Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Initiatives Workgroup

Meeting #3

Wednesday, January 29, 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.

Agenda

Our agenda has more content than 90 minutes. We will as efficiently as possible and move items not covered into next meeting's agenda.

- Plan for the Day (5 min)
- Size the Potential Benefits (20 min)
- Continue Discussion of Model Features and Key Questions (40 min)
- Average Commercial Rate Calculation Options *(15 min – time permitting)*
- Preprint Requirements *(15 minutes – time permitting)*
- Questions and Next Steps (5 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.

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.

These may be adjusted by the workgroup as situations arise

Recent Progress

- Shauna share a Milliman report showing AZ's approach to calculating NPR; added this to the Resource Bank

  → Seeking other examples and documented CMS feedback

- Engaged with CHA and their consultants to provide insight on how they proposed to calculate the Average Commercial Rate (ACR) and what data sources can be used→ will discuss today

Any other progress or engagement to share?

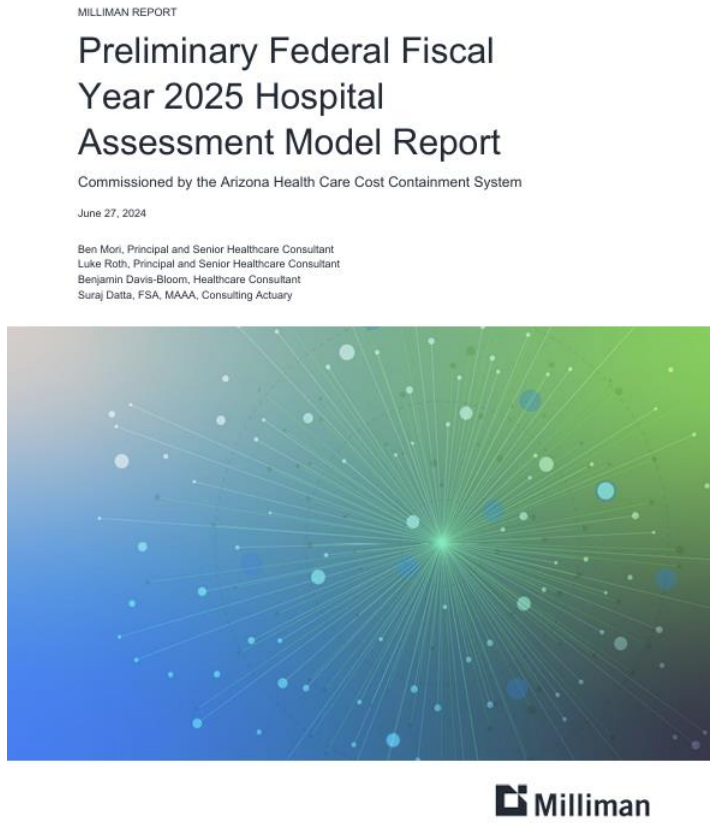
Other Open Questions/Assignments

Items not handled from the last meeting (pasted here for convenience):

- Status on the AG's response related to the viability of an IGT if directly to the Enterprise.
  - AG opinion is in process; even when we receive it, the opinion will not be definitive
  - Propose the workgroup move forward with an assumption of permissibility of the enterprise receiving an IGT and that not counting as TABOR revenue
  - The legislature is likely to want an opinion from their counsel, the Office of Legislative Legal Services, before they would appropriate an IGT to the enterprise.
- Size the potential impact ("size of the pie") at 5.54% and 6% for both the current convention (all hospitals paying the fee) AND for all hospitals in the market. ACTION: Discuss this at next meeting.
- AL: If there is some notable risk that CMS will not approve a proposal that doesn't include new regulations, seems that impacts our answers/decisions. I wonder if we simply assume what CMS will do (or can we find out / get guidance ahead of time), or do we do Plan A and Plan B? ACTION: Discuss this at next meeting.
- AS: Would all types of hospitals be supported equally or would there be priority support for critical access hospitals? ACTION: Discuss later this meeting.

Size the Potential Impact (20 min)

Potential Impact – Provider Fees



Last meeting we discussed how best to size the potential revenue impact/increase to the enterprise by adjusting assumptions of the Net Patient Revenue (NPR)

Shauna submitted that other states calculate the 6% NPR cap based on all hospitals, not just the fee-paying hospitals

Arizona commissioned Milliman to prepare a report with their B1B2 demonstration (fee waiver methodology) that shows this. Relevant pages include:

- Appendix B page 13 (page 72-75 of the PDF) columns D and E
- Description on page 4 (page 6 of the PDF).

Potential Impact – Provider Fees

Order of Magnitude Sizing has been calculated below for a few relevant scenarios:

Scenario	Source	Status Quo 5.54%	Increase	5.75%	Increase	6.0%	Increase
Current Assumptions: • NPR of all **fee-paying hospitals** • Includes inpatient and outpatient hospital services	Fee	$1,250.6	--	$1,300.4	*$49.8*	$1,356.9	*$106.4*
	Federal Funds	$2,129.3	--	$2,214.2	*$84.9*	$2,310.5	*$181.1*
	Total Funds	$3,379.9	--	$3,514.6	*$134.7*	$3,667.4	*$287.5*
All Hospitals: • Same as above except using an estimate of NPR of **all hospitals**, including those currently fee exempt	Fee	$1,285.4	*$34.8*	$1,336.7	*$86.2*	$1,394.8	*$144.3*
	Federal Funds	$2,188.6	*$59.3*	$2,276.0	*$146.7*	$2,375.0	*$245.6*
	Total Funds	$3,474.0	*$94.2*	$3,612.7	*$232.8*	$3,769.8	*$369.9*

