CHASE Board

June 3, 2024

Nancy Dolson
Department of Health Care Policy & Financing (HCPF)

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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.

CHASE

- Background & Federal Requirements
- Trends
- Proposed FFY 2023-24 CHASE Fees and Payments
- Discussion
- Public Comment
- Board Action
- Next Steps

CHASE Background

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

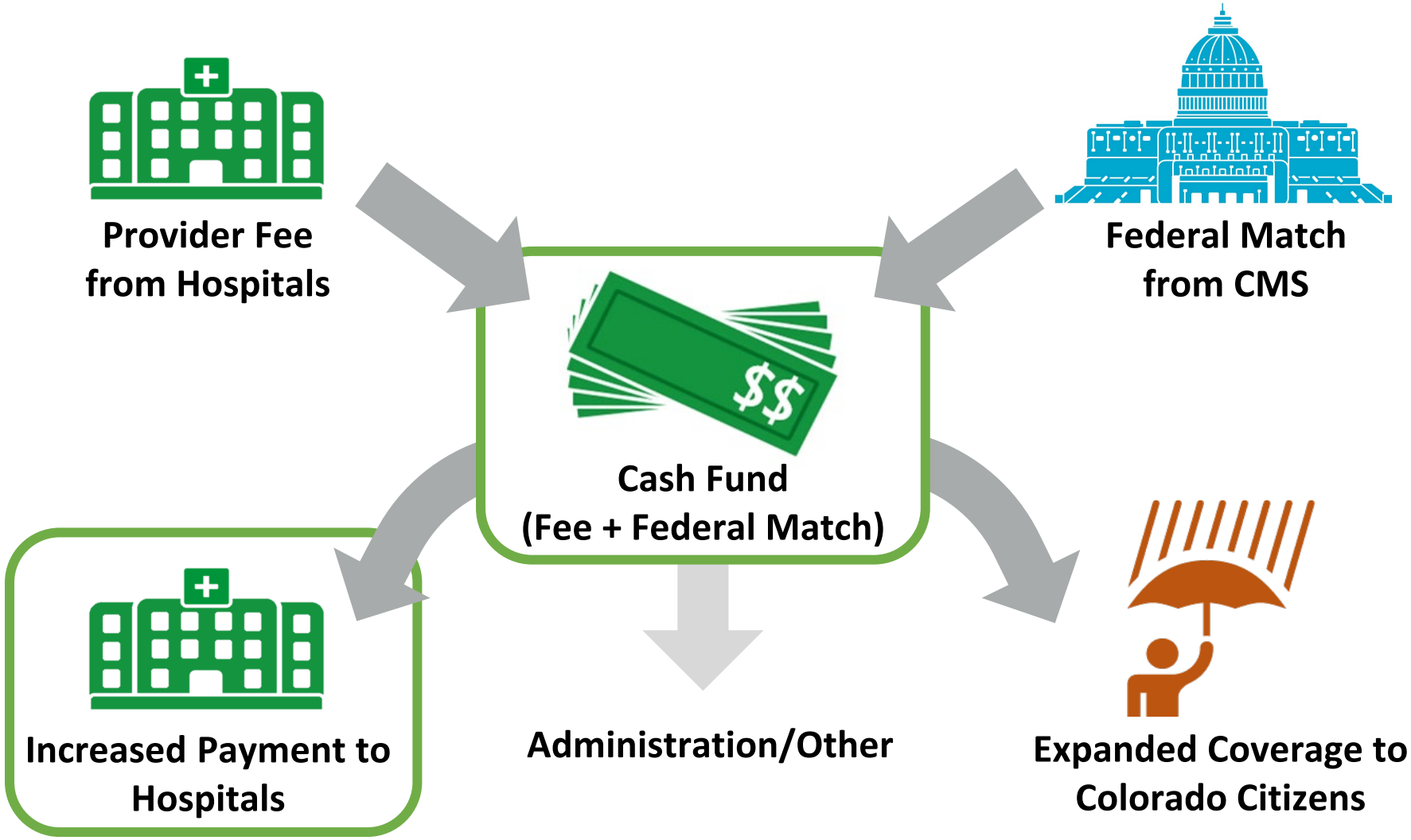
Purpose and Authority

- **HCPF** single state agency for administration of Colorado's Medicaid program and authorized to draw federal Medicaid funds
- **CHASE Board** recommending body for the hospital provider fee
  - Increase reimbursement to hospitals under Medicaid and Colorado Indigent Care Program (CICP)
  - Fund Hospital Quality Incentive Payments (HQIP)
  - Fund and implement the Hospital Transformation Program (HTP)
  - Increase Medicaid and Child Health Plan *Plus* (CHP+) coverage to reduce uncompensated care
  - Pay administrative costs limited to 3% of expenditures
- **Medical Services Board**
  - Promulgates rules for CHASE hospital provider fees with consideration of CHASE Board's recommendations
- **Centers for Medicare and Medicaid Services (CMS)** ultimate authority for approval of CHASE provider fees, hospital payments, and Upper Payment Limits (UPL)

Senate Bill 17-267, Concerning the Sustainability of rural Colorado, at § 25.5-4-402.4, C.R.S.

Purpose and Authority

- **HCPF** and the **CHASE Board** seek to meet the goals of the CHASE statute including
  - Maximize reimbursement to hospitals for care for Medicaid and CICP patients subject to UPLs, and
  - Increase the number of hospitals benefitting from the CHASE fee and minimize those hospitals that suffer losses
  - Payment categories and approach defined to meet these goals


Provider Fee
from Hospitals
Federal Match
from CMS
Cash Fund
(Fee + Federal Match)
Increased Payment to
Hospitals
Administration/Other
Expanded Coverage to
Colorado Citizens

CHASE Program	*Benefits to Hospitals*	*Benefits to Coloradans*
1. Increases reimbursement to Medicaid hospitals	*Reduced uncompensated care costs*	*Reduced need to shift costs to other payers like commercial insurance,* ***lowering the cost of care****. Quality incentive payments targeting* ***equity*** *and* ***outcomes***
2. Funds coverage for 500,000+ Medicaid & CHP+ expansion members	*Less uninsured = reduced uncompensated care costs*	***Access and low cost of care*** *for low-income Coloradans*
3. Hospital Transformation Program (HTP)	*Hospitals implement measures/interventions and improve quality to receive increased CHASE reimbursement*	***Better outcomes*** *through care redesign and integration of care across settings*

- No General Fund
- Low administrative costs

Federal Requirements

Medicaid Provider Fees*

- Limited to no more than 6% of net patient revenues (NPR)
- May not hold providers harmless, i.e., provide a direct or indirect guarantee that providers will receive all or a portion of their fees payments back
  - Fee *may not* be designed to reimburse providers based on amount paid (directly or indirectly)
  - Fee assessed on non-Medicaid statistic (e.g. inpatient days or outpatient charges)
  - Reimbursements are Medicaid payments

*Health-care related taxes under federal regulations; see 42 CFR § 433.68

Disproportionate Share Hospital (DSH) Payments

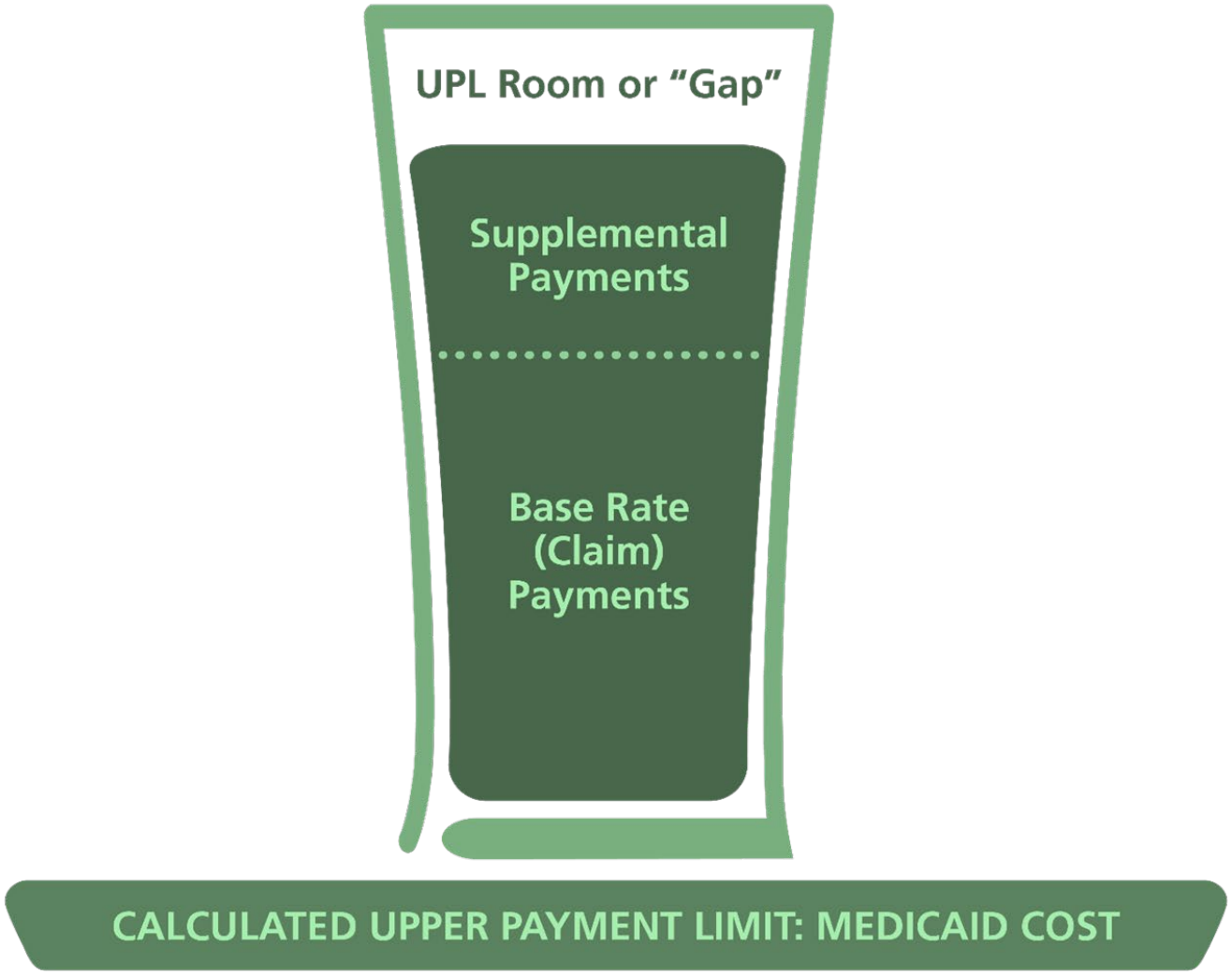
- Medicaid DSH payments required to hospitals that serve a high share of Medicaid and low-income patients
- State DSH spending is limited by federal allotments, which vary by state
- DSH payments cannot exceed the hospital-specific DSH limit which is the hospital's uncompensated care costs for both Medicaid-enrolled and uninsured patients

Upper Payment Limit

- UPL supplemental payments are lump-sum payments that are intended to fill in the difference between fee-for-service (FFS) claims payments and maximum amount that could be paid by Medicaid
- FFS and UPL payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles
- HCPF prepares UPL demonstrations, which must be submitted to CMS annually for review and approval

See: macpac.gov/wp-content/uploads/2021/11/Upper-Payment-Limit-Supplemental-Payments.pdf

Upper Payment Limit (UPL)

