Colorado Healthcare Affordability and Sustainability Enterprise Annual Report

Jan. 15, 2025

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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I. Executive Summary

Since the inception of the Colorado Healthcare Affordability and Accountability Act and through the implementation of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), the hospital provider fee and the healthcare affordability and sustainability fee increased hospital reimbursement an average of more than $430 million per year and substantially increased enrollment in Health First Colorado (Colorado's Medicaid program) and the Child Health Plan *Plus* (CHP+).

From October 2023 through September 2024, the CHASE:

- **Provided over $494.5 million in increased reimbursement to hospital providers**

  This figure reflects increasing the CHASE payments to reach an Upper Payment Limit (UPL) of 99.25% from 97% following the CHASE Board recommendations,[1] resulting in increased federal fiscal year (FFY) 2023-24 reimbursement of $19 million, from $475 million to $494.5 million. In total in FFY 2023-24, hospitals received $1.8 billion in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed with healthcare affordability and sustainability fees, including $128 million in hospital quality incentive payments (HQIP). This funding increased hospital reimbursement by $494.5 million for care provided to Health First Colorado members and Coloradans eligible for discounted health care services through the Colorado Indigent Care Program (CICP) with no increase in General Fund expenditures. In addition, of the $3.1 billion in claims paid for Health First Colorado and CHP+ expansion members, approximately 31%, or $968 million, was paid to hospitals.

- **Provided health care coverage through Health First Colorado and Child Health Plan Plus for more than 427,000 Coloradans**

  - As of Sept. 30, 2024, through healthcare affordability and sustainability fees, the following number of Coloradans have health care coverage through Health First Colorado and CHP+ with no increase in General Fund expenditures:
    - Approximately 319,000 Health First Colorado adults without dependent children up to 133% of the federal poverty level (FPL).
    - 48,000 Health First Colorado parents ranging from 61% to 133% of the FPL.
    - 35,000 CHP+ children and pregnant people ranging from 206% to 250% of the FPL.
    - 25,000 Health First Colorado working adults up to 450% of the FPL and children with disabilities up to 300% of the FPL.

[1] The change in payments to reach 99.25% of the UPL increased net reimbursement for FFY 2023-24 by $19 million and by $35 million for FFY 2022-23. In total, $54 million of new federal funds were paid to hospitals in December 2024. The changes in fees and payments by hospital for FFY 2022-23 are available at hcpf.colorado.gov/sites/hcpf/files/12.%20FFY%2022-23%20CHASE%20Hospital%20Net%20Reimbursement%20Change%20w%2099.25%25%20UPL.pdf.

- **Transferred $194.1 million to the state General Fund as a result of an increase in federal funding**

  To offset state revenue loss as a result of the COVID-19 public health emergency (PHE), the federal government funded $194.1 million of the state's Medicaid expenditures normally funded by the state General Fund for the period Jan. 1, 2020 through Dec. 31, 2023 as part of House Bill (HB) 20-1385 through the healthcare affordability and sustainability fees.

- **Saved hospitals $178 million in healthcare affordability and sustainability fees in FFY 2023-24, for a total of $764 million over four years, by using an enhanced federal medical assistance percentage methodology**

  If the enhanced federal medical assistance percentage methodology were not used, hospitals would pay $178 million more in healthcare affordability and sustainability fees to receive the same $1.8 billion in supplemental payments. This increased net benefit is to support Hospital Transformation Program (HTP) efforts. The HTP goals include transformative affordability and quality efforts through initiatives taken by hospitals that positively impact all Coloradans. In total, implementing this enhanced federal medical assistance percentage (FMAP) methodology has saved Colorado hospitals a total of $764 million in healthcare affordability and sustainability fees over the last four years. That is $127 million in FFY 2019-20, $141 million in FFY 2020-21, $152 million in FFY 2021-22, $167 million in FFY 2022-23 and $178 million in FFY 2023-2024.

- **Reduced uncompensated care costs and the need to shift uncompensated care costs to other payers**

  The CHASE reduces uncompensated care for hospital providers and the need to shift those costs to private payers by increasing reimbursement to hospitals and by reducing the number of uninsured Coloradans.

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/ Other	Overall
2019	0.75	0.63	1.84	0.30	0.89	1.08
2020	0.71	0.80	1.67	0.42	0.88	1.03
2020 w/ stimulus	0.76	0.87	1.76	0.49	0.95	1.10
2021	0.76	0.77	1.75	0.35	0.94	1.06
2022	0.73	0.79	1.64	0.33	0.90	1.02
2023	0.73	0.79	1.63	0.25	0.84	1.00

- In 2023, Health First Colorado payment to cost ratio remained the same at 79%, Medicare also remained the same at 73%, and private insurance decreased from 164% to 163%. Since 2009, Health First Colorado reimbursements have increased from 54% to 79% of hospital cost.[2] The overall payment to cost ratio in 2023 is 100% of hospital costs, while since 2009 Medicare payments to costs have declined from 75% to 73%, and private insurance payment to costs have increased from 155% to 163%. The payment to cost ratio of Health First Colorado has remained high over the last few years and has reimbursed hospitals at a state level of 79 cents to the dollar of cost.
- In 2023, the amount of bad debt and charity care decreased by approximately 30% compared to 2013. This reduction in hospitals' uncompensated care follows the increased reimbursement to hospitals under the CHASE and the reduction in the number of uninsured Coloradans due to the CHASE and the federal Affordable Care Act (ACA). However, in 2023 total bad debts and charity care have slightly increased 0.2% from 2022 or by $866,400. Uncompensated care is likely to continue to change in the near term in the aftermath of the unwinding of Medicaid continuous enrollment requirements under the COVID-19 PHE.
- Since 2009, the need to cost shift to private payers has been favorably impacted by increases in Health First Colorado reimbursements and declines in bad debt and charity care. The need to cost shift to private payers has been unfavorably impacted, however, by continued growth in the proportion of patients with public health coverage and the decline in the proportion of patients covered by private insurance given the shortfall in payment less costs for Health First Colorado and Medicare. The payer mix in Health First Colorado and Medicare has increased from 42.9% in 2009 to 62.1% in 2023 while private insurance has declined from 43.1% to 29.3%.
- Reflecting the impact of the COVID-19 PHE, all payers saw a reduction in patient volume between 2019 and 2020; however, patient volumes, starting in 2021, are returning to more typical pre-COVID-19 PHE levels. In fact, in 2023 all payers saw an increase in patient volume except private commercial insurers, which saw a decrease of 1.8%. Overall, patient volumes increased by 7.2% between 2022 and 2023. Between 2021 and 2022, total patient volume only increased by 3.3%, or roughly half that of the most recent year.
- At the same time, recent COVID-19 PHE inflation and staffing costs have lowered recent hospital reimbursement relative to costs for private payers and overall.

- **Between 2021 and 2023, there has been a sharp decline in payment less cost for hospitals. Between 2022 and 2023, there was a decrease of $325.8 million, or 97.4% in total payment less cost**.
- This was primarily driven by a decrease in hospitals' payment less costs for Medicare, Self Pay, and CICP/Other ($172.8 million, $59.2 million, and $95.2 million, respectively). Typically, and prior to the COVID-19 PHE, hospitals' payments less costs for private insurance payers increased over time and enough to compensate for under reimbursement from other payers. In 2023, private insurance payers saw an increase in payment less costs which had declined between 2021 and 2022.

[2] Includes data from the former Colorado Health Care Affordability Act (CHCAA).

- Compared to the previous year's growth, payments from private insurance payer payments grew roughly half as much as they grew between 2020 and 2021 (8.0% growth between 2020 and 2021). No other payer saw a reduction in growth of payments to this degree.
- Between 2022 and 2023, total costs have grown by $1.3 billion or an increase of 6.4% while payments have only grown by 4.8% over the same period, leading to a continued reduction in payment less costs since 2021.
- On a per patient basis, payment less cost is the lowest it has been since 2009, at $8.64 per patient in 2023 compared to $542 per patient in 2009.[3]
- The effects of inflation, wage pressure, and a tightening labor market continue to be important financial challenges for hospitals. While hospitals were largely able to negate severe financial losses during the COVID-19 PHE thanks to an injection of federal stimulus money, hospitals have continued to struggle to navigate the aforementioned workforce shortages and large wage increases for front line hospital staff. In sum, the effects of inflation, wage pressure, and a tightening labor market continue to be important financial challenges to recognize and monitor to determine their short-term versus continued impact, while collaborating on policy and other solutions to address them.

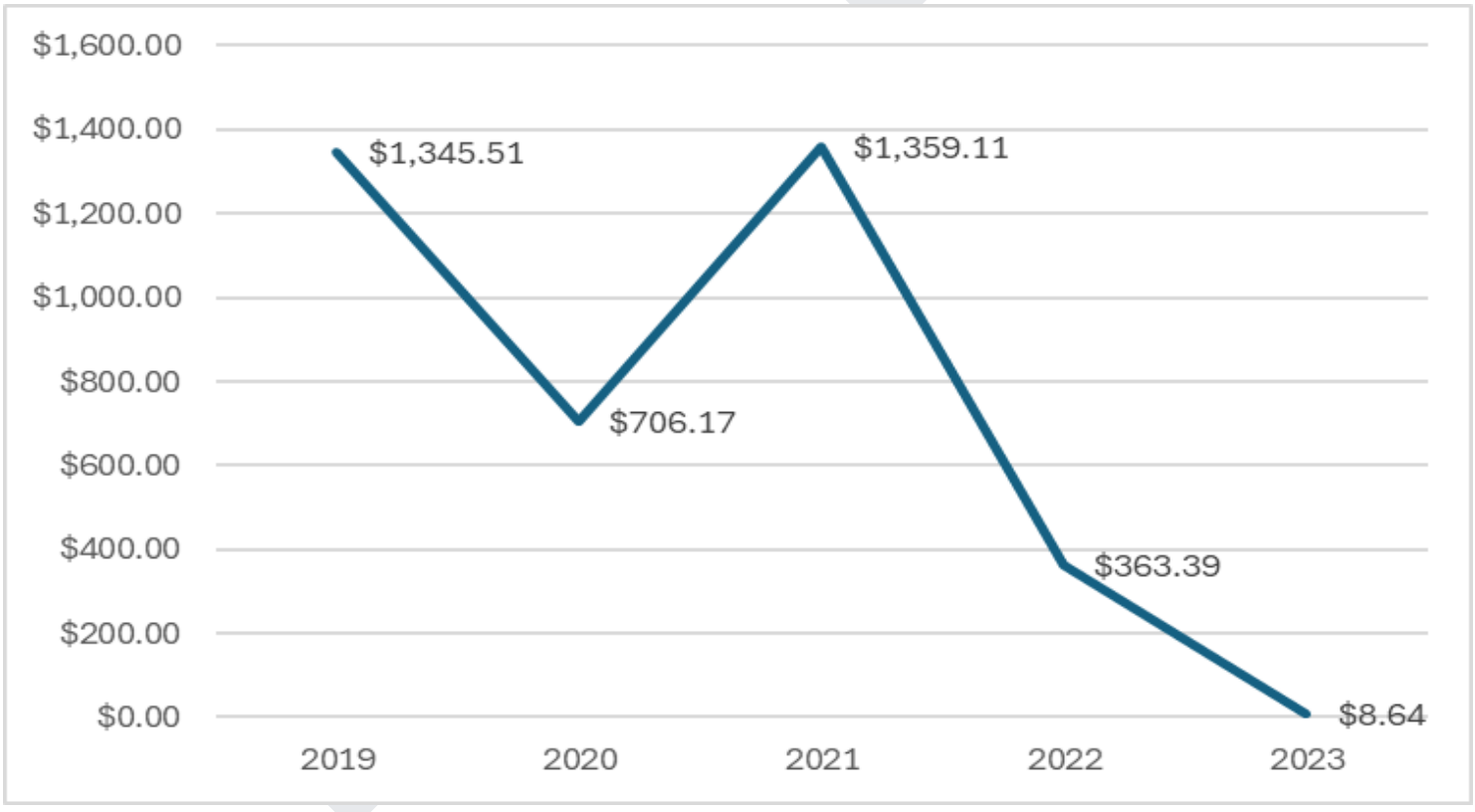

Figure 3. Payment less Cost per Patient 2019 to 2023

[3] See appendix tables to see 2009 to 2018 payment less cost per patient values.

- **Continued Success of the Hospital Transformation Program (HTP)**

  The Hospital Transformation Program (HTP) is the first major Value-Based Payment (VBP) effort for hospitals in Health First Colorado with goals to improve quality and affordability through the implementation of statewide and local measures. Starting in October 2024, HTP began its second pay-for-performance year, increasing the amount of at-risk dollars hospitals can earn through the implementation of their chosen HTP measures. Along with these hospital quality incentive payments, with the implementation of HTP, more than 97% of CHASE supplemental Medicaid payments are value-based. While Medicaid is the payer administering the HTP VBP, the entirety of Colorado benefits, not just Health First Colorado, from the improved health care affordability and quality outcomes that HTP delivers. Additionally, through the Rural Support Supplemental Payment, complementary funding to the HTP, $12 million has been paid out to 23 hospitals each year, totaling $2,086,956 per hospital for the first 4 years of the program.

  Cumulative summary of the current HTP activities:

  - 98% of hospitals have met their milestone reporting to date.
  - 95% of hospitals report that they are on track for future milestones.
  - Hospitals have 13,048 different interim activities across all hospital interventions.
  - Hospitals have also made significant Community Health Neighborhood Engagement (CHNE) progress under the HTP, as hospitals have reported having 3,754 consultations with key stakeholders.
  - 808 community advisory meetings.
  - 260 public engagement meetings.
  - Overall, this makes up over 4,800 unique CHNE activities and illustrates that hospitals are making strides in connecting with their community and partner organizations on pertinent HTP topics.

- **Maintained low administrative expenditures**

  Administrative costs are limited in statute to 3% of the total CHASE expenditures. CHASE continues to operate below that cap. In state fiscal year (SFY) 2023-24, CHASE's administrative costs were approximately 2.51% of expenditures, $24 million below the cap. Of note, only 0.26% of total CHASE expenditure for the fiscal year was for the personal services costs for the full-time equivalent (FTE) staff who administer the program. These administrative costs are only for operating CHASE, benefitting Colorado hospitals through direct payments and coverage expansions, and are not used for other HCPF administrative expenditures.

II. Colorado Healthcare Affordability and Sustainability Enterprise Overview

This legislative report is presented by the Colorado Department of Health Care Policy & Financing (HCPF) and the CHASE Board regarding the CHASE Act of 2017.

The CHASE is a government-owned business operating within HCPF. Its purpose is to charge and collect the healthcare affordability and sustainability fee to obtain federal matching funds. The healthcare affordability and sustainability fee and the federal matching funds are used to provide business services to hospitals by:

- Increasing hospital reimbursement for care provided to Health First Colorado members and Coloradans eligible for discounted health care services through the CICP;
- Funding HQIP;
- Increasing the number of individuals eligible for Health First Colorado and CHP+;
- Paying the administrative costs of the CHASE, limited to 3% of its expenditures; and
- Providing or arranging for additional business services to hospitals by:
    - Consulting with hospitals to help them improve both cost efficiency and patient safety in providing medical services and the clinical effectiveness of those services;
    - Advising hospitals regarding potential changes to federal and state laws and regulations that govern Health First Colorado and CHP+;
    - Providing coordinated services to hospitals to help them adapt and transition to any new or modified performance tracking and payment system for Health First Colorado and CHP+;
    - Providing any other services to hospitals that aid them in efficiently and effectively participating in Health First Colorado and CHP+; and
    - Providing funding for a health care delivery system reform incentive payments program.

Pursuant to section 25.5-4-402.4(7)(e), C.R.S., this report includes:

- The recommendations made by the CHASE Board to the Medical Services Board regarding the healthcare affordability and sustainability fee;
- A description of the formula for how the healthcare affordability and sustainability fee is calculated and the process by which the healthcare affordability and sustainability fee is assessed and collected;
- An itemization of the total amount of the healthcare affordability and sustainability fee paid by each hospital and any projected revenue received by each hospital, including quality incentive payments;
- An itemization of the costs incurred by the CHASE in implementing and administering the healthcare affordability and sustainability fee;
- Estimates of the differences between the cost of care provided and the payment

received by hospitals on a per-patient basis, aggregated for all hospitals, for patients covered by Health First Colorado, Medicare, and all other payers; and

- A summary of the efforts made by the CHASE to seek any federal waiver necessary to fund and support the implementation of a health care delivery system reform incentive payments program.

III. Healthcare Affordability and Sustainability Fee and Supplemental Payments

This section includes the following required report elements:

- *The recommendations made by the CHASE Board to the Medical Services Board regarding the healthcare affordability and sustainability fee*
- *A description of the formula for how the healthcare affordability and sustainability fee is calculated and the process by which the healthcare affordability and sustainability fee is assessed and collected.*
- *An itemization of the total amount of the healthcare affordability and sustainability fee paid by each hospital and any projected revenue received by each hospital, including quality incentive payments.*

A thirteen-member CHASE Board appointed by the governor provides oversight and makes recommendations to the Medical Services Board regarding the healthcare affordability and sustainability fee. Information about the CHASE Board and its meetings is available on our website.

Current CHASE Board members, listed by term expiration date, are noted below.

For terms expiring May 15, 2025:

- Jon Alford of Denver, representing a safety-net hospital in Colorado.
- Mathew Colussi of Aurora, representing HCPF.
- George Lyford of Boulder, representing a statewide organization of health insurance carriers.
- Dr. Claire Reed of Pueblo, representing the health care industry and who does not represent a hospital or a health insurance carrier.
- Mannat Singh of Denver, representing a consumer of health care.
- Robert Vasil of Larkspur, representing a hospital.
- Ryan Westrom of Aurora, representing a statewide organization of hospitals.

For terms expiring May 15, 2026:

- Jason Amrich of Gunnison, representing a rural hospital.
- Patrick Gordon of Denver, representing a health insurance provider, serving as Chair.
- Scott Lindblom of Thornton, representing HCPF.
- Jeremy Springston of Highlands Ranch, representing a hospital.

For terms expiring May 15, 2028:

- Dr. Kimberley E. Jackson of Windsor, representing persons with disabilities, serving as Vice Chair.
- Margo Karsten of Windsor, representing a hospital.

The Medical Services Board, with the recommendation of the CHASE Board, promulgated rules related to the healthcare affordability and sustainability fee, including the calculation,

assessment, and timing of the fee, the reports that hospitals will be required to report to the CHASE, and other rules necessary to implement the healthcare affordability and sustainability fee. Those rules are located at 10 CCR 2505-10, Section 8.3000.

The CHASE operates on a FFY basis, from October to September. Table 1 outlines the FFY 2023-24 healthcare affordability and sustainability fee and payment amounts. Table 1 reflects increasing the CHASE payments to reach an UPL to 99.25% from 97% following the CHASE Board recommendations,[4] resulting in increased FFY 2023-24 reimbursement by $19 million, from $475 million to $494.5 million.Table 16 and Table 17 (in the Appendix) detail hospital-specific FFY 2023-24 healthcare affordability and sustainability fee and payment amounts. Healthcare affordability and sustainability fees are collected and resulting hospital payments are made monthly by electronic funds transfer for each hospital.

Table 1. FFY 2023-24 CHASE Fee and Supplemental Payments

Item	Amount
Inpatient Fee	$543,695,022
Outpatient Fee	$716,741,892
Total Healthcare Affordability and Sustainability Fee	**$1,260,436,914**
Inpatient Supplemental Payment	$698,204,739
Outpatient Supplemental Payment	$633,184,156
Essential Access Supplemental Payment	$26,000,000
Rural Support Supplemental Payment	$12,000,000
Hospital Quality Incentive Supplemental Payment	$128,357,467
Disproportionate Share Hospital Supplemental Payment	$257,231,667
Total Supplemental Payments	**$1,754,978,030**
Net Reimbursement to Hospitals	**$494,541,116**

For an overview of the fee assessment and payment methodologies recommended by the CHASE Board for October 2023 through September 2024, see the sections below. While individual hospitals may not be eligible for all payments, all methodologies are described.

[4] The change in payments to reach a 99.25% UPL increased net reimbursement for FFY 2023-24 by $19 million and by $35 million for FFY 2022-23. In total, $54 million of new federal funds were paid to hospitals in December 2024. The changes in fees and payments by hospital for FFY 2022-23 are available at hcpf.colorado.gov/sites/hcpf/files/12.%20FFY%2022-23%20CHASE%20Hospital%20Net%20Reimbursement%20Change%20w%2099.25%25%20UPL.pdf.

A. Healthcare Affordability and Sustainability Fee

The total healthcare affordability and sustainability fee collected from hospitals during FFY 2023-24 was $1,260,436,914, with the inpatient fee comprising 43% of total fees and the outpatient fee comprising 57% of total fees.

The inpatient fee is charged on a facility's managed care days and non-managed care days. Fees charged on managed care days are discounted by 77.63% compared to the rate assessed on non-managed care days. Managed care days are Medicaid Health Maintenance Organization (HMO), Medicare HMO, and any commercial Preferred Provider Organization (PPO) or HMO days. Non-managed care days are all other days (i.e., fee-for-service, normal Diagnosis Related Group [DRG], or indemnity plan days). The outpatient fee is assessed as a percentage of total outpatient charges.

Hospitals that serve a high volume of Health First Colorado and CICP members or are essential access providers are eligible to receive a discount on the fee. High-volume Health First Colorado and CICP providers are those providers with at least 30,000 Health First Colorado inpatient days per year that provide over 35% of their total days to Health First Colorado members and CICP clients. The inpatient fee calculation for high-volume Health First Colorado and CICP providers was discounted by 47.79%. The outpatient fee for high-volume Health First Colorado and CICP providers are discounted by 0.84%. Essential access providers are those providers that are critical access hospitals and other rural hospitals with 25 or fewer beds. The inpatient fee calculation for essential access providers was discounted by 60% with no discount on the outpatient fee calculation.

Hospitals exempt from the healthcare affordability and sustainability fee include the following:

- State licensed psychiatric hospitals; or
- Medicare certified long-term care (LTC) hospitals; or
- State licensed and Medicare certified rehabilitation hospitals.

B. Enhanced Federal Medical Assistance Percentage

The CHASE supplemental payments are funded from two sources: healthcare affordability and sustainability fees and federal matching funds, calculated pursuant to the FMAP. Historically, the FMAP for supplemental payments was 50%. For every supplemental payment dollar, 50 cents were healthcare affordability and sustainability fees and 50 cents were federal matching funds. Effective FFY 2019-20 and forward, HCPF is approved to utilize an enhanced FMAP to make supplemental payments to hospitals. With the enhanced FMAP, HCPF requires less fee to make the same payment due to the federal share of the payment increasing.

The enhanced FMAP is allowable because of the Affordable Care Act (ACA) and Colorado's decision to expand Health First Colorado to individuals who would otherwise not have been eligible. Prior to the ACA, every Health First Colorado member received the base FMAP for all claims, generally 50% for Colorado. When the Health First Colorado expansion

occurred, individuals who were newly eligible as a result of the ACA received a higher FMAP, currently at 90%. Each claim submitted on a Health First Colorado member's behalf can be tied to the base FMAP group (50% FMAP) or the newly eligible group (90% FMAP). The federal share of the claims can be determined by multiplying the total amount paid for the claim by the FMAP for the Health First Colorado member on the claim. A similar methodology is used to calculate the federal share of the CHASE supplemental payments.

Switching to this enhanced FMAP methodology has saved Colorado hospitals a total of $764 million in healthcare affordability and sustainability fees over the last five years. That is $127 million in FFY 2019-20, $141 million in FFY 2020-21, $152 million in FFY 2021-22, $167 million in FFY 2022-23, and $178 million in FFY 2023-24.

C. COVID-19 Federal Medical Assistance Percentage

On March 18, 2020, the president signed into law House of Representatives (H.R.) 6021, the Families First Coronavirus Response Act (FFCRA). As it relates to the CHASE, this bill temporarily increased the base Medicaid FMAP from 50% to 56.2% during the COVID-19 PHE. The increased FMAP of 56.2% lasted until the end of March 2023 and is deescalating back to 50% by January 2024. The temporary increase in base FMAP was effective beginning Jan. 1, 2020, and extends through the last day of the calendar quarter in which the public health emergency was terminated.

Similar to the enhanced FMAP methodology mentioned in the previous section, the FFCRA allows HCPF to increase the federal funds used to make supplemental payments to hospital providers. As a direct result of the FFCRA, the Colorado General Assembly passed HB 20-1385, allowing HCPF to utilize the increase in base FMAP to offset General Fund expenditures for medical service premiums. HCPF was able to draw down an additional $194.1 million in federal funds for the period Jan. 1, 2020 through Dec. 31, 2023.[5]

D. Supplemental Payments

1. Inpatient Supplemental Payment

For qualified hospitals, this payment equals total Health First Colorado patient days multiplied by an inpatient adjustment factor. Inpatient adjustment factors vary by hospital groups. The inpatient adjustment factor for each hospital is published annually in the Provider Bulletin. State-licensed psychiatric hospitals are not qualified for this payment.

2. Outpatient Supplemental Payment

For qualified hospitals, this payment equals Health First Colorado outpatient billed costs, adjusted for utilization and inflation, multiplied by an outpatient adjustment factor. Outpatient adjustment factors may vary by hospital. The outpatient

[5] The American Rescue Plan Act of 2021 (ARPA) increased the DSH allotment for the remainder of the public health emergency by applying an enhanced FMAP to the total DSH funds available. This enhanced FMAP was applied retroactively to January 2020 resulting in a large influx of federal funds for SFY 2021-22.

adjustment factor for each hospital is published annually in the Provider Bulletin.[6] State-licensed psychiatric hospitals are not qualified for this payment.

3. Essential Access Supplemental Payment

This payment is for qualified Essential Access hospitals. The $26,000,000 fund is evenly distributed amongst all qualified hospitals. Psychiatric hospitals, LTC hospitals, and rehabilitation hospitals do not qualify for this payment.

4. Hospital Transformation Program Rural Support Supplemental Payment

The Rural Support Supplemental Payment is complementary funding to the HTP that enables critical access and rural hospitals to be successful in future value-based payment environments. Some rural hospitals have a difficult time layering quality-based initiatives on top of insufficient operational infrastructure; infrastructure limitations may not allow the hospitals to meet the needs of the communities they serve or the payment methodologies of the future. Select critical access or rural hospitals are eligible to receive additional support payments to prepare for alternative payment methodologies through strategic planning and financial modeling, and then to operationalize those strategies.

This payment is for qualified not-for-profit rural or critical access hospitals that submit an attestation form, documenting the planned use of the payment. Funding is allocated to low-revenue hospitals, which are defined as those that contribute to the bottom 10% of net patient revenues for all critical access or rural hospitals. Net patient revenue is determined from each hospital's Medicare cost report and is averaged between 2016, 2017 and 2018. In addition, funding is allocated to hospitals with a low fund balance, which are defined as those that contribute to the bottom 2.5% of the fund balance for all critical access or rural hospitals not eligible as a result of the net patient revenue criteria. Fund balance is determined from each hospital's 2019 Medicare cost report.

