April 25, 2024

Kim Bimestefer
Executive Director
Colorado Department of Health Care Policy and Financing
Via email to kim.bimestefer@state.co.us

Re: CHA Response to 4/18 HCPF Questions Regarding UPL Increase Request

Dear Kim,

Thank you for your efforts to engage with CHA on our request to maximize federal-allowable funding for Medicaid by increasing the Upper Payment Limit (UPL) from the historic 96-97 percent up to 100 percent. The following includes CHA responses to questions HCPF has raised throughout our discussions, with a primary focus on the list of written questions provided by HCPF on April 18.

1. Clarification of CHA Ask & Associated Implications[1]

Maximizing federal funding for Medicaid through the CHASE Fee is a long-standing principle for CHA and the hospital community, and one that has not been fully realized. CHA's core request is to increase the Upper Payment Limit (UPL) to the allowable amounts under federal law, up to 100 percent and within the allowable maximum of 6% of hospitals' net patient revenue. CHA estimates that if executed to the allowed amount under federal law (FFY 2022-2024), this could provide approximately $143 million in net federal dollars to supplement funding for Medicaid services and uncompensated care costs.

More specifically, CHA's current request is to prepare and submit for review and input to stakeholders a UPL model that achieves the federally allowable maximum amounts (100% of UPL or 6% of fees) for the years currently under consideration (FFY 2022, 2023, 2024) and in future years. The 2023-2024 CHASE model can be adjusted to provide appropriate consideration to disproportionate share (DSH) limits to avoid fee increases larger than payment increases, as discussed in Section 3 below.

[1] This section addresses the following questions:
Question 8: …Please clarify the CHA request: Is it for HCPF to recommend increasing to 100% UPL in 2024-24 and going forward, or is CHA asking for two years retrospectively? If the latter, how will the negative impacts to these hospitals that were paid the maximum DSH in prior years be mitigated

FFY	21-22	22-23	23-24	Total
Additional fees	$34.5	$35.1	$17.4	$87.0
Additional payments	$90.8	$92.4	$47.1	$230.3
Net Supplemental payments	$56.3	$57.3	$29.7	$143.3
Percent UPL	100.00%	100.00%	98.54%	
Percent NPR (2023-24)			6.00%	

Source: HCPF 4/24/2024

Implementation details are important. Recognizing that some hospitals may pay additional fees without a commensurate increase in Medicaid supplemental payments, we must avoid inadvertent negative impacts for individual hospitals. CHA's commitment, on behalf of our entire membership, is to implement this strategy in a way that does not result in fee increases larger than payment increases, within federally allowable payment mechanisms.

2. Mitigation of Risk Arising from Potential Federal Overpayment Demands[2]

CHA understands HCPF's concerns with potential federal scrutiny resulting in overpayment demands, which could in turn harm financially fragile hospitals or the General Fund. We respect this concern, and while experience from other states suggests the overpayment recoupment risk is low,[3] contingency plans should be in place to mitigate anticipated risk. CHA offers the following four considerations regarding risk mitigation and debt repayment:

A. Prevention

The primary mechanism for risk mitigation has been – and should continue to be – a prevention-based approach. As partners in ensuring the success of the CHASE program, both HCPF and CHA invest significantly in prospective analysis of proposed models to ensure accuracy and reliability before UPL demonstrations are submitted to CMS. Both organizations should continue to prioritize these investments, as errors are sometimes found and can be corrected before payments are made.

B. Recoupment Measures Based on Existing Processes

The second risk-mitigation mechanism is to mirror remedies already in use by the state: following the existing process for DSH adjustment, which is reconciled quarterly. Should the feds issue an

[2] This section addresses the following questions:
Question 2: From your perspective, what happens if the state incurs an overpayment?
Question 3: From your perspective, how would the state address (a) Colorado hospitals' return of overpayments in a way that ensures the state General Fund is not impacted and (b) we are found over the fee limit, with its immediate impact on our federal draw, let's discuss how hospitals would pay the lost federal funds to the state so the General Fund is not impacted.