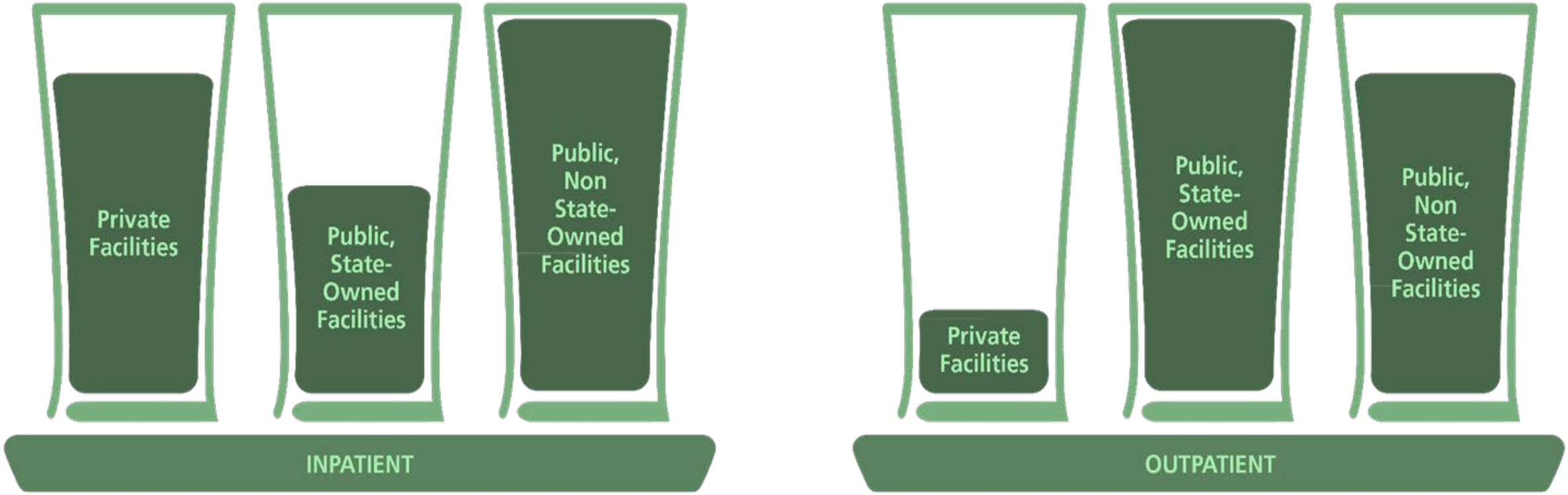


Upper Payment Limit

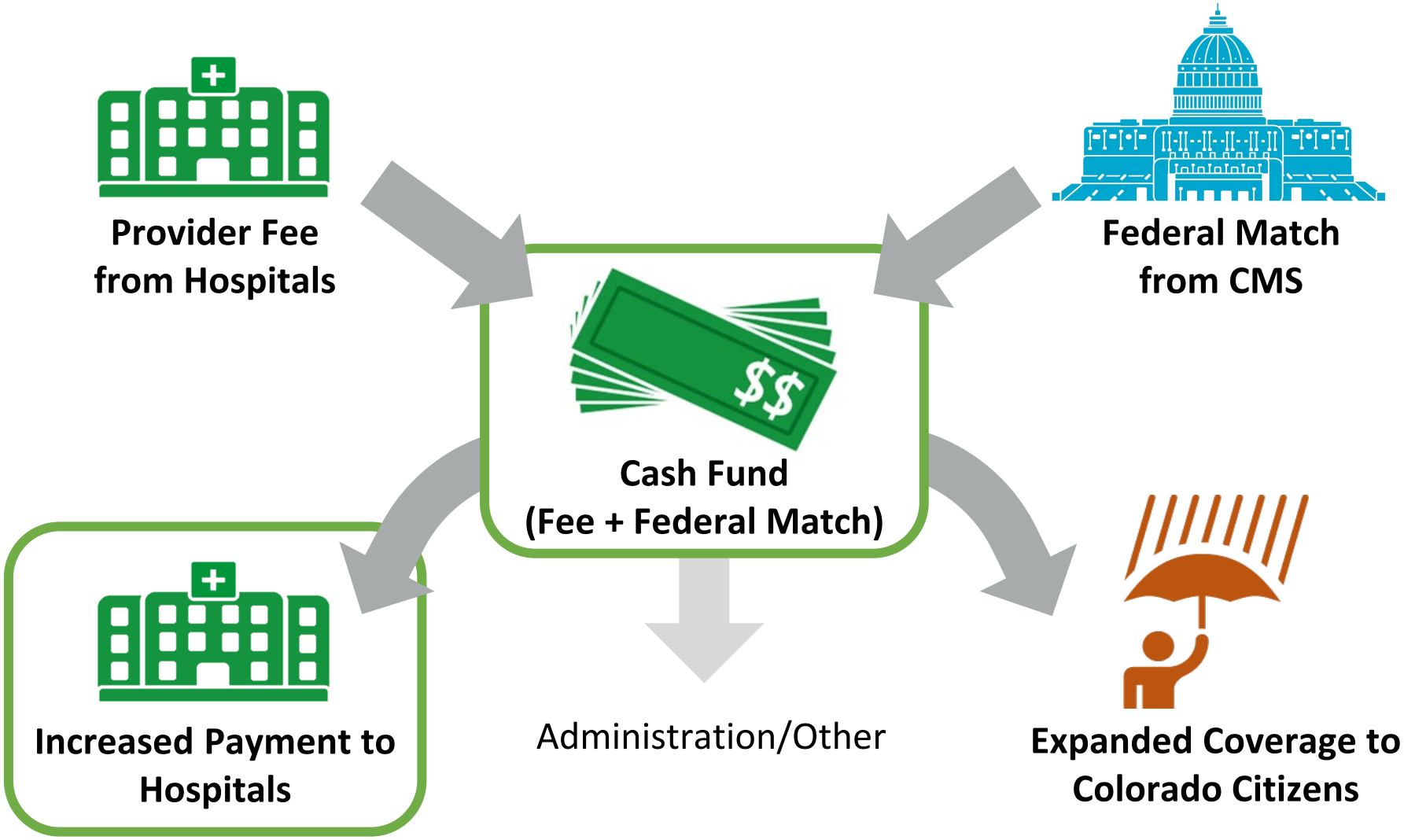
- Separate UPL demonstrations for Inpatient and Outpatient Hospital services
- Payments limited in aggregate by class of providers defined based on ownership (i.e., government, non-state government, and privately owned)
- 42 CFR 447.272 (a) Inpatient and 42 CFR 447.321 (a) Outpatient
  - (1) State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State)
  - (2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State).
  - (3) Privately-owned and operated facilities

See: medicaid.gov/medicaid/financial-management/payment-limit-demonstrations/index.html

UPL Pools


Private Facilities
Public, State-Owned Facilities
Public, Non State-Owned Facilities
INPATIENT
Private Facilities
Public, State-Owned Facilities
Public, Non State-Owned Facilities
OUTPATIENT

Trends

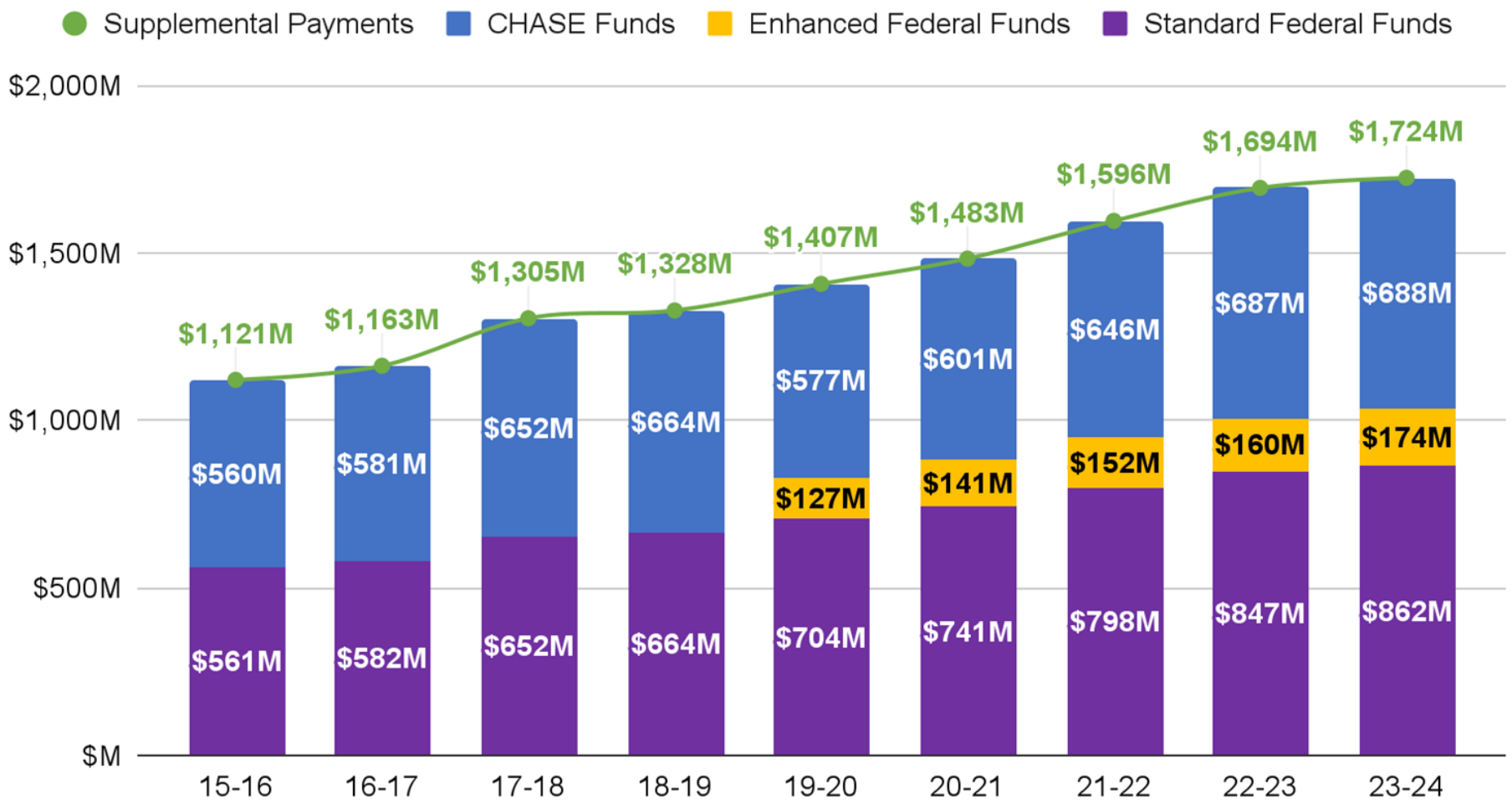

Provider Fee
from Hospitals
Federal Match
from CMS
Cash Fund
(Fee + Federal Match)
Increased Payment to
Hospitals
Administration/Other
Expanded Coverage to
Colorado Citizens

Fee & Payment

- CHASE statute regarding use of fees
  - § 25.5-4-402.4 (5)(b)(I) through (III), C.R.S.

