CHASE Board Meeting

August 2023

Nancy Dolson
Department of Health Care Policy & Financing

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

CHASE Background

Provider Fee from Hospitals

Federal Match from CMS

Cash Fund (Provider Fee + Federal Match)

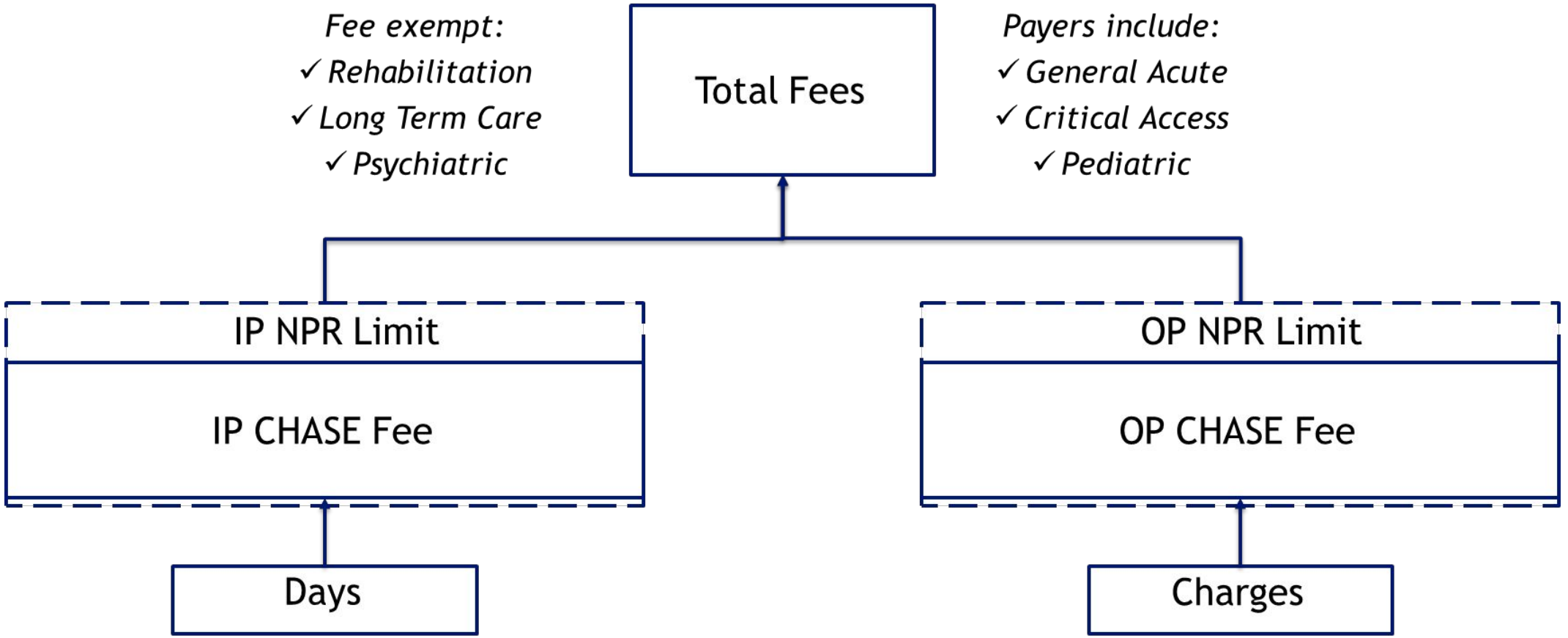
Increased Payment to Hospitals

Expanded Coverage to Colorado Citizens

Purpose and Authority

- **HCPF** is the single state agency for administration of Colorado's Medicaid program and authorized to draw federal Medicaid funds
- **CHASE Board** is recommending body for the hospital provider fee
  - Increase reimbursement to hospitals under Medicaid and Colorado Indigent Care Program
  - Fund Hospital Quality Incentive Payments
  - Fund and implement the Hospital Transformation Program
  - Increase Medicaid and CHP+ coverage to reduce uncompensated care
  - Pay administrative costs limited to 3% of expenditures
- **HCPF** and the **CHASE Board** seek to meet the goals of the CHASE statute including
  - Maximize reimbursement to hospitals for care for Medicaid and CICP patients subject to federal upper payment limits, and
  - Increase the number of hospitals benefitting from the CHASE fee and minimize those hospitals that suffer losses
  - Under the statute, the CHASE Board is charged with making recommendations to HCPF to meet these goals and payment categories have been defined to do so

CHASE Fees


Fee exempt:
✓ Rehabilitation
✓ Long Term Care
✓ Psychiatric
Total Fees
Payers include:
✓ General Acute
✓ Critical Access
✓ Pediatric
IP NPR Limit
IP CHASE Fee
OP NPR Limit
OP CHASE Fee
Days
Charges

Medicaid Provider Fees*

- Limited to 6% of net patient revenues
- Must be
  - Broadbased: imposed on all non-federal, non-public providers within a category of services in the state, and
  - Uniform: fee is the same amount for all providers furnishing the services within the same category
- States may seek CMS approval of a waiver of either the broad-based or uniformly imposed requirements
  - CMS may waive these requirements only if the net impact of the fee is generally redistributive and not directly correlated with Medicaid payments to the providers subject to the fee
  - CMS has granted waivers of broad-based and uniform fee requirements for both our inpatient and outpatient hospital provider fees

*Under federal regulations, referred to as Medicaid provider taxes
See: gao.gov/assets/gao-20-571r.pdf and medicaid.gov/sites/default/files/2023-02/cib021723.pdf

Medicaid Provider Fees

- May not hold providers harmless, i.e., provide a direct or indirect guarantee that providers will receive all or a portion of their fees payments back
  - Fee *may not* be designed to reimburse providers based on amount paid (directly or indirectly)
  - Fee assessed on non-Medicaid statistic (e.g. inpatient days or outpatient charges)
  - Reimbursements are Medicaid payments

Medicaid Provider Fees

- Section 1903(w)(4) of the Social Security Act describes what constitutes a hold harmless arrangement
- Specifically, Section 1903(w)(4)(C)(i) provides that a hold harmless provision exists where "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax"
- Implementing regulations at 42 C.F.R. § 433.68(f)(3) specify that a hold harmless arrangement exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount"

