CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

CHASE Initiatives Workgroup Meeting Notes

January 15, 2024
12:00pm- 1:30pm

CHASE Workgroup Meeting 2 Slides

Meeting Recording

1. Introductions and Recap

a. Workgroup members introduced themselves
   i. Alison Sbrana, Consumer
   ii. Annie Lee, President & CEO, Colorado Access
   iii. Emily King, Senior Policy Advisor/Deputy Director of the Office of Saving People Money on Health Care, Governor's Office
   iv. Josh Block, Deputy Chief Financial Officer, HCPF
   v. Dr. Kimberley Jackson, CHASE Board Vice President
   vi. Nancy Dolson, Special Financing Division Director, HCPF
   vii. Shauna Lorenz, Partner, Gjerset & Lorenz LLP
   viii. Tom Rennell, Senior Vice President Financial Policy and Data Analytics, CHA

b. Additional attendees:
   i. Bettina Schneider, Chief Financial Officer, HCPF
   ii. Melissa Eddleman, Behavioral Health Policy & Benefit Division Director, HCPF
   iii. Shay Lyon, CHASE Board Coordinator, HCPF
   iv. Danny Myers, Advent Health
   v. Matt Reidy, Public Consulting Group
   vi. Steve Perlin, Health Management Associates
   vii. Jacki Cooper Melmed, Chief Legal Officer, UCHealth
   viii. Greg Boyle, UCHealth
   ix. Noah Strayer, Office of State Planning and Budgeting

x. Jon Stall, Consultant

c. GPS recapped roles and responsibilities of the working group, consultants, and facilitators, workgroup ground rules and recent progress (slides 6-9)
   i. GPS interviewed 8 workgroup members, 3 key informants, and summarized 5 themes
   ii. HCPF met with CHA to review data sources and discuss modeling approach
   iii. Built a resource bank to house valuable materials for self-study (scroll to the end of the webpage and click on "Resource Bank")
   iv. Other progress or engagement
      1. N/A for this meeting

2. Review Insight Summary

a. GPS provided a brief overview of the interview participants, shared key themes, and reviewed potential actions (slides 10-14)
   i. Theme 1: Balance speed with surety
   ii. Theme 2: Contribute to balanced impact
   iii. Theme 3: Learn from other states
   iv. Theme 4: Guard against downside
   v. Theme 5: Operate with plenty of sunshine
   vi. Discussion:
      1. AS: scary prospect to be looking at changes to benefits for expansion populations. KJ: Second that concern

3. Roadmap, Model, and Key Questions

a. GPS reviewed the overall workgroup timeline and the charter's questions. HCPF (Nancy Dolson) discussed CHASE financial flows (slides 18-19).

b. Matt Reidy (PCG) discussed the interconnectedness of the CHASE Program along with factors that impact funds available and factors that impact supplemental payments (slide 20).
   i. ND: New federal regulations around directed payments: difference in timing between lump sum through directed payments vs add-on to managed care rates?
      1. MR: Federal rules published in May 2024 that made a lot of changes to SDP programs. Different implementation

dates that are staggered over next 5 years. One of those rules involved how SDP payments can be made.
    a. Extra payment as part of capitation rate OR
    b. Separate payment from capitation rate
2. JB: Federal rules say must be incorporated into the capitation, which transfers risk. HCPF must estimate amount of SDP up front, which means there will likely be a shortage or surplus.
3. TR: Reminder that we will have to provide an annual filing. There are steps we can take along the way and may do something different in year 2 or 3 than in year 1.
4. AL: To clarify - new regulations requires that the SDP be part of the capitation? JB: that is my understanding based on specific federal regulation. When CMS has regulations that will change as of dates certain, they are typically hesitant to approve under old regulations.
    a. 42 CFR 438.6(c)(6).Payment to MCOs, PIHPs, and PAHPs for State Directed Payments.
        i. (6) Payment to MCOs, PIHPs, and PAHPs for State Directed Payments. The final capitation rate for each MCO, PIHP, or PAHP as described in § 438.3(c) must account for all State directed payments. Each State directed payment must be accounted for in the base data, as an adjustment to trend, or as an adjustment as specified in § 438.5 and § 438.7(b). The State cannot withhold a portion of the capitation rate to pay the MCO, PIHP, or PAHP separately for a State directed payment nor require an MCO, PIHP, or PAHP to retain a portion of the capitation rate separately to comply with a State directed payment.
5. SP: Vast majority of uniform payment adjustments are being implemented using a separate payment term (outside the capitation and layered on top of) to balance how much the providers are financing and tracking payments through the system to the plan to the hospitals. Rule is nearly 1,000 pages and complex. Implementation timeline varies and there is a window.

