Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Initiatives Workgroup

Meeting #12

Wednesday, June 11, 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

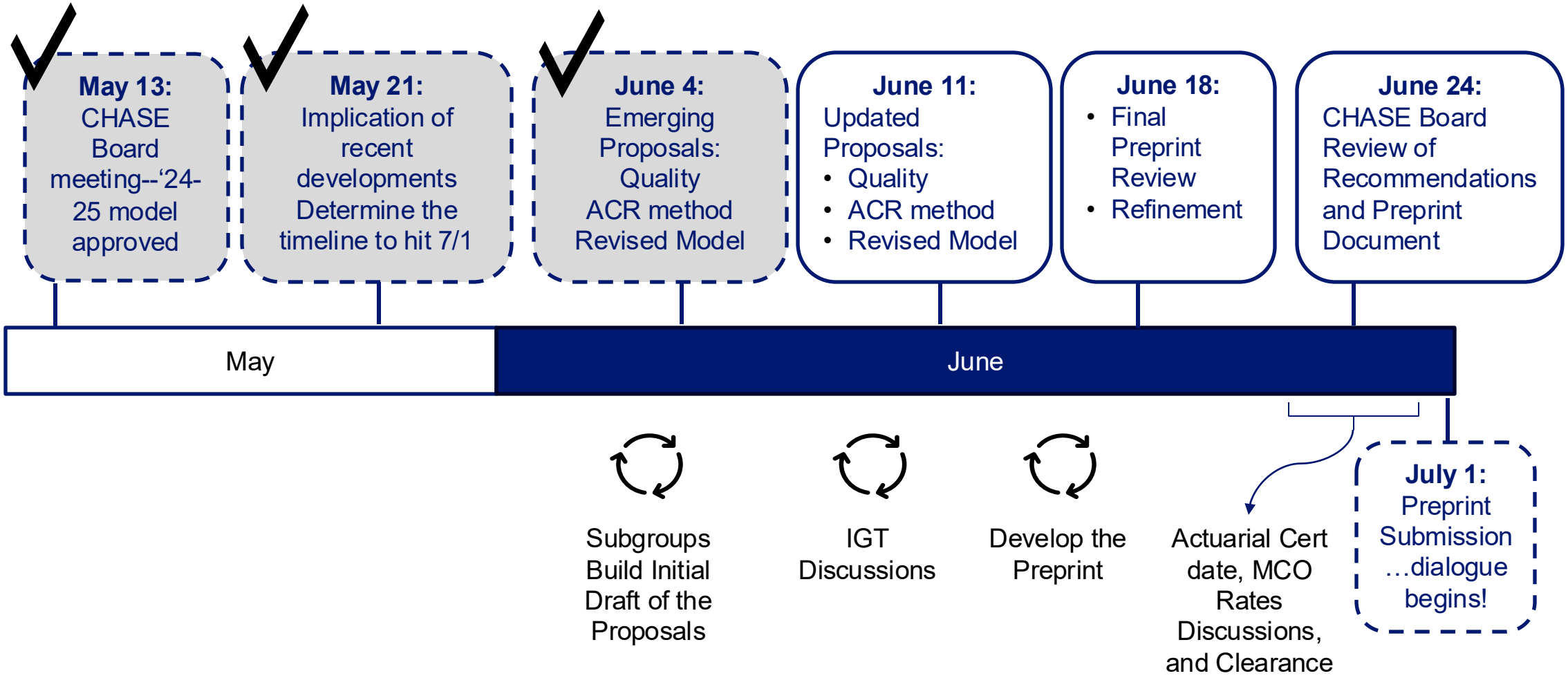
Develop comprehensive recommendations for revisions to CHASE including the addition of a State Directed Payment (SDP) for CHASE Board consideration. Such that HCPF can develop and advance a broadly supported proposal to submit to the federal Centers for Medicare and Medicaid Services (CMS) for implementation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

