Colorado Healthcare Affordability & Sustainability Enterprise (CHASE) Board

October 22, 2024

Our Mission

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Agenda

- State Directed Payment Program Overview
- Proposed Workgroup to Explore CHASE Program Reforms and State Directed Payment Program
- CHASE FFY 2022-23 and 2023-24 Adjustments to Reach 99.25% of the Upper Payment Limit
- Hospital Transformation Program Update, Severity Adjusted Length of Stay Measure
- Hospital Financial Transparency Annual Report Changes
- Public Comment
- Board Action Items

State Directed Payment Overview CHASE Board

October 24, 2024

PUBLIC CONSULTING GROUP

Solutions that Matter

Overview of State Directed Payments

What are State Directed Payments?

- An option created by CMS to assist states in achieving their overall objectives for delivery system and payment reform.
- A way for states to better control rates and methods used by MCOs to pay network providers.
- A way for states to hold MCOs to methods that advance specific state goals.
- Directed payment programs must comply with CFR Title 42 Chapter IV Subchapter C Part 433.
- To enforce requirements, CMS requires states to seek prior approval of directed payment arrangements each year

Current Scale of SDP Programs

- 40 States
- 249 Programs Across all Provider Types
- 93 Hospital Programs
- Est. ~$52B in Payments for FFY22

Directed Payment Regulations

Compliance with CFR Title 42 Chapter IV Subchapter C Part 438

Directed Payment Requirements Under 42 CFR 438.6(c)(2)(ii)

(A)	Be **based on the utilization and delivery** of services
(B)	**Direct expenditures equally**, and using the same terms of performance, for a class of providers providing the service under the contract;
(C)	Expect to **advance at least one of the goals and objectives in the quality strategy** in § 438.340;
(D)	Have an evaluation plan that measures the degree to which the State directed payment advances at least one of the goals and objectives in the quality strategy in § 438.340 and includes all of the elements outlined in paragraph (c)(2)(iv) of this section;
(E)	Not condition provider participation in State directed payments on the provider entering into or adhering to intergovernmental transfer agreements;
(F)	Result in achievement of the stated goals and objectives in alignment with the State's evaluation plan and, upon request from CMS, the State must provide an evaluation report documenting achievement of these stated goals and objectives;
(G)	Comply with all Federal legal requirements for the financing of the non-Federal share, including but not limited to, 42 CFR 433, subpart B;
(H)	Providers receiving payment under a State directed payment attest that they do not participate in any hold harmless arrangement for any health care-related tax as specified in § 433.68(f)(3)
(J)	Be developed in accordance with § 438.4, and the standards specified in §§ 438.5, 438.7, and 438.8.

New Regulatory Requirements

- Average Commercial Rate (ACR) rate ceiling for hospital state directed payments (rating periods on or after July 9, 2024)
  - CMS will allow total payment rates in a state directed payment up to the ACR for certain services.
  - CMS will impose the ACR as the regulatory limit on the projected total payment rate for IP/OP services.
  - ACR demonstration should be submitted with initial preprint submission and then updated at least every three years

- SDP preprint must be submitted by payment start date (rating periods on or after July 9, 2026)
  - SDP sections of rate certification and MCO contract must be submitted within 120 days after the payment start date
  - No allowance for retro cap changes unless “a material error in the data, assumptions, or methodologies”.

