CHASE Board Meeting

May 13, 2025

Nancy Dolson
Department of Health Care Policy & Financing (HCPF)

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Our Mission

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Thank You Departing Board Members

- Jon Alford
- Matt Colussi
- George Lyford

HCPF Updates

Federal Budget Picture

- House Energy & Commerce Committee's reconciliation recommendations
  - Summary Memo
  - Health legislative text
- CHASE related
  - State Directed Payments limited to Medicare published rates instead of average commercial rate
  - Moratorium on new provider fees or increases to existing fees; tightening uniform requirements
  - Work requirements for non exempt adults
  - 6 month redetermination for expansion adults
- Mark up in committee today
- This draft will change

CMS Proposed Rule

- CMS-2448-P
  - Proposed rule to be published May 15th
  - Press release
  - Fact sheet
  - Public comment will be open until July 14, 2025
- Per CMS, the proposed rule would:
  - Prohibit states from assessing fees on Medicaid business at higher rates than non-Medicaid business;
  - Bar the use of vague language to disguise Medicaid-specific fees;
  - Maintain statistical testing while adding safeguards to prevent system gaming; and
  - Provide a transition timeline based on the age of existing waivers.

State Legislation and Budget

- ☑ SB25-206 Long Bill
  - 1.6% provider rate increase
  - 1.5% HCPF personal services *decrease*
- ☑ HB25-1213 Updates to Medicaid (SDP/IGT CHASE authority)
- ☑ SB25-166 Health-Care Workplace Violence Incentive Payments
  - HQIP metric and stakeholder engagement
- ☑ SB25-078 Nonprofit Hospitals Collaborative Agreements
- ☑ SB25-228 Enterprise Disability Buy-In Premiums
- ☑ SB25-270 Enterprise Nursing Facility Provider Fees
- ☑ SB25-290 Stabilization Payments for Safety Net Providers

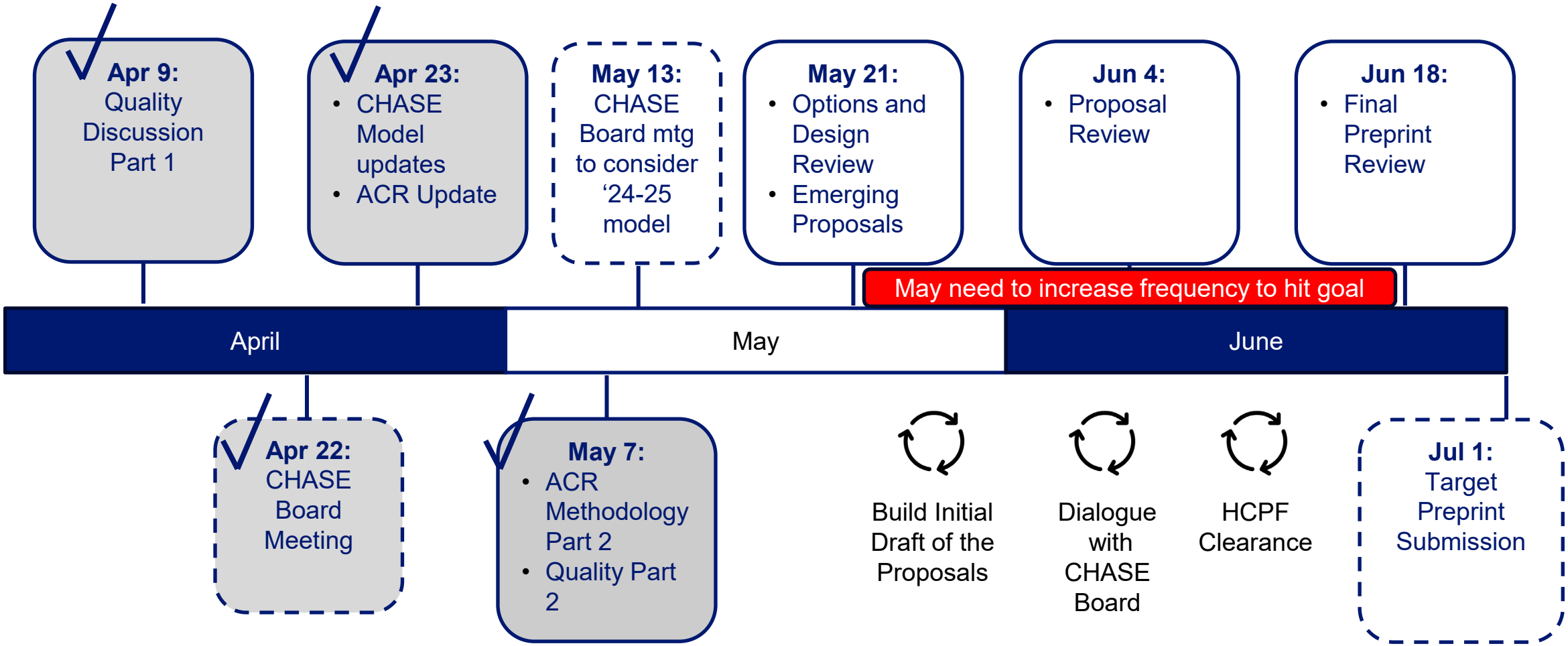
CHASE Workgroup Progress Update

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

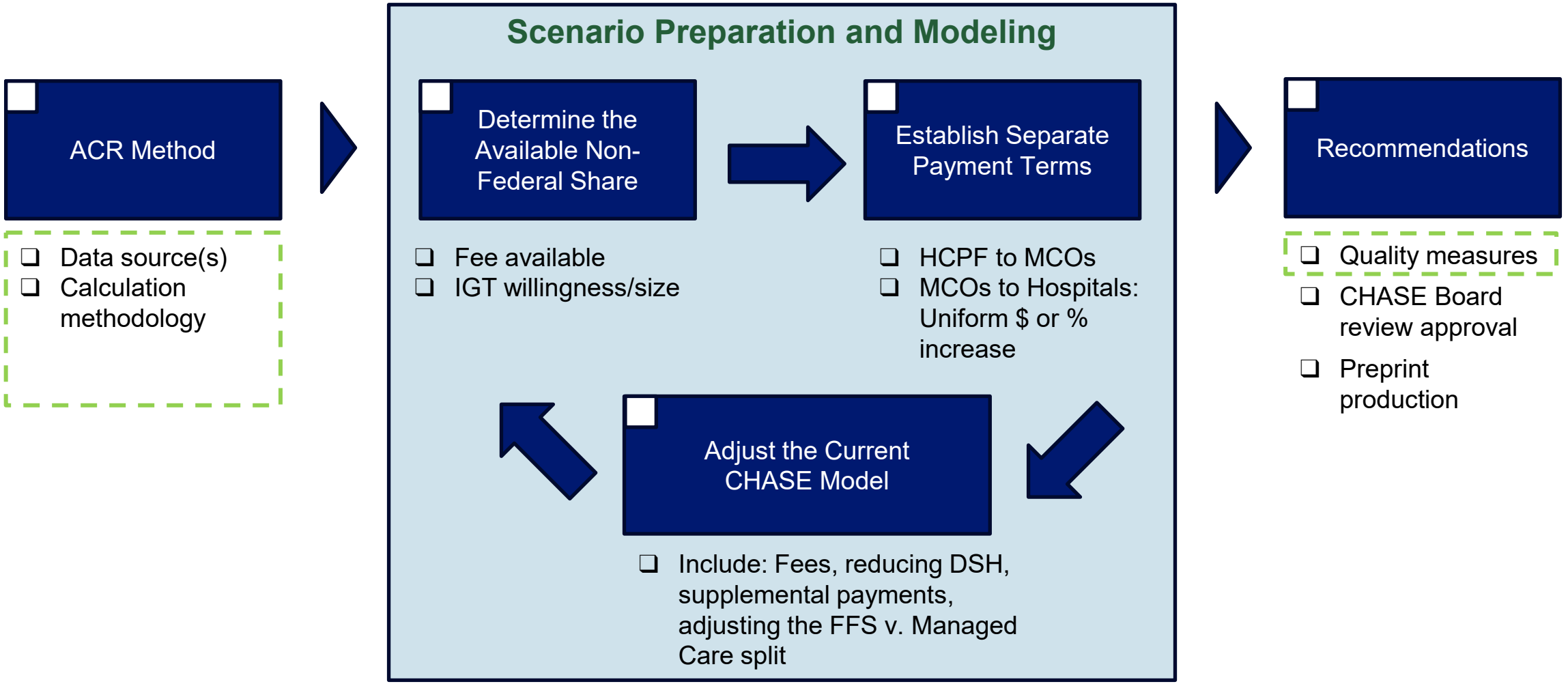
Dimension	Emerging Consensus
Overall Methodology	• Revise existing UPL supplemental payments to simplify payment calcs and tie to utilization • Simplify to the degree possible, but this is a secondary goal
Services	Include both inpatient and outpatient services
Hospital Types	Include general, acute care 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

Subject to CHASE Board Discussion

Planned Meetings



Upcoming Workgroup Deliberations



ACR Subgroup Progress: Approach

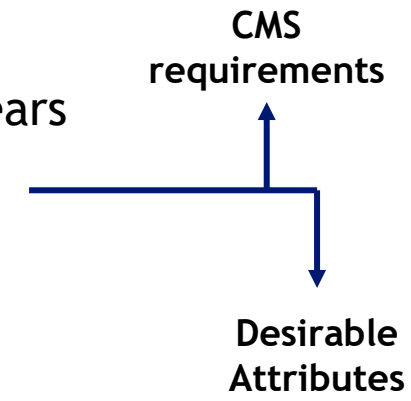
- ✓ Payment-to-cost ratio using Cost Reports as basis
- ✓ Weighting options: costs, revenues, volume (i.e., days/discharges)
- ✓ Medicaid encounter data preferred source for Medicaid MCO costs and base payment data
- ✓ Calculation of possible State Directed Payment amount
  - Medicaid MCO costs = Medicaid 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

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



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.

Quality Metrics: What's Next

- HCPF will work with Hospitals and RAEs to better understand how data is gathered on proposed quality measures 2-4 as well as perspectives on how these measures drive quality:
  - Follow-Up After Emergency Department Visit for Mental Illness (FUM)
  - Follow-Up After Emergency Department Visit for Substance Use (FUA)
  - Follow-Up After Hospitalization for Mental Illness (FUH)
- HCPF staff will bring findings to the workgroup for final consideration
  - Workgroup members Annie Lee volunteered to share the RAE perspective and Tom Rennell volunteered to help create connections to hospitals

