CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

CHASE Initiatives Workgroup Meeting Notes

May 7, 2025
12:00pm- 1:30pm
CHASE Workgroup Meeting 9 Slides
Meeting Recording

Actions Assigned:

- HCPF will work with Hospitals and RAEs to better understand how data is gathered currently on the Quality Subgroup's 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)
- Matt Haynes and Kami Tam Sing (emails linked) will manage the process and will bring findings to the workgroup for final consideration at the next meeting. Annie Lee volunteered to share the RAE perspective and Tom Rennell volunteered to help create connections to hospitals.

Questions to be Discussed at Future Meetings:

- **Tom Rennell**: When a new facility opens or new services start up, would they be able to participate in the SDP program once they begin providing services? What processes do we need to have in place to account for changes like this?
- **Matt Haynes** re: Quality Measures: Annie Lee, do you have a good sense of the data that might be available as well as any limitations related to the measures that are included in ACC II and will be included in ACC III measures? Do we feel like we have a good data set?

Notes:

1. Introductions and Recap

a. Workgroup members *(regrets with strikethrough)*
   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, HCPF
   ii. Bethany Pray, CCLP
   iii. Helen Ross, SLV RMC and CCH
   iv. Greg Boyle, UCHealth
   v. Jamie Whitney
   vi. Jaret Kanarek, LS Point
   vii. Jason Durrett, Adelanto HealthCare Ventures
   viii. Jeff Wittreich, HCPF
   ix. Jim Cairns, PCG
   x. Jon Stall, LS Point
   xi. Kami Tam Sing, HCPF
   xii. Mary Goddeeris, HMA for CHA
   xiii. Matt Haynes, HCPF
   xiv. Matt Reidy, Public Consulting Group (PCG)
   xv. Michael Joseph, PCG
   xvi. Rae True, UCHealth
   xvii. Shay Lyon, HCPF
   xviii. Scott Humpert, Public Consulting Group (PCG)
   xix. Windsar Fields, Adelanto HealthCare Ventures

c. GPS shared a plan for upcoming meetings, a progress update, and upcoming workgroup deliberations

c. Update on HB 25-1213: Nancy Dolson (HCPF) described legislation that is likely to head the Governor soon. This legislation is a technical amendment to allow the CHASE Cash Fund to receive IGT

and directs CHASE to seek approval for an SDP in collaboration with HCPF and the hospitals.

i. *Discussion:*

1. **KJ**: Does the bill address TABOR implications of IGT? **ND**: Assumption is that if the funds are appropriated to the CHASE enterprise, no TABOR implication. The legislation is clear that the IGT would be accounted for within the enterprise.

d. Current events or environmental updates:

i. **KJ:** Other states are looking at using provider taxes to cover General Fund shortfalls to address needs to meet coverage for MAGI (instead of expansion population coverage). Interesting to see what other states are doing. Glad we don't have provider taxes integrated into other state programs and/or to the General Fund, as it would be even harder to

1. **ND**: related to rhetoric around calling provider fees loopholes or gimmicks. Regulations around provider fees have been around for years and Colorado uses the provider fee and associated federal funds to cover benefits for a substantial population – more than 425,000 Coloradans (more than 1/3 of Medicaid caseload). Bringing in $3B to the state in total.
2. **TR**: we are all advocating against devastating cuts to Medicaid. Met with legislators yesterday and explained why and how important the provider fee is in Colorado, talked about the transparency, governance, etc. Encourage everyone to advocate and support the program.

