CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

CHASE Initiatives Workgroup Meeting Notes

January 29, 2024
12:00pm- 1:30pm

CHASE Workgroup Meeting 3 Slides

Meeting Recording

1. Introductions and Recap

a. Workgroup members in attendance
   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. Melissa Eddleman, Behavioral Health Policy & Benefit Division Director, HCPF
   ii. Jeff Wittreich, HCPF
   iii. Shay Lyon, CHASE Board Coordinator, HCPF
   iv. Matt Reidy, Public Consulting Group
   v. Steve Perlin, Health Management Associates
   vi. Jacki Cooper Melmed, Chief Legal Officer, UCHealth
   vii. Greg Boyle, UCHealth
   viii. Jon Stall, LS Point
   ix. Kristin Weissinger, UCHealth

c. GPS recapped ground rules, recent progress, and open questions (slides 6-9)
    i. Shauna shared a Milliman report showing AZ's approach to calculating NPR; added this to the Resource Bank. Seeking other examples and documented CMS feedback
    ii. Engaged with CHA and their consultants to provide insight on how they proposed to calculate the Average Commercial Rate (ACR) and what data sources can be used
    iii. Other progress or engagement
        1. N/A for this meeting

2. Sizing the Potential Impact

a. Provider Fees and Revenue (slides 11-12)
    i. Important to note that all proposals will require CMS approval
    ii. Columns show estimates for fee, federal funds, and total funds using status quo, 5.75%, and 6.0% of Net Patient Revenue (NPR) for both fee-paying hospitals only and for all hospitals. Focus on federal funds line for changes in overall revenue.

b. Discussion:
    i. *Steve Perlin*: any trending applied in these calculations? Nancy: Calculations based on 2022 cost reports (as filed through HCRIS) and trend data forward, using a 3-5 year rolling average change in NPR.
    ii. *Josh Block*: Clarify the difference between the figures on slide 12 regarding fee-paying hospitals and all hospitals and impact on fees paid by hospitals.
        1. *Annie Lee*: Is part of the charge of the workgroup to look at this impact and make recommendations based on the desired outcome? Why would we aim for or recommend a certain increase? *Nancy Dolson*: The charge is multiple things: add a state directed payment program and review existing provider fee and UPL. Understanding what different factors and variables apply.
    iii. *Tom Rennell*: We are trying to leverage available federal funding and not putting the CHASE program at risk. (This slide) demonstrates some possible scenarios and helps frame in some of the options we will have in front of us.
    iv. *Annie Lee*: Appreciate the interconnecting pieces and seeing these figures are helpful. If we start with the numbers rather

than working through the goals, we don't necessarily know what the costs are of the goals.

3. Model Features and Key Questions

a. GPS reviewed the overall workgroup timeline and emerging consensus around specific assumptions (slides 14-15).
b. Nancy Dolson (HCPF) discussed the interconnectedness of the CHASE Program along with factors that impact funds available and factors that impact supplemental payments that need to be considered in the model (slides 16-24).
    i. Current fee methodology was approved by CMS in 2010 and has not been adjusted since.
    ii. Assumption is that adjustments to CHASE supplemental payments will be focused on inpatient and outpatient supplemental payments and will comply with upper payment limits.
c. *Discussion:*
    i. *Annie Lee*: Are we considering adjustments to the current CHASE model (Current model "with adjustments")? *Nancy*: Yes, we will be revisiting the existing structure and is included in the overall charge for the workgroup.
    ii. *Tom Rennell*: The CHASE program has evolved over years where supplemental payments are based on fee-for-service. As we look at supplemental payments based on managed care, we will need to look at things together. One of the goals is to minimize the hospitals who are negatively impacted. As we look to bring managed care in, we may have to rebalance the existing model to make sure that it all makes sense in totality.
    iii. *Alison Sbrana*: With how tight our timeframe is, are we looking to review the existing model and the state directed payments? *Nancy*: Yes, that is what we have been charged with.
    iv. *Alison Sbrana*: How will the adjustments to the current model and the state directed payment work together? *Nancy*: We are using emerging consensus as guiding guardrails (e.g., essential access and rural support program payments remain consistent, etc.). We will use these guidelines to develop a proposal or model that demonstrates the changes in total.
    v. *Annie Lee*: How many and which hospitals we're talking about (and who do they serve) when we reference including the

currently/previously excluded hospitals? Not urgent or essential but helps make the potential impacts more real.

