COLORADO
Department of Health Care Policy & Financing

MEETING NOTES

HB23-1215 Hospital Facility Fee Steering Committee Meeting

Tuesday, March 12, 2024
4:00 – 6:00 p.m.

Remote participants: Register to attend the Zoom meeting

Meeting Materials found on Hospital Facility Fee Steering Committee | Colorado Department of Health Care Policy & Financing

- HB23-1215 Hospital Facility Fee Steering Committee Slides (colorado.gov)
- DRAFT Facility Fee Report OUTLINE

Meeting recording

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

a. Introduce steering committee members to the public
   i. Diane Kruse, Health Care Consumer
   ii. Dr. Omar Mubarak, Managing Partner, Vascular Institute of the Rockies
   iii. Dan Rieber, Chief Financial Officer, University of Colorado Hospital Authority
   iv. Bettina Schneider, Chief Financial Officer, Colorado Department of Health Care Policy and Financing (HCPF)
   v. Kevin Stansbury, Chief Executive Officer, Lincoln Community Hospital
   vi. Karlee Tebbutt, Regional Director, America's Health Insurance Plans
   vii. Not in attendance: Isabel Cruz, Policy Director, Colorado Consumer Health Initiative

b. Facilitator recaps the shared purpose, boundaries, open meeting law, and shared commitments (slides 5 -9)
   i. No comments or questions.

2. Data Update (40 minutes) Seth Adamson from Optumas

a. Discuss APCD data overview (slides 11 – 14)
   i. Kevin, Is the Children's Health Insurance Plan (CHP+) included with the Medicaid data?
      1. Optumas, I believe it is, and we will double-check that. I believe there are no facility fees paid through CHP.
   ii. Dan, are Medicare Advantage and workers' compensation through Pinnacol included?
      1. Workers' compensation is not included; however, Optumas will verify with CIVIC.
      2. 90 – 95% of all Medicare data is there, including Medicare Advantage.
   iii. Kevin, can we include a matrix showing what is NOT included in the data?
      1. Optumas, we can likely do that. Also, we do not have individual payer names in the data—just payer 1 and payer 2—and we cannot delineate a specific plan like United Healthcare.

b. Review Medicare billing guidance re: G codes & Q codes (slides 15 – 19)
   i. Kevin, it appears to be Medicare billing processes for Prospective Payment System (PPS) hospitals, not critical access hospitals, because those are paid in a different system.
      1. Optumas, will review the data and CMS guidelines to see if specific language is related to critical access hospitals.
      2. Per Rebecca Parrott in chat *"Your Billing 101 presentation in December helped define the Outpatient Prospective Payment System (OPPS), the payment system used by CMS to reimburse hospital outpatient services. All items and services paid for under the OPPS are assigned a payment group called Ambulatory Payment Classifications (APCs), which group together items and services that are similar clinically and regarding resource use."*

ii. Dan, we need to understand the data selection criteria. It would be helpful to understand a sample size that is large enough to arrive at conclusions. We need to ensure volume and dollars and understand what part of the population we are covering. For example, if it is 75% of the population but does not include the uninsured, we must be clear about using the data to arrive at conclusions.
    1. Optumas, we will be clear in the report about any caveats related to the data.
iii. Kevin, I am pointing out again that the Medicare rule applies to PPS, not critical access hospitals.
    1. Optumas, we will investigate this and see if there is additional guidance. Also, as a side note, we have the provider surveys to provide critical access hospital data.
iv. Kevin, I would like to say Medicare and medical billing are not straightforward. I think we all struggle with stagnant payment rates. We are all struggling with a myriad of issues, and it is confusing to consumers, too.
    1. Optumas: As a point of clarity, there is no single code, so it is complex.
v. Dr. Mubarak, billing complexity is challenging, and small practices have to hire out to handle billing, and sometimes, the administrative burden becomes too much. Since professional fees remain stagnant and billing is so complex, private practices try to mirror what hospitals do by hiring billing vendors. Small practices then sell to hospitals or private equity to recapture some of the money they've lost over time.

c. Discuss example claim structure(s) as seen in the data (slides 20 – 24)
    i. Kevin, as I understand it, I am billing for a professional fee and the technical fee, aka facility fee. If the technical fee is denied, will we have any data on that?
        1. Optumas, We will not have data on whether the entire claim is denied or whether a partial claim is denied. We will show this as a data limitation in the report.

2. Optumas, We want to be careful with terminology. The technical fee component of professional billing differs, especially regarding radiology, and we are talking about facility fees.

ii. Dr. Mubarak, the doctors get professional fees.

iii. Dan, I think we are compounding our data limitations because if we cannot capture the denials representing a large portion of patients, it could be 5 million being denied, so it has a huge impact.
    1. Optumas, is still a data limitation, but we have significant data that addresses what is outlined in the report. We've got approximately 95% of all Medicare data, which closes the gap considerably.

iv. Dan, in the Medicare example, the member share, plan payment, and facility fee charged still don't cover the cost of care.

v. Diane, for example, I don't want people to get confused because, as a consumer, without getting an MRI, the consumer still receives a facility fee.
    1. Optumas, the rules for commercial billing are different than Medicare. As we get the provider surveys back, we will investigate that further.
    2. Kevin, our billing process is not arbitrary. We code according to the payer's guidelines, which may be for other services.
    3. Dr. Mubarak, for clarification, you are saying you go to see a private practice and then get this big facility fee charge?
        a. Diane, right. They are not in the hospital, but I am getting these fees because they are associated with a hospital.
        b. Dan, an outpatient department's regulatory requirements are higher than those of a free-standing department. Consumers need to be aware of where they are going.
        c. Dr. Mubarak, I agree facility fees are needed, and the issue is consumer education – they need to know the different costs associated

with the other care options in an obvious way.

d. Nancy Dolson (Special Financing Division Director, HCPF), HB 23-1215 requires that, effective July 1, 2024, health care facilities notify patients in plain language that a facility fee may be charged.
e. Diane, unfortunately, I disagree with Dan. It was hidden. I tried to explore this with insurance and the hospital, and the facility fee was part of the appointment. I even looked online to see what I might be charged, and the facility fee was not broken out.