2. ACR Methodology

a. Nancy Dolson (HCPF), Matt Reidy (PCG) and Scott Humpert (PCG) shared an update on subgroup discussions related to the ACR calculation, including progress to date and remaining discussion points.

i. *Discussion:*

1. **TR:** 2 BH facilities closed this year (uncertain whether they will remain closed). This week, Vail has opened an inpatient BH facility. When a new facility opens or new services start up, would they be able to participate in the program once they begin providing services? What

processes do we need to have in place to account for changes like this?

a. **SL**: In other states, we have seen new facilities get the payments. States have a lot of discretion in how this plays out. Technically, when truing up interim to actual utilization, should be accounting for all utilization.
b. **MR**: Issue will come down to how the state completes the preprint form. Some states name the specific hospitals that are included (have to if there is an IGT), others refer to a class or category of providers without naming them specifically.
c. **TR**: Any recent preprints that have been moved forward and any methodologies for us to know about? Helpful intelligence for us to know what CMS is working their way through.
    i. **MR**: CMS has been approving and posting preprints. Most recent batch had 22 new preprints (April 2025); 19 of which were renewals, 2 were amendments, 1 was brand new (for dentists – SDP rolled up into capitation rate to MCOs). Quite a variety of data sources and methodologies. We have been tracking length of time for review, which is getting longer. Team at CMS going through these has a stack of 100-150 still needing review (and more being submitted all the time).
    ii. **MG**: Heard of at least 2 approved last week. Tennessee's SDP was approved using a state survey. Did a lot of back and forth with CMS around it. Still waiting on getting budget neutrality. New Hampshire was also approved – had been trying to use RAND study as support for their ACR; CMS pushed back. Ended up using APCD to justify CMS.
    iii. **KJ**: Would the proposed cuts have an impact on the timeline for approval? **MG**: Similar process for approval except that it is speculated that there's another layer of review/approval needed. More voices to be heard. **MR**: Not a lot of Reduction in Force

(RIF) in the part of CMS that reviews preprints. Additionally, EO calls for presidential appointees to have more a role in decisions than they have previously.

2. Quality Measures

a. Matt Haynes (HCPF) reviewed the requirements, framework, and selection principles related to SDP quality measures. The subgroup identified 6 potential measures to include in the preprint.
   i. *Discussion:*
      1. Workgroup member **Alison Sbrana** provided written comments indicating her support. Here are those remarks:
         a. "As a consumer representative, I support our quality subgroup's conclusion to recommend these 6 quality measures to the workgroup for the upcoming year's SDP. I agree with these 6 quality measures because they align with existing or future quality measures to minimize administrative burden, and these metrics can continue to support quality care for our communities. I particularly want to note my support for two quality measures listed at the bottom of the table — the follow-up after ED visit for people with multiple high risk chronic conditions, as well as the social need screening. Both of these align with recent feedback I've heard from members across several advisory councils I run for Medicaid as well as for behavioral health services here in CO.

            Lastly, I want to note for the workgroup that yes, I absolutely do support these quality measures for the upcoming fiscal year's SDP, and also it continues to be my hope that we recommend to the CHASE board a simultaneous short and long term strategy with the SDPs. I would still like to see a value based system explored in the long run when there is sufficient time to prepare that. In the meantime I feel good about these quality metrics with our current short term plan especially so we can work towards the July preprint submission."

2. **KJ**: Sympathetic to the challenges with introducing new measures, kept that in mind when selecting these measures. Agree with Alison about importance of the metrics and also note that not all are included in previously approved preprints. Will CMS view the 2 metrics that have not been identified as being included in other approved preprints as problematic? **SL**: Having extras isn't a bad thing but I'm also not aware of preference that CMS gives to things they've approved in other states.
3. **SL**: I've heard CMS giving preference to validated measures. Did the subgroup consider measures already included in the HQIP / what is the overlap with current quality programs? **MH**: The first 4 measures (on slide 27) are or will be included in ACC III, including several overlapping measures with Hospital Transformation Program.
4. **MG**: For measures that are not in another SDP and not currently reported on, the state can choose to measure those alongside other metrics included in preprint. CMS will want to see a baseline. Can always include additional measures in future year submissions and use Year 1 to gather baseline data.
5. **Psychiatric hospital emergency rooms**: psychiatric emergencies likely to be seen in a medical hospital for initial stabilization and then potential placement in other settings. **TR:** One approach could be to specify that measures apply for those facilities that have an emergency department (e.g., follow-up after ED visit for substance use)
6. **TR**: was the recommendation that we should be doing all of these measures or were you evaluating all of the measures? **KJ:** a little of both. Think these measures are valuable and meaningful to track, some are already being collected and reported on. These are the measures that should be focused on, could whittle down the list but shouldn't look outside of this list.
7. **Comment in chat (Jaret Kanarak, LS Point)**: Not all hospitals need to be evaluated using the same quality measures. For example, if only 3 of the six measures are applicable to psychiatric inpatient facilities, then those hospitals only need to be evaluated on those three.

