Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Initiatives Workgroup

Meeting #4

Wednesday, February 12, 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.

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   

Agenda

- Progress and Plan for the Day (15 minutes)
- Preprint Requirements (25 minutes)
- Directed Payment Discussion (35 minutes)
- Modeling Update (10 minutes)
- 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

...and welcome to Mary Goddeeris from HMA

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

Caveats…

- There are pending rule changes with application dates that we are aware of→ We must decide whether to have both short-term plans and long-term plans
- There are emerging proposals and qualified rumors about the new administration's plans for Medicaid→ Proceed quickly but keep an ear to the ground as the Reconciliation takes place

What else should we be considering?

Emerging Consensus

We will maintain a list of points covered by the work group and how they plan to handle each. This list will grow as meetings are held and agreements are reached.

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)
Average Commercial Rate Calculation	*Data sources and method are discussed in this meeting*

Maintain a running list

Open Questions/Assignments

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

- This meeting:
  - Annie Lee: 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 in this meeting.*
  - Josh Block: How does the ACR ratio turn into actual payments? What are the mechanics?
- Future meetings:
  - 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?
  - 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?

Proposal for Working Together

Likely Path:

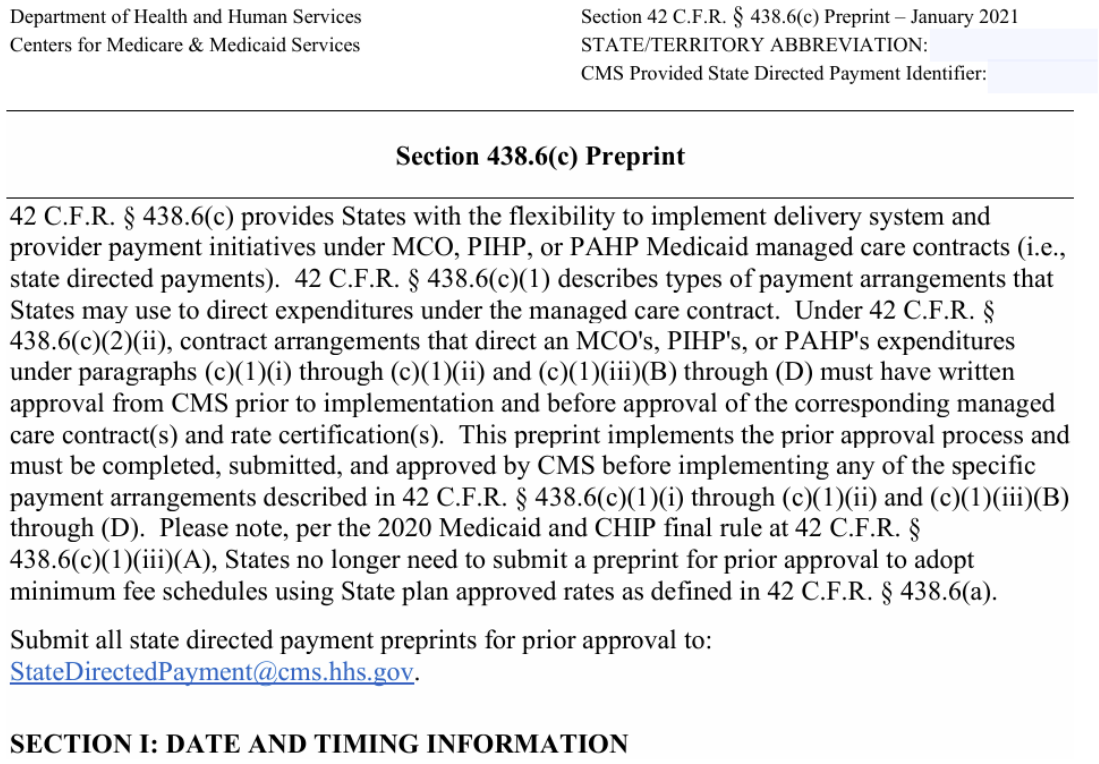
1. Share the situation and draft recommendation
2. Supply the considerations and information that support the proposal
3. Confirm agreement

Uncertain Path:

1. Share the situation and key questions to answer
2. Develop options and understand the implications of each
3. Debate with the work group to reach consensus
4. Document the agreement

Preprint Requirements (25 minutes)

Preprint Template



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

Section 42 C.F.R. § 438.6(c) Preprint – January 2021
STATE/TERRITORY ABBREVIATION:
CMS Provided State Directed Payment Identifier:

Section 438.6(c) Preprint

42 C.F.R. § 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 (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) 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 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

- The Preprint template:
  - Includes key decision points and branching logic
  - 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
- 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?