Funding for rural support payments is $12,000,000 annually for each of the five years of the HTP, equaling $60 million in total funding. For each qualified hospital, the annual payment is equal to $12,000,000 divided by the total number of qualified hospitals ($521,739 per year per hospital). Rural Support Funds for FFY 2023-24 were disbursed in monthly installments as part of the CHASE fee and supplemental payment program. To date, each qualified hospital has received $2,086,956 for the first four years of the program.

Psychiatric hospitals, LTC hospitals, and rehabilitation hospitals do not qualify for this payment.

5. Hospital Quality Incentive Supplemental Payment[7]

As part of our Value-Based Payment (VBP) effort for hospitals, CHASE includes a

[6] https://hcpf.colorado.gov/provider-news
[7] https://hcpf.colorado.gov/sites/hcpf/files/2024%20CO%20HQIP%20Measure%20Details_April%202023.pdf

provision to establish HQIP funded by the healthcare affordability and sustainability fee to improve the quality of care provided in Colorado hospitals. At the request of the CHASE Board, the HQIP subcommittee recommends the approach for quality incentive payments.

The HQIP subcommittee seeks to:

- Adopt measures that can be prospectively set to allow time for planning and successful implementation;
- Identify measures and methodologies that apply to care provided to Health First Colorado members;
- Adhere to value-based purchasing principles;
- Maximize participation in Health First Colorado; and
- Minimize the number of hospitals which would not qualify for selected measures.

HQIP Measures

For the year beginning Oct. 1, 2023, the HQIP subcommittee recommended, and the CHASE Board approved, the following measures for HQIP. A hospital was scored on all measures for a maximum possible score of 100 points. If a hospital was not eligible for any given measure, the measure was normalized for that hospital. There were a total of 15 measures separated into three measure groups. The measures for 2023 HQIP are presented below.

1. Maternal Health and Perinatal Care Measure Group
    a. Exclusive Breastfeeding
    b. Cesarean Section
    c. Perinatal Depression and Anxiety
    d. Maternal Emergencies and Preparedness
    e. Reproductive Life/Family Planning
2. Patient Safety Measure Group
    a. Zero Suicide
    b. Reduction of Racial and Ethnic Disparities
    c. Clostridium Difficile
    d. Sepsis
    e. Antibiotics Stewardship
    f. Adverse Event Reporting
    g. Culture of Safety Survey
    h. Handoff and Sign-outs
3. Patient Experience Measure Group
    a. Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS)[8]
    b. Advance Care Plan

Payment Calculation

[8] https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/hospital-cahps-hcahps

The payments earned for each of the FFY 2023-24 measures are based on points per Health First Colorado adjusted discharge. Health First Colorado adjusted discharges are calculated by multiplying total Health First Colorado discharges by an adjustment factor. The adjustment factor is calculated by dividing total Health First Colorado gross charges by Health First Colorado inpatient service charges and multiplying the result by the total Health First Colorado discharges. The adjustment factor is limited to five. For purposes of calculating Health First Colorado adjusted discharges, if a hospital has less than 200 Health First Colorado discharges, those discharges are multiplied by 125% before the adjustment factor is applied.

Each hospital's HQIP payment is calculated as quality points awarded, multiplied by Health First Colorado adjusted discharges, multiplied by dollars per adjusted discharge point.

Dollars per adjusted discharge point are tiered so that hospitals with more quality points awarded receive a greater per adjusted discharge point reimbursement. The dollars per adjusted discharge point for the five tiers are shown in Table 2.

Table 2. FFY 2023-24 HQIP Dollars Per Adjusted Discharge Point

Tier	Quality Points Awarded	Dollars Per Adjusted Discharge Point
0	0-19	$0.00
1	20-39	$2.07
2	40-59	$4.14
3	60-79	$6.21
4	80-100	$8.28

During the FFY 2023-24 timeframe, HQIP payments totaled over $128 million with 82 hospitals receiving payments. HQIP payments, Health First Colorado adjusted discharges, and quality points awarded by hospital are listed in Table 3.

Table 3. FFY 2023-24 Hospital Quality Incentive Payments

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
AdventHealth Avista	86	3,144	$8.28	$2,238,780
AdventHealth Castle Rock	92	1,441	$8.28	$1,097,696
AdventHealth Littleton	79	2,147	$6.21	$1,053,297
AdventHealth Parker	76	2,626	$6.21	$1,239,367
AdventHealth Porter	87	1,639	$8.28	$1,180,670
Animas Surgical Hospital	84	19	$8.28	$13,215
Arkansas Valley Regional Medical Center	81	1,037	$8.28	$695,495
Aspen Valley Hospital	63	170	$6.21	$66,509
Banner Health Fort Collins Medical Center	85	1,441	$8.28	$1,014,176
Banner Health McKee Medical Center	80	896	$8.28	$593,510
Banner Health North Colorado Medical Center	85	5,745	$8.28	$4,043,331
Children's Hospital Anschutz	95	10,041	$8.28	$7,898,251
Children's Hospital Colorado Springs	94	2,839	$8.28	$2,209,650
CommonSpirit Longmont United Hospital	83	1,636	$8.28	$1,124,325
CommonSpirit Mercy Hospital	88	2,164	$8.28	$1,576,777
CommonSpirit Penrose-St. Francis Hospital	82	8,749	$8.28	$5,940,221
CommonSpirit St. Anthony Hospital	82	2,688	$8.28	$1,825,044
CommonSpirit St. Anthony North Hospital	84	5,168	$8.28	$3,594,447
CommonSpirit St. Anthony Summit Hospital	87	1,289	$8.28	$928,544
CommonSpirit St. Elizabeth Hospital	94	1,095	$8.28	$852,260
CommonSpirit St. Mary-Corwin Hospital	81	2,165	$8.28	$1,452,022

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
CommonSpirit St. Thomas More Hospital	79	1,899	$6.21	$931,630
Community Hospital	86	1,060	$8.28	$754,805
Craig Hospital	42	46	$4.14	$7,998
Delta County Memorial Hospital	83	785	$8.28	$539,483
Denver Health	82	14,866	$8.28	$10,093,419
East Morgan County Hospital	98	1,131	$8.28	$917,739
Family Health West	95	31	$8.28	$24,385
Foothills Hospital	74	2,168	$6.21	$996,283
Grand River Health	84	251	$8.28	$174,576
Gunnison Valley Health	90	275	$8.28	$204,930
Haxtun Health	28	46	$2.07	$2,666
HCA HealthONE Aurora Hospital	51	5,667	$4.14	$1,196,530
HCA HealthONE Mountain Ridge Hospital	70	5,870	$6.21	$2,551,689
HCA HealthONE Presbyterian St. Luke's	79	3,861	$6.21	$1,894,168
HCA HealthONE Rose Hospital	75	4,653	$6.21	$2,167,135
HCA HealthONE Sky Ridge Hospital	76	2,863	$6.21	$1,351,221
HCA HealthONE Swedish Hospital	68	5,277	$6.21	$2,228,372
Heart of the Rockies Regional Medical	52	994	$4.14	$213,988
Intermountain Health Good Samaritan	89	2,378	$8.28	$1,752,396
Intermountain Health Lutheran Hospital	83	4,701	$8.28	$3,230,715
Intermountain Health Platte Valley Hospital	87	3,756	$8.28	$2,705,672
Intermountain Health Saint Joseph Hospital	93	6,477	$8.28	$4,987,549
Intermountain Health St. Mary's Regional	79	2,431	$6.21	$1,192,624

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
Keefe Memorial Hospital	100	63	$8.28	$52,164
Kit Carson County Memorial Hospital	100	25	$8.28	$20,700
Lincoln Community Hospital	20	181	$2.07	$7,493
Melissa Memorial Hospital	97	44	$8.28	$35,339
Memorial Hospital	85	16,016	$8.28	$11,272,061
Montrose Regional Health	72	1,654	$6.21	$739,536
Mt. San Rafael Hospital	54	494	$4.14	$110,439
National Jewish Health	97	131	$8.28	$105,214
OrthoColorado Hospital	86	41	$8.28	$29,195
Pagosa Springs Medical Center	86	213	$8.28	$151,673
Parkview Medical Center	63	8,613	$6.21	$3,369,664
Pioneers Medical Center	38	42	$2.07	$3,304
Prowers Medical Center	98	388	$8.28	$314,839
Rangely District Hospital	20	25	$2.07	$1,035
Rehabilitation Hospital of Colorado Springs	69	395	$6.21	$169,254
Rehabilitation Hospital of Littleton	56	229	$4.14	$53,091
Rio Grande Hospital	72	663	$6.21	$296,441
San Luis Valley Health Conejos County Hospital	89	166	$8.28	$122,329
San Luis Valley Health Regional Medical	85	3,088	$8.28	$2,173,334
Sedgwick County Health Center	28	75	$2.07	$4,347
Southeast Colorado Hospital	95	81	$8.28	$63,715
Southwest Health System	83	1,565	$8.28	$1,075,531

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
Spanish Peaks Regional Health Center	55	100	$4.14	$22,770
Sterling Regional MedCenter	83	1,315	$8.28	$903,721
UCHealth Broomfield Hospital	86	732	$8.28	$521,243
UCHealth Grandview Hospital	82	656	$8.28	$445,398
UCHealth Greeley Hospital	88	2,986	$8.28	$2,175,719
UCHealth Highlands Ranch Hospital	86	1,466	$8.28	$1,043,909
UCHealth Longs Peak Hospital	80	3,254	$8.28	$2,155,450
UCHealth Medical Center of the Rockies	89	2,603	$8.28	$1,918,203
UCHealth Pikes Peak Regional Hospital	82	238	$8.28	$161,592
UCHealth Poudre Valley Hospital	89	6,036	$8.28	$4,448,049
UCHealth University of Colorado Hospital	83	16,504	$8.28	$11,342,209
Vail Health Hospital	75	917	$6.21	$427,093
Valley View Hospital	82	1091	$8.28	$740,745
Wray Community District Hospital	85	617	$8.28	$434,245
Yampa Valley Medical Center	87	873	$8.28	$628,874
Yuma District Hospital	70	138	$6.21	$59,989
Total	**-**	**206,385**	**-**	**$128,357,467**

6. Disproportionate Share Hospital Supplemental Payment

The Disproportionate Share Hospital (DSH) payment equals $257,231,667 in total. To qualify for the DSH Supplemental Payment, a Colorado hospital must meet either of the following criteria:

- Be a CICP provider and have at least two obstetricians, or is obstetrician exempt, pursuant to Section 1923(d)(2)(A) of the Social Security Act; or
- Have a Medicaid Inpatient Utilization Rate (MIUR) equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates

for Colorado hospitals and have at least two obstetricians, or is obstetrician exempt, pursuant to Section 1923(d)(2)(A) of the Social Security Act.

No hospital receives a DSH supplemental payment greater than its estimated DSH limit.

The DSH Supplemental Payment for certain qualified hospitals equ[illegible] percentage of their estimated DSH limit. The hospital groups, r[illegible]ements, and percentage of estimated DSH limit used is published annuall[illegible]ne Provider Bulletin. The DSH Supplemental Payment for all other qu[illegible]spitals equals the lesser of each hospital's estimated DSH limit and e[illegible] hospit[illegible] uninsured costs as a percentage of total uninsured cost for all [illegible]ified hospit[illegible] multiplied by the remaining DSH allotment in tot[illegible] his methodology i[illegible]d to distribute the DSH allotment among qualified [illegible]pitals that have not met [illegible] estimated DSH limit. Psychiatric hospitals [illegible] hospitals, and rehabilitation hospitals do not qualify for this payment.

IV. Administrative Expenditures

This section includes the following required report elements:

- *An itemization of the costs incurred by the enterprise in implementing and administering the healthcare affordability and sustainability fee*

Administrative expenditures are reported on a state fiscal year basis. In SFY 2023-24, CHASE collected $1,310,113,321 in fees from hospitals,[9] which, with federal matching funds, funded Health First Colorado and CHP+ health coverage expansions for 521,678 Coloradans, payments to hospitals, and the CHASE's administrative expenses. Of the $3,107,054,694 in claims paid for health coverage expansions, approximately 31%, or more than $968 million, was paid to hospitals.

Administrative expenditures are for the CHASE related activities, including expenditures related to the CHASE funded expansion populations. These expenditures do not supplant existing Department administrative funds and are limited in statute to 3% of the total CHASE expenditures. In SFY 2023-24, CHASE operated $24 million below that cap at approximately 2.51%. Of note, only 0.26% of total CHASE expenditure for the fiscal year was for the personal services costs for the full-time equivalent (FTE) staff who administer the program.

Table 4 outlines the healthcare affordability and sustainability fee expenditures in SFY 2023- 24.

Table 4. SFY 2023-24 CHASE Expenditures

Item	Total Fund
Supplemental Payments	$1,696,739,252
CHASE Administration (Table 5)	$124,474,433
Expansion Populations	$3,107,054,694
25.5-4-402.4(5)(b)(VIII) – Offset Revenue Loss	$15,700,000
Subtotal Expenditures	**$4,943,698,379**
HB 20-1385 Use of Increased Medicaid Match	$6,744,132
Total Expenditures	**$4,950,712,511**

As a result of the COVID-19 PHE the Colorado legislature authorized several transfers from the CHASE cash fund (to include fees collected and any matching federal funds) to the state General Fund to be used as an offset against Health First Colorado's budget. HB 20-1385 authorized the transfer of fees equal to the additional federal financial participation that was provided by the federal government during the COVID-19 PHE. Senate Bill (SB) 21-286 authorized HCPF to develop a spending plan for using enhanced, one-time federal matching

[9] In addition, $7,178,505 was recorded as earned interest.

money received pursuant to the American Rescue Plan Act of 2021 to enhance, expand, and strengthen Medicaid-eligible home- and community-based services (HCBS) for older adults and people with disabilities. These transfers ended on December 31, 2023.

Funding in SFY 2023-24 was appropriated for the CHASE administrative expenses by the General Assembly through the normal budget process. The expenditures reflected in Table 5 are funded entirely by the healthcare affordability and sustainability fee and federal funds.

Table 5. SFY 2023-24 CHASE Administrative Expenditures

Item	Total Fund
General Administration	**$20,296,643**
Personal Services	$12,638,971
PERA Direct Distribution	$109,236
Worker's Compensation	$33,628
Operating Expenses	$593,354
Legal Services	$327,809
Administrative Law Judge Services	$109,236
Payments to Risk Management and Property Funds	$73,467
Leased Space	$262,370
Capitol Complex Leased Space	$0
Payments to OIT	$2,275,277
CORE Operations	$26,810
General Professional Services and Special Projects	$3,846,485
Transfer for Hospital Community Benefit	**$100,000**
Information Technology Contracts and Projects	**$55,520,377**
MMIS Maintenance and Projects	$35,104,053
CBMS Operating and Contract Expenses	$19,738,849
CBMS Health Care & Economic Security Staff	$677,475
Eligibility Determinations and Client Services	**$41,438,419**
Disability Determination Services	$1,028,660
County Administration	$30,184,847

Item	Total Fund
Medical Assistance Sites	$820,540
Customer Outreach	$667,110
Centralized Eligibility Vendor Contract Project	$6,813,178
Eligibility Overflow Processing Center	$617,541
Returned Mail Processing	$677,119
Work Number Verification	$629,424
Recoveries Contracts	**$1,022,704**
Acute Care Utilization Review	**$5,005,131**
Professional Audit Contracts	**$615,438**
Indirect Cost Assessment	**$322,342**
Children's Basic Health Plan Administration	**$59,740**
Dept. of Human Services, Office of Economic Security	**$46,820**
Total Administrative Expenditures	**$124,427,613**

More than $107.5 million in CHASE's administrative expenditures were related to contracted services, the majority of which were information technology contracts. Information technology contract expenditures were approximately $55.5 million and were for the CHASE's share of expenses for the Colorado Benefits Management System (CBMS, the eligibility determination system for Health First Colorado and CHP+ programs), the Medicaid Management Information System (MMIS, the claims system for the Health First Colorado and CHP+ programs), the Business Intelligence Data Management (BIDM) system, and the Pharmacy Benefits Management System (PBMS). The two other significant contract expenses funded by the CHASE were county administration contracts for eligibility determinations totaling approximately $30.2 million and a utilization management contract for approximately $3.1 million. The CHASE, as a government-owned business with the Department of Health Care Policy & Financing, follows the state procurement code codified at C.R.S. §24-101-101, et seq., statutory requirements for contracts for personal services codified at C.R.S. §24-50-501, and state fiscal rules at 1 C.C.R. §101-1, et seq. These state procurement requirements ensure that contracted services are competitively selected and approved by the State Controller (or designee), avoid conflicts of interest, and allow the CHASE to receive federal matching funds for services procured.

V. Cost Shift

This section includes the following required report elements:

- *Estimates of the differences between the cost of care provided and the payment received by hospitals on a per-patient basis, aggregated for all hospitals, for patients covered by Health First Colorado, Medicare, and all other payers.*

With the passage of HB19-1001, HCPF collects data directly from hospitals through Hospital Financial Transparency and utilizes the data to analyze the cost shift. Before calendar year 2019, data within the CHASE Annual Report for the cost shift section was provided by the Colorado Hospital Association (CHA) in a de-identified and aggregate manner. In order to maintain comparability between the legacy data between 2009 and 2018, HCPF continued to utilize a state-level aggregate cost-to-charge ratio[10] when determining costs, uncompensated care costs, and payment less costs for the CHASE Annual Reports between 2020 and 2024. However, with HB19-1001, HCPF collects sufficient data to calculate a cost-to-charge ratio for each hospital and apply it to that hospital's individual data to determine costs. This leads to a more accurate number when totaled to the state-level. For this report and moving forward, information presented for 2019 through the most recent year will utilize this updated methodology. Tables and figures utilizing the aggregate cost-to-charge ratio have been provided in the appendix of this report for comparison. When comparing figures from 2019 to 2023 by both methodologies, it is clear that while the values are different, overall the trends between the years are moving in the same direction. Table 20 in the appendix outlines the calculation for cost-to-charge ratio.

This section reports cost shift data from calendar year 2009 through calendar year 2023, with a primary focus between 2019 and 2023.[11] In the most recent cost shift data, specifically from 2021 through 2023, there has been an increase in overall inflation leading to higher costs and wage pressure. According to a report by the American Hospital Association (AHA), inflation and workforce labor costs have accounted for hospital expenses increasing from 2019 levels.[12] Additionally, nursing and overall health care worker shortages have led to substantial increases in labor costs since the COVID-19 PHE.[13] While hospitals were largely able to negate severe financial losses during the COVID-19 PHE thanks to an injection of federal stimulus money, hospitals have continued to battle the aforementioned workforce shortages and large wage increases for hospital staff. In sum, the effects of inflation, wage pressure, and a tightening labor market continue to be important financial challenges to recognize and monitor to determine their short-term versus continued impact, while collaborating on policy and other solutions to address them.

[10] A cost-to-charge ratio estimates the costs associated with the charged amount for each procedure. A cost-to-charge ratio helps to determine costs for uncompensated care and patient services which do not have costs directly associated with that care.
[11] The report includes data reported under the Colorado Health Care Affordability Act (CHCAA), which was enacted effective July 1, 2009, and repealed effective June 30, 2017, and data reported under CHASE, which was enacted July 1, 2017. Like the CHASE, the former CHCAA was intended to reduce the need for hospitals to shift uncompensated care costs to private payers by increasing reimbursement to hospitals for inpatient and outpatient care provided for Health First Colorado members and CICP clients and reducing the number of uninsured Coloradans. Reporting data from calendar year 2009 forward allows longitudinal analysis of the impact of the CHCAA and the CHASE on the cost shift.
[12] https://www.aha.org/costsofcaring
[13] https://www.mcknights.com/news/nurse-salaries-rising-but-more-considering-leaving-study/

Since the FFY 2015-16, the hospital provider fee and the healthcare affordability and sustainability fee increased hospital reimbursement by an average of more than $434 million per year and substantially increased enrollment in Health First Colorado and CHP+.

The cost shift analysis that follows shows hospital reimbursement compared to patient costs. When looking at the overall period, bad debt and charity care costs are significantly less in 2023 compared to 2009. With the reduction in private insurance payment to cost in 2022, there may be a change in overall hospital financing moving away from cost shifting. However, with increases in overall costs and effects of the labor market affecting hospitals particularly in 2022, it remains to be seen if this will hold true. Moreover, over the most recent years uncompensated care costs have begun to rise.

Some major findings of HCPF's analysis are:

- There is a return to pre-COVID-19 PHE levels for some hospital metrics such as patient volumes and payments, although bad debt and charity care costs have continued to increase since 2019.
- Total hospital payment less cost grew $726.1 million, or 174.1%, from 2009 to 2019. Without including stimulus funds, payment less cost continued to increase until 2020, where it began to decrease and has continued to decrease each year since then.
- From 2022 to 2023, hospital payment less cost decreased by $325.8 million, or 97.4%. Hospital payment less cost have reversed in their direction since 2020. When compared to pre-COVID-19 PHE amounts, the 2023 payment less cost is the lowest it has been since 2009 as shown in Table 6 and Table 7. The reduction in payment less cost was primarily driven by a large increase in costs and a slower growth in payments in comparison. Increases in costs were driven by increases in labor costs.[14]
- Also shown in Table 29, the 2023 payment less cost amounts decreased 99.3% from 2019.
- On a per-patient basis, hospital payment less cost:
    - Grew $631 per patient or 116% from 2009 to 2019, then declined ($639) per patient between 2019 and 2020, with no federal stimulus funds included.
    - Between 2020 and 2021, this trend reversed itself, when hospital payment less cost per patient increased by $653, or 141.4%.
    - Between 2021 and 2022, payment less cost per patient decreased by $996 or 73.3%.
    - In 2023, payment less cost per patient continued to decrease, reflecting a reduction of $355 per patient or a decrease of 97.6%.
- With legacy data, there is a significant decline in total bad debt and charity care after 2013 with the passage of the Affordable Care Act (ACA). Since 2018 uncompensated care costs have been increasing. Between 2019 and 2023, total bad debt has increased by $12.4 million or an increase of 6.2%, and charity increased by $84.5 million or an increase of 34.3%. However, the changes in uncompensated care costs only represent the nominal, or current, value and do not factor in changes to inflation throughout the period. When adjusted for inflation to 2023 values, bad debt costs actually decreased by 10.9% or a reduction of $26.3 million, and charity care increased by 12.7% or an increase

[14] Operating expenses and labor expenses are reported to HCPF through HB 19-1001. A more in depth analysis of operating expenses and labor expenses is available in the Hospital Financial Transparency Report available on HCPF webpage: https://hcpf.colorado.gov/hospital-reports-hub

of $37.3 million, which is significantly less than the nominal increase over this period. Overall, total uncompensated care costs have increased by 2.1% or $10.9 million between 2019 and 2023.

- The payment to cost ratio of Health First Colorado has remained high over the last few years and has reimbursed hospitals at a state level of 79 cents to the dollar of cost.

To provide a better understanding of the impact of the COVID-19 PHE on patient services, additional analysis was performed in the section below that had not been done prior to the 2022 CHASE Annual Report. The tables, figures and analysis that follow within this section primarily highlight years 2009, 2019 through 2023.[15]

A. Payment, Cost and Profit

The CHASE Board reviews cost shifting through the ratio of total payments to total costs for Medicare, Health First Colorado, private sector insurance, Self Pay, and CICP/Other payer groups. In Table 6, Table 7, and Figure 2, ratios below 1 mean that costs exceed payments, which is generally the case for Medicare and Health First Colorado. Values greater than 1 mean that payments exceed costs, as is the case for the private sector insurance group.

As shown in Table 6, prior to the implementation of the Colorado Health Care Affordability Act (CHCAA) in 2009, Health First Colorado reimbursement to Colorado hospitals was approximately 54% of costs, or 0.54 cents on the dollar of costs. Our most recent data from 2023 shows the payment to cost ratio for Health First Colorado was 79% of costs. Reimbursement for Health First Colorado has continued to grow in recent years. Through the COVID-19 PHE, reimbursement for Health First Colorado continued to measure around 80% of hospital cost, an outstanding accomplishment compared to 54% in 2009. The payment to cost ratio for the CICP/Other payer group was 84% of costs in 2022,[16] whereas the Self Pay payer group was reimbursed at 25% of costs.[17] Between 2009 and 2023, the payment to cost ratio for private sector insurance increased from 155% to 163% of costs. Between 2020 and 2023, the payment to cost ratio for private sector insurance decreased from 166% to 163% of costs. Compared to pre-COVID-19 PHE figures, the private insurance sector decreased from 184% to 163%. The 2023 payment to cost ratio of 1.00 is the lowest it has been since HCPF began its analysis. To summarize, this means that since the implementation of the first hospital provider fee under the CHCAA, hospital reimbursement for Health First Colorado has greatly increased compared to costs and remained high through the COVID-19 PHE. At the same time, recent COVID-19 PHE inflation and staffing costs have lowered recent hospital reimbursement relative to costs for private payers and overall.

- Between 2022 and 2023, hospital costs for private insurance payers grew faster (3.9% or $247.0 million) than payments from private insurance payers (3.1% or

[15] Accompanying tables and figures are within the Cost Shift section of the Appendix.
[16] HCPF will continue monitoring reimbursement for CICP/Other as it does appear higher than usual. This may be due to better reporting of supplemental payments and a breakout of DSH payments from total supplemental payments in 2020 and 2021.
[17] The payment less cost per patient for the CICP/Self Pay/Other payer group may show a result greater than 1 in calendar years 2015 through 2016 due to hospitals reporting revenue incorrectly as CICP revenue, rather than Medicaid revenue, or because of a decline in the allocation of bad debt and charity care to this payer group.

$321.1 million). While payment less cost for private insurance payers was higher compared to 2022, this continues the trend of costs out growing payments for private insurance. This represents hospital profits on privately insured patients, which are funded by employers and consumers.

- In 2023, Public payers saw growth in payments congruent to costs; specifically, for Medicaid, payments grew by 7.5% and costs grew by 7.4%; and for Medicare, payments grew 8.6% and costs grew 8.4%. However, other payors such as Self Pay and CICP/Other saw decreases in payments by 23.9% and 3.4%, respectively. Coupled with increases in costs for Self Pay and CICP/Other, payment less costs for these payors decreased by 13.9% and 76.8%, respectively.
- Between 2019 and 2023, overall costs have increased by 36.8% or an increase of $5.9 billion, while payments have increased 26.7%, reflecting an increase of $4.7 billion. These trends have decreased the overall payment to cost ratio during the same time period. Similar to uncompensated care costs above, the changes in payments and costs only reflect the nominal values and thus a similar adjustment for inflation can be made. When adjusted for inflation to 2023 values, total costs increased by $2.8 billion between 2019 and 2023 or an increase of 14.8%. However when adjusted for inflation total payments increased by $1.3 billion or an increase of 6.3%.[18]

Note: in Table 7 the row labeled "2020 w/stim" includes federal stimulus money provided in 2020 to provide a more complete accounting of total hospital reimbursement. The treatment of the federal stimulus is described further below.

