CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

CHASE Initiatives Workgroup Meeting Notes

March 26, 2025
12:00pm- 1:30pm
CHASE Workgroup Meeting 6 Slides
Meeting Recording

Commented [LS1]: Link to PDF slides

Decisions Made During This Meeting:
- N/A

Actions Assigned:
- PCG to share ACR weighting options spreadsheet
- PCG to follow-up to determine if an adjustment was made for teaching hospitals.
- GPS to follow up with CHA for other payment to cost benchmarks (e.g., RAND, CHASE report, HCPF pricing tool, etc)

Questions to be Discussed at Future Meetings:
- Confirm cost-to-payment data validity
- Revisit the frequency of these meetings
- Revisit the timeline – request an extension or not

Notes:

1. Introductions and Recap

a. Workgroup members *(regrets with strikethrough)*
   i. Alison Sbrana, Consumer
   ii. ~~Annie Lee, President & CEO, Colorado Access~~*; unable to attend but will review recording*
   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, HCPF
ii. Clay Phillips, Summit BHC
iii. Greg Boyle, UCHealth
iv. Jaret Kanarek, LS Point
v. Jason Durrett, Adelanto HealthCare Ventures
vi. JP Witt, unknown organization
vii. Kami Tam Sing, HCPF
viii. Katie Ryan, Denver Health
ix. Mary Goddeeris, HMA for CHA
x. Melissa Eddleman, HCPF
xi. Matt Reidy, Public Consulting Group (PCG)
xii. Rachel Gilbert, Burr & Forman on behalf of Peak View
xiii. Scott Humpert, Public Consulting Group (PCG)
xiv. Shay Lyon, HCPF
xv. Terri Massingill, Peak View Behavioral Health
xvi. Phone (last four digits): 3325

a. GPS recapped ground rules, caveats, emerging consensus, open questions, and an approach for working together

2. **Sizing the Potential Benefits and Considerations (~12:05 PM)**
   a. Nancy Dolson (HCPF) reviewed components of model development and current status and provided an update on the FY 2024-25 CHASE model.
      i. Discussion:
         1. KJ: We mentioned it might have implications in terms of paper and legislation.
         2. ND: Intergovernmental transfer (IGT) is assumed would not be considered Tabor Revenue. There would need to be a change to the CHASE statute to allow a transfer of funds. A number of items are in development.
         3. AS: Does this mean the path forward is to pursue IGTs and explore what is feasible there, and is that realistic within our timeline?
         4. ND: The timeline is aggressive. As the whole picture comes together, once an ACR methodology and fees are available,

it will make engagement with public hospitals more meaningful.

5. TR: We'll discuss timelines today, and we realize it's getting tighter. We are doing good base building. We need to discuss what to do if we cannot meet the deadline. It will be challenging to file a preprint by July 1.
6. JB: Regarding the quality strategy component, we haven't discussed that yet – what are the minimum requirements and boundaries that CMS will accept at the minimum level?
7. AS (from chat): I agree with JB.

3. ACR Calculation (~12:25 PM)

a. Scott Humpert (PCG) reviewed key details and considerations for calculating the average commercial rate (ACR), which is a key component to sizing the overall SDP program.
   i. Discussion:
      1. PCG: 85 ratios into a single value through a volume measure with several options for weighting (12:29 PM got into details of weighting options)
      2. KJ: Would this be the upper limit?
         a. PCG: Yes, depending on how much state funds are available
      3. ND: Are these total computable funds?
         a. PCG: Yes
      4. EK: Can you explain exactly what we are weighting?
         a. PCG: Screen shared a spreadsheet. For each hospital, there is a payment-to-cost ratio. There are currently 85 payment-to-cost ratios, and we aim to arrive at a single number. The different methods are different weighted averages to get to a single number.
      5. RG, Peak View (from chat): To clarify, why would the ACR calculation shift money to or from any hospitals? It's just a calculation of the room available, not a method of directing payments.
         a. PCG: When we consider the NCO revenue and weigh all 85 cost ratios together, mental health hospitals account for approximately one-third of the total amount.