Proposed FFY 2024-25 CHASE Fees and Payments

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

CHASE Background

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

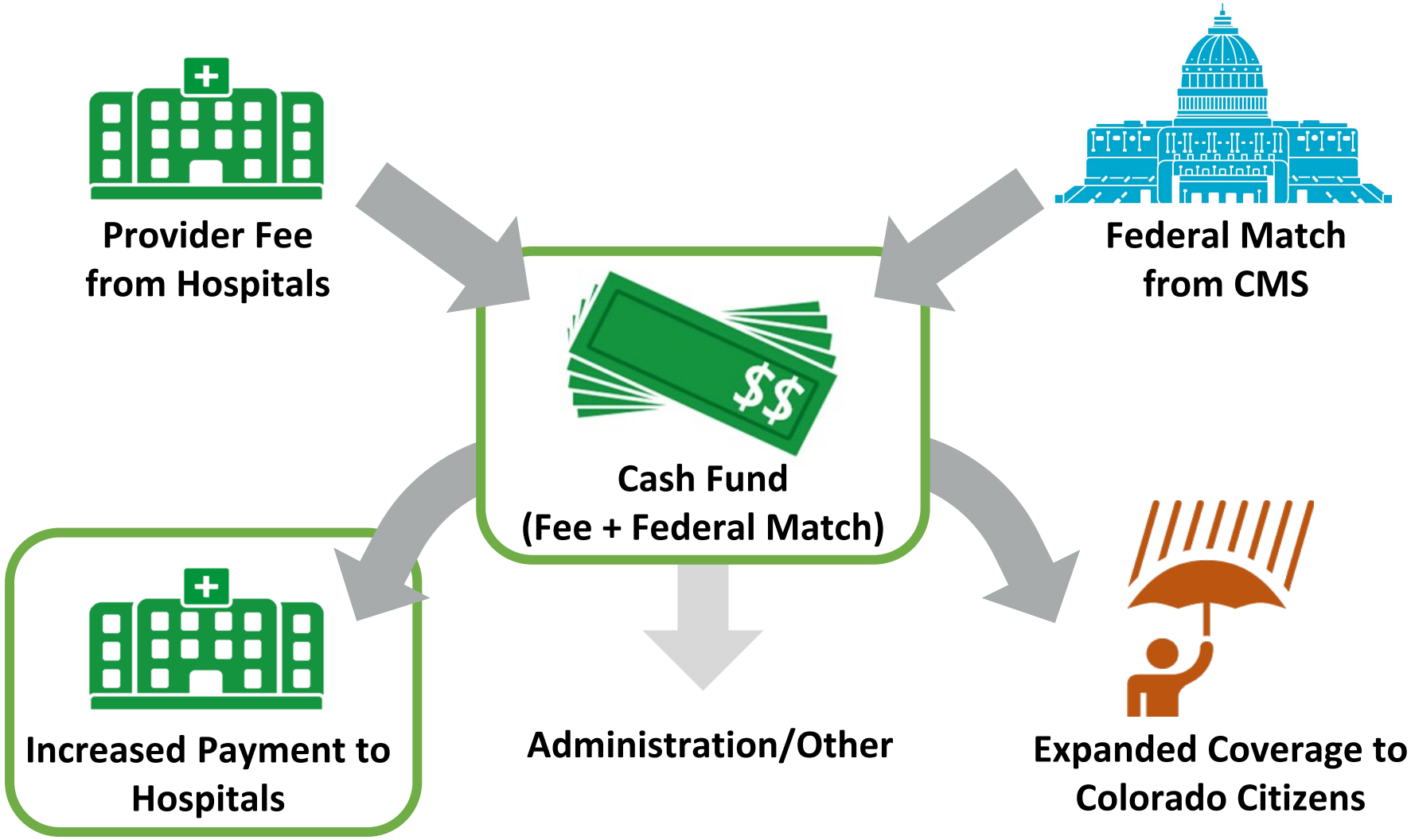
CHASE is a Win, Win, Win

	Benefits to Hospitals	***Benefits to Coloradans***
1. Increases reimbursement to Medicaid hospitals	*Reduced uncompensated care costs*	*Reduced need to shift costs to other payers like commercial insurance,* ***lowering the cost of care****.*
2. Funds coverage for 425,000+ Medicaid & Child Health Plan *Plus* (CHP+) expansion members	*Fewer uninsured = reduced uncompensated care costs*	***Access and low cost of care*** *for low-income Coloradans*
3. Hospital Quality Incentive Payments (HQIP) & Hospital Transformation Program (HTP)	*Earn funding for improved quality of hospital care*	***Better outcomes*** *through care redesign and integration of care across settings. Quality incentive payments targeting* ***equity*** *and* ***outcomes***

- No General Fund
- Low administrative costs

CHASE Purpose

- CHASE is a government-owned business within HCPF
- CHASE charges and collects healthcare affordability and sustainability (HAS) fees to obtain federal matching funds to provide business services to hospitals:
  - Increase hospital reimbursement for care provided to Medicaid members and through Disproportionate Share Hospital (DSH) payments
  - Fund Hospital Quality Incentive Payments (HQIP)
  - Fund and implement the Hospital Transformation Program (HTP)
  - Increase the number of Coloradans eligible for Medicaid and Child Health Plan *Plus* (CHP+) coverage
  - Pay the enterprise's administrative costs limited to 3% of expenditures
  - Any additional business services to hospitals outlined in statute


Provider Fee
from Hospitals
Federal Match
from CMS
Cash Fund
(Fee + Federal Match)
Increased Payment to
Hospitals
Administration/Other
Expanded Coverage to
Colorado Citizens

CHASE Authorities

- **General Assembly** appropriates healthcare affordability and sustainability (HAS) fee and federal funds through budget (Joint Budget Committee) and legislative processes
- **HCPF** single state agency for administration of Colorado's Medicaid program and authorized to draw federal Medicaid funds
- **CHASE Board** recommending body for CHASE to HCPF and the Medical Services Board
  - Recommends HAS fee, hospital payments including Quality Incentive Payments, Hospital Transformation Program, and approach to implementing coverage expansions
  - Also monitors impact of HAS fee on health care market, prepares annual CHASE legislative report, and any other duties to fulfill its charge

CHASE Authorities, continued

- **Medical Services Board**
  - Promulgates rules for HAS fees with consideration of CHASE Board's recommendations
  - 10 CCR 2505-10, § 8.3000, et seq
- **Centers for Medicare and Medicaid Services (CMS)** ultimate authority for CHASE
  - Approval of CHASE provider fees, hospital payments, and Upper Payment Limits (UPL), etc. and oversight of federal Medicaid funds

CHASE Goals

- **HCPF** and the **CHASE Board** seek to meet the goals of the CHASE statute including
  - ➢Maximize reimbursement to hospitals for care for Medicaid members subject to federal requirements
  - ➢Increase the number of hospitals benefitting from the CHASE fee and minimize those hospitals that suffer losses

Key Expenditure Trends

Proposed CHASE FFY 2024-25 Compared to 2023-24

	FFY 2024-25		*Compared to FFY 2023-24*	
A	Healthcare Affordability and Sustainability (HAS) Fee	$ 1,379,000,000	$ 188,400,000	15%
B	HAS Cash Fund	$ 71,000,000	-	-
C	Total HAS Revenue	$ 1,450,000,000	$ 188,400,000	15%
D	Expansions Estimate (HAS Fee)	$ 653,100,000	$ 152,100,000	30%
E	Administration Estimate (HAS Fee)	$ 47,300,000	$ 2,600,000	6%
F	Hospital Payment (Total Expenditures)	$ 1,890,200,000	$ 135,200,000	7%
F - A	**Net Hospital Reimbursement**	**$ 511,200,000**	$ 16,700,000	3%
	Estimated Hospital Net Patient Revenue (NPR)	$ 23,513,900,000	$22,615,600,000	4%
	HAS Fee % NPR	6.00%		
	HAS Payments % Upper Payment Limit (UPL)	99.25%		

HCPF Trends & Budget Picture

- HCPF's state fiscal year (SFY) 2025-26 budget is $18.2B total funds and $5.5B General Fund
- Medicaid cost trends growing 7-8% annually, while state revenue grows with standard inflation as required by TABOR revenue cap, or about 3-4%
  - HCPF asked for $123M more General Fund for SFY 2023-24 as claims rose higher than budgeted and we utilized CHASE cash fund for higher than forecasted coverage costs
  - Asked for $438M more General Fund with initial Governor's SFY 2025-26 budget submission in Nov. 2024
  - With Feb. 2025 update, asked for $114M more for current SFY 2024-25 and $83M more for SFY 2025-26

Key Medicaid Expenditure Trend Drivers

- ✓ Increased acuity and utilization of services
- ✓ Expanded access to services
- ✓ Increased provider payment rates

Trend Drivers: Medicaid Provider Rates

SFY	Across-the-board
2019-20	1.00%
2020-21	-1.00%
2021-22	2.50%
2022-23	2.00%
2023-24	3.00%
2024-25	2.00%
2025-26	1.60%

- From SFY 2019-20 through SFY 2025-26, provider rate increases total 11.1%
- Average: 1.6%

Health Coverage Expansion Cost Forecasting

- Expansion expenditure forecasts revised November and February
- Adjusted for historical trend factors (*utilization*) and policy considerations (*expanded benefits*, *rate increases*)
- Thorough internal review process
- Independent review then completed by executive and legislative branches
  - Office of State Planning and Budgeting (OSPB), and
  - Joint Budget Committee (JBC)
- Appropriated by the General Assembly through the budget process

CHASE Expansion Trend Drivers

- Medicaid Disabled Buy-In 34% increase in caseload and higher cost in acute care services, such as physician, pharmacy, and dental.
- Low-income adults [Affordable Care Act (ACA) expansion] costs increasing 2% due to higher per capita costs driven by higher acuity than those disenrolled. Biggest cost increases:
  - Dental services had significant targeted rate increases in FY 2024-25
  - Managed Care Organization (MCO) rates: large payments in July 2024 to true up the rates paid in FY 2023-24 in order to reflect the higher acuity of the population. The FY 2024-25 rates are higher than those set in FY 2023-24.

CHASE Expansion Trend Drivers, continued

- Behavioral Health
  - Capitation rates grew significantly year-over-year due to the rising acuity of the population and service expansions (38 bills since 2017 expanding services)
  - Capitation rates for disabled buy-in increased by 29%, for expansion parents increased by 48%, and for low-income ACA adults increased by 65% compared to the rates originally set in SFY 2023-24
- CHP+
  - Rapid growth since the end of the COVID-19 public health emergency (PHE). We are projecting enrollment growth of 14% in expansion children and 17% in expansion prenatal
  - Capitation rates for SFY 2024-25 are also higher than in SFY 2023-24, increasing 16% for expansion children and 17% for expansion prenatal

Health Coverage Expansion Caseload & Funds

Expansion Populations		Caseload	FMAP	HAS Fee	Federal Funds
MAGI Parents/Caretakers 60-68% FPL	ACA	4,758	50.0%	$12.9M	$12.9M
MAGI Parents/Caretakers 69-133% FPL	ACA	43,117	90.0%	$27.2M	$222.0M
MAGI Adults 0-133% FPL	ACA	333,472	90.0%	$332.7M	$2,320.5M
Buy-In for Adults & Children with Disabilities	Buy-In	28,544	50.0%	$181.6M	$181.6M
12 Month Continuous Eligibility for Children	ACA	18,927	50.0%	$26.3M	$26.3M
Non-Newly Eligible	ACA	4,201	80.0%	$22.5M	$89.0M
CHP+ 206-250% FPL	CHP+	35,000	65.0%	$38.3M	$71.0M
Incentive Payments	ACA	-	-	$11.6M	-$8.7M
Totals				**$653.1M**	**$2,914.6M**

MAGI = Modified Adjusted Gross Income

Administrative Expenditures

- Administrative expenditures for CHASE related activities, including expenditures related to CHASE funded expansion populations:
  - Full-time equivalent (FTE) staff positions for the administration of CHASE
  - CHASE's share of expenses for Colorado Benefits Managements System (CBMS), Medicaid Management Information System (MMIS), Business Intelligences Data Management, and Pharmacy Benefits Management System
  - County administration contracts for eligibility determinations
- Contracted services are competitively selected and approved by State Controller
- Appropriated by the General Assembly through the budget process

Administrative Expenditures, continued

- $2.6M CHASE funding increase between FFYs 2023-24 and 2024-25
- Increase due primarily to
  - Cost inflation increases
  - Utilization increases
  - PHE Unwind - County eligibility redetermination

