CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Colorado Healthcare Affordability & Sustainability Enterprise (CHASE) Board Meeting Minutes

Tuesday, November 16, 2021, 3:00 P.M
Via Zoom

1. Welcome - Allison Neswood, Chair - 3:03 P.M.

Allison Neswood has been designated the Chair of the CHASE Board. She introduced herself, and asked others to introduce themselves.

2. Roll Call

There were sufficient members for a quorum.

A. Members Present (Via Zoom)

Barbara Carveth, Dr. Kimberley Jackson, Scott Linblom, George Lyford, Bob Morasko, Allison Neswood, Dr. Claire Reed, Jeremy Springston, Bob Vasil, Janie Wade and Ryan Westrom.

B. Members Excused

Matt Colussi and Heather Lafferty.

C. Department Staff Present

Nancy Dolson, Matt Haynes, Karola Cochran, Gina DeCrescentis, Riley DeValois, James Johnston, Mete Ozcorekci, Daniel Pace, Rebecca Parrott, Joe Sekiya, America Rios, Jeff Wittreich, and Austin Wozniak.

All CHASE Board members introduced themselves.

3. Approval of Minutes from August 24, 2021 - 3:16 P.M.

Dr. Jackson asked to have her first name spelled with an "e." Dr. Reed motioned to approve the minutes, and **Dr. Jackson** seconded the motion to approve. Minutes passed unanimously.

4. Elect Vice Chair - Allison Neswood - 3:18 P.M.

Dolson - The role of the vice chair is to chair the meetings in the absence of the chair. That's the only official duty, as stated in the by-laws.
Neswood - Dr. Jackson, you have stepped up in the past, as well as Ryan Westrom.

Dr. Jackson volunteered. **Wade** motioned to approve, and **Dr. Reed** seconded. Vote unanimous for Dr. Kimberely Jackson to be Vice-Chair.

5. Hospital Transformation Program (HTP) Update – 3:21 P.M.

A. **Timeline** – Matt Haynes - Reviewed timeline. In the recent past and in the near future, the arrow shows “we are here.” The team is doing the comprehensive review of the implementations plans. We are holding office hours and one on one’s with hospitals. The hospitals have until November 30th. The Colorado Hospital Association (CHA) has been very helpful. Coming up next on the timeline is December 2021 through March 2022, which is the project ramp-up and planning. Then, will be a practice run. The first report is due in July 2022 for the period ending in April 2022.

The latest information regarding project plans is: 37 plans approved, 29 reviews in progress and we are still waiting on 17 hospitals for write-backs.

Wade – What’s the process for looking at applications to avoid inconsistencies?

Haynes – We meet weekly with the team. We make sure that the same group of reviewers handle the same hospital groups. If there are any questions, they are taken up to the team lead.

Wade – What is the clinical knowledge of the reviewers?

Haynes – We have discussions with SCL Health and we have people reviewing the plans that are experienced auditors.

Wade – Should we be escalating these? If we have a clinical question, do we escalate them to the Department?

Haynes – Yes, and we are working with SCL Health actively, so it will be clear when someone works at this in the future.

Wade – Is there any way to get more data claims in hospitals? Some of it is two years in arears.

Haynes – Data establishes trends and look back in time. We are looking at how to work through the timeliness of data. We have new data so, there will be only a 3 months delay. The data looks at episodes of care, and then follows it forward.

Wade – We do have access to our own data, but if they go to a different hospital, it is difficult to use old data. We need better data to make it more actionable.

Haynes – Thanks.

Neswood – Any other questions? I have one. There was a committee to review the applications that had representation for community partners, is that correct? Is there an implementation oversight committee?

Haynes – No, there isn't an implementation oversight committee. This is a project management part. We went with a different tactic. We thought that the hospital should be working on the appropriate way to work on project management structure. The implementation plans will be made public.

Neswood – Thank you.

B. **HTP Community Advisory Committee (CAC)** – Allison Neswood – HTP CAC serves as a sounding board. We meet monthly. **Neswood** is Chair of that committee. We hear updates about HQIP and HTP and provide feedback. Currently, we are working on an effort to survey community-based organizations, especially those who meet social needs. It is a survey to get feedback about how HTP intersects with community engagement, hospital patient needs and the referrals to community partners. We are asking if they are able to meet the needs and if they are willing to work with CAC to build their capacity and partnerships to meet the needs in the community.

The survey should be going out soon, and that can be shared at an upcoming CHASE Board meeting.

Any questions?

6. HB21-1198 Hospital Discounted Care – Nancy Dolson - 3:44 P.M.

Review of Bill – Strengthens hospital financial assistance. This is a significant piece of legislation. Short name is Hospital Discounted Care. It creates a safety net for our low-income patients at every hospital, emergency departments and all health care professionals that work within the facilities. Care received at the hospitals and emergency departments, will be capped at no more than the higher of Medicare or Medicaid rates, which the Department will set. Payment plans will be limited to no more than 4% of household income for the hospital and emergency department charges and 2% for health care professionals. Once the patient has made 36 payments, the hospital and professional bills will be considered paid in full.

