CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Colorado Healthcare Affordability & Sustainability Enterprise (CHASE) Board Meeting Minutes

Tuesday, August 24, 2021, 3:00 P.M
Via Zoom

1. Welcome – Nancy Dolson – 3:03 P.M.

New member Barbara Carveth. Dolson, Cochran and everyone on the Board introduced themselves.

2. Roll Call

There were sufficient members for a quorum.

A. Members Present (Via Zoom)

Barbara Carveth, Dr. Kimberley Jackson, George Lyford, Bob Morasko, Allison Neswood, Dr. Claire Reed, Jeremy Springston, Bob Vasil, Janie Wade and Ryan Westrom.

B. Members Excused

Scott Lindblom and Matt Colussi.

C. Department Staff Present

Nancy Dolson, Matt Haynes, Karola Cochran, Riley DeValois, Cynthia Miley, Mete Ozcorekci, Rebecca Parrott, Joe Sekiya, and America Rios and Jeff Wittreich.

3. Interim Chair – Dr. Kimberly Jackson volunteered

4. Approval of Minutes from April 27, 2021

Lyford motioned to approve the minutes, and **Carveth** seconded the motion to approve. Minutes passed unanimously.

5. Hospital Transformation Program (HTP) Update – Nancy Dolson

A. Overview - Five priority areas in hospital led interventions include, avoidable hospital utilization, Core populations, behavioral health and substance use disorder, clinical and operational efficiencies and community development efforts to address population health and total cost of care.

B. **HTP Rural Support Payments** program is a five-year plan, with a total of $60 million to be paid rural hospitals to help them as part of the HTP. The first payment to the 23 rural hospitals will be paid in October 2021, for FFY 2020-21, It is a $12 Million payment spread evenly over the 23 hospitals. Starting in November, the payments will be in monthly installments for the FFY 2021-22 period.
   - HTP is a five-year engagement plan with monthly hospital workgroups, weekly CHA one on one hospital meeting and ongoing technical assistance.
   - We have right-sized the measures, from 15, scaled to hospital size. Large hospitals have 10 measures, medium hospitals have 8 measures and small hospitals have 6 measures.
   - We have also reduced the reporting frequency from quarterly to twice yearly, and data reporting has been reduced to once yearly.
   - We have a 62% Federal match this year, which means increased funding.
   - HTP reporting requirements – all applications were completed and submitted on time, and the implementations plans are due September 30, 2021.
   - Other reporting requirements include: Quarterly Community and Health Neighborhood Engagement (CHNE), Interim activity, milestones and annual data reporting.

C. HTP Applications Review – The applications were submitted though the Hospital Portal and initially reviewed by Myers & Stauffer, our vendor. They did the initial review and scoring and requested more information from hospitals as applicable.
   - The Application Review Oversight Board was developed with the guidance from this board. There were six people on this board. They evaluated the process to ensure fair and equitable scores were given and determined if the applications were complete.
   - All 83 applications from hospitals submitted on time and had passing scores. All have been approved by the Department for participation in HTP.

D. HTP Community Advisory Council (CAC) Update – Allison Neswood - The HTP CAC continues to meet on a monthly basis. We have been providing feedback on metrics for HTP. We couldn't provide earlier comments for HTP, but we are providing feedback regarding the Hospital Quality Incentive Payment (HQIP). We are discussing ways hospitals can engage with their communities to receive community feedback, as well as how the State of Colorado might help hospitals in this role.

Chair Dr. Jackson – Any questions or comments? If none, let's continue.

6. Hospital Quality Incentive Payment (HQIP) Update – Matt Haynes - 3:30 P.M.

A. **Payment letters for 2020** are now available for viewing and download on the Dada Collection Tool (DCT). The scores them May 2021 will affect the payments that will be made from October 2021 through September 2022.

B. **Scoring process for 2021**: Scoring for measure groups one and two are complete, except for the distribution measure 1.B Cesarean Section. Hospitals received notification that their scores were available on the DCT on July 30, 2021 and had until August 13, 2021 to submit scoring review and reconsideration requests.

C. **HQIP review of distributions** for Cesarean section, advanced care and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). This explains the seemingly skewed, yet more evenly distributed scoring by quartile.

D. **HQIP Subcommittee recommended to keep the same distribution buckets.** HCAHPS distributions are essentially the same as the previous year. HCAHPS didn't have any data available in 2020. We have 6 months of new data for 2021. We decided to maintain the bounds we had in the previous year.

Wade – What is the plan for 2021? The federal plan for 2020? Are they going to try to catch up?

Haynes – That is a question we have as well. That's part of what the committee is looking into. We aren't going to collect data until May of 2022. We don't have that information yet.

Wade – 2020 isn't really an upheaval year, as you can see in the news.

Haynes continued –

E. **Timeline for Finalizing 2021 Scoring reviewed.**

F. **2023 HQIP Measures Development Cycle Overview** – We have already made the 2022 measures. The cycle starts in August. We don't want to change anything for 2023. We introduced five new measures in 2021. Hospital Wide Racial and ethnic disparities hospital wide, we added equity pieces into antibiotic stewardship and Zero Suicide in level 3 and 4. We are looking into streamlining processes and reducing administrative burden.