Table 6. Payment to Cost Ratio

Year	Medicare	Health First Colorado	Insurance	CICP/Self Pay/Other	Overall
2009	0.78	0.54	1.55	0.52	1.05
2010	0.76	0.74	1.49	0.72	1.06
2011	0.77	0.76	1.54	0.65	1.07
2012	0.74	0.79	1.54	0.67	1.07
2013	0.66	0.80	1.52	0.84	1.05
2014	0.71	0.72	1.59	0.93	1.07
2015	0.72	0.75	1.58	1.11	1.08
2016	0.71	0.71	1.64	1.08	1.09
2017	0.72	0.72	1.66	0.85	1.07
2018	0.70	0.77	1.70	0.88	1.09

[18] Inflation adjustments were calculated using Consumer Price Index value which were pulled from annual values for 2019 through 2023 from the Bureau of Labor Statistics website:https://www.bls.gov/cpi/data.htm

Table 7. Payment to Cost Ratio, Post HB19-1001

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/ Other	Overall
2019	0.75	0.63	1.84	0.30	0.89	1.08
2020	0.71	0.80	1.67	0.42	0.88	1.03
2020 w/ stimulus	0.76	0.87	1.76	0.49	0.95	1.10
2021	0.76	0.77	1.75	0.35	0.94	1.06
2022	0.73	0.79	1.64	0.33	0.90	1.02
2023	0.73	0.79	1.63	0.25	0.84	1.00

One important aspect noted in the information above is federal stimulus monies provided to hospitals through the Coronavirus Aid Relief and Economic Security (CARES) Act along with other federal stimulus sources. Colorado hospitals have accepted approximately $1.2 billion in financial assistance.[19] As a system, HCA HealthONE returned more than $6 billion of the federal stimulus dollars it received, including approximately $117 million provided to its Colorado hospitals.[20]

Federal stimulus improved hospitals' financial position for the year and increased the overall payment-to-cost ratio. However, the impact of this improvement is uncertain due to several factors. The stimulus relief could be used to make up for lost revenue or to cover COVID-19 PHE-related expenses.[21] A complicating factor is that a proportion of these COVID-19 PHE-related expenditures is reflected in the payment to cost ratio e.g., supplies and payroll; not including the associated stimulus deflates the ratio. However, not all COVID-19 PHE-related expenses are not reflected in this ratio (e.g., capital expenditures for medical equipment, telehealth infrastructure, hospital payments to other non hospital providers, etc.). Therefore, including all stimulus may overstate the payment portion of the ratio. Further complicating this, hospitals have stated that some stimulus funding was used for other business components and a portion of stimulus could be rolled over for use in 2021 if eligible costs and lost revenues for 2020 have been covered.For the purposes of this analysis, federal stimulus will be allocated only to 2020, as it was primarily intended for and will allow analysis in this and future reports to focus on true patient revenues and costs. Without stimulus, the overall payment-to-cost ratio for 2020 was 1.03 as noted above. When including the total $1.2 billion in federal stimulus, but not all the above costs, it is 1.10.

[19] For more information on federal stimulus see HCPF's *COVID-19's Impact on Colorado Hospitals' Finances* (2021). https://hcpf.colorado.gov/sites/hcpf/files/COVID19%20Impact%20on%20Colorado%20Hospitals%20Finan ces-f.pdf
[20] HCA Healthcare. (2020, October 8). HCA Healthcare Previews 2020 Third Quarter Results. https://investor.hcahealthcare.com/news/news-details/2020/HCA-Healthcare-Previews-2020-Third-Quarter-Results/.
[21] "Provider Relief Fund." *Official Web Site of the U.S. Health Resources & Services Administration*, 28 May 2021, https://www.hrsa.gov/provider-relief.

The payer mix continues to shift from private insurance to government payers, see Figure 1.[22] In 2023, Medicare payer mix increased by 1.0 percentage point. Health First Colorado payer mix remained the same percentage of total volumes, and private insurance decreased by 0.9 percentage points. . Since 2009, Health First Colorado and Medicare payer mix has increased from 42.9% to 62.1% in 2023, while private insurance has declined from 43.1% to 29.3% in 2023.

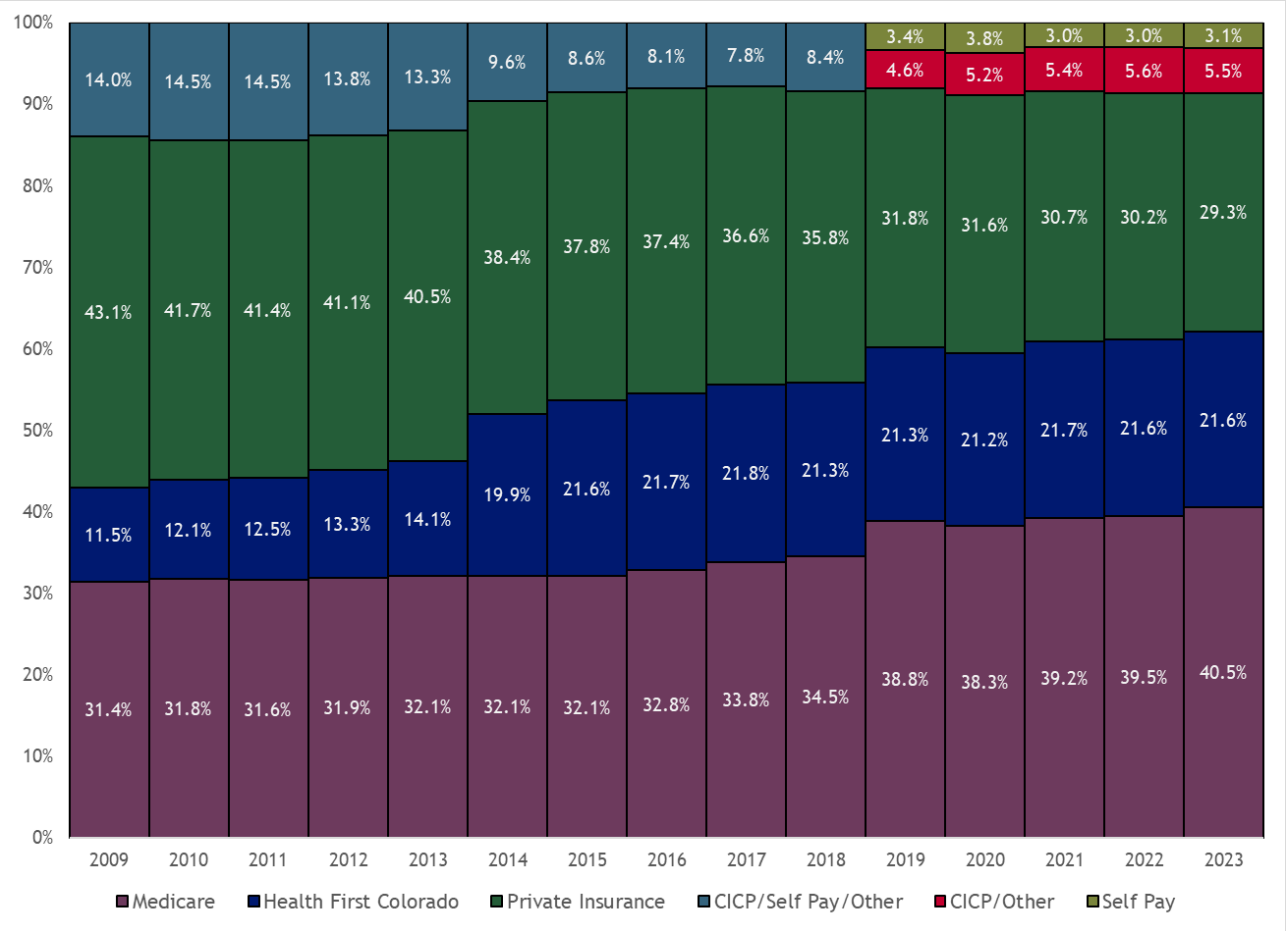

Figure 1. Payer Mix

HCPF's most recent data show cash reserves have declined from 2021 and 2020 levels to amounts similar to 2019. Cash reserves in 2021 and 2020 were assisted by federal COVID-19 PHE stimulus packages. While there has been a decrease in cash reserves, the state median of 150 in 2023 is still similar to the 2019 median of 149. A deeper analysis of cash reserves is available in the Hospital Financial Transparency Report.[23]

Payer type payments are available in Figure 11, Table 23, and Table 24. From 2022 to 2023, payment increased for Health First Colorado by 7.5%, or $276.5 million. Payments

[22] Payer mix is calculated on a percent of charges.
[23] https://hcpf.colorado.gov/hospital-reports-hub

for the CICP/Other category decreased by 3.4%, or $38.9 million.[24] Medicare payments increased by $500.9 million, or 8.6%. As mentioned above, private insurance payments increased in 2023 by 3.1%, or $321.1 million. Compared to the previous year's growth, payments from private insurance payer payments grew roughly half as much as they grew between 2020 and 2021 (8.0% growth between 2020 and 2021). No other payer saw a reduction in growth of payments to this degree.

As displayed in Figure 12, Table 25, and Table 26, overall costs grew by 6.4% or $1.3 billion between 2022 and 2023. CICP/Other saw an increase between 2021 and 2022 of 4.4%, or $56.3 million. Medicare saw the highest percentage growth with an increase of 8.4% ($673.8 million), followed by Medicaid with 7.4% ($349.0 million). Private insurance saw an increase in cost of 3.9% or $247.0 million, which when compared to the change from 2021 to 2022, was approximately 40% of the growth that occurred in the prior year (9.6% growth).

Figure 2 displays payment less cost by payer type using a stacked bar chart to better depict the variation of payment less cost of different payer types. Each color depicts the payment less cost of a payer type. The positive purple bars are the payment less cost of commercial insurance and represent the cost shift of noncommercial insurance payer types like Medicare, Medicaid, and the uninsured. These bars show the comparative impact of each payer type, with Medicare reflecting the bulk of payment less cost shifted. The difference between the positive and negative bars is reflected by the Total Line.

- In 2020 federal stimulus helped reduce the impact of the COVID-19 PHE's effects on hospitals' patient services. Between 2019 and 2021, hospital payment less cost declined by $101.4 million, or 7.7%.
    - Before including federal stimulus in 2020, total payment less cost (profits) equals $586.9 million.
- Between 2022 and 2023, overall payment less cost decreased by 97.4%, or $325.8 million.
- Colorado's increasing population and healthcare inflation rates are reflected in this visual by an increasing dollar amount for both payments and costs for hospitals in the state.

[24] HCPF has worked with hospitals to more accurately report DSH payments to HCPF through HB 19-1001, Hospital Transparency Measures to Analyze Efficacy, contributing to this increase. Therefore, increases in CICP/Other from 2019 are heavily influenced by increased reporting efforts.

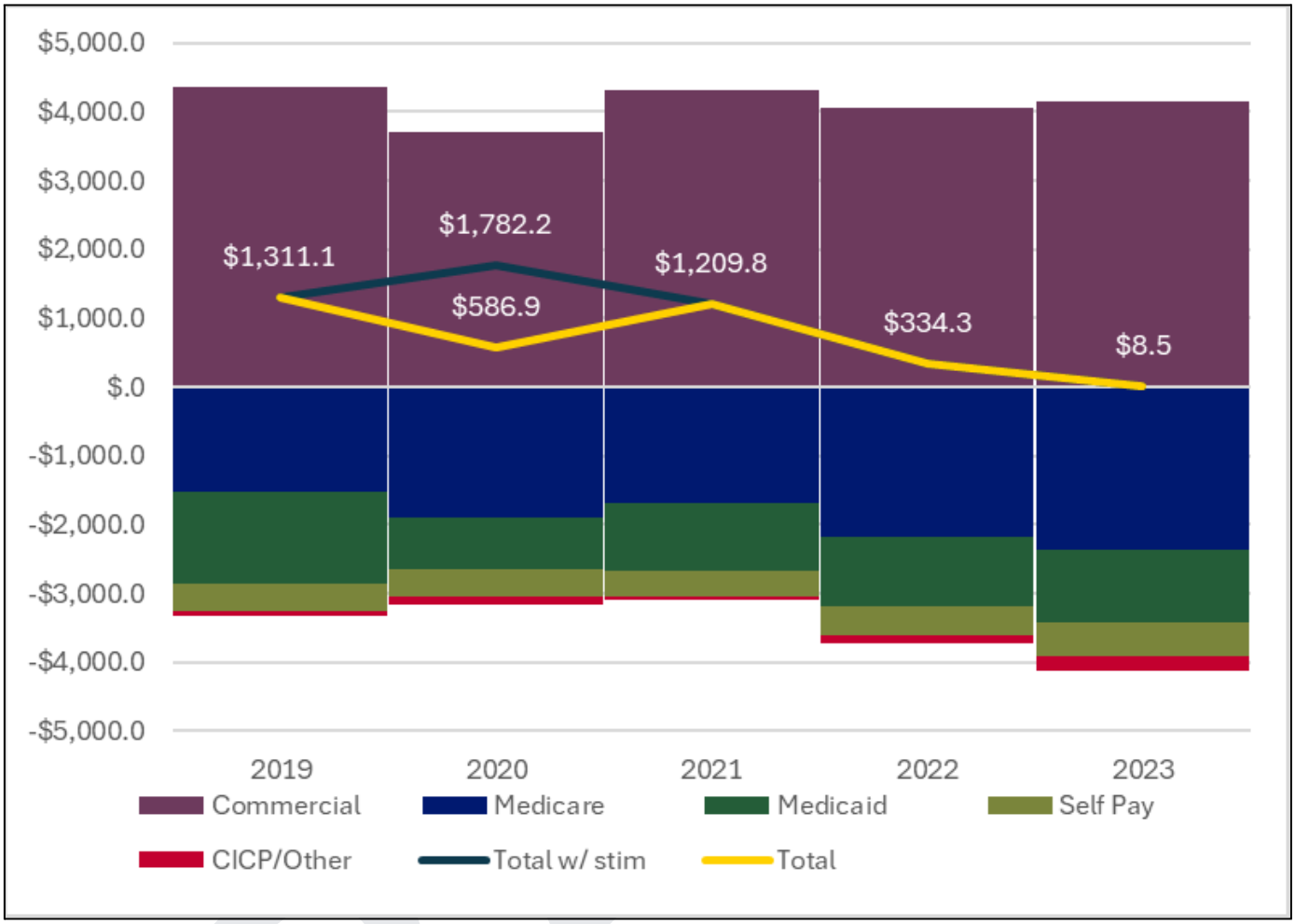

Figure 2. Payment Less Cost

Figures 1 and 2 above, when combined with payer payment to cost ratios, highlight an increasingly important issue for stakeholders in government payer funding rates. As the Medicare payer mix has increased as shown in Figure 1, and the payment to cost ratio for Medicare remains flat or decreases, this leads to increasing Medicare shortfalls as shown in Figure 2. Over the last decade, Medicare total payment to costs have driven the bulk of hospital payment to cost ratio reductions, greatly outpacing Health First Colorado. Discussions about government payment to cost rates should be focused on Medicare, which represent both a larger share of the payer mix and lower rates than Health First Colorado. These discussions should include rural hospitals' unique views on government payment models such as Medicare Advantage, which disproportionately impact rural hospitals. However, payment rates are only half the payment to cost equation. To increase the ratio, either payments can be increased or costs can be decreased. Previous HCPF reporting has shown that Colorado hospitals are high cost compared to the nation. Discussions regarding Health First Colorado's hospital payment rates should be viewed in context of Medicare's larger impact on hospitals along with Colorado hospitals' inflated costs.

Reflecting the impact of the COVID-19 PHE, all payers saw a reduction in patient volume between 2019 and 2020, see Figure 16. Between 2020 and 2021, patient volume increased 7.1%. Between 2021 and 2022, patient volume has continued to rise with an increase of 3.3%, or approximately 29,800 patients. In 2023, patient volumes continued to rise by 7.2% or approximately 66,500 patients. In 2023, patient volumes have returned to pre-COVID-19 PHE levels and have surpassed its 2019 value. Between 2022 and 2023, Medicare volume increased the most (17.8%), followed by CICP/Other (6.7%) and then Self Pay with %. Health First Colorado saw a 3.4% increase in patient volume between 2022 and 2023. Private insurance payors, however, saw a decrease of 1.8% in patient volume or approximately 5,600 patients. With the end of the public health emergency and the disenrollment of Medicaid members ramping up in 2023 and through 2024, HCPF will continue to monitor and measure patient volume movement between payer types.

Figure 3 shows the payment less costs on a per-patient basis between 2019 and 2023. Table 31 and Table 32, in the appendix, display these values for each payer type. Figure 3 shows massive swings between 2019 and 2023. For example, between 2022 and 2023, there was a reduction of $355 per patient or a decrease of 97.6%. This reduction was primarily due to a reduction of payment less cost per patient for Health First Colorado, Self Pay, and CICP/Other payers. In 2022, private insurance payers saw a decrease in payment less cost per patient, but rebounded in 2023 with an increase of $497 per patient.

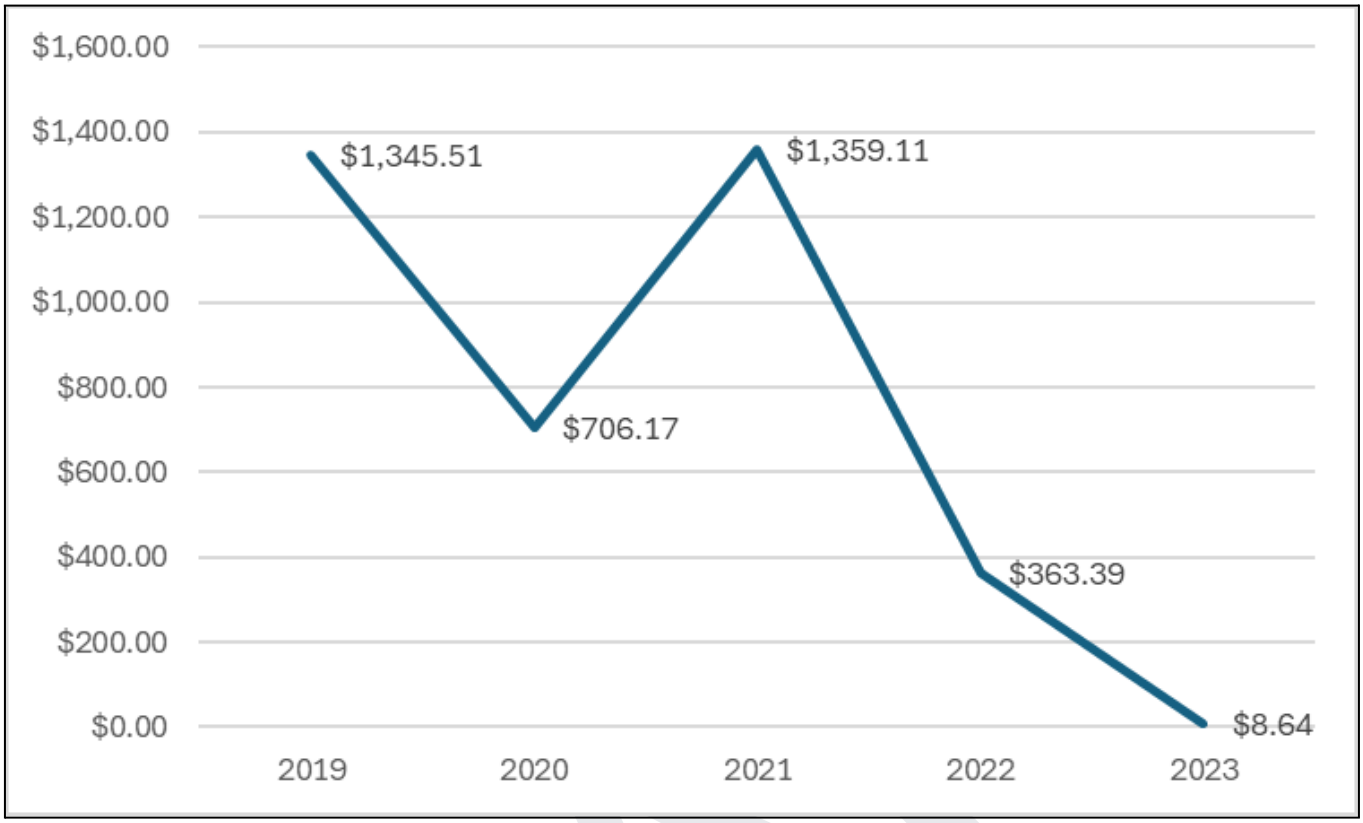

Figure 3. Total Payment Less Cost per Patient

Table 8. Payment Less Cost per Patient by Payer Group[25]

Year	Medicare	Health First Colorado	Private Insurance	CICP/Self Pay/Other	Overall
2009	($2,853)	($4,480)	$6,820	($4,563)	$542
2010	($3,361)	($2,586)	$6,518	($2,897)	$701
2011	($3,097)	($2,488)	$7,358	($3,920)	$918
2012	($3,886)	($2,465)	$7,746	($4,013)	$903
2013	($5,318)	($2,418)	$7,717	($2,070)	$747
2014	($4,706)	($3,665)	$8,838	($860)	$1,039
2015	($4,648)	($3,252)	$8,699	$1,286	$1,243
2016	($5,082)	($3,910)	$10,391	$862	$1,347
2017	($5,195)	($4,070)	$11,060	($2,016)	$1,222
2018	($5,659)	($3,574)	$11,806	($1,937)	$1,530

Table 8 displays payment less cost per patient between 2009 and 2018. Table 9 displays payment less per cost by payer group after passage of HB 19-1001, 2019 through 2023.

Table 9. Payment Less Cost Per Patient by Payer Group, Post HB 19-1001

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/ Other	Overall
2019	($4,554)	($5,903)	$13,370	($7,955)	($1,565)	$1,346
2020	($6,651)	($3,914)	$13,786	($9,450)	($2,258)	$706
2021	($5,482)	($4,571)	$14,802	($10,335)	($1,257)	$1,359
2022	($7,099)	($4,282)	$13,511	($11,562)	($2,375)	$363
2023	($6,502)	($4,442)	$14,008	($12,470)	($3,934)	$9

[25] The payment less cost per patient for the CICP/Self Pay/Other payer group may show a positive result in calendar years 2015 through 2016 due to hospitals reporting revenue incorrectly as CICP revenue, rather than Medicaid revenue, or because of a decline in the allocation of bad debt and charity care to this payer group. More analysis is needed to understand the change in payment less cost per patient for the CICP/Self Pay/Other payer group.

Table 10 presents overall hospital payments, costs, and payment less cost on a per-patient basis from 2009 to 2022.

Table 10. All Payers, Costs and Profit

Year	Payment Per Patient	Cost Per Patient	Payment Less Cost Per Patient
2019	$18,036	$16,691	$1,346
2020	$21,678	$20,972	$706
2020 w/ stimulus	$23,116	$20,972	$2,145
2021	$22,546	$21,187	$1,359
2022	$23,106	$22,743	$363
2023	$22,572	$22,563	$9

B. Bad Debt and Charity Care

Bad debt and charity care are costs hospitals typically write off as uncompensated care. Uncompensated care costs are calculated using a cost-to-charge ratio as well and thus values presented in 2019-2023 analysis will look different than those presented in graphs and tables dating back to 2009. Legacy data is provided in Figure 4 and Table 33. Total bad debt and charity care decreased significantly from 2013 to 2014 – the year health coverage expansion under the ACA was fully implemented.

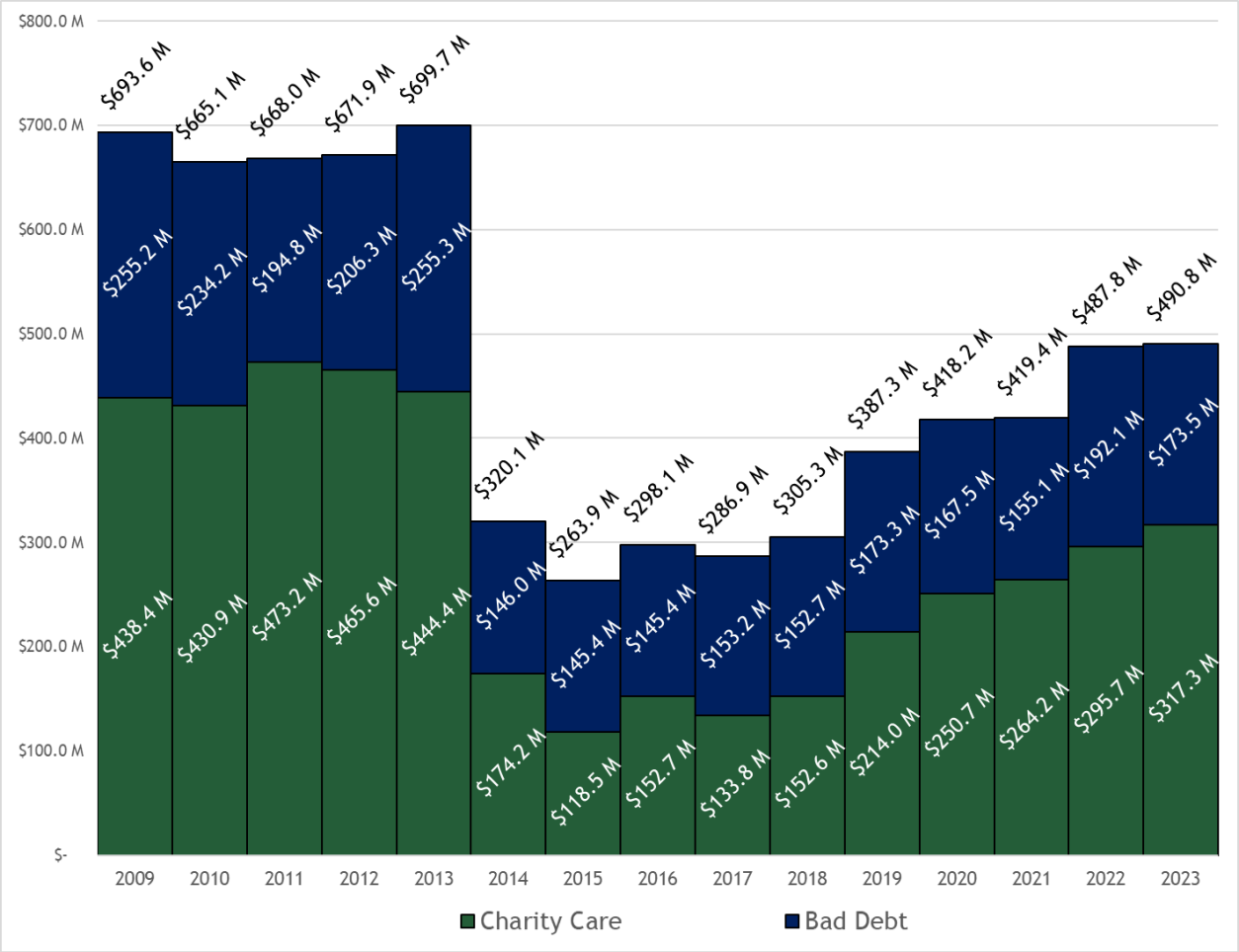

Figure 4. Bad Debt and Charity Care Costs, 2009 -2023

Uncompensated Care costs calculated under the new methodology are provided in Figure 5 and Table 11. Between 2022 and 2023, there was an increase in charity care costs of $4.7 million, or 1.4%. This increase in charity care is likely in part due to the end of continuous Medicaid coverage following the end of the COVID-19 PHE. Between 2022 and 2023, bad debt costs decreased $3.8 million, or 1.7%. Overall, total uncompensated care costs have increased by $866.4 thousand or 0.2% between 2022 and 2023. When adjusted for inflation to 2023 values, between 2019 and 2023, bad debt costs decreased by $26.3 million or 10.9%; charity care costs increased by $37.3 million or 12.7%. Overall, between 2019 and 2023, when adjusted for inflation, total uncompensated care costs increased by

2.1% or $10.9 million.

