Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board

June 2025
Department of Health Care Policy & Financing

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Acronyms

- ACR: Average Commercial Rate
- CHASE: Colorado Healthcare Affordability & Sustainability Enterprise
- CMS: Centers for Medicare and Medicaid Services
- DSH: Disproportionate Share Hospital
- EQRO: External Quality Review Organization
- FQHC: Federally Qualified Health Center
- HCPF: Department of Health Care Policy & Financing
- HTP: Hospital Transformation Program
- HQIP: Hospital Quality Incentive Payments
- IGT: Intergovernmental Transfer
- IMD: Institute for Mental Diseases
- MCO: Managed Care Organization
- NPR: Net Patient Revenue
- RAE: Regional Accountable Entity
- RSF: Rural Support Fund
- SDP: State Directed Payment
- SPA: State Plan Amendment
- UPL: Upper Payment Limit
- WIG: Wildly Important Goal

Agenda

- Welcome new board members
- Approve May 13, 2025 meeting minutes
- CHASE and HCPF updates
- Rural Support Fund Policy Recommendation
- State Directed Payments (SDP) Program Workgroup Recommendation

Welcome New Board Members

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New and Returning Board Members

Returning/Re-appointed Board Members

- Patrick Gordon, Board Chair, UnitedHealthcare/Rocky Mountain Health Plans
- Dr. Kimberley Jackson, Vice Chair, Consumer
- Jason Amrich, Gunnison Valley Health
- Margo Karsten, Banner Health
- Scott Lindblom, HCPF
- Dr. Claire Reed, High Plains Community Health Center
- Mannat Singh, Colorado Consumer Health Initiative
- Jeremy Springston, Denver Health and Hospital Authority
- Ryan Westrom, Colorado Hospital Association

New Board Members

- Raine Henry, HCPF
- Hillary Jorgensen, Colorado Cross Disability Coalition
- Julie Nickell, UCHealth
- Ryan Thornton, HCA HealthONE Mountain Ridge

May 13, 2025 Meeting Minutes

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HCPF Updates

Updates

- HCPF requested stay of district court's decision in Poudre Valley/Memorial Hospital pending appeal
- Rules related to 2024-25 CHASE model expected to be heard at the July 11th Medical Services Board Meeting
- Monitoring progress of federal budget reconciliation bill

Rural Support Fund

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Rural Support Fund: Current Hospitals

- Conejos County Hospital
- East Morgan County Hospital
- Haxtun Health
- Keefe Memorial Hospital
- Kit Carson County Memorial Hospital
- Lincoln Community Hospital
- Melissa Memorial Hospital
- Middle Park Medical Center
- Pagosa Springs Medical Center
- Pikes Peak Regional Hospital
- Pioneers Medical Center
- Rangely District Hospital
- Rio Grande Hospital
- Sedgwick County Health Center
- Southeast Colorado Hospital
- Southwest Health System
- Spanish Peaks Regional Health
- St. Vincent Hospital
- Sterling Regional MedCenter
- Memorial Regional Health (Craig, CO)
- Weisbrod Memorial County Hospital
- Wray Community District Hospital
- Yuma District Hospital

Current Requirements

1. Not-for-profit critical access or rural hospitals
2. Contribute to the bottom 10% of net patient revenues for all critical access or rural hospitals (averaged between 2016, 2017 and 2018)
3. Contribute to the bottom 2.5% of the fund balance for all critical access or rural hospitals not eligible as a result of the net patient revenue criteria (2019 Medicare Cost Report)

Source: https://hcpf.colorado.gov/htp-rural-support-fund

Remaining Timeline

1. Hospital Transformation Program (HTP) 1.0 Timeline
   a. Program Year 5 ends **September 30th, 2026**
   b. Final program reporting and reconciliation will occur between **October 1, 2026 and September 20, 2027**
   c. A sustainability plan is required for each hospital at the conclusion of HTP 1.0 in **April 2027**
      i. ***HTP 2.0 external stakeholder work is underway.**
2. Rural Support Fund (RSF) 1.0 Final Payment: **September 2025**
   a. The Rural Support Fund began 1 year ahead of HTP to help support the upcoming requirements of HTP
   b. Currently, the RSF will have a 1 year gap from its end and HTP's final year

