Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Initiatives Workgroup

Meeting #11

Wednesday, June 4, 2025

12:00 – 1:30 p.m.

Facilitated by:

Government Performance Solutions, Inc. (GPS)

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Virtual meeting guidelines

Here are some ideas to make virtual collaboration easy on us all:

This meeting is being recorded!

Please use your camera when speaking and use the blur or background as needed

Put your computer microphones (or phone) on mute

Use the chat feature to share ideas and ask questions

Click the Live Transcript icon at the bottom of your screen

To help all participants more quickly identify each other, please edit your name in your Zoom window to include your organization.

Right click on your Zoom image, select "Rename", and add details

CHASE Workgroup Objective

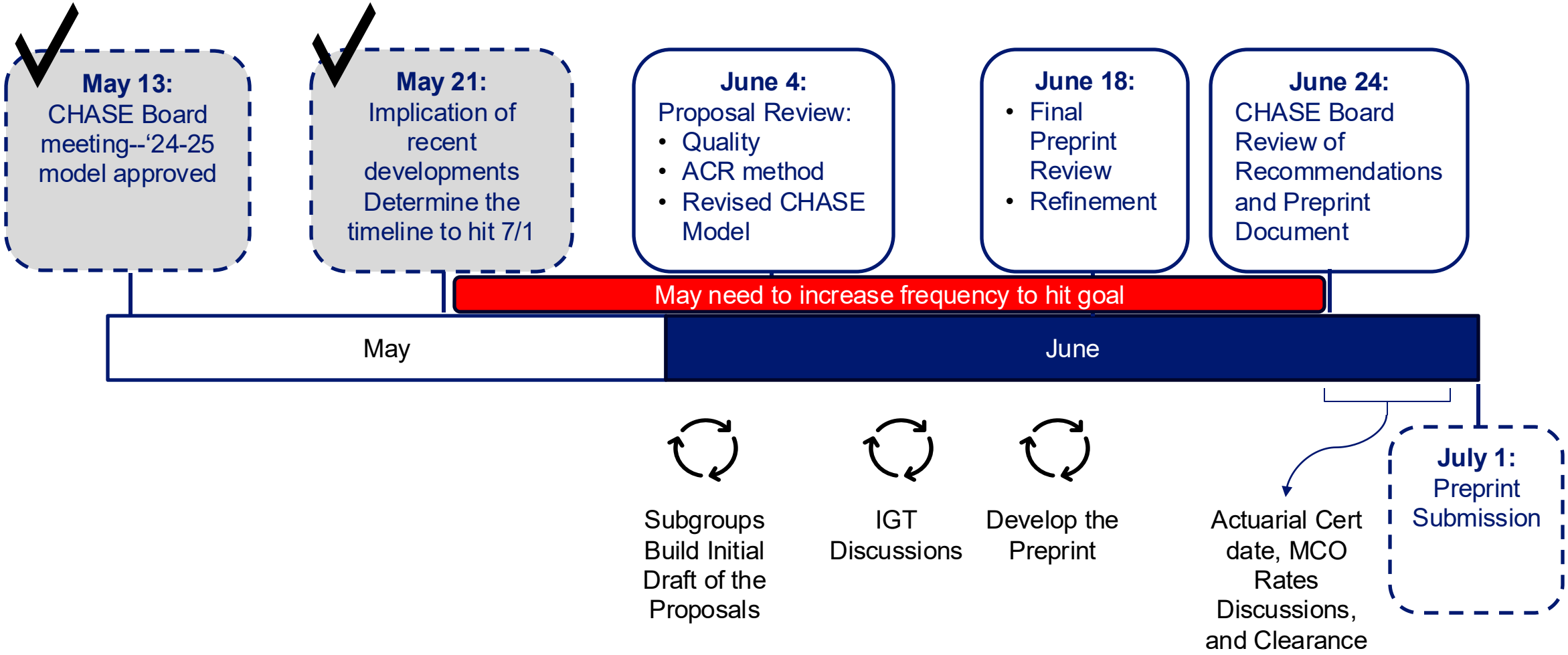
Develop comprehensive recommendations for revisions to CHASE including the addition of a State Directed Payment (SDP) for CHASE Board consideration. Such that HCPF can develop and advance a broadly supported proposal to submit to the federal Centers for Medicare and Medicaid Services (CMS) for implementation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

CHASE Program Objectives

As outlined in statute, the (4) CHASE program's goals are:

