Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Initiatives Workgroup

Meeting #9

Wednesday, May 7, 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:

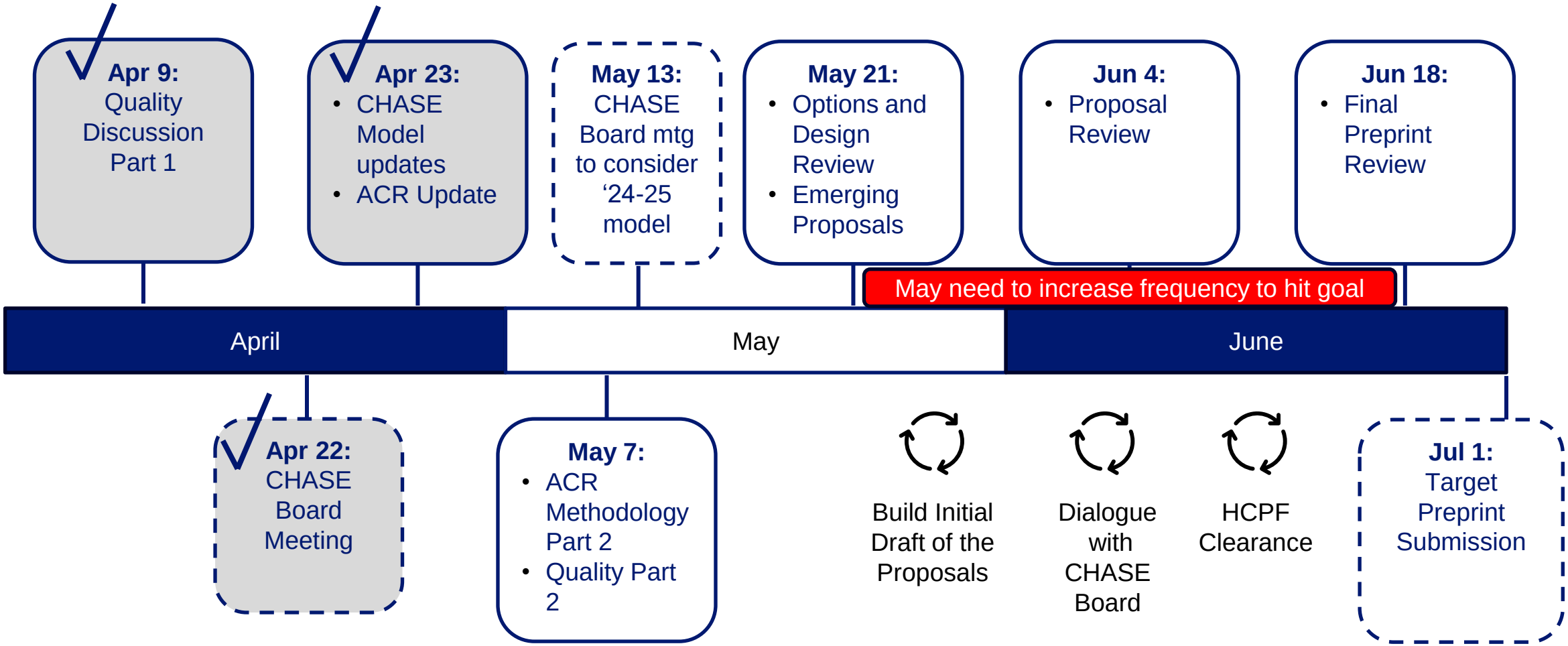
- Maximize reimbursement to hospitals for care for Medicaid members and uninsured patients subject to federal limits
- Increase the number of hospitals benefitting from the CHASE fee and minimize those hospitals that suffer losses.
- Support improvements in the quality of hospital care
- Support the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

Agenda

- Plan for this Meeting and Upcoming Meetings (10 minutes)
- ACR Methodology (15 minutes)
- Quality Measures (45 minutes)
- Questions and Next Steps (5 minutes)

Subject to CHASE Board Discussion

Planned 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

Charter Directives

Workgroup Objectives and Key Questions (1 of 2)

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

Key Questions:

- How does the recommendation(s) align with the goals of the CHASE Program as outlined in statute?
  - Maximize reimbursement to hospitals for care for Medicaid members and uninsured patients subject to federal limits
  - Increase the number of hospitals benefitting from the CHASE fee and minimize those hospitals that suffer losses
  - Support improvements in the quality of hospital care
  - Support the expanded health care coverage for the Medicaid and CHP+ programs

Charter Directives

Workgroup Objectives and Key Questions (2 of 2)

Key Questions (continued):

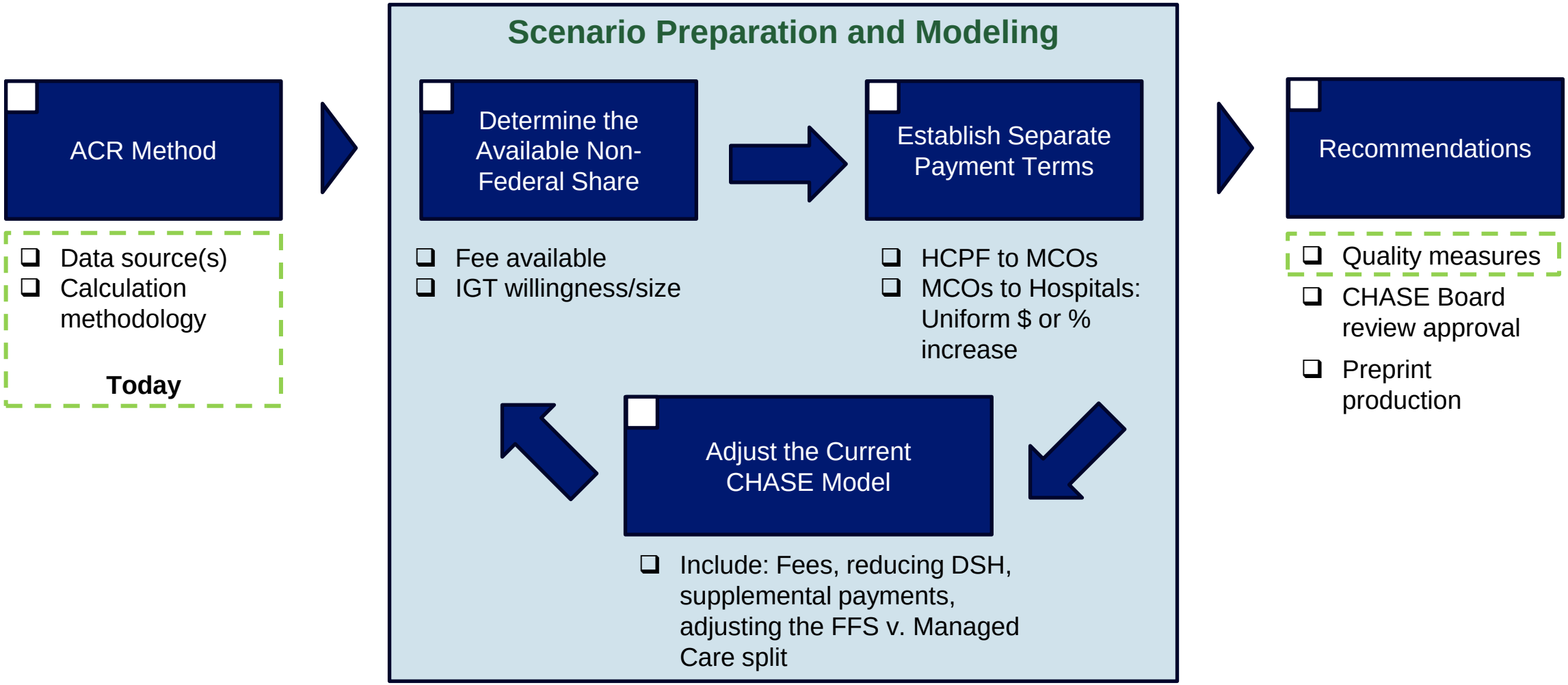
- Is legislation and/or changes to state regulations necessary to implement the recommendations?
- How do the recommendations align with federal requirements?
  - Are there any emerging or enacted changes to federal requirements that may affect these recommendations?
- What are the impacts on the CHASE program?
  - How do the net gains (losses) for hospitals compare to the CHASE status quo?
  - Is there any increased risk to expansion populations' health care coverage due to insufficient fees?
- What are the available funding source(s)?
- What are the different types of SDP and which best meet the workgroup's objective?
- Which services and provider types should be included in the SDP?