- Publicly post detailed evaluation reports every 3 years for SDPs > 1.5% of MCO payments (rating periods beginning on or after July 9, 2027)
  - Must include 2+ metrics tied to State quality strategy
  - CMS can deny renewals if no meaningful improvement

- Elimination of Separate Payment Terms (after July 9, 2027)
  - Require SDPs to be included in actuarially sound capitation rates

Directed Payment Steps

State Directed Payment Processes

A Preprint Form must be submitted to CMS annually outlining the Directed Payment Program for CMS review and approval along with supporting documentation including UPL Demonstration

Key Decision Points of a State Directed Payment Program

Define the Type of Directed Payment Program	Defining Relevant Provider Class and Services	Defining Quality Measures	Defining Funding Source	MCO Contracting & Actuarial Certification*
• VBP vs. Fee Schedule Requirements • *See more on subsequent slides*	• Inpatient hospital providers • Outpatient hospital providers • Exclusions and other considerations	• CMS requires that the payments be tied to state's managed care quality strategy • Quality measures are state specific and updated annually	• Providers participating in the program may fund the state share of the program • Typical financing strategies for the non-federal share include IGTs and Provider Taxes	• Directed Payment Programs must be incorporated into managed care contracts • Actuarial rate certification and adjusted monthly base capitation rates must be calculated

*MCO Contracting and Actuarial Certification can occur following Preprint Submission

Types of State Directed Payments

Types of Directed Payments

Value Based Payment (VBP)/Delivery System Reform (DSR):
In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

Fee Schedule Requirements:
In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for providers that provide a particular service; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for providers that provide a particular service.

Types of Directed Payments

VBP/DSR

- Quality Payment/P4P
- Bundled Payment/Episode-Based Payment
- Population-Based Payment/ACO
- Multi Payer Delivery System Reform or Medicaid-Specific Delivery System Reform
- Performance Improvement Initiative or Other VBP Model

Fee Schedule

- Minimum Fee Schedule using rates other than State plan approved rates (42 C.F.R. § 438.6(c)(1)(iii)(B))
- Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
- Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

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Solutions that Matter

Proposed Workgroup to Explore CHASE Program Reforms and State Directed Payment Program

Nancy Dolson

Project Goals

- Existing CHASE fee and supplemental payments and
- Potential State Directed Payment Program
- Must align with federal and state priorities
- Goal: effective July 2025

Workgroup

- Two HCPF (non CHASE Board) and HCPF consultant
- Two Colorado Hospital Association (CHA) (non CHASE Board) and CHA consultant
- One CHASE Board member (non-HCPF, -CHA, -Hospital)
- Third party facilitator

Potential Challenges

- Timeline and available resources
- TABOR revenue limit if funding sources in addition to CHASE fees
- Data compilation and review
- Managed care contract amendments and actuarial certification
- Additional CMS guidance expected

Next Steps

- By Nov. 7th
  - HCPF and CHA recommend their workgroup members and consultants
  - Interested Board members submit letter of interest
- By Nov. 19th
  - Board chair formally appoint workgroup
  - HCPF identify facilitator resources (gaps) and solicit vendors
- Workgroup meetings begin

FFY 22-23 and 23-24 Adjustments to Reach 99.25% Upper Payment Limit

Jeff Wittreich

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Colorado Healthcare Affordability and Sustainability Enterprise