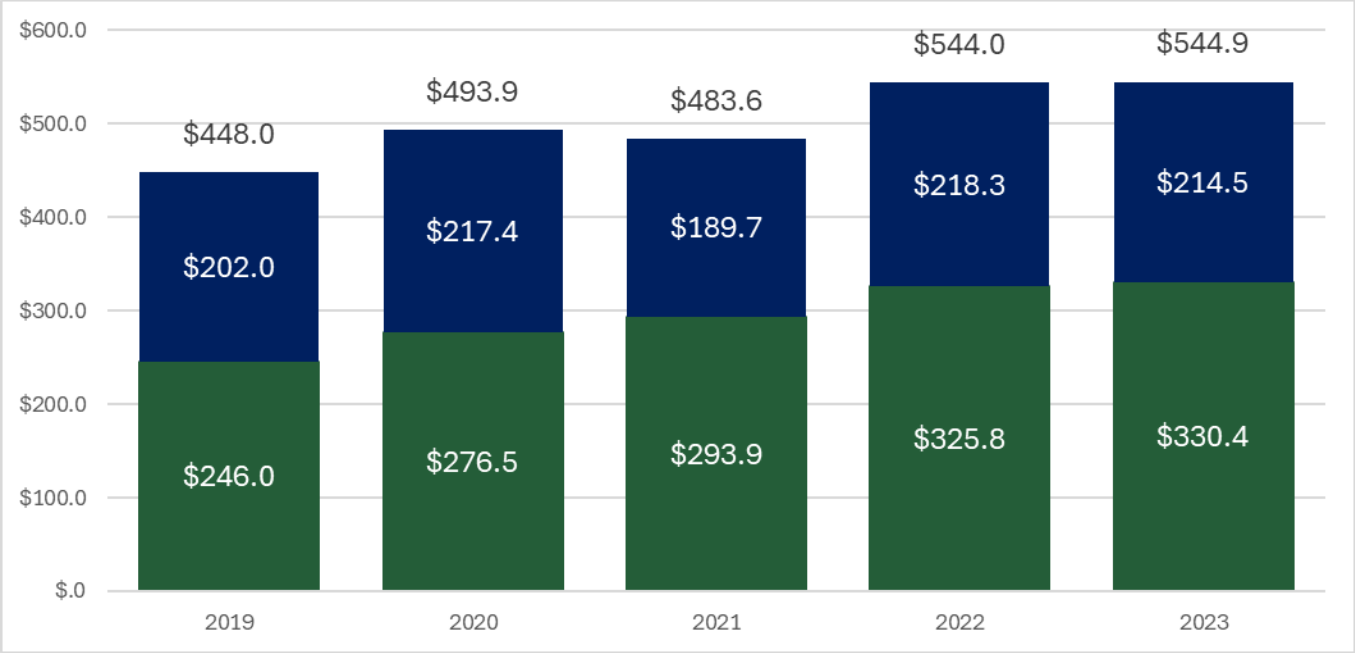

Figure 5. Bad Debt and Charity Care Costs, 2019 -2023

Table 11. Bad Debt and Charity Care Costs 2019 to 2023

Year	Bad Debt	Charity Care	Total
2019	$202,020,471	$245,951,333	$447,971,803
2020	$217,369,612	$276,482,946	$493,852,559
2021	$189,682,244	$293,881,595	$483,563,839
2022	$218,269,888	$325,758,088	$544,027,977
2023	$214,461,178	$330,433,210	$544,894,387

VI. Delivery System Reform Incentive Payment Program

This section includes the following required report elements:

- *A summary of the efforts made by the CHASE to seek any federal waiver necessary to fund and support the implementation of a health care delivery system reform incentive payments program.*

A. Hospital Transformation Program (HTP) Introduction

Currently, the HTP is in year four of the five-year program. Hospitals have received evaluations on their program year three interim activity and Community Health & Neighborhood Engagement (CHNE)[26] progress through September 2024. Within HTP, hospitals select statewide and local measures to be evaluated over the course of the program. Not all measures are required statewide, which allows hospitals to address local community needs. Large hospitals (91+ beds) must select six statewide measures plus at least four local measures. Medium hospitals (26-90 beds) must select six statewide measures plus at least two local measures. Small hospitals (25 or fewer beds) along with critical access hospitals must select six measures that may consist of either statewide or local measures. Below is a list of HTP focus areas and statewide measures that emphasize affordability and quality of care. Statewide measures are stated and included first under each focus area; local measures are listed subsequently.

- Reducing avoidable hospitalization utilization
    - 30-day all cause risk-adjusted hospital readmissions (Statewide Measure).
    - Pediatric all-condition readmission measure (Statewide Measure).
    - Follow-up prior to discharge and notification to the Regional Accountable Entity (RAE) within one business day.
    - Emergency Department (ED) visits for which the member received follow-up within 30 days of the ED visit.
    - Home management plan of care document given to pediatric asthma patient/caregiver.
- Core populations
    - Social needs screening and notification (Statewide Measure).
    - Readmission rate for a high frequency chronic condition.
    - Pediatric bronchiolitis - appropriate use of testing and treatment.
    - Pediatric sepsis time to first IV antibiotic in the ED early identification.
    - Screening for transitions of care support in adults with disabilities.
    - Reducing neonatal complications.
    - Screening/referral for perinatal and postpartum depression and anxiety and notification to the RAE.
    - Increasing access to specialty care.
- Behavioral health/substance use disorder

[26] As part of participation in the HTP, hospitals are required to conduct CHNE throughout the duration of their participation in the program. CHNE requires collaboration with local community organizations and other external stakeholders that will ensure hospitals and their interventions continue to be responsive to community needs throughout the life of the HTP. Hospitals are required to have engagement each quarter and during each program year it will include engagement with key stakeholders, community advisory meetings, and public input.

    - Collaborate discharge planning and notifications with RAEs (Statewide Measure).
    - Pediatric Screening for depression in inpatient and ED including suicide risk.
    - Using alternatives to opioids in ED (Statewide Measure).
    - Screening, Brief Intervention and Referral to Treatment (SBIRT) in the ED.
    - Initiation of Medication Assisted Treatment (MAT) in ED.
- Clinical and operational efficiencies
    - Hospital Index (Statewide Measure).
    - Increase the successful transmission of a summary of care record to a patient's primary care physician.
    - Implement/expand telemedicine visits.
    - Implement/expand e-Consults.
    - Energy Star Certification achievement and score improvement for hospitals.
- Population health/Total cost of care
    - Severity adjusted length of stay (Statewide Measure).
    - Increase the percentage of patients who had a well-visit within a rolling 12-month period.
    - Increase the number of patients seen by co-responder hospital staff.
    - Improve leadership diversity.

For more information, the Collaboration, Performance and Analytics System (CPAS) that hospitals will be using is a public dashboard for HTP that stakeholders can access to view each participating hospital's measures and interventions. The information is sortable and can be exported into Microsoft Excel. This tool allows for the exploration of all the interventions that the hospitals will be implementing and the measures that the interventions are focused on. To access the dashboard, visit https://cpasco.mslc.com/htp_dashboard.

HCPF is pleased to report robust progress and engagement thus far from hospitals in the HTP. In program year three, all 84 hospitals submitted all of their Interim Activity on time, and 83 hospitals submitted all of their CHNE Activity on time. Additionally, 98% of hospitals have met their milestone reporting to date and 95% of hospitals reporting that they are on track for future milestones. Throughout the HTP, hospitals have 13,048 different interim activities across all hospital interventions. Hospitals have also made CHNE progress under the HTP. Hospitals have reported having 3,754 consultations with key stakeholders, 808 community advisory meetings, and 260 public engagement meetings. Overall, this makes up over 4,800 unique CHNE activities and illustrates that hospitals are making strides in connecting with their community and partner organizations on pertinent HTP topics.

As the program continues the transition to pay for achievement, performance and improvement, hospitals will continue to be responsible for more complex reporting on their milestone achievements and driving performance improvements on their selected measures. The HTP's first pay-for-performance year started in October 2023 and continues through September 2024, while the second pay-for-performance year started in October

2024 and continues through September 2025. There will continue to be shared learning opportunities and technical assistance to hospitals regarding their continued Interim Activity and CHNE reporting. The number of hospitals on target to complete their future milestones is extremely encouraging, with 98% of hospitals on track to complete program year four interventions. Progress continues to be made as HTP continues in year four of its five-year program, there are exciting results that highlight hospitals' continued commitment to improving the quality of hospital care and engaging with the communities that they serve.

This section will provide a brief overview of the HTP program, current results, and future outcomes. Subsequent sections will provide more details about HTP, progress to date, community engagement, and future outcomes. The Hospital Transformation Program is a five-year program that was launched in April of 2021. There were 83 hospitals that were a part of the original application process, and that number has now grown to 84 hospitals enrolled in the HTP. Hospitals participating in the Hospital Transformation Program (HTP) must submit an Implementation Plan detailing the strategies and steps they intend to implement for each intervention(s) outlined in their applications.

Cumulative summary of current HTP activities:

- 84 Hospitals continue to submit interim activity on time.
- 95% of hospitals are on track to hit all their year four milestones.
- Over 13,000 interim activities across hospital interventions.
- Over 4,800 unique Community Health & Neighborhood Engagement (CHNE) activities.
- Over 3,750 consultations with key stakeholders.
- Over 800 community advisory meetings.
- 260 public engagement meetings.

B. Establishment of the HTP

HTP is a result of section 25.5-4-402.4 (8), C.R.S., which directed the CHASE, acting in concert with HCPF, to fund and support the implementation of a health care delivery system reform incentive payments (DSRIP) program to improve health care access and outcomes for Health First Colorado members, which is referred to as HTP. More information about HTP is on HTP's website.

The goal of the HTP is to improve the quality of hospital care provided to Health First Colorado members by tying provider fee-funded hospital payments to quality-based initiatives. By evolving quality care to Medicaid members and the related processes to achieve those results, HTP also serves to improve hospital quality care for all Coloradans. Over the course of the five-year program, provider fee-funded hospital payments will transition from pay-for-process and reporting to a pay-for-performance structure in an effort to improve quality, demonstrate meaningful community engagement and improve health outcomes over time. Key activities and quality measures for HTP are consistent across the state, yet flexible enough to allow hospitals to work with their communities on the interventions and approaches that best serve their communities and patient

populations. Through HTP, hospital-led projects will achieve the following to the benefit of not just Health First Colorado members, but all Coloradans and our employers:

- Improve patient outcomes through care redesign and integration of care across settings.
- Improve the performance of the delivery system by ensuring appropriate care in appropriate settings.
- Lower Health First Colorado costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery.
- Accelerate hospitals' organizational, operational and systems readiness for value based payment.
- Increase collaboration between hospitals, their community health partners and other providers.

Federal authority through the State Plan Amendment (SPA) and other authorities, if necessary, will be utilized for the implementation and operations of HTP. On July 26, 2021, the Centers for Medicare and Medicaid Services (CMS) approved HCPF's SPA for the pay-for-reporting component of the HTP, leveraging future CHASE supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost.

The following sections describe the HTP application process, implementation plan process, and HTP outcomes and deliverables to date. These sections provide an overview of the HTP while also expanding on hospitals' achievement status and CHNE progress.

C. HTP Application Process

HCPF agreed to delay the launch of HTP as a result of the COVID-19 PHE. The HTP officially launched on April 1, 2021, with hospital applications due by April 30, 2021.

Following technical assistance by HCPF during the application process, and review and feedback from the CHASE Board Application Review Oversight Committee, all 83[27] HTP hospital applications were approved and finalized in early August 2021.

Application information as well as guidelines about the scoring process for applications is on our website.

All hospital HTP applications are available to the public by request via email to COHTP@state.co.us.

D. Implementation Plan Process

Hospitals participating in the HTP submitted an implementation plan in September 2021. The implementation plans detailed the strategies and steps the hospital intended to take for each intervention outlined in their applications. All 83 hospitals submitted their implementation plans by the deadline; the goal was to approve all implementation plans by the end of the calendar year 2021, which was achieved. After approval, they were made available to the public, as hospitals began implementing interventions.

[27] There were 83 hospitals that were a part of the original application process, and that number has now grown to 84 hospitals enrolled in the HTP. OrthoColorado Hospital was added after the initial application process for the HTP.

Since the implementation plan process in late 2021, hospitals in the HTP program have made substantial progress as HTP continues into program year two, which began in October 2022. The subsequent sections outline deliverables and progress to date.

E. Outcome of Deliverables & Progress to Date

As of Oct. 1, 2024, HCPF notified hospitals of final scores for timeliness and completeness for the quarter ending September 2024, Interim Activity and CHNE Quarterly Reporting scores. All 84 hospitals in this reporting quarter were considered timely; 82 hospitals were considered complete for their Interim Activity reporting; and 84 hospitals were considered complete for their CHNE Activity reporting. Therefore, 82 hospitals earned the available 0.5% of at-risk funds for this quarter of reporting. Table 12 provides a program overview of hospitals quarterly reporting, amount of at-risk lost and redistribution and what the cause of losing the at-risk was.

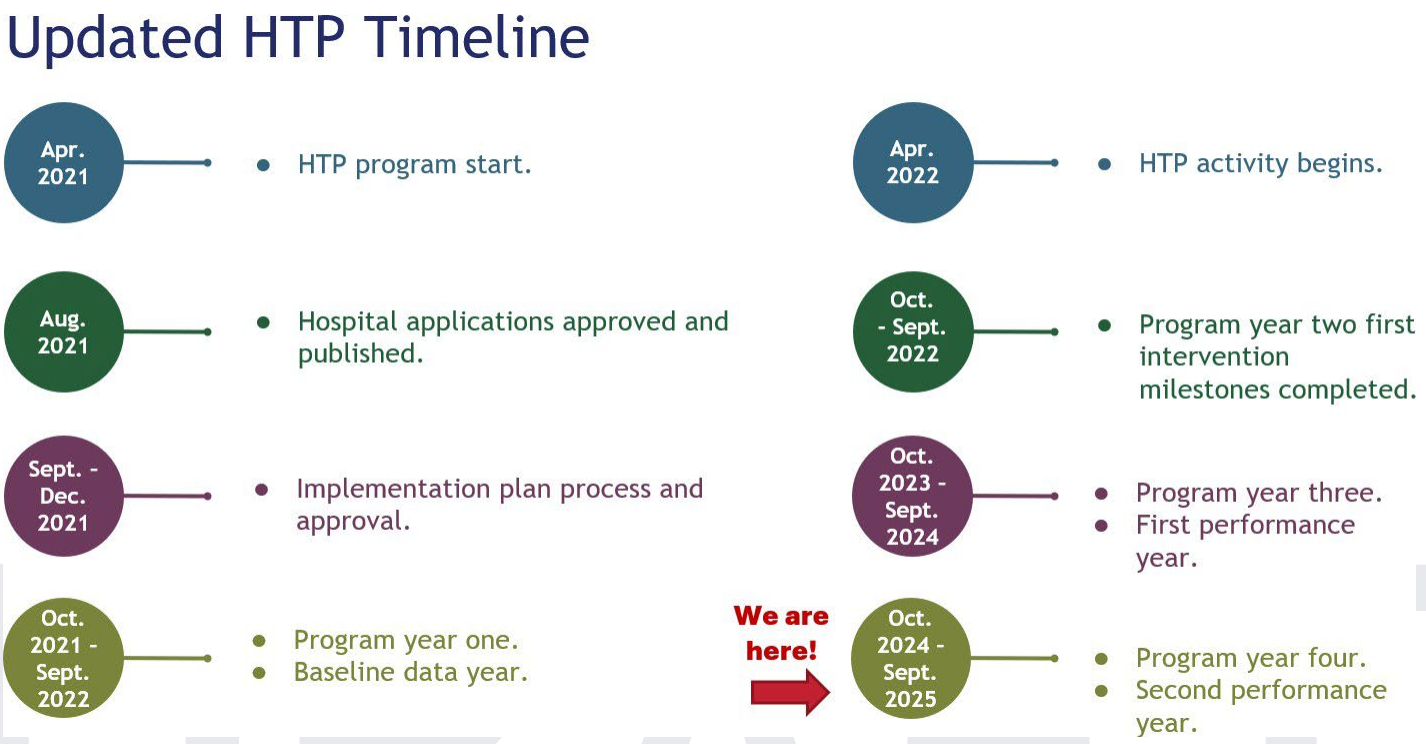

Figure 6. Hospital Transformation Program Timeline

Table 12. HTP Quarterly Report Reviews with At-Risk Lost and Redistributed[28]

Reporting Quarter	Quarterly Report Type	Hospital Count (Total)	Hospital Count (At-Risk Lost)	Hospital	Cause of At-Risk Lost?	At-Risk Amount Lost and Redistributed
Program Year 1 Quarter 3	Interim Activity	83	1	Animas Surgical Hospital	CHNE - Consultations with Key Stakeholders required in both Quarter 3 and Quarter 4. Hospital did not report in Quarter 3.	$11,338.00
Program Year 1 Quarter 4	Interim Activity	84	3	Animas Surgical Hospital	CHNE - Hospital did not report a Public Engagement in Quarter 3 or Quarter 4.	$11,338.00
Program Year 1 Quarter 4	Interim Activity	84	3	Heart of the Rockies Regional Medical Center	CHNE - Hospital did not report a Public Engagement in Quarter 3 or Quarter 4.	$39,032.00
Program Year 1 Quarter 4	Interim Activity	84	3	Middle Park Medical Center	CHNE - Hospital did not report a Public Engagement in Quarter 3 or Quarter 4.	$19,708.00
Program Year 2 Quarter 1	Interim Activity/Performance Measures	84	0	N/A	N/A	N/A
Program Year 2 Quarter 2	Milestone Achievement	84	0	N/A	N/A	N/A
Program Year 2 Quarter 3	Interim Activity	84	1	Animas Surgical Hospital	CHNE - Did not attend HTP Learning Symposium	$13,085.00
Program Year 2 Quarter 4	Milestone Achievement	84	6	Estes Park Health	CHNE - Hospital only reported one Community Advisory Meeting in program year 2 and reported no public engagements in program year 2.	$22,729.00

[28] There are three additional losses of funds not on the list for Program Year 2 for Milestone Reporting (Estes Park- $7,728, Heart of the Rockies- $93,563, The Memorial- $12,447). There is also no line for Animas' loss of funds in Program Year 1 for not meeting the implementation plan payment ($34,014).

Program Year 2 Quarter 4	Milestone Achievement	84	6	Foothills Hospital	CHNE - Hospital only reported one Community Advisory Meeting in program year 2.	$124,208.00
Program Year 2 Quarter 4	Milestone Achievement	84	6	Mt. San Rafael Hospital	CHNE - Hospital only reported one Community Advisory Meeting in program year 2.	$28,173.00
Program Year 2 Quarter 4	Milestone Achievement	84	6	Rangely District Hospital	CHNE - Hospital only reported one Community Advisory Meeting in program year 2.	$6,687.00
Program Year 2 Quarter 4	Milestone Achievement	84	6	St. Anthony North Hospital	CHNE - Hospital did not report a Public Engagement in program year 2.	$59,514.00
Program Year 2 Quarter 4	Milestone Achievement	84	6	The Memorial Hospital	CHNE - Hospital only reported one Community Advisory Meeting in program year 2.	$36,610.00
Program Year 3 Quarter 1	Interim Activity/Performance Measures	84	2	Estes Park Health	Interim Activity - performance measures RAH1, RAH2, COE1 (INT 1)	Will be calculated in 2025
Program Year 3 Quarter 1	Interim Activity/Performance Measures	84	2	National Jewish Health	Interim Activity - performance measure RAH3 (INT 2)	Will be calculated in 2025
Program Year 3 Quarter 2	Milestone Achievement	84	0	N/A	N/A	Will be calculated in 2025
Program Year 3 Quarter 3	Interim Activity	84	2	Estes Park Health	Interim Activity - performance measures SW-CP1, COE1 (INT 6)	Will be calculated in 2025
Program Year 3 Quarter 3	Interim Activity	84	2	The Memorial Hospital	Interim Activity - performance measure SW-BH1 (INT 5)	Will be calculated in 2025

Table 13. Year 3 Quarter ending Sept. 30, 2024, Interim and CHNE Activity Submission Achievement

Components	Scoring Criteria	Number of Hospitals
Year 3 Quarter ending Sept. 30, 2024, Reporting Submission	On Time	84
Year 3 Quarter ending Sept. 30, 2024, Reporting Submission	Late	0
Year 3 Quarter ending Sept. 30, 2024, Reporting – Interim Activity Completeness	Complete	82
Year 3 Quarter ending Sept. 30, 2024, Reporting – Interim Activity Completeness	Incomplete	2
Year 3 Quarter ending Sept. 30, 2024, Reporting – CHNE Activity Completeness	Complete	84
Year 3 Quarter ending Sept. 30, 2024, Reporting – CHNE Activity Completeness	Incomplete	0
Achievement Status	**At-risk earned**	**82**
Achievement Status	**At-risk unearned**	**2**

1. HTP Year 3 Quarter Ending September 2024 Activity Summary

During the project ramp-up and planning period of HTP, there are Interim Activity reporting periods prior to hospitals' Milestone reporting. Program year 3 quarter ending September 30 is the final quarterly reporting period for hospitals prior to their next Milestone reporting (October 2024 - December 2024). While payment was not tied to the successful completion of milestones during interim activity reporting, this reporting period provided insight into whether hospitals are on target to complete the upcoming milestones for all interventions designated in their implementation plans. Hospitals collectively reported they are on track with the vast majority of their interventions (99% of interventions reported on target).

Table 14. Interim Activity Summary – Intervention Progress

Interim Activity Progress	Number of Interventions
Count of Interventions reported to be on track to meet the upcoming Program Year 3 quarter ending December 2024 milestone	638
Total count of Interventions for all HTP hospitals	640

Similarly, 82 out of 84 hospitals (98% of hospitals) report they are on track to complete all of their upcoming milestones for program year three, quarter ending June 30, 2024.

Table 15. Interim Activity Progress

Interim Activity Progress	Number of Hospitals
Number of Hospitals that Reported Being on Track to Complete All Upcoming Program Year 3, quarter ending December 2024 Milestones	82
Total Number of Reporting Hospitals	84

The HTP is built around several phases for measuring progress, but primarily the Planning and Implementation Phase and Continuous Improvement Phase. Under the Planning and Implementation Phase, hospital milestones document the process through which the participant will complete all necessary preliminary activities that support implementation.

Interim activities during the Planning and Implementation Phase are categorized by one or more of the functional areas: People, Process, Technology, and Patient Engagement / Target Population. In Program Year 3 Quarter ending Sept. 30, 2024 hospitals are making progress toward 1,143 different interim activities attributed to the four functional areas across all hospital interventions.[29]

[29] Note, the interim activities summarized during quarter ending Sept. 30, 2023, Interim Activity Reporting could be attributed to one of the four functional areas (People, Process, Technology, and Patient Engagement/Target Population). Under these four standard areas, hospitals had a lot of latitude to describe any number of activities. Therefore, the actual complexity, breadth, and volume of activities may not be reflected in simple counts of interim activities but can still be a helpful metric to understand hospital efforts this quarter.

Hospitals are a major source of care delivery and point of entry to care across the state. In addition to serving the medically and socially complex day-to-day needs of their patients, they are also engaged in making an array of clinical, operational, and system improvements that directly impact patient care. Through the Interim Activity reporting survey, hospitals can document updates on these improvement activities, as categorized by the four functional area types.

Table 16. Program Year 3 Quarter Ending Sept. 30, 2024 Interim Activity Progress

Program Year 3 Quarter Ending Sept. 30, 2024 Interim Activity Progress	Number of Activities
Interim Activities Reported: People Functional Area	180
Interim Activities Reported: Process Functional Area	171
Interim Activities Reported: Technology Functional Area	174
Interim Activities Reported: Patient Engagement Functional Area	161
Continuous Learning and Improvement	457
Total Planning & Implementation Activities Reported	**1,143**

2. Program Year Three Quarter Ending Sept. 30, 2024, Submissions of Excellence

In many cases, hospitals demonstrated reporting above and beyond program requirements. In those cases, the review team captured "submissions of excellence" for both interim activity and CHNE reporting to highlight and recognize these hospitals. Program year three quarter ending Sept. 30, 2024, Submissions of Excellence demonstrated the following criteria:

- Interim Activity Submissions of Excellence
    - [The hospital] has been holding regular complex care meetings weekly to target their long stay, Medicaid and complex patients. [The hospital] is now developing a process in which they will flag patients at day 5 of their stay and discuss if a care conference is warranted with the care team.
    - Clinical Resource Nurse and CNO are developing educational training for Medical and Nursing Staff. Medical Staff training will focus on the referral process for visiting specialists. Additionally, new specialists attend monthly provider meetings and board meetings to educate staff on the services they provide.

        - [The hospital] outlined patient education materials administered by our staff. The team has met with the various subject matter experts to develop patient education on the importance of SDOH screening and referral as well as follow up appointments. While we are still working on the final education material, it will be completed and copies will be ready to be shared by milestone completion. These foundational activities will help us move towards our final impact milestone entailing patient education materials.
        - Director of Marketing is educating the public about specialty services through social media posts, the community newsletter, weekly community coffee meetings, and the local newspaper.
    - CHNE Submissions of Excellence
        - Some hospitals demonstrated community engagement efforts above and beyond program requirements. While hospitals were minimally required to report some type of ongoing CHNE activities this quarter (for example, key stakeholder engagements, community advisory meetings, and/or public engagements), some hospitals reported multiple engagements this quarter, demonstrating meaningful, inclusive, and collaborative engagement with their partners and the public.
        - In several instances, hospitals also demonstrated regular and ongoing meetings with stakeholders, which further emphasizes the hospitals' commitment to their partner relationships.
        - Many hospitals documented engagement across several stakeholder groups and interests. By engaging with multiple types of providers and organizations, a hospital can better understand and serve the broad interests of their community.
        - Hospitals shared feedback they received and how the feedback will inform their efforts going forward, which showcased the hospitals' intentionality and willingness to learn from their partners and community.

F. Community and Health Neighborhood Engagement

Community engagement is a cornerstone of the HTP and is required on an ongoing basis for program participants. Before hospitals submitted their application to the program, they participated in a CHNE process. The CHNE process was a pre-waiver mandate intended to build on existing health care partnerships, as well as grow collaboration within Colorado's health system. HTP participants were required to engage organizations that serve and represent the broad interests of their community, including clinical providers, to identify community needs and resources. Participants were expected to engage, consult, and be informed by health neighborhoods and community organizations as they put together their applications. Hospitals were asked to identify community needs to inform the selection of quality measures and interventions they chose to address those needs.

Hospitals were tasked with aligning their engagement activities with existing programs and alliances, advisory groups, and statewide initiatives. Hospitals produced midpoint and final reports for the CHNE process and will continue with community and health neighborhood engagement throughout the HTP as a required component of regular activity reporting.