6. TR: Thank you to Nancy for wrestling with these challenges. These calculations have a big range. When we started looking at this on Friday, we wanted to dig in to understand it better, and we are doing that today. Do these numbers make sense as we pull back out? The cost report method was understating the costs but we thought it was reasonable. There are other data points that are out there that seem a little higher. We considered using CIVHC data source that compares Medicare to Commercial at 239%, even though Medicare and Medicaid are not the same. The CHASE report is 223%, and RAND, although I'm not a fan of RAND, is at 290% for 2022, which seems way out of range. I want to ensure that we are computing this correctly or that we need to consider other data points. We should reevaluate some methods for discussion.
7. RG, Peak View (from chat): Is the model assuming that payments will be distributed based on hospitals' ACR room? That doesn't seem correct. Otherwise, the statewide ACR calculation shouldn't "shift" the payments one way or the other.
    a. JB: If we look at column K in PCG's spreadsheet, that information goes into the high-level 154% calculation, and the actual distribution to each hospital is based on (different factors). Column K, the numbers are shocking and concerning. If I'm reading this correctly, the UC Hospital has an inpatient cost ratio of 426%, and Parkview Medical Center has a cost ratio of 40%. I'm wondering about the reliability of the data because these numbers don't seem accurate. These numbers give me pause, and I want to ensure these numbers are reliable.
8. AS (from chat): How much should we be considering what is likely to be approved by CMS? It sounds like the commercial revenue path could be possibly riskier for getting approved given the range, and I am curious to know from the consultants if that is something to consider in choosing which rate calculation
    a. SL (from chat): We believe CMS will approve either of the commercial weighting methods. We have only seen CMS approve the commercial "payment" weighting.

9. ND: Can you help us understand the different cost-to-payment ratios? Why are these producing different numbers? (~12:53 PM)
    a. SH, PCG: Cost ratio in column L is the total revenue weight, multiples column K with column L to get to column M.
10. EK (from chat): Can you please share the spreadsheet with us? I think it would be helpful for some of us (at least me!) to be able to play around with the formulas to understand what is going on here.
    a. SH, PCG: Yes, we will share the spreadsheet after today's meeting.
    b. **ACTION:** Share the PCG spreadsheet along with the meeting notes.
11. JD, Adelanto (from chat): CMS has also approved the use of the RAND report and state-based surveys to calculate the ACR room for statewide hospital programs.
12. TR: I appreciate the spreadsheet. Before we get locked into saying what is right or not proper, I think we need to dig into the details. We are showing Denver Health a payment-to-cost ratio of 54%. I can tell you there is no way this is a real number. We went back to the hospital, and Denver Health stated that this understates our payment-to-cost ratio and includes items that are not commercial costs, and it underestimates the overall model. We need to make sure we are reasonable, because some things look weird in the data.
13. KJ: Looking at the outliers in this list, take within 2 standard deviations within the mean, or would that confound the data more?
14. SH, PCG: Overall, if we look at the block of hospitals the data looks reasonable. If we begin excluding hospitals that payment to cost ratios will begin creating calculation issues. The 104% is the average across all hospitals, and although somewhat off, it does get to an average across all hospitals.
15. KJ: Is the educational funding part of UC Health?
16. SH, PCG: I know that was considered but I don't know if we made an adjustment for education hospitals.
    a. **ACTION:** PCG to follow-up to determine if an adjustment was made for teaching hospitals.
17. MR, unknown organization: The state must describe the formula it uses to calculate ACR, and the state must select

a methodology that it feels comfortable defending during the initial CMS review. The state also needs to be able to defend against an auditor. The use of cost reports is allowable under federal rules because they are readily available but not perfect, and nothing is perfect. The federal OIG did not think the federal contractors were ensuring the accuracy and validity of the data. In 2024, there was a wide variety of data sources and methodologies, but it always comes back to reasonable methodology.

18. AS (from chat): I can ask this after Nancy and maybe it will come up, but I want to check in big picture. This calculates the ceiling of the payments that could be made, correct? However, given what we discussed earlier in our meeting, we may not have this level of funding to offer with a SDP, yes? Obviously, we want accurate data to calculate the ceiling of payments accurately, but if we don't have significant funds for a SDP, it's possible we couldn't even approach the ceiling.
19. JB (from chat): I think you're right about the big picture. If I understand this correctly, (e.g.,) 154% would be the key number in calculating the maximum amount we can potentially draw down under an SDP program. You're right again about the ceiling: The higher than number is, the higher the max SDP is, but also, the closer it puts us to the fee revenue limits and potentially crowds out other things.
20. JB (from chat): There are a number of different ways to calculate the statistic. Then, it is limited by 2 factors: a 6% MPR limit and the state statute that says how the fee has to be distributed with federal funds. Then we can run into we don't have enough money to pay for that. If there is not enough fee available – for example if there is only fees available to cover 150%, it doesn't matter if we select 154% or higher.
21. TR: I think those are important considerations. Maybe the IGTs will come into play. I'm going back to Denver Health because they handle a high volume of Medicaid managed care, and the cost ratio is coming in unusually low, which is weighing heavily due to the high volume. I believe Denver Health plays a significant role in Colorado's Medicaid-managed care. It doesn't address the financing,

but I would like more time to work through this calculation to ensure we are using a reasonable estimate.