Wade – Are you going to be communicating with hospitals what the likely measures are? It's not fair to give short notice.

Haynes – We aren't recommending any new changes for 2023. We do allow until April of the year to allow hospitals to ramp up to the requirements, when there are changes.

Dolson – Chair Dr. Jackson, would you like to continue with the agenda or vote on the HQIP measures plan for 2023 first?

Chair Dr. Jackson – Are there any questions or comments from the Board, whether you would like to continue or vote now? Hearing none, let's continue with the presentation of the Hospital Cost, Price and Profit Analysis Review.

7. Hospital Cost, Price & Profit (HCPP) Analysis Review – Nancy Dolson – 3:49 P.M.

A. **Overview** - Affectionally called "Hiccup" at the Department. This report is 176 pages with appendices, but the report itself is 58 pages long. This review is at a high level to bring you the highlights.

B. **All Colorado Hospitals who receive funds from Medicare are included in this report.** The sources for data come from the Medicare cost report CMS 2552-10. Price means overall revenue received on the per patient basis and costs means hospital only operating expenses (admin, capital and medical). When we are comparing data among hospitals in the United States in 2018 and 2019, we have found that Colorado hospitals were in the top 10 categories in the areas of price per patient, cost per patient, profit per patient and total profit. One of two states (Alaska is the other) in top 10 for all metrics. Governor Polis focus areas include saving people on healthcare. We see this as an opportunity to collaborate with hospitals on prices to impact employer and consumer premiums.

C. **Hospital Profits** - Turning to profit, more specifically in 2018, Colorado hospitals generated $2.5 billion in patient services and another, after allowing for cost of living, a 15.3% profit margin for Colorado hospitals compared to the national average of 6.5%. This report shows that Systems Hospitals show almost a 20% profit margin.

D. **Colorado systems hospitals have increased from 24 hospitals to 41 hospitals since 2009.** Hospital system growth drives up costs and profits. When hospitals reinvest profits into property rather than patients, costs rise. This does little to benefit patient health. We see an opportunity to focus on things that can help bring more benefit to the community, reduce prices and be more cost efficient.

E. **Rural Hospitals are different.** They have lower margins, serve more patients with higher public payer mix. We see the rural hospitals in need of smart investments.

F. **Community Benefit Category** – Are the profits being reinvested in the community? For profit hospitals are doing about ¾ as well as not-for-profit hospitals. But Colorado hospitals are lagging behind the national average.

G. COVID -19 Impact on Colorado Hospitals (other than Rural Hospitals) was minimal, as they received a total o $1.02 Billion in Federal Aid. Rural hospitals are different, as they didn't get much help from the COVID-19 stimulus. Big systems didn't have to reach into their reserves. The Federal government didn't have current information to base the payments on. Rural hospitals didn't fare as well from the federal stimulus.

H. Opportunities – As we take hospital cost price and profit trends, in conjunction with the pandemic, the administration is focused on driving value and improve health outcomes. We see these other opportunities:

- Hospital and hospital system-level financial analysis to understand the financial health of the hospital sector.
- Hospital price transparency (new federal requirements).
- Rural hospitals additional supports to drive rural affordability, access, equity, 21st century needs.
- Defining a new normal that includes full transparency, accountability, better community benefit impact, health equity, value-based rewards.

I. Available analysis and tools are available on our website, which include the Hospital Reports Hub, Health Care Affordability Hub and "A New Path Forward in Health Care."

Chair Dr. Jackson – Any questions or comments?

Chair Dr. Jackson – Glad that the stimulus funds helped Rural Hospitals.

Wade – Most of the Rural hospitals "Critical Access" hospitals were able to keep elective procedures for about 6 weeks during that time.

Dolson – Very good point. I'm hopeful that vaccine levels increase, and the spread of the virus, that those numbers decrease. We already see that the Medicaid levels have returned to normal and emergency department care levels have decreased. We will continue to watch these trends.

Chair Dr. Jackson – Any other questions or comments?

Springston – Nancy, you addressed this early in the presentation, and mentioned that the Medicare Cost Report data was used to complete the report. The financial statements data in that report is very rudimentary. Did you look at the Hospital Expenditure Report data? Were there any significant differences between the Cost Report data and the Hospital Expenditure Report data?

Dolson – Yes, thanks for the question. We used data from the cost report. When we look at the reports, the financial reports are generally similar. Colorado HB19-1001 is requiring more information from hospitals, including finances, charges, utilization and audited financial statements. This information can be used as an alternative data source.

Chair Dr. Jackson – Any other questions or comments?

8. Public Comment – No comments

9. Board Action – HQIP Vote – 4:15 P.M.

Chair Dr. Jackson – Could we get another explanation about are we voting on?

Haynes – What the recommendation the HQIP subcommittee has recommended is to keep the same distributions on the measures, as in 2020. So, we can lock that in and calculate the scores for 2021.

Wade - Moved to approve. **Dr. Reed** seconded. Measure passed unanimously.

10. Meeting Adjourned at 4:15 P.M.

Wade moved to adjourn. **Carveth** seconded.

11. Next meeting on October 26, 2021 at 3:00 P.M.