As displayed in Figure 6, hospitals continue to surpass CHNE reporting requirements for the Quarter ending Sept. 30, 2024. Additionally, they are making progress towards meeting their program year two annual reporting requirements. With over 460 unique CHNE activities conducted and captured this quarter, this shows that hospitals continue to make strides in connecting with their community and partner organizations on pertinent HTP topics.

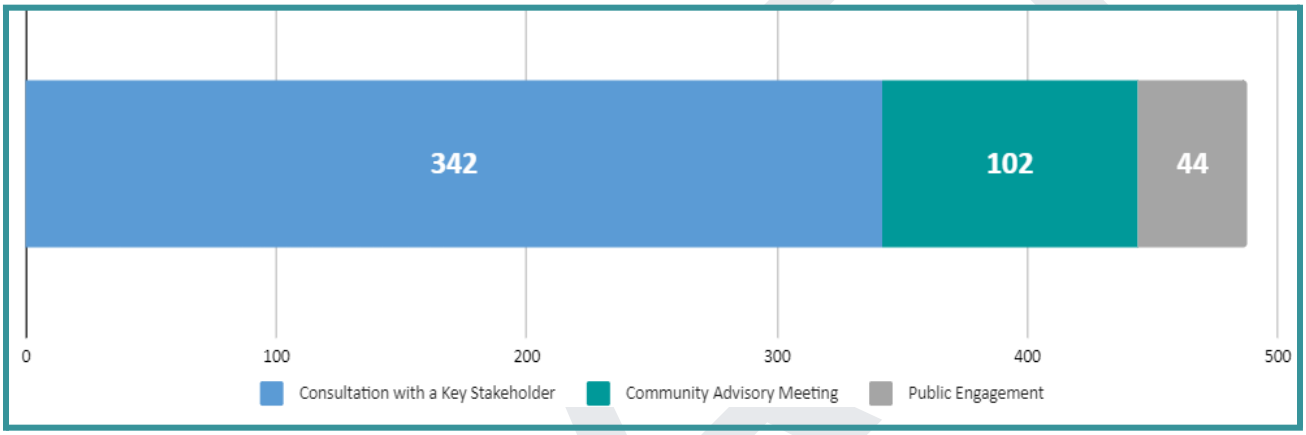

Figure 7. Program Year 2 Quarter Ending Sept. 30, 2023, CHNE Activities Reported

Table 17. Average CHNE Engagement Reported per Hospital

CHNE Component	Average CHNE Engagement Reported per Hospital
Consultation with Key Stakeholder	4.17
Community Advisory Meeting	1.32
Public Engagement	1.02

Further, hospitals are expected to engage a broad cross-section of the community and their health neighborhood. This should include clinical providers and organizations that serve and represent the different interests of the community. These stakeholders may also include representatives of any groups or categories that are impacted by, or particularly relevant to, any of the hospital's HTP initiatives. The stakeholders captured during Program Year 3 Quarter ending Sept. 30 reporting included, but were not limited to, the following:

- **Regional Accountable Entities** (or RAEs), such as Rocky Mountain Health Plans (Region 1), Northeast Health Partners (Region 2), Colorado Access (Regions 3 and 5), Health Colorado, Inc. (Region 4), and Colorado Community Health Alliance (Regions Six and Seven).
- **Local Public Health Agencies** such as Chaffee County Public Health, Las Animas-Huerfano Public Health Department, Summit County Public Health Eagle County Public Health.
- **Behavioral Health Providers**, such as Mind Springs Behavioral Health, SLV Behavioral Health Group, San Luis Valley Behavioral Health Group, Front Range Clinic.
- **Community Health Centers** (including Federally Qualified Health Centers and rural health centers), such as Colorado Rural Health Center, High Plains Community Health Center, Sedgwick County Health Center, STRIDE.
- **Primary Care Medical Providers** (PCMPs), such as Colorado Mountain Medical, Durango Primary Care, La Plata Family Medicine, and A Kidz Clinic.
- **Regional Emergency Medical and Trauma Services Advisory Councils** (RETACs), such as Southwest Regional Emergency Medical and Trauma Services Advisory Councils, SERETAC, Northwest Colorado RETAC.
- **Long-Term Service and Support** (LTSS) Providers, such as Castle Peak Senior Life and Rehabilitation, Wray Rehabilitation and Athletics Center, Caregiver Connections, Serenity Recovery Connection.
- **Consumer advocates or advocacy organizations**, such as Client Management Services, Riverside Education Center.
- **Health alliances**, such as West Mountain Regional Health Alliance, Northern Colorado Health Alliance, Adams County Health Alliance.
- **Community organizations addressing social determinants of health**, such as Food Bank of the Rockies, Peer Assistance Services, La Plaza Child and Migrant Services, Grand Junction City Housing Division
- **Other,** such as Riverside Education Center, A Woman's Work, Your Hope Center, and Wray School District.

G. Consultations with Key Stakeholders

Hospitals should consult key stakeholders on a regular basis to provide them with updates and to get their input and feedback. This consultation can be one-on-one or in a group setting. Hospitals had to report at least one consultation with a key stakeholder this quarter.[30]

During the Quarter ending Sept. 30, 2024:

- 82 out of 84 hospitals reported at least one consultation with a key stakeholder.
- In total, hospitals reported 342 consultations with key stakeholders.

[30] The following hospitals did not report a consultation with key stakeholder this quarter, but did report a community advisory meeting this quarter: *16-Middle Park Medical Center and 24- Pioneers Medical Center*

- There was stakeholder engagement with over 200 unique organizations.[31] While the majority of hospitals reported less than 5 consultations each, there were several hospitals that exceeded that frequency of reporting. Noticeably, the top six reporting hospitals are the following: Vail Health Hospital, 14; Pikes Peak Regional Hospital, 11; Intermountain Health St. Mary's Regional Hospital, 10; Adventist Health Avista, 10; University of Colorado Hospital, 10; Wray Community District Hospital, 10.

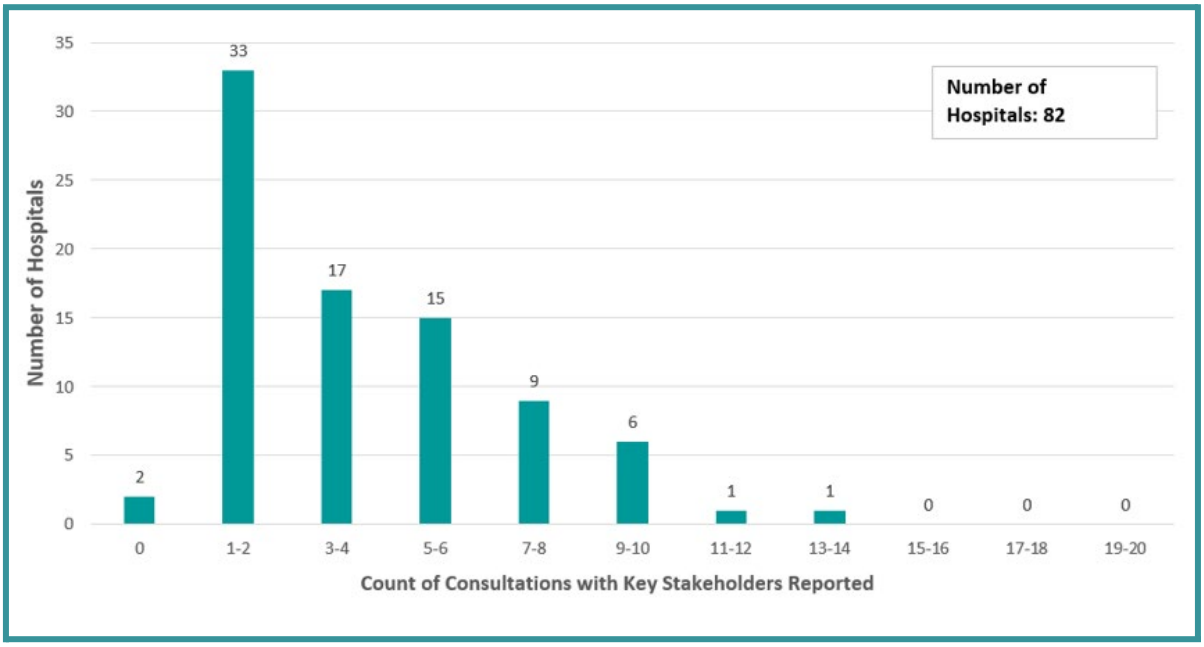

Figure 8. Number of Unique Engagements Reported by Each Hospital- Consultation with Key Stakeholders

[31] Since several consultations were noted to be re-occurring, the actual number of meetings held this quarter may be far greater.

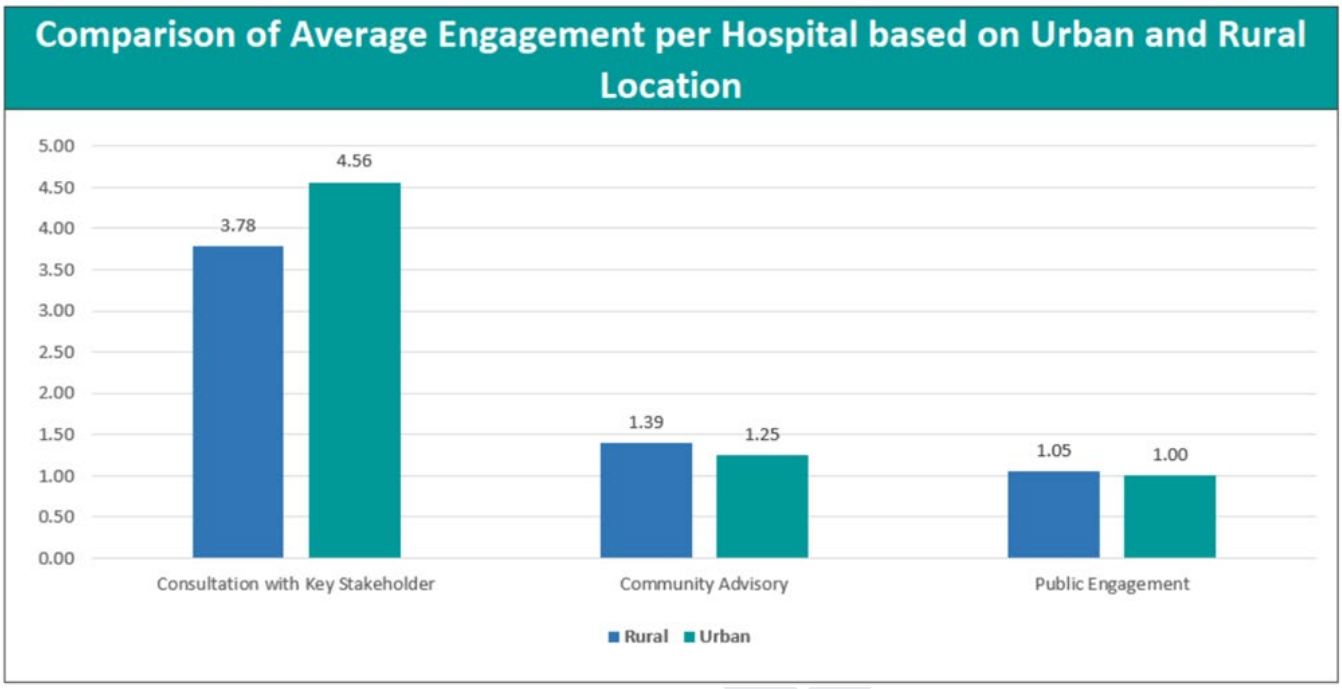

Figure 9. Rural vs Urban Comparison of Average Engagement per Hospital

Hospitals are also expected to engage key stakeholders in a group setting through either convening community advisory meetings or continued participation in existing advisory committees. Hospitals are responsible for determining the most appropriate manner of convening meetings and who should be recruited to participate based on local conditions and existing relationships and collaborations. As part of CHNE Activity reporting for community advisory meetings, hospitals report on a range of survey questions, including community advisory meeting name, date, and meeting organizer; participating organizations; key topics discussed; feedback received during the meeting; and any incorporation of the feedback as a result of the meeting. During the quarter ending Sept. 30, 2024:

- Hospitals reported 102 community advisory meetings.
- 77 out of 84, or 92% of hospitals reported at least one community advisory meeting.[32] This speaks to hospitals' commitment to maximizing their engagement with their community and critical partners. Hospitals are leveraging stakeholder input to make progress in addressing their interventions and making informed choices.

H. Public Engagements

Continued CHNE should also allow for periodic engagement with the public more broadly. This could be achieved via public forums, focus groups, and/or online or paper surveys.

[32] Since several community advisory meetings were noted to be re-occurring, the actual number of meetings held this quarter may be far greater. In addition, the number of unique stakeholder organizations/partners are not reflected in the simple count of community advisory meetings, as some hospitals have reported over 30 different stakeholders present at one event.

Hospitals should facilitate public engagement at least once per year.

Engagement is critical to ensuring successful collaborations and delivery system impacts throughout and following the HTP. Therefore, hospitals are required to meet with members of the public and provide a specific opportunity during that hearing to learn about and provide feedback on the hospitals' HTP initiatives.

During the quarter ending Sept. 30, 2024:

- Hospitals reported 44 public engagements.
- 43 out of 84 hospitals reported at least one public engagement.

1. Types of Feedback Received

- In several cases, hospitals reported that public engagements were fruitful. Hospitals noted they mostly received positive feedback regarding the goals and measures discussed.
- One hospital noted, "We had substantial conversations with the community, especially learning from other hospitals about the overlap in community benefit priorities, including access and behavioral health. One community member underlined the need for improved health care access. These priorities overlap directly with HTP, with follow-up appointment scheduling and behavioral health discharge planning metrics. This discussion coincides with ongoing conversations through Metro Denver Partnership for Health about how member organizations can collaborate on common priorities. Other participants from Community Based Organizations offered to partner and support community members who are patients."
- Another hospital noted, "The most pressing health needs in our community were identified as behavioral health (substance use and mental health, especially youth), access to care and chronic disease management, provider recruitment and retention, and increased awareness of DEI (Diversity, Equity & Inclusion) practices."
- Other feedback received helped hospitals better understand their communities' focus areas and priorities surrounding the following:
    - Access to mental and behavioral health care services and providers, including increasing the availability for follow-up or outpatient behavioral health services, and increasing training to respond to social and/or behavioral health needs.
    - Focus on prevention, education, and services to address high mortality rates, chronic diseases; this includes a need for increased emphasis on housing and transportation.
    - Access to affordable care and reducing health disparities among specific populations.
    - Expansion of provider networks and primary care access, particularly to meet community needs; additionally, hospitals and communities discussed experiencing trouble with provider diversity, recruitment, and staffing issues for supporting the various hospital interventions.

2. Community Advisory Council

In an effort to ensure the voices and needs of community health partners were heard in the wake of HTP implementation, the CHASE Board created the Community Advisory Council. Community Advisory Council (CAC) meetings provide valuable consumer input to all parts of the HTP.

The CAC provided impactful feedback and suggestions during the creation of HTP. However, since HTP has entered the reporting stage, CAC membership has declined. This decline has occurred despite various efforts by the CAC to increase membership. For example, the CAC has sent out letters to various organizations across the state to recruit new members. Some of the organizations targeted by the CAC include Area Agencies on Aging (AAA), Colorado Association of Local Public Health Officials (CALPHO) amongst other organizations across Colorado.

However, these efforts have not led to an increase in membership. The CAC informed the CHASE board about the decrease in membership during the Aug. 23, 2022, meeting to seek guidance and feedback for increasing membership and meaningful feedback for community engagement measures within HTP. The CAC continued to meet until midway through 2023 when they decided to postpone meetings until January 2024 in an effort to focus on new member recruitment. Unfortunately, membership did not increase and meetings have been postponed indefinitely. Additional information about the CAC can be found in a Department memo[33] and on the council's webpage.[34]

3. Continued Progress of the HTP

Over the course of this five-year program, the hospital payments are transitioning from pay-for-process and reporting, to a pay-for-performance structure in an effort to improve quality, demonstrate meaningful community engagement and improve health outcomes over time. The HTP is currently in its second pay for performance year. As hospitals continue through the process of pay for performance, all reports are reviewed by HCPF and are evaluated based on established scoring criteria described within this document to determine payment of at-risk dollars.

In ongoing support efforts, HCPF and partners have worked to compile and share learning opportunities and submissions of excellence (as documented earlier in the HTP Quarter Ending September 2024 Activity Summary section of this report) to assist hospitals moving forward. Technical support and peer learning opportunities will be imperative to hospitals moving forward. Therefore, HCPF will continue to provide regular FAQ updates, office hours, hospital workgroups, and one-on-one technical assistance, to ensure more seamless reporting and to build hospitals' confidence in their ongoing Interim Activity and CHNE requirements.

Another example of partnership with hospitals in the HTP is the altering of certain measures when appropriate. Due to a combination of circumstances related to data analytics support as

[33] https://hcpf.colorado.gov/sites/hcpf/files/2019%20September%20HTP%20Consumer%20engagement%20memo.pdf
[34] https://hcpf.colorado.gov/htp-community-advisory-council

well as inquiries from HTP participants, HCPF decided to change the measure for Severity Adjusted Length of Stay (SW-PH1). A change of this magnitude is never made lightly and HCPF used the following principles to determine the appropriate replacement,

- Hospitals will not be required to implement new interventions
- All hospitals that currently have SW-PH1 will be required to and shall be eligible to participate in the new measure
- Replacement should be aligned with other requirements and build on success seen in the current interventions
- Replacement should serve a benefit to and contribute towards HTP sustainability
- All at-risk will be awarded for SW-PH1 for program year 3

Using these guiding principles the Severity Adjusted Length of Stay (SLOS) measure (SW-PH1) will be retired from HTP and will be replaced with requirements of participation in the Inpatient Hospital Transitions (IHT) program. The IHT will be implemented as a replacement complementary effort for measuring hospitals' existing interventions around care coordination and utilization review. The transition has been initiated and was finalized by Oct. 1, 2024. HTP Hospitals that have SW-PH1 as a measure will be required to participate in the Inpatient Hospital Transitions Program (IHT) and will be measured for adherence to the program in HTP Program Years (PY) 4 and 5. The HEDIS Average Length of Stay (Avg LOS) measure will be calculated as a maintenance measure with no risk associated. The measure will continue to be tracked under the measure SW-PH1, which will replace the previous SLOS data moving forward. The previous SLOS data will be archived but not used for performance measurement. This is one example of HCPF's continued commitment to work with hospitals to ensure positive outcomes for Coloradans, alignment across programs, and sustainability efforts beyond the HTP.

Proactive approaches to support hospitals may be focused on additional training opportunities, regular outreach and troubleshooting with the hospitals, and connecting with peer and/or high performing hospitals to accelerate learning and practice advancements – both in supporting hospitals' intervention progress as well as their ongoing CHNE efforts. HCPF may wish to track these challenges reported, monitor the prevalence, and potentially address them through legislative or rule-making channels.

4. HTP Learning Symposium

In the summer of program year three, on June 5 and 6, 2024, HCPF held the second annual HTP Learning Symposium for HTP hospitals and stakeholders. The HTP Learning Symposium is a mandatory two-day event for hospitals and key stakeholders with strong connections to the HTP program. Hospitals were required to attend at least one session either virtually or in-person. Overall, 84 of 84 hospitals (100%) were represented at the learning symposium. This was an increase over the previous year when only 83 of the 84 hospitals attended the HTP Learning Symposium. In total, there were over 150 different attendees over the two-day learning symposium.The HTP Learning Symposium celebrated hospital achievements to date, provided resources, peer learning and panels on how to be successful within the HTP program. The HTP Learning Symposium is another avenue for HCPF to ensure hospital success in the HTP program.

One way to help hospitals through the learning symposium was to survey and have conversations about the most critical aspects of HTP. Therefore, hospitals were surveyed about what content they wanted to see presented and covered at the second annual HTP Learning Symposium. Based on hospital survey results, the content covered at the learning symposium included the following topics.

- HTP Recognition
    - celebration of successes-to-date
- Hospital Interventions
    - Length of Stay (LoS) measures
    - best practices and how can we best utilize the data we have
- Community Health and Neighborhood Engagement Impacts
    - patient and shared HTP stories
    - community organization outreach opportunities
- Regional Accountable Entity (RAE) Presentations
    - keynote speakers
    - rural and urban successes and challenges in the HTP
- Data and IT Reporting
    - the impact of small data
    - continuous learning and improvement

The third annual HTP learning symposium will be held June 11 and 12, 2025 for HTP hospitals and stakeholders. Hospitals were surveyed after the inaugural HTP learning symposium and asked about what content they would like to see presented at the 2025 learning symposium. Based on the hospital's responses the learning symposium will focus on the following topics.

- HTP Recognition
    - celebration of successes-to-date
    - HTP sustainability, beyond the HTP
- Hospital Interventions
    - collaboration efforts between hospitals on similar measures and best practices on data automation
    - feedback and information from top performers on how they met/exceeded the benchmarks
- Community Health and Neighborhood Engagement Impacts
    - patient and shared HTP success stories
    - community partners reporting on outcomes from our work
- Regional Accountable Entity (RAE) Presentations
    - keynote speakers
    - rural and urban successes and challenges in the HTP
- Measure Reporting
    - speakers on equity and inclusion as well as SDoH
    - peer performance comparison and best practices to achieve success in specific measures.
    - continuous learning and improvement

5. Rural Support Fund

Funding for the rural support payments is $12,000,000 annually for each of the five years of the HTP, equaling $60 million in total funding. Twenty-three hospitals with the lowest revenues or reserves qualify for the Rural Support Fund (also known as the Rural Support Supplement Payment Program). For each qualified hospital, the annual payment is equal to $12,000,000 divided by the total number of qualified hospitals ($521,739 per year per hospital). Rural Support Funds for FFY 2023-24 were disbursed in monthly installments as part of the CHASE fee and supplemental payment program. To date, each qualified hospital has received $2,086,956 for the first four years.

Hospitals were given guidance on how these funds should be used to align with the HTP goals and each hospital submitted an attestation form detailing the use of the funds. Section C in the Appendix has further detail on each hospital's use of the funds in the third year, from October 2023 through September 2024. Attestations are required for each subsequent year summarizing how the funds were utilized and how future funds will be allocated.

Attestations are also used to check-in with hospitals on challenges and needs. Themes from the hospitals' attestations include: staffing shortages and the labor market, distinct and significant of the program, differences between urban and rural areas, the impact of decisions that only consider urban areas, budget concerns, and the end of this five-year program.

See hcpf.colorado.gov/htp-rural-support-fund for information on the Rural Support Fund.

6. HTP Sustainability

At the conclusion of the final program year, hospitals will be at-risk for the completion and submission of a comprehensive sustainability plan. The sustainability plan incorporates and builds upon the information and knowledge gained from the work and reporting that was done throughout the program and transitions hospitals into the next generation of the HTP. In 2027, the year after HTP ends, each hospital must develop a strategic plan to be submitted to HCPF. These strategic plans need to demonstrate how they will ensure the continued success of the delivery system transformation efforts after the five-year HTP demonstration period. Over the course of this program year HCPF is working to develop the overall sustainability plan and next steps for HTP. These efforts will guide hospitals on what is needed to build their plans around.

The goal is to create a clear path forward, an action strategy, with steps and a timeline to ensure hospitals can build sustainability capacity in the future, and transition to the next iteration of the HTP. Through the knowledge gained across the HTP, there should be identified opportunities to build upon and sustain the system transformation success that have been achieved that will strengthen the ability to serve Coloradans into the next generation of the HTP and continue to improve care, innovate, and build capacity moving forward.

The sustainability of HTP is also important to preserve the critical funding HTP has generated to support and further transformation, improve quality outcomes, and reduce costs. HCPF has

enhanced net supplemental payment reimbursement to hospitals to support HTP implementation. Additionally, HCPF also provides Rural Support Funds to small rural hospitals to further support their efforts in HTP. As HTP sunsets, HCPF is working hard with various stakeholders to preserve the funding HTP has generated and to further hospital affordability and quality outcomes. This includes sustaining the ongoing efforts of the Rural Support Funds, continuing to help rural Colorado hospitals and communities.