CHASE Program Objectives

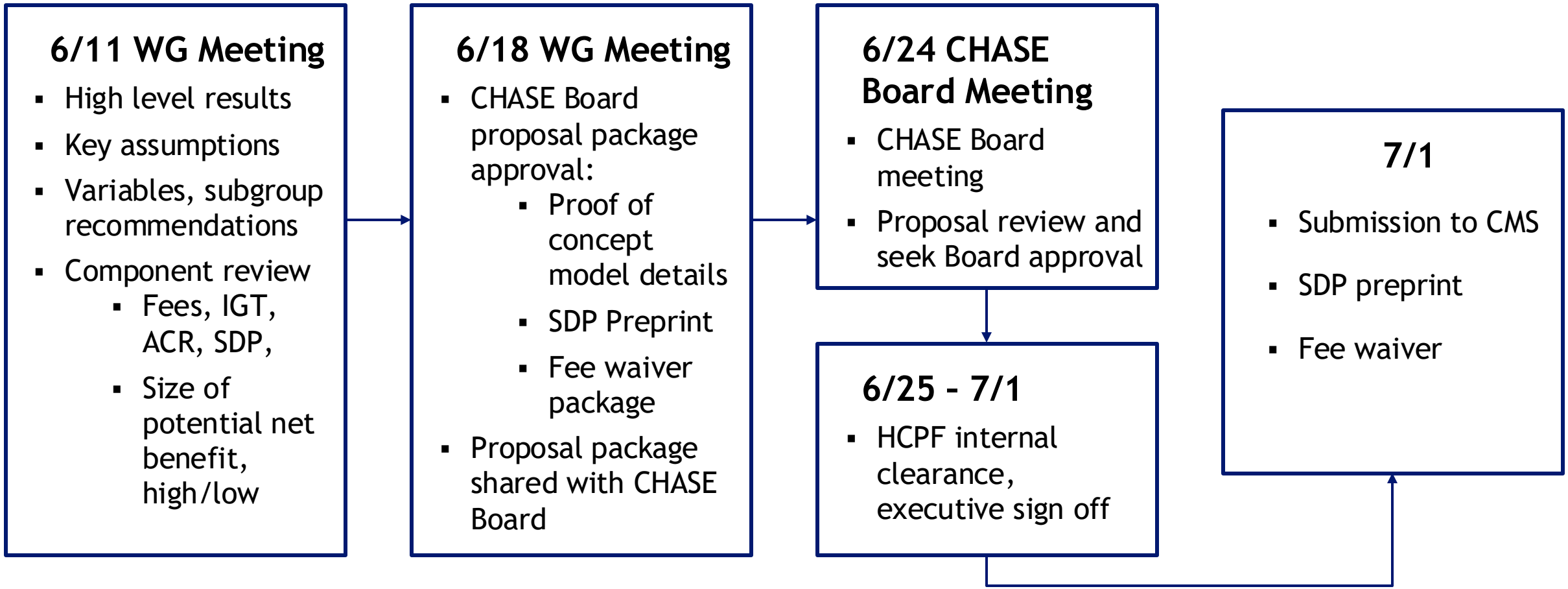
As outlined in statute, the (4) CHASE program's goals are:

- 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

Proposed Path to July 1



Road Map Details



Agenda

- Plan for this Meeting and Upcoming Meetings (10 minutes)
- CHASE Model and State Directed Payment Program Design (60 minutes)
  - Key assumptions & approaches
  - Managing expectations
  - Model Components: Funding, Defining provider classes, ACR percentage, Directed Payment Methodology and Amount
  - Proof of Concept: The emerging future of CHASE
- Remaining Activities
- Questions and Next Steps (20 minutes)