This group needs to decide what the best path forward is. Transparency is crucial.

6. ND: High level overview of implementation timeline can be seen here. There will be ongoing work and the approach will need to change over time. Important to set expectations.

c. HCPF (Nancy Dolson and Jeff Wittreich) provided an overview of the State Directed Payments Program Model (slides 21-22).
   i. MR: SDP need to be incorporated into managed care contracts (CMS requests copies to check them). Actuaries need to review, per CMS guideline.

d. Discussion Questions:
   i. **Funding:**
      1. Use inter-governmental transfer (IGT): from which public hospitals and amount?
         a. TR: Hospitals will want a voice in this if they are interested in using IGT funding. Expect some will and some will not. Be careful that we aren't mandating and that there is some flexibility.
         b. ND: Team is modeling now and need this information to successfully build the model.
         c. TR: Stepwise process. First thing we do is to size how much we are talking about: how much room do we have on the fee size, what is the ACR – how big or small the pie is, etc. Then determine how to divvy up the pie (e.g., determine how much and for whom).
         d. JB: worthwhile reminder that we need to consider TABOR when we are discussing IGTs.
         e. ND: IGT = allowable source of non-federal share of Medicaid that comes from another governmental agency that comes to HCPF and can be used to draw down federal funds. Don't use these often because IGT counts towards the TABOR revenue limit. Can have a negative General Fund impact (GF must pay excess funds collected above TABOR limit). It may be allowable for the CHASE Enterprise to accept an IGT and consider it exempt from TABOR. Will need to be vetted by legal experts.

f. AL: Process-wise, given the complexity and interconnectedness, understanding the implications of how decision points impacts other decision points/design. Is there a way to consider these decision points together/simultaneously? What will be helpful in considering questions as we move forward?
g. SL: Could do extensive analysis on impact on TABOR, but should we reduce our scope in analysis around IGTs if they are allowable/exempt from TABOR?
h. ND: Working from assumption that the state would not be able to do any IGT under TABOR at all, given current forecasts and TABOR caps. Making the assumption that any IGT would need to be considered TABOR exempt. Attorney General's Office and Legislative Legal Services would need to weigh in on the proposal.
i. SL: Don't see a way to make it work without IGT.
j. ND: We have sent the question to the AG's Office.
    i. **ACTION: Get a status on the AG's response related to the viability of an IGT if directly to the Enterprise.**

2. Revise inpatient and outpatient hospital provider fee methodologies with goal to simplify, amount of provider fee? Currently at 5.54% of 6% of NPR limit.
    a. SL: not sure simplification should be the primary goal. There are other goals that are more important such as whether providers and safety net hospitals are losing money.
    b. TR: important primary goal is to not have hospitals lose as a result of the program.
    c. ND: CHASE Board has charged us with considering how hospitals are impacted. Our provider fee methodology has been in place since 2010 and hasn't been reviewed since then. Reviewing that methodology for changes that both support primary goals and potentially simplify could be important.
        i. **DECISION: When revisiting the methodology, simplify to the degree possible, but this is a secondary goal**

d. SL: 6% is currently based on hospitals that are included in the fee. Federal law is 6% of ALL inpatient and outpatient services in the state (regardless of whether they are in the fee). Does not mean the net patient revenues are excluded in the 6% calculation.
e. AL: Implications of going to 6% limit?
f. ND: Net patient revenue is estimated. Build CHASE backwards and look at a variety of factors. Want to be sure we aren't doing anything that is a GF risk. NPR estimate needs to be as sound as possible (5.54% is pretty close to actual).
    i. **ACTION: Size the potential impact ("size of the pie") at 5.54% and 6% for both the current convention (all hospitals paying the fee) AND for all hospitals in the market.**