VII. Appendix

A. CHASE Fee, Supplemental Payments and Net Benefit

Table 18. Fee-Exempt Hospitals: Long-Term Care, and Rehabilitation Hospitals

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Cedar Springs	El Paso	$0	$0	$0	$0	$0	$0	$0	$0	$0
Centennial Peaks	Boulder	$0	$0	$0	$0	$0	$0	$0	$0	$0
Clear View Behavioral	Larimer	$0	$0	$0	$0	$0	$0	$0	$0	$0
Colorado Mental Health - Fort Logan	Denver	$0	$0	$0	$0	$0	$0	$0	$0	$0
Colorado Mental Health - Pueblo	Pueblo	$0	$0	$0	$0	$0	$0	$0	$0	$0
Craig Hospital	Arapahoe	$0	$47,532	$99,480	$0	$0	$7,998	$0	$155,010	$155,010
Denver Springs	Arapahoe	$0	$0	$0	$0	$0	$0	$0	$0	$0
Highlands Behavioral Health System	Douglas	$0	$0	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Hospital of Littleton	Arapahoe	$0	$58,716	$0	$0	$0	$ 53,091	$0	$111,807	$111,807
Kindred Hospital - Aurora	Adams	$0	$105,984	$0	$0	$0	$0	$0	$105,984	$105,984
Kindred Hospital - Denver	Denver	$0	$103,168	$0	$0	$0	$0	$0	$103,168	$103,168
PAM Specialty Hospital of Denver	Denver	$0	$104,601	$0	$0	$0	$0	$0	$104,601	$104,601
PAM Specialty Hospital of Westminster	Jefferson	$0	$9,882	$ 863	$0	$0	$0	$0	$10,745	$10,745
Peak View Behavioral Health	El Paso	$0	$0	$0	$0	$0	$0	$0	$0	$0
Northern Colorado Long Term Hospital	Larimer	$0	$25,001	$0	$0	$0	$0	$0	$25,001	$25,001
Northern Colorado Rehabilitation Hospital	Weld	$0	$22,910	$ 7,133	$0	$0	$0	$0	$30,043	$30,043
Rehabilitation Hospital of Colorado Springs	El Paso	$0	$76,437	0	$0	$0	$169,254	$0	$245,691	$245,691
Spalding Rehabilitation Hospital	Adams	$0	$53,099	$ 9,363	$0	$0	$0	$0	$62,462	$62,462

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Vibra Hospital of Denver	Adams	$0	$119,803	$0	$0	$0	$0	$0	$119,803	$119,803
Vibra Rehabilitation Hospital of Denver	Adams	$0	$72,320	$0	$0	$0	$0	$0	$72,320	$72,320
Reunion Rehabilitation Hospital - Denver	Denver	$0	$25,017	$0	$0	$0	$0	$0	$25,017	$25,017
Reunion Rehabilitation Hospital - Inverness	Arapahoe	$0	$27,950	$0	$0	$0	$0	$0	$27,950	$27,950
West Springs Hospital	Mesa	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total		**$0**	**$ 852,420**	**$116,829**	**$0**	**$0**	**$230,343**	**$0**	**$1,199,602**	**$1,199,602**

Table 19. Fee-Paying Hospitals: General and Acute Care Hospitals

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Rural Support Payment	Essential Access Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
AdventHealth Avista	Boulder	$11,364,757	$12,394,480	$8,470,556	$0	$0	$2,238,780	$0	$23,103,816	$11,739,059
AdventHealth Castle Rock	Douglas	$9,473,948	$1,579,926	$1,956,727	$0	$0	$1,097,696	$0	$4,634,349	-$4,839,599
AdventHealth Littleton	Arapahoe	$22,520,865	$13,390,726	$9,589,214	$0	$0	$1,053,297	$0	$24,033,237	$1,512,372
AdventHealth Parker	Douglas	$22,167,683	$13,218,365	$13,186,228	$0	$0	$1,239,367	$0	$27,643,960	$5,476,277
AdventHealth Porter	Denver	$24,797,549	$4,945,542	$4,575,056	$0	$0	$1,180,670	$0	$10,701,268	-$14,096,281
Animas Surgical Hospital	La Plata	$2,018,161	$14,770	$2,419,109	$0	$764,706	$13,215	$0	$3,211,800	$1,193,639
Arkansas Valley Regional Medical Center	Otero	$1,136,290	$1,102,839	$5,791,321	$0	$764,706	$695,495	$0	$8,354,361	$7,218,071
Aspen Valley Hospital	Pitkin	$2,320,812	$305,240	$1,727,516	$0	$764,706	$66,509	$306,377	$3,170,348	$849,536
Banner Fort Collins Medical Center	Larimer	$2,636,260	$1,077,372	$2,006,844	$0	$0	$1,014,176	$587,572	$4,685,964	$2,049,704
Banner McKee Medical Center	Larimer	$8,670,632	$1,559,515	$4,287,719	$0	$0	$593,510	$1,468,469	$7,909,213	-$761,419
Banner North Colorado Medical Center	Weld	$25,595,938	$22,953,166	$13,768,337	$0	$0	$4,043,331	$6,072,664	$46,837,498	$21,241,560
Children's Hospital Anschutz	Adams	$41,366,900	$38,198,224	$10,655,745	$0	$0	$7,898,251	$10,255,692	$67,007,912	$25,641,012

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Rural Support Payment	Essential Access Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Children's Hospital Colorado Springs	El Paso	$12,168,456	$12,896,699	$1,897,473	$0	$0	$2,209,650	$798,714	$17,802,536	$5,634,080
Commonspirit Longmont United Hospital	Boulder	$9,852,450	$2,596,065	$3,375,353	$0	$0	$1,124,325	$2,331,647	$9,427,390	-$425,060
Commonspirit Mercy Hospital	La Plata	$13,476,198	$2,793,640	$12,065,961	$0	$0	$1,576,777	$0	$16,436,378	$2,960,180
Commonspirit Penrose/St Francis Hospital	El Paso	$65,719,561	$61,184,708	$42,720,468	$0	$0	$5,940,221	$0	$109,845,397	$44,125,836
Commonspirit St. Anthony Hospital	Jefferson	$33,395,118	$8,583,674	$6,526,421	$0	$0	$1,825,044	$0	$16,935,139	-$16,459,979
Commonspirit St. Anthony North Hospital	Broomfield	$18,867,239	$4,752,465	$6,141,950	$0	$0	$3,594,447	$0	$14,488,862	-$4,378,377
Commonspirit St. Anthony Summit Hospital	Summit	$4,117,588	$699,993	$4,686,877	$0	$0	$928,544	$0	$6,315,414	$2,197,826
Commonspirit St. Elizabeth Hospital	Morgan	$3,167,679	$682,585	$3,837,667	$0	$0	$852,260	$0	$5,372,512	$2,204,833
Commonspirit St. Francis Hospital - Interquest	El Paso	$1,098,653	$27,031	$407,050	$0	$0	$0	$0	$434,081	-$664,572
Commonspirit St. Mary-Corwin Hospital	Pueblo	$10,494,045	$1,225,215	$6,094,119	$0	$0	$1,452,022	$0	$8,771,356	-$1,722,689
Commonspirit St. Thomas More Hospital	Fremont	$3,546,437	$1,115,663	$7,368,759	$0	$764,706	$931,630	$0	$10,180,758	$6,634,321
Community Hospital	Mesa	$10,002,132	$1,871,175	$3,706,723	$0	$0	$754,805	$4,068,499	$10,401,202	$399,070
Delta County Memorial Hospital	Delta	$4,708,172	$1,637,300	$7,955,669	$0	$0	$539,483	$0	$10,132,452	$5,424,280
Denver Health	Denver	$42,203,677	$32,344,651	$7,922,340	$0	$0	$10,093,419	$90,771,522	$141,131,932	$98,928,255
East Morgan County Hospital	Morgan	$944,217	$697,022	$3,591,384	$521,739	$764,706	$917,739	$0	$6,492,590	$5,548,373
Estes Park Health	Larimer	$1,227,412	$290,036	$4,162,114	$0	$764,706	$0	$0	$5,216,856	$3,989,444
Family Health West	Mesa	$1,845,598	$11,078	$2,861,874	$0	$764,706	$24,385	$0	$3,662,043	$1,816,445
Foothills Hospital	Boulder	$26,561,468	$10,363,900	$17,033,373	$0	$0	$996,283	$0	$28,393,556	$1,832,088
Grand River Health	Garfield	$1,916,558	$192,968	$2,954,833	$0	$764,706	$174,576	$2,891,794	$6,978,877	$5,062,319
Gunnison Valley Health	Gunnison	$1,571,472	$132,154	$1,932,389	$0	$764,706	$204,930	$0	$3,034,179	$1,462,707
Haxtun Health	Phillips	$168,703	$30,407	$649,541	$521,739	$764,706	$2,666	$0	$1,969,059	$1,800,356

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Rural Support Payment	Essential Access Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
HCA HealthONE Aurora Hospital	Arapahoe	$52,894,037	$37,081,746	$22,001,922	$0	$0	$1,196,530	$0	$60,280,198	$7,386,161
HCA HealthONE Mountain Ridge Hospital	Adams	$30,964,382	$18,715,322	$10,053,331	$0	$0	$2,551,689	$4,181,843	$35,502,185	$4,537,803
HCA HealthONE Presbyterian St. Luke's	Denver	$43,643,950	$47,080,407	$20,269,425	$0	$0	$1,894,168	$0	$69,244,000	$25,600,050
HCA HealthONE Rose Hospital	Denver	$37,317,758	$22,260,423	$12,468,809	$0	$0	$2,167,135	$0	$36,896,367	-$421,391
HCA HealthONE Sky Ridge Hospital	Douglas	$48,851,994	$14,259,426	$9,133,935	$0	$0	$1,351,221	$0	$24,744,582	-$24,107,412
HCA HealthONE Swedish Hospital	Arapahoe	$66,507,885	$46,153,105	$21,541,345	$0	$0	$2,228,372	$0	$69,922,822	$3,414,937
Heart of the Rockies Regional Medical Center	Chaffee	$3,183,841	$953,143	$8,458,356	$0	$764,706	$213,988	$0	$10,390,193	$7,206,352
Intermountain Health Good Samaritan Hospital	Boulder	$23,183,405	$4,600,209	$3,877,650	$0	$0	$1,752,396	$0	$10,230,255	-$12,953,150
Intermountain Health Lutheran Hospital	Jefferson	$35,193,861	$29,070,406	$19,749,707	$0	$0	$3,230,715	$0	$52,050,828	$16,856,967
Intermountain Health Platte Valley Hospital	Adams	$9,192,903	$6,955,679	$8,041,698	$0	$0	$2,705,672	$2,539,939	$20,242,988	$11,050,085
Intermountain Health Saint Joseph Hospital	Denver	$38,216,483	$36,486,342	$20,329,105	$0	$0	$4,987,549	$0	$61,802,996	$23,586,513
Intermountain Health St. Mary's Regional Hospital	Mesa	$29,967,417	$18,127,206	$9,343,033	$0	$0	$1,192,624	$5,802,144	$34,465,007	$4,497,590
Keefe Memorial Hospital	Cheyenne	$109,209	$66,662	$1,094,738	$521,739	$764,706	$52,164	$0	$2,500,009	$2,390,800
Kit Carson County Memorial Hospital	Kit Carson	$477,808	$242,087	$2,175,588	$521,739	$764,706	$20,700	$0	$3,724,820	$3,247,012
Lincoln Community Hospital	Lincoln	$490,691	$115,781	$2,237,729	$521,739	$764,706	$7,493	$0	$3,647,448	$3,156,757
Melissa Memorial Hospital	Phillips	$415,487	$107,594	$1,812,062	$521,739	$764,706	$35,339	$0	$3,241,440	$2,825,953
Memorial Hospital	El Paso	$63,938,694	$33,087,005	$9,063,860	$0	$0	$11,272,061	$11,489,008	$64,911,934	$973,240
Middle Park Medical Center	Grand	$1,035,256	$81,865	$3,786,991	$521,739	$764,706	$0	$0	$5,155,301	$4,120,045
Montrose Regional Health	Montrose	$7,781,153	$1,520,350	$6,093,713	$0	$0	$739,536	$2,421,933	$10,775,532	$2,994,379
Mt. San Rafael Hospital	Las Animas	$1,229,588	$237,903	$5,128,555	$0	$764,706	$110,439	$0	$6,241,603	$5,012,015
National Jewish Health	Denver	$4,607,335	$24,824	$6,645,359	$0	$0	$105,214	$602,482	$7,377,879	$2,770,544

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Rural Support Payment	Essential Access Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
OrthoColorado Hospital	Jefferson	$4,428,504	$0	$3,872	$0	$0	$29,195	$0	$33,067	-$4,395,437
Pagosa Springs Medical Center	Archuleta	$989,969	$136,832	$2,711,857	$521,739	$764,706	$151,673	$0	$4,286,807	$3,296,838
Parkview Medical Center	Pueblo	$48,324,467	$40,777,603	$28,858,132	$0	$0	$3,369,664	$0	$73,005,399	$24,680,932
Pioneers Medical Center	Rio Blanco	$512,190	$60,814	$695,348	$521,739	$764,706	$3,304	$0	$2,045,911	$1,533,721
Prowers Medical Center	Prowers	$912,244	$806,955	$6,522,806	$0	$764,706	$314,839	$0	$8,409,306	$7,497,062
Rangely District Hospital	Rio Blanco	$156,992	$9,356	$706,719	$521,739	$764,706	$1,035	$0	$2,003,555	$1,846,563
Rio Grande Hospital	Rio Grande	$807,705	$149,283	$2,522,750	$521,739	$764,706	$296,441	$0	$4,254,919	$3,447,214
San Luis Valley Health Conejos County Hospital	Conejos	$295,506	$58,025	$2,068,348	$521,739	$764,706	$122,329	$0	$3,535,147	$3,239,641
San Luis Valley Health Regional Medical Center	Alamosa	$5,074,416	$1,555,070	$13,176,079	$0	$0	$2,173,334	$0	$16,904,483	$11,830,067
Sedgwick County Health Center	Sedgwick	$284,834	$78,357	$1,049,241	$521,739	$764,706	$4,347	$0	$2,418,390	$2,133,556
Southeast Colorado Hospital	Baca	$291,424	$101,747	$1,311,363	$521,739	$764,706	$63,715	$0	$2,763,270	$2,471,846
Southwest Health System	Montezuma	$2,014,014	$1,757,759	$8,771,161	$521,739	$764,706	$1,075,531	$0	$12,890,896	$10,876,882
Spanish Peaks Regional Health Center	Huerfano	$320,459	$129,815	$2,209,437	$521,739	$764,706	$22,770	$0	$3,648,467	$3,328,008
St. Vincent Hospital	Lake	$308,951	$80,696	$2,675,417	$521,739	$764,706	$0	$0	$4,042,558	$3,733,607
Sterling Regional MedCenter	Logan	$2,138,549	$545,435	$6,609,034	$521,739	$764,706	$903,721	$0	$9,344,635	$7,206,086
The Memorial Hospital	Moffat	$1,554,652	$504,055	$5,867,720	$521,739	$764,706	$0	$0	$7,658,220	$6,103,568
UCHealth Broomfield Hospital	Jefferson	$5,570,351	$1,528,622	$2,115,353	$0	$0	$521,243	$0	$4,165,218	-$1,405,133
UCHealth Grandview Hospital	El Paso	$3,299,399	$285,755	$2,233,680	$0	$0	$445,398	$0	$2,964,833	-$334,566
UCHealth Greeley Hospital	Weld	$9,838,753	$2,313,620	$4,089,897	$0	$0	$2,175,719	$2,504,612	$11,083,848	$1,245,095
UCHealth Highlands Ranch Hospital	Adams	$12,419,741	$1,822,100	$2,675,851	$0	$0	$1,043,909	$1,532,703	$7,074,563	-$5,345,178
UCHealth Longs Peak Hospital	Weld	$11,386,362	$2,461,462	$4,020,106	$0	$0	$2,155,450	$1,698,999	$10,336,017	-$1,050,345

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Rural Support Payment	Essential Access Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
UCHealth Medical Center of the Rockies	Larimer	$28,778,247	$5,192,130	$5,490,609	$0	$0	$1,918,203	$5,129,362	$17,730,304	-$11,047,943
UCHealth Pikes Peak Regional Hospital	Teller	$1,235,697	$99,698	$3,562,578	$521,739	$764,706	$161,592	$0	$5,110,313	$3,874,616
UCHealth Poudre Valley Hospital	Larimer	$39,730,253	$13,020,224	$3,986,500	$0	$0	$4,448,049	$5,806,101	$27,260,874	-$12,469,379
UCHealth University of Colorado Hospital	Adams	$119,075,430	$47,900,390	$63,398,819	$0	$0	$11,342,209	$82,833,122	$205,474,540	$86,399,110
Vail Health Hospital	Eagle	$6,554,012	$704,213	$9,212,223	$0	$0	$427,093	$0	$10,343,529	$3,789,517
Valley View Hospital	Garfield	$9,192,635	$1,989,203	$5,191,108	$0	$0	$740,745	$10,511,602	$18,432,658	$9,240,023
Weisbrod Memorial County Hospital	Kiowa	$75,979	$7,017	$831,953	$521,739	$764,706	$0	$0	$2,125,415	$2,049,436
Wray Community District Hospital	Yuma	$686,531	$424,529	$2,351,966	$521,739	$764,706	$434,245	$0	$4,497,185	$3,810,654
Yampa Valley Medical Center	Routt	$3,375,217	$619,813	$5,918,343	$0	$0	$628,874	$624,867	$7,791,897	$4,416,680
Yuma District Hospital	Yuma	$477,666	$135,662	$2,595,426	$521,739	$764,706	$59,989	$0	$4,077,522	$3,599,856
Totals		**$1,260,436,914**	**$697,352,219**	**$633,067,317**	**$11,999,997**	**$26,000,004**	**$128,127,124**	**$257,231,667**	**$1,753,778,428**	**$493,341,514**
Totals (All Hospitals)		**$1,260,436,914**	**$698,204,739**	**$633,184,156**	**$11,999,997**	**$26,000,004**	**$128,357,467**	**$257,231,667**	**$1,754,978,030**	**$494,541,116**

B. Cost Shift

1. Payment to Cost Ratio by Payer Group

Table 20 Cost-to-charge Ratio Calculation

Calculation	Variable
	Total operating expense
÷	Sum of:
	Total gross charges
+	Other operating revenue.
=	Net patient revenue

Figure 10 is a visual display of payment to cost ratios by payer group from 2019 to 2023.

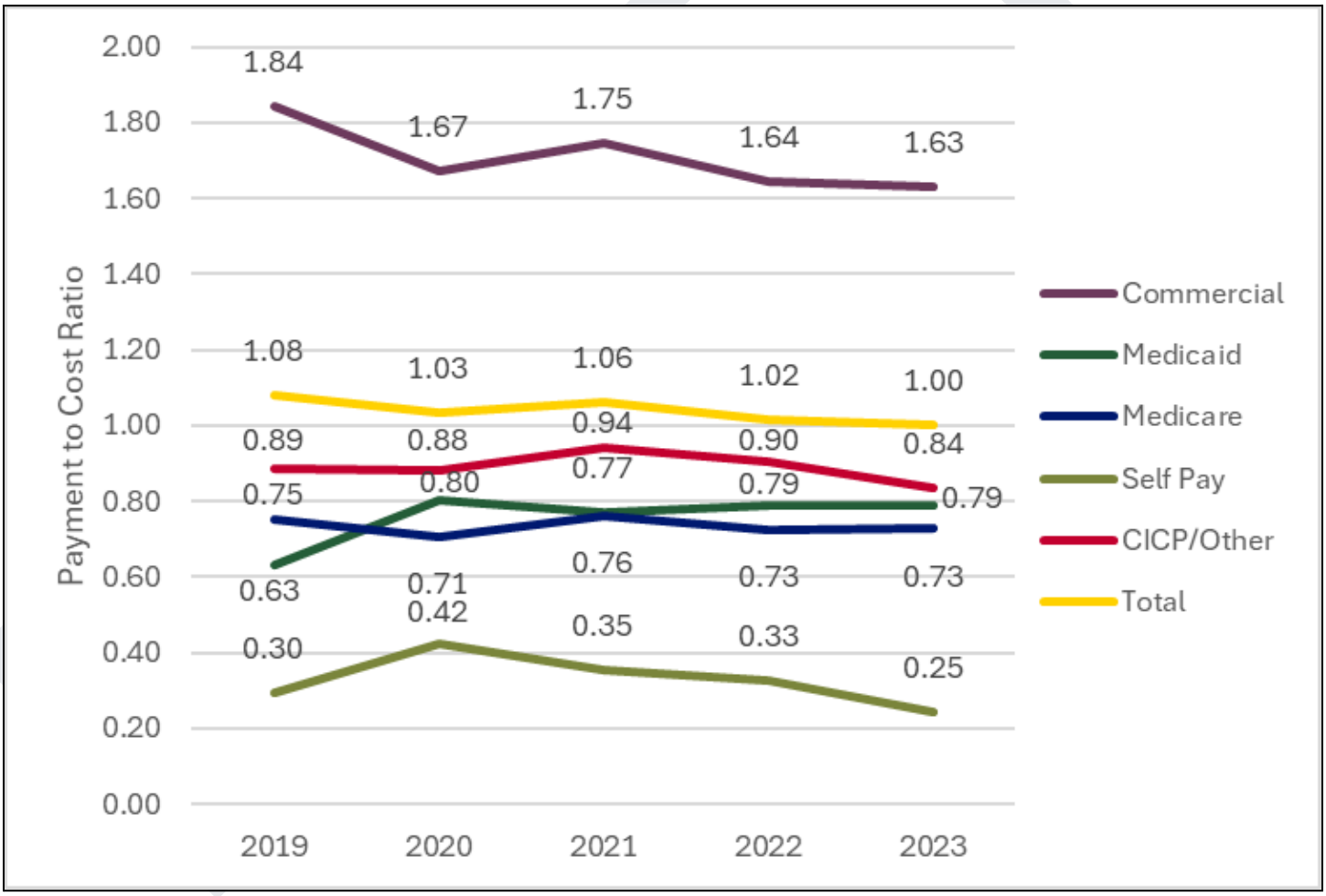

Figure 10. Payment to Cost Ratio by Payer Group

Table 21. Payment to Cost Ratio

Year	Medicare	Health First Colorado	Insurance	CICP/Self Pay/Other	Overall
2009	0.78	0.54	1.55	0.52	1.05
2010	0.76	0.74	1.49	0.72	1.06
2011	0.77	0.76	1.54	0.65	1.07
2012	0.74	0.79	1.54	0.67	1.07
2013	0.66	0.80	1.52	0.84	1.05
2014	0.71	0.72	1.59	0.93	1.07
2015	0.72	0.75	1.58	1.11	1.08
2016	0.71	0.71	1.64	1.08	1.09
2017	0.72	0.72	1.66	0.85	1.07
2018	0.70	0.77	1.70	0.88	1.09

Table 22. Payment to Cost Ratio, Post HB 19-1001[35]

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/ Other	Overall
2019	0.72	0.75	1.85	0.26	0.71	1.07
2020	0.67	0.83	1.66	0.43	0.94	1.02
2020 w/ stimulus	0.74	0.89	1.73	0.49	1.01	1.09
2021	0.73	0.80[36]	1.72	0.35	0.99	1.05
2022	0.70	0.81	1.63	0.32	0.95	1.01
2023	0.69	0.82	1.63	0.23	0.89	0.99

2. Payment, Cost by Payer Group

Figure 10 shows the total payments by payer from 2009 to 2023. The figure highlights figures from the first year and the two most recent years. Table 23 and Table 24 displays the total hospital payments by payer group from 2009 to 2023.

[35] Increases for Health First Colorado's reimbursement between 2019 and 2020 were likely driven by better reporting of supplemental payments from hospitals and the increase in the FMAP in response to the COVID-19 PHE.
[36] In the 2023 CHASE Annual Report, National Jewish Health provided total amounts for net income and operating income within the notes section of the reporting template instead of the revenue section. Revisions were made to revenues and expenses to account for this after publication of the 2023 CHASE Annual Report. Please refer to this addendum for more information: https://hcpf.colorado.gov/sites/hcpf/files/2023%20CHASE%20Annual%20Report%20FINAL_addendum.pdf

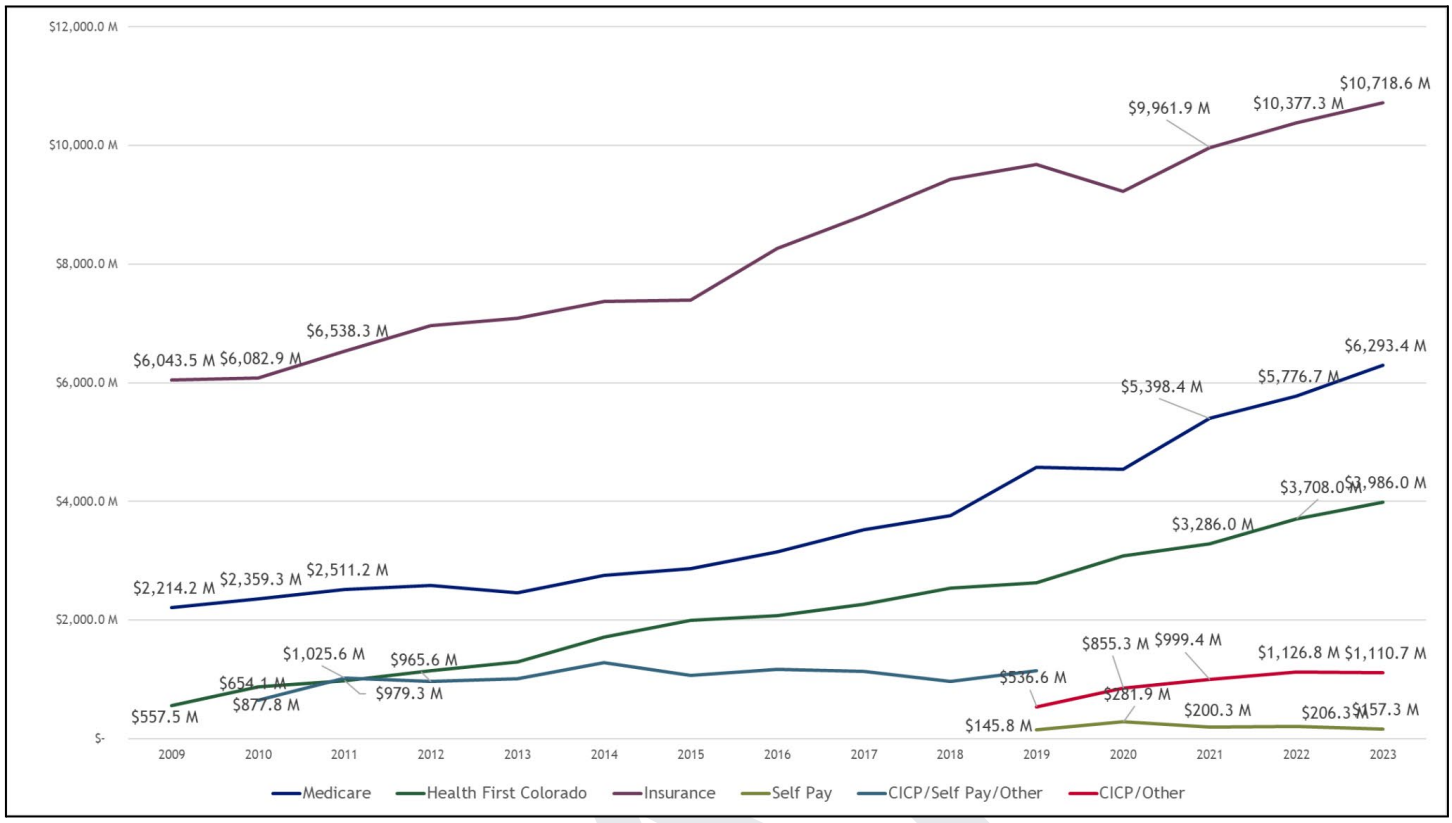

Figure 11. Total Payments by Payer Group

Table 23. Total Payments by Payer Group

Year	Medicare	Health First Colorado	Insurance	CICP/Self Pay/Other	Overall
2009	$2,214,233,425	$557,527,978	$6,043,450,921	$654,096,373	$9,469,308,697
2010	$2,359,258,345	$877,817,423	$6,082,937,998	$1,025,616,731	$10,345,630,496
2011	$2,511,236,539	$979,309,514	$6,538,322,288	$965,597,858	$10,994,466,200
2012	$2,581,505,340	$1,147,395,495	$6,962,969,923	$1,014,141,949	$11,706,012,707
2013	$2,455,232,152	$1,295,109,772	$7,081,529,981	$1,287,865,235	$12,119,737,140
2014	$2,756,637,578	$1,718,040,377	$7,373,458,448	$1,072,398,883	$12,920,535,286
2015	$2,862,382,554	$1,992,336,026	$7,396,133,964	$1,173,824,281	$13,424,676,824
2016	$3,153,602,748	$2,069,703,567	$8,270,697,106	$1,157,479,690	$14,651,483,110
2017	$3,525,196,468	$2,270,573,909	$8,815,032,304	$965,930,484	$15,576,733,165
2018	$3,760,985,656	$2,536,572,987	$9,433,882,965	$1,147,446,398	$16,878,888,005

Table 24. Total Payments by Payer Group, Post HB 19-1001

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/Other	Overall
2019	$4,574,794,438	$2,633,375,585	$9,677,011,459	$145,774,348	$536,643,710	$17,567,599,540
2020	$4,537,073,609	$3,076,549,628	$9,222,850,895	$281,933,961	$855,312,092	$17,973,720,186
2021	$5,398,371,097	$3,286,045,061	$9,961,889,729	$200,299,492	$999,394,062	$19,845,999,443
2022	$5,776,730,157	$3,707,962,806	$10,377,274,056	$206,278,265	$1,126,822,225	$21,195,067,510
2023	$6,293,428,972	$3,985,967,201	$10,718,626,433	$157,311,158	$1,110,669,814	$22,266,003,578

Figure 12 shows costs from 2019 to 2023. Table 25 and Table 26 show the total costs by payer from 2009 through 2018 and 2019 to 2023, respectively. Table 27 shows total costs for 2019 to 2023 utilizing an aggregate cost-to-charge ratio. Figure 13 shows costs for each payer from 2009 to 2023 and utilizes the aggregate cost-to-charge ratio as well.