Work Group Members

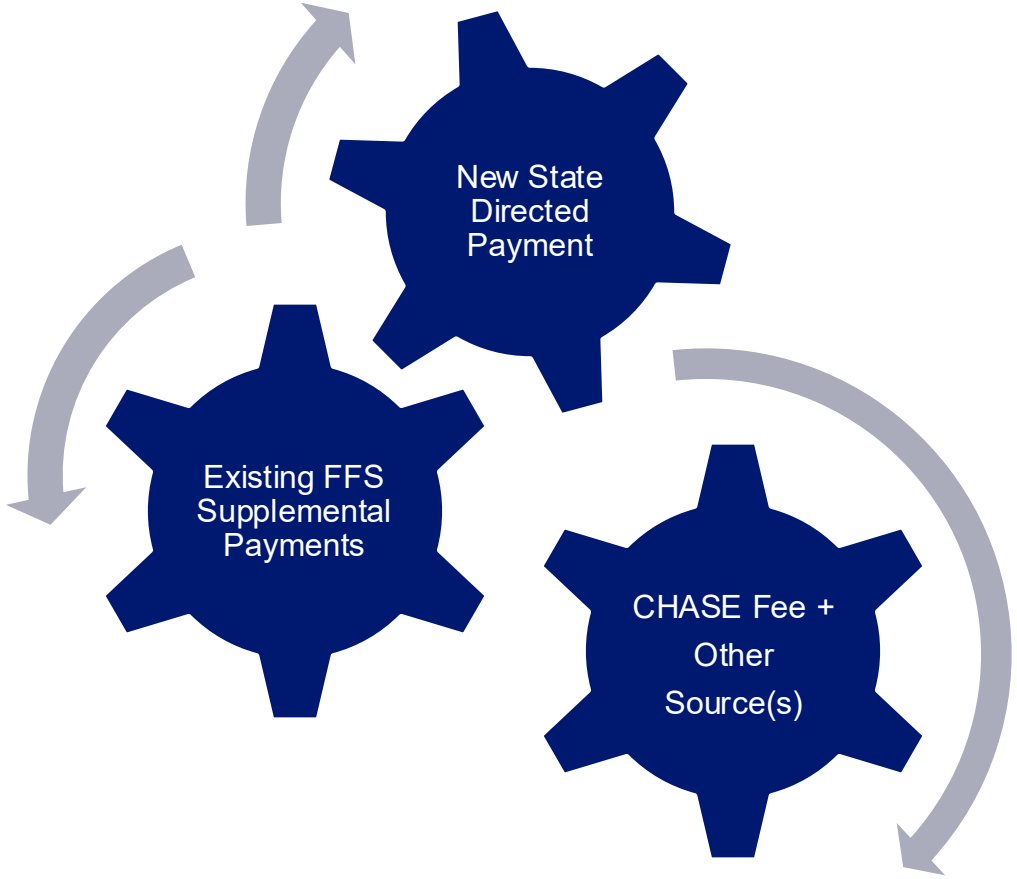
1. Alison Sbrana, Consumer
2. Annie Lee, President & CEO, Colorado Access
3. Emily King, Senior Policy Advisor/Deputy Director of the Office of Saving People Money on Health Care, Governor's Office
4. Josh Block, Deputy Chief Financial Officer, HCPF
5. Dr. Kimberley Jackson, CHASE Board Vice President
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

Environmental Updates

What other updates or information is important to share at this time?

CHASE Model and State Directed Payment Program Design (60 minutes)

Interconnectedness of CHASE Program



Reminder: The CHASE program is subject to federal and state requirements as well as CHASE goals and statutes. **A change to one element of CHASE may impact compliance or yield unintended consequences in other areas.**

Factors Impacting Funds Available

- Broad based/uniformity requirements for provider fees
- Hold harmless restrictions/6% NPR safe harbor threshold
- Expansion coverage and administrative costs
- Varying federal match rates across programs

Factors Impacting Supplemental Payments

- Upper payment limits for fee for service and managed care
- Alignment with CO managed care quality strategy
- Shifts in managed care utilization during rating period

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 CHA 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

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
- Resolve any questions from IGT hospitals, commitment on amounts
- CMS guidance on DH FQHC data permissibility
- 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 appeal decision
- Best case, CMS approval will be several months from now

The Upshot

Net reimbursement is estimated to be between $424M to $555M in additional dollars

Let’s explain how we got there

Proposed Parameters

Proposed parameters by remaining Preprint Section:

Funding

- ❑ Fee methodology
- ❑ IGT amount

Defining Provider Classes

ACR Percentage

Directed Payment Methodology and Amount

Funding

- Proposed fee methodology and amounts
  - Fees at 6% federal NPR limit, assessed as percentage of NPR
  - Inpatient: 40% discounted fee for IMDs; essential access rural hospitals* exempt
  - Outpatient:
    - 40% discounted fee for IMDs
    - 45% discounted fee high volume Medicaid metro hospitals (outside Denver metro)
    - 78% discounted fee essential access rural hospitals*
  - Fee Exempt hospitals: State University Teaching Hospitals,** Public IMDs, LTACs and Rehabilitation Hospitals
- IGT amount: estimated $276 to $346 million

*does not include western slope hospitals that receive SDP
**Denver Health and University Hospitals, who will be contributing IGTs

Defining Provider Classes

We envision (3) provider classes each with their own ACR:

- Hospital Inpatient—urban and rural subgroups
- Hospital Outpatient —urban and rural subgroups
- Behavioral Health (IMDs)—both inpatient and outpatient

Directed Payment Methodology and Amount

- SDP calculation =
  - ACR% *multiplied by* Medicaid MCO costs *equals* Total ACR
  - Total ACR *less* MCO base payments *equals* Directed Payment
- Separate for Urban / Rural and Behavioral Health (IMD) hospitals

