Colorado Healthcare Affordability and Sustainability Enterprise Annual Report

Jan. 16, 2024

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 $415 million per expansion year and substantially increased enrollment in Health First Colorado and CHP+.

From October 2022 through September 2023, the CHASE has:

- **Provided $464 million in increased reimbursement to hospital providers**

  Hospitals received $1.7 billion in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed with healthcare affordability and sustainability fees, including $119 million in hospital quality incentive payments (HQIP). This funding increased hospital reimbursement by $464 million for care provided to Health First Colorado and CICP members with no increase in General Fund expenditures. In addition, of the $3.3 billion in claims paid for Health First Colorado (Colorado's Medicaid program) and Child Health Plan *Plus* (CHP+) expansion members, approximately 42%, or more than $1.3 billion, was paid to hospitals.

- **Provided health care coverage through Health First Colorado and Child Health Plan Plus for more than 622,000 Coloradans**

  - As of Sept. 30, 2023, the Department of Health Care Policy and Financing (HCPF) has enrolled the following Health First Colorado and CHP+ members with no increase in General Fund expenditures:
  - Approximately 483,000 Health First Colorado adults without dependent children up to 133% of the FPL.
  - 93,000 Health First Colorado parents ranging from 61% to 133% of the federal poverty level (FPL)
  - 27,000 CHP+ children and pregnant people ranging from 206% to 250% of the FPL
  - 19,000 Health First Colorado working adults up to 450% of the FPL and children with disabilities up to 300% of the FPL

- **Transferred $187.4 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 pandemic, the federal government has funded $187.4 million of the state's medical assistance program expenditures normally funded by the state General Fund since January 2020 as part of House Bill (HB20-1385) through the healthcare affordability and sustainability fees.

- **Saved hospitals $160 million in healthcare affordability and sustainability fees by using an enhanced federal medical assistance percentage methodology**

  If the enhanced federal medical assistance percentage methodology were not used, hospitals would have had to pay $160 million more in healthcare affordability and sustainability fees to receive the same $1.7 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, switching to this enhanced federal medical assistance percentage (FMAP) methodology has saved Colorado hospitals a total of $580 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, and $160 million in FFY 2022-23.

- **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.

  - In 2022, Health First Colorado payment to cost ratio remained the same as 2021 at 80%, Medicare decreased from 73% to 72% and private insurance decreased from 172% to 163%. Health First Colorado reimbursements have increased from 54% to 80% of hospital cost.[1] The overall payment to cost ratio in 2022 is 101% of hospital costs, while Medicare payments to costs have declined from 78% to 72%, and private insurance payment to costs have increased from 155% to 163%.
  - In 2022, the amount of bad debt and charity care decreased by more than 30% compared to 2013. This sharp 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 2022 total bad debts and charity care have increased 16.7% from 2021 or by $70.1 million and $225.6 million since 2015 or by 85.5%.
  - 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 payments less costs for Health First Colorado and Medicare. The payer mix in Health First Colorado

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

and Medicare has increased from 42.9% in 2009 to 61.3% in 2022 while private insurance has declined from 43.1% to 30.2%.

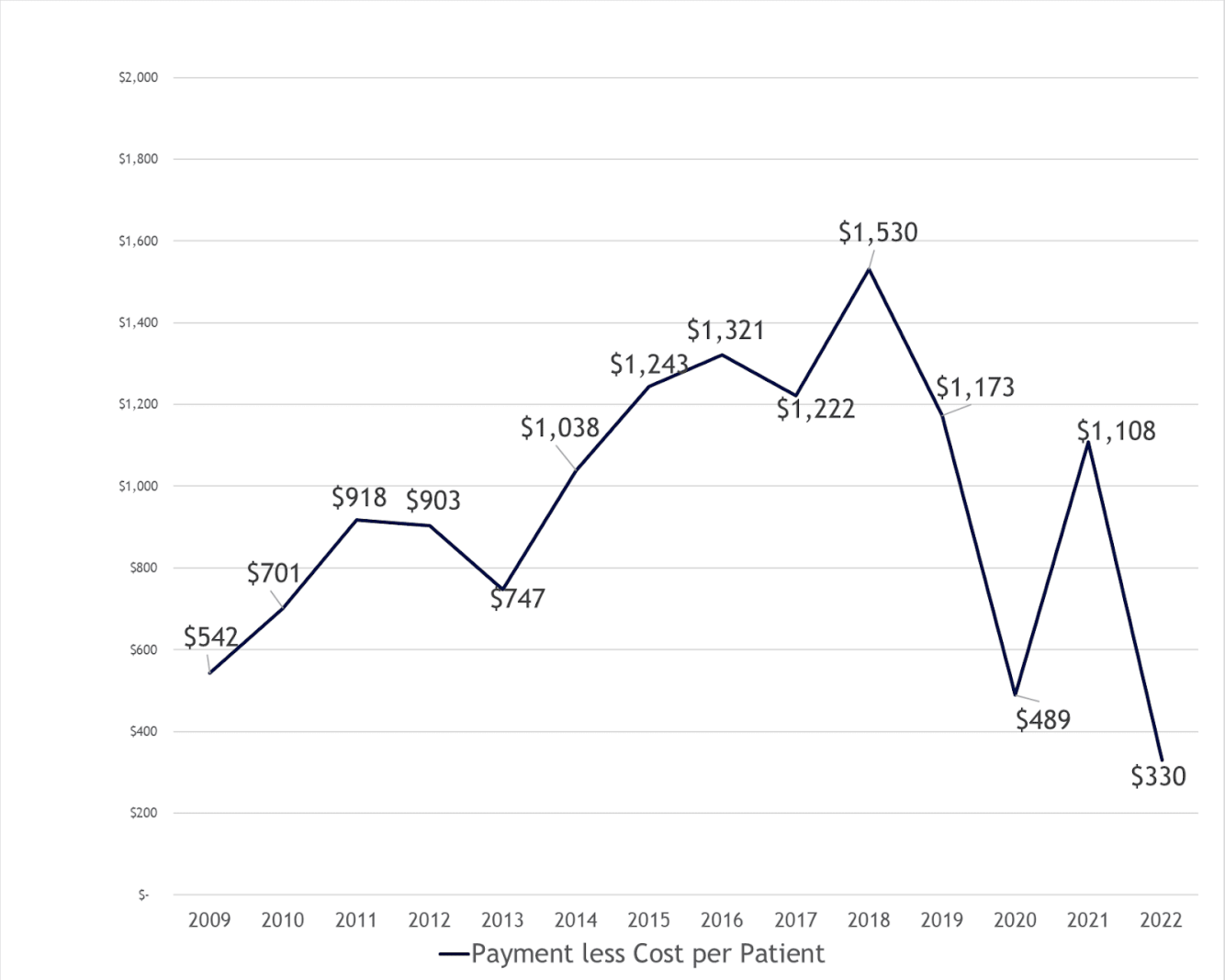
Year	Medicare	Health First Colorado	Insurance	Self Pay	CICP/ Other	Overall
2019	0.72	0.75	1.85	0.26	0.71	1.07
2020	0.67	0.83	1.66	0.43	0.94	1.02
2020 w/ stimulus	0.74	0.89	1.73	0.49	1.01	1.09
2021	0.73	0.80[2]	1.72	0.35	0.99	1.05[3]
2022	0.72	0.80	1.63	0.35	0.96	1.01

  - Reflecting the impact of the pandemic, all payers saw a reduction in patient volume between 2019 and 2020; however, 2021 volumes are returning to more typical pre-pandemic levels. Between 2020 and 2021, patient volume has begun to rise again, increasing by 7.1%. Between 2021 and 2022, patient volumes have continued to rise, with an increase of 3.7%

- **Between 2021 and 2022, there has been a sharp decrease in payment less cost for hospitals, with a decrease of $681.2 million, or 69.1%.**
  - This was primarily driven by a decrease in hospitals' payment less costs for Medicare and private insurance payer ($364.7 million and $156.9 million, respectively). Typically, and prior to the COVID19 pandemic, hospitals' payments less costs for private insurance payers increased over time; however, due to increasing hospital costs related to inflation and staffing, this is the first year (outside of the pandemic) that hospitals realized a decrease in payment less cost for private insurance payers.
  - Overall costs have grown to their highest level since 2009 at 11.8% between 2021 and 2022, while payments have only grown by 7.8% over the same period. The growth in payments is more inline with growth prior to the pandemic, while the increased costs are the highest seen since 2016.
  - On a per patient basis, payment less cost is the lowest it has been since 2009, at $330 per patient in 2022 compared to $542 per patient in 2009.

[2] The number is different from prior reporting in the CHASE 2023 Report due to hospital self-reporting template errors. Please reference this addendum for more information https://hcpf.colorado.gov/sites/hcpf/files/2023%20CHASE%20Annual%20Report%20FINAL_addendum.pdf
[3] The number is different from prior reporting in the CHASE 2023 Report due to hospital self-reporting template errors. Please reference this addendum for more information https://hcpf.colorado.gov/sites/hcpf/files/2023%20CHASE%20Annual%20Report%20FINAL_addendum.pdf

- 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 pandemic 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. These financial burdens have been coupled with weaker-than-expected financial markets and related investment losses that have led to more concerning financial hardships for many hospitals. 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.



- **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 Colorado Medicaid with goals to improve quality and affordability through the implementation of statewide and local measures. Starting in October 2023, HTP began its first 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 Medicaid, from the improved health care affordability and quality outcomes that HTP delivers.

- **Maintained low administrative expenditures**

  Administrative costs are limited in statute to 3% of the total CHASE expenditures. CHASE continues to operate below that cap, and in SFY 2022-23, CHASE's administrative costs were only approximately 1.99% of expenditures. 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 (Colorado's Medicaid program) members and Coloradans eligible for discounted health care services through the Colorado Indigent Care Program (CICP);
- Funding hospital quality incentive payments;
- Increasing the number of individuals eligible for Health First Colorado and Child Health Plan *Plus* (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, 2024:

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

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.