Based on FFY 2023-24 Net Patient Revenue (NPR) Calculations
In millions

Continue Discussion of Model Features and Key Questions (40 min)

Approach and Timeline

December 2024	January - March 2025	April - May 2025	June 2025
Prepare for success • Orient workgroup (Today!) • Conduct interviews & summarize insights • Confirm workgroup logistics and finalize schedule • Engage in learning about SDP • Define data scope, sources, and plan to fill any gap	**Develop, evaluate, & refine scenarios** • Collect data, develop, and evaluate scenarios • Finalize model assumptions and decisions • Workgroup meetings #2 – 9 to discuss analysis and implications, then create and evaluate options	**Draft proposal** • Establish framework of proposal (requires CHASE Board approval) • Identify requirements to address state and federal approvals • Workgroup meetings #10-11 • HCPF and consultants begin compiling the proposals into a draft final report • Actuary engagement	**Finalize submission** • Prepare materials for CHASE Board review and approval • Finalize materials for submission to CMS • Workgroup meetings #12-13 • HCPF and consultants incorporate edits into report Submission Due 7/1/25

Feedback Cycle   

Emerging Consensus

Based on last meeting's conversation:

- When revisiting the methodology, simplify to the degree possible, but this is a secondary goal
- Include both inpatient and outpatient hospital services
- Include these hospital types: General, acute care and Critical Access Hospitals, and psychiatric hospitals
- Replace some federal DSH funds with additional safety net hospital reimbursement
- Assume (3) additional things:
  1. An IGT is a permissible funding source; will not trigger TABOR
  2. Preserve funding to Critical Access Hospitals
  3. Support hospitals with high volume of Medicaid care (i.e., safety net)

Interconnectedness of CHASE Program

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.**

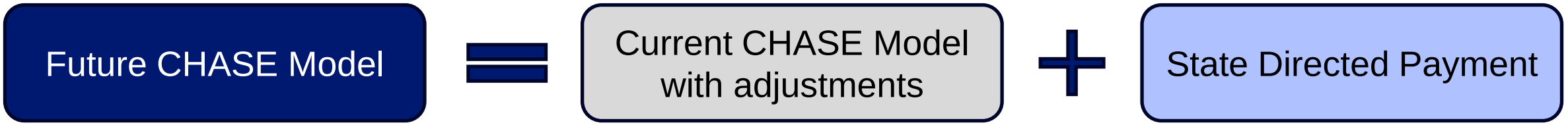
Factors Impacting Funds Available

- 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

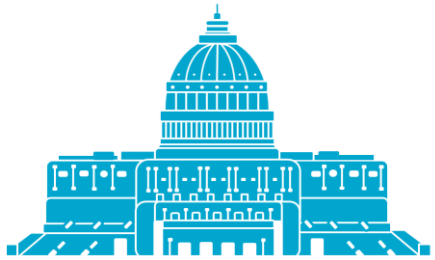
- Upper payment limits for fee for service and managed care
- Alignment with CO managed care quality strategy
- Shifts in managed care utilization during rating period

New Model


Future CHASE Model
Current CHASE Model with adjustments
State Directed Payment

Current CHASE Model

Provider Fee from Hospitals
$ 1,250M



Federal Match from CMS
$ 3,650M

Cash Fund (Fee + Federal Match)

Increased Payment to Hospitals
$ 1,725M
($700M Fees / $1,055M FF)

Admin./Other
$ 150M
($45M Fees / $ 100M FF)

Expanded Coverage to Colorado Citizens
$ 3,000M
($500M Fees / $ 2,500M FF)

Current CHASE Model

Provider Fee from Hospitals

Fee exempt

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

Payers include

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

CHASE Fees

IP NPR Limit

IP Fee

$ Amount per Day

OP NPR Limit

OP Fee

% of Charges

IP Fees reduced

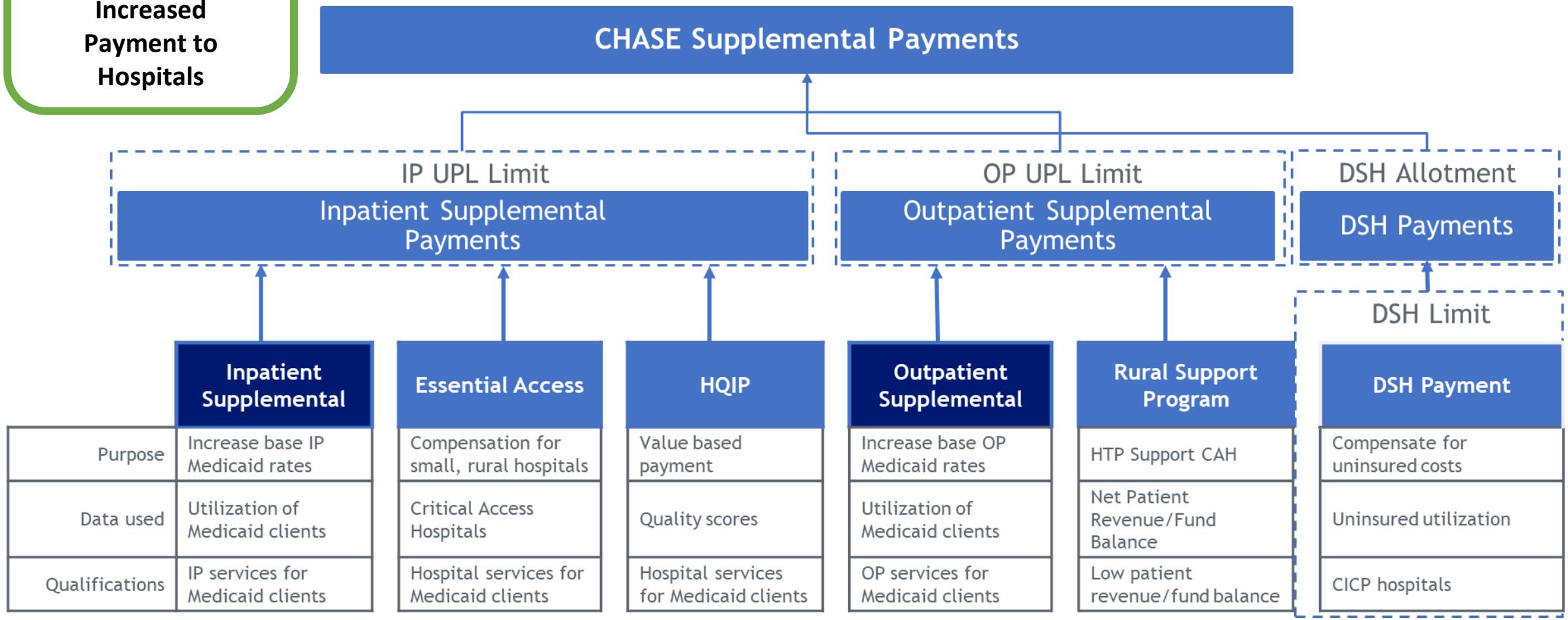
- *High Volume Medicaid/CICP Hospitals*
- *Essential Access Hospitals*
- *Managed Care Days*