Proposed FFY 2024-25 CHASE Fees & Payments

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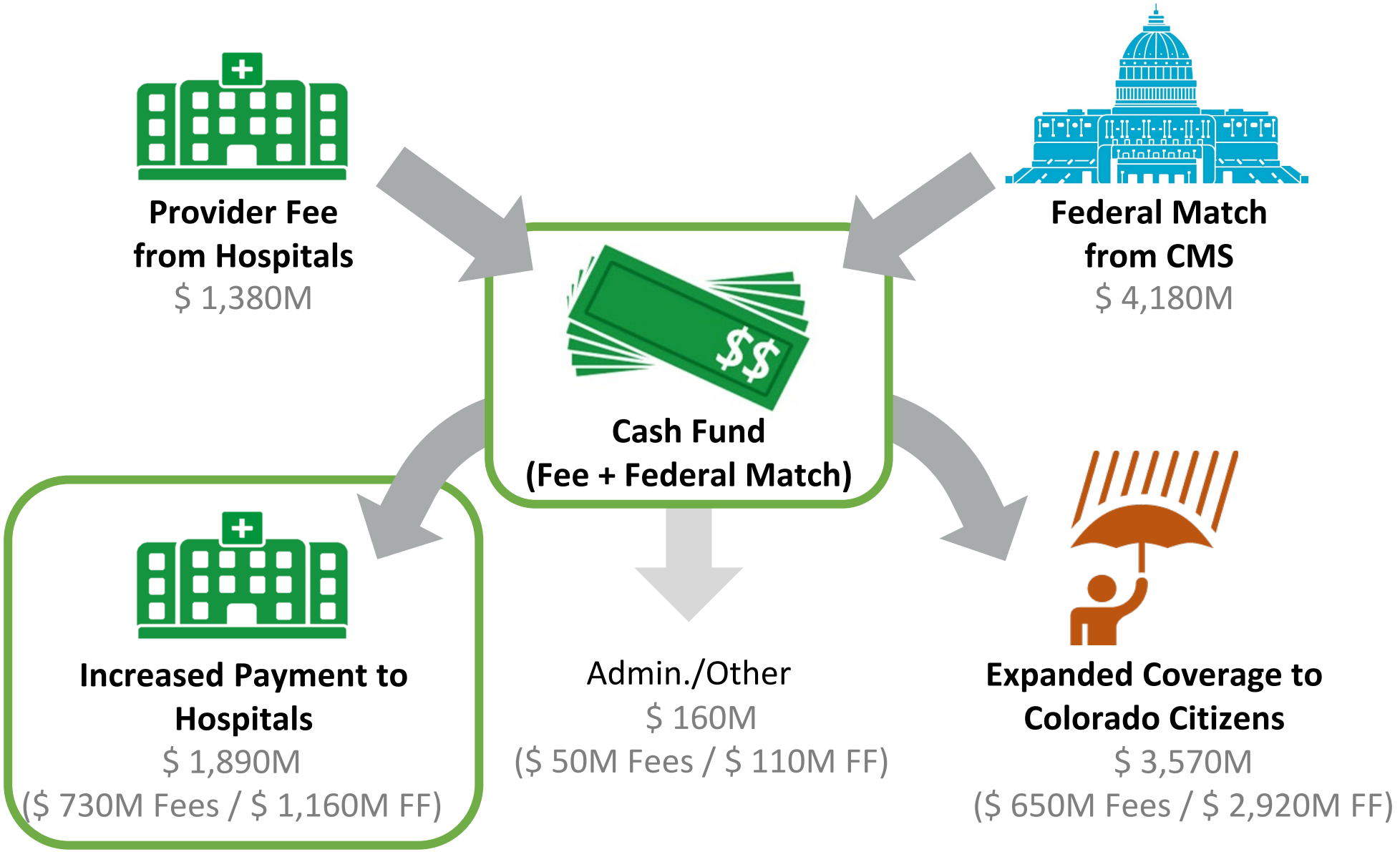
FFY 2024-25 Fees & Payments

- FFY 24-25 CHASE Adjustment Group Definitions
- FFY 24-25 CHASE Financial Statements
- FFY 24-25 CHASE Group Net Reimbursement
- FFY 24-25 CHASE Hospital UPL and Adjustment Group
- FFY 24-25 CHASE Hospital Net Reimbursement
- FFY 24-25 CHASE Model Limits (UPL & NPR)
- FFY 24-25 CHASE Overview



Amounts may not equal due to rounding

CHASE Model Sudoku

- Expansion and administration costs from budget forecast
- Calculate NPR, UPLs
- DSH allotment from CMS
- Essential Access, HQIP, Rural Support Fund payments
- Inpatient and Outpatient UPL payments
- Hospital specific DSH limits for DSH-eligible hospitals
- Calculate fees based on approved methodology and NPR limit

Fees and Payments Overview

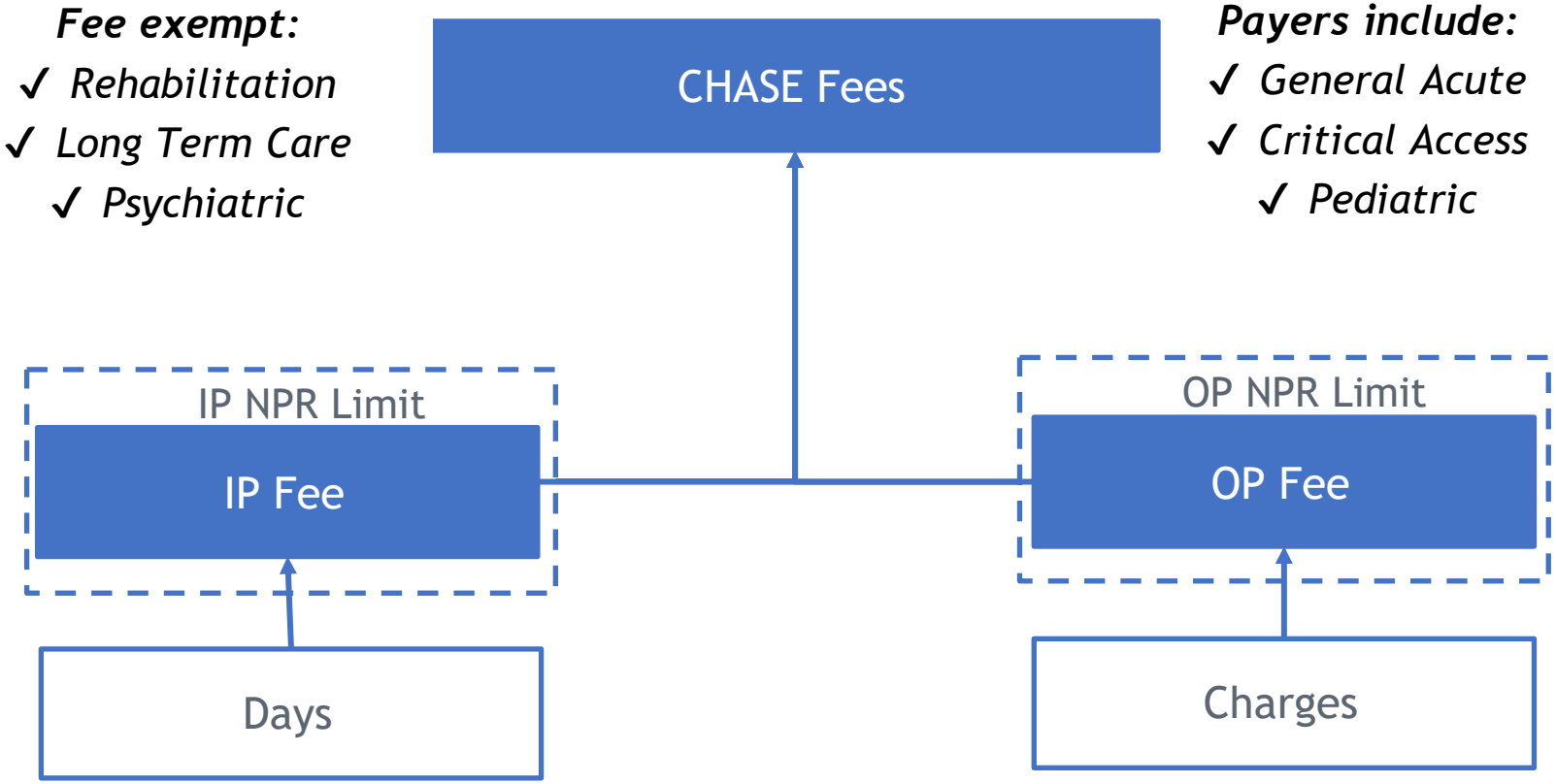
	Cash Fund	Federal Fund	Total Fund
Total Supplemental Payment	**$ 734M**	**$ 1,156M**	**$ 1,890M**
Medicaid & CHP+ Expansions	$ 653M	$ 2,915M	$ 3,568M
Administration	$ 47M	$ 112M	$ 159M
General Fund Transfer	$ 16M		$ 16M
Grand Total	**$1,450M**	**$ 4,183M**	**$ 5,633M**

Fees and Payments Overview, continued

- **$1.38 billion in fees (9.4% increase)**
  - At 6.00% NPR (100% of maximum fees)
- **Total federal funds: $4.2 billion, 303% return on fees**
- **$1.89 billion in hospital supplemental payments (7.7% increase)**
  - Including $127 million in quality incentive payments
  - UPL at 99.25%; Disproportionate Share Hospital (DSH) limit at 96%
- **$511 million in net reimbursement (total fees less supplemental payments) (3.4% increase)**
- **$3.57 billion for expansion claim; estimated 40% paid to hospitals**
  - $1.4 billion in claims payments to hospitals

Inpatient (IP) & Outpatient (OP) Fees

Fee exempt:
- ✓ *Rehabilitation*
- ✓ *Long Term Care*
- ✓ *Psychiatric*

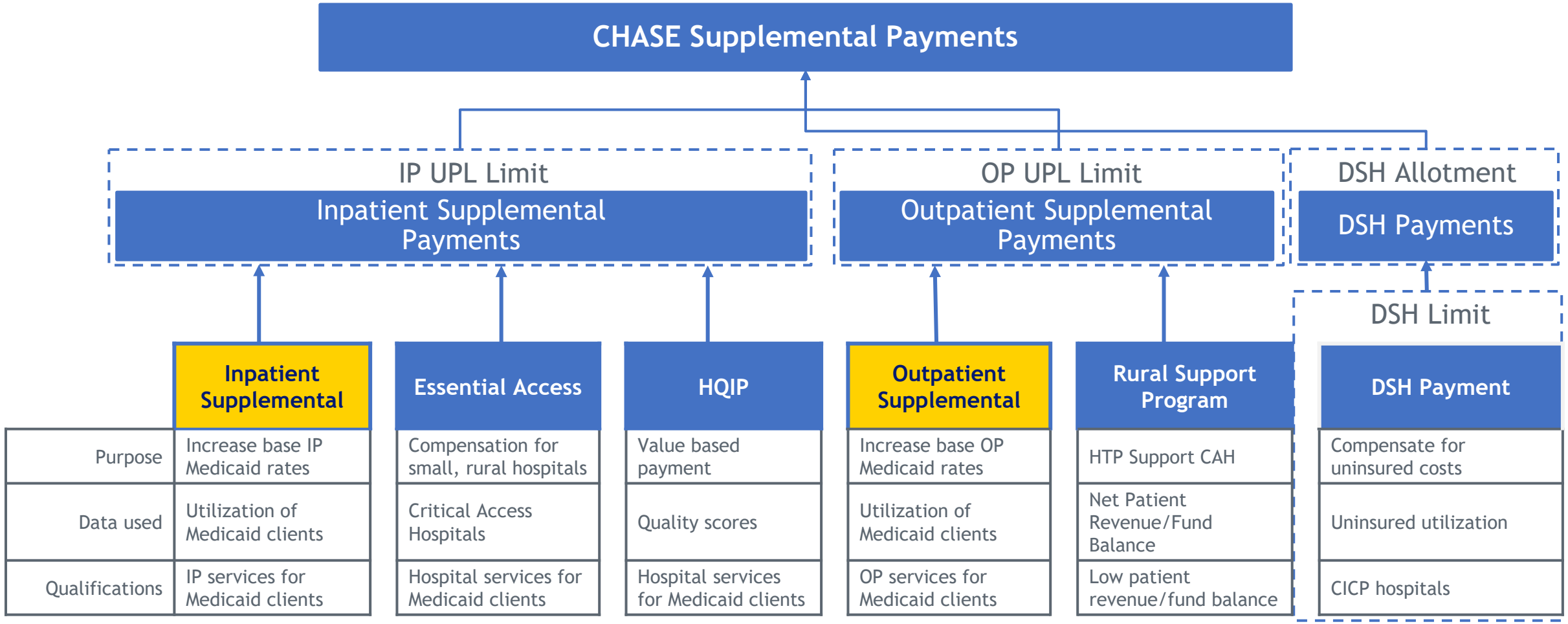


Payers include:
- ✓ *General Acute*
- ✓ *Critical Access*
- ✓ *Pediatric*

Inpatient & Outpatient Fees

- Methodology and discounts per CMS approval of broad-based and uniform fee requirements waiver
- Inpatient fee assessed on managed care and non-managed care days
  - **Inpatient Fee - $564 million**
    - Per non-managed care day: $ 487.20
    - Per managed care day: $ 108.99
- Outpatient fee assess on percentage of total outpatient charges
  - **Outpatient Fee - $816 million**
    - Percentage of total charges: 1.6910%
- High Volume and Essential Access hospitals pay discounted fees
- Psychiatric, long-term care, and rehabilitation hospitals are fee exempt