In addition, the CHASE Board has one vacancy for a representative of 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 federal fiscal year (FFY) basis, from October to September. Table 1 outlines the FFY 2022-23 healthcare affordability and sustainability fee and payment amounts. Table 16 and Table 17 (in the Appendix) detail hospital-specific FFY 2022-23 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 2022-23 CHASE Fee and Supplemental Payments

Item	Amount
Inpatient Fee	$548,066,874
Outpatient Fee	$681,984,798
Total Healthcare Affordability and Sustainability Fee	**$1,230,051,582**
Inpatient Supplemental Payment	$631,995,568
Outpatient Supplemental Payment	$667,614,563
Essential Access Supplemental Payment	$20,000,000
Rural Support Supplemental Payment	$12,000,000
Hospital Quality Incentive Supplemental Payment	$118,510,744
Disproportionate Share Hospital Supplemental Payment	$244,068,958
Total Supplemental Payments	**$1,694,189,820**
Net Reimbursement to Hospitals	**$464,138,238**

For an overview of the fee assessment and payment methodologies recommended by the CHASE Board for October 2022 through September 2023, see the sections below. While individual hospitals may not be eligible for all payments, all methodologies are described.

A. Healthcare Affordability and Sustainability Fee

The total healthcare affordability and sustainability fee collected from hospitals during FFY 2022-23 was $1,230,051,582, with the inpatient fee comprising 45% of total fees and the outpatient fee comprising 55% 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 27,500 Health First Colorado inpatient days per year that provide over 30% 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 $580 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, and $160 million in FFY 2022-23.

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 public health emergency. 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 terminates.

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. So far, HCPF has been able to draw down an additional $187.4 million in federal funds for the period Jan. 1, 2020 through Sept. 30, 2023[4].

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 may vary by hospital. 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

[4] 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.

factor. Outpatient adjustment factors may vary by hospital. The outpatient adjustment factor for each hospital is published annually in the Provider Bulletin[5]. State-licensed psychiatric hospitals are not qualified for this payment.

3. Essential Access Supplemental Payment

This payment is for qualified Essential Access hospitals. It equals the hospital's percent of beds compared to total beds for all qualified Essential Access hospitals multiplied by $200,000,000. 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 2022-23 were disbursed in monthly installments as part of the CHASE fee and supplemental payment program. To date, each qualified hospital has received $1,565,217 for the first three years of the program.

[5] https://hcpf.colorado.gov/provider-news

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

5. Hospital Quality Incentive Supplemental Payment[6]

As part of our Value-Based Payment (VBP) effort for hospitals, CHASE includes a provision to establish Hospital Quality Incentive Payments (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, 2022, 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 2022 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

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

3. Patient Experience Measure Group
    a. Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS)[7]
    b. Advance Care Plan

Payment Calculation

The payments earned for each of the FFY 2022-23 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 2022-23 HQIP Dollars Per Adjusted Discharge Point

Tier	Quality Points Awarded	Dollars Per Adjusted Discharge Point
0	0-19	$0.00
1	20-39	$2.46
2	40-59	$4.92
3	60-79	$7.38
4	80-100	$9.84

During the FFY 2022-23 timeframe, HQIP payments totaled over $119 million with 80 hospitals receiving payments. HQIP payments, Health First Colorado adjusted discharges, and quality points awarded by hospital are listed in Table 3.

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

Table 3. FFY 2022-23 Hospital Quality Incentive Payments

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
Animas Surgical Hospital	55	81	$4.92	$21,919
Arkansas Valley Regional Medical Center	46	885	$4.92	$200,293
Aspen Valley Hospital	68	151	$7.38	$75,778
Avista Adventist Hospital	82	2,929	$9.84	$2,363,352
Banner Fort Collins Medical Center	83	1,077	$9.84	$879,607
Broomfield Hospital	89	552	$9.84	$483,420
Castle Rock Adventist Hospital	73	1,278	$7.38	$688,510
Centura St. Elizabeth Hospital	62	1,027	$7.38	$469,914
Children's Hospital Anschutz	88	8,801	$9.84	$7,620,962
Children's Hospital Colorado Springs	84	2,523	$9.84	$2,085,411
Community Hospital	80	834	$9.84	$656,525
Conejos County Hospital	86	159	$9.84	$134,552
Craig Hospital	38	53	$2.46	$4,954
Delta County Memorial Hospital	60	1,047	$7.38	$463,612
Denver Health Medical Center	69	13,839	$7.38	$7,047,096
East Morgan County Hospital	88	1,064	$9.84	$921,339
Family Health West	95	31	$9.84	$28,979
Foothills Hospital	65	1,927	$7.38	$924,382
Good Samaritan Medical Center	85	2,377	$9.84	$1,988,123
Grand River Health	82	198	$9.84	$159,762
Grandview Hospital	92	869	$9.84	$786,688
Greeley Hospital	80	2,245	$9.84	$1,767,264

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
Gunnison Valley Health	85	200	$9.84	$167,280
Heart of the Rockies Medical Center	28	962	$2.46	$66,263
Highlands Ranch Hospital	81	1,235	$9.84	$984,344
Keefe Memorial Hospital	47	50	$4.92	$11,562
Kit Carson County Memorial Hospital	70	394	$7.38	$203,540
Lincoln Community Hospital	24	169	$2.46	$9,978
Littleton Adventist Hospital	57	1,855	$4.92	$520,216
Longmont United Hospital	84	1,720	$9.84	$1,421,683
Longs Peak Hospital	81	2,265	$9.84	$1,805,296
Lutheran Medical Center	82	4,648	$9.84	$3,750,378
McKee Medical Center	79	1,538	$7.38	$896,685
Medical Center of the Rockies	82	2,229	$9.84	$1,798,536
Melissa Memorial Hospital	78	115	$7.38	$66,199
Memorial Hospital	77	14,571	$7.38	$8,280,116
Mercy Regional Medical Center	59	1,991	$4.92	$577,947
Middle Park Medical Center	54	113	$4.92	$30,022
Montrose Regional Health	90	1,277	$9.84	$1,130,911
Mt. San Rafael Hospital	70	519	$7.38	$268,115
National Jewish Health	69	131	$7.38	$66,708
North Colorado Medical Center	82	5,347	$9.84	$4,314,387
North Suburban Medical Center	59	6,160	$4.92	$1,788,125
Pagosa Springs Medical Center	90	194	$9.84	$171,806
Parker Adventist Hospital	68	2,329	$7.38	$1,168,785

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
Parkview Medical Center	65	8,888	$7.38	$4,263,574
Penrose-St. Francis Health Services	82	8,315	$9.84	$6,709,207
Pikes Peak Regional Hospital	74	369	$7.38	$201,518
Pioneers Medical Center	20	50	$2.46	$2,460
Platte Valley Medical Center	77	2,817	$7.38	$1,600,788
Porter Adventist Hospital	87	1,464	$9.84	$1,253,301
Poudre Valley Hospital	86	5,348	$9.84	$4,525,692
Presbyterian-St. Luke's Medical Center	77	3,624	$7.38	$2,059,374
Prowers Medical Center	84	1,156	$9.84	$955,503
Rehabilitation Hospital of Colorado Springs	45	375	$4.92	$83,025
Rehabilitation Hospital of Littleton	86	228	$9.84	$192,943
Rio Grande Hospital	27	469	$2.46	$31,151
Rose Medical Center	68	4,247	$7.38	$2,131,314
San Luis Valley Regional Medical Center	72	2,365	$7.38	$1,256,666
Sedgwick County Health Center	27	106	$2.46	$7,041
Sky Ridge Medical Center	66	2,817	$7.38	$1,372,104
Southeast Colorado Hospital	73	131	$7.38	$70,575
Southwest Health System	77	1,296	$7.38	$736,465
Spanish Peaks Regional Health Center	53	138	$4.92	$35,985
St. Anthony Hospital	73	2,707	$7.38	$1,458,369
St. Anthony North Health Campus	73	4,098	$7.38	$2,207,757
St. Anthony Summit Medical Center	77	1,067	$7.38	$606,333
St. Joseph Hospital	92	6,077	$9.84	$5,501,387

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
St. Mary-Corwin Medical Center	78	1,705	$7.38	$981,466
St. Mary's Medical Center	82	2,311	$9.84	$1,864,700
St. Thomas More Hospital	54	1,682	$4.92	$446,874
Sterling Regional MedCenter	91	1,300	$9.84	$1,164,072
Swedish Medical Center	62	5,262	$7.38	$2,407,681
The Medical Center of Aurora	50	5,461	$4.92	$1,343,406
University of Colorado Hospital	80	14,989	$9.84	$11,799,341
Vail Health Hospital	72	654	$7.38	$347,509
Valley View Hospital	87	677	$9.84	$579,566
Wray Community District Hospital	83	366	$9.84	$298,920
Yampa Valley Medical Center	89	696	$9.84	$609,529
Yuma District Hospital	85	160	$9.84	$133,824
Total	**-**	**187,374**	**-**	**$118,510,744**

6. Disproportionate Share Hospital Supplemental Payment

The Disproportionate Share Hospital (DSH) payment equals $244,068,958 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 qualified hospitals equals the lesser of each hospital's DSH limit and each hospital's uninsured costs as a percentage of total uninsured cost for all qualified hospitals multiplied by the DSH allotment in total. This methodology is used to distribute the remaining allotment among qualified hospitals that have not met their DSH limit.

Psychiatric hospitals, LTC 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 2022-23, CHASE collected $1,230,051,582 in fees from hospitals,[8] which, with federal matching funds, funded Health First Colorado and CHP+ health coverage expansions for 684,604 Coloradans,[9] payments to hospitals, and the CHASE's administrative expenses. Of the $3,266,759,582 in claims paid for health coverage expansions, approximately 42%, or more than $1.3 billion, 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 2022-23, CHASE operated below that cap at approximately 1.99%. Of note, only 0.14% 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 2022- 23.