OP Fees reduced

- *High Volume Medicaid/CICP Hospitals*

Current CHASE Model

Increased Payment to Hospitals

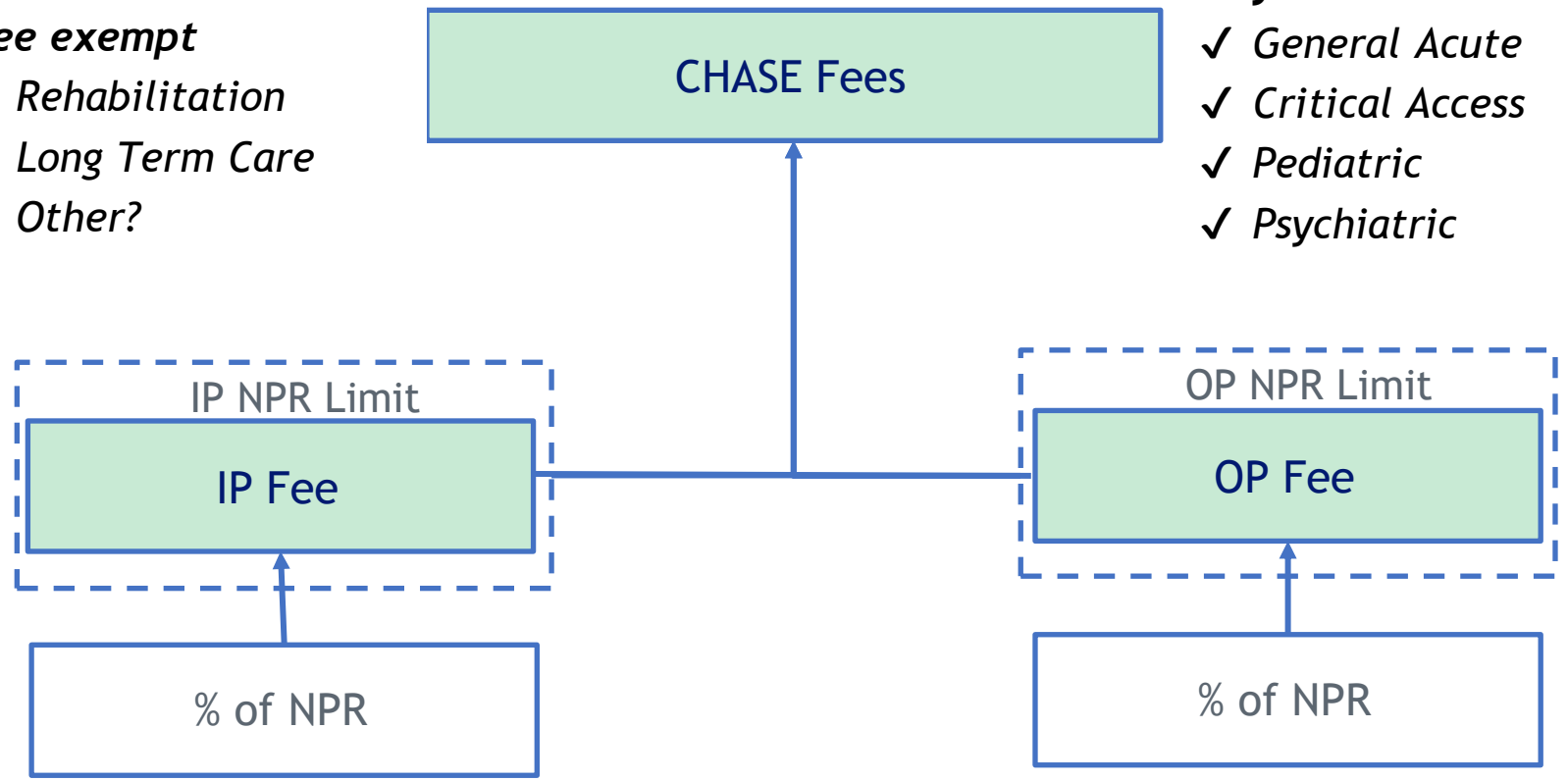


	Inpatient Supplemental	Essential Access	HQIP	Outpatient Supplemental	Rural Support Program	DSH Payment
Purpose	Increase base IP Medicaid rates	Compensation for small, rural hospitals	Value based payment	Increase base OP Medicaid rates	HTP Support CAH	Compensate for uninsured costs
Data used	Utilization 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