Supplemental Payments with Enhanced Federal Funds

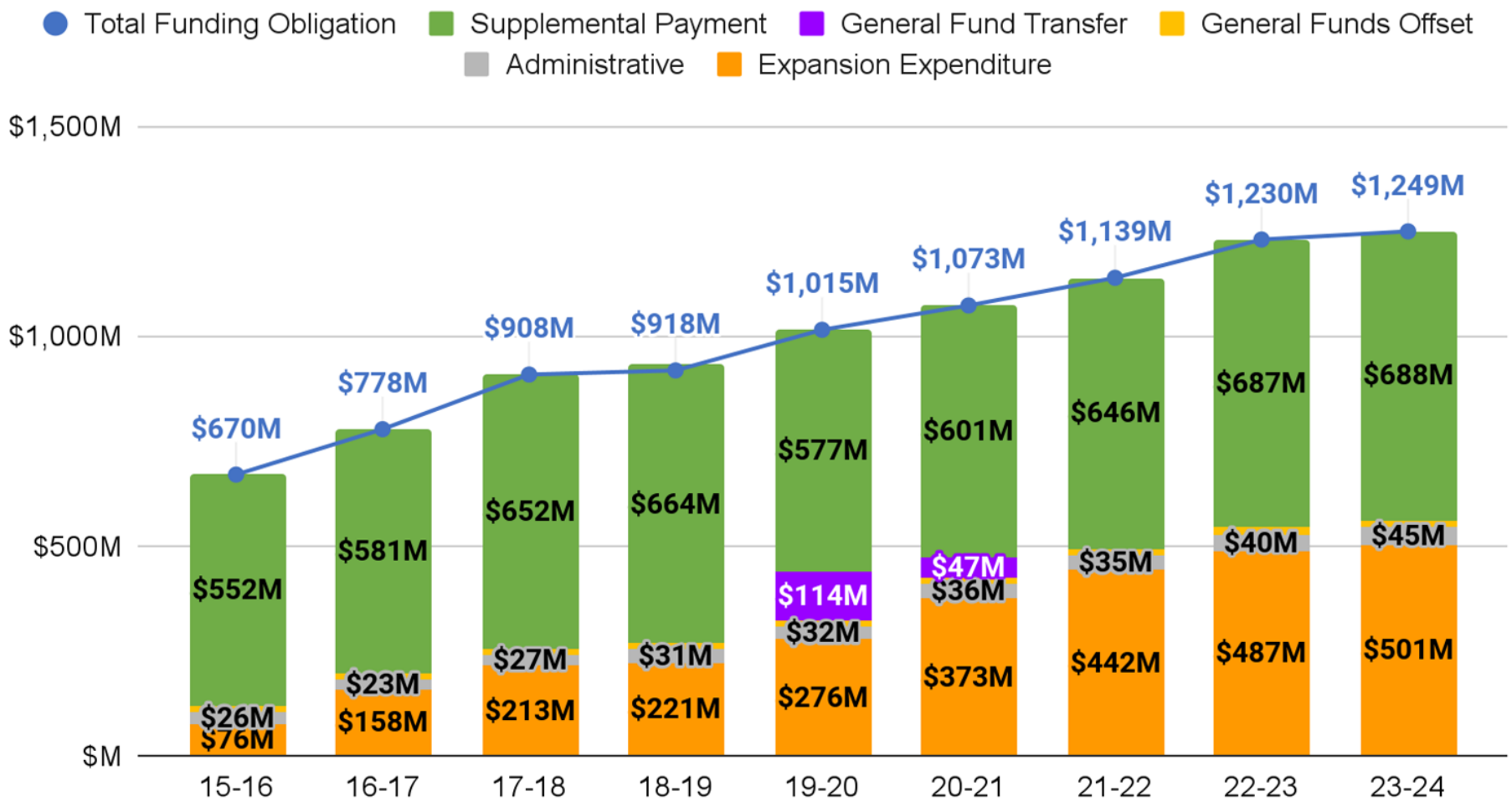
Increased Payment to Hospitals



Annual Payment Change :	-	3.8%	12.2%	1.8%	6.0%	5.4%	7.6%	6.2%	1.8%

Provider Fees

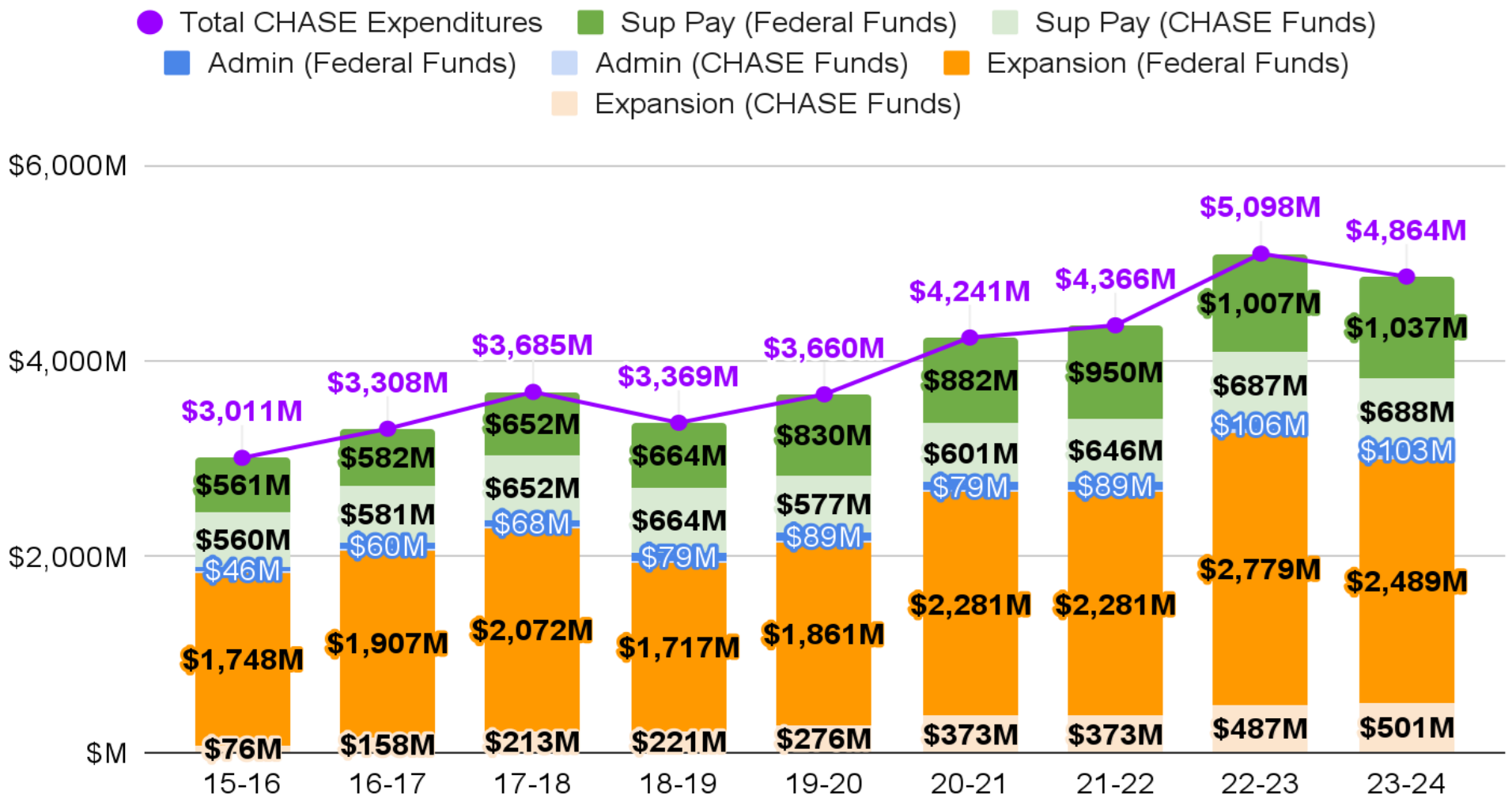
Provider Fee from Hospitals



Annual Fee Change :	-	16.2%	16.8%	1.1%	10.6%	5.4%	6.1%	8.0%	1.6%

Total CHASE Funding Obligation by FFY

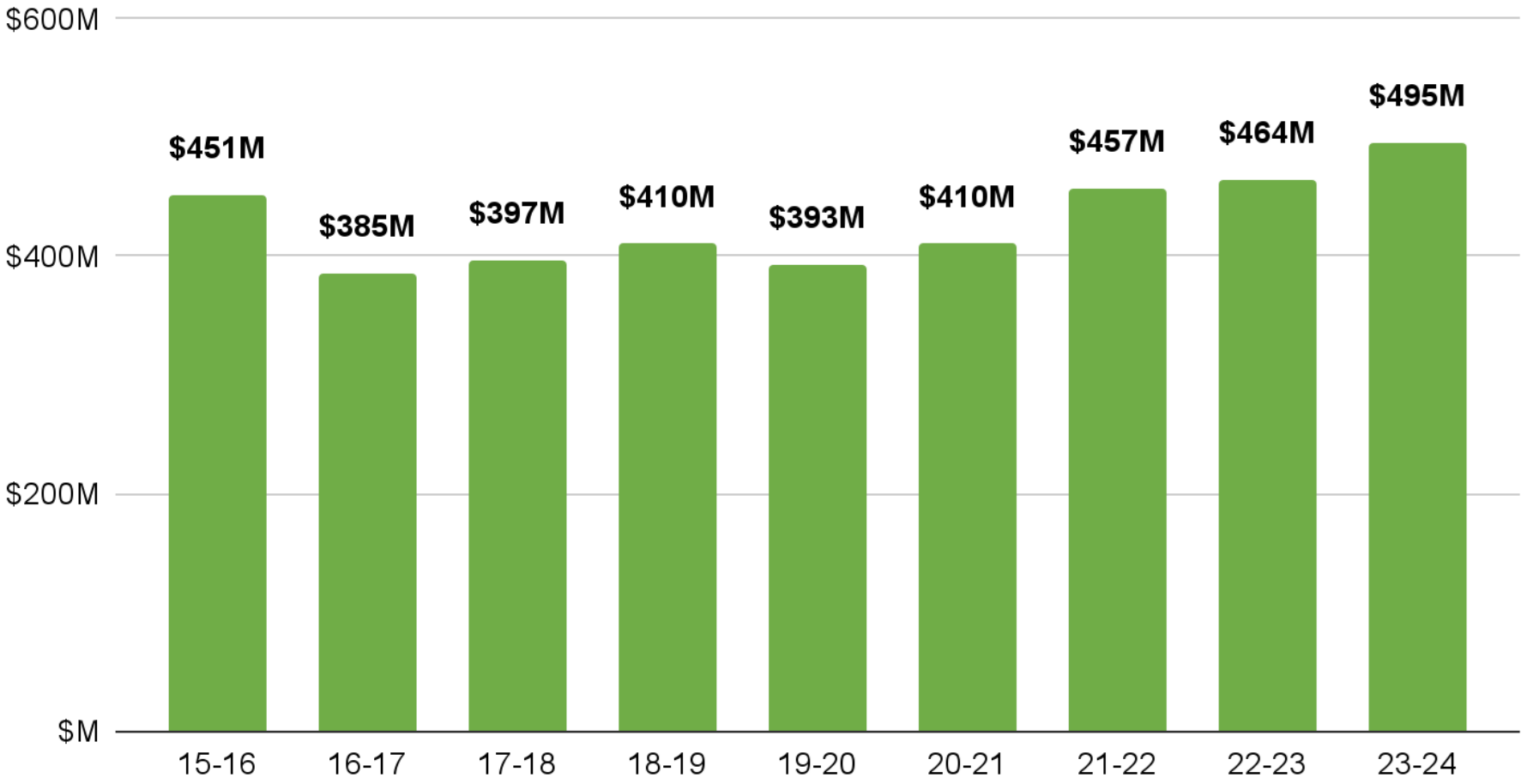
Cash Fund
(Fee + Federal Match)



FFY = federal fiscal year, October through September

CHASE Net Reimbursement

Net Reimbursement Experienced by Hospitals



Annual Net Reimbursement Change :	-	-14.7%	3.0%	3.4%	-4.3%	4.5%	11.4%	1.6%	6.6%

Why 96-97% UPL Historically?

- All components of Colorado's hospital provider fee have a 10+ year history of staying below federal limits to reduce risk of recoupment of federal funds
- Supported by the CHASE Board (and its predecessor) through the years
  - 96-97% UPL
  - 96% of DSH hospital-specific limit, and
  - Approximately 96% of the hospital fees under federal requirements
- Maximize federal funds to hospitals while minimizing losses and risks

Why 96-97% UPL Historically?

- Colorado's hospital UPL payments and use of hospital provider fee more expansive than other states
- Methodology produces the highest total UPL amount possible
- CMS explicitly stated our methodology subjects Colorado to particular scrutiny
- Over time CMS increased review and scrutiny of UPL payment arrangements
  - ➢ Requiring states to submit UPLs to CMS annually
  - ➢ Medicaid and CHIP Payment and Access Commission (MACPAC) reports to Congress concerning CMS oversight of UPL payments, such as this 2019 report and 2021 Issue Brief

Why 96-97% UPL Historically?

- Provides some protection against recovery of federal funds from hospitals
- Increasing percentage of UPL increases the magnitude of the funds to be recovered if CMS requires changes to our UPL methodology, currently under audit
- Recovering overpayments complicated, lengthy process that can take years, leaving the state potentially on the hook to repay federal funds

Health Coverage Expansions

- CHASE statute regarding use of fees
  - § 25.5-4-402.4 (5)(b)(IV) and (V), C.R.S.

Change in Medicaid Population

ACA Expansion (2014-2016)

Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2012-13	682,994	5,194,662	13%
2015-16	1,296,986	5,446,593	24%

COVID-19 Pandemic (March 2020-April 2023)

