Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Initiatives Workgroup

Meeting #5

Wednesday, February 26, 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 (10 minutes)
- Confirm Emerging Consensus, including ACR Elements (10 minutes)
- Provide an Update on Model Development Progress (10 minutes)
- Discuss the Evolution of CHASE (25 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

Let's introduce Scott Humpert who will share an update with the group.

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. PROPOSAL *Pursue Consensus* (see text on upcoming page)

These may be adjusted by the workgroup as situations arise

Confirm Emerging Consensus (10 minutes)

Emerging Consensus (1 of 2)

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)

Emerging Consensus (2 of 2)

We confirmed the ACR data source but didn't actually ask for consensus on the other two ACR elements discussed last time. Let's confirm consensus now.

Dimension	Emerging Consensus
Average Commercial Rate Data Source	Utilize Medicare Hospital Cost Reports as the base data
Average Commercial Rate Calculation	• Recommended using the Payment-to-Cost Ratio method last meeting • Pages available in Appendix if additional discussion is required
Payment Design	• Recommended Uniform Dollar or Percentage Increase method per 42 C.F.R. § 438.6(c)(1)(iii)(C) last meeting because a value-based payment is not practical within the WG's timetable • Pages available in Appendix if additional discussion is required
…	

Confirmed last meeting

Confirm consensus

Proposal for Working Together

Proposed process:

- Continue presenting things in terms of the “likely path” and the “uncertain path”
- Identify interdependencies—which elements/decisions must lead and what may lag
- Debate options to broad consensus, with consensus defined as general agreement; “Even if I don’t 100% agree with it, I can live with it”
- On the dimensions where consensus cannot be reached, the final report should offer space for brief dissenting opinion

→ The ground rule could read: 6. *Pursue Consensus* - workgroup members will explore options, seek to understand different points of view, and seek compromise so that recommendations represent a broad consensus consistent with the work group’s purpose.

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?
  - Josh Block: Has CMS approved preprints that include separate payment terms since the new regulations have been issued (i.e., what has been most recently approved)?
- Future discussions:
  - 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?

Provide an Update on Model Development (10 minutes)

Modeling Progress Update

- Progress on sizing the potential benefit (How large is the pie?)
  - Budget submission on 2/14
  - Will build out a range of potential benefit (all taxpayers v. only participating)
- Progress on the initial ACR calculation
  - HCPF with their consultant, PCG, is developing the ACR based on the payment-to-cost ratio methodology advanced by CHA
  - The group is working to validate the methodology and data feeds to get to an answer that can be shared with the workgroup
- Other in-process work includes
  - Analyzing the encounter data
  - Working to close the gap in psych hospital data

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?

Evolution of CHASE (25 minutes)

New Regulatory Requirements (from Jan 15 mtg)

- Average Commercial Rate (ACR) rate ceiling for hospital state directed payments (rating periods on or after July 9, 2024)
  - CMS will allow total payment rates in a state directed payment up to the ACR for certain services.
  - CMS will impose the ACR as the regulatory limit on the projected total payment rate for IP/OP services.
  - ACR demonstration should be submitted with initial preprint submission and then updated at least every three years

- SDP preprint must be submitted by payment start date (rating periods on or after July 9, 2026)
  - SDP sections of rate certification and MCO contract must be submitted within 120 days after the payment start date
  - No allowance for retro cap changes unless “a material error in the data, assumptions, or methodologies”.

- 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

- Elimination of Separate Payment Terms (after July 9, 2027)
  - Require SDPs to be included in actuarially sound capitation rates

Questions for Consideration

- What is Colorado's appetite for pursuing a short-term opportunity knowing that we will need to adjust the program as available options disappear?
- How willing are we to pursue a design that may be rejected by CMS (stated they are phasing out separate payment terms and reconciliation in April 2024 All-States call)?
- What actions can we take to minimize general fund risk now and in the future?
- What if the other portions of the CHASE model have some unanticipated trends, such as changes to the caseload or utilization in the expansion populations, decreased net patient revenue, etc?