The bill also mandates that all uninsured patients be screened for Health First Colorado (Medicaid), Child Health Plan Plus (CHP+), Medicare, emergency Medicaid, Colorado Indigent Care Program (CICP), and this discounted care program.

There will also be a uniform screening process, between CICP and Hospital Discounted Care. Unlike CICP, where hospitals voluntarily participate, the

Hospital Discounted Care legislation requires all Colorado Hospitals and Health Care Professionals that work in those facilities to participate.

We have convened a Policy Development Team (PDT) and we thank the Colorado Hospital Association, consumer representatives and Department staff. Folks are dedicating quite a bit of time as we work on as we work on the uniform screening, and to determine income. The PDT will also be determining what steps providers must take before sending patient debt to collections. Also, patients' complaints and appeals processes will be determined.

Looking forward to the timeline. The rules will be in effect in June 2022. The rules will be submitted to the Medical Services in March 2022. Our PDT is meeting every two weeks. We are reaching out to stakeholders and developing an electronic newsletter and a web page for this legislation.

Wade – What resources are available for the counties and MA sites. We have significant delays there. What will be done about delays in awaiting coverage? Is there any support for counties?

Dolson – I will want to consult with the folks in our operations and eligibility divisions. And I will be happy to circle back with where they are with how they will meet that need. We do have a requirement for Medicaid a 45-day application process and the eligibility goes back to the application date. I don't know what the performance is on that. I'll certainly note that we have adequate resources for our County partners. Also of note, is that all current Medicaid members are locked in till the end of the health emergency.

Wade – I would appreciate that.

Neswood – Any other questions?

Springston – Question about the Medicaid and Medicare rate. How will they be determined?

Dolson – From a technical standpoint, one of the things that is the most challenging. We have a couple of Rate Analysts in our Division working with the Rates Analysts in the Rates Division. We are looking at the rates per hospital and to make sure we are meeting the requirements of the bill. We also want to make it transparent for consumers as well as the hospitals. We will work with the CHA and other stakeholders to take any feedback.

Springston – Thank you.

Dolson – Hospital rate setting is complex.

Neswood – Thank you Nancy for your work on this.

7. CHASE Annual Report Draft and CHASE Model Overview - Nancy Dolson – 3:56 P.M.

A. **CHASE Annual Report Draft** – This is the draft of the CHASE Annual Report. Following feedback and any additional corrections and additions, we will be looking for approval at the December meeting. The first section goes over what is included per statute. This report is due each January.

Dolson reviewed the requirements of the report. At the top of each section in italics is where the required elements of the CHASE Annual Report are stated, as is in statute.

Review of Details – Dolson went through the highlights of the report, based on the 2020-21 year. $47 million in health care affordability and sustainability. She went through the high-level numbers, and how the COVID-19 pandemic affected it. She also talked about the Enhanced Federal Medical Assistance Percentage (eFMAP), COVID Federal Medical Assistance Percentage, and Supplemental payments.

Of note: In the paragraph about COVID Federal Medical Assistance Percentage, the $33 million in federal funds will be updated with a new figure.

De Valois – The figure will be updated.

Dolson – The amount is closer to $65 million. Next up is Hospital Quality Incentive Program. She reviewed this section of the report.

Neswood – I see the points assigned to a hospital. Do you have more information about the Hospital Quality Incentive Program regarding the points assigned?

Dolson – We do have a spreadsheet that shows the points assigned. We can get back to you about this.

Neswood – Has there been any thinking about support or collaboration with lower scoring hospitals to improve? What needs to happen to help them improve?

Haynes – We do have a detailed final report, and we have a plan to provide that to the CAC. We have something that is technical in a spreadsheet, but we can provide our final report. Quality Incentive Program is a great program. These hospitals are competing for payments. They are out-performing other hospitals. The hospitals may want to do better. We are thinking about other tools and resources that we can provide and, to identify root causes.

Neswood – That's helpful. Thank you.

Administrative Expenditures. Dolson provided an overview of total CHASE Expenditures. There is no general fund impact due to the CHASE fee. Administrative costs are reported and itemized from July to June, when other costs are reported from October to September. The total expenditures were nearly $4.2 Billion, from $1.1 billion in collected fees. It provides a great return on investment. They are appropriated with the Long Bill.

She then reviewed the Administrative costs. The CHASE statute limits administrative fees to 3%. Our actual was 1.9% of total CHASE expenditures for administrative fees. Department staff cost is 0.19% of the total CHASE expenditures.