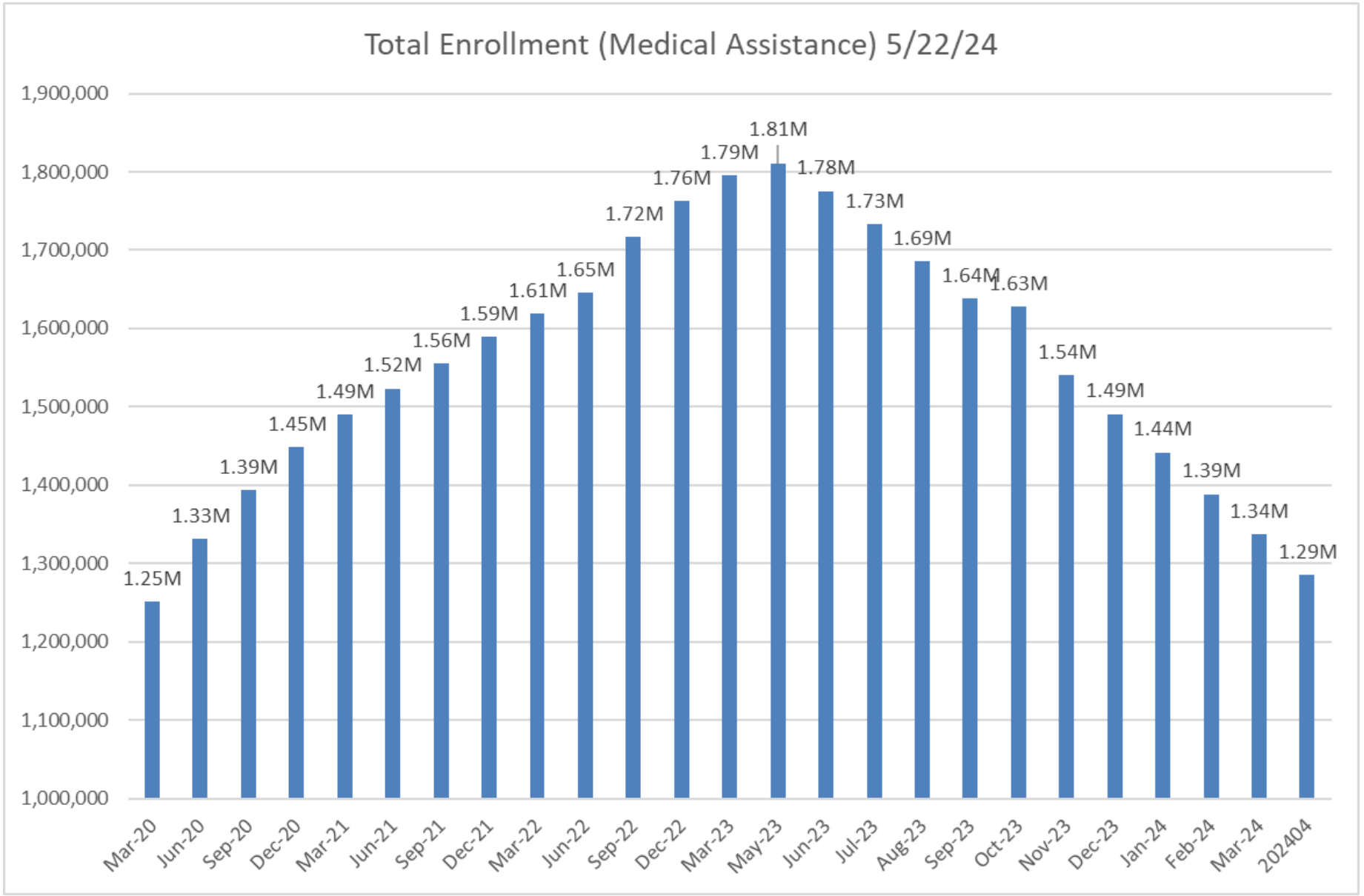
Year	Medicaid Members	Colorado Population	Medicaid as a Percentage of Colorado Population
2018-19	1,261,365	5,676,913	22%
2022-23	1,719,393	5,838,736	29%

- Significant surges in Medicaid enrollment. Now end of COVID-19 Public Health Emergency (PHE) disenrollments.
- Changing demographics impact costs, trends, needs
- Federal funding impacts revenue: 90/10% expansion; 6.2% added FMAP through PHE
- Returned $1.7B to Medicaid General Fund through add'l 6.2% FMAP through June 2023
- Enhanced federal match fully expires fiscal year 2023-24, accounting for $89M of the General Fund requested in FY 2024-25

ACA = Affordable Care Act
FMAP = Federal Medical Assistance Percentage

Medicaid & CHP+ Enrollment Change:

- 45%+ growth Q2 2020 thru May 2023 PHE continuous coverage
- Taking the full 12 months federally allowed to unwind
- All members redetermined for eligibility on their anniversary month
- 1st month: May 2023
- Last month: April ‘24
- Decrease thru 12 months post PHE (538k, 29.7%)

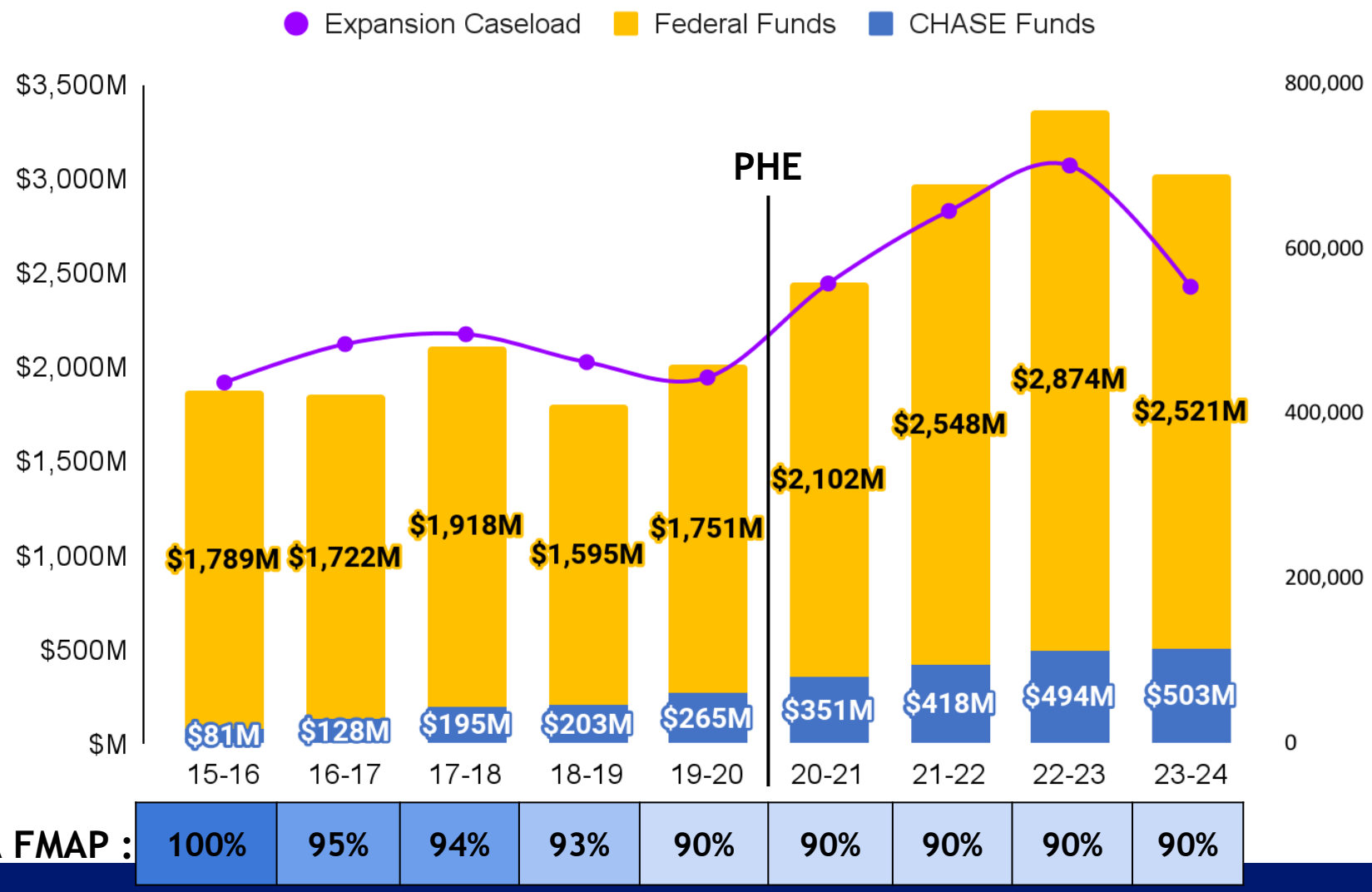


Health Coverage Expansions

- Expansion estimates revised November and February, by expansion population, based on previous six months actual payment data
- Adjusted for historical trend factors (*utilization*) and policy considerations (*rate increases*)
- Thorough internal review process
- Independent review then completed by both:
  - ➢Office of State Planning and Budgeting (OSPB), and
  - ➢Joint Budget Committee (JBC)
- Appropriated by the General Assembly through the budget process

Expansion Actuals By State Fiscal Year (SFY)

Expanded Coverage to Colorado Citizens



ACA FMAP :	100%	95%	94%	93%	90%	90%	90%	90%	90%

Health Coverage Expansion Populations

MAGI Parents/Caretakers 60-68% FPL	ACA
MAGI Parents/Caretakers 69-133% FPL	ACA
MAGI Adults 0-133% FPL	ACA
Buy-In for Adults & Children with Disabilities	Buy-In
12 Month Continuous Eligibility for Children	ACA
Non-Newly Eligible	ACA
CHP+ 206-250% FPL	CHP+
Incentive Payments	ACA

MAGI = Modified Adjusted Gross Income

Year over Year Expansion Estimates Comparison

- **ACA (6 sub-populations)**
  - 21% caseload decrease
  - $342M total funds decrease
  - $20M CHASE funds decrease
    - Limited decrease due to limited CHASE funding obligation

- **Buy-In**
  - 31% caseload increase
  - $59M total funds increase
  - $31M CHASE funds increase

- **CHP+**
  - 21% caseload increase
  - $22M total funds increase
  - $8M CHASE funds increase

Year over Year Expansion Estimates Comparison

Expansion Expenditures Estimates Change (FFY 23 to FFY 24)	ACA (6)	Buy-In for Individuals with Disabilities	CHP+ 206% to 250%	Total (8)
Blended FMAP	86 - 87%	51 - 52 %	66 - 67%	
Caseload	-131,413	4,660	5,394	-121,359
Δ	-21%	31%	21%	-19%
CHASE Funds	-$19.9M	$31.3M	$8.2M	$19.6M
Δ	-5%	44%	36%	4%
Federal Funds	-$331.5M	$28.1M	$13.4M	-$290.M
Δ	-12%	37%	29%	-10%
Total Funds	-$351.4M	$59.4M	$21.6M	-$270.4M
Δ	-12%	40%	-$270.4M	-8%

- Caseload and total expenditures decrease, CHASE fees increase

Administrative Expenditures

- CHASE statute regarding use of fees
  - § 25.5-4-402.4 (5)(b)(VI), C.R.S.

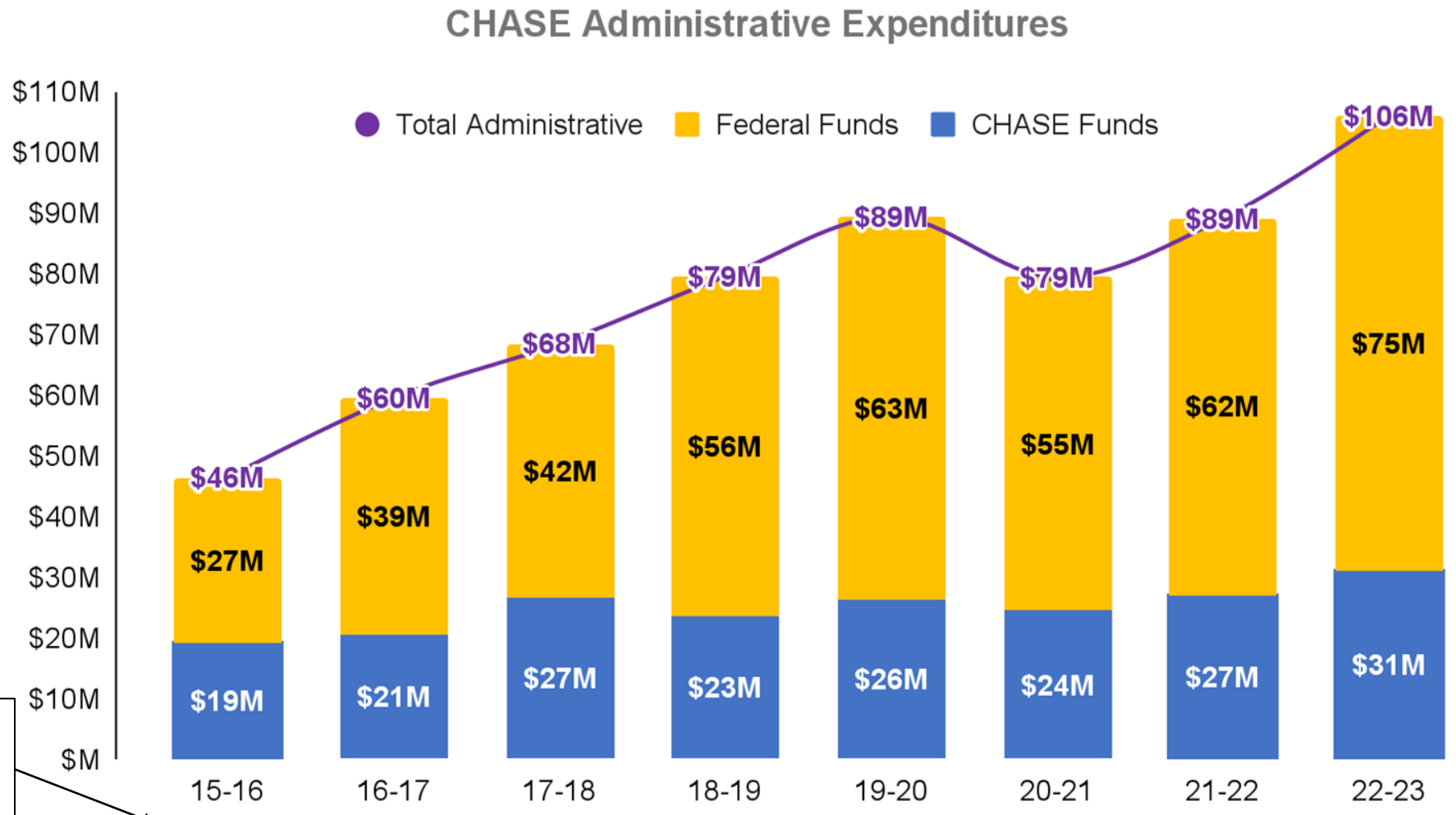
Administrative Expenditures

- Administrative expenditures for CHASE related activities, including expenditures related to CHASE funded expansion populations:
  - Full-time equivalent (FTE) staff positions for the administration of CHASE
  - CHASE's share of expenses for Colorado Benefits Managements System (CBMS), Medicaid Management Information System (MMIS), Business Intelligences Data Management, and Pharmacy Benefits Management System
  - County administration contracts for eligibility determinations
- Contracted services are competitively selected and approved by State Controller
- Appropriated by the General Assembly through the budget process