Supplemental Payments



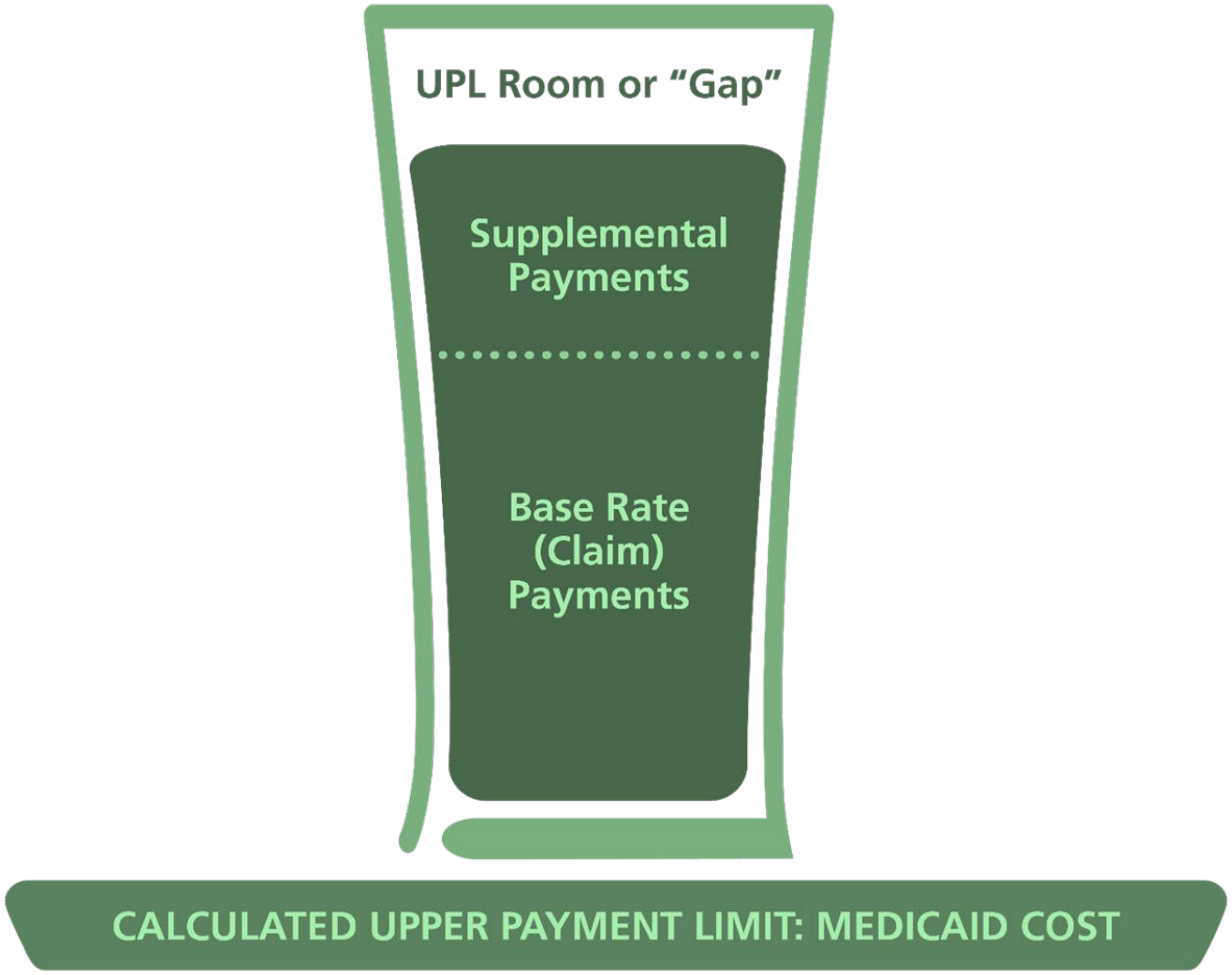
	Inpatient Supplemental	Essential Access	HQIP	Outpatient Supplemental	Rural Support Program	DSH Payment
Purpose	Increase base IP Medicaid rates	Compensation for small, rural hospitals	Value based payment	Increase base OP Medicaid rates	HTP Support CAH	Compensate for uninsured costs
Data used	Utilization of Medicaid clients	Critical Access Hospitals	Quality scores	Utilization of Medicaid clients	Net Patient Revenue/Fund Balance	Uninsured utilization
Qualifications	IP services for Medicaid clients	Hospital services for Medicaid clients	Hospital services for Medicaid clients	OP services for Medicaid clients	Low patient revenue/fund balance	CICP hospitals

UPL Supplemental Payments

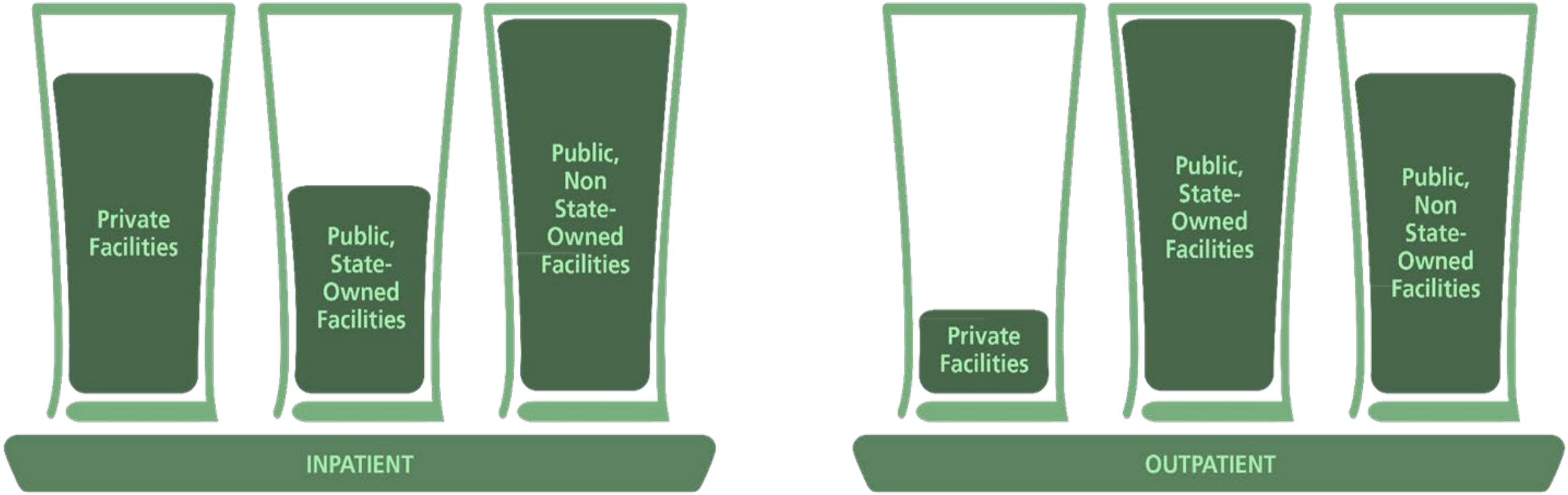
- Inpatient UPL
  - Inpatient Supplemental Payment†
  - Essential Access (EA) Payment
    - Lump sum payments directed to Critical Access/rural hospitals with 25 or fewer beds
  - Hospital Quality Incentive Payment (HQIP)
    - Amount set by statute
    - Payments determined by quality metrics and scoring methodology approved by CHASE Board
- Outpatient UPL
  - Outpatient Supplemental Payment†
  - Rural Support Program (RSP)
    - Fixed amount for 5 years for 23 qualified hospitals

†Adjustment factors apply

Upper Payment Limit (UPL)



UPL Pools


Private Facilities
Public, State-Owned Facilities
Public, Non State-Owned Facilities
INPATIENT
Private Facilities
Public, State-Owned Facilities
Public, Non State-Owned Facilities
OUTPATIENT

Essential Access Supplemental Payment

- Reimbursement to rural and Critical Access hospitals with 25 or fewer beds
- **Total supplemental payment: $26 million**
- Payment calculation = $26 million / total number of Essential Access hospitals

Rural Support Supplemental Payment

- Reimbursement to rural and Critical Access Hospitals (CAH) that meet revenue and fund balance requirements:
  - ➢Must be a nonprofit hospital AND
  - ➢Must fall within bottom 10% NPR of rural or CAH OR
  - ➢Must fall within bottom 25% fund balance of rural or CAH
- **Total supplemental payment: $12 million**
- Payment calculation = $12 million / # of total qualified hospitals
- Each qualified hospital required to submit application showing the funds will be used to implement initiative that enables success in the Hospital Transformation Program (HTP)

HQIP Supplemental Payment

- Reimbursement to hospitals providing services that improve health care outcomes
- **Total supplemental payment: $127 million**
- Payment Calculation = normalized awarded points * Medicaid adjusted discharges * dollars per adjusted discharge point
- Quality measures and payment methodology approved by the CHASE Board

HQIP Tier	Lower Bound	Upper Bound	Dollar per Adjusted Discharge Point	Count
0	0	19	$ -	19
1	20	39	$ 1.87	5
2	40	59	$ 3.74	3
3	60	79	$ 5.61	12
4	80	100	$ 7.48	61

Inpatient Supplemental Payment

- Increased reimbursement for inpatient Medicaid utilization
- **Total supplemental payment: $826 million**
- Payment calculation = Medicaid non-managed care patient days * inpatient adjustment factor
- Allows for greater variation in reimbursement due to changing Medicaid utilization

Outpatient Supplemental Payment

- Increased reimbursement for outpatient hospitals services for Medicaid members
- **Total supplemental payment: $633 million**
- Payment calculation = Estimated Medicaid Outpatient Costs * Outpatient adjustment factor