Rural Support Fund Proposal (1 of 2)

Rural Support Fund Proposal (Action Item)

Extend Phase 1: Keep the same hospitals, for the same amount, for one more year

- **Highlights: With the Extension**
  a. No gap in funding
  b. The end of RSF 1.0 would align with the end of HTP 1.0, for larger programmatic reporting
  c. Hospitals currently in the fund would receive the same amount: $521,739 per hospital, for one additional year to support the current iteration of HTP
  d. Will support the transition to the next phase of RSF and HTP

Rural Support Fund Proposal (2 of 2)

Without the extension, the current qualifying hospitals (23) would not receive a payment for 2026

- **Highlights: Without the Extension**
  a. A gap in funding will occur
  b. A new financial analysis of hospitals (2022 - 2024) for the next iteration of RSF will take time
  c. A new State Plan Amendment (SPA) approved by CMS will take time
  d. State Directed Payments might include changes to CHASE that are unknown
  e. RSF and HTP phase 2 will take time to develop and receive stakeholder buy-in, CHASE board approval, federal approval, and implementation

Partner Engagement

- Colorado Hospital Association
  - Joshua Ewing
- Lincoln Health
  - Kevin Stansbury
- San Luis Valley Health
  - Zachary Weiderspon
  - Shane Mortensen
- Colorado Rural Health Center
  - Michelle Mills
  - Kelly Erb Zager

Questions?

State Directed Payments (SDP) Program Workgroup Recommendation

Work Group Members

1. Alison Sbrana, Consumer
2. Annie Lee, President & CEO, Colorado Access
3. Emily King, Senior Policy Advisor/Deputy Director of the Office of Saving People Money on Health Care, Governor's Office
4. Josh Block, Deputy Chief Financial Officer, HCPF
5. Dr. Kimberley Jackson, CHASE Board Vice President
6. Nancy Dolson, Special Financing Division Director, HCPF
7. Shauna Lorenz, Partner, Gjerset & Lorenz LLP
8. Tom Rennell, Senior Vice President Financial Policy and Data Analytics, CHA

CHASE Workgroup Objective

Develop comprehensive recommendations for revisions to CHASE including the addition of a State Directed Payment (SDP) for CHASE Board consideration. Such that HCPF can develop and advance a broadly supported proposal to submit to the federal Centers for Medicare and Medicaid Services (CMS) for implementation to begin no later than July 1, 2025.

CHASE Program Objectives

As outlined in statute, the CHASE goals include:

- Increase reimbursement to hospitals up to federal limits for care for Medicaid members and uninsured patients
- Increase the number of hospitals benefitting from the CHASE fee and minimize those hospitals that suffer losses.
- Support improvements in the quality of hospital care
- Support the expanded health care coverage for the Medicaid and CHP+ programs

State Directed Payment Preprint

- Section I: Date and Timing Information
- Section II: Type of State Directed Payment
- Section III: Provider Class and Assessment of Reasonableness
- Section IV: Incorporation into Managed Care Contracts
- Section V: Incorporation into the Actuarial Rate Certification
- Section VI: Funding for the Non-Federal Share
- Section VII: Quality Criteria and Framework for All Payment Arrangements

SDP Quality Metric Framework

IS:

- Intended to demonstrate that the payment arrangement advance a goal of the quality strategy
- Expected to start upon submission (not approval)
- Able to be amended in future years

IS NOT:

- Not a pay-for-performance situation
- Does not determine how funds are distributed