- Maximize reimbursement to hospitals for care for Medicaid members and uninsured patients subject to federal limits
- 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

Proposed Path to July 1



Agenda

- Plan for this Meeting and Upcoming Meetings (10 minutes)
- CHASE Model and State Directed Payment Program Design (35 minutes)
- Quality Measures (35 minutes)
- Questions and Next Steps (10 minutes)

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

Recap: Workgroup Ground Rules (1 of 2)

1. *Workgroup Members and Participation* – members of the workgroup have been appointed by the CHASE Board chair in line with the Board's bylaws and serve at the pleasure of the Board.
    - While the meetings will be open to the public, and the workgroup may request information from subject matter experts, participation in the workgroup is limited to appointed workgroup members themselves with no alternates or proxies.
    - Workgroup members must commit to consistently attending meetings and actively engaging in the work.
    - Workgroup members are allowed actual and necessary traveling and subsistence expenses when in attendance at meetings away from their places of residence.
2. *Stick to the workgroup's objectives* – the workgroup will devote its efforts to the work set out in this charter and not creep into other subjects unless directed by the CHASE Board.
3. *Transparency within the group and commitment to working within the bounds of this process* – to foster trust, all parties need to be honest, direct, and forthcoming within the workgroup.

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Recap: Workgroup Ground Rules (2 of 2)

4. *Participate in good faith, assume best intent, and extend the benefit of the doubt* – the workgroup must work together in good faith and assume best intent. To do so, the workgroup should agree at the outset to align around the shared goal of developing a mutually beneficial proposal and commit to working in good faith.
5. *Coordinated communications* – workgroup member communication about this work outside of the workgroup should be aligned and coordinated using agreed-upon shared messaging and talking points. Following the CHASE Board's bylaws, individual workgroup members may not make a position statement that purports to be that of the workgroup or the CHASE Board unless the workgroup or Board has adopted such a position. However, no workgroup member is prohibited from stating his or her personal opinions, provided they are clearly identified as such.
6. ADOPTED *Pursue Consensus* - workgroup members will explore options, strive to understand different points of view, and seek compromise so that recommendations represent a broad consensus consistent with the work group's purpose.

These may be adjusted by the workgroup as situations arise

Charter Directives

Workgroup Objectives and Key Questions (1 of 2)

Objective: Develop comprehensive recommendations for revisions to CHASE including the addition of a 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.

Key Questions:

- How does the recommendation(s) align with the goals of the CHASE Program as outlined in statute?
  - Maximize reimbursement to hospitals for care for Medicaid members and uninsured patients subject to federal limits
  - 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

Charter Directives

Workgroup Objectives and Key Questions (2 of 2)

Key Questions (continued):

- Is legislation and/or changes to state regulations necessary to implement the recommendations?
- How do the recommendations align with federal requirements?
  - Are there any emerging or enacted changes to federal requirements that may affect these recommendations?
- What are the impacts on the CHASE program?
  - How do the net gains (losses) for hospitals compare to the CHASE status quo?
  - Is there any increased risk to expansion populations' health care coverage due to insufficient fees?
- What are the available funding source(s)?
- What are the different types of SDP and which best meet the workgroup's objective?
- Which services and provider types should be included in the SDP?

Progress Update

The workgroup has met (10) times and reached consensus on several dimensions:

Dimension	Emerging Consensus
Overall Methodology	• Revise existing UPL supplemental payments to simplify payment calcs and tie to utilization • Simplify to the degree possible, but this is a secondary goal
Services	Include both inpatient and outpatient services
Hospital Types	Include general, acute care and Critical Access Hospitals, and psychiatric hospitals
Funding Sources	• Assume that an IGT is a permissible funding source; will not trigger TABOR • Replace some federal DSH funds with additional safety net hospital reimbursement
Funding Priorities	• Preserve funding to Critical Access Hospitals • Support hospitals with high volume of Medicaid care (i.e., safety net)
Quality Principles	Aligned on 10 quality principles aligned with Colorado's Managed Care Quality strategy to guide measure selection

Maintain a running list

Open Questions/Assignments

Items not yet handled from recent meetings (pasted here for convenience):

- Alison Sbrana: Can we get some info on how many psych hospitals, how many rehab and LTC hospitals etc., we are talking about who are being currently excluded and may benefit? Or some more info on pros/cons of including them?
- Alison Sbrana: Commercial payers don't pay as much for behavioral health and Medicaid/Medicare payers pay more? Do we need to factor this in?
- Josh Block: What is the sequence and timeline for related activities that must follow the preprint submission (e.g., contract development and rate setting that also need CMS approval, reporting requirements for MCOs incorporated into contracts, timeline reviews for payments, frequency of payments, etc.)?
- Tom Rennell: When a new facility opens or new services start up, would they be able to participate in the SDP program once they begin providing services? What processes do we need to have in place to account for changes like this?