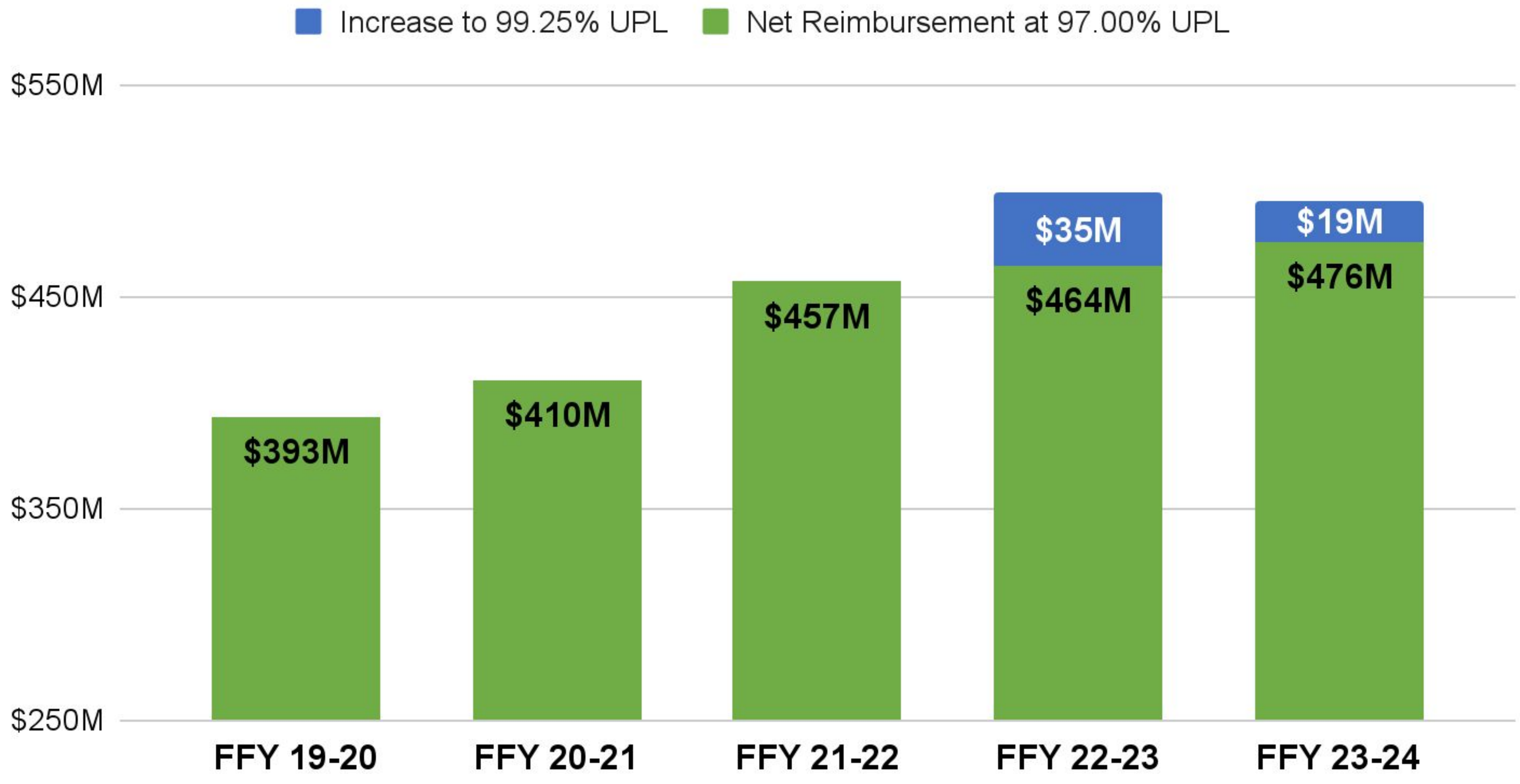
Net Reimbursement Increase

- June 3rd CHASE Board presentation and support for future FFY 22-23 & FFY 23-24 Inpatient & Outpatient supplemental payment increases from 97.00% to 99.25% of the Upper Payment Limit (UPL)
- Contingent upon Centers for Medicare & Medicaid Services (CMS) audit findings
- CMS concluded audit on July 29th, reporting no findings and requiring no actions

Net Reimbursement Increase

- **FFY 22-23 Increase**
  - Fee - $21M increase ($1,230M to $1,251M)
  - Payment - $56M increase ($1,694M to $1,750M)
  - Net Reimbursement - $35M increase ($464M to $499M)
- **FFY 23-24 Increase**
  - Fee - $10M increase ($1,250M to $1,260M)
  - Payment - $29M increase ($1,726M to $1,755M)
  - Net Reimbursement - $19M increase ($476M to $495M)
- **<u>Total $54M net reimbursement increase</u>**