[3] HCPF currently maintains a "buffer" within the UPL by setting it at 97% in case CMS does a retrospective reconciliation of the program (as it does with DSH payments). However, unlike DSH, the UPL is a "reasonable estimate," and the feds don't reconcile the estimate with actual data – MACPAC noted this in a 2018 report. CMS has never required Colorado or any state to perform a retrospective reconciliation of its UPL calculation and CMS has never prepared one for any state. To the extent Colorado pays in accordance with the Medicaid SPA and does not pay more than the supplemental payment amounts identified during the Medicaid SPA review process, there is no recoupment risk. Many states pay 100% of UPL, including CA, MI, NY, TX, NV, UT, SC, and GA.

overpayment demand as the result of increasing the UPL to 100 percent, HCPF can – and should – execute a legally binding agreement with the hospitals that requires return of all federal funds identified by CMS as overpayments. HCPF could further protect its fiscal interests under the agreement by stipulating that collection of overpayments would be performed via an offset to Medicaid payments otherwise due to the affected hospitals. If modeled after the DSH reconciliation process, HCPF would have the option of offering lump-sum or payment plan options to hospitals, as long as funds were repaid within 12 months.

C. Hospital-Level Financial Practices

Individual hospitals can play a role in mitigating risk at the hospital level by implementing best practices. Many DSH hospitals, for example, have a DSH reserve in anticipation of the DSH reconciliation process – similar UPL reserves could be built and maintained by hospitals, particularly if UPL funds increase. Critically, 92 percent of fee payments come from system and urban independent hospitals, and presumably, overpayment demands would be incurred proportionate to fees, such that collectively, rural hospitals bear less risk than their urban counterparts.

D. Improving Hospital Financial Conditions

During the Apr. 22 call, HCPF raised the issue of being unable to collect an estimated $60 million currently owed by a subset of hospitals due to prior overpayments resulting from the implementation of the state's MMIS system in the last decade. The Department indicated that during COVID, payment plans for these amounts owed were dropped to $0.01 per week, and regular payments have not resumed. Hospitals should be prepared and have reserves to pay outstanding liabilities. Cash flow, however, for some hospitals has been constrained in recent years due to unexpected revenue and expense impacts related to COVID, higher than expected expense trends in 2021 and beyond, and more recently, with the billing and payment impacts from Change Healthcare.

While the goal of increasing the UPL is not to provide funding to support repayments to the State, if the UPL were increased for available years, hospitals would be better positioned to repay these funds. As shown below in the following example, UPL provides hospitals with additional funds to support financial viability.

Hospital	FFY 2022-24 Scenario of Net Payment Change	HCPF Funds Owed Source: HCPF	
Hospital A	$1.5m	$973k	
Hospital B	$756k		$1.1m
Hospital C	$312k		$520k

Beyond the aforementioned mitigation mechanisms, there are limited options for ***guaranteeing*** individual hospitals or types of hospitals would not experience harm from a federal overpayment demand because federal law prohibits states from engaging in "hold harmless" arrangements. As rearticulated in a CMS letter released this week, "CMS expects that states will not develop or implement health care-related taxes that involve provider payment redistributions or develop, implement, endorse, or encourage new provider payment redistribution arrangements tied to existing health care-related taxes."[4]

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/cib042224.pdf

3. Distribution of Additional Federal Funds and Procedural/Timing Considerations[5]

To specifically address some HCPF questions regarding limitations on the fee model and use of additional federal funds:

- As has always been the case, pursuant to federal law, if fees reach 6% of estimated hospital NPR, UPL would need to be set to achieve the maximum UPL percentage within allowable federal fee limits (below 100%).
- CHA does not anticipate any impact to Medicaid expansion financing. We currently fully fund Medicaid and CHP+ expansion in accordance with federal matching criteria, and additional funds should go exclusively toward hospital payments.