Recent Preprint Approvals

- Shauna promised to follow up with examples of recently-approved preprints and the text related to the applicability date
- This document contains 19 examples of state directed payments approved between May 2024 – January 15, 2025 involving hospitals and other provider types
- PCG took an assignment to research recent preprints and found (9) approvals for *new* state directed payments with hospitals only from June-December 2024
- The new administration has placed a communication hold, and no new preprints have been approved under the new administration

No expectation that you read these

There have been plenty of recent approvals under the current regulation, but none under the current administration.

There may be differences in interpretation and no shortage of speculation.

Proposal: Likely Path for Near-term

- CMS may delay in reviewing our proposal well into the next fiscal year→ This is not uncommon and reconciliation happens often
- CMS may decline this proposal because of 1) the new administration and/or 2) their stated position of phasing out separate payment terms from the State to the MCO/RAEs
- The known rule changes effective for rating periods beginning on or after July 9, 2027 (approximately FY 2029; begin ~July 1, 2028)
  - Separate payment terms→ We will need to move to upgraded rates or a value-based payment
  - Prohibits post-payment reconciliation on actual utilization → this represents an increased risk to the general fund v. our current design

  → PROPOSAL: Pursue separate payment terms in the near term (~3 years) AND advise the CHASE Board to continue evolution discussions to accommodate these two changes
- Even in the near-term, we must always design to avoid General Fund risk and risks to the existing CHASE model (…and there are strategies we could use)

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 1: WG Questions

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

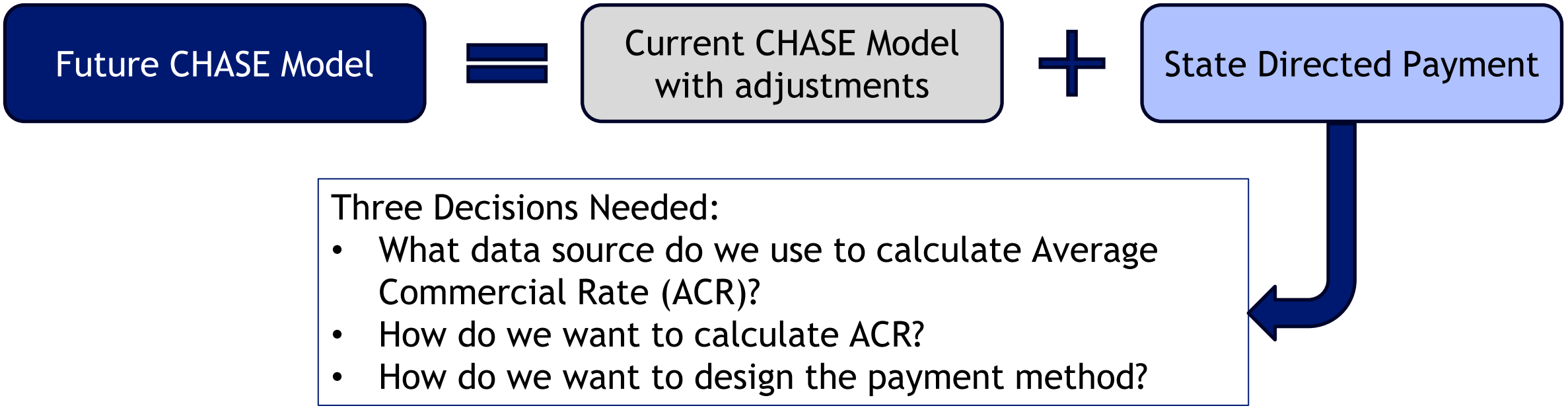
Workgroup Objectives and Key Questions (2 of 2)

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 2: ACR Slides from 2/12

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?