Table 4. SFY 2022-23 CHASE Expenditures

Item	Total Fund
Supplemental Payments	$1,769,662,779
CHASE Administration (Table 5)	$106,004,010
Expansion Populations	$3,368,575,226
25.5-4-402.4(5)(b)(VIII) – Offset Revenue Loss	$15,700,000
Subtotal Expenditures	**$5,259,942,015**
HB 20-1385 Use of Increased Medicaid Match	$67,563,766
Total Expenditures	**$5,327,505,781**

As a result of the COVID-19 pandemic the Colorado legislature authorized several transfers from the CHASE cash fund (to include fees collected and any matching federal funds) to the

[8] In addition, $6,317,727 was recorded as earned interest.
[9] Expansion caseload for Health First Colorado and CHP+ was 684,604 in SFY 2022-23, 628,694 in SFY 2021-22; 540,260 in SFY 2020-21; and 427,460 in SFY 2019-20.

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 pandemic. Senate Bill (SB) 21-286 authorized HCPFto develop a spending plan for using enhanced, one-time federal matching 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.

Funding in SFY 2022-23 was appropriated for the CHASE administrative expenses 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 2022-23 CHASE Administrative Expenditures

Item	Total Fund
General Administration	**$13,565,833**
Personal Services	$7,468,166
PERA Direct Distribution	$147,452
Worker's Compensation	$23,197
Operating Expenses	$572,786
Legal Services	$149,126
Administrative Law Judge Services	$127,056
Payments to Risk Management and Property Funds	$56,540
Leased Space	$409,622
Capitol Complex Leased Space	$45,482
Payments to OIT	$1,394,306
CORE Operations	$24,334
General Professional Services and Special Projects	$3,147,766
Information Technology Contracts and Projects	**$49,335,291**
MMIS Maintenance and Projects	$30,328,487
CBMS Operating and Contract Expenses	$18,462,468
CBMS Health Care & Economic Security Staff	$544,336
Eligibility Determinations and Client Services	**$38,605,853**

Item	Total Fund
Disability Determination Services	$909,018
County Administration	$28,087,389
Medical Assistance Sites	$785,761
Customer Outreach	$637,902
Centralized Eligibility Vendor Contract Project	$6,338,517
Eligibility Overflow Processing Center	$707,764
Returned Mail Processing	$513,970
Work Number Verification	$625,532
Recoveries Contracts	**$752,438**
Acute Care Utilization Review	**$3,316,963**
Professional Audit Contracts	**$292,432**
Indirect Cost Assessment	**$122,280**
Children's Basic Health Plan Administration	**$12,920**
Total Administrative Expenditures	**$106,004,010**

More than $87.9 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 $38.6 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 $28.0 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*

This section reports cost shift data from calendar year 2009 through calendar year 2022.[10] 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.[11] Additionally, nursing and overall health care worker shortages have led to substantial increases in labor costs since the COVID-19 pandemic.[12] While hospitals were largely able to negate severe financial losses during the COVID-19 pandemic thanks to an injection of federal stimulus money, hospitals have continued to battle the aforementioned workforce shortages and large wage increases for hospital staff. These financial burdens have been coupled with weaker-than-expected financial markets and associated investment losses that have led to financial hardships for many hospitals. 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.

Since the inception of the Colorado Health Care Affordability Act (CHCAA) and through the implementation of the CHASE, the hospital provider fee and the healthcare affordability and sustainability fee increased hospital reimbursement by an average of more than $415 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 write-off costs have all improved from 2009 to 2022 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:

[10] 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.

[11] https://www.aha.org/costsofcaring

[12] https://www.mcknights.com/news/nurse-salaries-rising-but-more-considering-leaving-study/

- HCPF is seeing a return to pre-pandemic levels for some hospital metrics such as patient volumes and payments, although bad debt and charity care costs have continued to increase since 2018.
- Total hospital payment less cost grew $726.1 million, or 174.1%, from 2009 to 2019, then declined ($736.4 million or 64.4%) between 2019 to 2020, without considering the impact of stimulus funds. From 2020 to 2021, payment less cost increased at 142.5% ($579.5 million) when no federal stimulus is included in the 2020 figures. When federal stimulus is included in the 2020 figures, payment less cost decreased 38.4% ($615.9 million) from 2020 to 2021.
- From 2021 to 2022, hospital payment less cost decreased by $681.2 million, or a 69.1% decrease. Hospital payment less cost have reversed in their direction since 2020. When compared to pre-pandemic amounts, the 2022 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. Increases in costs were driven by increases in labor costs, especially a large increase in contracted labor expenses which saw an increase of 75.5% or $403.4 million from 2021 to 2022.[13]

Also shown in Table 22 and Table 23, the 2022 payment less cost amounts decreased 73.3% from 2019 and 77.8% from 2018.

- On a per-patient basis, hospital payment less cost grew $631 per patient or 116% from 2009 to 2019, then declined ($684) 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 $692, or 141.4%. Between 2021 and 2022, payment less cost per patient decreased by $778 or 70.2%.
- Total bad debt and charity declined ($394.4 million) from 2013 to 2018 then increased $112.9 million between 2018 and 2020. 2021 saw a decrease of $292.2 thousand in total uncompensated care costs or a 0.1% decrease. Overall, from 2013 to 2022 bad debt and charity care write-off costs declined by $210.3 million, or 30.1%. However, 2021 and 2022 bad debt and charity costs have increased by $70.1 million, or 16.7%. HCPF will continue to monitor trends in uncompensated care.
- The payment to cost ratio of Health First Colorado has remained high over the last few years and has reimbursed hospitals at a state aggregate level of 80 cents to the dollar of cost.

To provide a better understanding of the impact of the COVID-19 pandemic 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 and figures and analysis that follow within this section primarily highlight years 2009, 2019 through 2022.[14]

[13] 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

[14] Accompanying tables and figures are within the Cost Shift section of the Appendix.

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 1, 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 CHCAA in 2009, Health First Colorado reimbursement to Colorado hospitals was approximately 54% of costs. Our most recent data from 2022, shows the payment to cost ratio for Health First Colorado was 80% of costs. Reimbursement for Health First Colorado has continued to grow in recent years. Through the pandemic reimbursement for Health First Colorado continued to measure above an 80% of cost reimbursement rate, an outstanding accomplishment compared to 54% in 2009. The payment to cost ratio for the CICP/Other payer group was 96% of costs in 2022,[15] whereas the Self Pay payer group was reimbursed at 35% of costs.[16] Between 2009 and 2022, the payment to cost ratio for private sector insurance increased from 155% to 163% of costs. Between 2020 and 2022, the payment to cost ratio for private sector insurance decreased from 166% to 163% of costs. Compared to pre-pandemic figures, the private insurance sector decreased from 185% to 163%. The 2022 payment to cost ratio of 1.01 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 pandemic. At the same time, recent COVID-19 pandemic inflation and staffing costs have lowered recent hospital reimbursement relative to costs for private payers and overall.

- Between 2021 and 2022, costs for private insurance payers grew faster (9.7% or $562.4 million) than payments from private insurance payers (4.1% or $405.4 million), leading to a reduction in payments less costs of 3.8% or $159.9 million. The increase in costs was primarily driven by increases in labor costs, especially increases in contracted labor expenses between 2021 and 2022. This represents hospital profits on privately insured patients, which are funded by employers and consumers.
- When compared to pre-pandemic figures, 2022 private insurance payments grew by 7.1% compared to 2019, while private insurance costs increased by over 21.7%. Between 2019 and 2022 payment less cost for private insurance has decreased by

[15] 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.
[16] 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.

10.0%. There has still been a reduction in the private insurance payment to cost ratio, which decreased from 1.85 to 1.63 between 2019 and 2022.

- Between 2019 and 2022, overall costs have increased by 28.4%, while payments have increased 21.8%. These trends have decreased the overall payment to cost ratio during the same time period.
- Since 2009, Medicare costs have increased 195.4% and Medicaid costs have increased 336.2%, while private insurance costs have increased 62.9%.

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

Table 7. Payment to Cost Ratio, Post HB 19-1001[17]

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[18]	1.72	0.35	0.99	1.05
2022	0.72	0.80	1.63	0.35	0.96	1.01

[17] 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 pandemic.

[18] 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

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] Admirably and uniquely, 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-related expenses.[21] A portion of these COVID-19-related expenditures is reflected in the payment to cost ratio e.g., supplies, payroll, etc.; not including stimulus deflates the ratio. However, some COVID-19-related purchases are not reflected in this ratio (e.g., capital expenditures for medical equipment, telehealth infrastructure, hospital payments to other non hospital providers, etc.); 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. Additionally, 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 1.02 as noted above; with the $1.2 billion in federal stimulus, but not all the above costs, it is 1.09.

The payer mix continues to shift from private insurance to government payers, see Figure 1.[22] In 2022, Medicare increased by 0.6% and Health First Colorado payer mix decreased by 0.2%, while private insurance decreased by 0.6%. Between 2021 and 2022, CICP/Other grew by 0.2% and Self Pay remained the same at 3.0%. Since 2009, Health First Colorado and Medicare payer mix has increased from 42.9% to 61.3% in 2022, while private insurance has declined from 43.1% to 30.2% in 2022.

[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.
[22] Payer mix is calculated on a percent of charges.