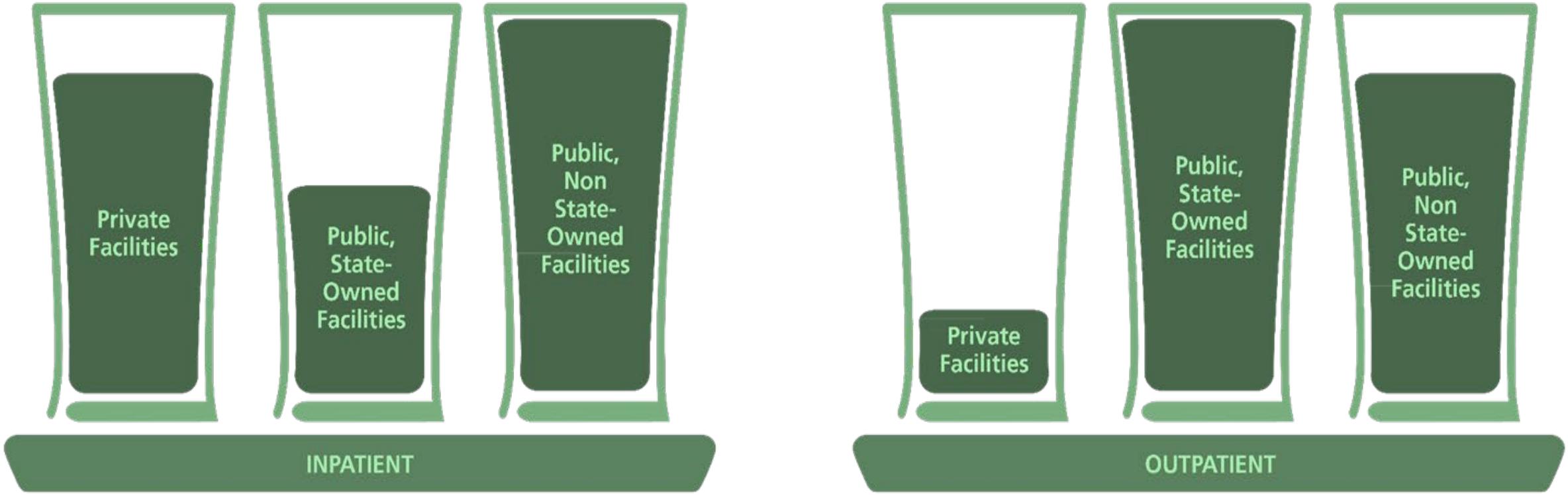
Adjustment Factors Overview

- Purpose
  - Maximize hospitals benefiting from fee and minimize losses
  - Tied to Medicaid utilization and higher cost service needs of Medicaid population (e.g., NICU level III, teaching hospitals, pediatric speciality, CAH)
  - Reach targeted UPL 99.25% for each UPL pool
- History
  - Since inception of original hospital provider fee in 2009-10, different supplemental payments and/or adjustment factors to maximum benefits and minimize losses

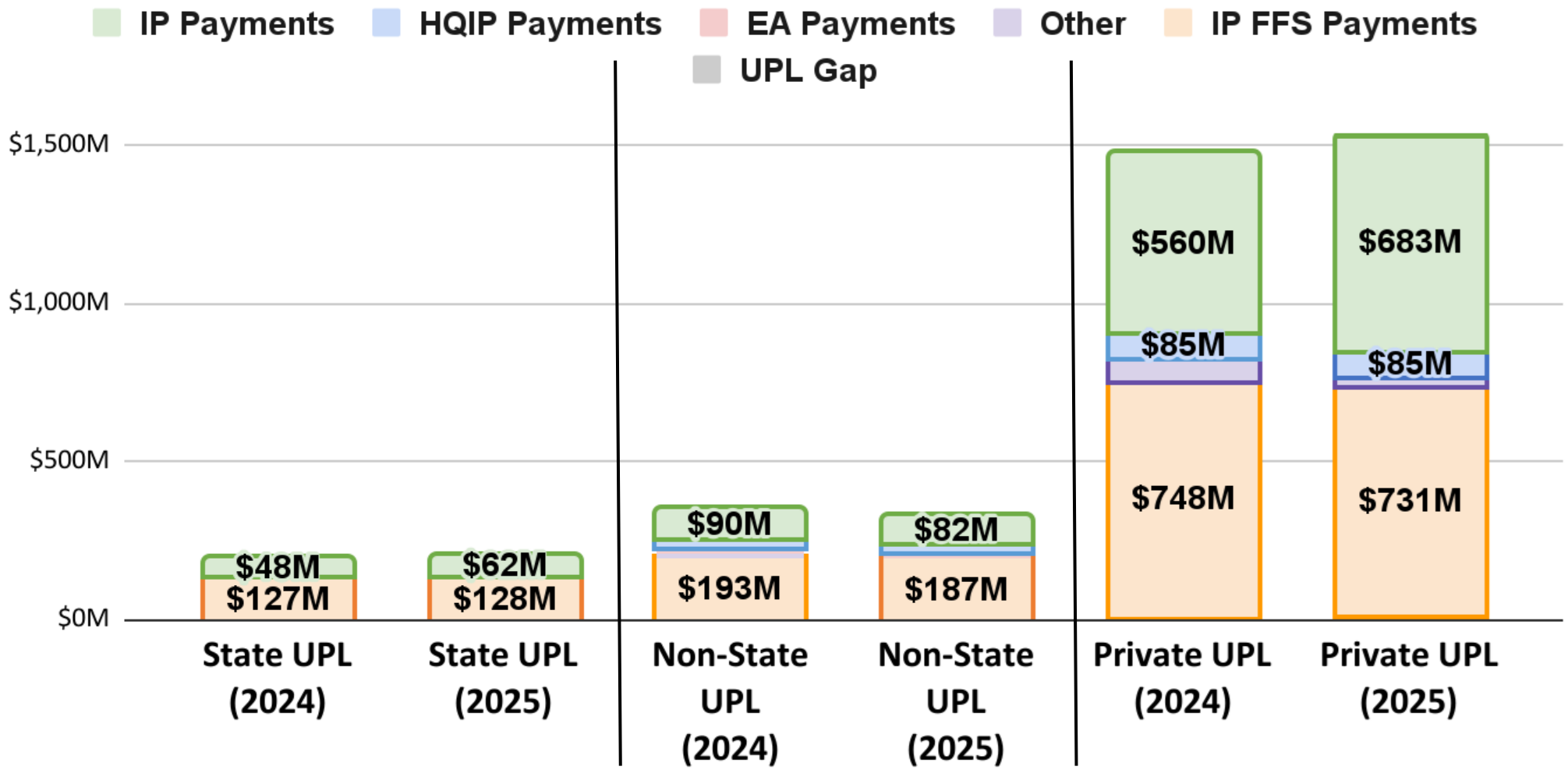
Adjustment Factors

FFY 24-25 Inpatient & Outpatient Adjustment Factors				
Adjustment Group	**UPL Category**	**Percent of Hospitals**	**Inpatient Adjustment Factor**	**Outpatient Adjustment Factor**
Rehabilitation or LTAC	All	15%	$16.50	16.10%
State Government Teaching Hospital	State Gov.	1%	$821.25	51.73%
Non-State Government Teaching Hospital	Non-State Gov.	1%	$195.75	2.85%
Non-State Government Rural or CAH	Non-State Gov.	28%	$1,389.35	105.00%
Non-State Government Hospital	Non-State Gov.	2%	$875.75	16.80%
Private Rural or CAH	Private	15%	$400.00	116.65%
Private Heart Institute Hospital	Private	1%	$1,605.00	60.00%
Private Pediatric Specialty Hospital	Private	2%	$752.25	4.50%
Private High Medicaid Utilization Hospital	Private	3%	$1,345.00	37.75%
Private NICU Hospital	Private	12%	$2,001.00	81.40%
Private Independent Metropolitan Hospital	Private	2%	$1,690.00	107.00%
Private Safety Net Metropolitan Hospitals	Private	1%	$1,690.00	107.00%
Private Hospital	Private	17%	$722.25	35.35%

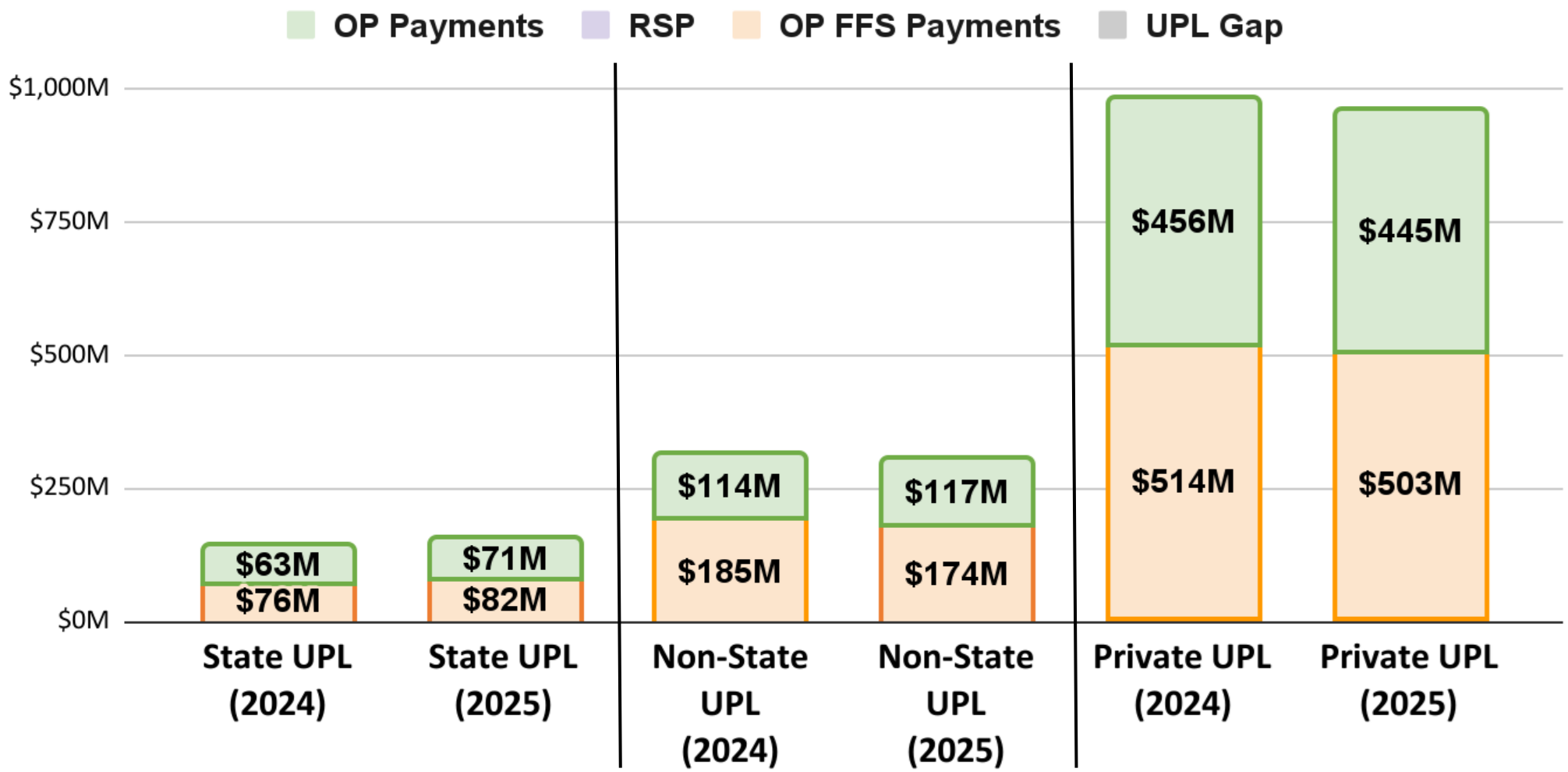
Recall UPL Pools



Annual Change in Inpatient (IP) UPL Pools



Annual Change in Outpatient (OP) UPL Pools



DSH Supplemental Payment

- Reimbursement to hospitals serving disproportionate share of Medicaid members and uninsured patients
- **Total supplemental payment: $265 million**
- DSH payment capped at 96% of estimated hospital-specific DSH limit
  - High uninsured cost hospital DSH payment equals 90% of their estimated DSH limit
  - State Teaching hospital DSH payment equals 96% of their estimated DSH limit
  - Critical Access hospital DSH payment equals 86% of their estimated DSH limit
  - Small independent metropolitan hospital DSH payment equals 55% of their estimated DSH limit
  - Low Medicaid Inpatient utilization rate (MIUR) hospital DSH payment limited to 20% of their estimated DSH limit