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

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

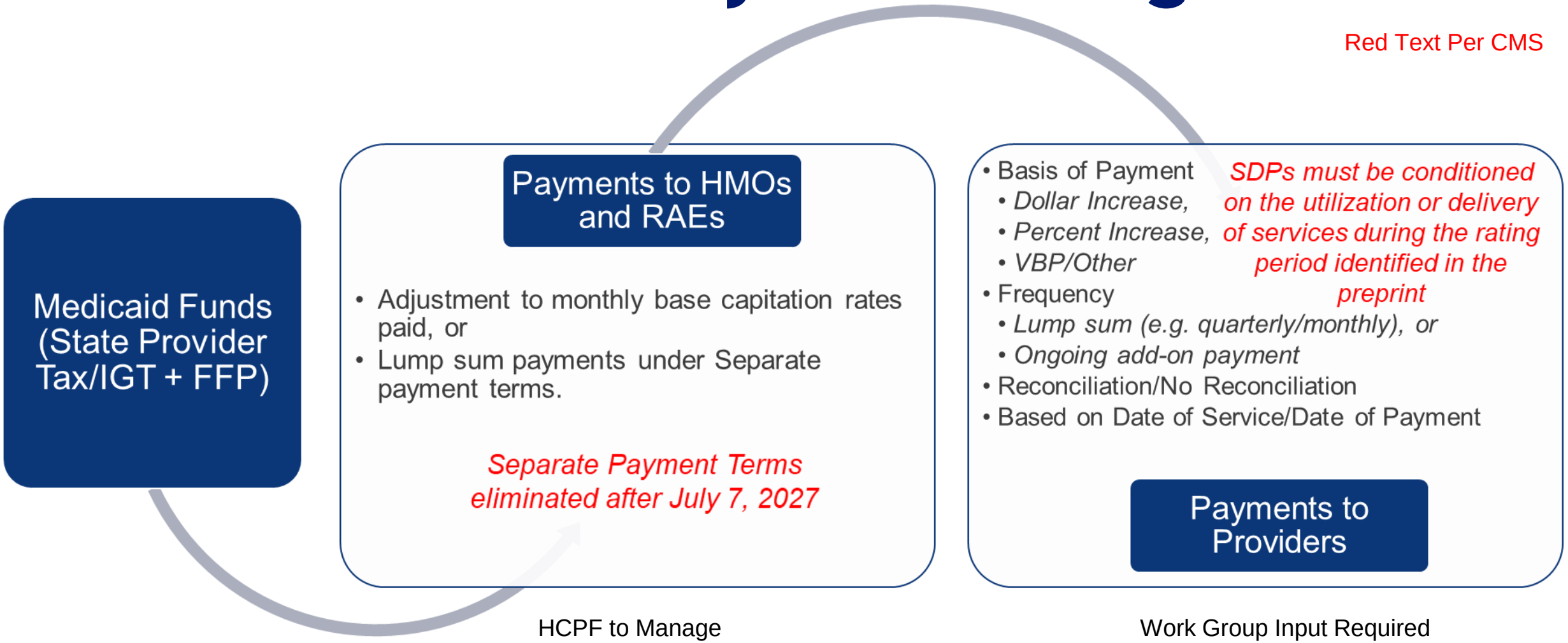
RECOMMENDED: Advocated by CHA & initial draft completed

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

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

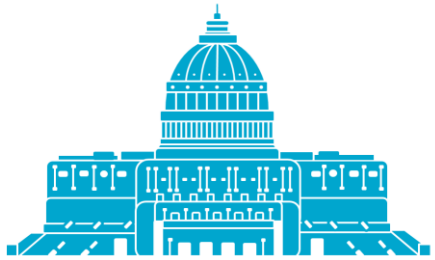
Fee Schedule

- 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

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)

Appendix 3: Slides from CMS All-States Call on April 30, 2024

State Directed Payments (1 of 6)

Background

- State directed payments (SDPs) are contractual obligations that enable states to direct Medicaid managed care plans' expenditures for services under the contract.
- SDPs have become a significant payment method for states, accounting for more than $52 billion annually across 39 states.[1]
- SDPs allow states to take a more proactive role in directing managed care plans towards key policy and delivery system investments. However, some SDPs are correlated with financing challenges.

1: Regulatory Impact Analysis in Medicaid and CHIP Access, Finance, and Quality final rule

State Directed Payments (2 of 6)

1. Reduce state burden by implementing appropriate flexibilities for SDPs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
CMS approval of a preprint was required	Eliminate the need for CMS approval of a preprint for SDPs that are minimum fee schedules at 100 percent of Medicare. [42 CFR § 438.6(c)(2)(i) and § 438.6(c)(1)(iii)(B)]	None	July 9, 2024
SDPs for value-based purchasing must be based on utilization and delivery of services during the rating period only	Eliminate unnecessary regulatory limitations on value-based purchasing arrangements to enable states to more easily link SDP payments to quality metrics and other performance-based data while ensuring payments are tied to actual performance and not reporting only. [42 CFR § 438.6(c)(2)(vi)]	None	Applicability date varies with some provisions aligned with effective date
Fee schedule based SDPs are not allowed for non-network providers	Allow states to utilize SDPs for non-network providers to ensure access to care that is often provided by non-network providers, such as family planning services. [42 CFR § 438.6(c)(1)(iii)]	None	July 9, 2024