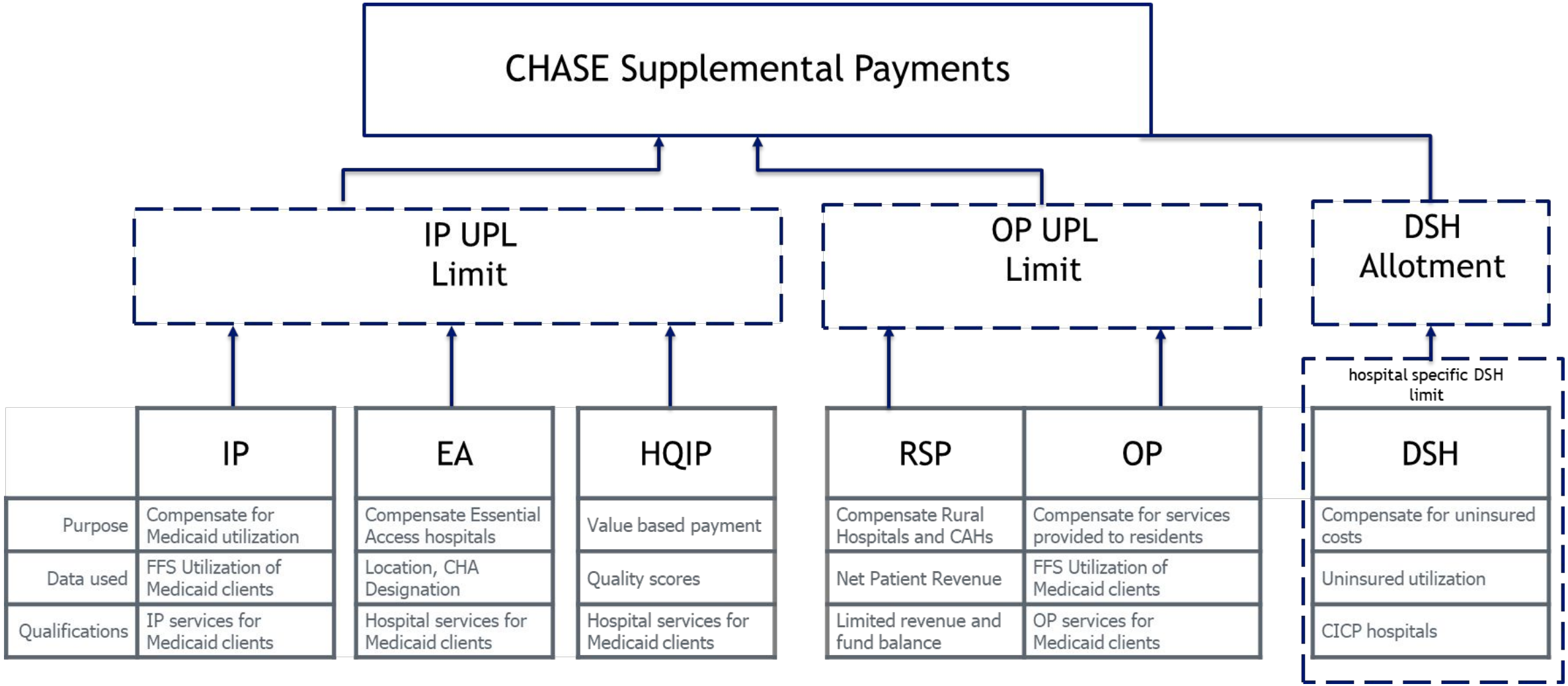
See CMS, Center for Medicaid & CHIP Services Informational Bulletin dated 2/17/2023: medicaid.gov/sites/default/files/2023-02/cib021723.pdf

Medicaid Provider Fees

- Effects on providers vary based on the extent to which they participate in the Medicaid program
- For example, if provider fees are used to finance a supplemental payment—which is not tied to care for individual enrollees—some providers could receive Medicaid payments that total more than their fees paid, while others could pay fees and not receive any Medicaid payments

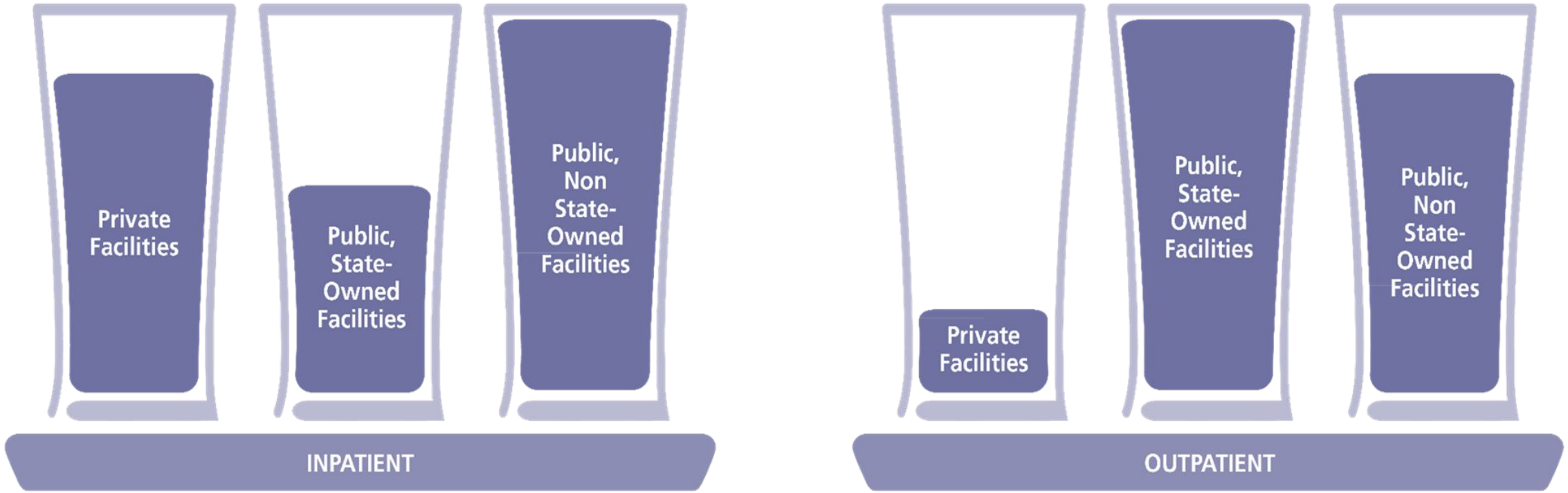
See: gao.gov/assets/gao-20-571r.pdf and medicaid.gov/sites/default/files/2023-02/cib021723.pdf