Progress Update

The workgroup has met (7) times and reached consensus on several dimensions:

Dimension	Emerging Consensus
Overall Methodology	• Revise existing UPL supplemental payments to simplify payment calcs and tie to utilization • Simplify to the degree possible, but this is a secondary goal
Services	Include both inpatient and outpatient services
Hospital Types	Include general, acute care and Critical Access Hospitals, and psychiatric hospitals
Funding Sources	• Assume that an IGT is a permissible funding source; will not trigger TABOR • Replace some federal DSH funds with additional safety net hospital reimbursement
Funding Priorities	• Preserve funding to Critical Access Hospitals • Support hospitals with high volume of Medicaid care (i.e., safety net)
Quality Principles	Aligned on 10 quality principles aligned with Colorado's Managed Care Quality strategy to guide measure selection

Upcoming Workgroup Deliberations



Maintain a running list

Open Questions/Assignments

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

- Alison Sbrana: Can we get some info on how many psych hospitals, how many rehab and LTC hospitals etc., we are talking about who are being currently excluded and may benefit? Or some more info on pros/cons of including them?
- Alison Sbrana: Commercial payers don't pay as much for behavioral health and Medicaid/Medicare payers pay more? Do we need to factor this in?
- Josh Block: What is the sequence and timeline for related activities that must follow the preprint submission (e.g., contract development and rate setting that also need CMS approval, reporting requirements for MCOs incorporated into contracts, timeline reviews for payments, frequency of payments, etc.)?

Environmental Update: HB25-1213 with the SDP amendment

- Technical amendment that:
  - Allows the CHASE fund to receive Intergovernmental Transfers (IGT) and
  - Directs CHASE to seek federal approval of an SDP in cooperation with HCPF hospitals
- Passed by both chambers, now pending Governor's signature

Any other current events or environmental updates?

ACR Methodology (15 minutes)

Recall…

- Balance fulfillment of additional federal dollars in our target timeline with an approach that produces appropriate and reasonable results
- The Average Commercial Rate represents the revenue hospitals would have received if the Medicaid MCO enrollees were covered by commercial insurers
- The total State Directed Payment is the difference between hospital revenue determined from ACR and the actual Medicaid MCO revenue
- There are several different ways to calculate ACR and the ACR subgroup has been meeting to sort through the different Commercial and Medicaid reference points
    - RAND hospital pricing, CIVHC reference pricing, HCPF breakeven tool
- The subgroup is exploring methodologies to arrive at an Average Commercial Rate using a payment-to-cost approach from the Hospital Cost Reports

ACR Subgroup Progress: Inputs and References

- ✓ Cost Reports
- ✓ Managed Care revenues, days, and discharges from Cost Reports and hospital financial reporting to HCPF
- ✓ Reference points: CIVHC, RAND, HCPF Breakeven Tool
- ❒ Medicaid MCO encounter data
- ❒ Psychiatric hospital Cost Reports, supplemental data

ACR Subgroup Progress: Approach

- ✓ Payment-to-cost ratio using Cost Reports as basis
- ✓ Weighting options: costs, revenues, volume (i.e., days/discharges)
- ✓ Medicaid encounter data preferred source for Medicaid MCO costs and base payment data
- ✓ Calculation of possible State Directed Payment amount
  - Medicaid MCO costs = Medicaid MCO billed charges x cost-to-charge ratio
  - Total ACR = Weighted payment-to-cost ratio x Medicaid MCO costs
  - Maximize SDP = Total ACR – Medicaid MCO base payments
- ✓ Separate ACR calculation for psychiatric hospitals

ACR Subgroup: What's Next

- ❒ Continue refining encounter data and working with hospitals on variances
- ❒ Gather outstanding Psychiatric Hospital data and explore separate ACR methodology options using best sources available
- ❒ Prepare distribution modeling options for Workgroup review
- ❒ Make a final recommendation based on how the Directed Payment interacts with the rest of the CHASE model
- ❒ Throughout: monitor CMS's decisions over the next 30-60 days including preprint submissions/approvals

Quality Measures (45 minutes)