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State Directed Payments (3 of 6)

2. Strengthen fiscal and program integrity for SDPs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
No prior regulation, but this provision reflects existing standards in statute, regulation, and prior rulemaking	Ensure that existing requirements for allowable sources of non-federal share are explicitly applied to SDPs, and noting CMS may disapprove and take enforcement action on SDPs that do not comply with non-federal share financing requirements. [42 CFR § 438.6(c)(2)(ii)(G)]	None	July 9, 2024
None	Require states to ensure that providers attest that they do not participate in a hold harmless arrangement, as defined by statute and regulation. [42 CFR § 438.6(c)(2)(ii)(H)(*1*)] Require states provide such attestations upon request, or a satisfactory explanation about why attestation(s) are unavailable. [42 CFR § 438.6(c)(2)(ii)(H)(*2*)]	Revised the applicability date Added language allowing states the opportunity to explain why a provider did not attest	First rating period beginning on or after January 1, 2028

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State Directed Payments (4 of 6)

2. Strengthen fiscal and program integrity for SDPs (cont.).

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
No regulatory ceiling but this is consistent with operational practice	Establish a payment rate ceiling at the average commercial rate (ACR) for hospital services, nursing facility services, and qualified practitioner services furnished at academic medical centers. [42 CFR § 438.6(c)(2)(iii)]	None	First rating period beginning on or after July 9, 2024
Allows post-payment reconciliation processes	Require states to condition fee schedule based SDPs on actual utilization during the rating period and prohibit post-payment reconciliation processes that initially condition payment on historical utilization outside the rating period. [42 CFR § 438.6(c)(2)(vii)]	Revise the applicability date to allow states additional time to make the necessary operational changes (initially proposed 2 years)	First rating period beginning on or after July 9, 2027

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State Directed Payments (5 of 6)

2. Strengthen fiscal and program integrity for SDPs (cont.).

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
Allow separate payment terms with required documentation	Require SDPs to be included in actuarially sound capitation rates (i.e., prohibit use of separate payment terms). [42 CFR § 438.6(c)(6)]	This was an option considered that was finalized	First rating period beginning on or after July 9, 2027
Require submission of preprint prior to the end of the rating period	Establish submission timeframes for all SDP preprints to require submission before the start date of the SDP or the start date of the amendment. [42 CFR § 438.6(c)(2)(viii)]	Simplify the submission timing requirements	First rating period beginning on or after July 9, 2026
None	Establish submission timeframes for documentation of SDPs in rate certifications and managed care plan contracts to require submission no later than 120 days after the start date of the SDP. [42 CFR §§ 438.6(c)(5)(v) and 438.7(c)(6)]	Simplify the submission timing requirements	First rating period beginning on or after July 10, 2028

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State Directed Payments (6 of 6)

3. Enhance evaluation and reporting of SDPs.

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Applicability Date
States were required to include an evaluation plan as part of SDP submission	Strengthen evaluation requirements for SDPs, require states with SDP spending above 1.5% of total capitation payments to submit evaluation results to CMS, and post these evaluation results publicly. [42 CFR §§ 438.6(c)(2)(ii)(D) and (F), 438.6(c)(2)(iv) and (v), and 438.6(c)(7)]	Require all states to provide an evaluation report upon CMS request	First rating period beginning on or after July 9, 2027
No regulatory requirement to capture SDP actual spending separately, but expect data to be included in the Transformed Medicaid Statistical Information System (TMSIS) in enrollee encounter data paid amounts	Require provider level reporting on actual SDP expenditures in TMSIS. [42 CFR § 438.6(c)(4))]	Require reporting one year after each rating period to allow additional time for claims runout and data validation (initially proposed 180 days)	No later than the date specified in the T-MSIS reporting instructions released by CMS

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