Administrative Expenditures

- $5M CHASE funding increase between 2022-23 and 2023-24
- Increase due primarily to:
  - Cost inflation increases,
  - Utilization increases,
  - PHE Unwind - County eligibility redetermination, and
  - MMIS reprocurement

Administrative Actuals By SFY



% of Total CHASE Exp.	15-16	16-17	17-18	18-19	19-20	20-21	21-22	22-23
	1.4%	2.0%	2.1%	2.3%	2.6%	1.90%	1.90%	2.0%

CHASE
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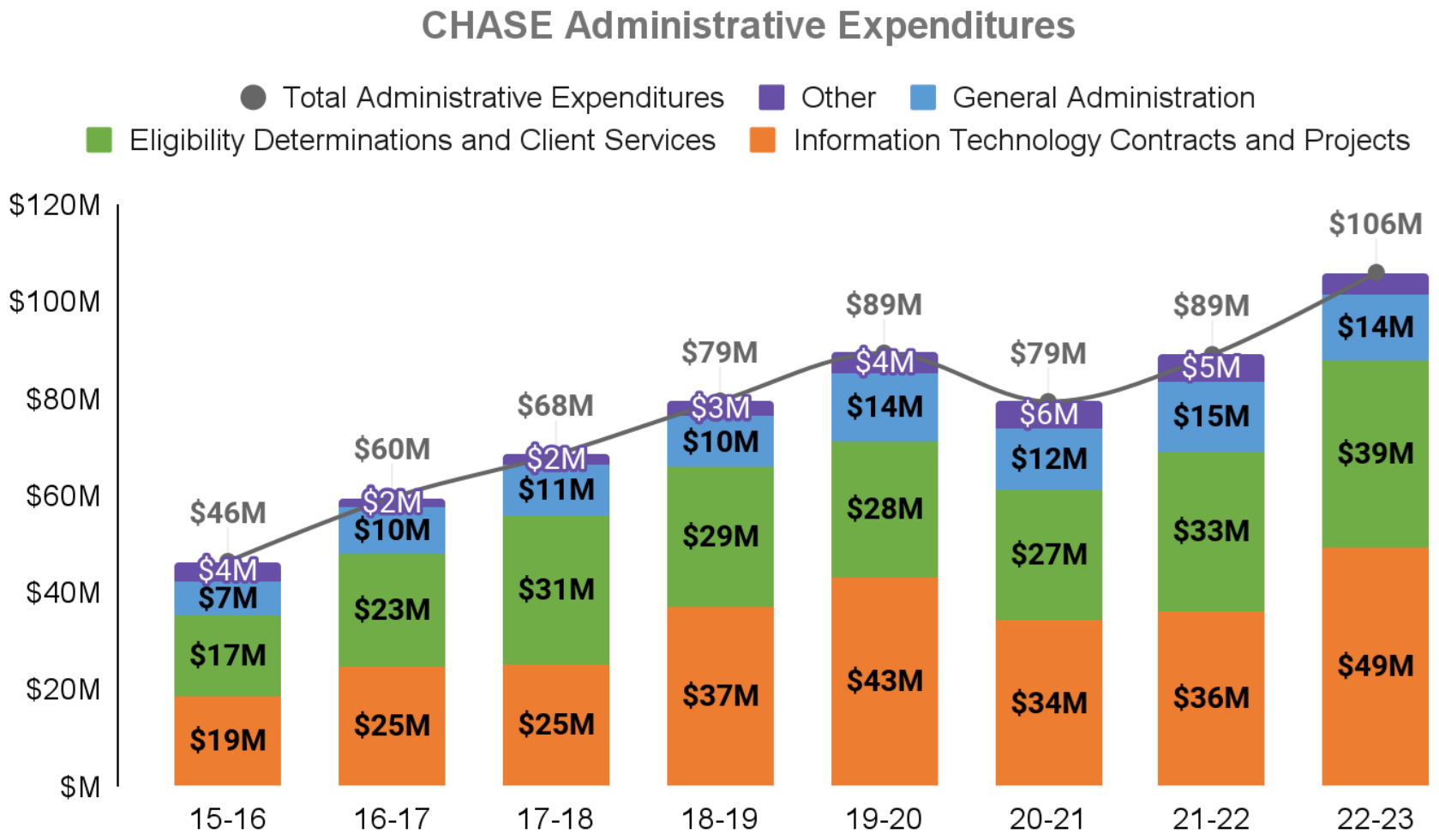
Administrative Actuals By SFY



Proposed 2023-24 Fees & Payments

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

2023-24 Fees & Payments

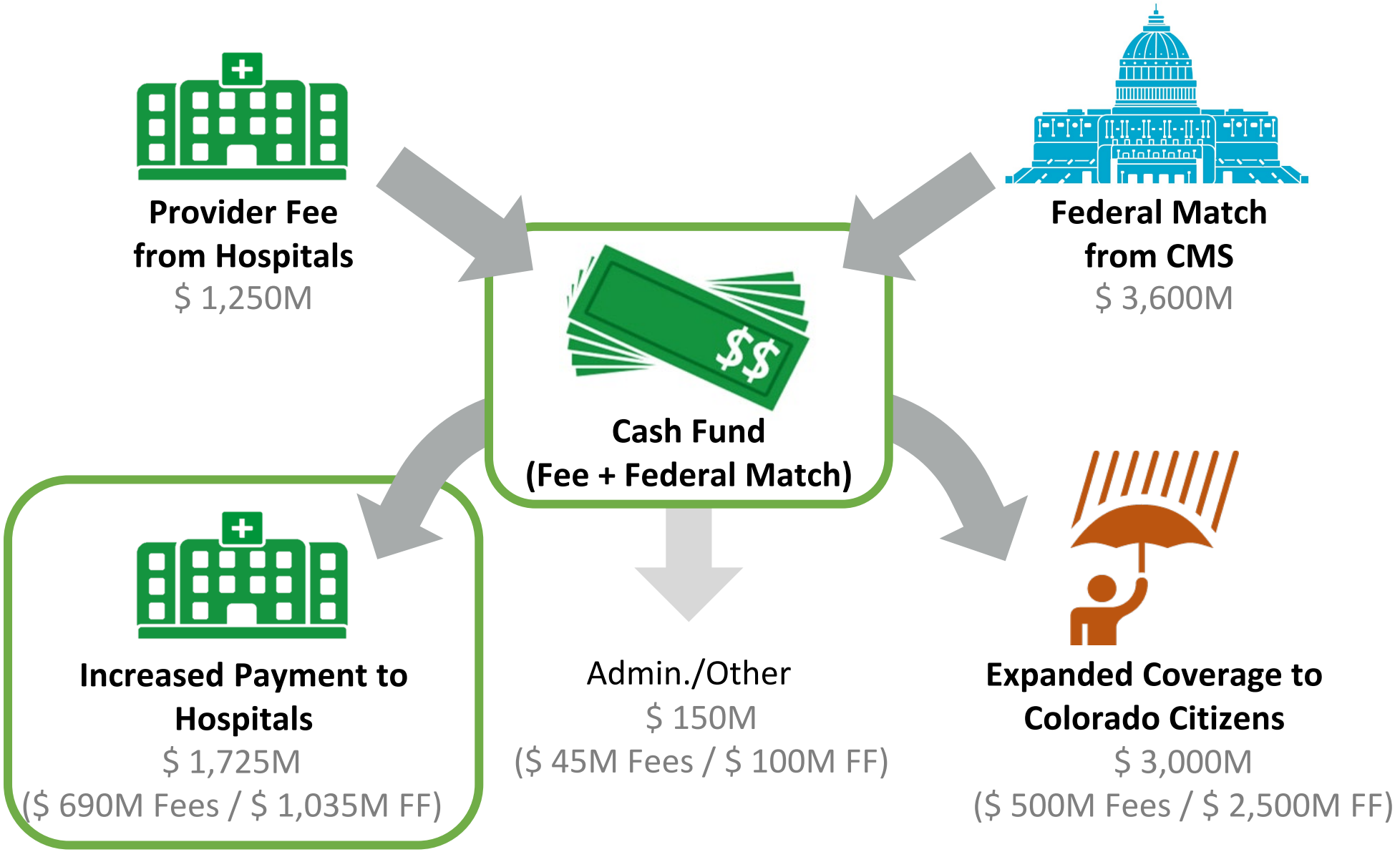
- FFY 2023-24 CHASE Adjustment Group (By Hospital)
- FFY 2023-24 CHASE Adjustment Group Definitions
- FFY 2023-24 CHASE Financial Statements
- FFY 2023-24 CHASE Group Net Reimbursement
- FFY 2023-24 CHASE Hospital by UPL and Payment Groups
- FFY 2023-24 CHASE Hospital Net Reimbursement
- FFY 2023-24 CHASE Model Limits (UPL & NPR)
- FFY 2023-24 CHASE Overview

HCPF Recommendation

- Status quo 97.2% 2023-24 model as presented
- Support to return to CHASE Board with retrospective changes to 2023-24 and 2022-23 to 99.25% UPL
  - Under two year federal timely filing
    - 2023-24 revised DSH and other payment adjustments
    - 2022-23 payments proportional to those made at time, subject to limits
  - Conditioned on favorable CMS audit results and subject to Medical Services Board rulemaking

Why 99.25% UPL and Why Wait?

- Balance increasing hospital reimbursement while maintaining current UPL methodology
- Provide some protection against recovery of federal funds from hospitals
- Minimize risk to 550,000 Coloradans whose health coverage financed by hospital fees
- Minimize risk to overall Medicaid program and General Fund
- Allow time for CMS audit findings
- Allow time for CHASE Board and Medical Services Board processes



Amounts may not equal due to rounding

Fees and Payments Overview

- **$1.25 billion in fees (1.58% increase)**
  - At 5.53% NPR (92% of maximum fees)
- **Total federal funds: $3.6 billion, 290% return on fees**
- **S1.73 billion in hospital supplemental payments (1.84% increase)**
  - Including $128 million in quality incentive payments
  - UPL at 97.2%; DSH limit at 96%
- **$475 million in net reimbursement (total fees less supplemental payments) (2.52% increase)**
- **$2.99 billion for expansion claim; estimated 40% paid to hospitals**
  - $1.2 billion in claims payments to hospitals

Fees and Payments Overview

	Cash Fund	Federal Fund	Total Fund
Total Supplemental Payment	**$ 688M**	**$ 1,037M**	**$ 1,725M**
Medicaid & CHP+ Expansions	$ 501M	$ 2,489M	$ 2,990M
Administration	$ 45M	$ 103M	$ 148M
General Fund Transfer	$ 16M		$ 16M
Grand Total	**$1,250M**	**$ 3,629M**	**$ 4,879M**

Net Reimbursement

	2022-23	2023-24	Difference
Supplemental Payments	$ 1,694M	$ 1,725M	$ 31M
Provider Fees	$ 1,230M	$ 1,250M	$ 20M
Net Reimbursement	**$ 464M**	**$ 476M**	**$ 12M**

Fees and Payments Overview

Expansion Populations	Cash Fund	Federal Fund	Total Fund
MAGI Parents/Caretakers 60-68% FPL	$12.0M	$12.3M	$24.3M
MAGI Parents/Caretakers 69-133% FPL	$28.1M	$230.9M	$259.0M
MAGI Adults 0-133% FPL	$267.7M	$1,962.5M	$2,230.2M
Buy-In for Adults & Children with Disabilities	$102.4M	$105.0M	$207.4M
12 Month Continuous Eligibility for Children	$24.2M	$24.9M	$49.2M
Non-Newly Eligible	$22.0M	$87.4M	$109.4M
CHP+ 206-250% FPL	$31.3M	$59.3M	$90.6M
Incentive Payments	$13.4M	$6.9M	$20.3M
Expansion Estimates (Total)	**$501.0M**	**$2,489.3M**	**$2,990.3M**