Public Comment

Board Action

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Next Steps

Medical Services Board Rulemaking

- Emergency rules
  - June 13th, 9 a.m. Medical Services Board hearing
- Public rule review meeting July 21st
- Final adoption
  - August 8th Medical Services Board hearing
- Medical Services Board open to public

Thank You

Nancy Dolson & Jeff Wittreich
Special Financing Division
Department of Health Care Policy & Financing
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Appendix

Net Reimbursement

	2023-24	2024-25	Difference
Supplemental Payments	$ 1,755M	$ 1,890M	$ 135M
Provider Fees	$ 1,260M	$ 1,379M	$ 119M
Net Reimbursement	**$ 495M**	**$ 511M**	**$ 16M**

Return on Fee

- **$1.38 billion** in fees generates **$4.18 billion** in federal funds, a 303% return rate
- Estimated administrative expenditures are 3% of total expenditures ($5.6 B)
- Administrative expenditures include:
  - Staff cost
  - Contracted services, including utilization management and quality review
  - IT systems (i.e., eligibility and claims) and staffing for the customer contact center for more than **450,000 covered lives**

Increased Federal Matching Funds

- To support the Hospital Transformation Program (HTP), drawing down increased federal matching funds for a portion of Medicaid supplemental payments allocated to Affordable Care Act (ACA) populations
- Provided additional federal matching funds, **reducing necessary provider fees collected from hospitals.**
  - **FFY 2019-20: $126m**
  - **FFY 2020-21: $141m**
  - **FFY 2021-22: $152M**
  - **FFY 2022-23: $167M**
  - **FFY 2023-24: $178M**
  - **FFY 2024-25: $211M**
- A Total of $975M in fee savings has been realized using this methodology
- Net reimbursement $495M rather than $300M

Federal Requirements

Medicaid Provider Fees*

- Limited to no more than 6% of net patient revenues (NPR)
- May not hold providers harmless, i.e., provide a direct or indirect guarantee that providers will receive all or a portion of their fees payments back
  - Fee *may not* be designed to reimburse providers based on amount paid (directly or indirectly)
  - Fee assessed on non-Medicaid statistic (e.g. inpatient days or outpatient charges)
  - Reimbursements are Medicaid payments

*Health-care related taxes under federal regulations; see 42 CFR § 433.68

Disproportionate Share Hospital (DSH) Payments

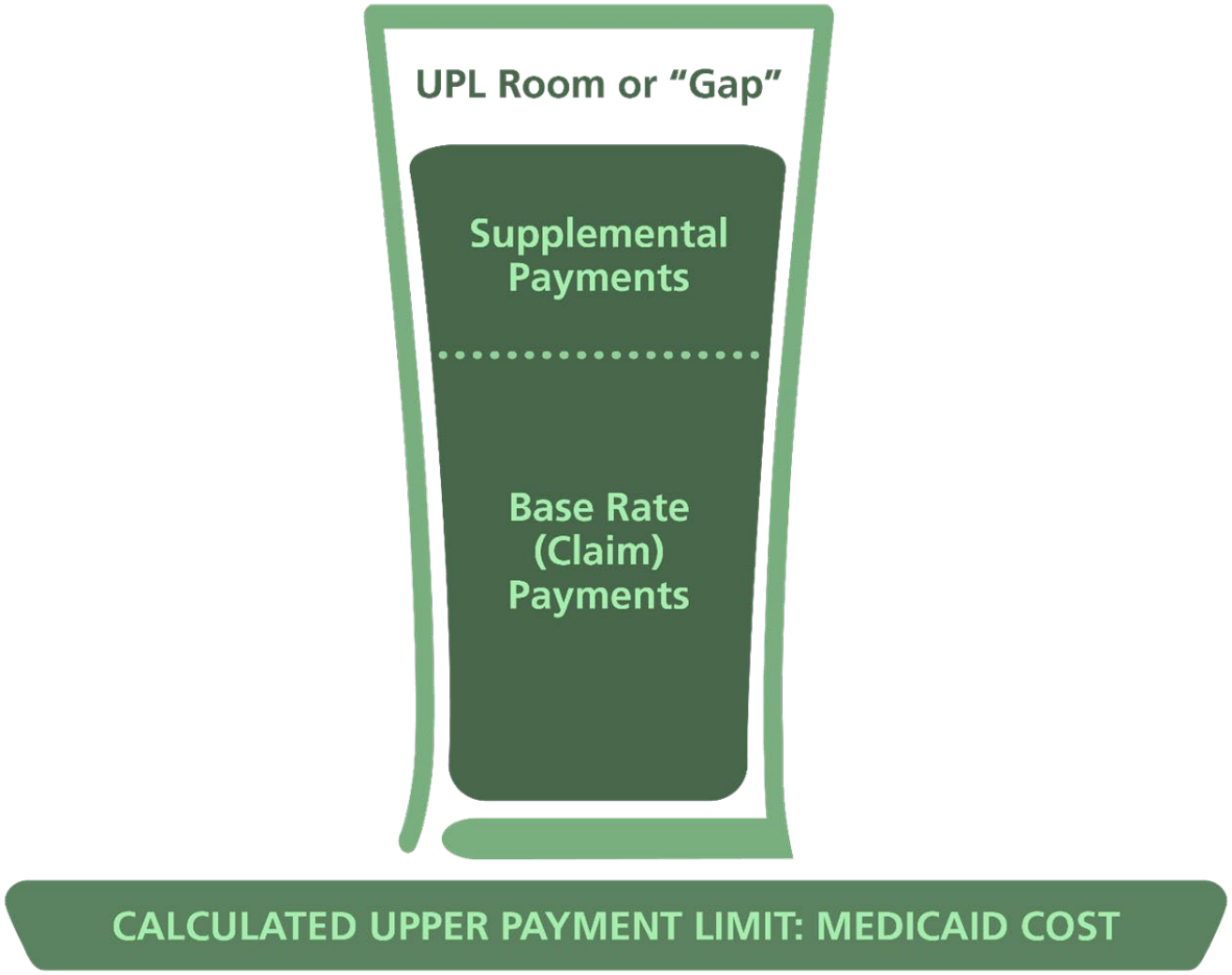
- Medicaid DSH payments required to hospitals that serve a high share of Medicaid and low-income patients
- State DSH spending is limited by federal allotments, which vary by state
- DSH payments cannot exceed the hospital-specific DSH limit which is the hospital's uncompensated care costs for both Medicaid-enrolled and uninsured patients

Upper Payment Limit

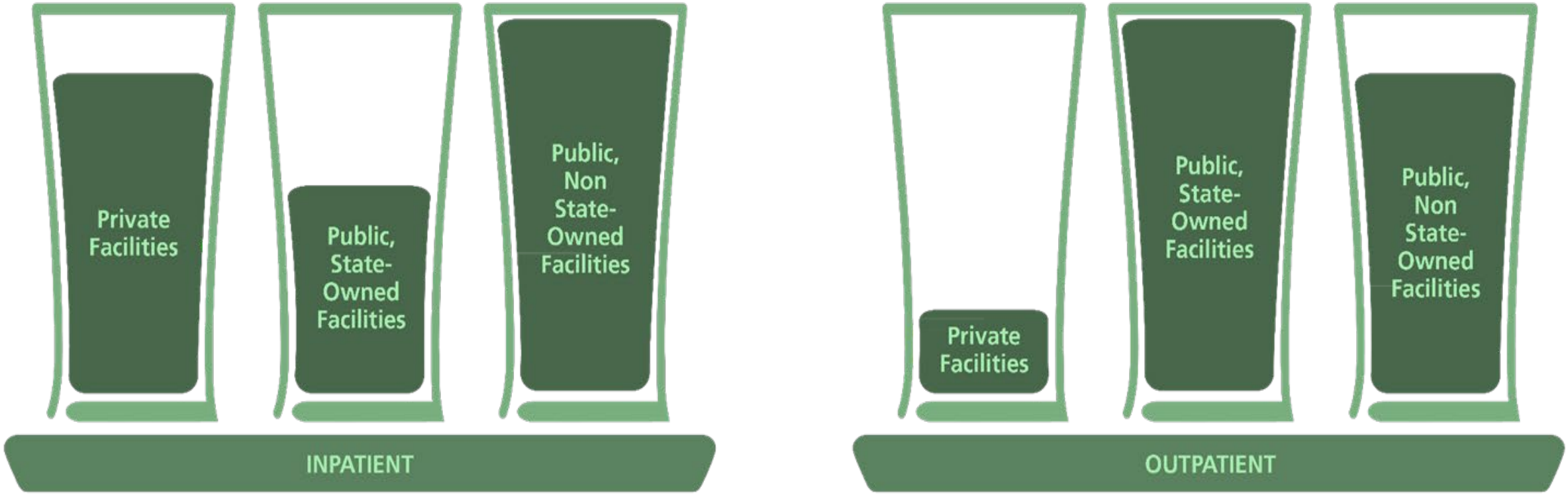
- UPL supplemental payments are lump-sum payments that are intended to fill in the difference between fee-for-service (FFS) claims payments and maximum amount that could be paid by Medicaid
- FFS and UPL payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles
- HCPF prepares UPL demonstrations, which must be submitted to CMS annually for review and approval

See: macpac.gov/wp-content/uploads/2021/11/Upper-Payment-Limit-Supplemental-Payments.pdf

Upper Payment Limit (UPL)



UPL Pools


Private Facilities
Public, State-Owned Facilities
Public, Non State-Owned Facilities
INPATIENT
Private Facilities
Public, State-Owned Facilities
Public, Non State-Owned Facilities
OUTPATIENT

Upper Payment Limit

- Separate UPL demonstrations for Inpatient and Outpatient Hospital services
- Payments limited in aggregate by class of providers defined based on ownership (i.e., government, non-state government, and privately owned)
- 42 CFR 447.272 (a) Inpatient and 42 CFR 447.321 (a) Outpatient
  - (1) State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State)
  - (2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State).
  - (3) Privately-owned and operated facilities

See: medicaid.gov/medicaid/financial-management/payment-limit-demonstrations/index.html