CHASE Payments



	IP	EA	HQIP	RSP	OP	DSH
Purpose	Compensate for Medicaid utilization	Compensate Essential Access hospitals	Value based payment	Compensate Rural Hospitals and CAHs	Compensate for services provided to residents	Compensate for uninsured costs
Data used	FFS Utilization of Medicaid clients	Location, CHA Designation	Quality scores	Net Patient Revenue	FFS Utilization of Medicaid clients	Uninsured utilization
Qualifications	IP services for Medicaid clients	Hospital services for Medicaid clients	Hospital services for Medicaid clients	Limited revenue and fund balance	OP services for Medicaid clients	CICP hospitals

Upper Payment Limit



Upper Payment Limit

- UPL payments are lump-sum payments that are intended to fill in the difference between fee-for-service (FFS) base payments and maximum amount that could be paid by Medicaid
- In the aggregate for each class of providers, FFS and UPL payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles
- HCPF prepares UPL demonstrations, which must be submitted to CMS and approved annually
- Classes of providers are defined based on ownership (i.e., government, non-state government, and privately owned)

See: macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf

Upper Payment Limit

- The designation of a hospital as state-owned, non-state government owned, or private owned determines which UPL pool it belongs to
- Federal Medicaid law [Section 1903(w) (7) (G) of the Social Security Act] identifies the four types of local entities that, in addition to the State itself, are considered a unit of government: a city, a county, a special purpose district, or other governmental units in the State

Upper Payment Limit

- The interpretation of a “public-owned provider” is broad and not defined through federal regulations
- HCPF considers a provider to be public-owned if the provider has a financial relationship with the governmental unit that may include one of the following:
  - Provider receives operating revenues from the governmental unit,
  - Governmental unit provided tax revenues to support bonds to construct the facility,
  - Governmental unit has some financial obligation even if its daily operations of the facility have been assigned to private-owned company, or
  - Liabilities and assets of the provider revert to a governmental unit upon bankruptcy

Disproportionate Share Hospital Payments

- Medicaid DSH payments are statutorily required payments to hospitals that serve a high share of Medicaid and low-income patients
- State DSH spending is limited by federal allotments, which vary by state
- DSH payments cannot exceed the hospital's uncompensated care costs for both Medicaid-enrolled and uninsured patients, defined as follows:
  - Medicaid shortfall is the difference between a hospital's costs of serving Medicaid-enrolled patients and the payments that it receives for those services, including FFS and UPL payments
  - Unpaid costs of care for uninsured patients includes both charity care (for which the hospital does not charge the patient at all or charges the patient a discounted rate below the hospital's cost of delivering the care) and bad debt (for which the hospital charges the patient but is not able to collect)
- Medicaid DSH does not pay for bad debt expenses for patients with insurance who cannot pay because they cannot afford deductibles or copays

See: macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf

Adjustment Factor Groups

- Rehabilitation / Long Term Acute Hospital – An inpatient rehabilitation hospital or a long-term care hospital certified by the Colorado Department of Public Health and Environment (CDPHE).
- State Government Teaching Hospital – A hospital within the state government ownership Upper Payment Limit (UPL) category that provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education.
- Non-State Government Teaching Hospital – A hospital within the non-state government ownership UPL category that provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education.
- Non-State Government Rural or Critical Access Hospital – A hospital within the non-state government ownership UPL category that is not located within a Metropolitan Statistical Area designated by the United States Office of Management and Budget (MSA) or is certified as a critical access hospital by the CDPHE.

Adjustment Factor Groups

- Non-State Government Hospital - A hospital within the non-state government ownership UPL category not meeting any other adjustment factor category definitions.
- Private Rural or Critical Access Hospital – A hospital within the private ownership UPL category that is not located within a MSA or is certified as a critical access hospital by the CPDHE.
- Private Heart Institute Hospital – A hospital within the private ownership UPL category that is recognized as a HeartCARE Center by the American College of Cardiology (ACC) with a least 25,000 Medicaid non-Managed care days per year.
- Private Safety Net Metropolitan Hospital – A hospital within the private ownership UPL category that provides services in the Pueblo MSA with no less than 15,000 days per year.

Adjustment Factor Groups

- Private Pediatric Specialty Hospital – A hospital within the private UPL ownership category that provides care exclusively to pediatric populations.
- Private Neonatal Intensive Care Unit (NICU) Hospital – A hospital within the private UPL ownership category with a NICU classification of Level III or Level IV according to the guidelines published by the American Academy of Pediatrics (AAP).
- Private Independent Metropolitan Hospital – A hospital within the private UPL ownership category independently owned or operated within a MSA with greater than 1,500 Medicaid days per year.
- Private Hospital - A hospital within the private UPL ownership category not meeting any other adjustment factor category definitions.

Legislative Updates

HB23-1243: **Hospital Community Benefit** - strengthens community benefit transparency; the bill won't take effect until at least 90 days after HCPF rules are adopted by the Medical Services Board (no earlier than July 1, 2024).

SB23-298: **Allow Public Hospital Collaboration Agreements** - Enables rural hospitals to collaborate to improve access, affordability, quality, equity - after HCPF and Attorney General's office quick sign-off.

HB23-1226: **Hospital Transparency** - increases hospital financial transparency reporting by requiring an annual summary of hospitals' financial transfers, quarterly financial reports, plain language patient billing, and allows HCPF to enforce data collection procedures.

SB23-252: **Medical Price Transparency** - strengthens HCPF's ability to assess hospital adherence to federal price transparency rules.

SB23-1215: **Limits On Hospital Facility Fees** - creates a steering committee to develop report detailing impact of outpatient facility fees on health care system by Oct 1, 2024. Effective July 1, 2024, prohibits billing patients for facility fees for preventive health care services not covered by their insurance.

Hospital Transparency Updates

Changes from HB19-1001 to HB23-1226 for hospital financial transparency

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1. Title of the report changed from Hospital Expenditure Report to Hospital Transparency Report.
2. Removal of good faith effort clause.
3. A summary of the hospital's transfer of cash, equity, investments, or other assets to and from related parties.
4. Inclusion of the statement of cash flows.
5. A narrative report of major planned and completed projects and capital investments greater than $25 million.
6. Information on current affiliations and a report of physician practice acquisitions.
7. Salary and total compensation data of the top five highest paid administrative positions of each nonprofit hospital.

8. Quarterly financial reporting: income and balance sheet. May be reported on a consolidated basis if owned by a hospital system or has more than one billion dollars in reserves.
9. By 7/1/2024 historic reporting (FY14-15 to FY19-20) of the following:
    a. Transfers of cash, equity, investments, and other assets to and from related parties.
    b. Information on affiliations and a report of physician practice acquisitions.
10. By 7/1/2024 historic reporting (FY19-20 to FY22-23) of significant other revenue that would be otherwise be reported in the Medicare cost report.
11. The state department shall inform non-reporting hospitals of noncompliance. The state department shall issue a corrective action plan for noncompliant hospitals should noncompliance continue after initial notice.

