45 – 5:55 p.m.)

a. Time divided equally between the people who ask to speak
b. Written comments are also welcome at hcpf_facilityfee@state.co.us
   i. Adeline Ewing, Colorado Hospital Association: provided comments and suggestions on the draft report outline, specific to data and sources. Appreciate the opportunity to engage with the steering committee and will provide written comments detailing their suggestions and position.
   ii. Erica Pike, Colorado Academy of Family Physicians: appreciate responsiveness to public engagement process. Context is key about the historical and potential future of facility fees, and other factors, influenced independent physician practices in Colorado and the nation is important. We will provide written comments to the steering committee. Want to show what happens to the quality of patient care when practices are consolidated. Also want to see the difference in outpatient from primary care vs. outpatient surgical centers.

5. Steering committee Q&A (5 minutes)

a. Steering Committee asks its final questions
   i. Kevin, I can't let the comment about higher quality in freestanding facilities go by without a comment. Gave an example of a NY hospital that had a high mortality rate but when you dig into the data, that hospital sees more of the highest risk and sickest patients, so that

saying their higher mortality rate was related to quality of care is not necessarily accurate.

b. Hear about the next steps

6. Next meeting: March 12, 2024, from 4:00 – 6:00 p.m.

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

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 prior to the meeting to make arrangements.