NOTES

HB23-1215 Hospital Facility Fee Steering Committee Meeting

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

Participants register for Zoom meeting

Meeting Resources:

- Hospital Facility Fee Steering Committee Website| Colorado Department of Health Care Policy & Financing
- HB23-1215 Hospital Facility Fee Steering Committee Slides (colorado.gov)
- Medicare Facility Fee Identification Methodology Draft (colorado.gov)
- House Bill 23-1215
- Meeting recording

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

a. Introduce steering committee members to the public
   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 Community Hospital
   vii. Karlee Tebbutt, Regional Director, America's Health Insurance Plans

b. Facilitator recaps the shared purpose, boundaries, open meeting law, and shared commitments
   i. Bettina, I'd like to stick to the topic of impact of facility fees and stop bringing up banning facility fees and other

topics that we've already discussed and moved on from because we have a limited amount of time each month. We need to stick to topics that are in the scope of the work as laid out in legislation.

ii. Kevin, I think it is difficult to not bring up topics we've previously discussed.

iii. Karlee, I agree with Bettina, I think we need to stick to the bill language, and we have veered from this because we've had a lot of conversations that are off-topic and creating unbalanced perspectives.

iv. Isabel, I agree we've had robust discussions, but I have seen a theme of us getting into the weeds on things that are not within the scope or boundaries of the legislation. We could use a parking lot and once we get through the required topics, then we can revisit.

v. Dan, I think the first meetings were foundational, educational, because we didn't have any data to start looking at and discussing. We need to start structuring the PowerPoint to match the legislation. To keep us moving, we specifically call out the section of the legislation and if it crosses sections note that too.

vi. Facilitator, if you feel we are off topic, please raise that concern.

2. Data Collection Update (15 minutes)

a. Review data collection progress and initial insights from survey responses (See slides 11 – 16)

   i. Rebecca from HCPF, all surveys have been distributed and the close deadlines have passed.

      1. Today is about high-level introduction, HCPF will be conducting the analysis and sharing that analysis back with the steering committee.

   ii. Dan, Is there something being done to increase the response rate beyond extending the deadlines? Will the steering committee have access to the raw responses?

      1. We can discuss the data availability later.

   iii. Karlee, It is not correct that carriers did not respond and that we only had two weeks' notice.

1. Nancy, we did get a response yesterday, and we are reviewing it now.

iv. Rebecca, reviewed slides 12 – 13 and noted the suggestion to exclude 2017-2018 data from trend lines and bar charts.

v. Rebecca, encouraged people who are interested in seeing the survey questions to visit the website: https://hcpf.colorado.gov/hospitalfacilityfeesteeringcommittee and go to the subheading “Facility Fee Survey Data Request”

1. Dan, what questions are being asked? Are we OK with excluding 2017-2018? Answer: Hospitals use the ODHIN System, so those questions were not populated.
2. Dan, following up seems appropriate.
3. Diane, was there anything in our instructions that required us to get data for those gap years? Answer: Yes, the legislation goes back to 2014; however, there are gaps in the data, and APCD data goes back to 2017.

vi. Rebecca, reviewed slides 14 – 15 including the initial insights. Two options: we can add quotes/experiences from the frontline perspective, or we can try again with the survey and resend it to a different listserv.

1. Diane, How many surveys did you send out to only get 10 in return? Answer: We used associations and representatives, and a few went directly to providers.
    a. *Action: HCPF to follow up with the steering committee by notifying them of how many providers the surveys were sent to.*
2. Dan, it seems like quotes and perspectives are included in the data. Is this related to section 3.2? Can we link this to the actual legislative requirement?
3. Kevin, It sounds like you did a tiered approach? Do you have numbers of who the associations and representative sent the survey to? We need to try

to capture comparable data from this group; otherwise, we will dilute the value of the report.

4. Isabel, we want data to be as robust as possible. So, if we can reissue the survey in a way that we think will get better results, we should. Also, the legislation is pretty flexible on this specific data request.
5. Dr. Mubarak, CMS, represents multiple disciplines and has a fairly robust membership across Colorado. He said he could coordinate a phone call to set up the survey through CMS. It may cost money, but I think it will be worthwhile.
    a. *Action: HCPF to call Dr. Mubarak, and he will arrange a meeting with the Colorado Medical Society to discuss ways to improve the response rate for the provider surveys.*
6. Comment from the public in the chat: *This is Emily Bishop with the Colorado Academy of Family Physicians. We would be happy to encourage more of our independent members to take the survey.*
    a. *Action: HCPF to resend the survey link email to Emily Bishop.*
7. Karlee, we should look at research into publicly available data on independent research to supplement the survey.
8. Karlee, Our suggestion regarding carrier data is to use the APCD data because carriers report quarterly to the APCD. Then, if there are gaps, we can make recommendations to close those gaps.