HB 23-1226 Implementation Timeline

When
- Quarterly reporting Feb. 2024 (tentative due date)
- Annual & One-time Historic July 1, 2024

What
- *NEW* Quarterly report with income statement and balance sheet
- Annual
  - Hospital Transparency template
    - *NEW* Current affiliations, cash transfers, capital projects
  - Audited Financial Statement, Medicare Cost Reports
- *NEW* One-time Historic
  - Acquisitions
  - Cash transfers
  - Other revenue

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Hospital Transformation Program (HTP)

Matt Haynes, Special Finance Projects Manager
Department of Health Care Policy & Financing

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Hospital Transformation Program (HTP)

- Value-based purchasing strategies to more than $1 billion/year hospital provider fee payments.
- Rural Support Fund $12 million per year x 5 years = $60 million to 23 Critical Access/Rural hospitals with low revenue/reserves. ($33 million paid to date)
- Improves health outcomes through pay-for-performance incentives.

HTP GOALS

01

Improve patient outcomes through care redesign and integration of care across settings

02

Improve patient experience in the delivery system by ensuring appropriate care in appropriate settings

03

Lower Medicaid costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery

04

Accelerate hospitals' organizational, operational and systems readiness for value-based payment

05

Increase collaboration between hospitals and other providers, particularly Regional Accountable Entities (RAEs)

Hospital Transformation Program (HTP)

- Hospital led interventions and quality metrics to address priorities
  - Avoidable hospital utilization
  - Core populations
  - Behavioral health and substance use disorder (SUD)
  - Clinical and operational efficiencies
  - Community development efforts to address population health and total cost of care
- Community Health Neighborhood Engagement (CHNE)
  - Public Input Meetings
  - Community Advisory Meetings
  - Stakeholder Engagement

HTP Hospital Support

- 5+ years engagement: monthly hospital workgroups, weekly CHA meetings, 1:1 hospital meetings, plus ongoing technical assistance
- Program was delayed from 10/2019 to 4/2020 to 10/2020 to 4/2021
- Measures scaled by size
  - Large (91+ beds) hospitals 10 measures
  - Medium (26-90 beds) 8 measures
  - Small hospitals (<26 beds) 6 measures; Critical Access risk reduced 40%
- Reporting frequency
- Milestones twice annually, along with quarterly data reporting

Enhanced Matching Rate

The Department estimates that net reimbursement increases due to the eFMAP will be at least $100 million per year.

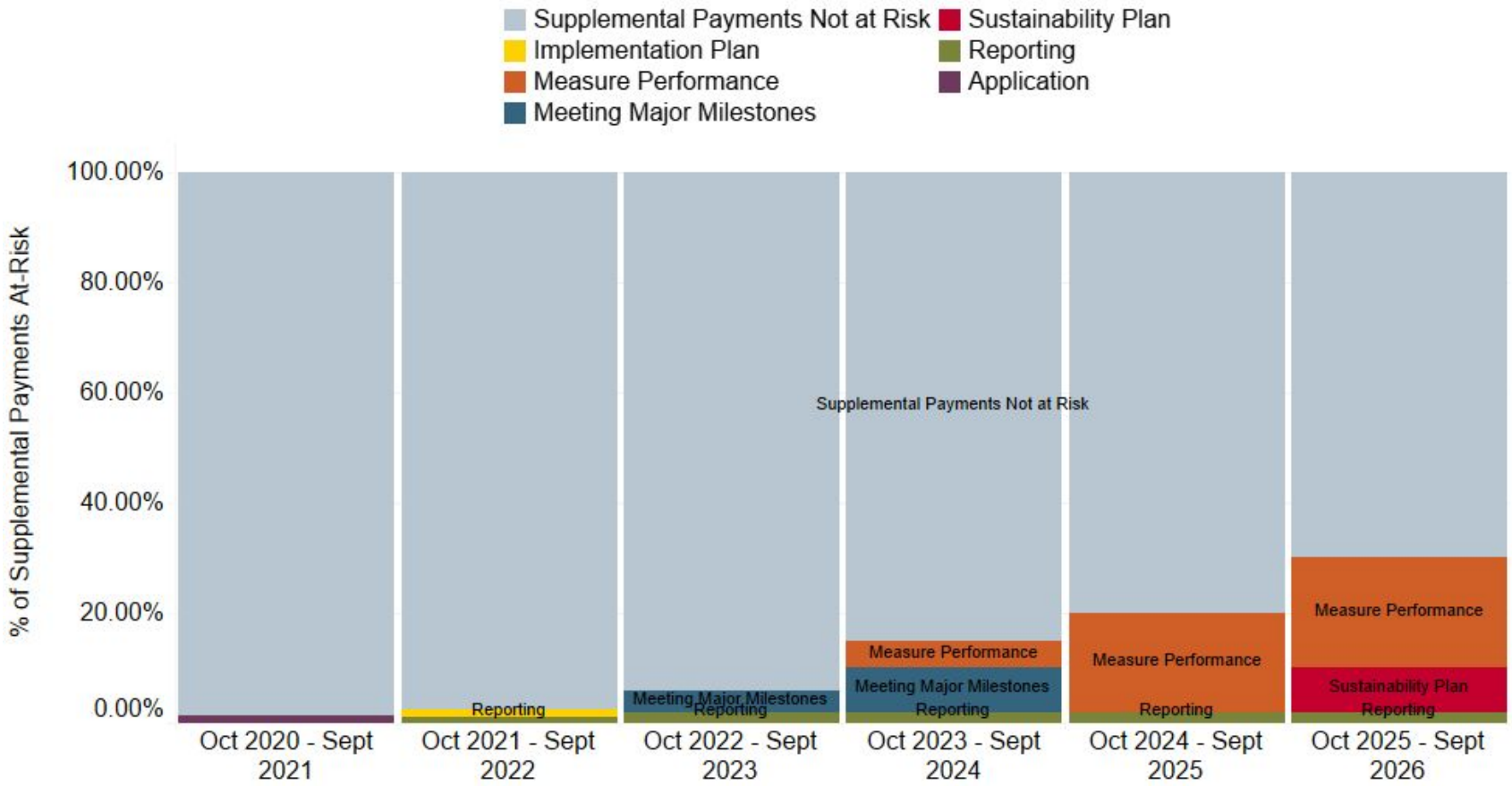
The eFMAP net reimbursement increases for each FFY to date are:

- FFY 2019-20 (Oct. 2019 – Sept. 2020) = $127 million
- FFY 2020-21 (Oct. 2020 – Sept. 2021) = $141 million
- FFY 2021-22 (Oct. 2021 – Sept. 2022) = $152 million
- FFY 2022-23 (Oct. 2022 – Sept. 2023) = $160 million

What is at-risk?