Return on Fee

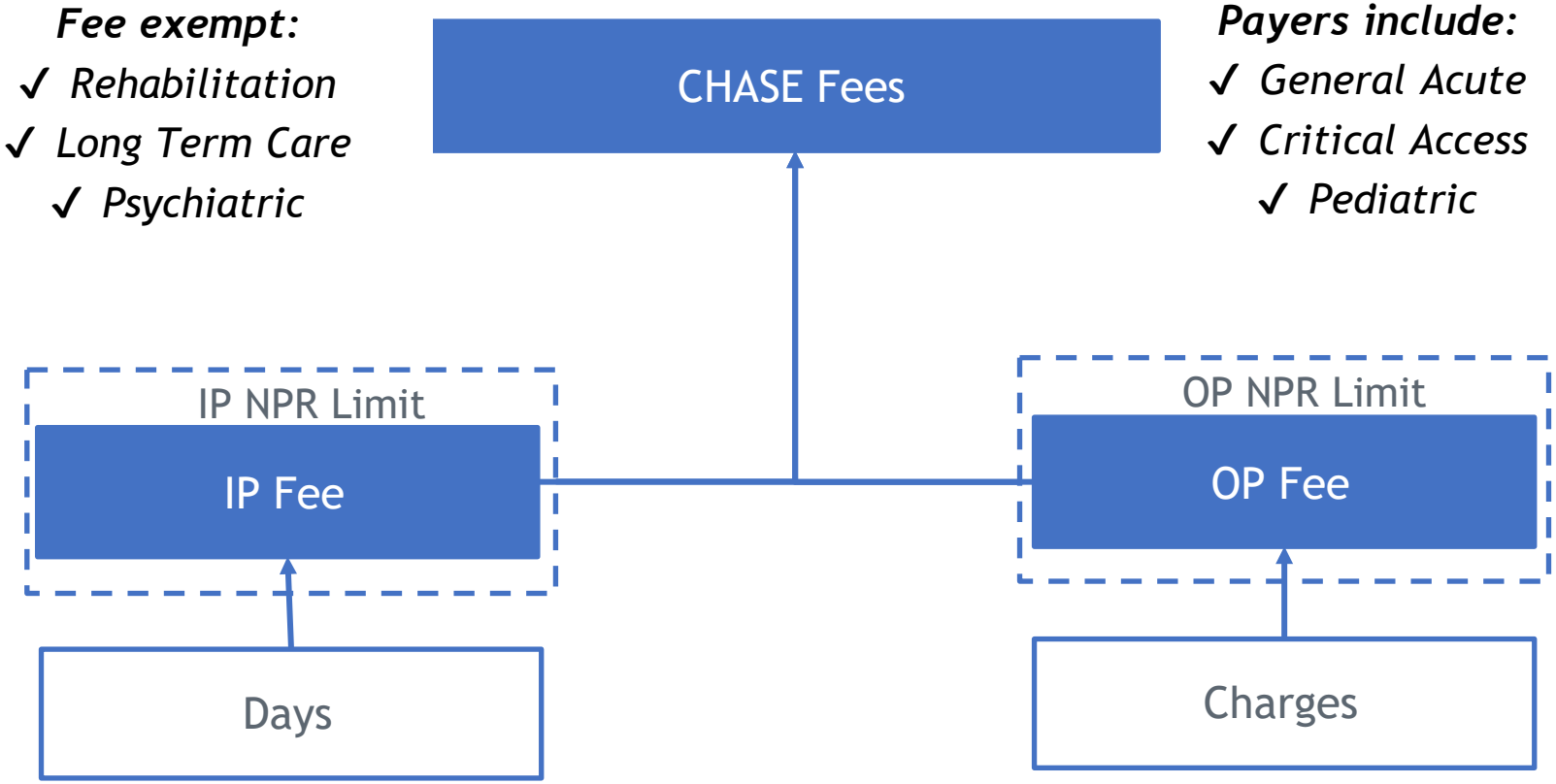
- **$1.25 billion** in fees generates **$3.63 billion** in federal funds, a 290% return rate
- Estimated administrative expenditures are 3% of total expenditures ($4.9 B)
- Administrative expenditures include:
  - Staff cost
  - Contracted services, including utilization management and quality review
  - IT systems (i.e., eligibility and claims) and staffing for the customer contact center for more than **550,000 covered lives**

Increased Federal Matching Funds

- To support the Hospital Transformation Program (HTP), drawing down increased federal matching funds for a portion of Medicaid supplemental payments allocated to Affordable Care Act (ACA) populations
- Provided additional federal matching funds, **reducing necessary provider fees collected from hospitals.**
  - **FFY 2019-20: $126m**
  - **FFY 2020-21: $141m**
  - **FFY 2021-22: $152M**
  - **FFY 2022-23: $160M**
  - **FFY 2023-24: $174M**
- A Total of $753M in fee savings has been realized using this methodology
- Net reimbursement $475M rather than $301M

Inpatient (IP) & Outpatient (OP) Fees

Fee exempt:
- ✓ *Rehabilitation*
- ✓ *Long Term Care*
- ✓ *Psychiatric*



Payers include:
- ✓ *General Acute*
- ✓ *Critical Access*
- ✓ *Pediatric*

Inpatient & Outpatient Fees

- Methodology and discounts per CMS approval of broad-based and uniform fee requirements waiver
- Inpatient fee assessed on managed care and non-managed care days

➢**Inpatient Fee - $539 million**

- Per non-managed care day: $ 473.90
- Per managed care day: $ 106.01

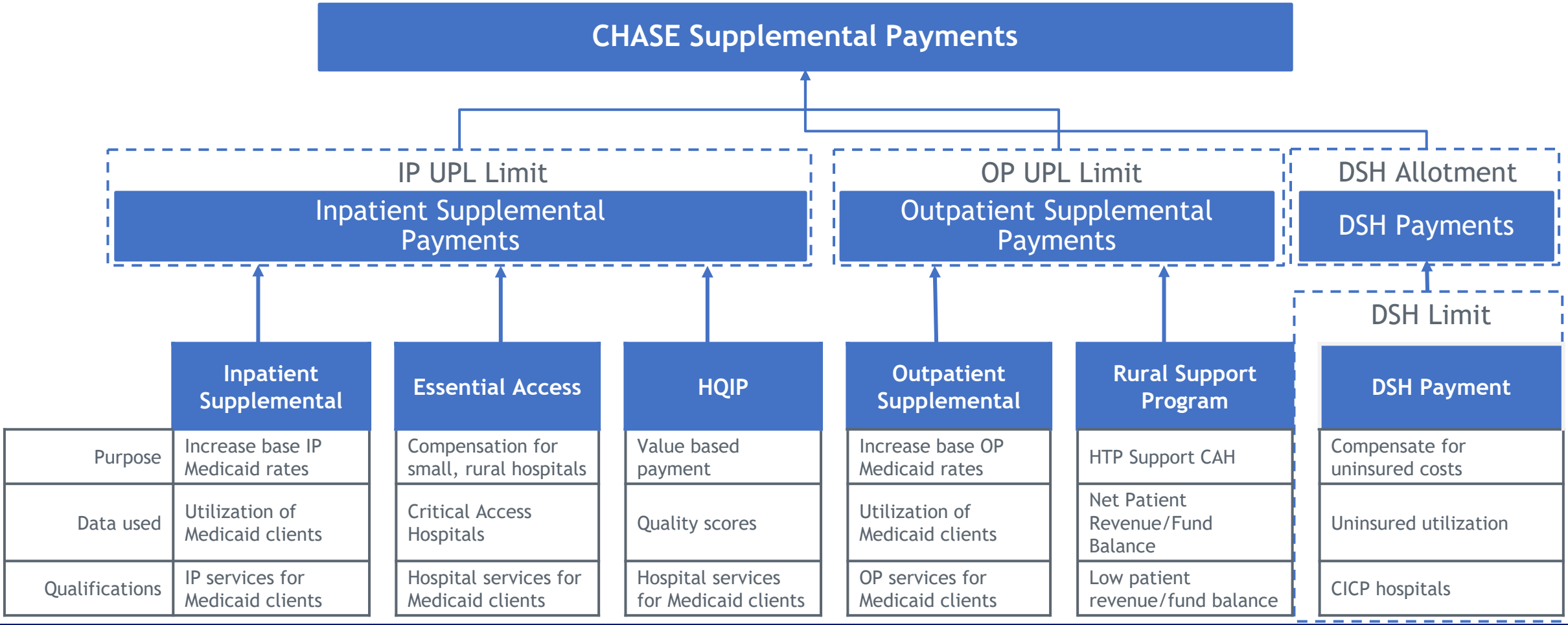
- Outpatient fee assess on percentage of total outpatient charges

➢**Outpatient Fee - $710 million**

- Percentage of total charges: 1.6625%

- High Volume Colorado Indigent Care Program (CICP) and Essential Access hospitals pay discounted fees
- Psychiatric, long-term care, and rehabilitation hospitals are fee exempt

Supplemental Payments



	Inpatient Supplemental	Essential Access	HQIP	Outpatient Supplemental	Rural Support Program	DSH Payment
Purpose	Increase base IP Medicaid rates	Compensation for small, rural hospitals	Value based payment	Increase base OP Medicaid rates	HTP Support CAH	Compensate for uninsured costs
Data used	Utilization of Medicaid clients	Critical Access Hospitals	Quality scores	Utilization of Medicaid clients	Net Patient Revenue/Fund Balance	Uninsured utilization
Qualifications	IP services for Medicaid clients	Hospital services for Medicaid clients	Hospital services for Medicaid clients	OP services for Medicaid clients	Low patient revenue/fund balance	CICP hospitals

UPL Supplemental Payments

- Inpatient UPL
  - Inpatient Supplemental Payment†
  - Essential Access (EA) Payment
    - Lump sum payments directed to Critical Access/rural hospitals with 25 or fewer beds
  - Hospital Quality Incentive Payment (HQIP)
    - Amount set by statute
    - Payments determined by quality metrics and scoring methodology approved by CHASE Board
- Outpatient UPL
  - Outpatient Supplemental Payment†
  - Rural Support Program (RSP)
    - Fixed amount for 5 years for 23 qualified hospital

†Adjustment factors apply

Inpatient Supplemental Payment

- Increased reimbursement for Inpatient Medicaid utilization
- **Total supplemental payment: $675 million**
- Payment calculation = Medicaid non-managed care patient days * Inpatient Adjustment factor
- Allows for greater variation in reimbursement due to changing Medicaid utilization

Outpatient Supplemental Payment

- Increased reimbursement for Outpatient hospitals services for Medicaid members
- **Total supplemental payment: $627 million**
- Payment calculation = Estimated Medicaid Outpatient Costs * Outpatient adjustment factor

Adjustment Factors

- Purpose
  - Maximize hospitals benefiting from fee and minimize losses
  - Tied to Medicaid utilization and higher cost service needs of Medicaid population (e.g., NICU level III, teaching hospitals, pediatric speciality)
  - Reach targeted UPL percentages by UPL pool
- History
  - Since inception of original hospital provider fee, different supplemental payments and/or adjustment factors to reach these goals

Adjustment Factors

FFY 23-24 Inpatient & Outpatient Adjustment Factors				
Adjustment Group	**UPL Category**	**Percent of Hospitals**	**Inpatient Adjustment Factor**	**Outpatient Adjustment Factor**
Rehabilitation or LTAC	All	14%	$16.00	16.00%
State Government Teaching Hospital	State Gov.	1%	$618.75	47.14%
Non-State Government Teaching Hospital	Non-State Gov.	1%	$676.00	9.70%
Non-State Government Rural or CAH	Non-State Gov.	29%	$1,040.00	94.00%
Non-State Government Hospital	Non-State Gov.	2%	$720.00	10.00%
Private Rural or CAH	Private	15%	$485.00	88.25%
Private Heart Institute Hospital	Private	1%	$1,310.00	72.50%
Private Pediatric Specialty Hospital	Private	2%	$755.00	5.65%
Private High Medicaid Utilization Hospital	Private	3%	$1,118.00	41.00%
Private NICU Hospital	Private	11%	$1,675.00	84.45%
Private Independent Metropolitan Hospital	Private	2%	$1,395.00	88.00%
Private Safety Net Metropolitan Hospitals	Private	1%	$1,395.00	88.00%
Private Hospital	Private	17%	$536.00	28.45%

Essential Access Supplemental Payment

- Reimbursement to rural and Critical Access hospitals with 25 or fewer beds
- **Total supplemental payment: $26 million**
- Payment calculation = $26 million / total number of Essential Access hospitals
- Essential Access payment has increased only 5% since FFY 19-20, compared to an almost 25% increase in total CHASE supplemental payments during the same period
- Senate Bill 17-267 legislative declaration includes:
  - (1)(b) The purpose of this legislation is to ensure and perpetuate the sustainability of rural Colorado by addressing some of these demographic, economic, and geographical challenges and by such other means as the general assembly, in its considered judgment, finds necessary and appropriate.
  - (2) The general assembly further finds and declares that the sustainability of rural Colorado is directly connected to the economic vitality of the state as a whole, and that all of the provisions of this act, including provisions that on their face apply to and affect all areas of the state but that especially benefit rural Colorado, relate to and serve and are necessarily and properly connected to the general assembly's purpose of ensuring and perpetuating the sustainability of rural Colorado.

