COLORADO
Department of Health Care Policy & Financing

Notes

HB23-1215 Hospital Facility Fee Steering Committee Meeting

Tuesday, August 20, 2024
4:00 – 6:00 p.m.

Participants register for Zoom meeting

Resources:

- Draft Hospital Facility Fee Report
- Proposed Edits to the Preliminary Report
- Video recording of today's Steering Committee Meeting

1. Agenda, shared purpose, and commitments (5 minutes)

a. Facilitator recaps the shared purpose and goals for the session
   i. Achieve consensus on proposed edits and
   ii. Vote to approve to advance the preliminary draft report to the General Assembly on September 3
b. 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 Health
   vii. Karlee Tebbutt, Regional Director, America's Health Insurance Plans

2. Continue to review proposed edits to the preliminary report and embody agreed-upon edits (90 minutes)

a. Facilitator shares proposed edit list, and a draft version of the report

b. Steering committee discussion discuss proposals and debate to consensus (starting with proposals where 2 or more steering committee members disagree, marked as red)
   i. The draft report was live edited during the meeting and resolutions were captured in the proposed edit list (spreadsheet)
   ii. Index 29: Suggestion when read in context, to delete the sentence “All payers experience facility fees because they are the bill the hospital sends for their services”
      1. Not objecting to deleting the sentence but worried it implies facility fees are frivolous
      2. Government subsidized insurance doesn’t get much of it, whereas those with commercial insurance do get facilities fee which are not covered by insurance.
         a. Disagree, hospitals do not charge for services not provided, and we do not charge when patient cares for charity care.
      3. Specific to the proposed edit, agree to the suggestion to delete the sentence.
      4. Hospital billing systems are setup, and the wording makes it seem that the fee is put upon patients by the hospitals. OK with including Medicare billing, and not comfortable with the
      5. Confirmed agreement to delete delete the sentence “All payers experience facility fees because they are the bill the hospital sends for their services”
      6. Confirmed agreement with revised edit in the report
   iii. Index 30 & 31:
      1. Do not agree with the proposal as written
      2. Every hospital has a charity program and works with patients who have no resources. We provide care without regard of their ability to pay regardless if there is a law.
      3. Suggestion to add there are hospital charity programs in the sentence with laws and programs.
      4. You are heading in the right direction.

5. I don't think this is the place to have the debate, but I can share thousands of patients who have to hospitals and not received.
6. There are other examples – we went to an HCA pediatric hospital and were told they would charge $3,000 per day. I think it depends on the hospital and who you encounter.
7. Can we change intended to protect? We do have requirements in Colorado that require hospitals to screen low-income patients.
8. Suggestion: add *voluntary, charity care programs* and *intended to help* to the sentence.
9. Do we want to call out the policies and requirements like a 501R, Hospital Discounted Care, etc.?
    a. Suggestion: List the requirements in the appendices.
10. Suggestion: add *to help low-income households with high health care costs*.
11. Steering committee agreed to the revised edit as captured in the draft report.

iv. Index 32: Medicaid data was not analyzed but the Medicaid data is in the APCD
    1. Agreed to the proposed edit as captured in the draft report

v. Index 35: suggestion of section to be rewritten and/or cited
    1. Surveys went out to only a couple of employers and did not understand the issue of facility fees. I also think we did not successfully engage employers and we ran out of time, so I don't think we can say what the impact on employers is.
    2. I think this should be moved into the perspective section because we didn't review data and the sample size is too small.
    3. No objection to the suggested edit in pink as written in the draft report of the first 2 statements.

4. Not agreement on first sentence of new paragraph because it is conclusion not based on data we reviewed.
    a. There may be higher costs but it depends on the types of services provided. Where are resources going to come from to pay for the cost of care. It is a complicated issue.
    b. We know the allowable amounts. We didn't do analysis of cost and allowable and therefore the way the sentence is written bothers me.
5. Suggestion: *Higher cost of care and higher expected reimbursement that* are driven by site of service, and change from "are passed on to employers" to *may be* passed on…and include "additional research and analysis is needed to complete the examination of facility fees on health coverage premiums."
    a. There is clear evidence that costs greatly increase in a hospital.
    b. This is talking about insurance premiums, when you are talking about millions of dollars in facility fees, I think it makes sense to say those are passed on to employers and consumers as part of their monthly premiums.
    c. I think the sentence about additional research needs to be part of the data caveat and not in this section.
6. Steering committee agreed to changes as written in the draft report.