Cost Shift – Dolson reviewed the history of the Cost Shift section in the report, including the payment to cost ratio. The hospital payments less cost have fluctuated over time. Beginning in 2009, Health First Colorado reimbursed 54 cents for every dollar of cost, and now, the CHASE fee helps Health First Colorado pay 82 cents per dollar. Payments to cost, Table 6 shows payment to cost ratio. We have greatly increased our payments with the help of the CHASE fee. The 2020 numbers do not reflect the extra stimulus dollars paid to hospitals during the COVID-19 pandemic. In the Bad Debt and Charity Care section, we notice that there has been an uptick in bad debt and charity care, which is concerning.

Wade – Health One returned their dollars, and SCL Health recognized all of the dollars in 2020, but I'm not sure that is accurate. It's a provider relief fund, not a hospital relief fund. Provider relief funds weren't used to offset hospital operating costs. They were used to offset physician practice lost revenue, and to increase access to telehealth. So, the report is misleading and inaccurate.

Carveth – I echo Wade. There was a lot of capital investment that had to be made, to deal with the COVID-19 pandemic.

Wade – That's right, since when you buy equipment, that doesn't get expensed. It becomes capitalized as an asset.

Westrom – I echo Wade and Carveth. Additionally, the federal government have released regulations that this is not be considered patient revenue. What we are trying to measure is patient revenue. What table 8 shows is showing patient revenue where it shouldn't. The 2020 entry shows patient revenue that shouldn't be considered patient revenue. Allocating it across the payers isn't relevant, either because it wasn't paid on a per patient basis for patients, it was issued to providers.

Dolson – I appreciate all of the thoughtful comments. An we recognize that most of these funds have been accounted for, and some could have gone into 2021. The provider relief fund was designed to be used for costs associated with the pandemic, operating costs, equipment costs and lost revenue. I would like to make an offer that the general assembly this went down and the

provider relief fund did provide some support for lost revenue, to make it more accurate. We would like to be able to explain and provide the context.

Neswood – Appreciate all the comments made. It will be good to include information about how the provider relief fund was designed to replace lost revenue. It will be good to find the right balance in the Annual Report.

Westrom – I think there is a right balance. Including this in the cost shift section I think that's where it gets skewed somewhat. The relief fund money should be counted in the total income, but some hospitals may not have recognized it yet. It depends on the context and how it's reported. Reporting it in this section, it is misleading. If you want to report it in total revenue, I think there is something that can be agreed to there.

Wade – I want to be careful. SCL didn't use all the provider relief funds in hospitals. We lost income not only in hospitals. Provider relief funds that went to Colorado entities could be used across entities and between states as well. We used them at SCL, not only in hospitals and we used those dollars besides hospitals. When this gets released to the public, it's going to be misinterpreted. It's inaccurate.

Dolson – I think we can put a blurb in there about the Provider Relief fund.

Wade – The way it worked, is it was sent to hospitals to get the money out fast.nHospitals with a bigger payer mix got more money. It was intended as an emergency action, and we were able to move the money around to the places of highest need. I'm not interested in putting out an inaccurate report. I'm not suggesting that you not mention them at all, but it makes it looks like hospitals profited off of the pandemic and ignores all of the other work that hospitals do. This isn't the provider fee. I think we are overstepping on this report.

Carveth – Suggest you include a brief section about the intended use of the provider relief fund, as well as how it was used to respond to the pandemic. Some of it was not used as operating income.

Wade – We are going to have a bigger issue in 2021, because the vaccination clinics were not hospital expenses. We will have a bigger mismatch next year.

Dolson – Thank you for the comments. I think it would be worthwhile to work with Ryan and the Hospital Association to come back in December with information in a context that makes sense and that is accurate.

Westrom – Of course. I'm always happy to work with your team.

Chair Neswood - Thanks for you continued efforts and work on this. Will you be able to get the draft out to us before the next meeting? As early as possible?

Dolson – Yes, we can do that. My team are some of the attendees, and we meet regularly with the Hospital Association. You'll have another opportunity to provide feedback before the report is final.

Dolson continued with the Hospital Transformation Program (HTP) section of the report. This is an update on the program, to get federal approval. Our State Plan Amendment was approved. This is a substantial overview of the HTP. Any questions or feedback on this section?

The appendix shows hospitals that don't pay a fee, but get a payment, then the hospitals that pay a fee and their payments. We moved a lot of the tables that show the information into the appendix, so we could preserve it.

B. **2022 CHASE Model Review – Dolson –** Quick review of CHASE Model for 2022. More to come next month. High level overview of the 2021-22 Model. CHASE Model Summary, net reimbursement and supplemental payments. Upper payment limit is at 97% and the net patient revenue limitation is at 5.67%.the eFMAP benefit brings a benefit of $151 million and the cumulative benefit since October 2019 is $419 million in fee relief.

8. Suggested 2022 Meeting Dates – Nancy Dolson – 4:56 P.M.

Chair Neswood suggested to voice any objections, otherwise the dates are good. There were no objections. Dates were agreed upon. Go ahead with the proposed dates.

9. Public Comment – No comments – 4:57 P.M.

10. Meeting Adjourned at 4:59 P.M.

11. Next meeting on December 14, 2021 at 3:00 P.M.