CHASE Historic Trends

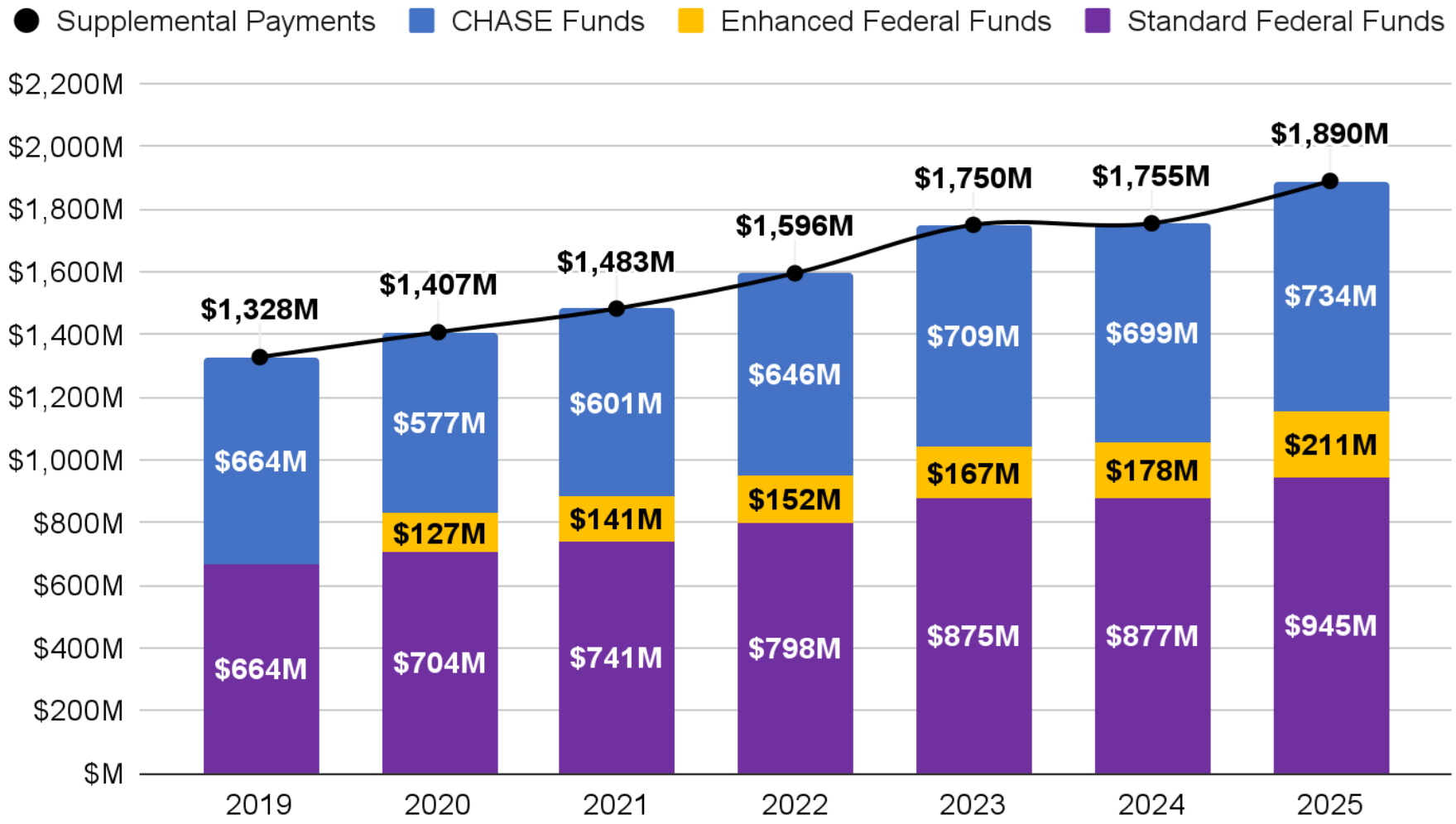
CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Fee & Payment

- CHASE statute regarding use of fees
  - § 25.5-4-402.4 (5)(b)(I) through (III), C.R.S.

Supplemental Payments (FFY)

Increased Payments to Hospitals

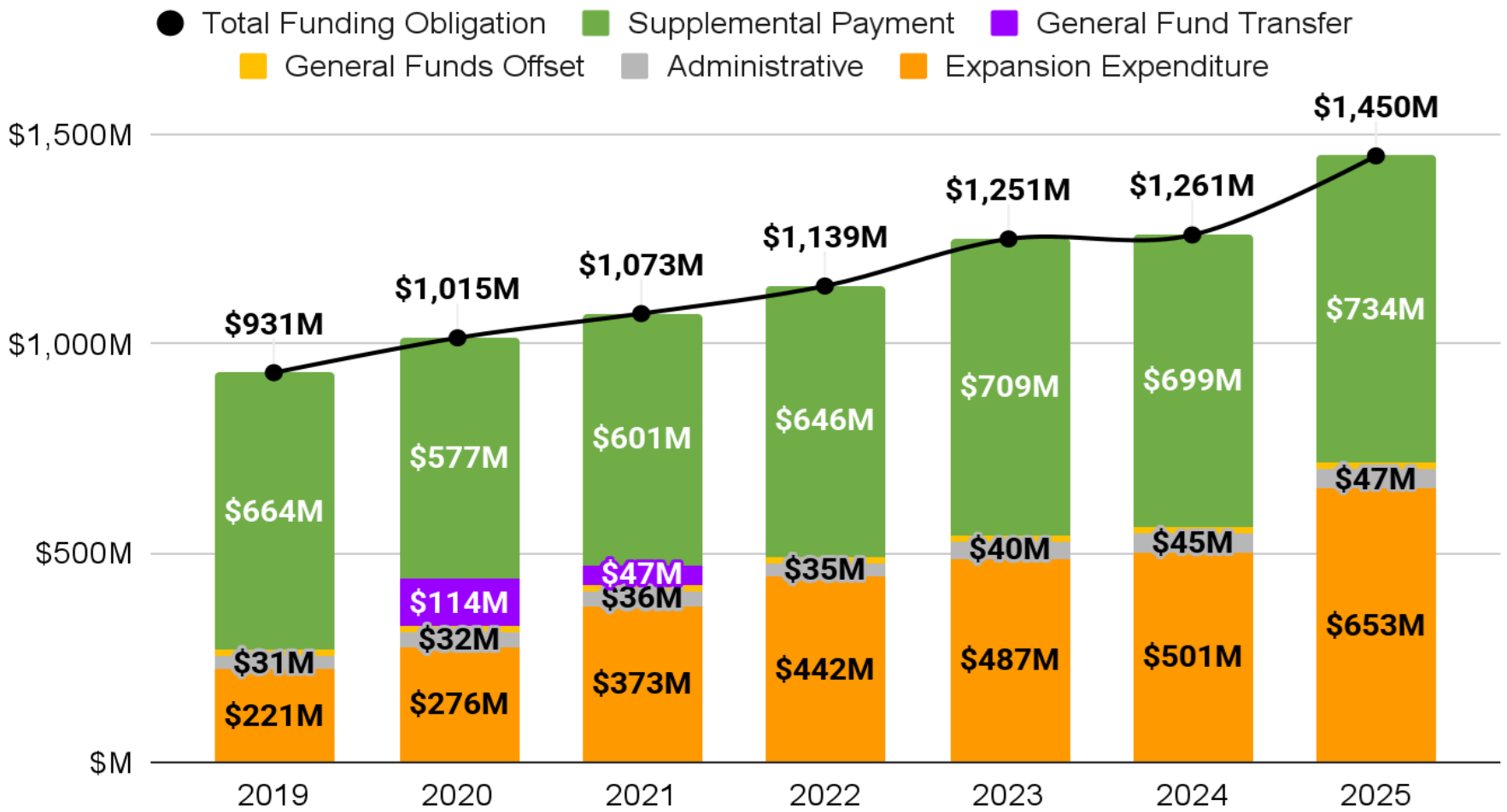


Annual Change :	-	6.0%	5.4%	7.6%	9.7%	0.3%	7.7%

FFY = federal fiscal year, October through September

CHASE Funding Obligation (FFY)

Provider Fees from Hospitals

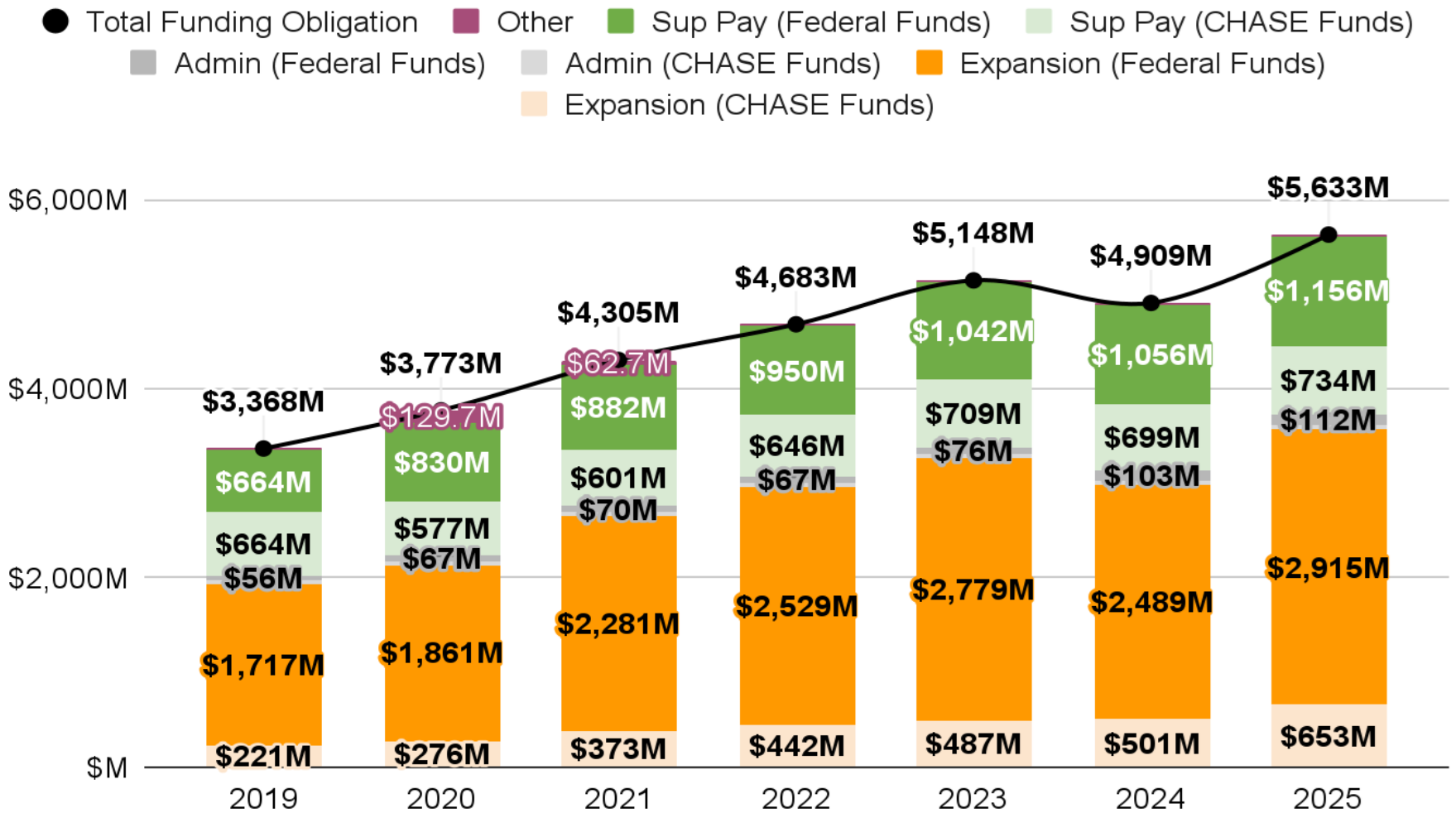


Annual Change :	-	9.0%	5.7%	6.2%	9.9%	0.8%	15.0%

FFY = federal fiscal year, October through September

Total Funding Obligation (FFY)

Cash Fund
(Fee + Federal Match)