Preprint Sections (1 of 2)

- 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

4. Total dollar amount of this SDP

8. Detailed description of **how** the payment is based on utilization

19. Uniform dollar amount or percentage increase, and magnitude (e.g., $3 or 3%). How the uniform increase will be paid out, how the increase was developed, and why it is reasonable

20. Provider types (IP, OP, BH IP , BH OP), any further definition of those classes (e.g., CAHs); and justifications

27. Data sources and methodology for ACR

28. Description of how the SDP was determined appropriate and reasonable. Not necessarily for WG to write, but to be aware of

Preprint Sections (2 of 2)

- 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 ARRANGEMENT

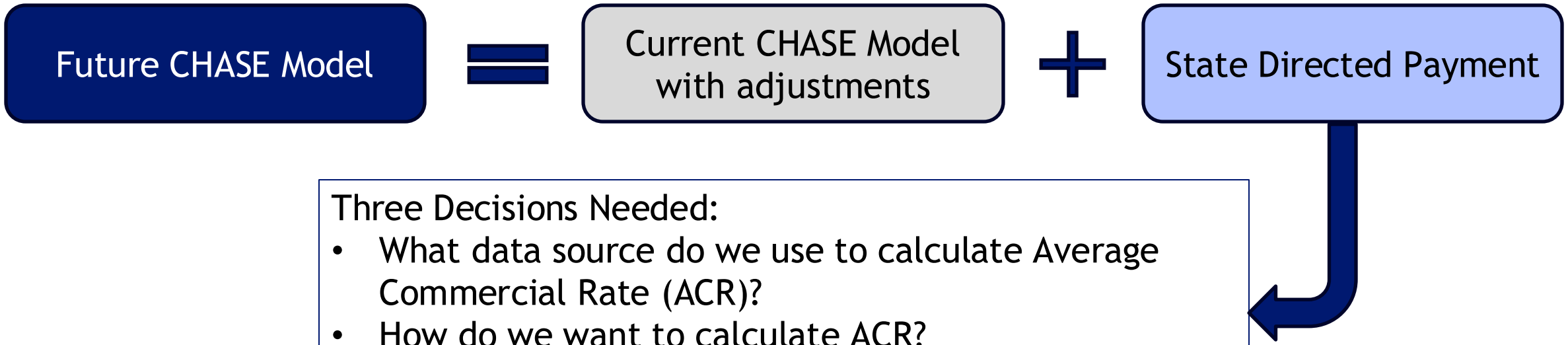
34. Funding for non-federal share (tax, IGT). Name of each entity or entities doing IGTs, total amounts .

36. Provider tax (name; broad based?, uniform?, under the 6% hold harmless limit? Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the taxpayer? Status of tax waiver(s) (under review, approved).

43. Describe how the payment arrangement is expected to advance goals from the state's Quality Strategy plan. Include quality metrics.

State Directed Payment (SDP) Discussion (35 minutes)

New Model


Future CHASE Model
Current CHASE Model with adjustments
State Directed Payment
Three Decisions Needed:
• What data source do we use to calculate Average Commercial Rate (ACR)?
• How do we want to calculate ACR?
• How do we want to design the payment method?

Part 1:
ACR Data Source Recommendation

Use hospital cost reports as the data source to compute the Average Commercial Rate ("ACR")

ACR Data Source Comparison (1 of 2)

CMS asks for the "average of the highest commercial payers by claims volume." There are at least (3) viable sources to feed ACR calculations:

1) Medicare Hospital Cost Reports

These reports are familiar to CMS and publicly-available in HCRIS; latest audited reports are older and unaudited are available from 2023 for all hospitals

2) All-Payers Claims Database

APCD contains claims-level data for 74% of covered lives but does not include majority of self-insured employers

3) Private Commercial Databases

Actuaries and consultants maintain database and can be hired to use this data and/or states can source data and perform calculations themselves

Notes:

1) CMS stated in the Final Rule: "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."
2) Some states have also used surveys of hospitals to obtain data. Typically, the states will verify the survey data with the hospitals' audited financial statements or other supplemental information.