Net Reimbursement Increase



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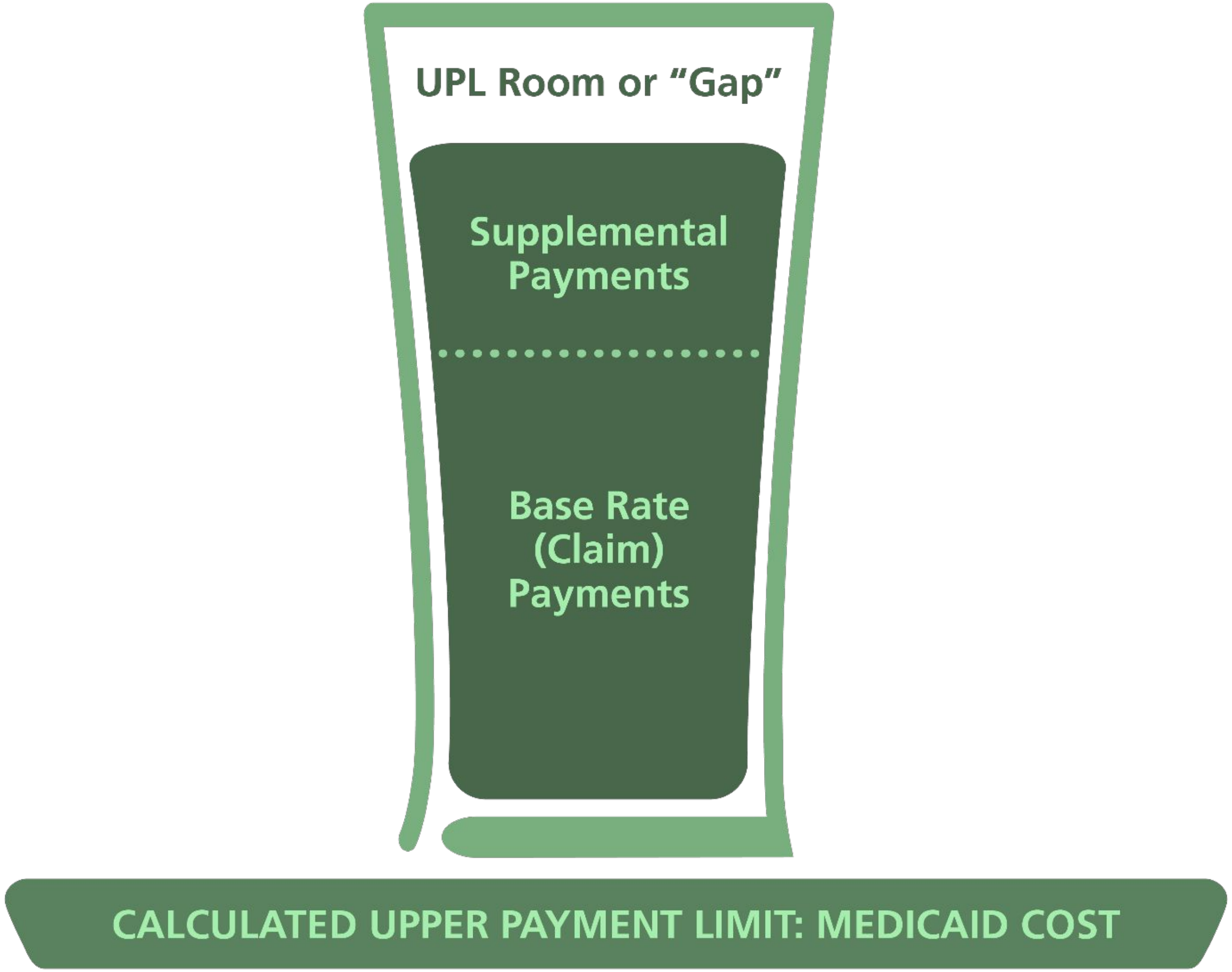
Required Multi-Step Process

