Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Initiatives Workgroup

Meeting #7

Wednesday, April 9, 2025

12:00 – 1:30 p.m.

Facilitated by:

Government Performance Solutions, Inc. (GPS)

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Virtual meeting guidelines

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

This meeting is being recorded!

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

Put your computer microphones (or phone) on mute

Use the chat feature to share ideas and ask questions

Click the Live Transcript icon at the bottom of your screen

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

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

CHASE Workgroup Objective

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

CHASE Program Objectives

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

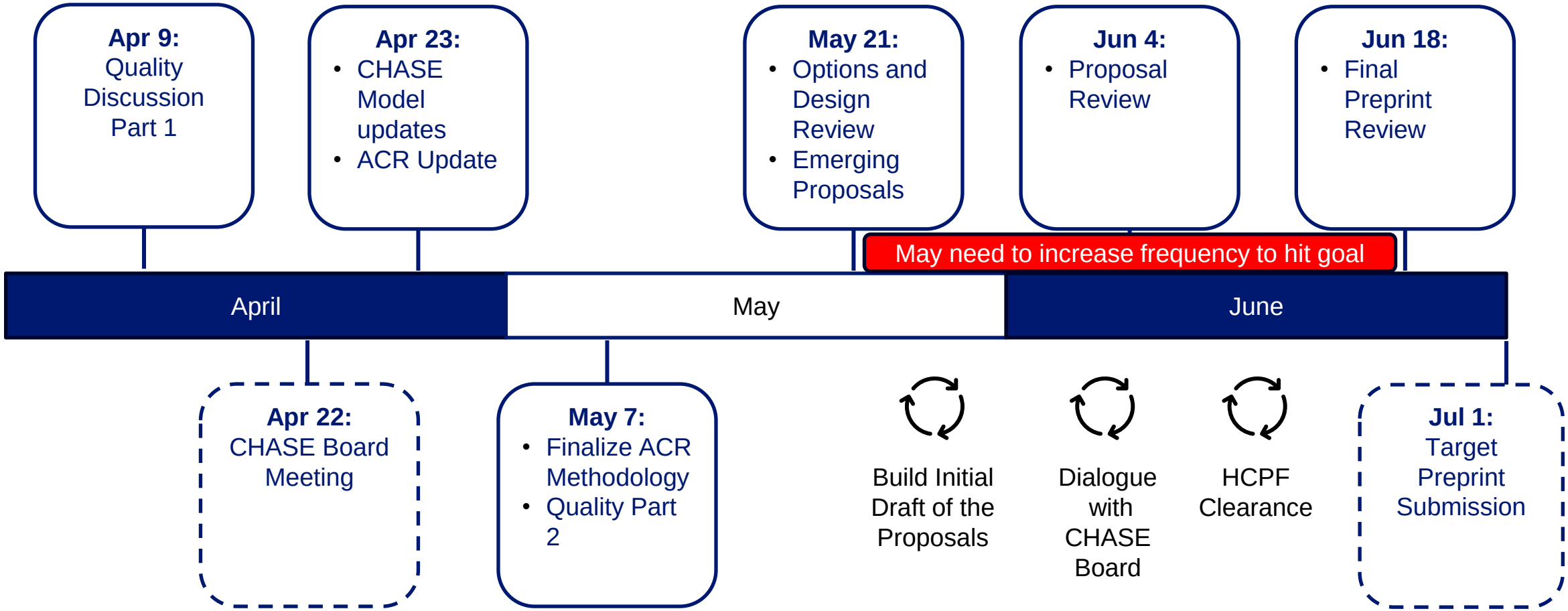
- Maximize reimbursement to hospitals for care for Medicaid members and uninsured patients subject to federal limits
- Increase the number of hospitals benefitting from the CHASE fee and minimize those hospitals that suffer losses.
- Support improvements in the quality of hospital care
- Support the expanded health care coverage for the Medicaid and CHP+ programs

Agenda

- Plan for this Meeting and Upcoming Meetings (15 minutes)
- Quality Metrics and the Impact on Other Quality Programs (30 minutes)
- Continued Discussion of ACR Methods (20 minutes)
- Options for Going Forward (20 minutes)
- Questions and Next Steps (5 minutes)

Welcome, Matt Haynes (HCPF) and Michael Joseph (PCG)

Upcoming Meetings



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.
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

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
…	

Ongoing discussion

Revisit at an upcoming 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?
- 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?

Any other current events or environmental updates?