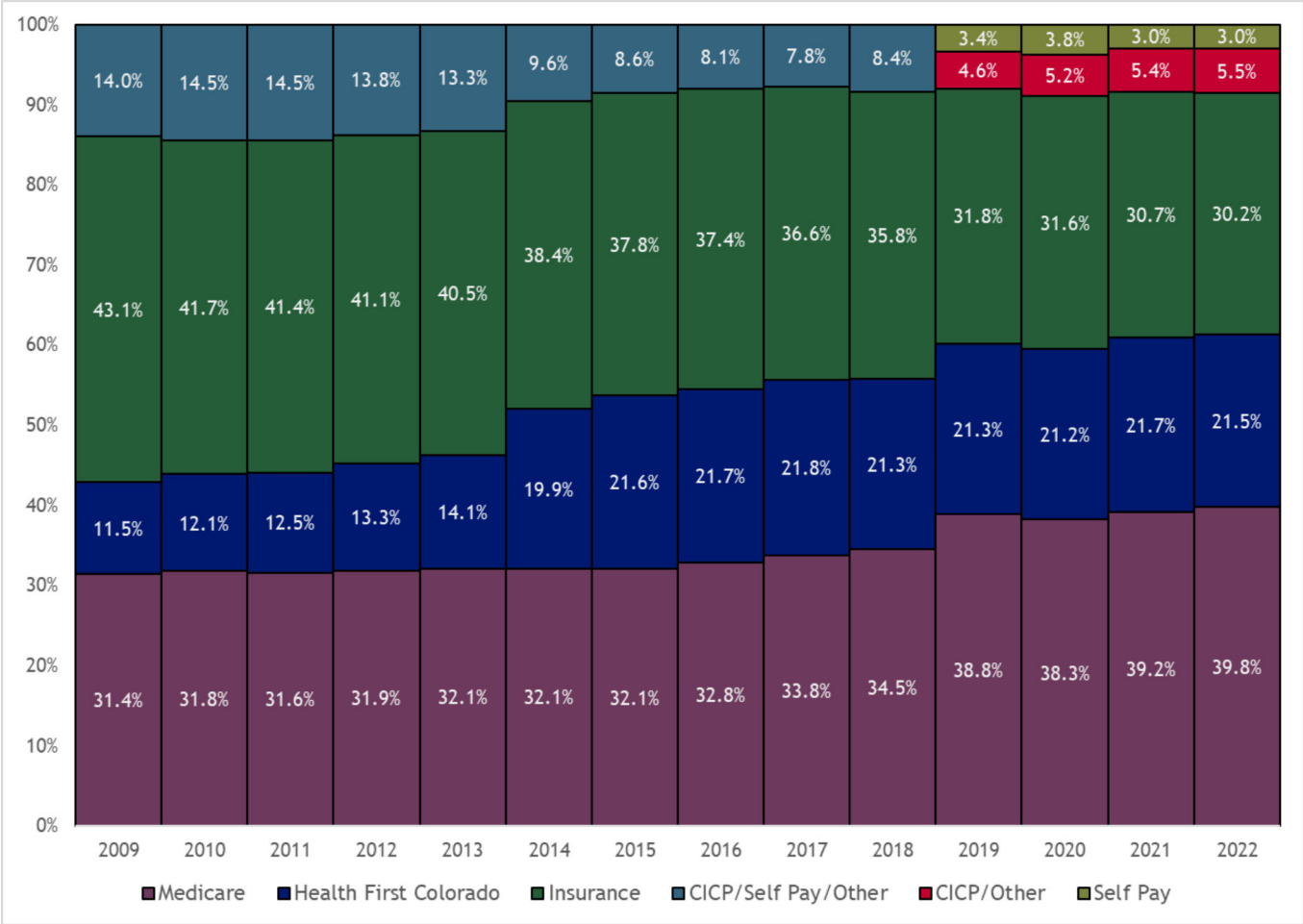


Figure 1. Payer Mix

HCPF's most recent data show cash reserves have declined from 2021 and 2020 levels. However, cash reserves in 2021 and 2020 were assisted by federal COVID-19 stimulus packages. While there has been a decrease in cash reserves, the state median of 183 in 2022 still remains above the 2019 amount of 149. A deeper analysis of cash reserves is available in the Hospital Financial Transparency Report.[23]

[23] https://hcpf.colorado.gov/hospital-reports-hub

Table 8. Hospitals Days Cash on Hand 2019 Through 2022

Hospital/System Name	Note[24]	2019 Days Cash on Hand	2020 Days Cash	2021 Days Cash	2022 Days Cash
Animas Surgical Hospital		14	116	85	36
Arkansas Valley Regl Med Ctr		98	76	153	141
Aspen Valley Hospital District		235	254	316	249
Banner Health		225	284	256	218
Boulder Community Hospital		325	403	382	267
AdventHealth		238	260	228	167
Commonspirit	‡	153	202	245	176
Children's Hospital Colorado		321	333	358	299
Colorado Canyons		103	85	88	70
Community Hospital		86	144	118	80
Delta County Memorial Hospital		82	108	71	30
Denver Health Medical Center		131	155	117	87
Estes Park Medical Center		151	196	178	96
Grand River Hospital District		154	183	201	201
Gunnison Valley Hospital		324	412	352	282
Haxtun Hospital District		87	288	189	131
Heart Of The Rockies Reg Med Center		248	272	289	255
Keefe Memorial Hospital		336	392	316	272
Kit Carson County Memorial Hospital		94	306	325	281
Kremmling Memorial Hospital District	+	33	182	185	140
Lincoln Community Hospital		22	148	123	56
Melissa Memorial Hospital		200	233	190	129
Montrose Memorial Hospital		149	251	198	201
Mt. San Rafael Hospital		120	218	220	199
National Jewish Health	*	97	106	127	111
Pagosa Springs Medical Center		72	189	177	126

[24] *2019 Hospital data from Medicare cost reports, +Updated days cash on hand from 2019 and 2020 due to more accurate data, ‡ UCHealth Commonspirit have been updated from reflecting the amount at the end of the Calendar year to the amount at the end of the System's fiscal year, matching the rest of the hospitals.

Hospital/System Name	Note[24]	2019 Days Cash on Hand	2020 Days Cash	2021 Days Cash	2022 Days Cash
Parkview Medical Center	+	195	201	205	156
Pioneers Medical Center		26	132	227	126
Prowers Medical Center		127	193	215	199
Rangely District Hospital		176	321	324	218
Rio Grande Hospital		295	375	352	395
San Luis Valley		186	235	223	100
Intermountain (formerly SCL Health)		334	411	400	343
Sedgwick County Health Center		293	317	318	235
Southeast Colorado Hospital		92	175	130	112
Southwest Memorial Hospital		79	108	117	97
Spanish Peaks Regional Health		77	149	170	276
St. Vincent General Hospital		46	43	4	6
The Memorial Hospital	*	25	100	72	68
UCHealth	‡	346	397	469	325
Vail Valley Medical Center		751	531	527	384
Valley View Hospital		251	281	340	291
Weisbrod Memorial County Hospital		145	331	223	247
Wray Community District Hospital		52	146	177	183
Yuma District Hospital		230	286	333	235
Median of all hospitals		**149**	**218**	**215**	**183**

Payer type payments are available in Figure 10, Table 18, and Table 19. From 2021 to 2022, payment increased for Health First Colorado by 11.1%, or $365.6 million. Payments for the CICP/Other category increased by 12.0%, or $119.8 million[25]. Medicare payments increased by $634.4 million, or 11.8%. As mentioned above, private insurance payments increased in 2022 by 4.1%, or $405.4 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. Overall, hospital payments have grown an average of 6.5% every year from 2009 through 2022.

[25] 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.

As displayed in Figure 11, Table 20, and Table 21, overall costs grew by 11.8% or a $2.2 billion increase between 2021 and 2022. CICP/Other saw the highest cost growth as a percentage between 2021 and 2022 with 15.0%, or a $152.0 million increase; followed by Medicare and Self Pay with an increase of 13.5% ($999.2 million) and 11.7% ($66.7 million), respectively. Medicaid saw an increase in costs by 10.9%, or $446.2 million. Private insurance saw an increase in cost with an increase of 9.7% or $562.4 million, which,when compared to the change from 2020 to 2021, was double the growth that occurred in the prior year (4.4% growth between 2020 and 2021), a higher rate of growth than any other payer.

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 being the bulk of payment less cost shifted. The difference between the positive and negative bars is reflected by the total line.

- Federal stimulus helped to bridge the difference of payment less cost between 2019 and 2021 that the reduced patient services of the COVID-19 pandemic created in 2020. Between 2019 and 2021, hospital payment less cost declined by only $91.7 million, or 8.0%.
    - Before including federal stimulus in 2020, total payment less cost (profits) equals $406.7 million.
- Between 2021 and 2022, overall payment less cost decreased by 69.1%, or a $681.2 million decrease.