Process for Selecting Measures

- Workgroup reviewed HCPF Quality Strategy – Pillars and Priorities
- Agreed on measure selection principles
- Process:
  - Subgroup evaluated potential measures with the selection principles and refined the list for inclusion in the SDP
  - Workgroup recommended 4 measures for preprint

Colorado Quality Strategy

Strategic Pillars - HCPF manages projects under several pillars to achieve Executive Leadership Team individual goals and Department goals, Governor's Wildly Important Goals (WIGs) and the Health Cabinet WIGs

- Member Health: Improve quality of care and member health outcomes while reducing disparities in care
- Care Access: Improve member access to affordable, high-quality care
- Operational Excellence and Customer Service: Provide excellent service to members, providers and partners with compliant, efficient, effective person- and family-centered practices
- Health First Colorado Value: Ensure the right services, at the right place and the right price
- Affordability Leadership: Reduce the cost of health care in Colorado to save people money on health care

Ten Principles in Quality Measure Selection

1. Map to goals and objectives in quality strategy
2. Be able to be used in the state's evaluation plan to measure the degree to which the payment advances one of the goals
3. Data available for managed care and fee for service populations to calculate baseline rates and future years
4. Based on existing validated measures (CMS preference)
5. Include the majority of hospitals and providers in this payment arrangement
6. Align with other quality measures and programs
7. Limit impact to provider administrative burden
8. Have room for improvement
9. Has been supported by CMS in other SDP programs
10. Quality measures may be added and/or amended in future years

Recommended Quality Measures with Criteria

Measure Name	Data Landscape	Baseline Options	Performance Target Methodology
30-day all-cause Readmissions (HEDIS)	Data for this measure is calculated by EQRO for the MCO population EQRO reports this at the MCO level.	EQRO publishes annual rates at the MCO level and the statewide weighted average through 2023	HTP has a benchmark of 0.85 which was the 90th percentile for HEDIS Medicaid nationally in 2022. A 10% gap-to-goal towards that benchmark.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Data for this measure is calculated by EQRO for the MCO population The RAEs calculate it for the behavioral health capitation population	Baselines are reported for the MCO population by the EQRO. Baselines are reported for the RAE in the Behavioral Health Incentive Program Specifications FY24-25	A 10% gap-to-goal is published in the Behavioral Health Incentive Program Specifications FY24-25
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Data for this measure is calculated by EQRO for the MCO population The RAEs calculate it for the behavioral health capitation population	Baselines are reported for the MCO population by the EQRO. Baselines are reported for the RAE in the Behavioral Health Incentive Program Specifications FY24-25	A 10% gap-to-goal is published in the Behavioral Health Incentive Program Specifications FY24-25
Follow-Up After Hospitalization for Mental Illness (FUH)	Data for this measure is calculated by EQRO for the MCO population The RAEs calculate it for the behavioral health capitation population	Baselines are reported for the MCO population by the EQRO. Baselines are reported for the RAE in the Behavioral Health Incentive Program Specifications FY24-25	A 10% gap-to-goal is published in the Behavioral Health Incentive Program Specifications FY24-25

The Future of CHASE

Future CHASE Model = **Current CHASE Model with adjustments** + **State Directed Payment**

Estimated net reimbursement increase: $378 M

Current CHASE Model with adjustments

- Revise fees
- Revise DSH and UPL supplemental payments such that all systems/independent providers do at least as well as status quo
- Reduced number of UPL payment "adjustment groups"
- Continue directed funding for Critical Access Hospitals through Essential Access and Rural Support Fund
- No changes to HQIP

State Directed Payment

- Inpatient—urban and rural
- Outpatient—urban and rural
- Psychiatric/IMDs

Funded by provider fees + IGT

Key Assumptions and Approaches (1 of 2)

- Optimize federal funding
  - 6% NPR limit, maximize ACR and IGT amounts
- All systems and independent hospitals better than status quo
- Revise fees to update 15-year-old fee methodologies, simplify, follow latest CMS guidance
- Payments tied to volume of services
- State Directed Payments increase per day (inpatient) and per visit (outpatient) up to ACR ceiling