Turning now toward details on how CHA views next steps for implementing a UPL increase, we ask for HCPF's commitment to develop revised models ***without delay*** for FFY 2022, 2023, and 2024, reflecting the allowable federal funding maximum (100% UPL or 6% NPR). As is HCPF's custom, these models should be reviewed for accuracy by CHA and promptly presented to the CHASE Board (and by extension, all hospitals) for stakeholder feedback.

CHA listened carefully to HCPF's concerns regarding changes to the State Plan Amendment for prior years, as articulated on our Apr. 22 call. As such, we recommend the following:

- DO NOT retroactively change the DSH allotment or underlying UPL calculations, both of which would necessitate a State Plan Amendment.
- DO move the UPL for available prior years to 100 percent, subject to federal limitations.
- DO increase the DSH limit percent for the 2023-24 model year, to help mitigate the impacts of increased fees exceeding increase payments for the 2022 and 2023 model.

CHA recognizes that there are a variety of scenarios under which HCPF could distribute additional federal funds, decisions which are primarily within the regulatory discretion of HCPF. As shown in Attachment B, CHA has modeled at least one potential scenario under which all but one hospital statewide will receive additional funds if the UPL is increased for all three model years. This model is intended to be illustrative and is not the only scenario under which additional funds could be distributed.

As HCPF noted, timing is an important consideration. The 2023-24 model needs to be finalized, and with regard to the retrospective UPL increase, federal regulations only permit changes within a two-year window. Delays may limit the opportunities to draw down federal funds currently available.

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[5] This section addresses the following questions:
Question 7: We should talk about timing, given our deadlines, rules revisions for the 2023-24 CHASE fees and payments, reconciliation before the end of the model year, etc.
Question 5: If HCPF recommends and the state goes forward with a 100% UPL standard, what happens in a future year if we reach the 6% NPR fee limit but cannot reach 100% UPL?
Question 1: Can you share your thoughts on how additional funds would be distributed from increasing the UPL? Consider and discuss systems, rurals, struggling, safety net, etc.
Question 4: How do you see this UPL decision impacting Medicaid and CHP+ expansion membership financing?

4. Additional CHASE Changes & Conclusion[6]

Through a Strategic Advisory Group established by the CHA Board of Trustees, CHA is considering other opportunities to improve the CHASE program. This Group is comprised of a subset of CHA Board members and at-large members representative of our full membership and is chaired by Dr. Rob Vissers, CEO of Boulder Community Hospital. Some ideas under evaluation are complex or longer-term improvements, and we commit to an open and collaborative partnership with HCPF and the Governor's Office on these ideas as we are ready to bring them forth in a meaningful way. In furtherance of that, two ideas we are currently processing include:

- Beginning with the FFY 2024-25 model, re-evaluate the current model design of fees and payments in alignment with policy principles of engagement, input, transparency, consistency, predictability, fairness, and consideration of statewide priorities.
- Evaluate additional or alternative federal programs, including State directed payment programs to provide supplemental payments related to Medicaid managed care and behavioral health.

We appreciate HCPF's desire to understand these concurrently, but increasing the UPL is an immediate step that can be implemented within current federal and state guidelines, whereas the others will require additional analysis and enagagement.

Finally, on Apr. 22, HCPF indicated a perceived concern that only a subset of CHA members were supportive of the UPL request that CHA has advanced. This request not only has the endorsement of the CHA Board of Trustees and the CHASE Strategic Advisory Group, but we have also enclosed (as Attachment A) a letter signed by our broader membership indicating their unwavering support for the Association's efforts to increase the UPL.

[6] This section addresses the following questions:
Question 6: Is the UPL the only target for additional CHASE funds or changes? That insight is critical. If you have other levers you want to pull, we need to understand that concurrently.