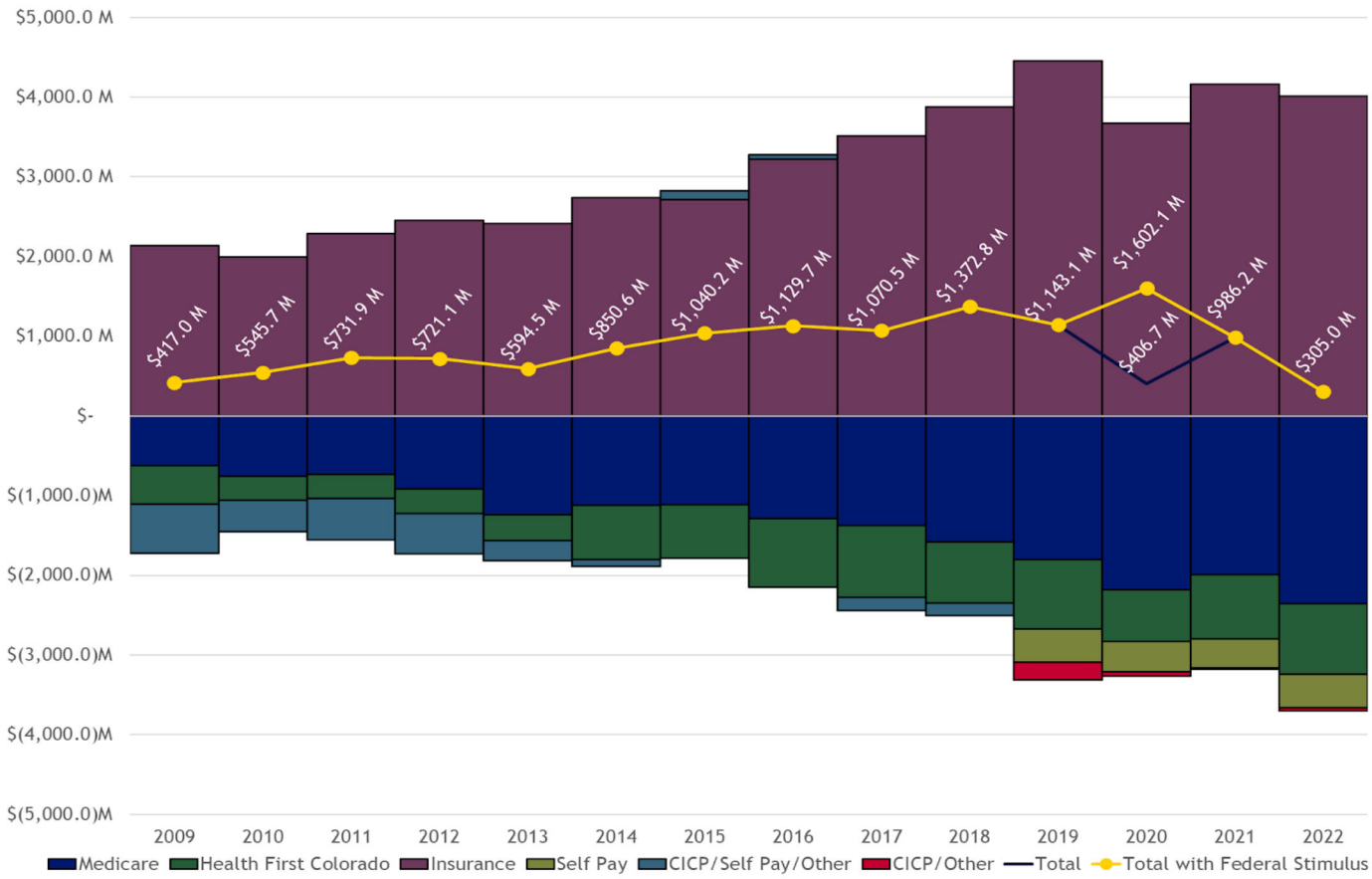


Figure 2. Payment Less Cost

Reflecting the impact of the pandemic, all payers saw a reduction in patient volume between 2019 and 2020, see Figure 13. Between 2020 and 2021, patient volume saw an increase of 7.1%. Between 2021 and 2022, patient volume has continued to rise with an increase of 3.7%, or an increase of approximately 33,000 patients. Between 2021 and 2022, Health First Colorado volume increased the most (8.4%), followed by CICP/Other (4.3%) and private insurance (3.4%). Self Pay saw an increase in patient volume between 2021 and 2022 of 3.1%. Medicare, however, only saw an increase of 0.8% in patient volume. Overall, between 2019 and 2022 patient volumes have declined 5.2%. Except for Medicaid, almost no payer type has increased beyond its 2019 volume. Even though there has been a decrease in patient volume from 2019, volumes in 2022 continue to indicate that patient volumes are returning to more typical pre-pandemic levels. With the end of the public health emergency and the disenrollment of Medicaid members ramping up in 2023, HCPF will continue to watch patient volumes as they change.

Figure 3 shows the difference between total payments and total costs on a per-patient basis, whereas Table 22 and Table 23 display these values for each payer. Before including federal stimulus, overall payment less cost per patient was $489 in 2020.

Between 2020 and 2021, there was an increase of $692 million, or 141.4%. Considering the limitations of adding total federal stimulus to the numbers, overall payment less cost per patient would have a maximum decrease of 38.7% between 2020 and 2021. Between 2021 and 2022, there was a reduction of $778 per patient or a decrease of 70.2%. This reduction was primarily due to a reduction of payment less cost per patient for private insurance payers which overall saw a decrease of $995 per patient. This decrease deviates from prior year over year upward trending. This reduction is primarily driven by increases in costs growing faster (11.8% increase) than payments (7.8% increase) between 2021 and 2022. Additionally, patient volumes increased between 2021 and 2022 by 3.7% therefore, payment less cost per patient numerator (payment less cost) decreased and the denominator (patient volume) increased resulting in an even lower payment less cost per patient. The impacts result in the lowest overall payment less cost per patient over all years of analysis.

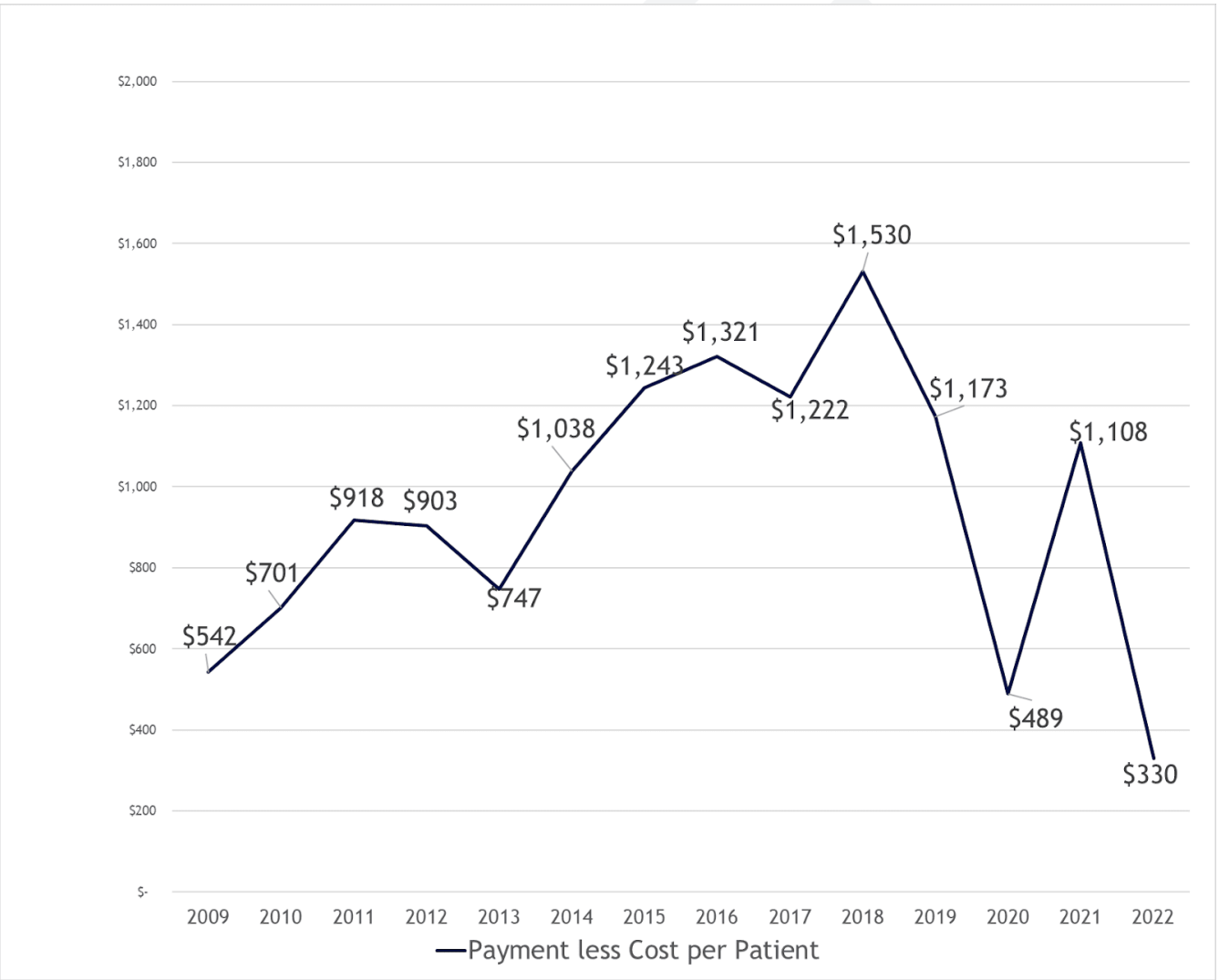


Figure 3. Total Payment Less Cost per Patient

Table 9. Payment Less Cost per Patient by Payer Group[26]

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 2022.

Table 10. Payment Less Cost Per Patient by Payer Group, Post HB 19-1001

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	($7,558)	($3,828)	$13,302	($11,284)	($891)	$330

[26] 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. 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 7.6%. Table 10's averages do not include stimulus funds and therefore the 7.6% 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 4.2%.

Table 11. 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	$23,167	$22,837	$330
Average Annual Change	5.1%	5.4%	7.6%

B. Bad Debt and Charity Care

Bad debt and charity care are costs hospitals typically write off as uncompensated care. As shown in Figure 4 and Table 11, total bad debt and charity care decreased significantly from 2013 to 2014 – the year health coverage expansion under the ACA was fully implemented. Between 2021 and 2022, there was an increase in charity care costs of $31.9 million, or 12.1%. Between 2021 and 2022, bad debt costs increased by $38.2 million, or 24.6%. Total uncompensated care costs have increased by $70.1 million or an increase of 16.7%. In 2022 total uncompensated care costs are higher than they have been before the implementation of the Affordable Care Act; 85% higher than the lowest figure of $263.9 million in 2015. Note: these figures have not been adjusted for inflation or patient volumes.