Conversely, there may be measures not applicable to acute care hospitals that are only applicable to psychiatric inpatient facilities.

8. **TR**: It may matter to hospitals if there's a new data collection effort required, as it takes quite a lot of work and coordination.
9. **JB**: There's may be a reason for asking for all these measures, driving toward different behaviors.
10. **KJ:** Improving areas of care is the goal for these measures: using the SDP and other programs together.
11. **GPS**: Do the first and fourth measures address requirements (2 measures one of which must be an outcome measure) and apply across all hospitals?
12. **MH**: Re: Do other preprints have measures that apply to some but not all hospitals? Re: Establishing a benchmark: do we have to have a benchmark already in place or do we have to have a specific plan to have a benchmark in place by a certain date?
    a. **MG**: Some preprints provide a list of measures and indicate that some apply to all hospitals and some apply only to a few hospitals. CMS has not been too strict about how broadly the measures apply.
    b. **MG**: Benchmark: Right now, you might not have filtered the data to establish a benchmark for the preprint but already collecting the data → this is different from setting up all new data collection efforts to establish a benchmark. Hard to set a goal without a benchmark in the preprint (preprint needs benchmark and target).
    c. **SL**: Need to be thinking about whether we will say: don't have a benchmark yet because we will set it in Year 1. This would likely be fine. This is different from saying we already have the reporting baseline and the metric (vs. saying we are working on setting the baseline and the metric).
    d. **AL**: Thought we had baselines and data for these measures already (those included in ACC III).
    e. **MG**: Agree with Shauna. Add that some of the measures may already be collected at a different population level that may not be Medicaid specific → if so, could share that Colorado does not have it

at this population level, but overall state picture is XYZ.

13. **TR:** Seems like measures 2-4 need more pressure testing to determine what data/baselines are available. Measures 5-6 need to evaluate how we build for the future.

ii. GPS Question: Is the group okay with saying the first measure is good as is, measures 5-6 could be recommended as year 2 measures and numbers 2-4 need a bit more exploration.

1. Tom yes, Nancy yes, Shauna yes, Annie yes, Dr Kim yes but want to say what exactly we need before making a final decision on #2-4; Emily yes (JB had left the meeting).
2. Action: HCPF and others to gather additional information regarding the first 4 measures on slide 27, including who collects what information now, potential data limitations, and what might be different in the future. This will involve RAE and Hospital reps. Bring this info back to the workgroup for final consideration of the following:
   i. Include measures #1 –include in Year 1 preprint
   ii. Depending on the outcome of information gathering – include in Year 1 preprint
   iii. Measures 5 and 6 – agree to lay the groundwork to include these in preprints submitted in Years 2 and beyond.

3. Reminders

a. Draft 2024-25 CHASE Model to be considered during the May 13, 2025 CHASE Board meeting. Posted on Board's web page May 5th
b. CHASE Model Q&A Webinar on May 8, 2025, from 9:00-9:45 am
   i. Registration
   ii. No more than one Board member may attend

4. Next Steps

a. GPS to share meeting notes with decisions and actions.

b. Small group work will continue where necessary and tap 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.

5. **Next Meeting:** May 21, 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