As of August 2023 for each of the components of the program (application, implementation plan, timely reporting, milestones), 96% or more hospitals fully earned their at-risk dollars and have or will receive 100% of their supplemental payments.

HTP Supplemental Payments at Risk by Program Year and Program Component



Depending on the program year, 1.5% to 30% of non critical access hospital supplemental payments are at risk
Depending on the program year, 1.5% to 20% of critical access hospital supplemental payments are at risk

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Unearned at-risk **is <u>redistributed</u>** to other hospitals based on performance

HTP Progress So Far

2020

Oct 2020

- Hospital Transformation Program begins.
- COVID delay and preparation for Application submission.

2021

Apr - June 2021

- Hospitals submitted Application with public input.
- Application reviews conducted and final Applications published.

Aug - Dec 2021

- Hospitals submitted Implementation Plans.
- Implementation plans were reviewed and finalized.

2022

Jan - Mar 2022

- Project ramp up and planning

April 2022

- Hospitals completed PY0 measure dress rehearsal.

July - Sept 2022

- First Interim Activity and CHNE reporting period.

Oct - Dec 2022

- Interim Activity and CHNE reporting period.

2023

Jan - Mar 2023

- Interim Activity and CHNE reporting period.
- Hospitals submitted Program Year 1 measure data.

Apr - June 2023

- First Milestone Activity and CHNE reporting period.

July - Sept 2023

- Interim Activity and CHNE reporting period.

HTP Reporting Summary

Hospitals participating in the HTP have **completed an Application and Implementation Plan** detailing the strategies and steps (milestones) they intend to take in implementing each of the selected interventions.

Hospitals participating in the HTP have also **completed four cycles of quarterly reporting**. Quarterly reporting requires hospitals to discuss **interim progress**, **CHNE activities, and/or milestone completion**, based off the details outlined in hospitals' approved Implementation Plans.

Reporting Requirement	Report Due Date	At-Risk %	Hospitals Earned	Hospitals Unearned	Total Hospitals
Application	April 30, 2021	1.5%	84	84	84
Implementation Plan	September 30, 2021	1.5%	84	84	84
PY1Q3 Quarterly Report	July 31, 2022	0.5%	82	1	83*
PY1Q4 Quarterly Report	October 31, 2022	0.5%	80	3	83*
PY2Q1 Quarterly Report	January 31, 2023	0.5%	84	0	84
PY2Q2 Quarterly Report	April 30, 2023	0.5%	84	0	84

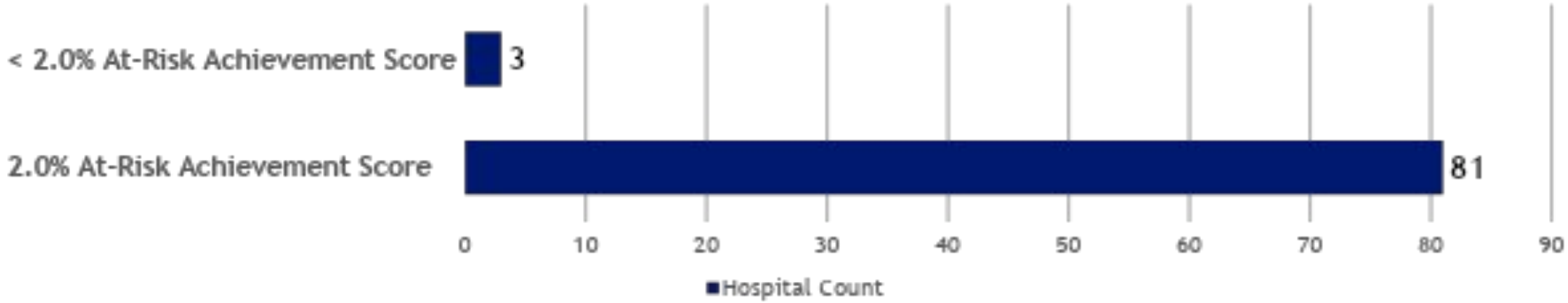
*Impact from new hospital application

HTP Milestone Achievement Summary

All hospitals (84) reported timely and compete for milestones earning 0.5% at-risk during the first Milestone Reporting period (PY2Q2, Jan-Mar 2023).

81 hospitals earned the full 2.0% at-risk associated with the Achievement component (Meeting Major Milestones). While **3 hospitals earned partial at-risk** due to one or more **course corrections** for missed milestones.

Overall, hospitals demonstrated milestone completion on a total of **1,380 activities.** These activities spanned People, Process, Technology, and Patient Engagement functional areas that hospitals chose in the Planning and Implementation Phase.



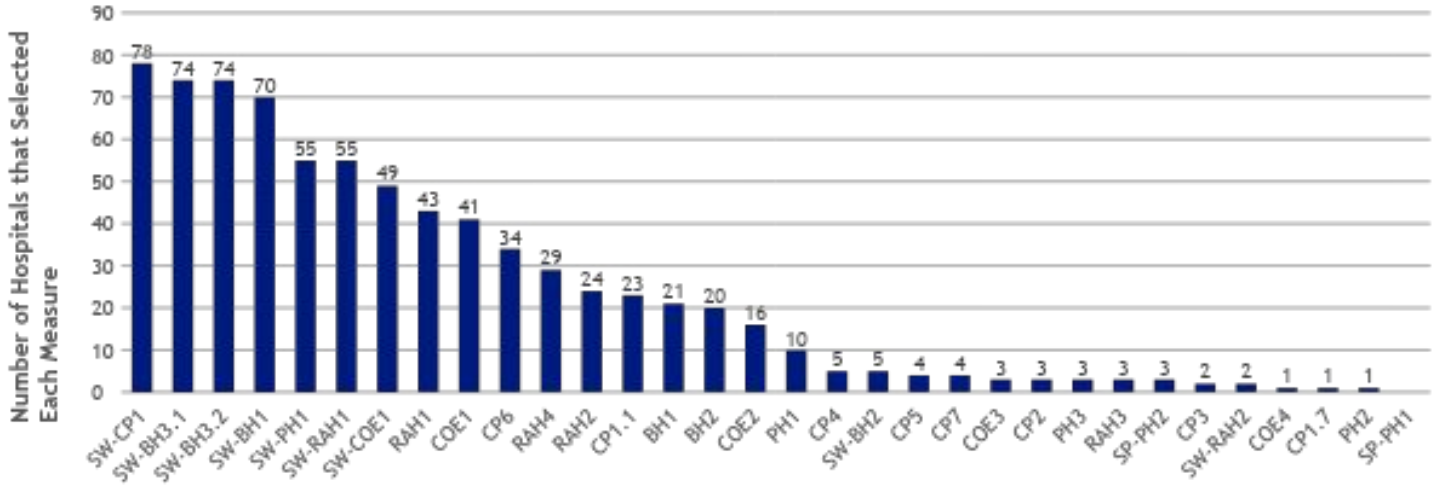
CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Measures - Transitioning to Pay for Performance