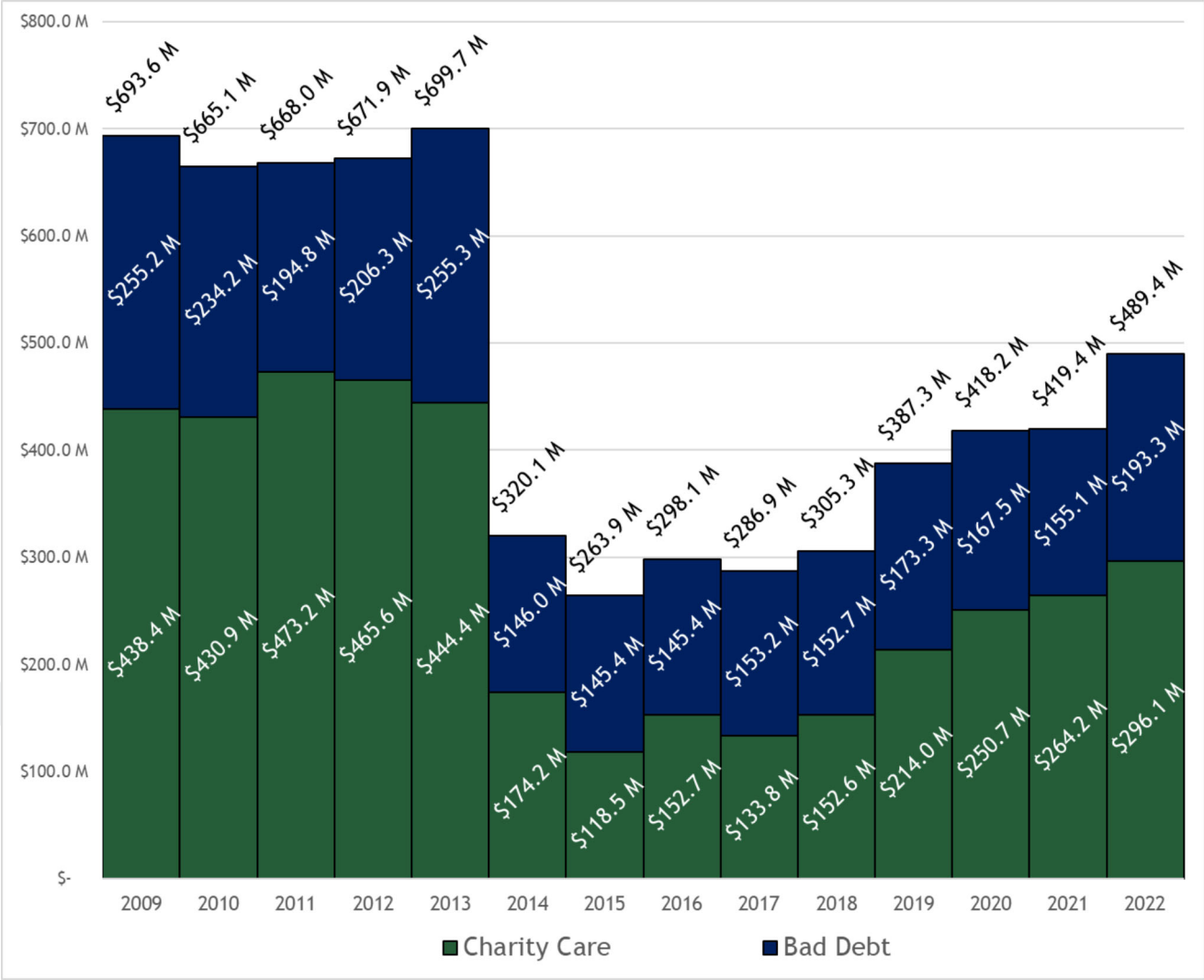


Figure 4. Bad Debt and Charity Care Costs

Table 12. 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
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	$193,313,122	$296,130,428	$489,443,550

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 three of the five-year program. Hospitals have received evaluations on their program year two, quarter ending in September 2023, interim activity and Community Health & Neighborhood Engagement (CHNE)[27] progress. 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 supports in adults with disabilities.
    - Reducing neonatal complications.
    - Screening/referral for perinatal and postpartum depression and anxiety and notification to the RAE.

[27] 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.

    - Increasing access to specialty care.
- Behavioral health/substance use disorder
    - 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. All 84 hospitals submitted their Interim Activity on time, and all 84 hospitals submitted their CHNE Activity on time, although one hospital's CHNE was deemed incomplete. This trend should continue with 95% of hospitals reporting they are on track to hit all of their milestones for program year two. This is an increase from 94% in program year one. Throughout the HTP hospitals have 5,823 different interim activities across all hospital interventions. Hospitals have also made CHNE progress under the HTP. Hospitals have reported having 2,322 consultations with key stakeholders, 440 community advisory meetings, and 163 public engagement meetings. Overall, this makes up over 2,900 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 transitions to pay for achievement, performance and improvement, the hospitals will 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. 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 99% of hospitals on track to complete program year three interventions. Progress continues to be made as HTP continues in year three 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 three milestones.
- Over 5,823 interim activities across hospital interventions.
- Over 2,925 unique Community Health & Neighborhood Engagement (CHNE) activities.
- Over 2,322 consultations with key stakeholders.
- Over 440 community advisory meetings.
- 163 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 our 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. 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.

A combination of a State Plan Amendment (SPA) and federal waiver under section 1115 of the Social Security Act 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 pandemic. 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 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(s) 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.[28] After approval, they were made available to the public, as hospitals began implementing interventions.

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. 2, 2023, HCPF notified hospitals of final scores for timeliness and completeness for the quarter ending September 2023, Interim Activity and CHNE Quarterly Reporting scores. All 84 hospitals in this reporting quarter were considered timely; 84 hospitals were considered complete for their Interim Activity reporting; and 83 hospitals were considered complete for their CHNE Activity reporting. Therefore, 83 hospitals earned the available 0.5% of at-risk funds for this quarter of reporting. One hospital's submission was considered incomplete; therefore, the hospital did not earn the available 0.5% of at-risk funds for this component of the program.

[28] 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.

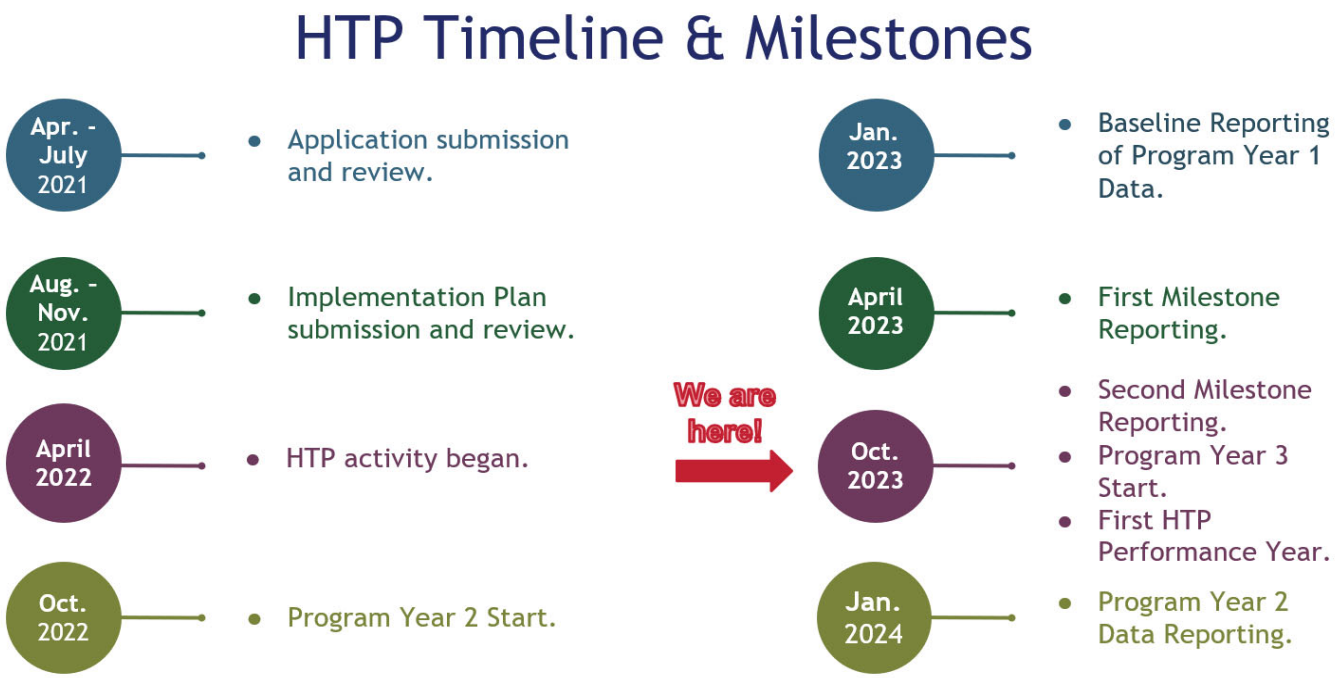


Figure 5. Hospital Transformation Program Timeline

Table 13. Year 2 Quarter ending Sept. 30, 2023, Interim and CHNE Activity Submission Achievement

Components	Scoring Criteria	Number of Hospitals
Year 2 Quarter ending Sept. 30, 2023, Reporting Submission	On Time	84
Year 2 Quarter ending Sept. 30, 2023, Reporting Submission	Late	0
Year 2 Quarter ending Sept. 30, 2023, Reporting – Interim Activity Completeness	Complete	84
Year 2 Quarter ending Sept. 30, 2023, Reporting – Interim Activity Completeness	Incomplete	0
Year 2 Quarter ending Sept. 30, 2023, Reporting – CHNE Activity Completeness	Complete	83
Year 2 Quarter ending Sept. 30, 2023, Reporting – CHNE Activity Completeness	Incomplete	1
Achievement Status	**At-risk earned**	**83**
Achievement Status	**At-risk unearned**	**1**

1. HTP Year 2 Quarter Ending September 2023 Activity Summary

During the project ramp-up and planning period of HTP, there are Interim Activity reporting periods prior to hospitals' first Milestone Activity which took place from January to March 2023. 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). Hospitals second milestone reporting took place in October 2023.