b. Engage in Q&A with the Steering Committee
    i. Comment from public in the chat: Adeline Ewing from CHA: *Data submitted to CHA from hospitals prior to 2019 was in differing formats resulting in CPT codes not being captured for all hospitals. CHA estimates that 54% of CPT codes in 2017 and 75% of CPT codes in 2018 were captured for those years. Beginning in 2019 and beyond, hospitals began submitting data through standard 837 claim format and CPT data represents data for all hospitals.*

ii. Seth from Optumas, there will definitely be validation. The comment about using the surveys is specific to a couple of questions, such as billing policies that help us dig into the commercial data. Ideally, we will be able to flag the facility fees in commercial data, and we can use the survey data as backup.
iii. Isabel, I think the challenges of identifying facility fees in the APCD data
    1. Seth, the billing guidelines in terms of identifying the facility fee would be helpful
    2. Seth, Claims data is comparable.
iv. Nancy, we did receive carrier data, so we will share information on that by the next meeting.
v. Diane, called out that Emily Bishop volunteered to help distribute the independent provider survey.
vi. Kevin, I think we need to continue to push all interested parties to get the best picture possible to inform the legislature in the final report.
vii. Isabel, from a practical perspective when is the outer bounds to get the data in order to meet the deadlines of the legislative report?
    1. Seth from Optumas, getting started on the commercial data currently. I think we can keep pushing on the provider survey data for at least another month.
viii. Dan, 25.5-4 There are many required data sections from independent providers, and I don't see how the survey questions fill in all of the sections required in the legislation. I think there are many things not relevant to the report, as stated in the HB23-1215 legislation.

3. Medicare Facility Fee Identification Methodology Discussion (45 minutes)

a. Review Optumas' draft memo:
    i. Seth provided an overview of the segments, objectives, and data limitations. There is 95% data available for each year, so there are minimal data limitations.
        1. Overview is what they are tasked with and the purpose of the memo.

2. Listed 4 questions for the steering committee.
3. Data validation verification that APCD has the fields needed to do the analysis. There is a data limitation for an entire claim that has been denied because it is not in the APCD data, however partial denials are in the APCD data.
4. Medicare is a solid representative sample because 95% of all data requirements.
5. Billing guidelines research, the prospective payment system (PPS) – Optumas found some data on critical access hospitals and what codes they use. Some critical access hospitals used the G code. If they did not, it was challenging to identify the facility fee so they will be listing that as a data limitation.

Seth from Optumas reviewed and explained the remaining sections of the memo which are tied directly to the legislation sections:

1. 25.5-4-216(6)(a)(I) of legislation is highlighted in the memo on pages 4 – 5.
2. 25.5-4-216(6)(a)(II) of legislation is highlighted in the memo on pages 6 – 8.
3. 25.5-4-216(6)(a)(III) of legislation is highlighted in the memo on pages 9 - 10.
4. 25.5-4-216(6)(a)(IV) of legislation is highlighted in the memo on pages 11 - 13.
5. 25.5-4-216(6)(a)(V) of legislation is highlighted in the memo on pages 14 - 16.
6. 25.5-4-216(6)(a)(VI) of legislation is highlighted in the memo on pages 17 - 19.
7. 25.5-4-216(6)(a)(VII) of legislation is highlighted in the memo on page 20.

6. Appendix starts on page 22.

b. Discuss insights and limitations
   i. Dan, does this exclude emergency department data, and does it include inpatient encounters? Answer: it does not include inpatient encounters.

1. *Action: Seth verify whether emergency department data is included and whether this data is required by the legislation.*

ii. Kevin, how much are we missing critical access data? Answer: I think it is small due to the lower volume of patients compared to other hospitals and urban hospitals.

iii. Kevin, I get that our piece is small, but it is not insignificant, and I'm concerned that the gap will negatively impact the outcome of our report.

1. *Action: HCPF review the provider surveys to determine how much we are capturing or missing for critical access hospitals.*

iv. Diane, I want to clarify if this is specifically for critical access hospitals. Answer: Non-critical access hospitals all use the G codes.

v. Dan, there is a component that Medicare pays, but are you able to capture the patient portion? Answer: Yes, we can capture the patient share portion.

vi. Dan, what are the cost share implications if they are out of network under Medicare? Answer: there is a delineation between Medicare and Medicare Advantage. For Medicare, the patient would go to a Medicare provider, so they are in the network. Whereas, Medicare Advantage, the patient could be outside the carrier network but still with a Medicare provider. 97% of the time, they are in the network.

vii. Dan, in your tables you are capturing the full encounter and not just the G code? Answer: yes, we are capturing the allowed amounts and visits.

viii. Dan, how do we make sense of the top codes? How is everything pre-op and post-op captured for an encounter? Is there a section about the impact by service line? Answer: from the revenue code perspective, it is broader. However, we have stuck with the specific language of the legislation regarding the codes.

ix. Dan, are emergency department codes supposed to be excluded?

1. *Action: Seth to check the language of the HB23-1215 to confirm if emergency department is listed as excluded.*

x. Diane, are physician visits and facility fee scenario included? Answer: This is just Medicare data, so it does not reflect that, however, when we get into the commercial data, we will likely see that scenario.

xi. Kevin, there is typo on pages 16 & 19. I believe it should be MRI – Brain and not MRT – Brain.