Current CHASE Model with adjustments

Provider Fee from Hospitals

Fee exempt
- ✓ *Rehabilitation*
- ✓ *Long Term Care*
- ✓ *Other?*



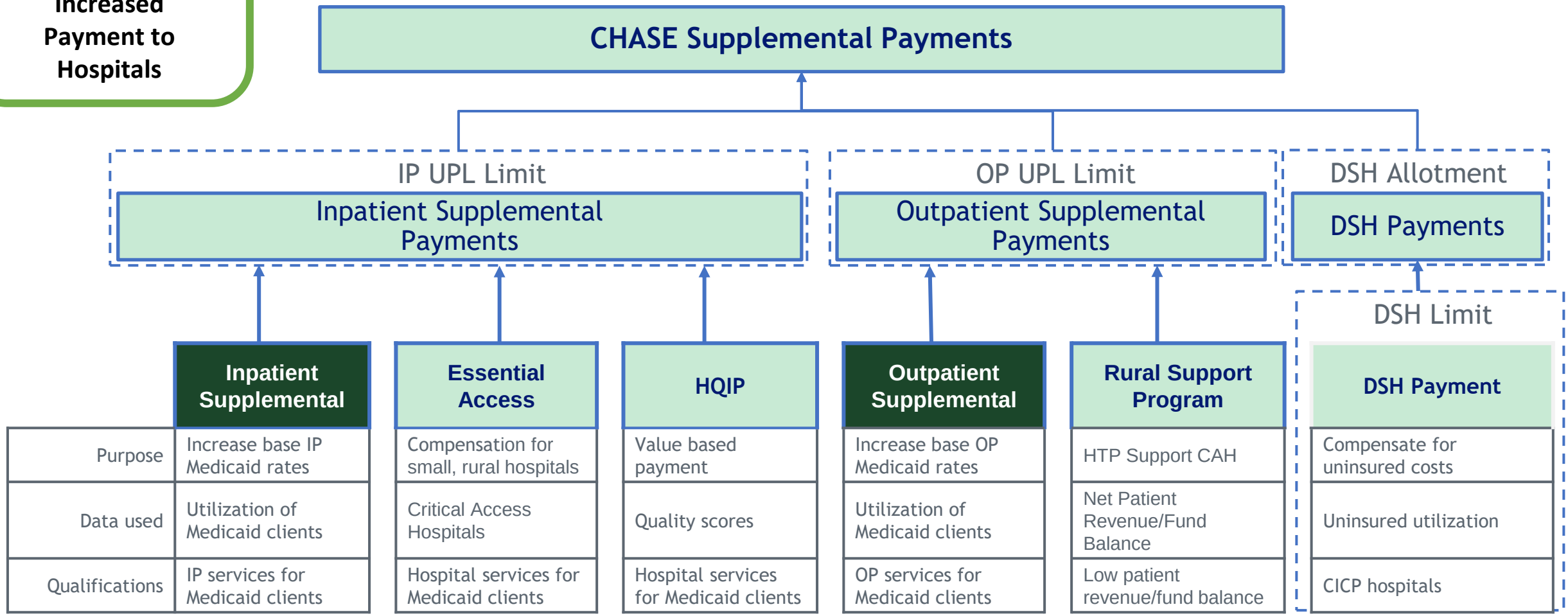
Payers include
- ✓ *General Acute*
- ✓ *Critical Access*
- ✓ *Pediatric*
- ✓ *Psychiatric*

IP Fees reduced
- *To be determined*

OP Fees reduced
- *To be determined*

Current CHASE Model with adjustments

Increased Payment to Hospitals



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Preserve funding to Critical Access Hospitals
Support hospitals with high volume of Medicaid care (i.e., safety net)

Working Assumptions – Funding / UPL

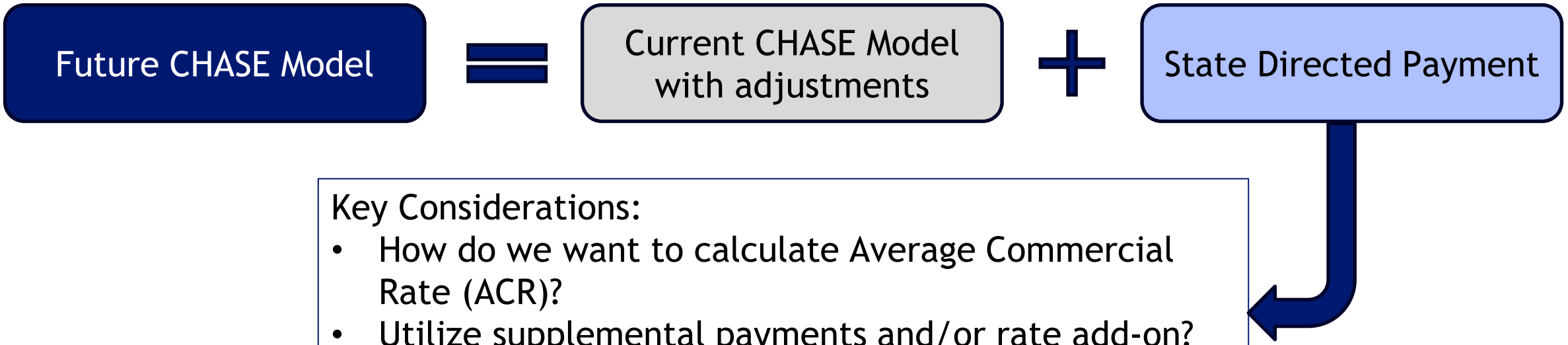
Let's learn work group members' opinions on these additional questions:

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?