22. JB: Speaking of confidence in these numbers. Can we compile a bunch of other information about these ratios, other states, and RAND to acknowledge even if we have to proxy, they all fall within this range so we can confront these numbers straight on?
    a. **ACTION:** GPS to follow up with CHA for other payment to cost benchmarks (e.g., RAND, CHASE report, HCPF pricing tool, etc)
23. EK (from chat): I have to drop to attend a conflicting meeting but appreciate the discussion, and look forward to reviewing the numbers offline -- sounds like more time to review all of these numbers would be helpful for everyone.

4. Evolution of CHASE (1:12 PM)

a. The workgroup discussed the proposal to pursue separate payment terms as part of the SDP program in the near term and advising the CHASE Board to re-evaluate over time. The workgroup also discussed the pros and cons of using this approach versus requesting additional time from the CHASE Board to consider alternative approaches.
    i. Discussion:
    1. KJ: A few thoughts. I've done a lot of research in our off time. CMS has not approved any new preprints under the current administration.
        a. MR: 1 state-directed payment from New Hampshire that was submitted in June 2024 approved in February 2025.
        b. MG: One more preprint was approved, and they are now looking at these.
    2. KJ: Any further guidance from CMS?
        a. MR: Not yet
    3. KJ: If we try to get a proposal and take advantage of the funding while it is there, is there a risk of putting together a proposal that CMS denies and then wait another year? We it be prudent to wait to see what comes down the pipe for Medicaid and then try something in a year?

a. MG: I haven't seen CMS completely deny a preprint. There is no rule that if they don't like a preprint you need to wait a year. States need time to align their state legislation to the new regulations to comply with the new rules. It could be beneficial to go after using the current regulations in place. When starting from scratch CMS has historically understood there will be back-n-forth to find a solution.
b. JK (from Chat): To the extent helpful, CMS just approved a preprint in February 2025 (https://www.medicaid.gov/medicaid/managed-care/downloads/NH_VBP_BHO_New_20240901-20250630.pdf).
c. JB (from chat): For that NH approval, was that a preprint under the "old" methodology? It looks like they're heavily relying on VBP arrangements based on utilization, and I wonder if it's materially different than the option we're considering.
d. AS (from chat): I was wondering the same.
e. JK (from chat): It would have been subject to several of the new rules because the effective date was after July 9, 2024. However, this NH program is different in a lot of ways than what CO is proposing.
f. MG (from chat): Just adding to that, the NH approval is different from what we're talking about here and it is a VBP arrangement rather than what is referred to as a "fee schedule requirement" which is what we're looking to do. The VBP arrangements are a different type of directed payment and have different requirements. The other preprint I referred to that we have seen approved by this administration (that hasn't been posted yet) was a hospital separate payment term preprint.
g. SL (from chat): We have a similar experience as Mary. We have never seen CMS deny/reject a pre-print. We have only seen CMS engage in dialogue with states to request that they amend the pre-print. Some states have submitted more than 5

amendments to the pre-print based on CMS feedback.

4. AS (from chat): How does our current information on size of potential SDP and the likely need for IGT impact our conversation on the timeline? If I put that aside, given the current uncertainty, I would be comfortable with a short-term solution and recommend to the board that we develop a longer-term plan.

5. TR: We need to establish a level of commitment if we are going to conduct an IGT, and we must determine what that level is. Until we reach an agreement on this, we cannot submit anything. We are all pushing to move this forward, but I want to acknowledge Nancy and HCPF are doing everything they can. We could file for an effective date of July 1, 2025; however, the actual filing date is August 1, 2025. However, I would like experts to weigh in on the risks and benefits of this option.
    a. MG: In the regulations, they are trying to move those dates, but they acknowledge they get requests after the start of the fiscal year.
    b. MR: The origin was CMS was getting preprints midway through the year, and that's why they moved to the start of the fiscal year. There is sub-regulatory guidance that they can issue at any time.
6. KJ: Should we meet more frequently or do people need the time to get a handle on the data and information we are reviewing?
7. TR: We might need to pull the group together more as we get closer to the deadline.