vi. *Tom Rennell*: Would hope that all hospitals would be included in the future model. BH or psychiatric hospitals typically worked in managed care so the current CHASE program doesn't work well for them, since they would have been paying fees and not receiving any payments. Now, we might want to reimagine who can participate so that we can look for ways to benefit all hospitals.
    1. Are we discussing assessing fees on hospitals who are not currently paying fees in the future model? *Nancy Dolson:* If we are increasing the number of hospitals that are benefitting from the increased payments, then we may also want to consider increasing the number of hospitals that are paying the fee.

vii. *Alison Sbrana*: **For a future meeting:** Commercial payers do not pay as much for behavioral health and Medicaid/Medicare payers pay more? Do we need to factor this in? As a consumer rep is that I want to try to preserve coverage for expansion populations as much as possible. So whatever strategies get us there is what I am interested in
    1. *Matt Reidy:* We do not yet have an answer and need to gather the data.

viii. *Alison Sbrana*: **For a future meeting:** 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?

ix. *Josh Block*: Are there hospitals who do not receive payments and do not pay fees? *Nancy*: Psychiatric hospitals, based on the fact the behavioral health services are under managed care and very little that are under fee for service. The current CHASE program does not provide a mechanism to make supplemental payments for managed care.

x. *Josh Block*: Regarding the preprint, the top says January 2021. Have we seen anything from CMS since they updated their regulations? Would we expect an update from CMS to reflect recent regulations? *Matt Reidy*: 2021 is the current version and yes, we should expect an update.

xi. *Annie Lee*: What is the rationale for not using a value-based payment approach in year 1? *Tom Rennell*: Under the current CHASE program, there is a sizable value-based program (VBP)

that already exists that has taken years to implement. Creating a VBP is a sizable and significant undertaking, and we have an extensive VBP already in existence.

xii. *Josh Block*: VBP is an interesting phrase because it means different things to different people. Is the pertinent question: are there minimum requirements (SDP) payment recipients must meet before payment is triggered? There may be something along the VBP spectrum that meets the needs and goals of the program. Is there an overlay with HQIP that can be used? *Nancy Dolson*: The preprint requires inclusion of quality metrics and an evaluation strategy. *Matt Reidy*: State can choose the approach for SDP (add-on to claim) or VBP (state can withhold funds pending satisfactory performance). Seven pages of the preprint are dedicated to quality. The state's managed care quality strategy is a required component.

4. Average Commercial Rate (ACR) Calculation Options

a. Tom Rennell (CHA) and Matt Reidy (PCG) reviewed options and variables associated with calculating the average commercial rate (ACR). We are proposing to use cost reports as data source to calculate ACR given their credibility and accessibility. CMS has accepted this methodology (in other states). (slides 26-29)

b. Discussion:

i. Josh Block: To what extent does this information already exist? What would we be asking of hospitals for cost reporting? *Shauna Lorenz:* Cost reports can be pulled from the federal database (HCRIS). There is a 6-month delay between when they are filed and when they are published. There is also a Rand publication and sign up for their cost report summary/synthesis. These are filed costs for Medicare program and for the purpose of Medicare, but they include other data that allows us to understand the variables we need to calculate CMS views this as a conservative method of calculating. Some states survey hospitals to gather the ACR (but there is no vetting of the information) and there are some other 3rd party surveys.

ii. Annie Lee: The advantages of this option are that it has been approved in other states, CMS likes it, it yields what we want to see in terms of what we want to see going to hospitals. Are there drawbacks or disadvantages? *Shauna*: some would say

that this methodology understates what the commercial rate is. The ”noise” in the calculation deflates what it could be.

iii. *Tom Rennell:* This data can be obtained quickly and while it does not hit all the way up to the maximum, it is reasonable to go forward with. Not getting pushback from within the hospital industry and we are ok with this. *Annie Lee*: this option already has the buy-in of the CHA membership.

iv. *Annie Lee*: It seems like all the prework has been done on option 1, so there is not much for us to consider on the other options. Feels like more of an education than a decision.

v. *Josh Block*: **For a future meeting**: How does the ACR ratio turn into actual payments (in terms of mechanics)?

5. State Directed Payment Preprint Requirements *(held for next meeting)*

a. Matt Reidy and Megan Morris (PCG) will review CMS requirements for the state directed payment preprint at the next meeting (slides 30-33)

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

Resources

1. 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”
2. Opportunities for independent study, feedback, and questions
    a. 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).

b. There is also a dedicated email box for this project, available to workgroup members and any other stakeholders: HCPF_CHASE_SDP@state.co.us
c. The Workgroup will have a few business days in advance of each meeting to review upcoming meeting materials
d. Agendas, meetings materials, and notes will be posted on the CHASE SDP Workgroup website

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