- Increasing reimbursement to 99.25% of UPLs requires a multi-step process
- This includes:
    1) Making necessary modifications to UPL gaps for changes to data since original UPL calculations
    2) Uniformly increasing hospital adjustment factors within different UPLs pool so that total reimbursement equals 99.25% of UPLs
    3) Making other necessary adjustments to certain hospitals and/or adjustment groups

1) Modifications to UPL Gap

- Modifications required to UPL gap to reflect materialized data changes used in FFY 22-23 and FFY 23-24 UPL calculations
  - UPL gap is available room under UPL for CHASE supplemental payments
  - UPL gap equals *<u>estimated</u>* Medicaid cost (UPL) minus *<u>estimated</u>* claims based Medicaid reimbursement minus *<u>estimated</u>* non-CHASE payments

1) Modifications to UPL Gap



1) Modifications to UPL Gap

- Estimates based on best available data at the time, adjusted to UPL demonstration period
  - *Estimated* Medicaid Cost - most recently available audited Medicaid cost, adjusted for **utilization** & **inflation**
  - *Estimated* Claims Based Medicaid Payment - paid claim data for period similar to Medicaid cost, adjusted for **utilization** and **payment rate changes**
  - *Estimated* Non-CHASE Payments - Estimated non-CHASE payments for UPL demonstration period

1) Modifications to UPL Gap

- Changes to data used to calculate FFY 22-23 and FFY 23-24 utilization, inflation, and payment rate adjustments and non-CHASE payments have occurred since original UPL calculations
  - Due primarily to replacement with actual data
- Required to consider these changes so that total Medicaid reimbursement does not exceed available UPL totals using reasonable estimates based on the most readily available data at the time of calculation

1) Modifications to UPL Gap

- $7.3M Inpatient & Outpatient decrease for FFY 22-23
  - Payment Rate Adjustment - Estimated SFY24 0.5% rate increase revised to actual 3.0% rate increase
  - Non-CHASE Payment - $71.9M estimated payment amount decreased to $67.5M actual payment amount

Changes to FFY 22-23 UPL Gap	Inpatient UPL	Outpatient UPL	Total UPL
Payment Rate Adjustment	$(7.2M)	$(4.5M)	$(11.7M)
Non-CHASE Payments	$4.4M	$0.0M	$4.4M
Total	$(2.8M)	$(4.5M)	$(7.3M)

1) Modifications to UPL Gap

- $45M Inpatient & Outpatient decrease for FFY 23-24
  - <u>Utilization Adjustment</u> - Originally used November 2023 published caseload. Revised to use February 2024 published caseload which is based on more recent actuals
  - <u>Inflation Adjustment</u> - CMS published Outpatient Hospital Prospective Payment System (PPS) market basket increase to fiscal year 2024

1) Modifications to UPL Gap

- <u>Payment Rate Adjustment</u> - Estimated 1.0% rate increase revised to actual 2.0% rate increase
- <u>Non-CHASE Payment</u> - $67.4M estimated payment amount increased to $74.7M actual payment amount

Changes to FFY 23-24 UPL Gap	Inpatient UPL	Outpatient UPL	Total UPL
Utilization Adjustment	$(7.5M)	$(28.8M)	$(36.3M)
Inflation Adjustment	$0.0M	$5.0M	$5.0M
Payment Rate Adjustment	$(4.0M)	$(2.9M)	$(6.9M)
Non-CHASE Payments	$(7.3M)	$0.0M	$(7.3M)
Total	$(18.8M)	$(26.7M)	$(45.5M)

2) Increase Adjustment Factors

- Uniformly applied a percent increase to all adjustment factors within a UPL pool
- Separate percent increase applied to each UPL pool to increase supplemental payments to 99.25% of the UPL
- Changes made only to Inpatient and Outpatient payments.
- No changes made to Essential Access, Rural Support Fund, Hospital Quality Incentive Payments (HQIP), or Disproportionate Share Hospital (DSH) payments

2) Increase Adjustment Factors

- FFY 22-23 Example:

UPL Group	Inpatient Percent Increase	Outpatient Percent Increase
State Gov.	100.00%	100.00%
Non-State Gov.	114.12%	105.92%
Private	106.28%	103.66%

Adjustment Group	Original Inpatient Adjustment Factor	Inpatient Percent Increase	Revised Inpatient Adjustment Factor
Private Rural/CAH	$700.00	106.28%	$743.96
Private Heart Institute	$1,055.00	106.28%	$1,121.25
Private Pediatric Specialty	$534.00	106.28%	$567.54
Private NICU	$1,355.00	106.28%	$1,440.09
Private Independent Metro	$1,280.00	106.28%	$1,360.38
Private	$560.00	106.28%	$595.17

3) Other Adjustments

- All non-system hospitals and hospital systems experience a net benefit increase when considering both years
  - Net Benefit = Payments *minus* Fees
- Required percent increases for several specific adjustment groups to differ from other adjustment groups with a UPL pool to achieve this
- Also required adjustments to specific hospitals and/or adjustment groups due to DSH limitations in both years

3) Other Adjustments

- **FFY 22-23 DSH Payment Limitations**
- No changes made to DSH payments
- Changes to Inpatient/Outpatient supplemental payments affect a hospital's DSH limit
    - Hospital-Specific DSH limit = Medicaid & uninsured costs *minus* Medicaid & uninsured payments
        - Medicaid & uninsured payments include all non-DSH payments

3) Other Adjustments

- FFY 22-23 regulations sets DSH payments for certain hospitals equal to 96.00% their DSH limits
    - Includes DSH eligible Critical Access, High CICP Cost, and Small Independent Metro Hospitals
- Could not increase Inpatient/Outpatient supplemental payments for these hospitals because it would mean a DSH payment greater than 96.00% of their DSH limit
- Any supplemental payment increase to these hospitals will be out of compliance with regulations
- <u>Cannot retroactively change FFY 22-23 regulations</u>

3) Other Adjustments

Example Hospital Specific DSH Limit Calculation w Payment Increase			
Row A	W Payment Increase	No	Yes
Row B	Total Costs	$5,100,000	$5,100,000
Row C	Medicaid Payments	4,000,000	$4,000,000
Row D	Supplemental Payments	$500,000	$510,200
Row E	Uninsured Payments	$100,000	$100,000
Row F	Total Payments	$4,600,000	$4,610,200
Row G	DSH Limit	$500,000	$489,800
Row H	DSH Payment	$480,000	$480,000
Row I	% of DSH Limit	96.00%	98.00%

3) Other Adjustments

- No changes to adjustment factors made for hospitals at 96.00% of their DSH limits for FFY 22-23
- A greater percent increase is applied to the remaining adjustment factors within a UPL pool to get to 99.25%
- State UPL pool still at 97.5% due to University Hospital limited to 96.00% of their DSH limit and no other hospital within State UPL pool

UPL Group	Inpatient Increase	Outpatient Increase
State Gov.	100.00%	100.00%
Non-State Gov.	114.12%	105.92%
Private	106.28%	103.66%

3) Other Adjustments

- FFY 23-24 regulations allow increased supplemental payments to all hospitals including up to 100% of DSH limits
- Increase limited for several hospitals as DSH payments cannot be more than 100% of their DSH limits
  - Adjustment factors set so that total payments equal 100% of hospital's DSH limit
- State IP UPL pool less than 99.25% due to University Hospital limited to 100% of their DSH limit and no other hospital within State IP UPL pool

Provider Fees

- $31M fees will be collected in FFY 24-25
  - Fees calculated using data to be used in FFY 24-25 CHASE model
    - Cost Report Year End (CRYE) 2022 total days, Medicare days, total outpatient costs
- Fees apply to the net patient revenue (NPR) limit at time when collected included in FFY 24-25 NPR limit calculation
  - <u>Fees will not be included in FFY 22-23 or FFY 23-24 NPR limit calculations</u>