Section In Process;
Slides to be Shared
During June 4 meeting

CHASE Model and State Directed Payment Program Design (35 minutes)

Quality Measures (35 minutes)

Updated Activities for Quality Measures

- Based on the agreed-upon principles for Quality Measure selection, the subgroup proposed (6) measures. At the May 7 meeting, the workgroup asked for additional information before making a final recommendation.
  - Data availability
  - Ability to calculate a baseline
  - Ability to determine target
- Make a proposal for which measures to include in Year 1 preprint and which measures, if any, to include in the program for tracking purposes and/or consider future year submissions and debate to consensus

Reminder: Must have at least two measures, one of which must be an outcome measure.

Recap: Potential Quality Measures v. Criteria

Measure Name	Principles Met	Challenges v. Criteria	Notes
30-day all-cause Readmissions (HEDIS)	9/10	Have not quantified room for improvement	It is an outcome measure and there are many pathways hospitals can work on to improve performance. It is included in ACC III. It is calculated for MCOs by EQRO.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	9/10	Have not quantified room for improvement	It is included in ACC II currently and will be in ACC III. It is calculated for MCOs by EQRO.
Follow-Up After Emergency Department Visit for Substance Use (FUA)	9/10	Have not quantified room for improvement	It is included in ACC II currently and will be in ACC III. It is calculated for MCOs by EQRO.
Follow-Up After Hospitalization for Mental Illness (FUH)	9/10	Have not quantified room for improvement	It is included in ACC II currently and will be in ACC III; relevant to psychiatric inpatient facilities. It is calculated for MCOs by EQRO.
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	*7/10*	*Data is not currently being collected/reported* *Not identified in other SDP* *Potential additional reporting requirement*	*This measure is not something that hospitals are currently working on, as such this measure will likely have room for improvement.*
Social Need Screening and Intervention- HEDIS (SNS-E)	*7/10*	*Data is not currently being collected/reported* *Not identified in other SDP* *Potential additional reporting requirement*	*Implementing this measure would provide more complete data than is currently being collected on this topic through HTP or ACC III.*

Consensus ↑

Info Requested ↓

↑ Year 2 or beyond ↓

Reminder: Must have at least two measures, one of which must be an outcome measure.

Potential Quality Measures v. 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

Potential Quality Measures Data Review

- All four measures are able to be calculated using data currently being collected
- Target methodologies currently exist and can be referenced in the development of targets for the SDP
- Next Steps
  - Gain consensus on including the (4) measures in the preprint → **TODAY**
  - Baselines and targets based on the provider class established before pre-print submission

Other Activities

We must also:

- ❑ Hold IGT discussions with Denver Health to establish the size of the transfer
- ❑ Engage with HCPF Rates team and the actuary to determine the certification date
- ❑ Begin working with HCPF Procurement team + MCOs for contract amendments
- ❑ Develop the drafts for approval:
  - ❑ Preprint document
  - ❑ Revised fee methodology
  - ❑ State plan amendment**

**Need to submit for public noticing

Questions?

Next Steps and Actions

- Determine whether or not to meet on June 11
- GPS to share meeting notes with decisions and actions.
- Execute the plan as agreed
- HCPF will post the next workgroup meeting on its website.
- HCPF will post an agenda ahead of the second workgroup meeting.

Government Performance Solutions, Inc.