Key Assumptions and Approaches (2 of 2)

Variables/decisions

- Data from calendar year 2023 and state fiscal year 2022-23
- Utilizing 2024-25 CHASE model for basis to calculate revised fees, UPL supplemental payments, and DSH payments
- ACR percentages calculated from hospital cost reports
- MCO costs from Colorado Hospital Association hospital survey, when no survey response from CHASE data reporting, except
  - For Denver Health from MCO encounter data without FQHC costs
  - For IMDs, estimated costs using available proxy data

ACR Percentages

Inpatient ACR		Outpatient ACR	
Rural	Urban	Rural	Urban
153%	253%	255%	373%

- Actual SDP will be calculated from a percentage of the above maximum ACR
- Currently Behavioral Health (IMD) ACR and State Directed Payment estimates using proxy data: Medicare to Medicaid payment rate and cost estimates

Funding

- Proposed fee methodology and amounts (requires CMS approval)
  - Fees at 6% federal NPR limit, assessed as percentage of NPR
  - Inpatient: 40% discounted fee for IMDs; essential access rural hospitals exempt (except western slope hospitals that receive SDP)
  - Outpatient:
    - 40% discounted fee for IMDs
    - 45% discounted fee high volume Medicaid metro hospitals (outside Denver metro)
    - 79.5% discounted fee all essential access rural hospitals
  - Fee Exempt hospitals: State University Teaching Hospitals,* Public IMDs, Long Term Acute Care and Rehabilitation Hospitals
- IGT funding: estimated $279 million