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:** April 9, 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

Keep Up to Date with CHASE Workgroup Activities
Subscribe to the Newsletter
HCPF_CHASE_SDP@state.co.us

Meeting Chat Transcript

Alison Sbrana - Consumer 12:19 PM
I agree with Josh on quality strategy
Messages addressed to "meeting group chat" will also appear in the meeting group chat in Team Chat
Due to the large number of participants in this meeting, system messages for those who joined or left have been disabled

Rachel Gilbert (Burr & Forman) 12:33 PM
Hello. I am listening in behalf of Peak View. To clarify, why would the ACR calculation shift money to or from any hospitals? It's just a calculation of the room available not a method of directing payments.

Rachel Gilbert (Burr & Forman) 12:42 PM
I tried to speak but didn't come through. Is the model assuming that payments will be distributed based on hospitals' ACR room? That doesn't seem correct. Otherwise, the statewide ACR calculation shouldn't "shift" the payments one way or the other.

Alison Sbrana - Consumer 12:43 PM
How much should we be considering what is likely to be approved by CMS? It sounds like the commercial revenue path could be possibly more risky for getting approved given the range, and I am curious to know from the consultants if that is something to consider in choosing which rate calculation

Rachel Gilbert (Burr & Forman) 12:47 PM
Thank you, I appreciate the clarification.

lorenz 12:49 PM
We believe CMS will approve either of the commercial weighting methods. We have only seen CMS approve the commercial "payment" weighting.

Emily King 12:49 PM
Can you please share the spreadsheet with us? I think it would be helpful for some of us (at least me!) to be able to play around with the formulas to understand what is going on here

Jason Durrett 12:52 PM
CMS has also approved the use of the RAND report and state based surveys to calculate the ACR room for statewide hospital programs.

Alison Sbrana - Consumer 1:01 PM
I can ask this after Nancy and maybe it will come up, but I want to check in big picture. This is calculating what is the ceiling of what payments could be, right? But given what we talked about earlier in our meeting, we may not have this level of funds to offer with a SDP, yes? So obviously we want accurate data to appropriately calculate the ceiling of payments, but if we don't have significant funds for a SDP then it's possible we couldn't even get close to the ceiling?

Josh Block (HCPF) 1:02 PM
Alison, I think you're right on about the big picture. If I understand this correctly, the (e.g.) 154% would be the key number in the calculation of the maximum of how much we can potentially draw down under an SDP program.

Josh Block (HCPF) 1:03 PM (Edited)
And I think you're right again about the ceiling: The higher than number is, the higher the max SDP is; but also, the closer it puts us to the fee revenue limits and potentially crowds out other things

Emily King 1:12 PM
I have to drop to attend a conflicting meeting but appreciate the discussion, and look forward to reviewing the numbers offline -- sounds like more time to review all of these numbers would be helpful for everyone. Thanks!

Jaret Kanarek (LS Point) 1:17 PM
To the extent helpful, CMS just approved a preprint in February 2025 (https://www.medicaid.gov/medicaid/managed-care/downloads/NH_VBP_BHO_New_20240901-20250630.pdf).

lorenz 1:23 PM
We have similar experience as Mary. We have never seen CMS deny/reject a pre-print. We have only seen CMS engage in dialogue with states to ask them to amend the pre-print. Some states have submitted more than 5 amendments to the pre-print based on CMS feedback.

Alison Sbrana - Consumer 1:23 PM
How does our current information on size of potential SDP and likely need for IGT impact our conversation on timeline?

Josh Block (HCPF) 1:22 PM
For that NH approval, was that a preprint under the "old" methodology? It looks like they're heavily relying on VBP arrangements based on utilization, and I wonder if it's materially different than the option we're considering

Alison Sbrana - Consumer 1:22 PM
I was wondering the same

Jaret Kanarek (LS Point) 1:25 PM
It would have been subject to several of the new rules because the effective date was after July 9, 2024. However, this NH program is different in a lot of ways than what CO is proposing.

Mary Goddeeris - HMA for CHA 1:27 PM
Just adding to that, the NH approval is different from what we're talking about here and it is a VBP arrangement rather than what is referred to as a "fee schedule requirement" which is what we're looking to do. The VBP

arrangements are a different type of directed payment and have different requirements. The other preprint I referred to that we have seen approved by this administration (that hasn't been posted yet) was a hospital separate payment term preprint.

Clay Phillips 1:31 PM
Can you please add clay.phillips@summitbhc.com to the meeting invitation list.

Nancy Dolson - HCPF 1:32 PM
the meeting invites are only to the workgroup members and consultants. but the workgroup's schedule is on the website with zoom link https://hcpf.colorado.gov/for-our-stakeholders/committees-boards-and-collaboration/colorado-healthcare-affordability-and