4. Diane, I'm not speaking about hospital admissions but about outpatient clinics.
5. Bettina, the committee is tasked with developing a report that details the impact of facility fees, so I am trying to understand why people say the goal is to eliminate facility fees.
    a. Dan, I understood that legislation seeking to eliminate facility fees drove the origin of this steering committee.

d. Engage in Q&A with the Steering Committee (slides 26 – 27)
    i. Nancy, Health Care Policy and Financing sent the request to complete the provider survey on February 29, 2024. 3 independent hospitals have responded, and 5 hospitals are all part of Banner Health System. There are another 5 that have opened the survey and partially completed it. We are also having conversations with our colleagues at the Division of Insurance regarding carrier data. We are looking forward to a good response rate by the time the data is due.
    ii. Kevin, related to Diane's mention, no one wants patients to get a surprise bill. To Dan's point, I, too, heard that some legislators wish to eliminate facility fees and refer to them as junk fees.
    iii. Bettina, it is important that health facility fees are clearly stated in their billing. As a health care consumer,

I had to ask how they would bill me, such as a free-standing ER or urgent care, and they did not know.

iv. Dr. Mubarak, it sounds like you and Diane experienced a hustle. Unfortunately, there are bad outliers who take advantage of the system, whether business people or doctors. There needs to be a way to address the bad actors and not have facility fees disappear. We need better transparency so people understand their billing ahead of time.

v. Facilitator Comment:
    1. The job of this steering committee is to stay within the boundaries of the legislation related to determining the impact of facility fees.

vi. Dan, I think it is important to define what we are discussing regarding facility fees and what is on and off campus. Many patients are in the hospital for "observation," which is considered outpatient even though the person is in the hospital.

vii. Karlee, I had a question about the data requests. Is CHA providing aggregated, or are we expecting individual responses from hospitals?
    1. Nancy, it is both. The survey was sent to all hospitals, and CHA said it would provide additional information industry-wide.

viii. Karlee, when the data is submitted. What is the process for us to review the data? Are we receiving the data unfiltered in its entirety or will it be parsed through before we receive it?
    1. Nancy, we can talk to Seth from Optumas about that. We should not be getting any PHI. However, there is a lot of data because the legislation asks for 6 years of data disaggregated by year for the top 25 – 50 CPT codes. Sharing that in the raw form will not be particularly useful. We are working with Optumas to do the analysis. In future meetings, we can discuss what information will be meaningful to you.

3. **CHASE Education and Discussion (20 minutes)**
    a. Review the law's requirements related to the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) (Slide 29)
        i. No comments or questions.
    b. Understand the background of CHASE (slides 30 – 33)
        i. No comments or questions.
    c. Discuss the approach for analyzing the impact of facility fees on CHASE, including the Medicaid coverage expansion, uncompensated care, and under-compensated care (slide 34)
        i. Dan, From the steering committee perspective, if net patient revenue is $21 billion and the revenue impacted by changes to facility fees is $1 billion, is it safe to extrapolate that 6% of a billion dollars and the three times return is $180 million lost?
        ii. Nancy, please describe the potential impact on services and how those outpatient, off-campus facility fees are coming in compared to the emergency department.

4. **DRAFT Final report outline discussion (20 minutes)**
    a. Review proposed edits perspectives section of the draft report (slide 36)
        i. This topic was tabled because the group did not have sufficient time to address it.

5. **Discuss the plan for upcoming meetings (15 minutes)** (slide 37)
    a. Seth from Optumas, we will look at the Medicare data in April and the specific analytics outlined in the APCD section. We will walk through the methodology. Looking at the response rate and data from the provider surveys, we will be able to give high-level insights in May. We will also look into the critical access hospital Medicare component.
    b. A reminder to stay within the boundaries of what the HB23-1215 legislation requires this steering committee to do.

6. **Public Comment (10 minutes; 5:45 – 5:55 p.m.)** (slide 38)
    a. Time is divided equally between the people who ask to speak

b. Written comments are also welcome at hcpf_facilityfee@state.co.us
c. Highlights from 2 speakers:
    i. Adeline Ewing, with CHA, I want to highlight a facility fee white paper to help steering committee members better understand their vital role in supporting the broader health care system. The white paper explains the origins and role of facility fees. It is important that existing payment policies being debated at the federal level recognize the need for facility fees. The reimbursement structure must consider the unique requirements and capabilities of providing care to their communities.
    ii. Kat Gruschow, CCHI, we appreciate the complex work that has been done on this. The goal is to shine a light on the extent the data allows and that we honor what the data tells us. We want to raise consumers' experiences struggling with surprise billing and look forward to the July 1, 2024, implementation of the noticing requirements regarding surprise billing.

7. Steering committee Q&A (5 minutes)

a. Steering Committee asks its final questions (slide 39)
    i. Dan, it was a good discussion today. We were able to disagree without being disagreeable.

8. Next meeting: April 9, 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.