Recap: Section 7 Quality Criteria & 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

Recap: 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

Process for Selecting Measures

Subgroup members:
Annie Lee, Dr. Kim Jackson, Alison Sbrana, Emily King, Matt Haynes

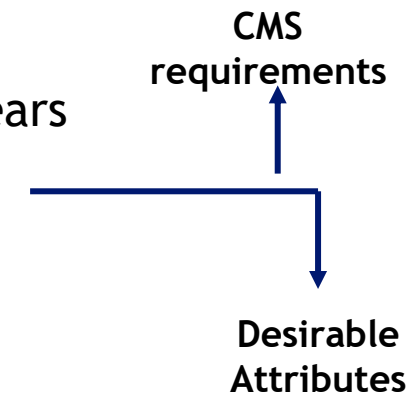
- Review Quality Strategy – Pillars and Priorities
- Agree on measure selection principles

4/9

- Process:
  - HCPF provided a list of measures that map to the principles established by the WG, some in other states' SDPs and some not
  - Subgroup evaluated potential measures v. the 10 principles and refined the list to 6 measures they endorse for inclusion in the SDP
  - WG now must select measure(s) for preprint

Ten Principles in Quality Measure Selection

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



Reminder: Must have at least two measures, one of which must be an outcome measure.

Potential Quality Measures v. Criteria

Measure Name	Principles Met	Challenges v. Criteria	Notes
30-day all-cause Readmissions (HEDIS)	9/10	Have not quantified room for improvement	It is an outcome measure and there are many pathways hospitals can work on to improve performance. It is included in ACC III
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	9/10	Have not quantified room for improvement	It is included in ACC III
Follow-Up After Emergency Department Visit for Substance Use (FUA)	9/10	Have not quantified room for improvement	It is included in ACC III
Follow-Up After Hospitalization for Mental Illness (FUH)	9/10	Have not quantified room for improvement	It is included in ACC III; relevant to psychiatric inpatient facilities
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	7/10	Data is not currently being collected/reported Not identified in other SDP Potential additional reporting requirement	This measure is not something that hospitals are currently working on, as such this measure will likely have room for improvement.
Social Need Screening and Intervention-HEDIS (SNS-E)	7/10	Data is not currently being collected/reported Not identified in other SDP Potential additional reporting requirement	Implementing this measure would provide more complete data than is currently being collected on this topic through HTP or ACC III.

Discussion Questions

Let’s talk through the options on the previous page using these questions:

- How comfortable are you that any/all of these measures improve hospital care?
- Do we want to have different measures for different hospital types?
- What risks do these measures represent, if any?
- What are the challenges to implementing any/all of these measures?

Next Steps for Quality Measures

- ❑ Determine data flows between Hospitals, MCOs, and HCPF (this *may* be part of the managed care contracting discussions)
- ❑ Finalize the mapping of selected measures to the Pillars (goals) and Priorities (objectives) in preparation for the preprint submission
- ❑ Document which of the measures we could pursue over time as amendments are made and/or we move to a value-based model

Questions?

Reminders

- Draft 2024-25 CHASE Model to be considered during the May 13, 2025 CHASE Board meeting
  - Posted on Board's web page May 5th

- CHASE Model Q&A Webinar on May 8, 2025, from 9:00-9:45 am
  - Registration
  - No more than one Board member may attend

Next Steps and Actions

- GPS to share meeting notes with decisions and actions.
- Small group work will continue where necessary and tap 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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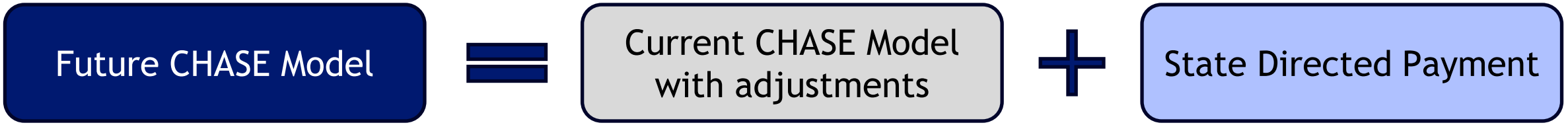
.Appendix: Slides from Past Meetings for Reference Only

Important Considerations



- Because we know there is limited 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.)

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*	

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