ACR Data Source Comparison (2 of 2)

? Unknown + Positive ● Neutral — Negative

	Rejection Risk (or at least extended negotiations)	High Dollar Capture	Speed to Answer	Human Effort
Option 1: Medicare Hospital Cost Reports* **(RECOMMENDED)**	?	●	+	+
Option 2: APCD Data	+	+	—	—
Option 3: Private Commercial Databases	+	+	—	—

* Further need to assess the viability of utilizing cost reports to calculate ACR for Psychiatric Hospitals

Part 2: Calculating ACR

There are <u>many</u> different ways of calculating ACR.

Per CMS: *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.

CMS states that whatever methodology a state uses, all ACR demonstrations 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.

Part 2: ACR Calculation Options

Examples of ways states have calculated ACR include:

- **Payment-to-Cost Ratio:** 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
- **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

RECOMMENDED: Advocated by CHA & initial draft completed

Challenging for year 1 given data availability and timing

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

Mechanics: ACR Calculation

Payment to Cost Ratio Method--PROPOSED

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.

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

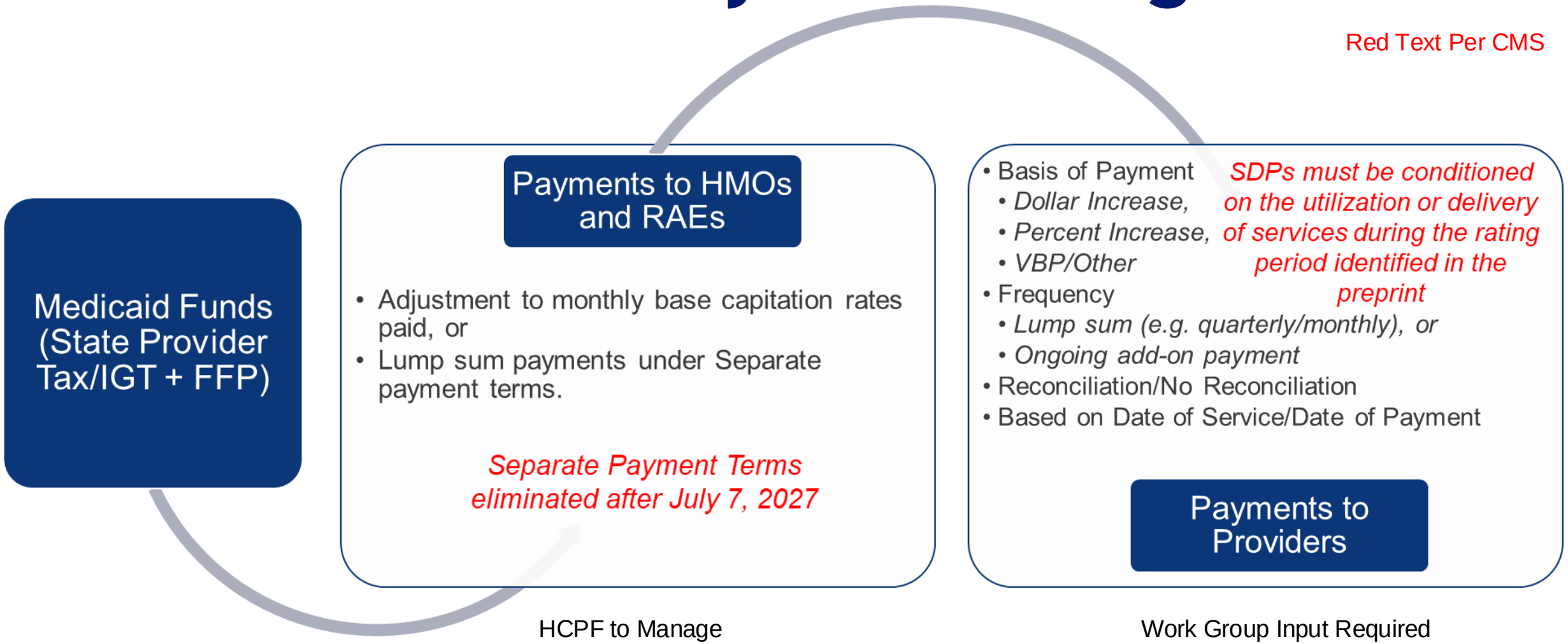
3. Calculate statewide weighted inpatient and outpatient ACR Pay-to-Cost Ratios using each hospital's respective percentage share of statewide commercial revenues as a weighting factor.