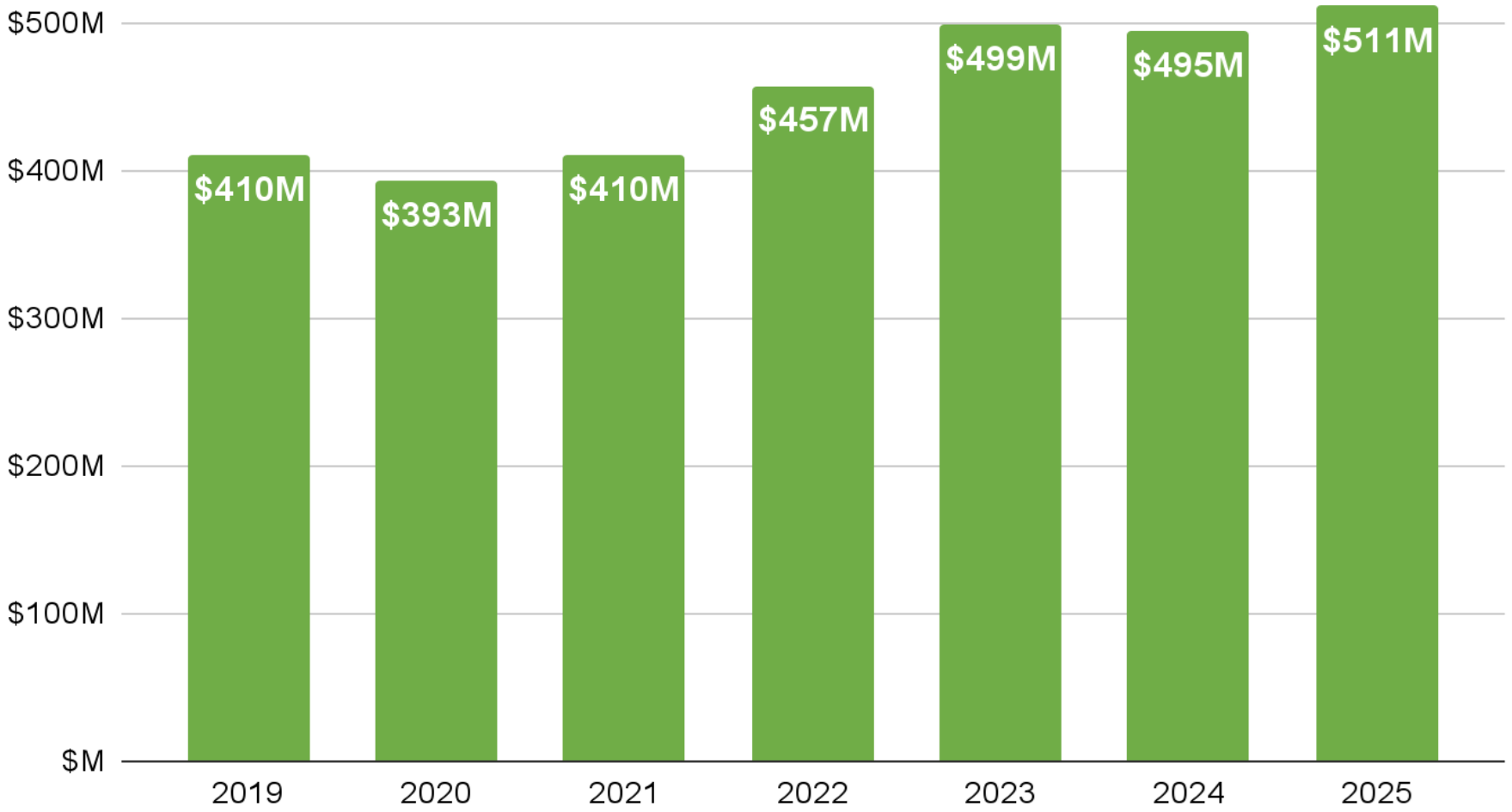
Annual Change :	-	12.0%	14.1%	8.8%	9.9%	-4.6%	14.7%

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

FFY = federal fiscal year, October through September

Net Reimbursement (FFY)

Net Reimbursement Experienced by Hospitals



	2019	2020	2021	2022	2023	2024	2025
Annual Change :	-	-4.3%	4.5%	11.5%	9.1%	-0.9%	3.4%

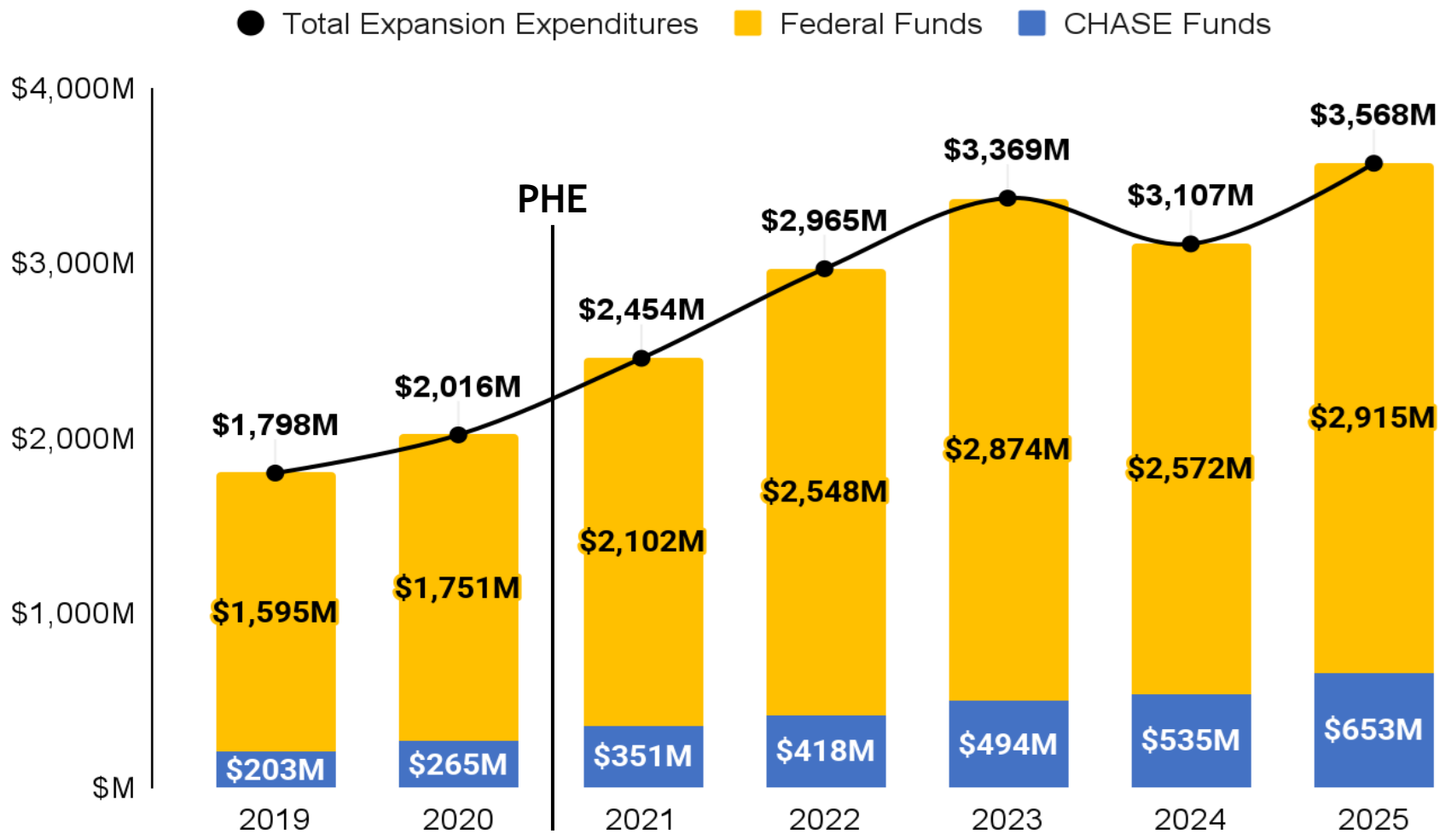
FFY = federal fiscal year, October through September

Health Coverage Expansions

- CHASE statute regarding use of fees
  - § 25.5-4-402.4 (5)(b)(IV) and (V), C.R.S.

Expansion Actuals (SFY)

Expanded Coverage to Colorado Citizens

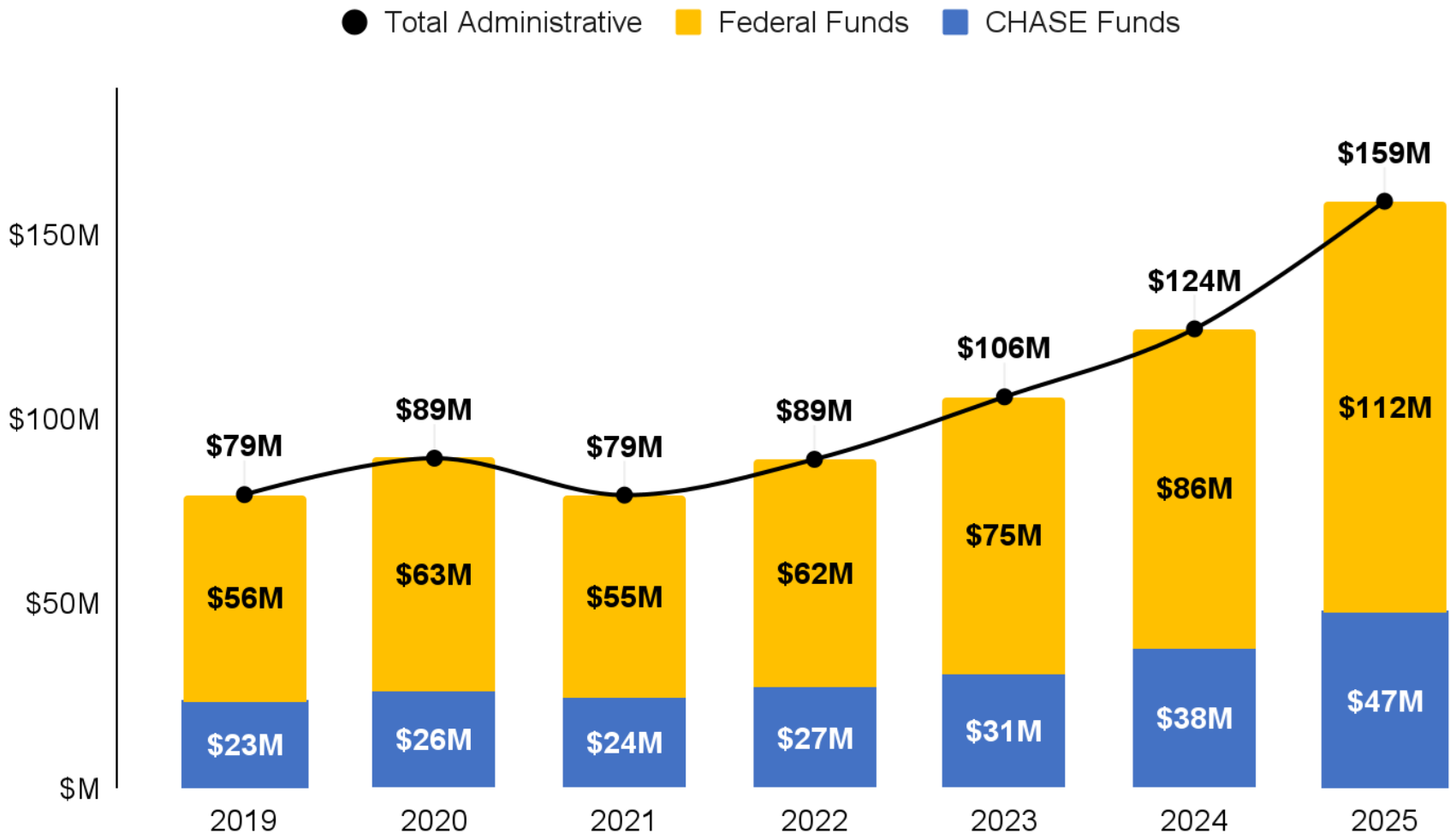


ACA FMAP :	93.25%	90.75%	90%	90%	90%	90%	90%

Administrative Expenditures

- CHASE statute regarding use of fees
  - § 25.5-4-402.4 (5)(b)(VI), C.R.S.

Administrative Actuals (SFY)



% of Total CHASE Exp. :	2.3%	2.6%	1.9%	1.9%	2.0%	2.51%	3.0%