ACR Percentages

IP ACR		OP ACR	
Rural	Urban	Rural	Urban
92%	207%	212%	299%
153%	253%	255%	373%

Currently Behavioral Health (IMD) ACR and State Directed Payment estimates using proxy data: Medicare to Medicaid payment rate and cost estimates

Fees, IGT, Directed Payment, and Net New Fund Amount Range Estimates

Total Fees	Total IGT	Total SDP	Net New Funds
$1,458 M	$276 M	$726 M	$424 M
$1,458 M	$346 M	$960 M	$555 M

The (emerging) Future of CHASE

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

Estimated net reimbursement increase: Low $ 424M to high $555M

Current CHASE Model with adjustments

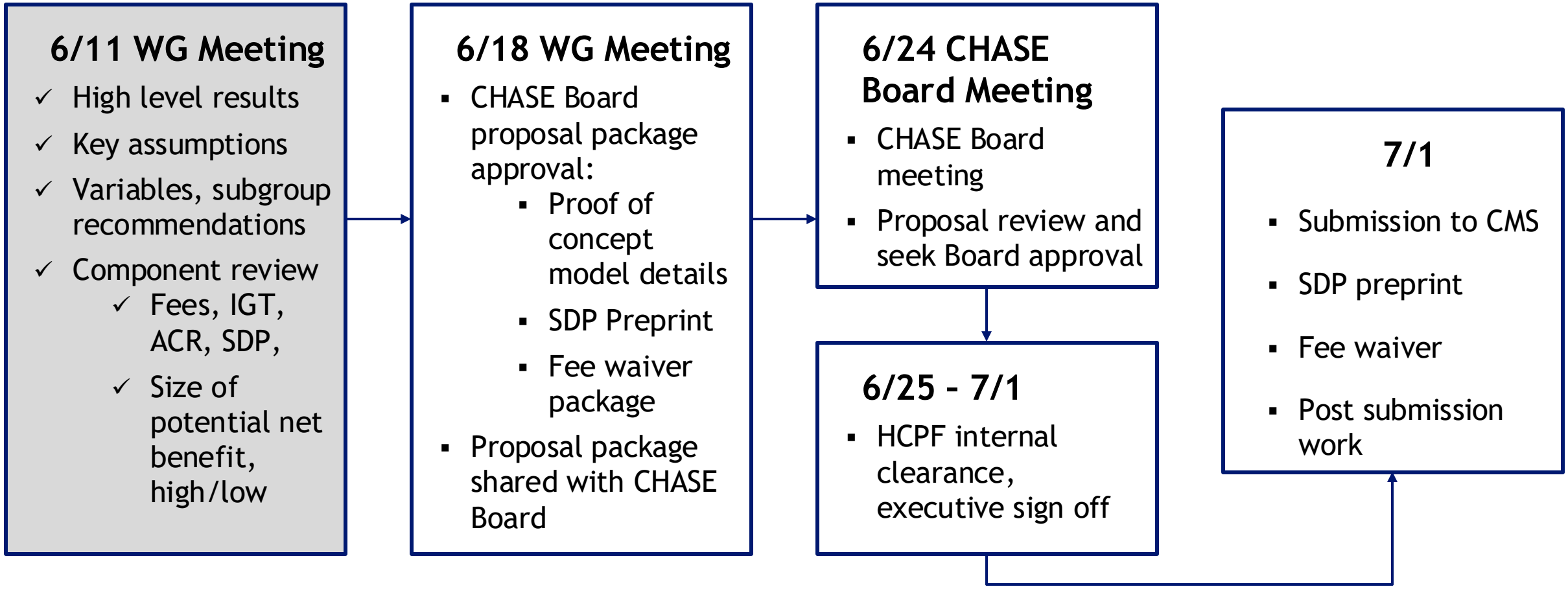
- Revise DSH and UPL supplemental payments such that all systems/independent providers do at least as well as status quo
- Reduced number of UPL payment “adjustment groups”
- Continue directed funding for Critical Access Hospitals through Essential Access and Rural Support Fund
- No changes to HQIP

State Directed Payment

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

Funded by provider fees + IGT

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 psych 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?

Next Steps and Actions

- GPS to share meeting notes with decisions and actions.
- Determine the remaining activities, timeline, and owners for each task, including post-submission work
- Share the planned agenda for 6/18
- Execute the plan and hit milestones, 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.

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Appendix:
Slides from Previous Meetings

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.

Continued on next page

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?