Rural Support Supplemental Payment

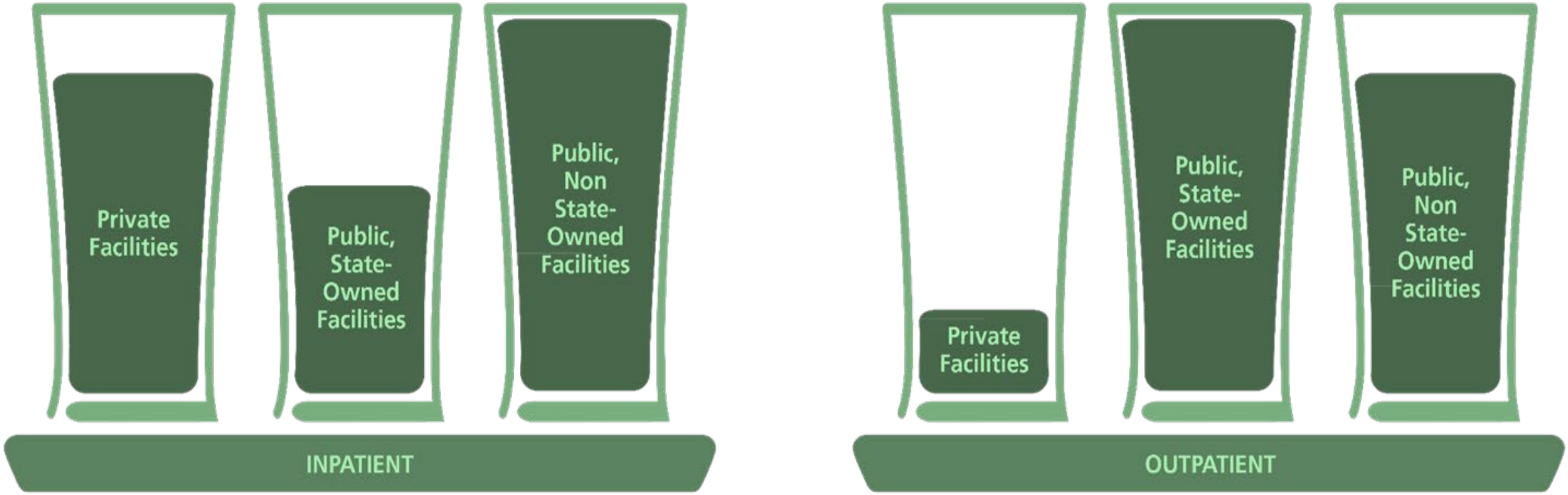
- Reimbursement to rural and Critical Access Hospitals (CAH) that meet revenue and fund balance requirements:
  - ➢Must be a nonprofit hospital AND
  - ➢Must fall within bottom 10% NPR of rural or CAH OR
  - ➢Must fall within bottom 25% fund balance of rural or CAH
- **Total supplemental payment: $12 million**
- Payment calculation = $12 million / # of total qualified hospitals
- Each qualified hospital required to submit application showing the funds will be used to implement initiative that enables success in the hospitals Transformation Program (HTP)

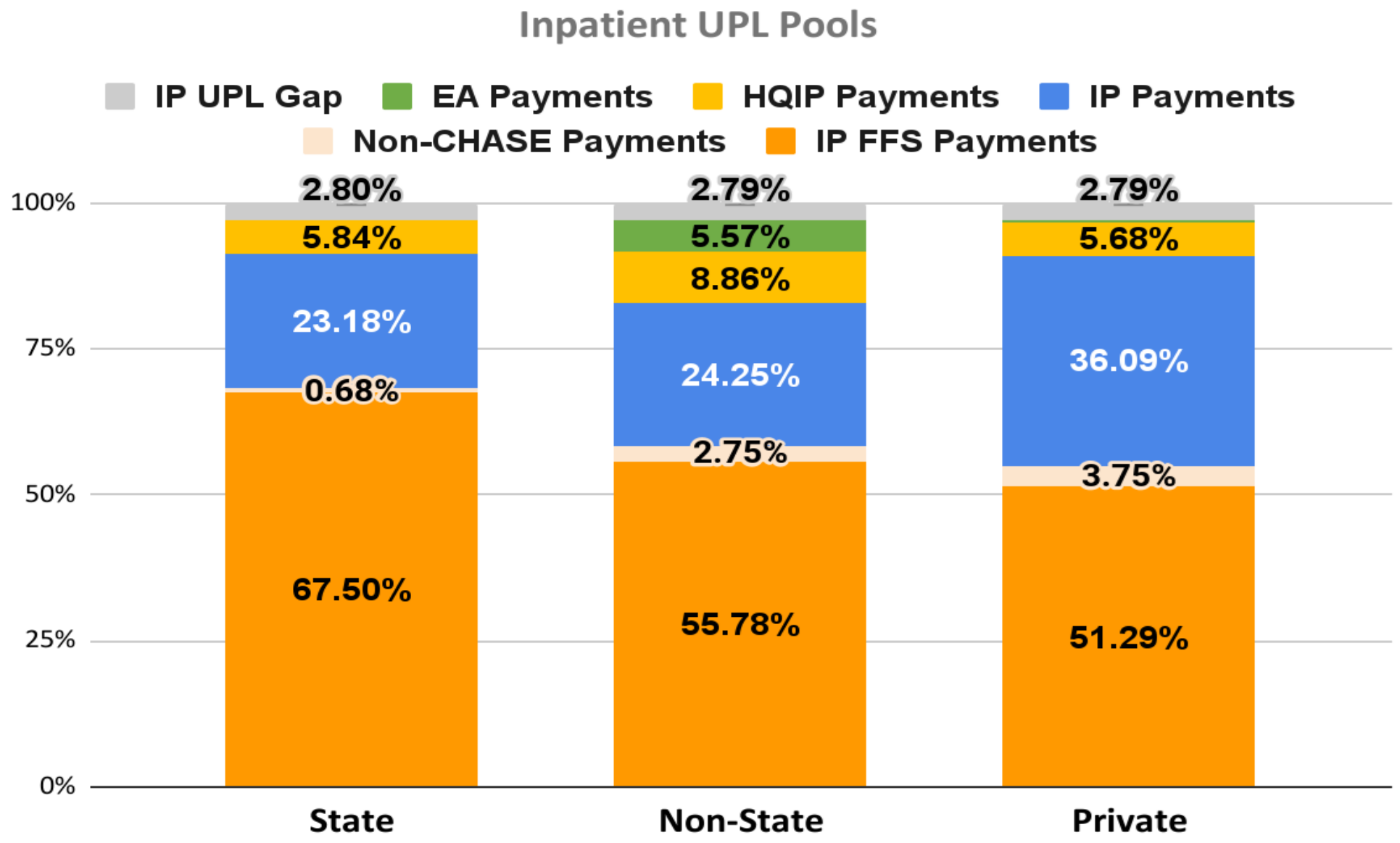
HQIP Supplemental Payment

- Reimbursement to hospitals providing services that improve health care outcomes
- **Total supplemental payment: $128 million**
- Payment Calculation = normalized awarded points * Medicaid adjusted discharges * dollars per adjusted discharge point
- Quality measures and payment methodology approved by the CHASE Board

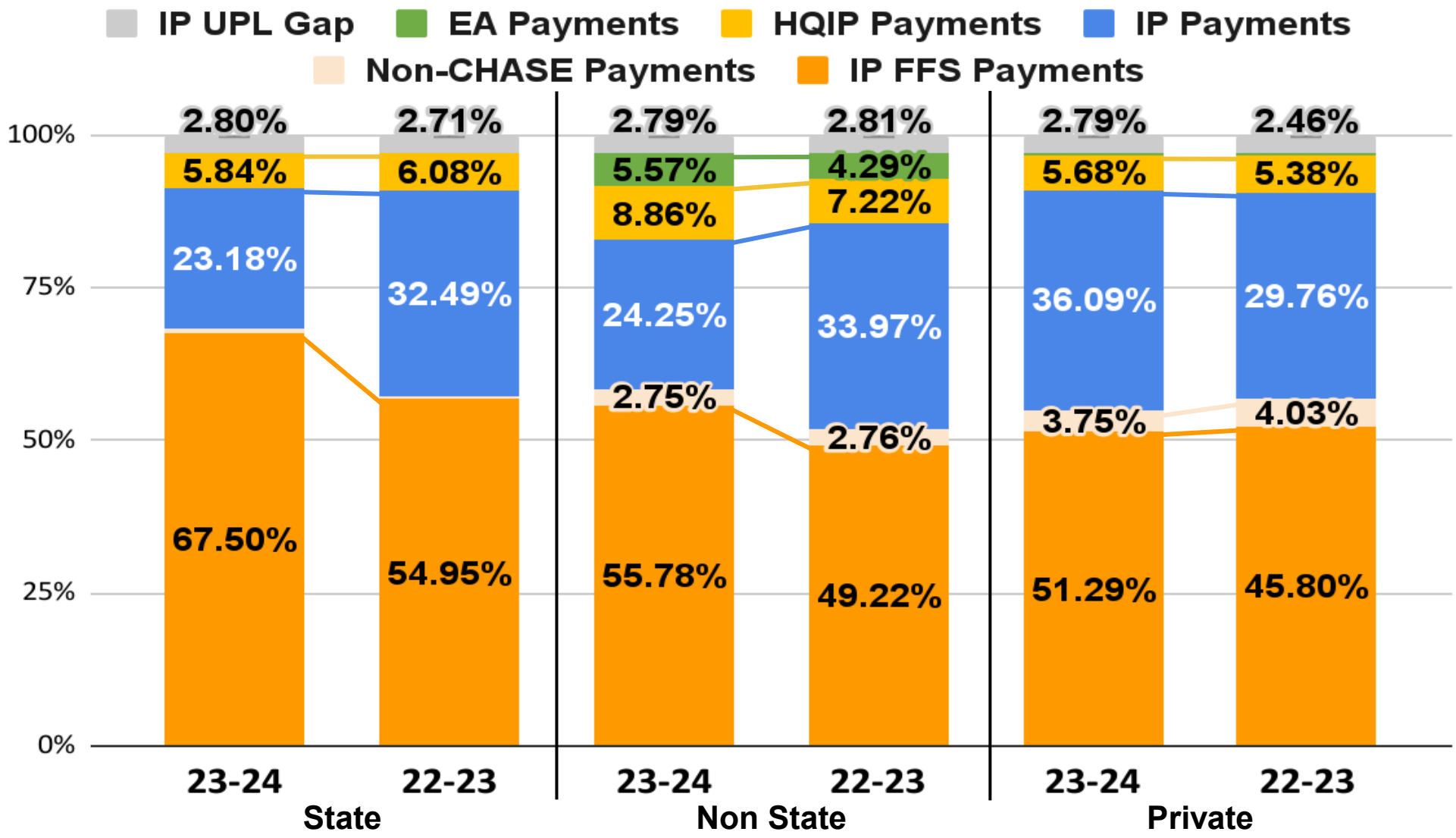
HQIP Tier	Lower Bound	Upper Bound	Dollar per Adjusted Discharge Point	Count
0	0	19	$ -	16
1	20	39	$ 2.07	5
2	40	59	$ 4.14	6
3	60	79	$ 6.21	17
4	80	100	$ 8.28	54