Quality Metrics and the Impact on Other Quality Programs (30 minutes)

Section 7 Quality Criteria and Framework

- Review of required elements
- Principles in quality measure selection
- Colorado CMS Medicaid & Children's Health Insurance Plan (CHIP) Managed Care Quality Strategy
- Next Steps

Section 7 Quality Criteria and Framework for All Payment Arrangements

- #42 - To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy.
- Table 7 input the goal, objective and page number they can be found in the quality strategy
- #43 - Describe how the payment arrangement is expected to advance the goals and objectives identified in Table 7
- #44 - The state must have an evaluation plan which measures how the payment arrangement advances the goals and objectives in the quality strategy, but this does not have to be described in the preprint
- Table 8 List the quality measures, baseline data and performance targets

Setting Expectations for the Quality Framework

IS:

- Intended to demonstrate that the payment arrangement advance a goal of the quality strategy
- Expected to start upon submission (not approval)
- Able to be amended in future years

IS NOT:

- Not a pay-for-performance situation
- Does not determine how funds are distributed

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

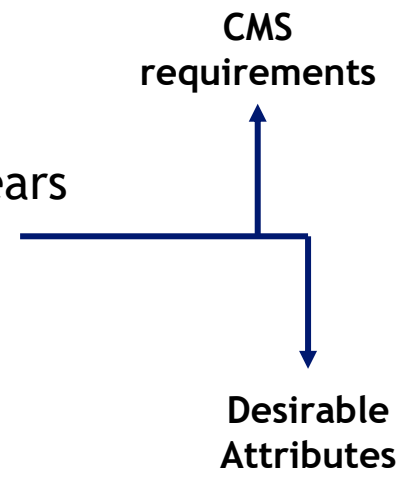
Goals	Objectives	Quality Strategy Page
Example: Improve Care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*Example: 5* *Refers to the page in the CO Managed Care Quality Strategy; make it easy to find*

Table 8: Evaluation Measures, Baseline and Performance Targets

Measure Name	Baseline Year	Baseline Statistic	Performance Target	Notes
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Example: Increase the percentage of adults 18-64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	

Principles in Quality Measure Selection

- Map to goals and objectives in quality strategy
- Be able to be used in the state's evaluation plan to measure the degree to which the payment advances one of the goals
- Based on existing validated measures (CMS preference)
- Data available for MCO and FFS populations to calculate baseline rates and future years
- Include the majority of hospitals and providers in this payment arrangement
- Align with other quality measures and programs
- Limit impact to provider administrative burden
- Have room for improvement
- Has been supported by CMS in other SDP programs
- Quality measures may be added and/or amended in future years



From Draft 2024 CO Quality Strategy

Colorado Quality Strategy

Strategic Pillars - HCPF manages projects under several pillars to achieve Executive Leadership Team individual goals and Department goals, Governor's WIGs and the Health Cabinet WIGs.

- Member Health: Improve quality of care and member health outcomes while reducing disparities in care.
- Care Access: Improve member access to affordable, high-quality care.
- Operational Excellence and Customer Service: Provide excellent service to members, providers and partners with compliant, efficient, effective person- and family-centered practices.
- Health First Colorado Value: Ensure the right services, at the right place and the right price.
- Affordability Leadership: Reduce the cost of health care in Colorado to save people money on health care.

Colorado Quality Strategy - Pillars and Priorities

Member Health	Care Access	Operational & Service Excellence	Health First Colorado Value	Affordability Leadership
*Support health related social needs like housing and food security *Transform behavioral health and improve care for high acuity children and youth *Improve health equity in prevention, maternity care, behavioral health *Improve child/youth immunizations and prenatal care	*Keep Coloradoans covered *Expand coverage (1115, Cover All Coloradoans) *Protect member coverage, benefits, and services * Expand provider network, incl. behavioral health, specialists, rural, dental *Regularly review provider reimbursement rates to ensure access to care *Transform HCBS services for people with disabilities	*Improve eligibility systems, experience, county workload, automation, letter clarity *Resource counties *Stabilize LTSS ecosystem for people with disabilities *Drive service quality across all partners (calls/claims) *Innovate systems; smoothly implement system changes; bolster cyber security *Maximize and close-out ARPA funding	*Address Medicaid costs and trends *Modernize Medicaid delivery system through ACC Phase III *Advance value-based payments to drive quality, equity, access, and affordability *Right care, right time, right place, right price *Ensure appropriate Medicaid payments balancing provider admin *Prevent avoidable ER visits and hospital care	*Manage within difficult state budget limitations *Reduce uninsured rate *Mitigate rising pharmacy cost trends *Increase hospital affordability and price transparency (tools, reports, and policies) *Drive innovation (eConsults, Prescriber Tools, SHIE, cost and quality indicators) *Lead value-based payments across payers

Next Steps

- Review Quality Strategy – Pillars and Priorities

  Note: goals and objectives are not the structure of the Colorado Quality Strategy, rather it is Pillars and Priorities

- Agree on measure selection principles
- Upcoming dialogue:
  - HCPF to identify available quality measures that map to goals and objectives in quality strategy *(your engagement welcome!)*
  - WG to evaluate measures based on selection criteria
  - WG to select measure(s) for preprint

Today

Continued Discussion of ACR Methods (20 minutes)

ACR Weighting Discussion (1 of 2)