1. *Action: Seth to fix the typo (MRT should be MRI) in the memo.*

xii. Isabel, to clarify is the outpatient clinic visit included? Answer, the 510 code is the standard outpatient visit.

c. We can begin to understand application of a similar method to the commercial market

i. We can start to validate once we begin analyzing the commercial data.

4. DRAFT final report outline discussion (20 minutes)

a. Review the proposed edits perspectives section of the draft report

i. Greg asked the steering at 5:20 PM if they wanted to continue reviewing the draft memo or stop and move on to the draft final report outline.

1. Kevin, Isabel, Karlee, Dr. Mubarak, and Dan agreed to table the draft report outline discussion until the May steering committee meeting.

ii. Brief discussion of the structure and parameters regarding the perspective section or elimination of the perspective section.

1. Isabel, It is helpful to share perspectives, and using citations makes sense. I would like to see the same amount of space, word count in a concise sharing of the perspectives.
2. Dan, The perspectives are not required in the legislation, and I don’t think we need to force people into word count or concise.
3. Karlee, I share the concerns that Isabel shared. I think we should all have the same amount of space

to 4 – 5 bullets or we each get 2 pages like the hospitals added. I also think we should discuss what counts as a citation and what is appropriate to cite in our perspectives, so we are not citing our own organizations.

4. Kevin, On citations, I think we should be free to cite whatever we want since this is our perspective. I would resist making it into bullets, but some reasonable limitations make sense.
5. Karlee, I think since we are emphasizing factual information, we should not be citing ourselves or drawing conclusions as part of the perspectives.
    a. Karlee, do we have a plan for how we will include the employer perspective?
6. Isabel, I think one page for each perspective makes sense.
7. Diane, I second one page. Regarding citations, we should be able to share them unless they are inaccurate.
8. Kevin, who determines whether a citation is valid or invalid? I think since it is a perspective section and each group is bringing, then a perspective can include an objection to another perspective. One page is insufficient to present our perspective on this complicated issue reasonably.
9. Dan, I agree with Kevin; it is important to represent the complexity of this perspective section. It is the free form area for each of us and I don't feel it is right to reduce a perspective.
    a. Hospital's perspective is currently approximately 2 ½ pages.
10. Karlee, I think hospitals should separate rural from urban hospitals; each could have 1 page. My concern is how the hospital cites the American Hospital Association (AHA) and which is not an unbiased source.
11. Karlee, I was told AHIP is not an unbiased source and told to remove it so I think AHA citations should be removed too.

12. Diane, from a consumer perspective and individual, it is more challenging for me to cite sources. I like the suggestion of keeping each perspective to 1 page and breaking the hospital into a rural 1 page and an urban 1 page. Also, the complicated issues and data should be shown in the report and not necessarily in our perspectives.
13. Bettina, I think the perspectives should stay in the report, but we should keep it to 1 page for each perspective.
14. Isabel, I want to second the point and if needed come to a consensus and take a vote at the May meeting. If we want to talk about appendices or referrals to other reports, and keep the perspective to 1 page.
15. Kevin, I have no problem with anyone citing who they want because we need to respect each others perspectives.
16. Kevin, regarding splitting urban and rural hospitals I think it will just add more content and make it look more in the hospital favor. I think we keep the hospitals together and narrow it down to 2 and half pages because 1 page is too much.
17. Kevin, we can talk about adding dissent and minority report which will add even more to the report.
18. Karlee, I think we need to be consistent and that if we want opinions based on facts then we need to do that in the perspectives section too. For example, if someone is saying eliminating facility fees will damage hospitals then we need to include data from other states. CHA has already issued a white page report and I think other non committee members can put out whatever information they want.
19. Dan, I agree it is a perspective section so we should not question each other's citation and keep it truly as each person's perspectives.

20. Dan, can we compromise and keep rural and urban together and our section to two pages?

iii. *Action: Table the draft outline perspective's discussion until the May meeting. Greg to make a proposal for parameters of the perspective section for the steering committee to consider and vote on.*

5. Discuss the plan for upcoming meetings (15 minutes)

a. Greg and Seth shared slide 23.

6. Public Comment (10 minutes; 5:45 - 5:55 p.m.)

a. Time divided equally between the people who ask to speak
    i. Adeline Ewing with Colorado Hospital Association (CHA), we reviewed the memo from Optumas, and UV4 837i aligns with our methodology, but it is important to call out this works for Medicare but not for commercials. CHA requests why an identified service, such as a laboratory fee, has a facility fee associated with it. We appreciate the consumer advocate letter. Colorado hospitals have committed to providing financial assistance to low-income patients. Concerns about gaps in data and analysis are not generalizable.
b. Written comments are also welcome at hcpf_facilityfee@state.co.us

7. Steering committee Q&A (5 minutes)

a. Steering Committee asks its final questions
    i. Kevin, we will have more questions once we have time to really read through the memo and data.
b. Hear about the next steps
    i. In May, we will review draft methodology in the commercial market and provide similar type of analysis in the June and July meetings as we have shared for Medicare.
    ii. Plan for sharing legislative section-by-section analysis.

8. Next meeting: May 14, 2024, from 4:00 - 6:00 p.m.

a. **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.