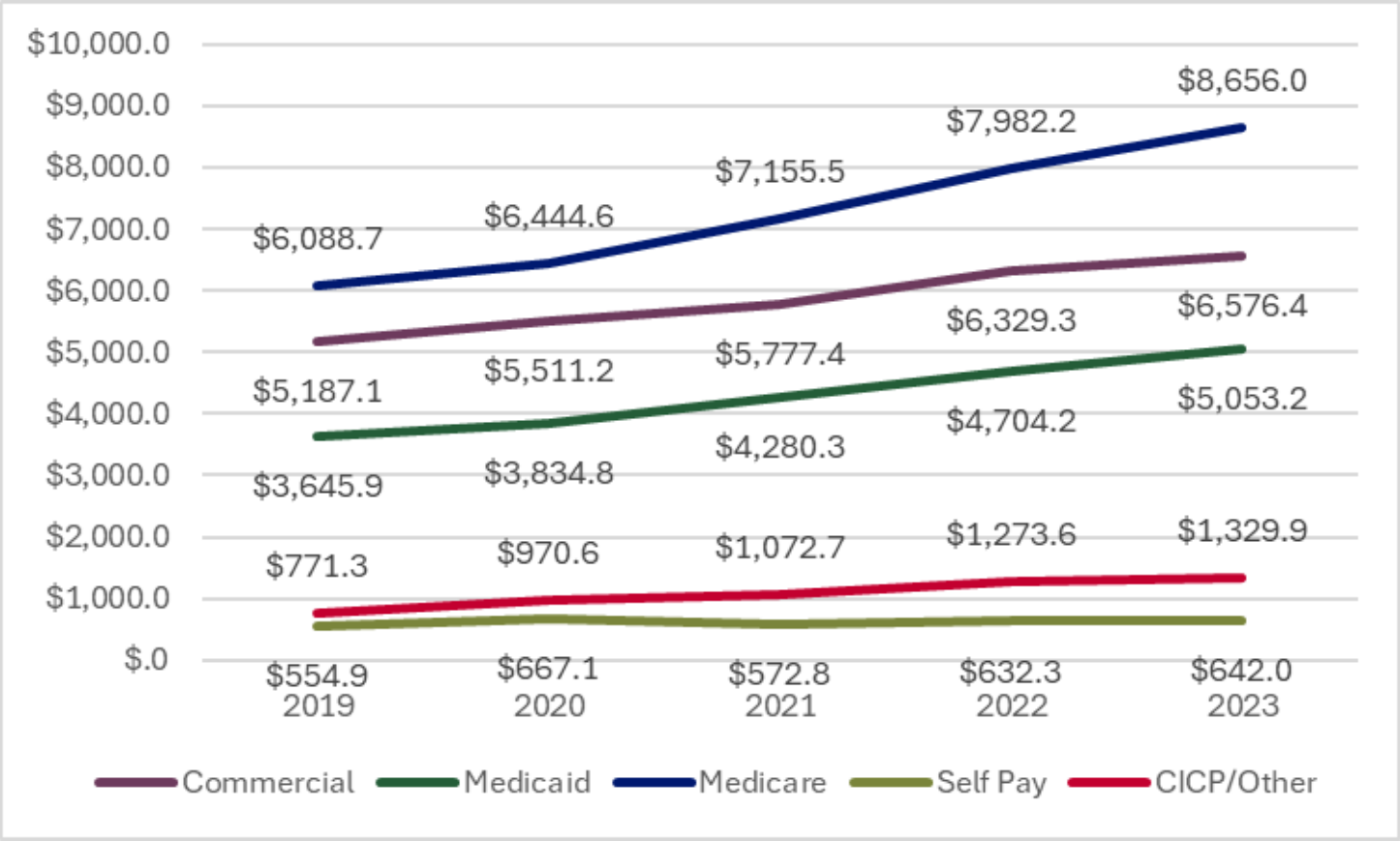

Figure 12. Total Costs by Payer Group 2019 to 2023

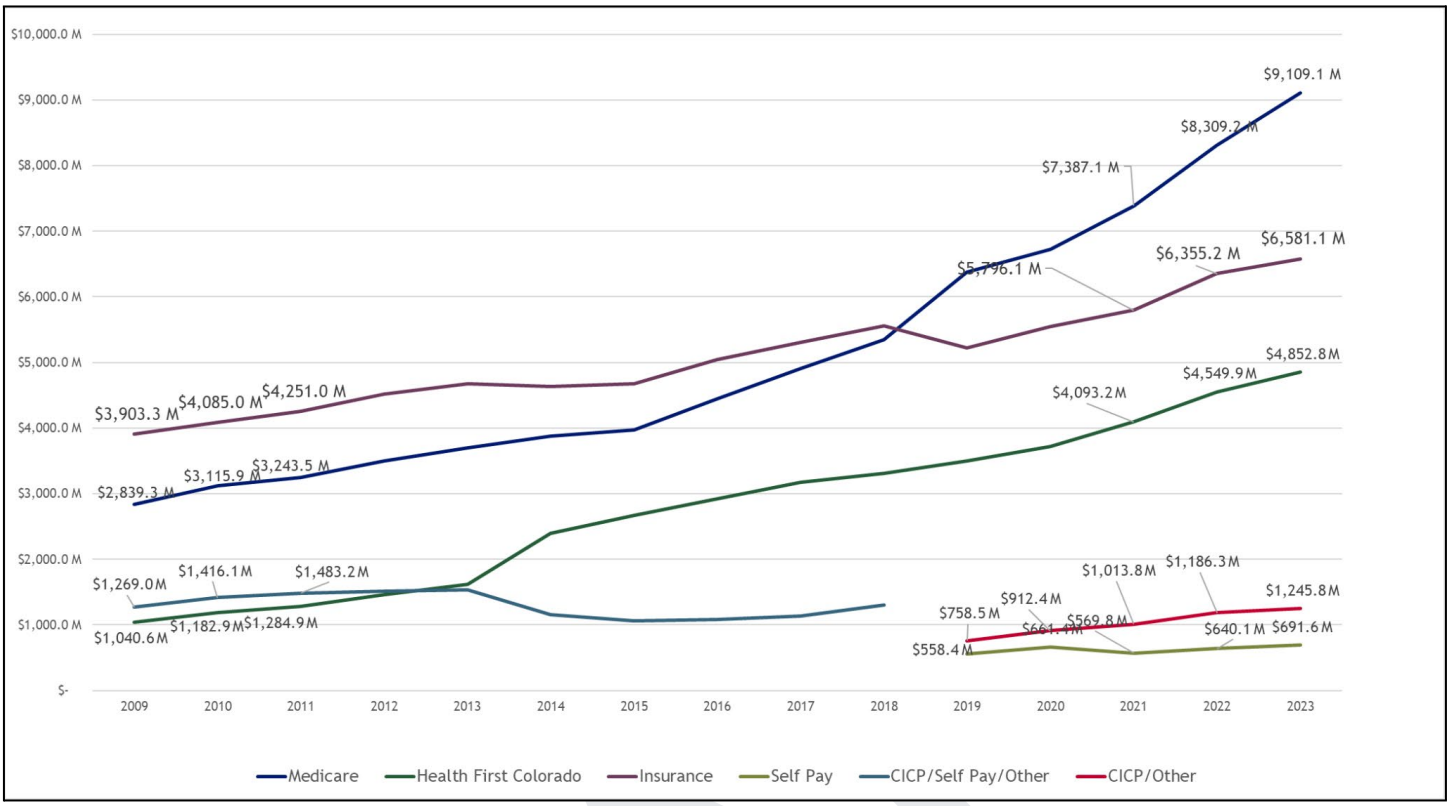

Figure 13. Total Costs by Payer Group 2009 to 2023

Table 25. Total Costs by Payer Group

Year	Medicare	Health First Colorado	Insurance	CICP/Self Pay/Other	Overall
2009	$2,839,342,944	$1,040,627,618	$3,903,275,906	$1,269,020,760	$9,052,267,229
2010	$3,115,937,802	$1,182,883,012	$4,084,993,448	$1,416,139,436	$9,799,953,697
2011	$3,243,478,502	$1,284,909,168	$4,250,957,528	$1,483,234,322	$10,262,579,519
2012	$3,499,461,617	$1,455,905,942	$4,512,890,351	$1,516,650,711	$10,984,908,621
2013	$3,695,876,322	$1,622,994,698	$4,670,085,639	$1,536,290,634	$11,525,247,293
2014	$3,878,325,532	$2,400,790,546	$4,635,720,459	$1,155,110,731	$12,069,947,268
2015	$3,974,650,475	$2,668,966,765	$4,678,708,961	$1,062,124,632	$12,384,450,834
2016	$4,443,278,973	$2,924,209,541	$5,044,457,104	$1,086,819,126	$13,498,764,744
2017	$4,903,744,347	$3,168,793,725	$5,301,515,281	$1,132,134,862	$14,506,188,215
2018	$5,343,329,547	$3,305,808,620	$5,552,968,410	$1,304,014,180	$15,506,120,757

Table 26. Total Costs by Payer Group, Post HB 19-1001

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/Other	Overall
2019	$6,088,689,726	$3,645,898,717	$5,187,060,485	$554,910,669	$771,346,201	$16,264,469,800
2020	$6,444,577,373	$3,834,808,869	$5,511,247,676	$667,110,439	$970,585,595	$17,428,329,952
2021	$7,155,523,825	$4,280,278,574	$5,777,406,482	$572,774,378	$1,072,694,853	$18,858,678,113
2022	$7,982,217,131	$4,704,178,021	$6,329,343,476	$632,269,535	$1,273,600,754	$20,921,608,947
2023	$8,655,954,223	$5,053,179,543	$6,576,375,599	$642,044,407	$1,329,922,413	$22,257,476,185

Table 27. Total Costs by Payer Group, Post HB 19-1001 and Aggregate CCR

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/Other	Overall
2019	$6,379,944,382	$3,503,491,222	$5,224,156,904	$558,378,876	$758,530,612	$16,424,501,999
2020	$6,722,556,873	$3,721,312,851	$5,549,276,827	$661,423,033	$912,442,762	$17,567,012,347
2021	$7,387,056,867	$4,093,167,274	$5,796,054,050	$569,795,624	$1,013,753,162	$18,859,826,978

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/Other	Overall
2022	$8,309,165,652	$4,459,861,373	$6,355,214,890	$640,087,402	$1,186,341,084	$21,040,670,402
2023	$9,109,072,085	$4,852,753,716	$6,581,136,474	$691,620,800	$1,245,795,748	$22,480,378,824

Table 28. Payment Less Cost by Payer Group

Year	Medicare	Health First Colorado	Insurance	CICP/Self Pay/Other	Overall
2009	($625,109,519)	($483,099,641)	$2,140,175,015	($614,924,387)	$417,041,468
2010	($756,679,457)	($305,065,589)	$1,997,944,550	($390,522,704)	$545,676,799
2011	($732,241,963)	($305,599,653)	$2,287,364,760	($517,636,463)	$731,886,680
2012	($917,956,277)	($308,510,447)	$2,450,079,572	($502,508,762)	$721,104,085
2013	($1,240,644,170)	($327,884,926)	$2,411,444,343	($248,425,399)	$594,489,847
2014	($1,121,687,953)	($682,750,169)	$2,737,737,990	($82,711,848)	$850,588,019
2015	($1,112,267,921)	($676,630,739)	$2,717,425,002	$111,699,649	$1,040,225,991
2016	($1,289,676,225)	($854,505,974)	$3,226,240,002	$70,660,564	$1,152,718,366
2017	($1,378,547,878)	($898,219,816)	$3,513,517,023	($166,204,378)	$1,070,544,950
2018	($1,582,343,891)	($769,235,633)	$3,880,914,554	($156,567,782)	$1,372,767,248

Table 29. Payment Less Cost by Payer Group, Post HB 19-1001

Year	Medicare	Health First Colorado	Insurance	Self pay	CICP/Other	Overall
2019	$(1,514,089,023)	$(1,344,411,740)	$4,367,307,658	$(390,788,208)	$(88,263,293)	$1,311,136,670
2020	$(1,900,486,039)	$(757,018,244)	$3,712,991,439	$(385,247,814)	$(114,836,117)	$586,851,068
2021	$(1,692,936,064)	$(977,482,407)	$4,313,006,999	$(369,855,178)	$(62,962,967)	$1,209,770,382
2022	$(2,189,702,729)	$(994,686,097)	$4,068,178,211	$(425,492,302)	$(124,005,918)	$334,291,209
2023	$(2,362,525,251)	$(1,067,212,342)	$4,142,250,834	$(484,733,249)	$(219,252,599)	$8,527,393

Table 30. Payment Less Cost by Payer Group, Post HB 19-1001 and Aggregate CCR

Year	Medicare	Health First Colorado	Insurance	Self pay	CICP/Other	Overall
2019	($1,805,149,943)	($870,115,637)	$4,452,854,554	($412,604,528)	($221,886,903)	$1,143,097,541
2020	($2,185,483,264)	($644,763,222)	$3,673,574,068	($379,489,073)	($57,130,670)	$406,707,840

Year	Medicare	Health First Colorado	Insurance	Self pay	CICP/Other	Overall
2021	($1,988,685,770)	($807,122,212)	$4,165,835,680	($369,496,132)	($14,359,100)	$986,172,466
2022	($2,532,435,495)	($841,898,567)	$4,022,059,166	($433,809,137)	($59,518,859)	$154,397,108
2023	$(2,815,643,113)	$(866,786,515)	$4,137,489,959	$(534,309,642)	$(135,125,934)	$(214,375,245)

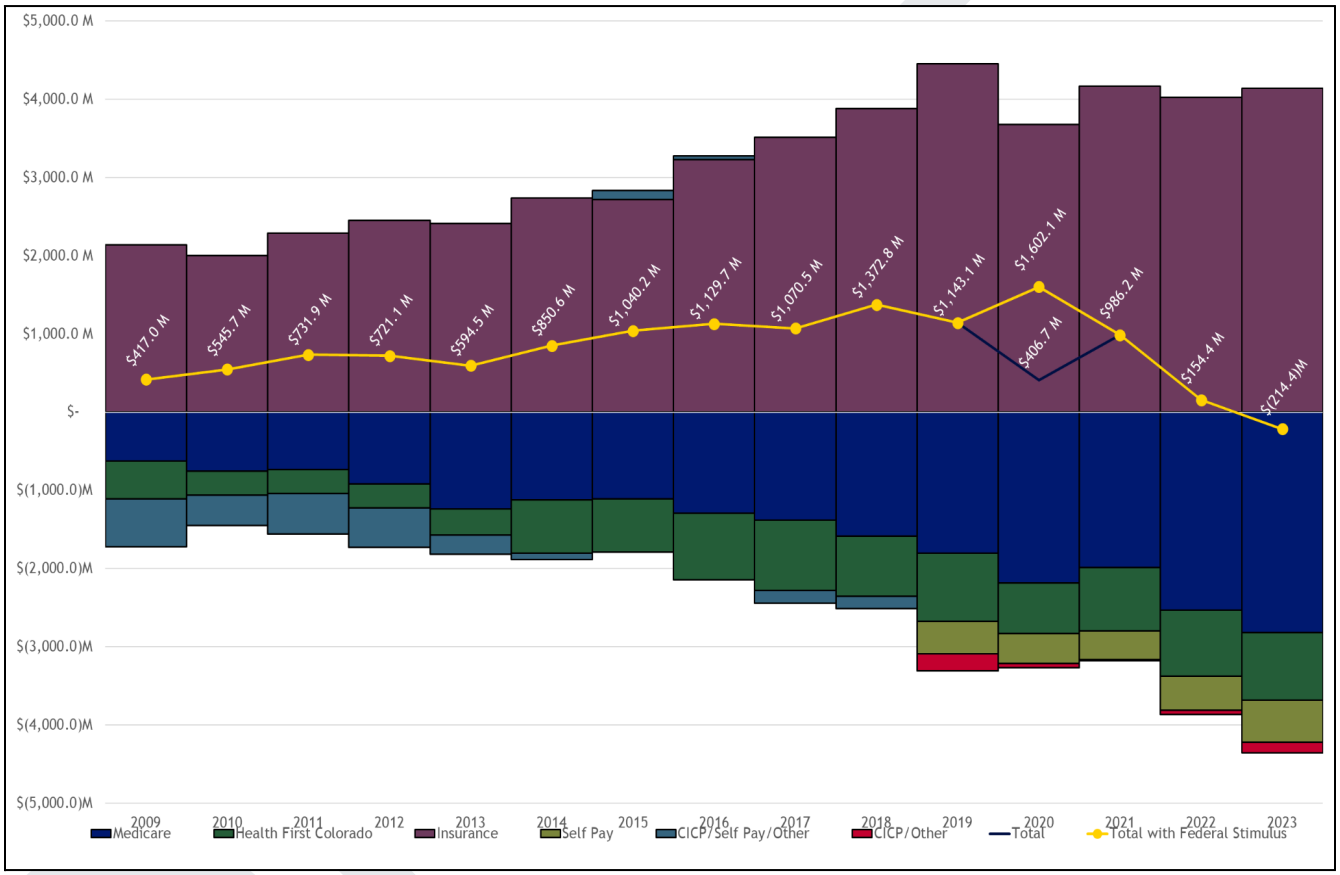

Figure 14. Payment Less Cost

Table 31. Payment Less Cost Per Patient by Payer Group, Post HB 19-1001 and Aggregate CCR

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/ Other	Overall
2019	($5,429)	($3,820)	$13,632	($8,399)	($3,935)	$1,173
2020	($7,649)	($3,333)	$13,640	($9,309)	($1,123)	$489
2020 w/ stimulus	($6,048)	($2,024)	$15,042	($8,205)	$97	$1,928

2021	($6,439)	($3,774)	$14,297	($10,325)	($287)	$1,181
2022	($8,211)	($3,625)	$13,358	($11,788)	($1,140)	$168
2023	($7,749)	($3,608)	$13,992	($13,745)	($2,425)	($217)

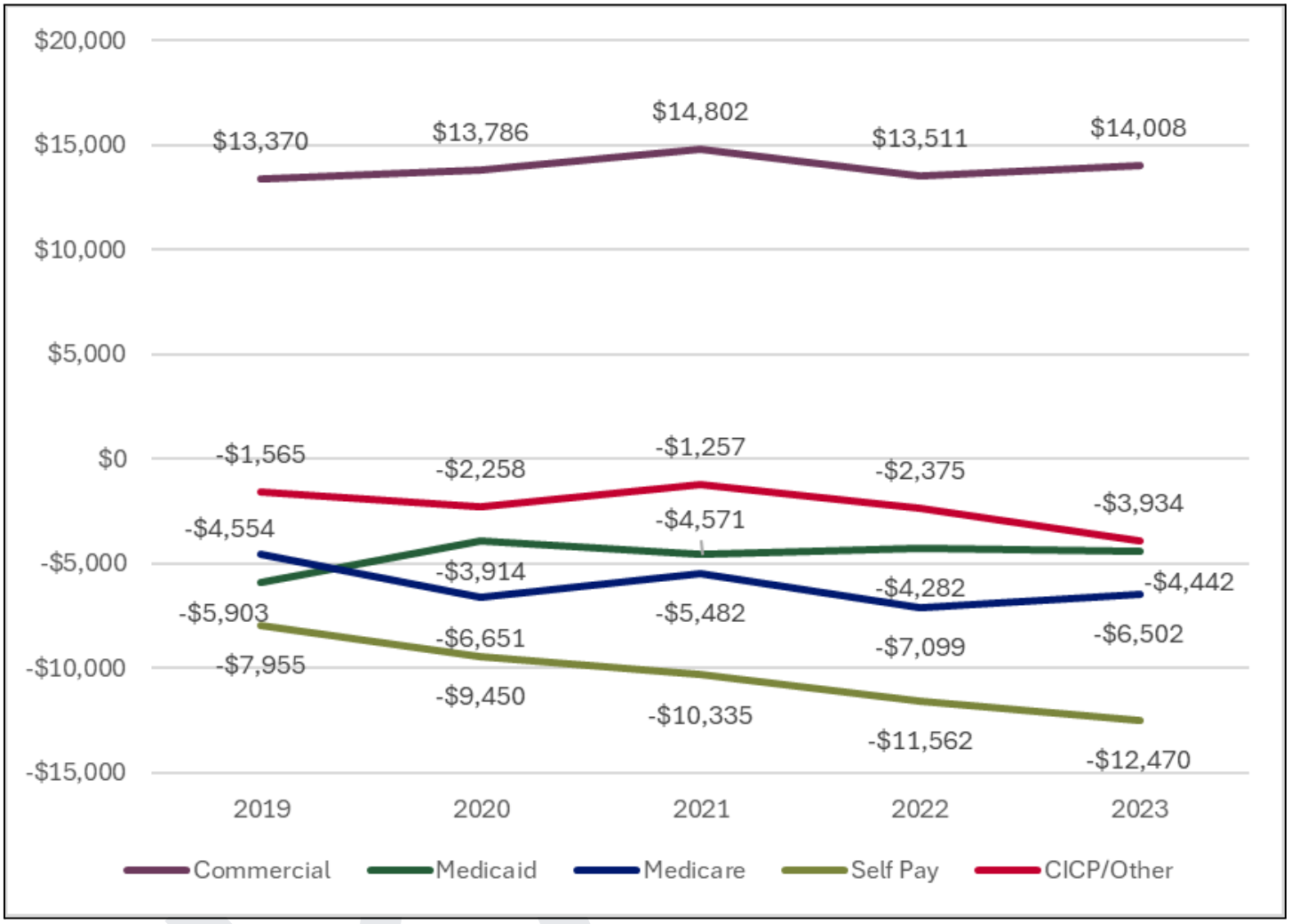

Figure 15. Payment less cost per patient by Payer Type 2019 to 2023

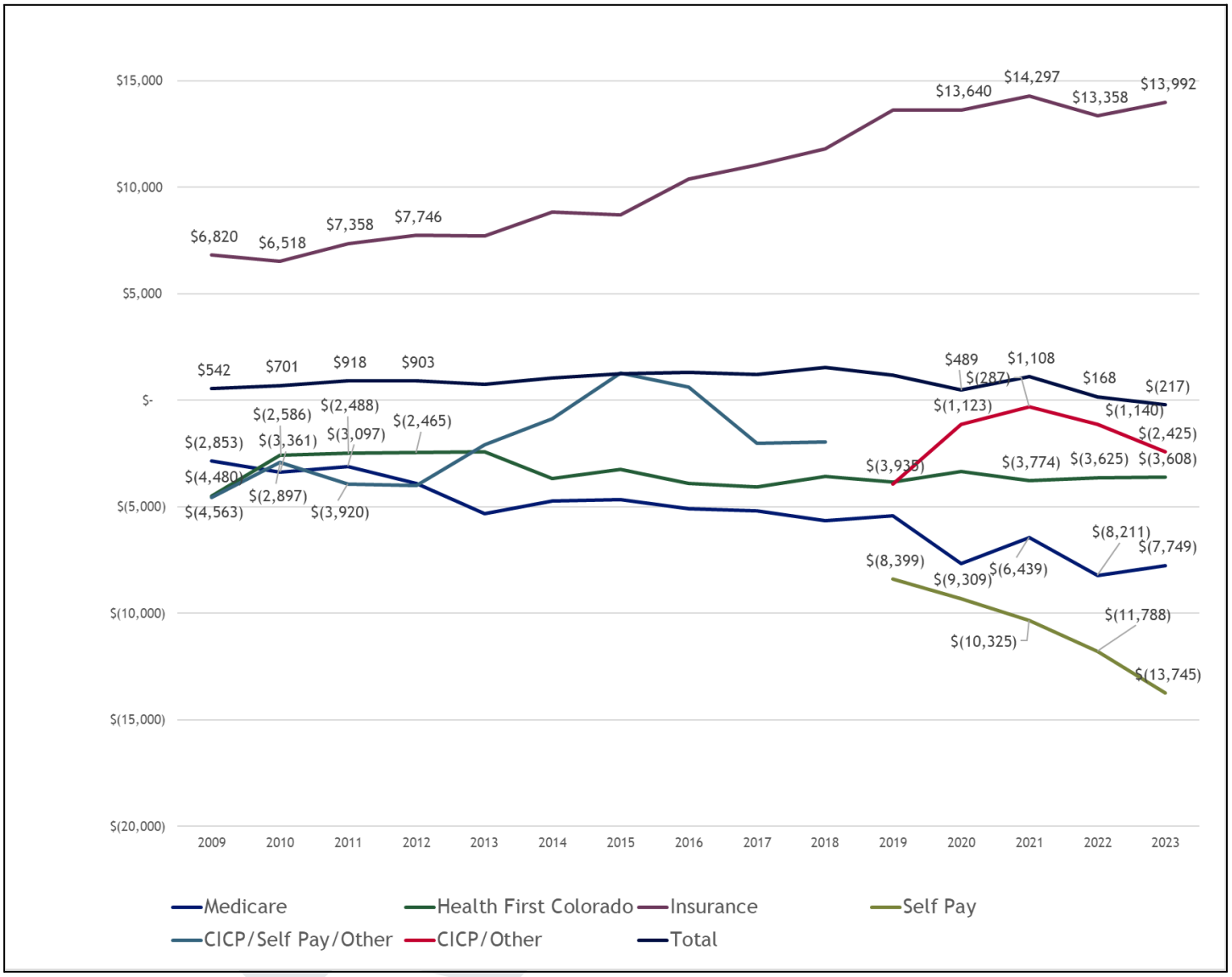

Figure 15. Payment less cost per patient by Payer Type 2009 to 2023

Table 32 presents overall hospital payments, costs, and payment less cost on a per-patient basis from 2009 to 2022. While costs have increased at an annual average rate of 5.4% over the 13-year period, payments have increased an average of 5.1% per year, resulting in an average annual increase in payment less cost of 6.5%. Table 10's averages do not include stimulus funds and therefore the 6.5% average annual increase is inflated due to the above-average payment less cost increase between 2020 and 2021. When stimulus is included in 2020 figures the average annual increase would be 3.1%.