ii. **UPL Supplemental Payments**

1. Revise existing UPL supplemental payments to simplify payment calculations and tie to utilization?
2. Preserve funding to Critical Access Hospitals?
3. Support hospitals with high volume of Medicaid care (i.e., safety net)?
    a. **DECISION**: **Consensus to include all items below as they are components of the existing CHASE model**

iii. **State Directed Payment Program**

1. AS: SDPs can be directed to community-based care, HCBS, other outpatient services. This is cost effective and beneficial for all parties. Are we talking about using SDP only for hospitals or are we thinking about supporting other services that prevent hospitalizations?
2. TR: This program is funded through hospital fees to generate supplemental payments. There are other ways to fund all other important services. It is slightly outside the scope of what the CHASE program does (with exception for expansion populations). Not intended to take a piece of the fund and direct to other specific provider types. CHASE Enterprise was set up to fund hospital provider types. Unsure if we have the authority under current program.

3. ND: CHASE law and feeding the fee under TABOR requirements require that fee payers are the ones that benefit from the funds collected. Accountable Care Collaborative is really important and the need for the hospitals to be working with the RAEs is included in the Hospital Transformation Program.
4. KJ: Working with and including MCOs in this program. Are there MCOs that are more connected to the work now? My understanding is that we don't have a lot of managed care yet. If we move in that direction, does that change where services are delivered and do we need to think about that?
5. JB: One of the major differences between this program and UPL is the initiative to fund through a managed care organization. Because the rate is a fixed amount, it can draw money away from other places to meet that fixed amount. It is critical to figure out how we develop an SDP model that does not put other programs at risk.
6. TR: Could it go the other way? Could be underfunded but could also be overfunded. Estimates and actuary work is going to be critical.
7. SL: There is no risk under a separate payment term and CMS is doing presentations to states on how to protect against the potential risk in SFY 2029.
8. AL: 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?
    a. **ACTION: Discuss this at next meeting.**
9. Include inpatient and outpatient hospital services?
10. Hospital types? General, acute care and Critical Access Hospitals and free-standing psychiatric hospitals?
    a. Expect these to be included in model
    b. AS: Would all types of hospitals be supported equally or would there be say priority support for critical access hospitals?
        i. **ACTION: Discuss this at next meeting.**

iv. **Disproportionate Share Hospital (DSH) Payments**

1. Forgo some federal DSH funds if safety net hospital reimbursement can be increased?
    a. TR: replacing (rather than forgoing). SDP would exceed and then replace DSH. See this as a mechanic of putting the new program in.
    b. **DECISION: Consensus that this replacement or substitute of DSH funding should be included in model.**

4. Resources

a. HCPF has created a resource bank to enable asynchronous and self-paced learning. Scroll to the bottom of the Work Group webpage and click on "Resource Bank"
b. Opportunities for independent study, feedback, and questions
    i. Individualized support and deeper learning for workgroup-relevant topics are available upon request. Please direct requests to Laura and Greg and they will facilitate responses (laura@governmentperformance.us and greg@governmentperformance.us).
    ii. There is also a dedicated email box for this project, available to workgroup members and any other stakeholders: HCPF_CHASE_SDP@state.co.us
    iii. The Workgroup will have a few business days in advance of each meeting to review upcoming meeting materials
    iv. Agendas, meetings materials, and notes will be posted on the CHASE SDP Workgroup website

5. Next Steps

a. GPS to share meeting notes with decisions and actions.
b. Modeling resources will begin doing their work and tap analytic support as needed.
c. HCPF will post the next workgroup meeting on its website.
d. HCPF will post an agenda ahead of the second workgroup meeting.

6. **Next Meeting:** January 29, 2025, from 12:00-1:30pm MT. Please visit Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) State Directed Payment Program Workgroup

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