Timeline

- **April 2022 dress rehearsal period**. This activity carried no at-risk.
- Pay for Reporting
  - Beginning **January 2023**, hospitals earn at-risk dollars annually for **reporting on established performance measures** applicable to each of their interventions.
- Measure data collected was used to set **measure baselines,** as well as **establish program performance measure benchmarks.**
- Pay for Performance
  - Beginning **October 2023, hospitals will be compared to baselines and benchmarks.**

This graph indicates the number of hospitals that selected each measure: Overall **756 total measures** have been selected.

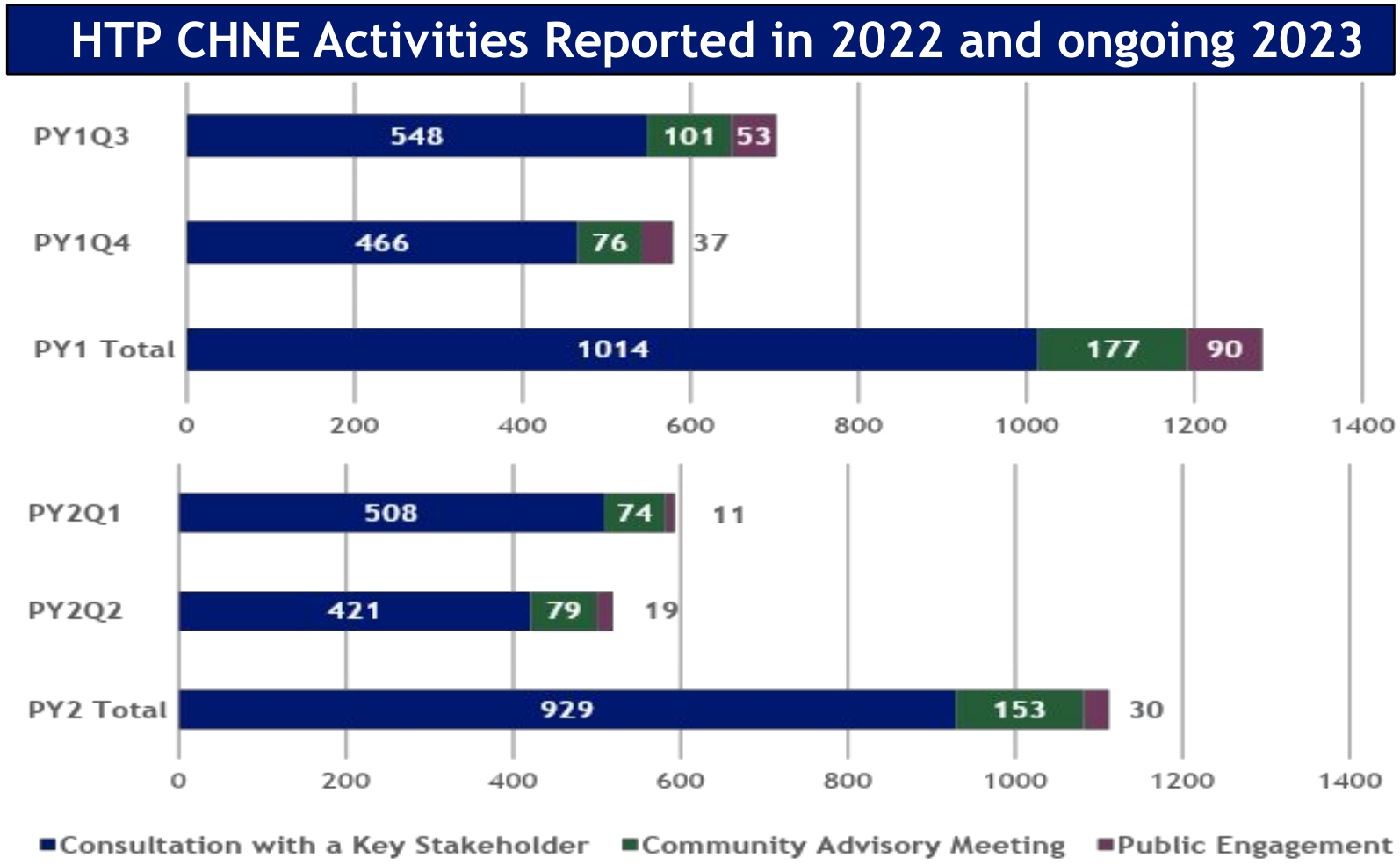


CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

HTP CHNE Summary

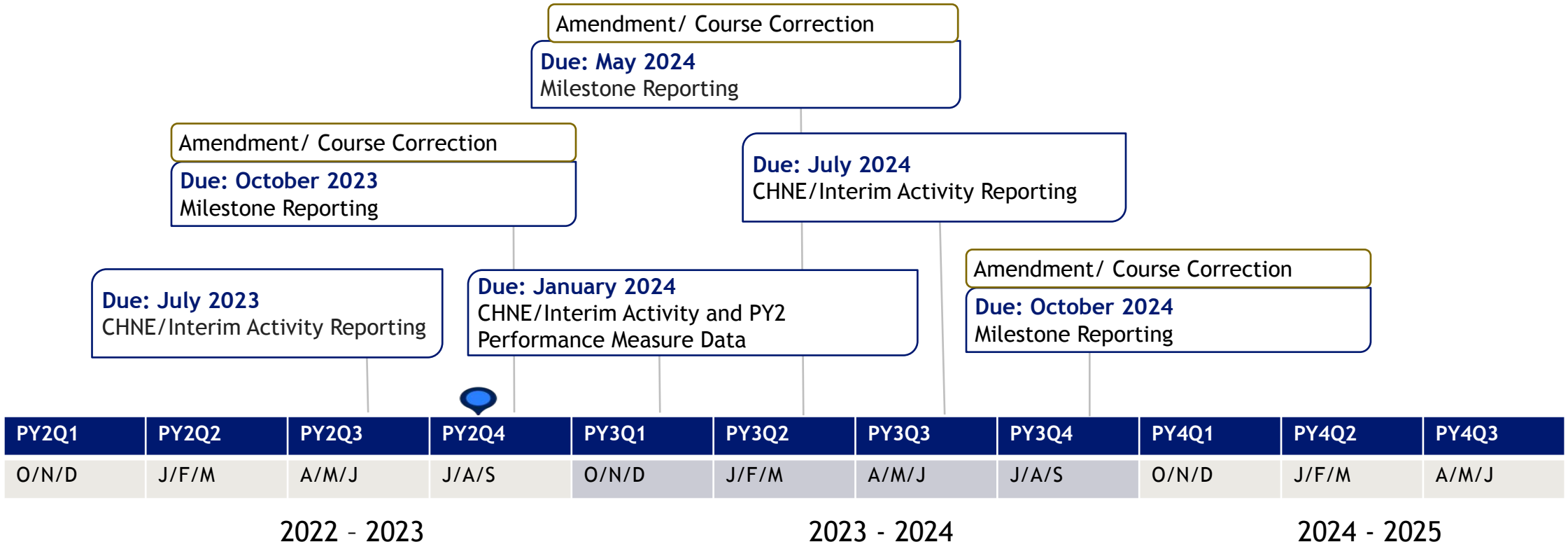
Hospitals are required to report some type of **ongoing CHNE activity** each quarter of the HTP.

The idea is to have hospitals move engaged in the communities that they serve. We are happy to report that, hospitals have **surpassed minimum CHNE requirements** and are making strides in demonstrating **meaningful, inclusive, and collaborative engagement** with their partners and the public on pertinent HTP topics.



CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

What's Next?: Upcoming HTP Timeline



Note:

- CHNE is reported every quarter.
- Reports are due the last day of the month following quarter end.
- Hospitals will have an opportunity to review scores and request reconsiderations during Scoring Review and Reconsideration (SRRP).

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

HTP Learning Symposium: Recap From June 8 & 9

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

HTP Community Advisory Council (CAC)

- The CAC plans to postpone meetings until January 2024.
- Request a CHASE member to volunteer to chair/co-chair the CAC.
- In the interim, review and consider other Community Benefit Policy as it unfolds like the Implementation of HB23-1243.
- Potential outcome and next step may involve dissolving or repurposing the CAC as it has served its purpose as it relates to Community Benefit and the HTP. Potential for stakeholder engagement of other Community Benefit Policies outside of HTP

HQIP

Matt Haynes, Special Finance Projects Manager
Department of Health Care Policy & Financing

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Program Overview

- The statutory authority for HQIP is found at Section 25.5-4-402.4, and the regulatory authority is found at 10 CCR 2505-10, Section 8.3004.F.
- Hospital Quality Incentive Payment (HQIP) Program incentive payments are based on each hospital's performance on the measures recommended by the HQIP Subcommittee and approved by the CHASE Board.

Program Overview

Three Measure Groups

- Maternal Health and Perinatal Care
- Patient Safety
- Patient Experience

Maternal Health and Perinatal Care

Measure	Measure Basis	Source	Measurement Period