Table 32. All-Payer Payment, Cost and Profit

Year	Payment Per Patient	Cost Per Patient	Payment Less Cost Per Patient
2009	$12,313	$11,771	$542
2010	$13,285	$12,584	$701
2011	$13,786	$12,868	$918
2012	$14,663	$13,760	$903
2013	$15,224	$14,477	$747
2014	$15,766	$14,727	$1,039
2015	$16,045	$14,802	$1,243
2016	$17,126	$15,779	$1,347
2017	$17,777	$16,555	$1,222
2018	$18,816	$17,286	$1,530
2019	$18,028	$16,855	$1,173
2020	$21,628	$21,138	$489
2020 w/ stimulus	$23,066	$21,138	$1,928
2021	$22,296	$21,115	$1,181
2022	$23,040	$22,872	$168
2023	$22,572	$22,789	($217)
Average Annual Change	5.0%	5.9%	1.2%

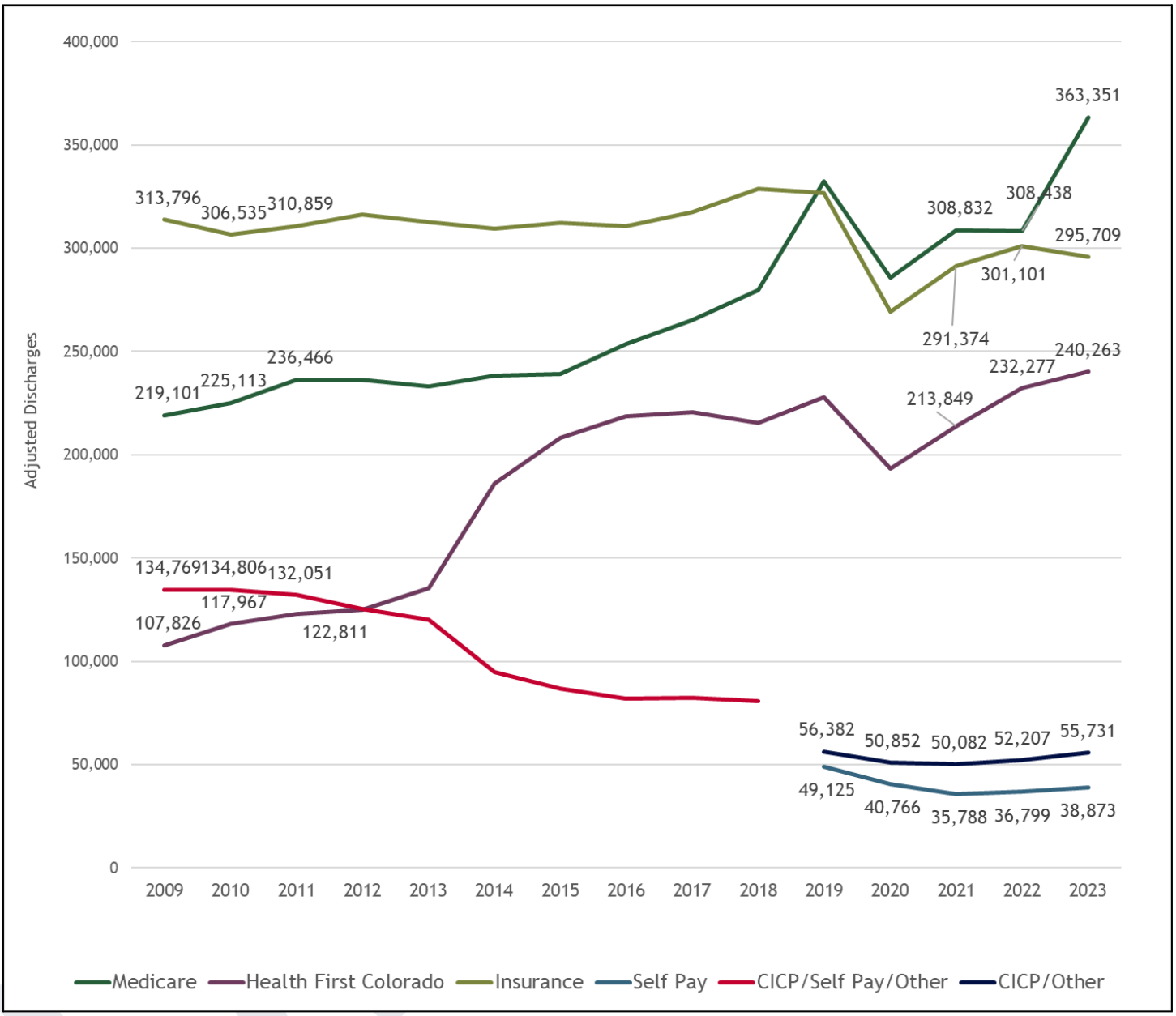

Figure 16. Patient Volume

Table 33. Bad Debt and Charity Care Cost

Year	Bad Debt	Charity Care	Total
2009	$255,161,427	$438,432,609	$693,594,036
2010	$234,216,738	$430,871,543	$665,088,281
2011	$194,825,791	$473,157,782	$667,983,573
2012	$206,347,067	$465,558,867	$671,905,934

Year	Bad Debt	Charity Care	Total
2013	$255,306,707	$444,436,807	$699,743,514
2014	$145,964,802	$174,150,188	$320,114,990
2015	$145,358,187	$118,526,410	$263,884,597
2016	$145,381,741	$147,180,251	$292,561,992
2017	$153,155,478	$133,783,564	$286,939,042
2018	$152,713,948	$152,595,060	$305,309,008
2019	$173,262,902	$213,901,358	$387,164,261
2020	$167,473,212	$250,719,192	$418,192,404
2021	$154,567,392	$263,332,787	$417,900,180
2022	$192,133,901	$295,699,566	$487,833,467
2023	$173,493,208	$317,257,015	$490,750,224

Table 34. Patient Mix by Payer Group

Year	Medicare	Health First Colorado	Insurance	CICP/Self Pay/Other
2009	31.4%	11.5%	43.1%	14.0%
2010	31.8%	12.1%	41.7%	14.5%
2011	31.6%	12.5%	41.4%	14.5%
2012	31.9%	13.3%	41.1%	13.8%
2013	32.1%	14.1%	40.5%	13.3%
2014	32.1%	19.9%	38.4%	9.6%
2015	32.1%	21.6%	37.8%	8.6%
2016	32.8%	21.7%	37.4%	8.1%
2017	33.8%	21.8%	36.6%	7.8%
2018	34.5%	21.3%	35.8%	8.4%

Table 35. Patient Mix by Payer Group, Post HB 19-1001

Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/ Other
2019	38.8%	21.3%	31.8%	3.4%	4.6%
2020	38.3%	21.2%	31.6%	3.8%	5.2%
2021	39.2%	21.7%	30.7%	3.0%	5.4%
2022	39.5%	21.6%	30.2%	3.0%	5.6%
2023	40.5%	21.6%	29.3%	3.1%	5.5%

C. Program Year Three Rural Support Fund Attestation Summaries

The following are summaries of excerpts from year three of the Rural Support Fund Attestations on hospital priorities, milestones, outcomes, progress, plans, and how these payments are used to change patient care, services, and outcomes. Request more information by contacting HCPF_RSF@state.co.us .

Conejos County Hospital

- Increased staffing to assist departments, such as discharge planning.
- Contracted with third party consulting: CereCore. To build and validate detailed reports for various HTP measures, such as readmissions and discharge notification to the RAE.
- Added Biofire laboratory panel to identify a wider range of respiratory infections; Added high sensitivity troponin laboratory testing to transfer fewer patients to a higher level of care.
- IV certified EMT techs, to assist with ED throughput by helping the nurses and providers in the ER.
- Enhance discharge assessment, plan documentation, and education.
- Purchased: medical grade camera for documenting wound healing that interfaces with EMR.
- Purchased: health carts to aid in treatment and diagnosis through specialist and provider consultations.
- Patient Portal: completed a spring campaign to increase usage of the patient portal. 1,113 new users; patient portal is being translated to Spanish.

Program Year Four Plans

- Plan to increase staffing to assist departments, such as discharge planning, will continue to use funds to help support these positions.
- Continue to work towards IV certified EMT techs, to assist with ED throughput by helping the nurses and providers in the ER.

East Morgan County Hospital

- Hired two Case Managers - Increase ability to screen pregnant patients for anxiety and depression by expanding screening in the ED, Observation, and inpatient settings.
- Connected with Contexture: SW-BH1 and SW-CP1 (RAE notifications) - automated ability to engage the RAE. Automated workflows to meet community needs.
- Kicked off SDoH pilot in the inpatient setting to support patients.
- Created a more robust screening method to SDoH barriers.
- Implemented the Alternatives to Opioid (ALTO) Program that targets the opioid epidemic.
- Augmented existing service lines and will introduce new ones that include ENT

Program Year Four Plans

- Invest in case management.
- Support the beginning of ENT services while covering expenses for equipment and physicians.
- Focus on Women's Service line and Behavioral Health.

- Support the funding of Midwife support and start our own behavioral health program.
- Engage in quarterly community meetings.

Haxtun Health

- Retention of our Quality Director as a full time staff member.
- Ongoing Care Coordination for patients with the RAE.
- Continued collaboration and regular meetings with the RAE and their mental health partner Centennial Mental Health.
- Renovation of the Clinic in Fleming is complete and a counseling room is available.
- CHA Colorado ALTO program has been implemented.

Program Year Four Plans

- Continued collaboration with the RAE.
- Provide a space for Centennial Mental Health to provide counseling and outpatient services.
- Relocate our Haxtun Clinic to the Main Street in town and build counseling rooms.
- Weekly meetings with the RAE and ongoing coordination of care.
- Identify options for software to support HTP measures.

Keefe Memorial Hospital

- Expanded telehealth platform: expanded services for local providers.
- Integrated Health Center completely implemented with rapid growth - additional services added.
- Hired a Director of Quality and patient navigator.
- 1st phase of Contexture complete, integrating prescription drug monitoring program with local EHR. Completed new fiber data cabling throughout the facility.
- Trained a local radiologist to become certified mammographer; Implementation of Omnicare breast imaging reporting software.
- Partnered with Colorado Cancer Coalition (CCC) for early detection: resources, education and marketing.
- Identified endoscope for purchase; identified physician group to assist in implementation and ongoing support of endoscopy services.
- New pathology service secured.
- Expanded services: psychiatric behavioral health, addiction medicine services, and speech therapy.

Program Year Four Plans

- Continue to expand telehealth services.
- Acquire partners to extract data from EMR's training staff on data entry requirements and entering screening.
- Upgrade to a 3D mammography unit; more patient outreach efforts for breast cancer awareness as well as other cancers.

- Purchase endoscope and engage a provider to perform endoscopies and colonoscopies for patients to have access to local screening/care.
- Continued use of Chronic Care Management Program.
- Expand specialty doctor visits.

Kit Carson County Memorial Hospital

- Hired a Behavioral health professional licensed LCSW.
- Continued contract with i2i: Data pulling software for HTP measures.
- Continue to utilize Avel eCare telehealth system - for the emergency department and Co-Doc telemedicine - also used in the ED for Behavioral Health Evaluations.
- Pays the salary of the Quality Director who is the lead for HTP to abstract data and report metrics.
- Hired support staff to the Quality Director to support HTP.
- Contracted with a marketing company: Jet Marketing to assist with newspaper and social media promoting of public engagements.
- Hired Paramedics, EMTS.
- Partnered with Grand Canyon University to assist with furthering education and tuition reimbursement.
- Specialty area growth: Ophthalmology surgeries and follow up care, pulmonary rehab.
- Patient Safety: Great Plains Monitoring. Signed with Canon.
- installed panic buttons in 11 areas.
- Enhanced imaging services.
- Updated Ultrasound Equipment.
- Expanded diagnostic equipment for vascular patients.

Program Year Four Plans

- Continue with software updates.
- Continue supporting newly hired staff.
- Continue with telehealth support for patients and specialty care.

Lincoln Community Hospital

- Implemented Cerner - EMR, i2i population health and data analyst.
- Addition of the Addiction Medicine Clinic to support SUD patients.
- Signed Contracts: Cerner, i2i, Merakinos, Spacelabs, Nuance DAX AI, Jet marketing, HCATon.

Program Year Four Plans

- Improve technology infrastructure.
- Optimize the newly implemented CommunityWorks, EMR.
- Continue to work with Contexture and i2i.
- Continue to utilize social media to share HTP updates.

Melissa Memorial Hospital

- Partners with Elevate Services Group: professional services.
- Support the network/system engineer position.
- Purchased various licensing requirements to operate hardware and software needs.
- Reimplement Athena EHR.
- Hired Ellington EMR consulting: informaticist and other EHR professionals.
- Finalized implementation of the ADT feed with Contexture through CRHC.
- Contracted with COORS Leadership: Identify organizational gaps and opportunities, set foundation for 2024 strategic plan and address challenges.
- Hired case manager to establish a swing bed program.
- Partnered with two nursing facilities to provide primary care.
- Onboarded an orthopedic surgeon; obstetrics; increased infusion and chemotherapy.
- Provide specialty care, increase patient revenue, keep patients local.
- Increased volume: physical therapy, surgery, lab, and radiology.
- Expand nursing skills and operating hours.
- New Contracts: Elevate, Ellington EMR Consulting, Office Assistant, Hunter Ambrose, 121, COORS Leadership, Banner Health Obstetric Providers, and Boulder Center for Orthopedics.

Program Year Four Plans

- Information technology enhancements.
- Reimplementation of Athena EHR, coding, and documentation enhancement.
- Continued work on a data analysis platform.
- Implement a strategic leadership plan.
- Reimplementation of case management and swing bed program.
- Expansion of specialty clinic visits for rural health patients.

The Memorial Hospital

- Hired a Licensed Clinical Social Worker to oversee Safety Advocates within the Emergency Department and Behavioral Health Department.
- Established a Data Analytics department in recognition of the specialized knowledge and skills associated with extracting, analyzing, and reporting out data.
- Hired data analytics team.
- Hired an additional team member to the Discharge Planning team.

Program Year Four Plans

- Continued work with the data analytics team and reporting.
- Collaboration with Intermountain Health and Epic, on the build and training of a Discharge Planning/Utilization Review module in Epic - improve discharge planning workflows and evaluate readmissions.
- Continued collaboration with Intermountain Health and QHN on workflows and reporting in regard to HTP measures.

- Work on the enhancement for our follow-up appointment reporting for a year.
- Employee Development and Customer Service.
- Service Line development and implementation.

Middle Park Medical Center

- Implemented a process including the case manager and unit secretaries to schedule Medicaid patients before discharge.
- Training and education of staff regarding ALTO concerns.
- Reviewed mental health first aid training.
- Additional Specialty Care added: Speech Therapy through telehealth.

Program Year Four Plans

- Incorporate clinic care coordinators and case management to be more involved in the discharge process and follow ups after discharge.
- RAE collaboration and daily audit pulls to confirm the processes are being followed.
- Quarterly meetings with nursing staff and continuous training materials will be provided during huddle boards.
- Improve telehealth intervention.

Pagosa Springs Medical Center

- Cerner Interface: Requested proposal process complete, software chosen, project lead names/steering committee created, full implementation expected to take 1 year.
- Training and education of hospital and clinic staff on Medication Assisted.
- Treatment (MAT), care coordination, chronic disease management and discharge planning.
- Purchase equipment for training and education for frontline caregivers and to create a Subject Matter Expert (SME) training program to enhance training, accountability and sustainment of measures post HTP.

Program Year Four Plans

- Improve services, technology, and overall patient care.
- Patient portal implementation will allow for easier access with bi-directional texting, appointment reminders, health/wellness campaigns (via text), and improve support and services for health fairs.
- Expand services through the renovation of the medical wellness building and create a new and improved location for both patients and community partners.
- Salaries for RN care managers.

Pikes Peak Regional Hospital

- Contracted with Virtual Hospitalist service through Virtual Health Center - to reduce LOS.

- Addition of Behavioral Health safe rooms.
- Training offered by BH clinician to staff/community, resources for mental health first aid course.
- Behavioral Health Clinicians are supporting direct patient care.

Program Year Four Plans

- Educate workforce on new ERAS/early therapy workflow and new care delivery workflows.
- Operationalize ERAS/Early Therapy workflow.
- Implement a patient teaching tool.
- Final stage and completion of the Emergency Department room conversion and triage space redesign.

Pioneers Medical Center

- Implemented, trained, and sustained a Complex Care Coordination and Care Transitions program that will focus on a comprehensive Meds to Beds Program and the integration of Behavioral Health in the hospital.
- Hired two part time in-house Behavioral Health Therapists.
- Contracted for tele-medicine psychiatry services.
- Extended contracts with QHN in order to continue the Health Information Exchange services and expand our care coordination processes.
- Standard screening processes are in effect.
- Auditing and tracking of compliance are in progress.

Program Year Four Plans

- Sustain EMR implementation.
- Procure new technological and infrastructure equipment.
- Integration of quality methodologies in all strata of the hospital.
- Offer education by external experts to educate staff on behavioral health concepts.

Rangely District Hospital

- The hospital continues to meet requirements with the collaboration of the QHN interface and includes development fees, provider fees, and provider connection fees.
- Vendor: CorroHealth (now owns PARA)- enables the hospital to comply with price transparency and No Surprises Act requirements.
- Contract: continue to work with Revenue Cyclists (TRC) and Heidi Helms Consulting to improve billing operations, clinical efficiency, design and build out of surgery documentation coding, and billing operations.
- Partnered with Organizations for Behavioral Health: Psychiatric Medical Care (PMC), Fitz Ilias, and Mind Springs
    - Psychiatric Medical Care (PMC): Senior Life Solutions provides intensive outpatient behavioral health for older residents

- Fitz Ilias: Provides medication management and therapy services for patients through the Hospital's Rural Health Clinic, as well as students of the local community college through an agreement
- Mind Springs: Provides services for patients who are in crisis and present through the Hospital's emergency room.

- Construction on a surgery suite to provide general surgery services to the community, has begun.
- Implemented a Cardiac Rehabilitation Program.
- Contract: Outside Chiropractor who comes to the hospital weekly.

Program Year Four Plans

- Increase and improve technical capacity.
- Transformation capital to operationalize a strategic plan.
- Invest in value-based organizational improvements.
- Hire new staff to support case managers to help with coordination of care.

Rio Grande Hospital

- Recovery Clinic supplementation will be used this year for data collection to show successes and failures and population being served.
- Employee time and benefits to work in community events, planning ways to reach out to migrant populations, attending functions.
- IT personnel costs associated with designing technical capacity to improve information sharing as well as developing HL7 infrastructure.
- Purchased additional equipment to allow patients and family access to education.
- Care coordinators hired for SDOH, MAT, recovery clinic and education.
- Meetings and educational seminar costs for improving population health, best practices for addiction medicine, and community services.
- Supplement the cost of Infectious Disease specialists to diagnose and treat those diseases often associated with addiction.
- New service associated with Recovery Clinic.
- Financial and operational support with Public Health of the National Fitness Campaign, specifically bringing to the community the outdoor fitness court.

Program Year Four Plans

- Recovery clinic operations.
- Support for staff to be in the community for outreach: health fairs and educational presentations.
- Personnel and EHR cost and to develop reports interfaces with Contexture.
- Hire additional care coordinators.
- Plan and operationalize programs sponsored by the wellness center.

Sedgwick County Health Center

- Contracted with a new group, Integrative Healthcare Center, to expand clinical offerings for

behavioral and mental health services via telehealth, with a projected go live of January 2024.
- New EMR implementation: Cerner.
- Partnered with i2i to assist in abstracting data from EMRs for use in the Hospital Transformation Program.

Program Year Four Plans

- Maintain and expand essential services.
- Provide comprehensive healthcare services to the community.
- Devote resources as needed to meet the growing demand for mental and behavioral health services in the region.
- Maintain partnership with Centennial Mental Health - assists with emergent cases requiring patient referrals and placements.
- Expand specialty clinic.
- Transition EMR to Oracle/Cerner as the new EMR system.
- Continued partnership with i2i to assist in abstracting data from EMRs to understand data trends and meet the needs of patients.

Southeast Colorado Hospital

- Improved care related to telehealth with specialists, allowed patients to keep appointments, decrease time off from work, and decrease cost of travel expenses.
- Upgraded our Electronic Medical Record.
- Added *Community United* educational sessions, both in-person and virtual.
- *Staffing* - addition of another administrative FTE.
- Zero Suicide program has been launched.

Program Year Four Plans

- Offset staffing and technology expenses involved in completing all requirements to meet the milestones, priorities and expected outcomes of the project.
- Continue to work with i2i.
- Continued collaboration with Medici for the Antibiotic Stewardship.
- Focus on operational needs specific to HTP.

Southwest Health System

- Secured a robust and streamlined data communication for HTP efforts.
- Cybersecurity upgrades completed between Year 1 and Year 2, which will continually cost the hospital $125,000 annually to maintain.
- Complete information technology work.
- IT upgrades to ensure data and storage stability were completed and will cost SHS $194,000 over a three year period.

Program Year Four Plans

- Maintain Cyber Security upgrades.

- Completed information technology will continue to have costs to maintain.
- Additional IT upgrades to ensure data and storage stability.
- Data backup systems.

Spanish Peaks Regional Health Center

- Meditech Expanse: developed the Quality Vantage (QV) module, which provided customizable patient trackers and status boards to evaluate quality metrics.
- Developed the Business Clinic Analytics (BCA) module, which provided enhanced patient level detail and reports related to QV data.
- Partnered with a new Sequel Report Writer Vendor, WestHealth Solutions, to create custom reports on our HTP measures to further guide program development and create patient-centered solutions.
- The rural support funds helped empower our Patient-Family Advocacy Council (PFAC) and our Marketing Department, to create and deploy patient-facing education around our HTP initiatives.
- Educated the community on the importance of having a primary care provider, the dangers of opioid use/abuse and the impact of social needs on healthcare outcomes.
- Rural Support funds have helped to organize community neighborhood engagement events.

Program Year Four Plans

- Continue to evolve and improve electronic health record (EHR, Meditech Expanse.
- Continue to optimize the Quality Vantage module to provide customizable patient trackers and status boards to evaluate quality metrics.
- Customize the Business Clinic Analytics module to provide enhanced patient level detail and reports
- Continued partnership with Sequel Report Writer Vendor, WestHealth Solution.

St. Vincent Hospital

- The Hospital has contracted with TRC (The Revenue Cycle) to assist with the development of a number of systems.
- TRC's expertise in Revenue Cycle Processes and the Electronic Health Record System will be invaluable to our efforts to keep the hospital on a course to financial recovery
- Beginning in January 2024, St. Vincent Health will begin participating in the 340B drug program
- Pediatric screening for depression in inpatient and ED including suicide risk: activated the screening tools in hour EMR, we will initiate screening this program year.
- Increase the successful transmission of a summary of care: With the completion of supplemental training, we intend to initiate transmission of summary of care this Program Year.
- Hired a new case manager: Main focus will be HTP measures: RAH2 - emergency department visits for which the member received follow up within 30 days of the ED visit.
- Hired a Clinic RN: Able to promote and track Well Visits in PY3

Program Year Four Plans

- Contract with a third party coding vendor to improve accuracy of our claims before they go to insurance and billing.
- Contract with Iron Edge for IT management.
- Increase primary care providers and open a foot-care clinic.
- Continue to audit performance to ensure compliance and identify opportunities for improvement. Utilize PHQ2/9 as our screening tool fo suicide risk.
- Continue to develop relationships with specialists - telehealth specialists are under review.
- Training for staff will be done throughout this next year to ensure that our staff are asking and documenting the PCP appropriately.
- Funds have been used to support operations and recovery of the hospital during our financial turnaround.

Sterling Regional MedCenter

- Construction will continue in the Emergency Department, to add a behavioral health room as well as improve the flow within the department. The ED project is close to being finished and a portion of the expenses ($270K) will hit in PY3.
- The equipment purchases are for two (2) dialysis machines, allowing SRM to offer inpatient nephrology services, and a C-arm that is larger and more advanced than our previous unit.
- Executed a formal contract with Contexture to support us with RAE Notifications for measures SW-BH1 and SW-CP1.

Program Year Four Plans

- Complete Emergency Department Refresh.
- Continue to invest into case management.
- Expand in Specialty Services: offer inpatient dialysis with tele-nephrology support from contracted vendors.
- Equipment for Ortho PA's and Pain Management.

Weisbrod Memorial County Hospital

- Cyber security risk assessment completed.
- Strategic quality support system annual payment.
- Replacement computers purchased.
- Upgraded information technology servers and backup system.
- Contracted coding support through TruBridge.
- OnSolve Emergency Communications System.
- Haugen contract for HIM consulting services.
- Payment for i2i data extraction software.
- Eastern Plains Healthcare Consortium Annual Conference registration & hotels Vertical Strategies support with Community Health Needs Assessment for strategic planning.
- Purchased a new transportation vehicle for patients.
- 25% of Quality Directors Salary.

- Community Hospital Consulting to support the new GPO.
- McCormick Group provided board education.
- HTP Annual Conference registration & hotels.
- Klara patient communication software for reminder calls and texts.
- Dragon Microphone equipment and software purchased.
- Pararev consultation for price transparency.
- Wipfli Engagement for market analysis and strategic planning.

Program Year Four Plans

- Transition new EMR to Cerner Community Works.
- Continue to invest in workforce development.
- Educate and inform the community we serve on the services offered, the quality work we are engaging in, and the benefits that the hospital district provides to the community.
- Partner with a consultant to create a foundation for our quality assurance and quality improvement program - improve survey readiness through tiered auditing processes.

Wray Community District Hospital

- All funds were expended to improve the well-being of the patient population and improve the processes and quality of care through increased technology infrastructure.
- Utilization of consultants to drive needed patient services will assist the facility over the next three years to develop, build, and execute actions to reach our strategic goals.
- Continued collaboration with local EMS to provide home services.
- Advancement in facility as pay-for-value continues to be an important milestone.
- Keeping the community involved through the CHNE process.
- The addition of providers and specialists to Wray to make rare services available to the community.
- Improving IT and data analytics within the system to accelerate communication with patients and give providers and staff closer to real-time information for quality improvement.

Program Year Four Plans

- Improve behavioral health through continued collaboration with the ROOTS program.
- Continued work with the Barbara Davis Center for Childhood Diabetes telemedicine program.
- Contract with HealthONE for tele-stroke program.
- HealthONE tele-psychiatry for backup crisis intervention in the emergency department implemented.
- Hire a LPN as a behavioral health care manager.
- The United States Department of Agriculture (USDA) gave its conditional approval for an expansion program to expand the physical footprint of the hospital.
- Hire additional FTE Physician Assistant.
- Move the Medical Records and Billing/Collections to the off-site East Campus

has opened up the opportunity to renovate and expand exam rooms in the specialty clinic.

Yuma District Hospital

- MRI: Contractors have been chosen to remove the hospital's exterior wall and will identify a vendor of choice.
- Rehab: The Rehabilitation Department at our satellite Clinic in Akron is implementing a new program focused on supporting employers and injured workers, currently only available on the front range. The program is Functional Capacity Evaluations, or FCEs.
- Another service added is Pre-employment/Post-offer screening which is offered to local employers. The purpose is to screen potential employees by running them through a series of tests that have been established by the employer, to ensure prospective hires are capable of performing the job tasks required, and to help better place prospective employees into the most appropriate job title for their capabilities.
- Purchased a cardiac monitoring system with a broader healthcare infrastructure, strengthening our ability to facilitate prompt diagnosis, more accurate treatment decisions, and early intervention, leading to improved patient outcomes and reduced morbidity and mortality rates.
- Implemented the use of CareBoards. This technology provides a virtual platform for specialty care consultations.
- Purchased a portable ultrasound system. The hospital has been able to improve patient outcomes with timely and accurate diagnosis in trauma care.
- Education: The Trauma Coordinator, Director of Patient Care Services, and the Emergency Room Provider attended the Annual Trauma Conference.

Program Year Four Plans

- Staff and provider education.
- Develop workflows, protocols, and policies for HTP milestones.
- Continue Care Coordination and RAE collaboration and assist patients in getting the resources they need.
- Rural Care Manager and the RAE will continue to meet monthly.
- Acquire new interfaces for Cerner EMR and continue collaboration with i2i platform and Merakonas for data reporting and analysis.
- Upgrade technology through acquiring new HIE access.