*Denver Health and University Hospitals, who will be contributing IGTs

Estimated CHASE Model with SDP

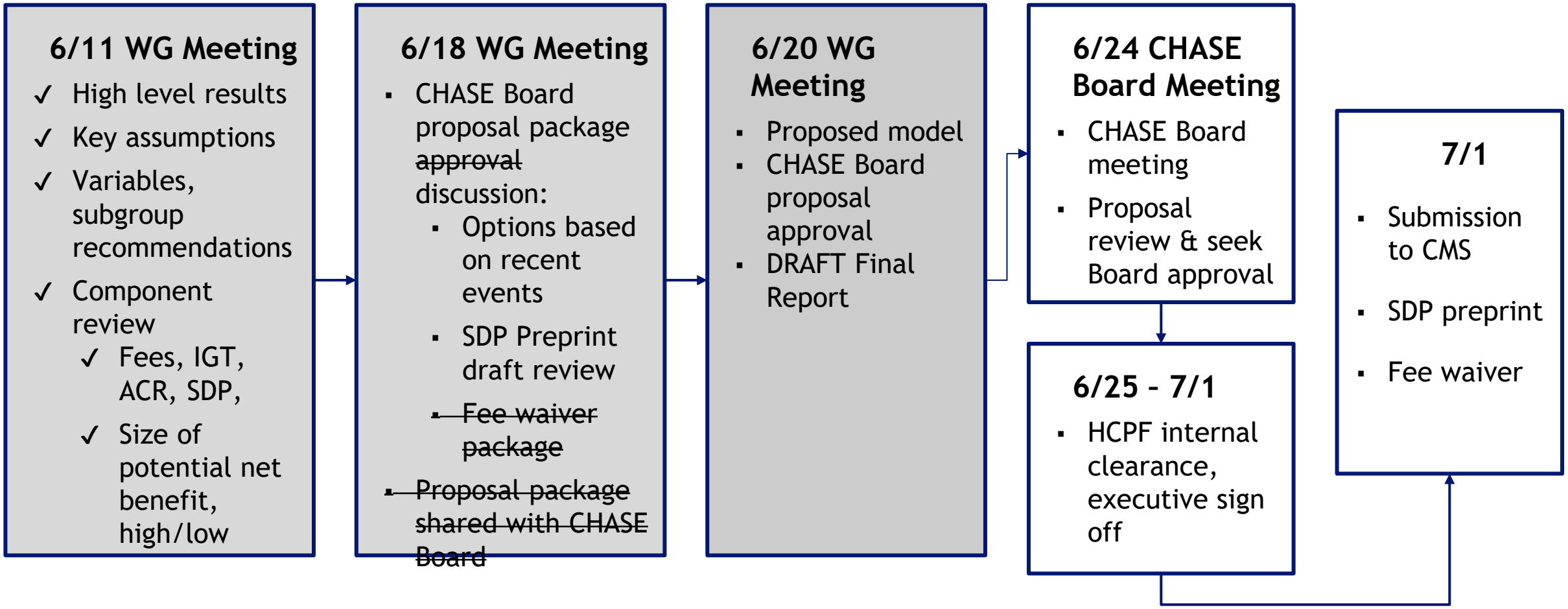
	Fee	IGT	SDP	Other Payments	Net Reimbursement	Net New Funds
Denver Health	-	$170.3 M	$259.3 M	$49.2 M	$138.2 M	$33.1 M
UCHealth	$322.8 M	$108.5 M	$86.6 M	$455.9 M	$111.2 M	$25.6 M
Psych (IMD)	$7.5 M	-	$11.5 M	-	$4.0 M	$4.0 M
Banner Health	$52.4 M		$0.3 M	$94.8 M	$42.7 M	$4.8 M
AdventHealth	$131.1 M		$24.3 M	$110.9 M	$4.2 M	$1.1 M
CommonSpirit Health	$191.8 M		$11.1 M	$277.6 M	$96.9 M	$64.0 M
HCA HealthONE	$277.5 M		$67.4 M	$300.1 M	$90.1 M	$73.8 M
Intermountain Health	$201.5 M		$114.5 M	$199.9 M	$112.9 M	$70.2 M
Others	$309.0 M		$150.0 M	$447.8 M	$288.8 M	$101.1 M
Total	**$1,493.6 M**	**$278.8 M**	**$725.1 M**	**$1,936.2 M**	**$888.9 M**	**$377.7 M**
Urban	$1,429.6 M	$278.8 M	$635.7 M	$1,699.6 M	$626.9 M	$301.1 M
Critical Access	$27.8 M		$34.6 M	$156.2 M	$163.0 M	$31.9 M
Other Rural	$36.1 M		$54.8 M	$80.4 M	$99.0 M	$44.7 M
Total	**$1,493.6 M**	**$278.8 M**	**$725.1 M**	**$1,936.2 M**	**$888.9 M**	**$377.7 M**

Managing Expectations

Actuals will change from our estimates based on these factors:

- Data revisions and refinement
  - More recent data for calculating NPR, UPL, Medicaid utilization
  - MCO data from encounter data
  - Additional psychiatric hospital data to incorporate into model rather than cost proxy
- CMS guidance on permissibility of Denver Health's FQHC data
- DSH qualifying hospitals with new rules effective 7/1/25
- Federal changes: budget bill, CMS regulatory or policy changes
- Poudre Valley Hospital/Memorial Hospital lawsuit stay and appeal decisions
- Best case, CMS approval will be several months from now

Road Map Details



No order implied

Work Planned AFTER Submission

- ❒ Engage with CMS on SDP and fee waiver questions
- ❒ Continue sourcing data
  - More recent data: NPR, UPL, expansion/administration costs
  - Refining encounter data for MCO costs
  - Obtain psychiatric hospital data for ACR
- ❒ Managed care contract amendments / actuarial work
- ❒ Monitor federal action: legislation, regulations, policy
- ❒ Monitor Poudre Valley/Memorial lawsuit status (i.e., request for stay, appeal)
- ❒ Develop 2025-26 CHASE model

Questions?

Public Comment

Board Action

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Action Items

- Rural Support Fund Policy Recommendation
- State Directed Payments (SDP) Program Workgroup Recommendation

Thank You

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