New Model



Key Considerations:

- How do we want to calculate Average Commercial Rate (ACR)?
- Utilize supplemental payments and/or rate add-on?
- Confirm that we don't want to use a value-based payment approach in year 1

ACR Calculation Options (15 min)

ACR Calculation Option 1

Payment to Cost Ratio Method

- The Average Commercial Rate ("ACR") is calculated based on a pay-to-cost methodology and represents the amount third-party, non-government managed care payers would pay relative to costs of care.
- ACR can be applied to Medicaid managed care costs to determine the commercial equivalent payment, which CMS has codified as the federally allowed payment threshold for Medicaid managed care directed payment programs.
- Under the 2024 final rule, CMS permits states to use statewide ACR data sources and rates for all hospital types as a means of advancing state policy objectives.
- CMS specifically stated, for example, that using ACR rates specific to public and rural hospitals (i.e., hospitals with low commercial volumes) disadvantages them and allowing the use of a statewide ACR provides flexibility to support hospitals with lower commercial volumes. Behavioral health hospitals, which rely predominantly on government payers, are similarly positioned to public and rural hospitals, which CMS also noted.

ACR Calculation Option 1

Payment to Cost Ratio Method

The steps used in a Statewide ACR calculation are as follows:

1. Subtract separately identifiable government and self-pay payments and costs from total hospital payments and costs (as reported on hospital Medicare cost reports available on the Healthcare Cost Report Information System or "HCRIS") to calculate the "commercial" remainder.

2. Split commercial payments and costs between inpatient and outpatient. Then divide each hospital's commercial payments by its commercial costs to calculate hospital ACR Pay-to-Cost Ratios for inpatient and outpatient services.

$$\frac{Total\ Pmts - (Gov.Pmts + Self\ Pay\ Pmts)}{Total\ Costs - (Gov.Costs + Self\ Pay\ Costs)} = \frac{Commercial\ Pmts}{Commercial\ Costs} = ACR\ Pay\ to\ Cost\ Ratio$$

3. Calculate statewide weighted inpatient and outpatient ACR Pay-to-Cost Ratios using each hospital's respective percentage share of statewide commercial revenues as a weighting factor.

$$ACR\ Pay\ to\ Cost\ Ratio * ACR\ Weight = Hospital\ Contribution\ to\ Statewide\ ACR$$

$$Sum\ of\ All\ Hospital\ Contributions = Statewide\ Weighted\ ACR\ Pay\ to\ Cost\ Ratio$$

Other ACR Calculation Options

1. Data sources

From CMS Final Rule:

States with SDPs for hospital services have provided analyses using hospital cost reports and all-payer claims databases. Others have relied on actuaries and outside consultants, which may have access to private commercial databases, to produce an ACR analysis. At times, States have purchased access to private commercial databases to conduct these analyses.

We believe each of these approaches, provided the data used for the analyses meet the proposed requirements in § 438.6(c)(2)(iii), will be acceptable to meet our proposed requirements.

Other ACR Calculation Options

2. ACR Calculation Methodologies

From CMS Final Rule:

Average commercial rate means the average rate paid for services by the highest claiming third-party payers for specific services as measured by claims volume.

ACR Demonstration must use payment data that: (1) is specific to the State; (2) is no older than the 3 most recent and complete years prior to the start of the rating period of the initial request following the applicability date of this section; (3) is specific to the service(s) addressed by the SDP; (4) includes the total reimbursement by the third party payer and any patient liability, such as cost sharing and deductibles; (5) excludes payments to FQHCs, RHCs and any non-commercial payers such as Medicare; and (6) excludes any payment data for services or codes that the applicable Medicaid managed care plans do not cover under the contracts with the State that will include the SDP.

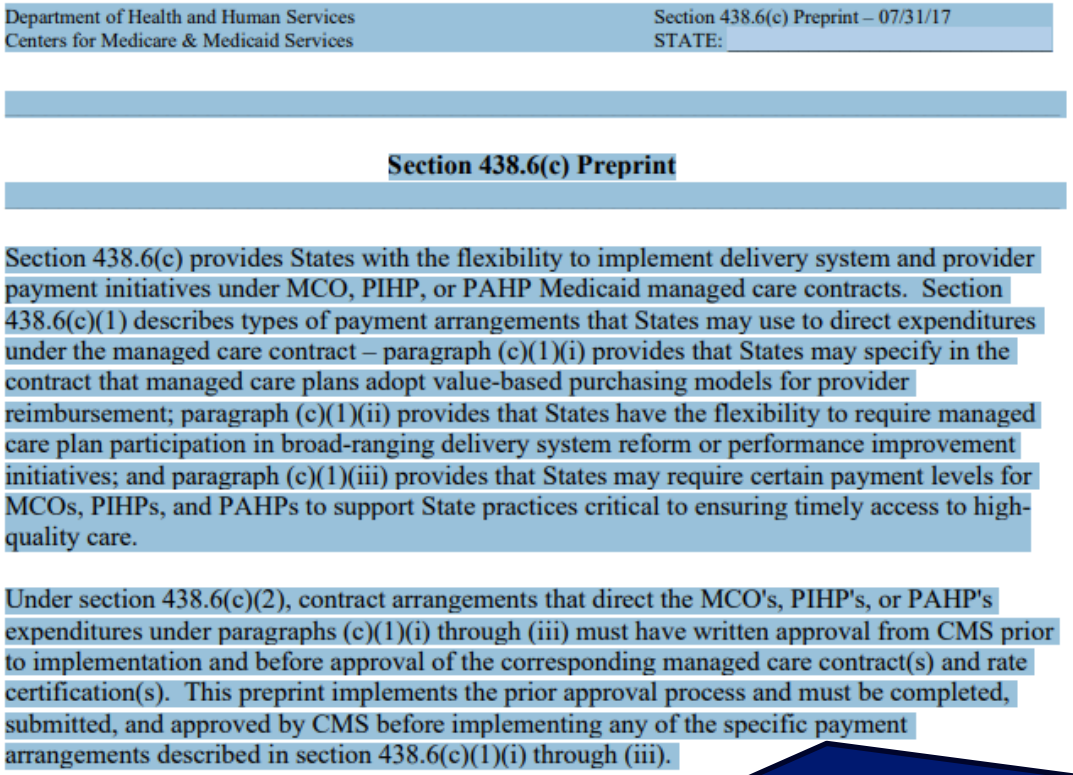
There are many different ways that states have calculated ACR. Here are just a few examples from other states:

- **Procedure Code Level:** Calculate discrete ACR using top 3/Top 5 commercial payers by procedure code and convert Medicaid managed care encounters to procedure-code specific ACR
- **Pay-to Charge Ratios:** Medicaid managed care charges multiplied by commercial pay-to-charge ratio
- **Medicare Equivalent:** Calculating the Medicaid base rate as a percentage of Medicare as compared to the ACR percentage of Medicare

We will need to discuss risks and benefits, and the State may engage CMS for a better understanding of each

Preprint Requirements (15 min)

Preprint Template



Department of Health and Human Services
Centers for Medicare & Medicaid Services

Section 438.6(c) Preprint – 07/31/17
STATE: _____

Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

Segment Overview:

1. Share the Preprint template design
2. Demonstrate the template's requirements (e.g., check boxes/confirmation of meeting regulations, open-ended fields)
3. Contains branching logic that drives key questions
4. May be prudent to engage CMS; communication hold currently in place

AL/JB: If there is some notable risk that CMS will not approve a proposal that doesn't include new regulations, seems that impacts our answers/decisions. I wonder if we simply assume what CMS will do (or can we find out / get guidance ahead of time), or do we do Plan A and Plan B?

The Uses of the Preprint

- The Preprint template:
  - Includes key decision points
  - May appear at first glance to contain a limited range of options, but there are many different design elements that states have submitted to CMS
  - Serves as the framework through which the federal government views the State’s proposal and determines allowability
- Ultimately, the Workgroup's work will lead to Colorado's Preprint submission for this project

The Sections of the Preprint

- SECTION I: DATE AND TIMING INFORMATION
- SECTION II: TYPE OF STATE DIRECTED PAYMENT
  - SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):
  - SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES
- 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

Questions?

Next Steps and Actions

- GPS to share meeting notes with decisions and actions.
- Modeling resources will continue doing their work and tap analytic support as needed.
- 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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Laura Sigrist	laura@governmentperformance.us	720.474.7291

Thank you!