vi. Index 38: steering committee agreed with expected reimbursement

vii. Index 43 & 44: steering committee agreed with expected reimbursement

viii. Index 47:steering committee agreed with the replacement of allowable payments to expected reimbursement throughout the report.

ix. Index 48: desire to rewrite "The estimated impact is presented as a range of 10%, 50%, and 100% of HOPD patient revenue applied to estimated facility fee hospital patient revenue."
    1. Clarify estimated annual impact --
        a. Suggestion: the total estimated annual impact is presented as a range from 10% to 100% of HOPD…with the bullets clarified to… reduction between 10%, ($24.4 Million) to ($244.5 Million) at 100%
            i. Parentheses are used to indicate negative numbers
            ii. Time frame of one year is described in the appendix
        b. Steering committee agreed to the edits as captured in the draft report.

x. Index 50: Agreement with the proposed edit as captured in the draft report.
    1. Question whether there are citations available to the original text.
    2. Note that this is required to be answered as part of HB23-1215.
    3. Understand but if we didn't review the data, I don't think we can arrive the conclusion as originally stated. It leaves out other issues of private practices being acquired by private equity or insurance companies.
    4. I agree this needs to be cited and that there is additional complexity not captured.
    5. The consumer perspective does get a little into this topic.
        a. ACTION ITEM: Department to update the appendices with the consumer perspective Isabel Cruz resubmitted today (the current one is incorrect)
    6. The cost of behavioral health settings for inpatient and outpatient was not analyzed and reviewed by the steering committee.

7. Suggestion: use a placeholder to allow additional research and rewriting before the final report.
    a. Suggestion as placeholder: Although not specifically reviewed by steering committee, the steering committee is relying on published (cited) materials.
    b. Agreement from the steering committee to use a placeholder in the preliminary report.

xi. Index 53:
1. Rather than citing 24/7 outpatient departments often are 9:00 -5:00 PM so proposal to make that clearer that we are talking about off campus potentially leads more into the regulation.
2. Agree that 24/7 is the issue for disagreeing the proposed text change.
3. If we include higher costs make it clear it is associated with regulations and payer mix
4. Suggestion to make it *license and accreditation requirements*.
5. Suggestion: delete the 24/7 operations and add "providing more coordinated care."
6. Agreement from the steering committee to the edits as captured in the draft report.

xii. Index 55: Main issue was lack of cited source.
1. I read this as related to vertical integration and we reviewed that data.
2. Suggestion: better define vertical integration and add a citation.
3. It is not just the vertical integration between hospitals and health systems and physician practices -- it is driven by complexity of regulation, higher cost of staff, etc. not just vertical integration.
4. If you lose certain ways to get care (e.g., independent providers) the system narrows and over the course of time you have fewer choices and the system is more expensive.
5. The steering committee did not specifically study vertical integration – we studied the billing

difference between HOPD. If we keep vertical integration, we need to include private equity and call it out that the steering committee did not review this type of data. We also cannot say it always occurs.

6. We did not have a discussion of health equity. Medicaid does not pay facility fees and this would need to be included in health equity.
    a. I thought the data showed us that costs were higher for physicians associated with a hospital. I also think it hits people with commercial insurance more than those who are on Medicaid.
7. From the rural perspective, vertical integration between a hospital and health system maintains the access to care. What is the true cost of care (e.g., a person who has to travel, stay in hotel to access care). It may drive up expected reimbursement, but emphasis on *may*.
8. Suggestion: to add a new sentence that in other situations it may keep care in rural areas and other marginalized areas so patients don't have to drive long distances to access to care. Also include private equity.
9. I don't think we actually analyzed a specific case where a practice was converted and vertically integrated with a hospital and costs increased. We need to talk about HOPD conversion to a free standing HOPD that may occur.
10. I don't think we reviewed the data based on geography, zip code or race so we didn't review the data based on equity
11. Suggestion: Put a placeholder here similar to what we used above for the preliminary report and rework this section for the final report.

xiii. Index 56: health care workforce has a lot of dynamics and is far more complex than what is suggested in this paragraph

1. We need to focus on the impact of facility fees on this issue, and the other issues.
2. We didn't really review this so it is going to be based on citations and clear it is not

xiv. Index 58: agreement by steering committee on proposed edit

xv. Index 59:

1. I don't think we can make this conclusion, where in the data did we see this trend? I thought HOPD allowable as a percentage going down.
2. It is a broader issue of how to maintain access to independent physicians and if keep this in, we need to include private equity buying practices.
3. Suggestion delete the first sentence and keep the pink part.
4. Suggestion: It's complicated (with reason why) and more analysis is needed.
5. Agreement as captured in the draft report.

xvi. Index 60: Impact on rural hospitals (page 39 of draft report)

1. This is a new section was written since the August 13 meeting that Kevin broadened a bit and noted the market pressures are different.
2. Would like to see statistics and/or citations or further qualifications that the majority are free standing.
3. The vast majority of rural hospitals are independent or governmental run.
    a. There is an appendix that lists all rural and frontier hospitals and their affiliation.
4. Steering committee members did not have an opportunity to review the new section/content.

xvii. Index 61: We don't have the employer perspective, so it should mirror what we previously agreed.

1. Suggestion: change to our ability to gather employer perspective was limited. And further outreach and engagement would be good.

3. Public comment 5:35 – 5:45 p.m. (10 minutes)

a. Time is divided equally between the people who ask to speak
b. Written comments are also welcome at hcpf_facilityfee@state.co.us
    i. Katherine Mulready from Colorado Hospital Association (CHA)
        1. Concern about process rather than substance. Tab 2 has not been integrated into the report so voting on a not final report will bias legislature. I think having areas highlighted that are in contention. Prefer that a more final version is voted on.
    ii. Erica Pike, from Colorado Academy of Family Physicians (CAFP)
        1. Vertical integration phrasing (index 14 and 15) we are supportive of the original language and it is important to preserve sentiments from independent providers. Also, we can provide research and data sources. I will follow up via email.
        2. From Chat: "I want to also reiterate Diane & Dr Mubarak's comments that the data reviewed support the findings about affiliation / vertical integration, so should not be struck."
    iii. Dr. Pramenko, I would like to keep the independent providers being kept. Mesa County primary care providers are being bought up by hospitals and none have gone to private equity or insurance companies so Mesa County is a good case study.

4. **Request a vote to approve the preliminary draft report without appendices for submission to the General Assembly on September 3 (10 minutes)**
    a. Roll call vote (yes=approve, no=does not approve) on "Do you feel comfortable submitting this preliminary draft to the general assembly?"
        i. Isabel Cruz, Yes – to the things we agreed on already to move forward.
            a. Alternately, if we can review one last time and do an email vote. I do agree it is important that we have a draft ready and submitted by the legislative deadline.

ii. Diane Kruse, Yes – to the things we already agreed on to move forward.
    a. I am not available to meet.
iii. Dr. Omar Mubarak,
    a. If you send me just the sentences that are changed via email, I could vote by email, or whatever is needed to get this over the line.
iv. Dan Rieber, No
    a. I would like to see a clean version before voting.
v. Bettina Schneider, Yes
    a. Directly from Chat: "Sorry, I have to drop. I support submitting a draft report to the GA with areas we haven't come to agreement on marked as "incomplete" or something similar."
vi. Kevin Stansbury,
    a. Why the September 3 date? Answer: Legislation required a preliminary report to be submitted by August 1 and we requested an extension to September 1, which is a Sunday before a state holiday so the due date became September 3.
vii. Karlee Tebbutt,

Other:

- The Department needs to make sure the report is in an accessible format and meets other requirements so the Department does not have until September 1.
- Open meeting laws will not allow us to do a vote by email, it needs to be public.
- Appendices with proposed edits to be discussed at the September 10 steering committee meeting.
- Regarding tab 2 things that were part of the report have been pulled in, but the Department can review to confirm.
- Suggestion: get a clean version with callouts for areas where under construction for the steering committee to vote on the clean version at another meeting on Tuesday, September 27.

5. Next steps (5 minutes)

a. Department publish a clean version by COB Friday, August 23 for steering committee and public review.

b. August 27, from 4:00 – 5:00 PM Steering Committee meeting to do final review on outstanding items and vote on the preliminary version of the report to be sent to the General Assembly on Tuesday, September 3.
c. Next meeting is scheduled for **September 10**, from 4:00 – 6:00 p.m. to review proposed edits to the appendices.
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.