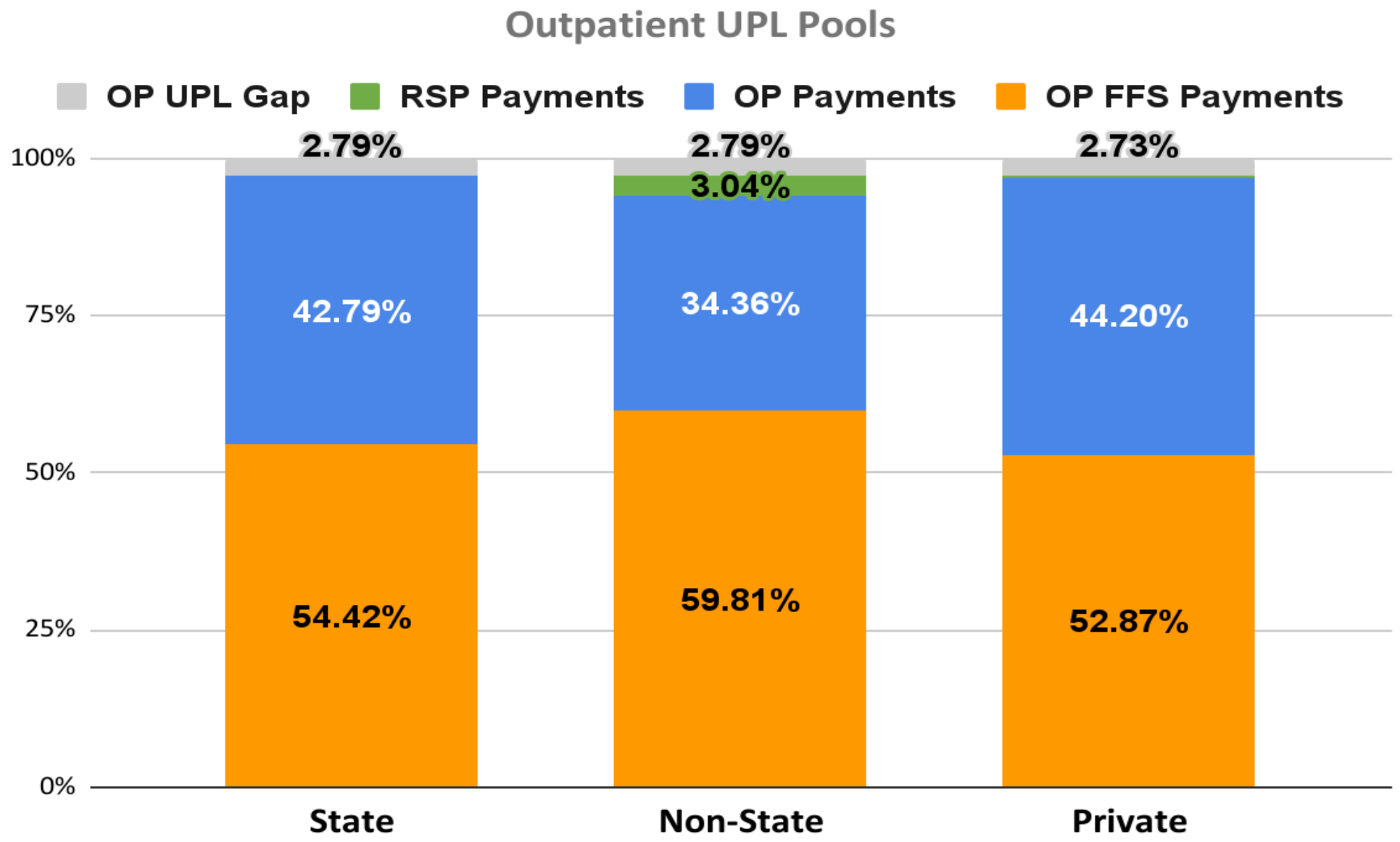
UPL Pools


Private Facilities
Public, State-Owned Facilities
Public, Non State-Owned Facilities
INPATIENT
Private Facilities
Public, State-Owned Facilities
Public, Non State-Owned Facilities
OUTPATIENT

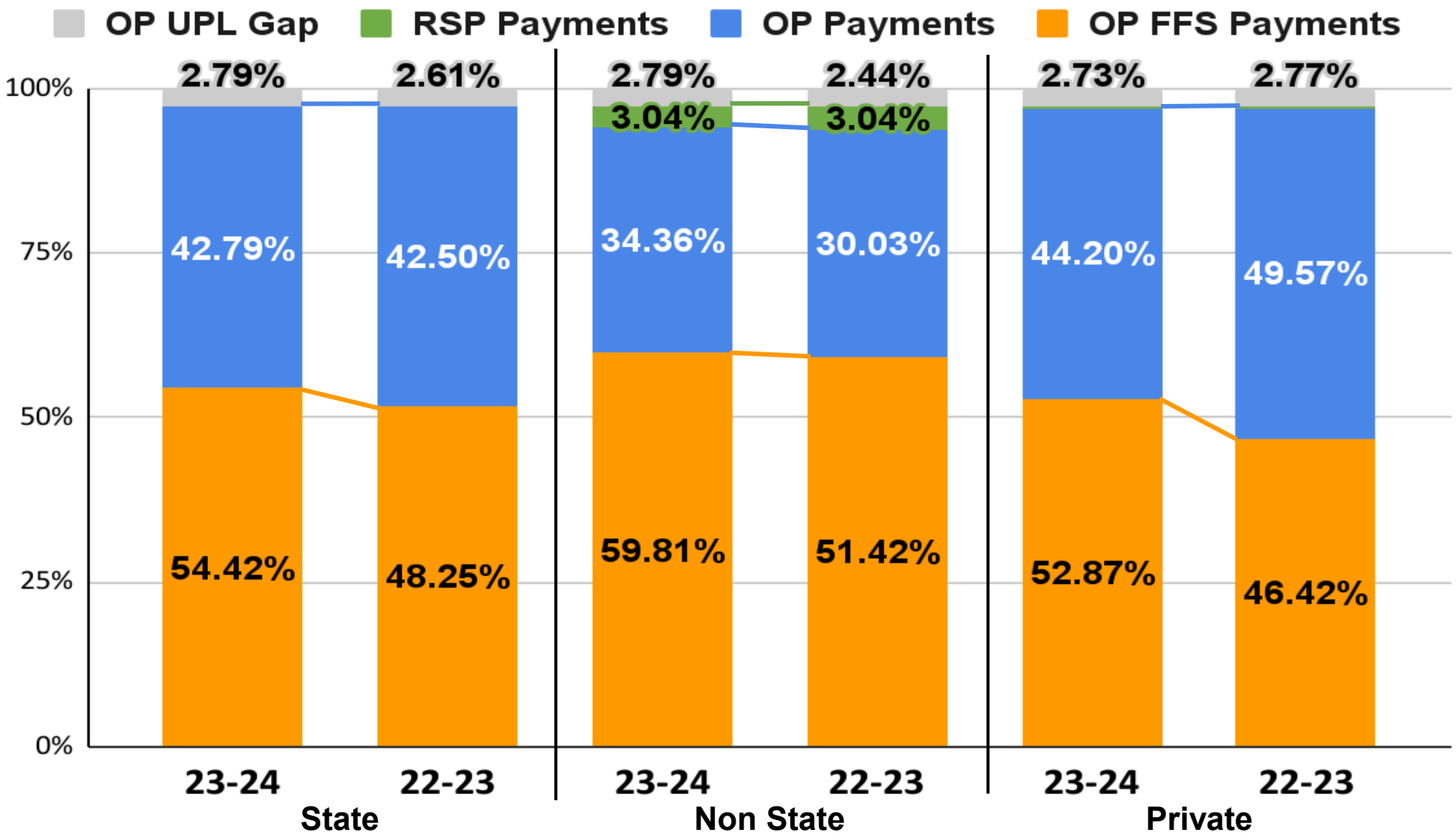

Inpatient UPL Pools
IP UPL Gap
EA Payments
HQIP Payments
IP Payments
Non-CHASE Payments
IP FFS Payments
100%
75%
50%
25%
0%
2.80%
5.84%
23.18%
0.68%
67.50%
2.79%
5.57%
8.86%
24.25%
2.75%
55.78%
2.79%
5.68%
36.09%
3.75%
51.29%
State
Non-State
Private

Annual Change in Inpatient UPL Pools




Outpatient UPL Pools
OP UPL Gap
RSP Payments
OP Payments
OP FFS Payments
100%
75%
50%
25%
0%
2.79%
42.79%
54.42%
2.79%
3.04%
34.36%
59.81%
2.73%
44.20%
52.87%
State
Non-State
Private

Annual Change in Outpatient UPL Pools



DSH Supplemental Payment

- Reimbursement to hospitals serving disproportionate share of Medicaid members and uninsured patients
- **Total supplemental payment: $257 million**
- DSH payment capped at 96% of estimated hospital-specific DSH limit
  - High CICP cost hospital DSH payment equals 96% of their estimated DSH limit
  - Critical Access hospital DSH payment equals 86% of their estimated DSH limit
  - Small independent metropolitan hospital DSH payment equals 80% of their estimated DSH limit
  - Low Medicaid Inpatient utilization rate (MIUR) hospital DSH payment limited to 10% of their estimated DSH limit

HCPF Recommendation for CHASE Board Consideration

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

HCPF Recommendation

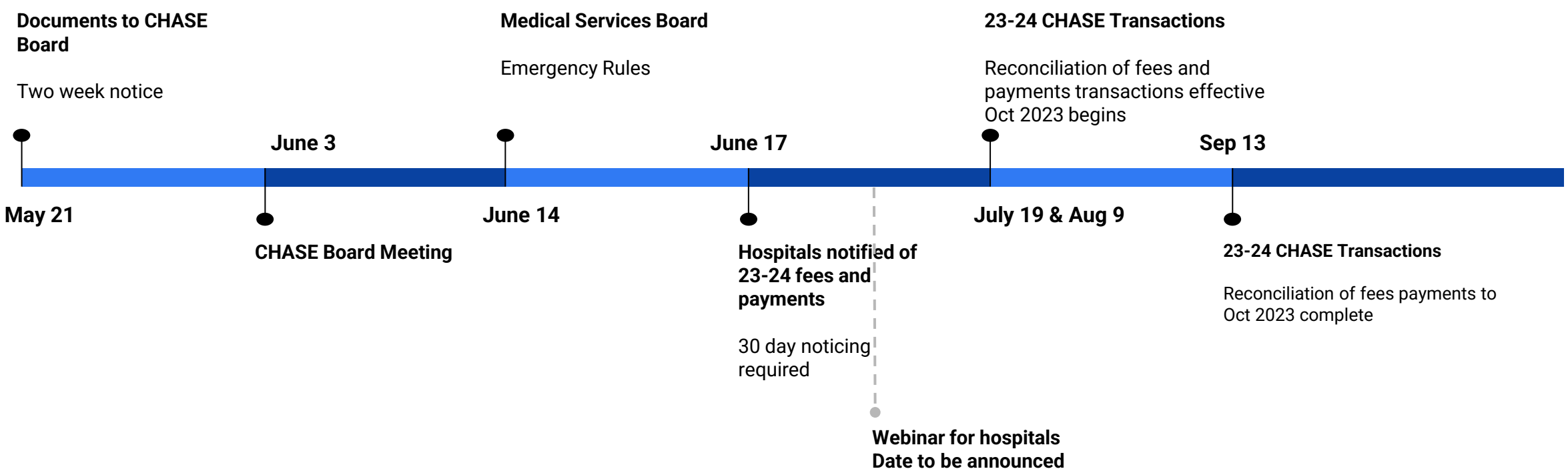
- Today, ask for CHASE Board favorable recommendation
  - Status quo 97.2% 2023-24 model as presented
  - Support to return to CHASE Board with retrospective changes to 2023-24 and 2022-23 to 99.25% UPL
    - 2023-24 revised DSH and other payment adjustments
    - 2022-23 payments proportional to those made at time, subject to limits
    - Conditioned on favorable CMS audit results, subject to Medical Services Board rulemaking and regulatory constraints, such as two-year federal timely filing

Discussion, Public Comment, Board Action

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Next Steps

2023-24 CHASE Timeline



Rulemaking

- Emergency rules
  - 6/7 HCPF share draft with CHASE Board and stakeholders
  - 6/14 Medical Services Board hearing
- Public rule review meeting 7/22
- Final adoption
  - 8/9 Medical Services Board hearing
- Medical Services Board open to public
- Rule comments or questions to nancy.dolson@state.co.us or jeff.wittreich@state.co.us

Consideration of 99.25% UPL

- Following conclusion of current CMS audit
  - Revised, proposed 2023-24 model and 2022-23 fees/payments will be shared with CHASE Board and stakeholders ahead of a CHASE Board meeting
  - Earliest expected timeline
    - 99.25% 2023-24 and 2022-23 release in Dec. 2024 / Jan. 2025
    - CHASE Board meeting in Jan. / Feb. 2025
  - 2024-25 and forward subject to CHASE Board recommendation, Medical Services Board rulemaking, and CMS approval
  - Caveats matter: CMS findings, audit report timing, regulatory constraints

Thank You

Nancy Dolson
Special Financing Division Director
Department of Health Care Policy & Financing
nancy.dolson@state.co.us