Appendix

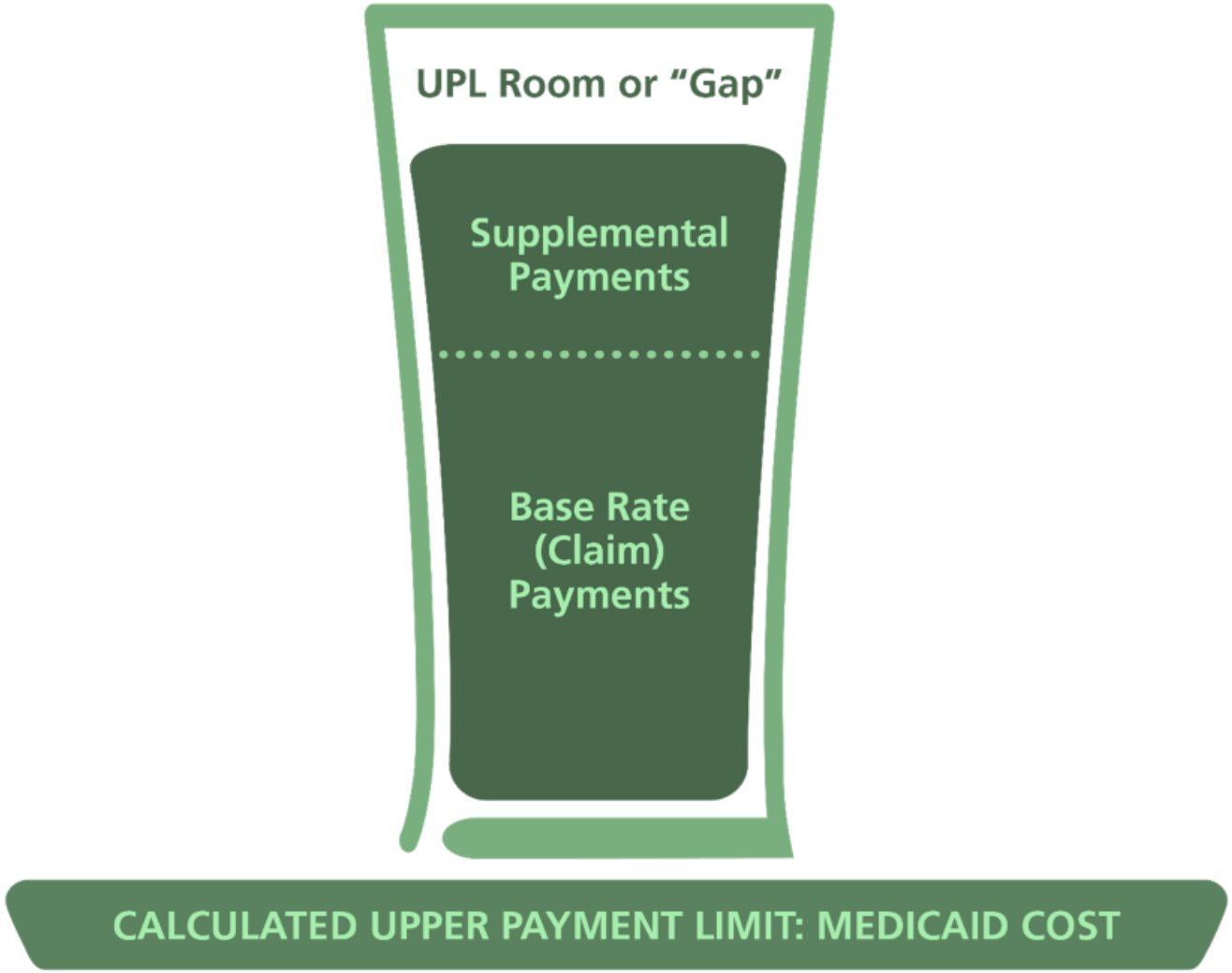
Fees and Payments Overview

Payment	Hospital Fees	Federal Funds	Total Funds	Hospitals
Inpatient Supplemental	$258M	$440M	$698M	All (82)
Essential Access Supplemental	$10M	$16M	$26M	CAH (34)
Hospital Quality Incentive Payment	$64M	$64M	$128M	All (82)
Outpatient Supplemental	$234M	$399M	$633M	All (82)
Rural Support Fund	$4M	$8M	$12M	Lower resourced CAH (23)
Disproportionate Share Hospital	$129M	$129M	$257M	CICP (24)
Total	**$699M**	**$1,056M**	**$1,755M**	