Exclusive Breastfeeding (PC-05)	The Joint Commission/CMS	Hospital Reported	January 1, 2022 to December 31, 2022
Cesarean Section (PC-02)	The Joint Commission/CMS	Hospital Reported	January 1, 2022 to December 31, 2022
Perinatal Depression and Anxiety	Council on Patient Safety in Women's Health Care	Hospital Reported	In place on April 30, 2023
Maternal Emergencies	National Partnership for Maternal Safety	Hospital Reported	In place on April 30, 2023
Reproductive Life/Family Planning	Department of Health Care Finance/US Office of Population Affairs	Department/ Hospital Reported	In place on April 30, 2023

Maternal Health and Perinatal Care Cont'd

Measure	Points Available	Scoring Method	Scoring Levels
Exclusive Breastfeeding (PC-05)	1	Points awarded on an all or nothing basis	All or Nothing
C-section	5	Ranking method –no points awarded to equal to or above threshold rate	3
Perinatal Related Depression	5	Scoring tiered depending on number of elements in place	2
Maternal Emergencies	5	Points awarded for Structure and Process Measures on an all-or-nothing basis	All or Nothing
Reproductive Life and Family Planning	5	Points awarded on an all or nothing basis	All or Nothing

Patient Safety

Measure	Measure Basis	Source	Measurement Period
Zero Suicide*	HQIP	Hospital Reported	In place by April 30, 2023
Reduction of Racial and Ethnic Disparities*	Council on Patient Safety in Women's Health Care	Hospital Reported	In place by April 30, 2023
Clostridium difficile (C. Diff)	Center for Disease Control (CDC)	Department/ Hospital Reported	October 1, 2021 to September 30, 2022
Sepsis	HQIP	Hospital Reported	In place by April 30, 2023
Antibiotics Stewardship	CPHE	Hospital Reported	In place by April 30, 2023
Adverse Event	HQIP	Hospital Reported	January 1, 2022 to December 31, 2022
Culture of Safety Survey	Agency for Healthcare Research and Quality (AHRQ)	Hospital Reported	Within the 24 months prior to data collection
Handoffs and Sign-outs	HQIP – based on Agency for Healthcare Research and Quality (AHRQ) & The Joint Commission	Hospital Reported	In place by April 30, 2023

Patient Safety Cont'd

Measure	Points Available	Scoring Method	Scoring Levels
Zero Suicide	10	Points awarded for Level 1, additional points available depending on number of Level 2- 4 elements in place	4
Reduction of Racial and Ethnic Disparities	10	Points awarded for Readiness; additional points for each additional element, up to 5	2
C. Diff infections	5	Comparison to the national benchmark - "worse, no different than, better" ranking. Points only awarded to those in "no different than" or "better" categories	3
Sepsis	7	Scoring tiered depending on number of elements in place	2
Antibiotics Stewardship	10	Points awarded for Group 1, additional points available depending on number of Group 2-4 elements in place	4
Adverse Event	5	Points awarded on an all or nothing basis	All or Nothing
Culture of Safety Survey	5	Points awarded on an all or nothing basis	All or Nothing
Handoffs and Sign-outs	7	Scoring tiered depending on number of elements in place	4