Greg Bellomo	greg@governmentperformance.us	303.601.7319
Laura Sigrist	laura@governmentperformance.us	720.474.7291

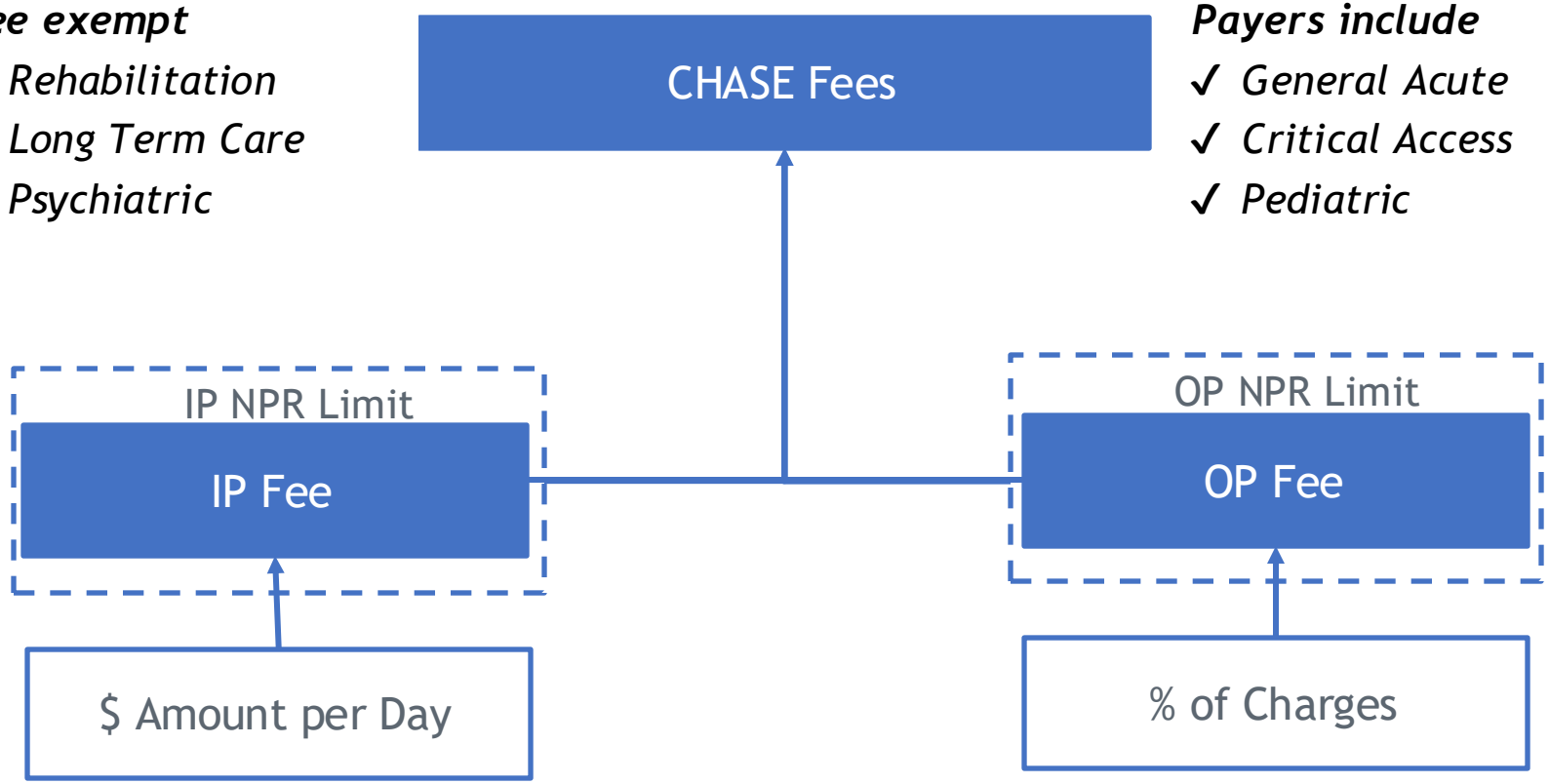
Appendix:
Slides from Previous Meetings

Current CHASE Model

Provider Fee from Hospitals

Fee exempt

- ✓ *Rehabilitation*
- ✓ *Long Term Care*
- ✓ *Psychiatric*



Payers include

- ✓ *General Acute*
- ✓ *Critical Access*
- ✓ *Pediatric*

IP Fees reduced

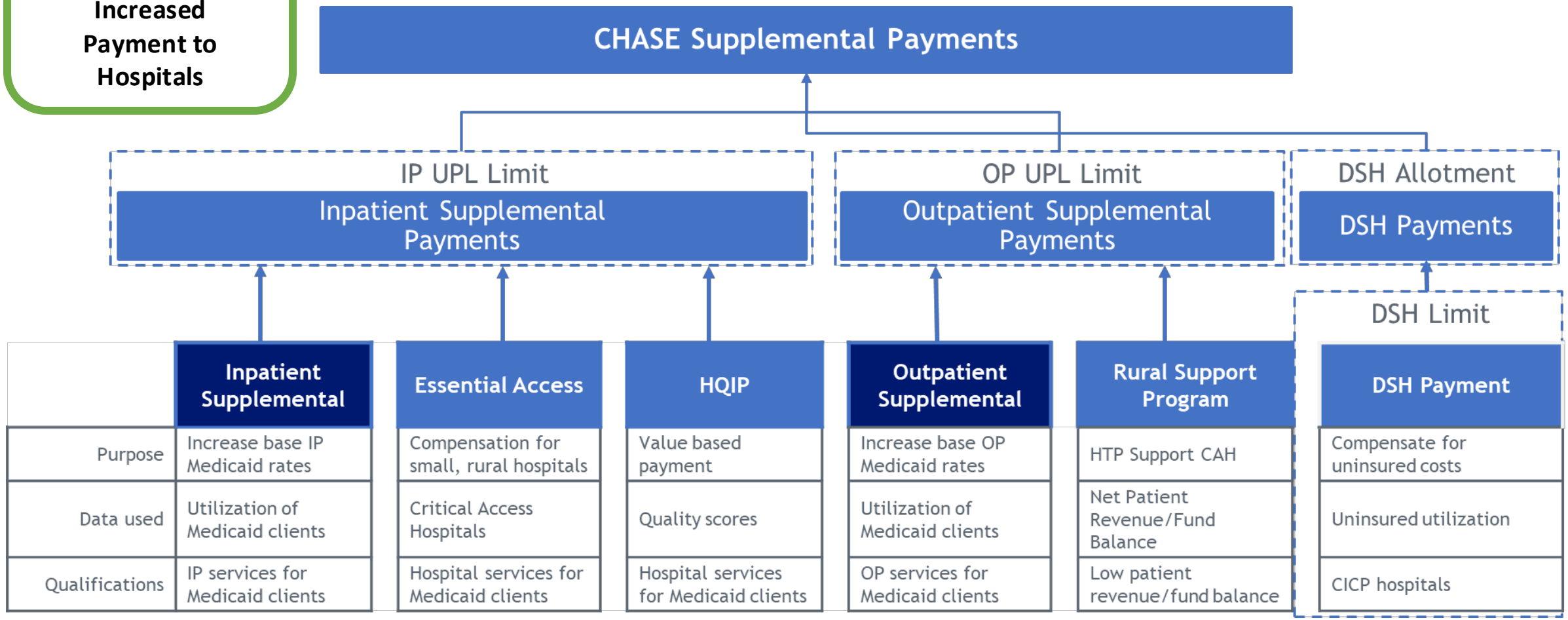
- *High Volume Medicaid/CICP Hospitals*
- *Essential Access Hospitals*
- *Managed Care Days*

OP Fees reduced

- *High Volume Medicaid/CICP Hospitals*

Current CHASE Model

Increased Payment to Hospitals



	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

Working Assumptions – Funding / UPL

Let's learn work group members' opinions on these additional questions:

1. **Funding:**
   - Assume use of inter-governmental transfer (IGT)
   - Revise inpatient and outpatient hospital provider fee methodologies with goal to simplify, amount of provider fee
   - Include psychiatric hospitals?
   - Increase amount of fee limit?

2. **UPL Supplemental Payments**
   - Revise existing UPL supplemental payments to simplify payment calculations and tie to utilization
   - Focus on inpatient and outpatient supplemental payments
   - Preserve funding to Critical Access Hospitals (Essential Access and Rural Support Fund)
   - Support hospitals with high volume of Medicaid care (i.e., safety net)

AS: Would all types of hospitals be supported equally or would there be priority support for critical access hospitals?

Reminder: Model Overview

Characteristics:

- Owned and administered by HCPF
- Produce results that are federally compliant
- Use most relevant data
- SDP incorporated in managed care contracts and validated by the HCPF's actuaries

Features:

- Funding source(s): provider fee, IGT
- UPL supplemental payments for fee for service care and SDP for managed care: behavioral health and physical medical care
- Enable scenario modeling to understand funding impact on hospitals compared to the current state based on:
  - Application to different populations/ services
  - Alignment with CHASE goals for hospital reimbursement, quality of care, and health coverage and CMS requirements that payments are consistent with efficiency, economy, and quality of 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 MCO and FFS 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