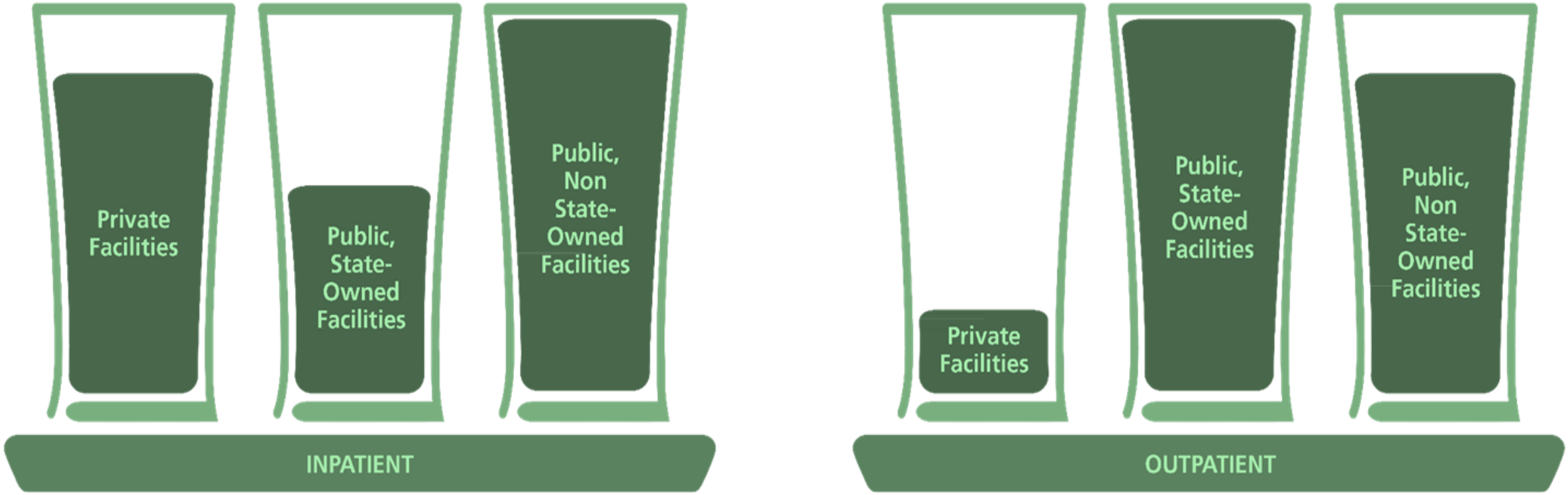
Adjustment Factors

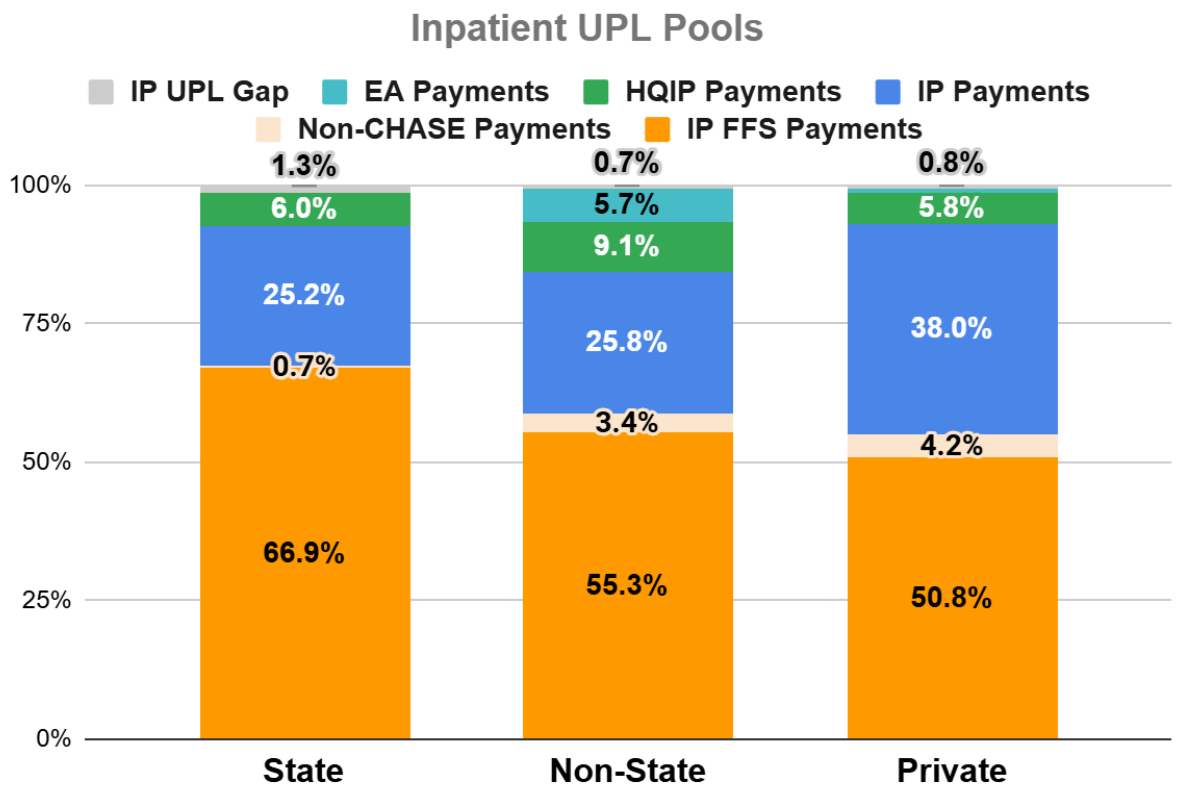
FFY 23-24 Inpatient & Outpatient Adjustment Factors				
Adjustment Group	**UPL Category**	**Percent of Hospitals**	**Inpatient Adjustment Factor**	**Outpatient Adjustment Factor**
Rehabilitation or LTAC	All	14%	$16.00	16.00%
State Government Teaching Hospital	State Gov.	1%	$618.75	47.14%
Non-State Government 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%

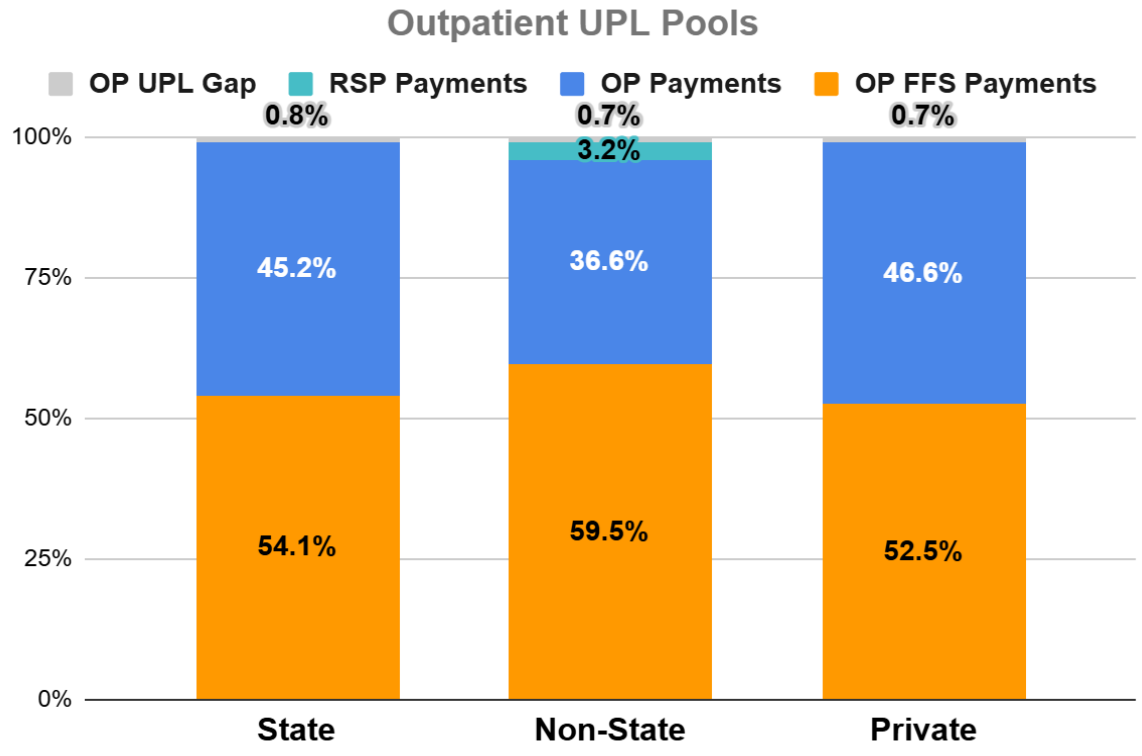
Upper Payment Limit (UPL)



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





State (1)
Non-state (31)
Private (53)

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?

Recap: Roles and Responsibilities

Workgroup:

- Read all required materials to prepare for meetings
- Participate actively in all workgroup meetings
- Understand implications and evaluate options, recognizing constraints and data limitations
- Debate proposals to consensus

HCPF & Consultants:

- Conduct research
- Perform analysis based on available data
- Share analysis in a user-friendly format
- Answer questions as timely as feasible

GPS Facilitators:

- Provide a structured approach
- Ensure meetings are productive with balanced participation
- Deliver regular project management updates