Patient Experience

Measure	Measure Basis	Source	Measurement Period
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	AHRQ/ Hospital Compare	Department	October 1, 2021 to September 30, 2022
Advance Care Plan*	National Committee for Quality Assurance (NCQA)	Hospital Reported	January 1, 2022 to December 31, 2022

Patient Experience Cont'd

Measure	Points Available	Scoring Method	Scoring Levels
HCAHPS composite 5	5	Ranking method—points awarded to top three quartiles only	3
HCAHPS composite 6	5	Ranking method—points awarded to top three quartiles only	3
HCAHPS composite 7	5	Ranking method—points awarded to top three quartiles only	3
Advance Care Planning	5	Points awarded based on comparison to threshold and completion of narrative response, if applicable	All or Nothing

HQIP Timeline

Lifecycle of the 2023 Application

2021

- **August – December:** Develop measure criteria with Subcommittee and industry experts.
- **December:** Finalize the 2023 Measure Details.

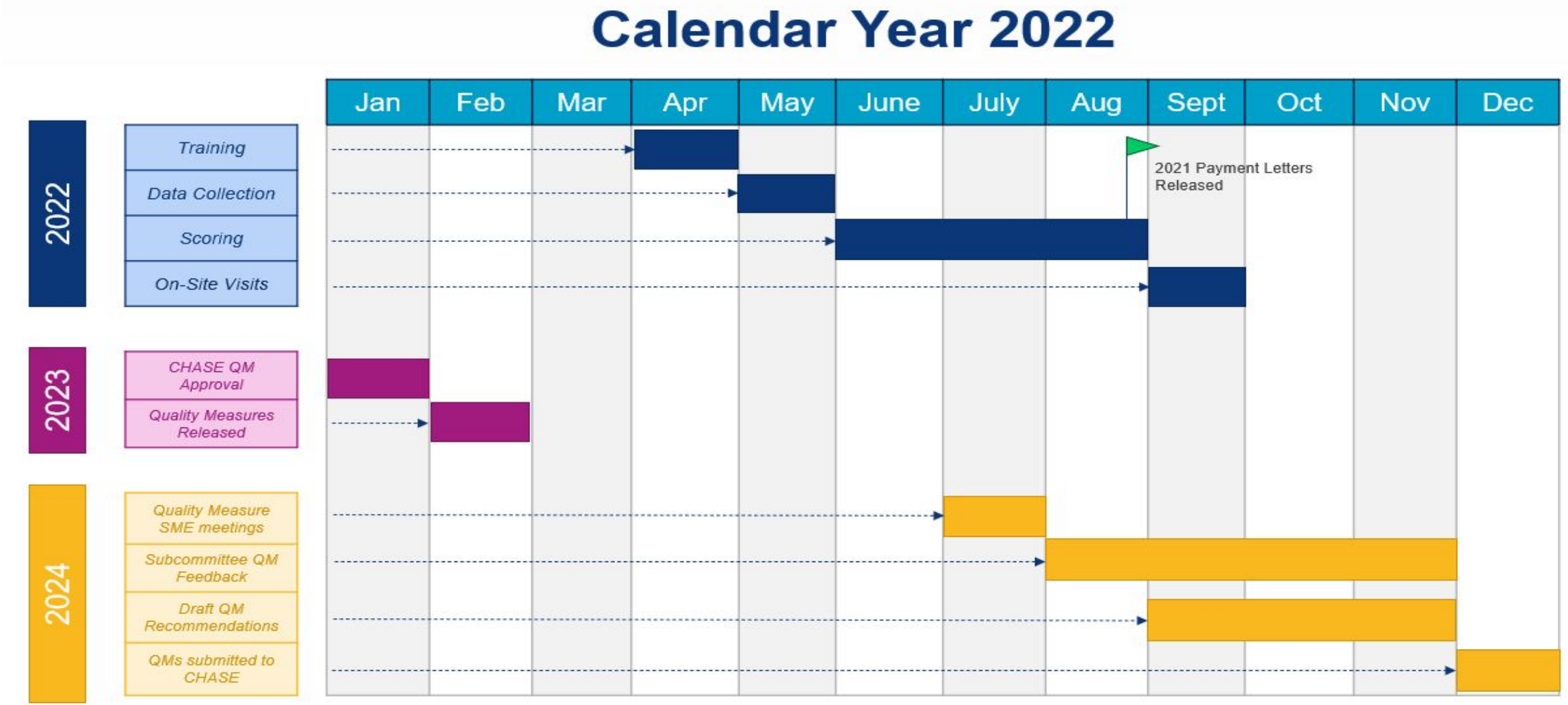
2022

- **January:** 2023 Application Measure Details Approved and Published.
- **Throughout the year,** hospitals are in the performance period for the 2023 program data collection.

2023

- **April:** Performance period for hospitals ends.
- **May:** Data Collection Tool opens and hospitals submit their 2023 HQIP Survey.
- **June – July:** Scoring occurs.
- **August:** Preliminary Scores are released and SRRP occurs.
- **September:** Onsite visits occur, and final scores are submitted.

Program Timeline - Across 1 Year



CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

HQIP Program Updates

2023 Scoring

- 2023 Applications have been scored
- Preliminary Scoring Letters were released by August 18th
- The Scoring Review and Reconsideration Period will begin when Preliminary Scoring Letters are released. Step 1 will close after 10 business days
- Step 2 of Scoring Review and Reconsideration Period, the Escalation Phase, ends 5 business days after Step 1
- Onsite reviews will be conducted in September
- Final scoring letters will be sent to Hospitals in September
- Final scores will be submitted to HCPF by Sept. 29th

2024 Program Updates

- The 2024 Measure Details were published in April 2023
  - Added measure elements related to auxiliary aids/services for individuals with communications disabilities
  - Add measure elements related to improving health disparities by ensuring equitable care is provided to all patients
- Hospitals are currently in the performance period (January 2023 – April 2024) for 2024 program data collection

2025 Program Updates

- HCPF and consultant with the HQIP Subcommittee from August 2023 – December 2023 to develop the 2025 application
- Efforts in progress:
- Met with subject matter experts from CDPHE to discuss updates for the 2025 application.
  - Antibiotic Stewardship – Lauren Biehle, PharmD and Christopher Czaja, MD
  - Zero Suicide – Conlin Bass, Office of Suicide Prevention (OSP)
- Subcommittee feedback began on August 3, 2023
- Drafting of measure recommendations is ongoing

Thank You