Implementation

- Increased fees and payments will occur as a one-time transaction in December
- Require Medical Services Board approval of regulation changes
- Communication to hospitals in mid-November
- Transaction to hospitals on Monday, December 16th
  - Payments recorded for FFY 22-23 and FFY 23-24
  - Fees recorded for FFY 24-25

Public Comment

Board Action Items

1. Workgroup to Explore CHASE Program Reforms and State Directed Payments
2. CHASE FFY 2022-23 and 2023-24 Adjustments to Reach 99.25% Upper Payment Limit

Hospital Transformation Program (HTP) Update, Severity Adjusted Length of Stay (LOS) Measure

Matt Haynes

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Measure Replacement to SW-PH1 - Severity Adjusted LOS: Background and Overview

- Due to a combination of circumstances related to data analytics support as well as inquiries from HTP participants, HCPF decided to change the measure for SW-PH1.
- We utilized the following principles to determine the appropriate replacement:

Guiding principles

- ✔ Measures/Requirements must be aligned with current hospital intervention efforts
- ✔ Hospitals will not be required to implement new interventions
- ✔ All hospitals that currently have SW-PH1 will be required to and shall be eligible to participate in the new measure
- ✔ Replacement should be aligned with other requirements and build on success seen in the current interventions
- ✔ Replacement should serve a benefit to and contribute towards HTP sustainability
- ✔ All at-risk will be awarded for SW-PH1 for PY3

Measure Replacement to SW-PH1 - Severity Adjusted LOS: Background and Overview

- **The Severity Adjusted Length of Stay (SLOS)** measure (SW-PH1) will be retired from HTP and will be replaced with requirements of participation in the Inpatient Hospital Transitions (IHT) program.
- **Inpatient Hospital Transitions (IHT)** will be implemented as a replacement complementary effort for measuring hospital’s existing interventions around care coordination and utilization review. The transition has been initiated with plans to finalize by **October 1, 2024**.

Measure Replacement to SW-PH1 - Severity Adjusted LOS: Details

- HTP Hospitals that have SW-PH1 as a measure will be **required** to participate in the Inpatient Hospital Transitions Program (IHT) and will be measured for adherence to the program in **HTP Program Years (PY) 4 and 5.**
- The HEDIS Average Length of Stay (Avg LOS) measure will be calculated as a maintenance measure with **no risk** associated.
- The measure will continue to be tracked under the measure SW-PH1, which will replace the previous SLOS data moving forward. The previous SLOS data will be **archived** but not used for performance measurement.

SW-PH1 Inpatient Hospital Transitions (IHT)

SW-PH1 Inpatient Hospital Transitions: Measure Overview

- **Inpatient Hospital Transitions** are:

✔ A mechanism for hospitals to share focused member-specific information with the Regional Accountable Entities (RAEs) to ensure successful discharge planning.

✔ The first step in the official communication from hospitals to the RAEs when the hospitals need assistance for a member discharge or transition.

✔ Focused on complex inpatient hospital transitions from one level of care to another.

✔ Not associated with authorization for inpatient stay or provider reimbursement.

SW-PH1 Inpatient Hospital Transitions: Next Steps and Resources

- Visit the IHT Website for additional information and resources

Hospital Financial Transparency Updates

James Johnston

Annual Report Changes

Major changes to be included in the annual report:

- Summary of the hospital's financial transfers to/from related parties.
- Narrative report of planned & completed projects and capital investments >$25 million. Narratives are provided in the appendix.
- Information on physician affiliations and acquisitions.
  - *Information is de-identified and presented in aggregate*.
- Summary information on changes to service lines.
- Salary and total compensation data of the top five highest paid administrative positions.
  - *Information is de-identified and presented in aggregate*.
- Breakouts of uncompensated care costs by new categories (by county designation, by system, by Critical Access Hospital)

Thank You

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