- During 3/26 Meeting:
  - We reviewed the weighting options that are available based on the cost reports
  - We acknowledged that the underlying data is “all over the place”
- After 3/26 Meeting:
  - Distributed the spreadsheet shared by Scott from PCG
  - Shared links to (3) sources for the ACR reference points:
    a. CIVHC: https://civhc.org/get-data/public-data/focus-areas/reference-pricing/
    b. RAND: https://www.rand.org/health-care/projects/hospital-pricing/round5.html
    c. HCPF: https://hcpf.colorado.gov/HospitalPriceTransparencyTool
- As pre-reading: Shared Price Transparency, shared Breakeven Analysis, and Payment Variation and posted under "Hospital Tools" at https://hcpf.colorado.gov/hospital-reports-hub

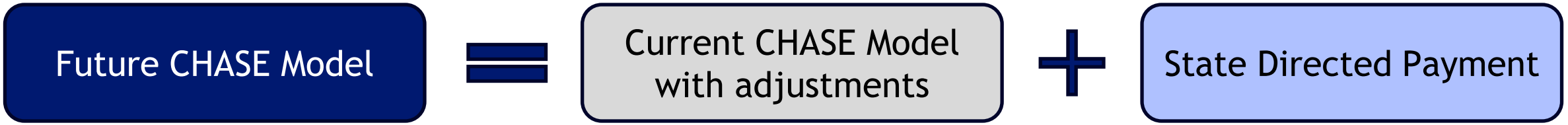
ACR Weighting Discussion (2 of 2)

Path to Identifying ACR Method:

- Review all available sources
- Determine which are most reasonable
- Align on weighting
- Propose a method to this group

Options for Going Forward (20 minutes)

Important Considerations



- Because we believe there may not be much fee available, continue to pursue discussions of which public hospitals are willing and able to engage in IGTs, and for what amounts
- Describe how the payment arrangement advances goals of the state's Quality Strategy Plan (Reminder: CMS requires that SDPs promote quality of care and access to care for Medicaid members)
- Begin to look at adjustments to the existing CHASE methodology—fees, reducing DSH, supplemental payments, adjusting the FFS v. Managed Care split
- Define scenarios to feed into the model so the group understands which hospitals may benefit and how much (e.g., rural hospitals, etc.)

Options for Going Forward

GPS sees at least (3) options for how the group can move forward:

1. **Continue Working Under the Current Timeline:** Work on a near-term set of recommendations and propose that the CHASE Board also pursue a long-term option including value-based payments and potentially other data sources.
2. **Request a Timeline Change:** Go back to the CHASE Board, sharing that we are not able to complete the assigned task within the time offered and propose a new timeline. This option could include a later submission but an effective date of July 1.
3. **Narrow the Focus:** Accept that the size of the program steers us toward a focused set of beneficiaries.

Pro-Con Analysis

1 Continue Working Under the Current Timeline

Pros:
- Maximizes the near-term revenue to support the CHASE program goals
- Learn lessons by operating an SDP
- …

Cons:
- May be unintended consequences that would be uncovered with more time
- …

2 Request a Timeline Change

Pros:
- Avoids hasty policy
- May allow for some uncertainly to resolve
- …

Cons:
- Forgoes near-term revenue to support the CHASE program goals
- …

3 Narrow Program

Pros:
- Learn lessons by operating an SDP
- Focused roll-out could be less burdensome on hospitals
- …

Cons:
- No funding flow to some hospitals that may be been expecting it
- CMS may consider amendments differently than renewals (or parallel mgt)
- …

Questions?

Next Steps and Actions

- GPS to share meeting notes with decisions and actions.
- Engage with CHASE Board to:
  - Provide progress update
  - Review options for moving forward
  - Schedule additional sessions with them as needed
- 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

Appendix: Select Slides from Prior Meetings

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?

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   

ACR Weighting Options

		Inpatient		Outpatient		Total
Method		**ACR %**	**SDP $**	**ACR %**	**SDP $**	**SDP $**
Weighting based on <u>commercial cost</u> (HCPF's preference): • Results in the market average commercial pay-to-cost ratio	w/o psych hospitals	154%	*$53.1m*	221%	*$75.9m*	***$128.9m***
	w/ psych hospitals	153%	*$77.9m*	221%	*$81.1m*	***$158.9m***
Weighting based on <u>commercial revenues</u> (CHA's preference): • Influenced by commercial market fee schedules	w/o psych hospitals	201%	*$98.0m*	282%	*$114.5m*	***$212.5m***
	w/ psych hospitals	199%	*$145.0m*	282%	*$122.4m*	***$267.4m***
Weighting based on <u>Medicaid costs</u> (not preferred) • More appropriately reflects Medicaid MCO volume by hospital • Total SDP for acute care hospitals reduces to $84.0m when psych hospitals are included	w/o psych hospitals	156%	*$54.1m*	175%	*$46.8m*	***$100.9m***
	w/ psych hospitals	140%	*$58.7m*	172%	*$48.3m*	***$107.1m***