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

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

Part 3: Payment Design

Red Text Per CMS



HCPF to Manage

Work Group Input Required

Part 3: Directed Payment Designs (1 of 2)

Value Based Payment (VBP)/Delivery System Reform (DSR):
In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

Fee Schedule Requirements:
In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for providers that provide a particular service; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for providers that provide a particular service.

Part 3: Directed Payment Designs (2 of 2)

VBP/DSR

- Quality Payment/P4P
- Bundled Payment/Episode-Based Payment
- Population-Based Payment/ACO
- Multi Payer Delivery System Reform or Medicaid-Specific Delivery System Reform
- Performance Improvement Initiative or Other VBP Model

Fee Schedule

- Minimum Fee Schedule using rates other than State plan approved rates (42 C.F.R. § 438.6(c)(1)(iii)(B))
- Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
- Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

Recommended

Considerations on the Mechanics

There are operational issues for HCPF to make payments to MCOs/RAEs and for MCOs/RAEs to make payments to hospitals that HCPF must work to resolve:

- Actuarial review & certification
- Increase the amount of claims by a certain $ or %
- Monthly/quarterly payments
- Reconciliations to actual utilization
- Amendments to HCPF's contracts with MCOs/RAEs
- Monitoring & reporting

Per Josh Block: How does the ACR ratio turn into actual payments? What are the mechanics?

Yeah, but what about Quality?

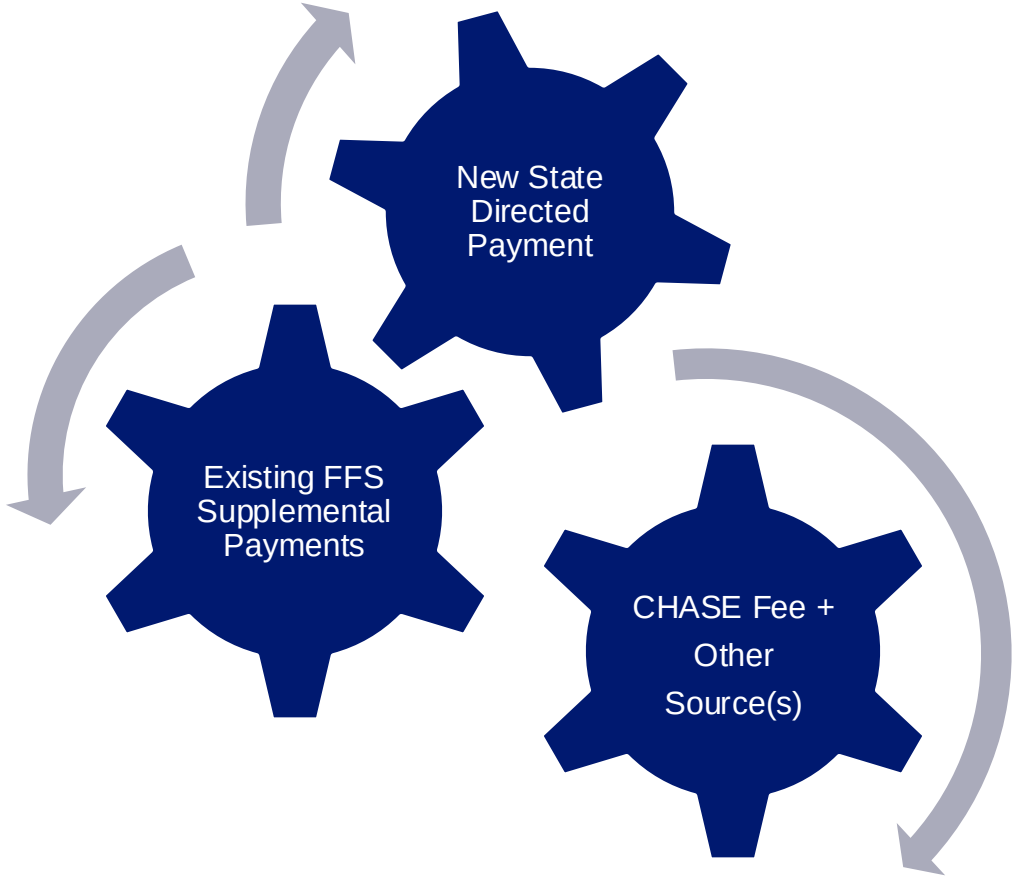
In the absence of a VBP, states are still held to these requirements:

- Publicly post detailed evaluation reports every 3 years for SDPs > 1.5% of MCO payments (rating periods beginning on or after July 9, 2027)
- Must include 2+ metrics tied to State quality strategy
  CMS can deny renewals if no meaningful improvement

For discussion in upcoming WG Meetings

Model Update Requirements (10 minutes)

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.**

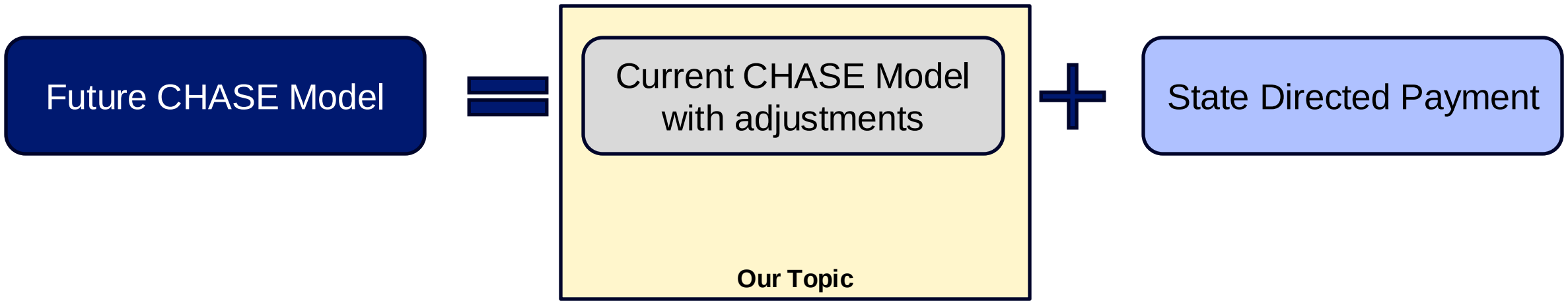
Factors Impacting Funds Available

- 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
Our Topic

Current CHASE Model

- Currently HCPF staff calculating 2024-25 CHASE model
  - Will serve as basis for recommended future CHASE model
  - Some data is historic from COVID-19 public health emergency (PHE) timeframe so newer data needed
  - Plus, end of COVID-19 PHE Medicaid continuous enrollment coupled with increasing utilization means we need most recent Medicaid and CHP+ expansion coverage spending forecast
- Complete
  - Hospital data gathering
  - Net patient revenue calculation
  - Preliminary Disproportionate Share Allotment from CMS
- In Progress
  - Upper payment limits (inpatient and outpatient) calculations
  - Coverage expansion and administrative funding needs
    - Feb. 15th HCPF budget update

2024-25 CHASE Model

Provider Fee from Hospitals

✓ **Complete**: Inpatient and Outpatient Net Patient Revenue

Federal Match from CMS

Cash Fund (Fee + Federal Match)

Increased Payment to Hospitals

✓ **Complete**: DSH Allotment

❑ **In progress**: Upper Payment Limit calculations

Admin./Other

❑ **In progress**: Administrative funding needs

Expanded Coverage to Colorado Citizens

❑ **In progress**: Coverage funding needs

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.

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

Thank you!

Appendix

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?

Appendix: ACR Calculation Methodologies

There are <u>many</u> different ways of calculating ACR. In the hundreds of SDPs that have been approved by CMS over the years, <u>just a few</u> examples are illustrated below from various CMS approved SDPs:

- IP: Medicare payment rate per day compared to Medicaid payment amount per day with and without state directed payment. OP: payment to charge ratio using Medicare cost report data
- The ACR is calculated by determining each provider's top 5 commercial payment per diem multiplied by their respective Medicaid MCO days.
- Medicaid managed care and reimbursement from top five commercial payers used to calculate commercial reimbursement on a per visit and per diem basis for outpatient and inpatient services. Based on data collected from hospitals. FY 2023 MMC Claims adjusted to FY 2025 rating period * Commercial as % Medicaid = Est. Commercial Reimbursement @100%. The ACR is calculated based upon four separate groups, two for inpatient hospitals and two for outpatient hospitals
- Two different sources of hospital specific proprietary data were used to develop ACR percentages with inpatient ACR being approximately 154% of Medicare and outpatient ACR being approximately 192% of Medicare.