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 2 quarter ending December 2023 milestone	642
Total count of Interventions for all HTP hospitals	647

Similarly, 80 out of 84 hospitals (95% 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 June 2024 Milestones	80
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 2 Quarter ending Sept. 30, 2023 hospitals are making progress toward 1,210 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 2 Quarter Ending Sept. 30, 2023 Interim Activity Progress

Program Year 2 Quarter Ending Sept. 30, 2023 Interim Activity Progress	Number of Activities
Interim Activities Reported: People Functional Area	279
Interim Activities Reported: Process Functional Area	408
Interim Activities Reported: Technology Functional Area	328
Interim Activities Reported: Patient Engagement Functional Area	195
Total Planning & Implementation Activities Reported	**1,210**

2. Program Year Two Quarter Ending Sept. 30, 2023, 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 two quarter ending Sept. 30, 2023, Submissions of Excellence demonstrated the following criteria:

- Interim Activity Submissions of Excellence
  - Robust, detailed answers were provided that effectively communicated hospital progress towards the upcoming milestone.
  - As a part of the Planning and Implementation Phase, all functional areas were addressed in the upcoming milestone that aligned with the hospital's Implementation Plan. For example, a hospital Implementation Plan may indicate its upcoming milestone will address the Process and Technology functional area. During the quarter ending Sept. 30, 2023, Interim Activity Reporting, the hospital provided sufficient detail and addressed both Process and Technology functional areas.

        - Where progress in the current quarter was not made, the hospital still addressed the functional area and provided future plans and anticipated start dates.
    - 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, 2023. Additionally, they are making progress towards

meeting their program year two annual reporting requirements. With over 500 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.

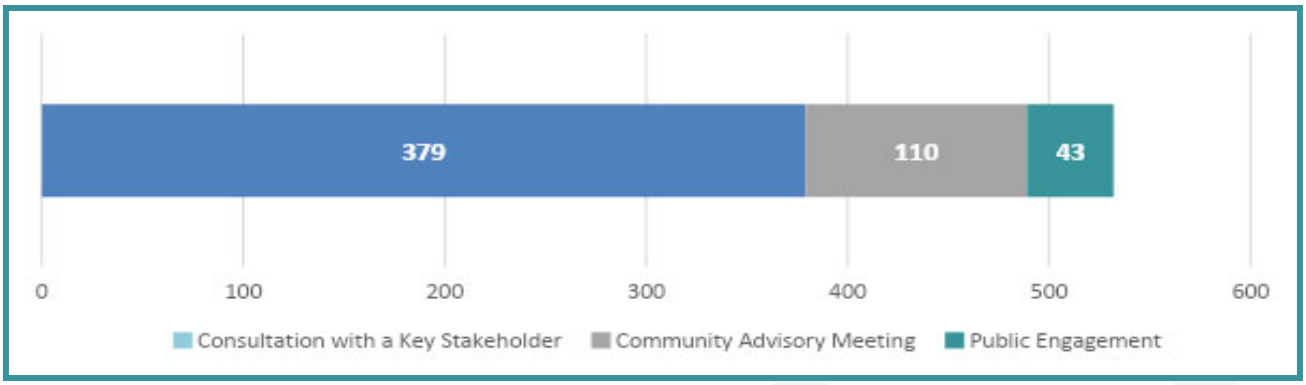


Figure 6. Program Year 2 Quarter Ending Sept. 30, 2023, CHNE Activities Reported

Table 17. Average CHNE Engagement Reported per Hospital

CHNE Component	Average CHNE Engagement Reported per Hospital
Consultation with Key Stakeholder	4.80
Community Advisory Meeting	1.64
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 2 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** Broomfield Behavioral Health Coalition, Morgan County Health Department, Summit County Public Health.
- **Behavioral Health Providers**, such as Broomfield Community Service Network, Southeast Health Group, and Your Hope Center Crisis Services.

- **Community Health Centers** (including Federally Qualified Health Centers and rural health centers), such as Cedar Point Health, Clinica, Marisol Health, Access Health Connections (formerly PAC), and Salud.
- **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 Northwest Colorado RETAC, Rocky Mountain Health Plans, and South Eastern RETAC.
- **Long-Term Service and Support** (LTSS) Providers, such as Broomfield Senior Services, Flatirons SNF, and Orchard Park Health Care Center.
- **Consumer advocates or advocacy organizations**, such as Colorado Health Institute-MDPH S-HIE Implementation Workgroup.
- **Health alliances**, such as St. Mary Corwin and Western Healthcare Alliance.
- **Community organizations addressing social determinants of health**, such as Cedar Point Health, Colorado Coalition for the Homeless, Coal Creek Meals on Wheels, La Plata County Office of Emergency Management, Zero Suicide Colorado Monthly Learning Collaborative.
- **Other, such as Department of Housing Stability (HOST), Meeker Fire & Rescue, and Pitkin County Human Services.**

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, 2023:

- 79 out of 84 hospitals reported at least one consultation with a key stakeholder.
- In total, hospitals reported 379 consultations with key stakeholders.
- There was stakeholder engagement with over 200 unique organizations.[31] While the majority of hospitals reported less than 10 consultations each, there were several hospitals that exceeded that frequency of reporting. Noticeably, the top five reporting hospitals are the following: Vail Health Hospital, 14; Pikes Peak Regional Hospital, 9; Wray Community District Hospital, 18; Centura Avista Adventist Hospital, 12; University of Colorado Hospital, 10.

[30] The following hospitals did not report a consultation with key stakeholder this quarter, but did report a community advisory meeting this quarter: *49-Good Samaritan Medical Center, 11-Gunnison Valley Health, 64-Mt. San Rafael Hospital, 74-Platte Valley Medical Center*
[31] Since several consultations were noted to be reoccurring, the actual number of meetings held this quarter may be far greater.

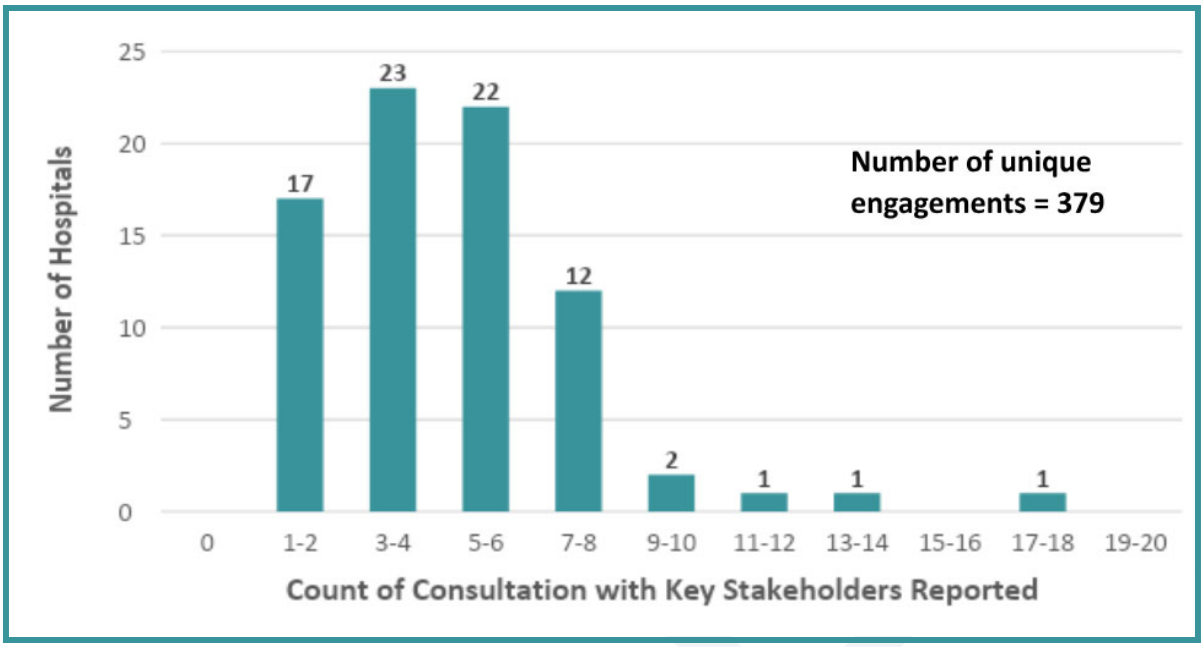


Figure 7. Number of Unique Engagements Reported by Each Hospital- Consultation with Key Stakeholders

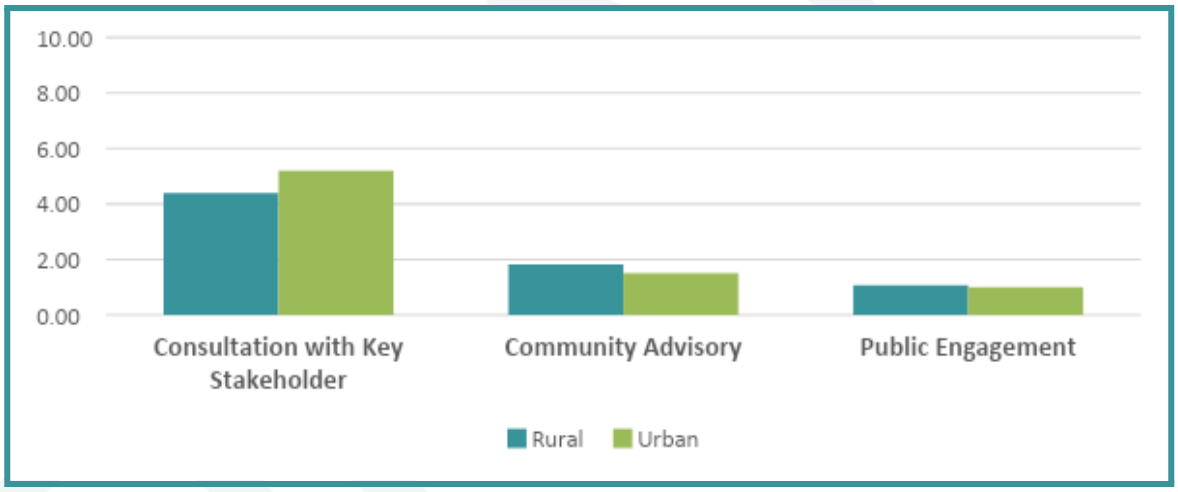


Figure 8. Rural vs Urban Comparison of Average Engagement per Hospital

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, 2023:

- Hospitals reported 110 community advisory meetings.
- 67 out of 84, or 80% 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. 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, 2023:

- Hospitals reported 43 public engagements.
- 42 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, "Based upon community feedback, which was supportive of our current efforts, our hospital will continue to move upstream into people's life experiences; focus on systemic issues; and, leverage our strengths statewide to have a greater impact."
- One hospital noted, "Based upon community feedback, which was supportive of our current efforts, our hospital will continue to move upstream into people's life experiences; focus on systemic issues; and, leverage our strengths statewide to have a greater impact."
- 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,

[32] Since several community advisory meetings were noted to be reoccurring, 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.

including increasing the availability for follow-up or outpatient behavioral health services, and increasing training to responding 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. Meetings are set to resume in January 2024 where the CAC will discuss how to best proceed. If membership has increased the CAC will host internal discussions about potential action plans to ensure the needs of individuals and communities are being met and best served by HTP initiatives. Additional information about the CAC can be found in a Department memo[33] and on the council's webpage.[34]

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

3. Continued Progress of the HTP

Over the course of this five-year program, the 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. The HTP is currently in its first 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 2023 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.

HCPF is aware that some hospitals have noted several setbacks throughout the HTP and are considering different mitigation strategies. In program year 2 quarter ending September 2023, many hospitals were responsible for reporting on Continuous Learning and Improvement in their Interim Activity Report for the first time following their impact milestones in the program year 2, quarter ending June 30, 2023 reporting period. Some hospitals experienced technical issues in reporting due to this shift, such as entering responses in an incorrect field. Several hospitals requested survey retake links and were provided the opportunity to revise surveys due to user error.

While the goal is for all hospitals to be on target, HCPF is aware that situations arise, and progress is not linear. Thus, as there are several quarters prior to hospitals having to demonstrate achievement, early interventions and continued Department support should help to alleviate problems as HTP progresses. HCPF anticipates that delivery system changes on this scale will continue to be met with unforeseen challenges.

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 two, on June 8 and 9, 2023, HCPF held the first 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, 83 of 84 hospitals (98.81%) were represented at the learning symposium.[35] 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 was 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 HTP Learning Symposium. Based on hospital survey results, the content covered at the learning symposium included the following topics.

- Data and IT Reporting
    - specifically for clinicians, quality workers, IT workers
    - reporting to Regional Accountable Entities (RAEs)
- Hospital Interventions
    - Social Determinants of Health (SDoH) measures
    - Behavioral Health (BH) measures
    - workflow best practices
- Continuous Learning and Improvement
    - urban and rural hospital breakout sessions
- Community Health and Neighborhood Engagement
    - public input meeting best practices
    - community organization outreach opportunities
- National Strategy Alignment
    - keynote speakers
    - hospital staff resiliency and celebration of current success

The second annual HTP learning symposium is being held June 4 and 5, 2024 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 2024 learning symposium. Based on the hospital's responses the learning symposium will focus on the following topics.

[35] Animas Surgical Hospital did not have any representative attend in- person or virtually.

- 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

I. Rural Support Fund

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. 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 2022-23 were disbursed in monthly installments as part of the CHASE fee and supplemental payment program. To date, each qualified hospital has received $1,043,478 for the first two years of the program.

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 second program year which ran from October 2022 through September 2023. 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 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.

For More Information

For more information about CHASE, please contact Nancy.Dolson@state.co.us.

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 Hospital	El Paso	$0	$0	$0	$0	$0	$0	$0	$0	$0
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0	$0	$0	$0	$0	$0
Clear View Behavioral Health	Larimer	$0	$0	$0	$0	$0	$0	$0	$0	$0
Colorado Mental Health Institute Fort Logan	Denver	$0	$0	$0	$0	$0	$0	$0	$0	$0
Colorado Mental Health Institute Pueblo	Pueblo	$0	$0	$0	$0	$0	$0	$0	$0	$0
Craig Hospital	Arapahoe	$0	$49,050	$109,619	$0	$0	$4,954	$0	$163,623	$163,623
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	$52,650	$0	$0	$0	$192,943	$0	$245,593	$245,593
Kindred Hospital - Aurora	Adams	$0	$113,415	$0	$0	$0	$0	$0	$113,415	$113,415
Kindred Hospital - Denver	Denver	$0	$97,320	$0	$0	$0	$0	$0	$97,320	$97,320
PAM Specialty Hospital of Denver	Denver	$0	$129,105	$0	$0	$0	$0	$0	$129,105	$129,105
Peak View	El Paso	$0	$0	$0	$0	$0	$0	$0	$0	$0

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Behavioral Health										
Northern Colorado Long Term Hospital	Larimer	$0	$20,175	$0	$0	$0	$0	$0	$20,175	$20,175
Northern Colorado Rehabilitation Hospital	Weld	$0	$19,755	$4,008	$0	$0	$0	$0	$23,763	$23,763
Rehabilitation Hospital of Colorado Springs	El Paso	$0	$70,005	$9,989	$0	$0	$83,025	$0	$163,019	$163,019
Spalding Rehabilitation Hospital	Adams	$0	$47,190	$6,266	$0	$0	$0	$0	$53,456	$53,456
Vibra Hospital of Denver	Adams	$0		$0	$0	$0	$0	$0	$139,500	$139,500
Vibra Rehabilitation Hospital of Denver	Adams	$0	$65,370	$0	$0	$0	$0	$0	$65,370	$65,370
Reunion Rehabilitation Hospital - Denver	Denver	$0	$0	$0	$0	$0	$0	$0	$0	$0
West Springs Hospital	Mesa	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	-	$0	$803,535	$129,882	$0	$0	$280,922	$0	$1,214,339	$1,214,339

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

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Animas Surgical Hospital	La Plata	$1,368,317	$19,600	$2,009,200	$588,235	$0	$21,919	$0	$2,638,954	$1,270,637
Arkansas Valley Regional Medical Center	Otero	$1,602,619	$1,193,400	$5,809,503	$588,235	$0	$200,293	$0	$7,791,431	$6,188,812
Aspen Valley Hospital	Pitkin	$1,875,710	$294,525	$1,566,965	$588,235	$0	$75,778	$333,465	$2,858,968	$983,258
Banner Fort Collins Medical Center	Larimer	$2,153,828	$1,080,240	$1,951,162	$0	$0	$879,607	$1,717,394	$5,628,403	$3,474,575
Broomfield Hospital	Jefferson	$4,057,011	$1,650,320	$1,885,539	$0	$0	$483,420	$0	$4,019,279	-$37,732
Centura Avista Adventist Hospital	Boulder	$11,513,426	$9,513,455	$9,953,878	$0	$0	$2,363,352	$0	$21,830,685	$10,317,259
Centura Castle Rock Adventist Hospital	Douglas	$8,546,440	$1,633,520	$2,377,242	$0	$0	$688,510	$0	$4,699,272	-$3,847,168
Centura Littleton Adventist Hospital	Arapahoe	$22,456,704	$10,121,850	$11,638,478	$0	$0	$520,216	$0	$22,280,544	-$176,160
Centura Longmont United Hospital	Boulder	$11,416,885	$2,601,760	$4,253,849	$0	$0	$1,421,683	$6,193,957	$14,471,249	$3,054,364
Centura Mercy	La Plata	$12,925,708	$3,843,700	$13,382,560	$0	$0	$577,947	$0	$17,804,207	$4,878,499

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Hospital										
Centura Parker Adventist Hospital	Douglas	$21,639,167	$10,583,905	$15,403,581	$0	$0	$1,168,785	$0	$27,156,271	$5,517,104
Centura Penrose-St. Francis Hospital	El Paso	$65,491,448	$47,182,455	$46,978,667	$0	$0	$6,709,207	$0	$100,870,329	$35,378,881
Centura Porter Adventist Hospital	Denver	$23,662,679	$4,693,360	$4,779,606	$0	$0	$1,253,301	$0	$10,726,267	-$12,936,412
Centura St. Anthony Hospital	Jefferson	$33,870,351	$8,687,280	$6,583,547	$0	$0	$1,458,369	$0	$16,729,196	-$17,141,155
Centura St. Anthony North Hospital	Broomfield	$17,569,454	$4,850,720	$7,052,064	$0	$0	$2,207,757	$0	$14,110,541	-$3,458,913
Centura St. Anthony Summit Hospital	Summit	$4,208,545	$937,300	$4,984,676	$0	$0	$606,333	$0	$6,528,309	$2,319,764
Centura St. Elizabeth Hospital	Morgan	$3,880,456	$904,400	$4,653,128	$0	$0	$469,914	$0	$6,027,442	$2,146,986
Centura St. Mary-Corwin Hospital	Pueblo	$10,947,886	$1,240,960	$8,043,548	$0	$0	$981,466	$0	$10,265,974	-$681,912
Centura St. Thomas More Hospital	Fremont	$3,170,008	$1,471,400	$7,340,228	$588,235	$0	$446,874	$0	$9,846,737	$6,676,729
Children's Hospital Anschutz	Adams	$39,178,082	$26,067,210	$12,535,854	$0	$0	$7,620,962	$22,603,600	$68,827,626	$29,649,544
Children's Hospital Colorado Springs	El Paso	$13,406,028	$8,507,154	$2,162,984	$0	$0	$2,085,411	$2,474,398	$15,229,947	$1,823,919

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Community Hospital	Mesa	$8,892,154	$1,603,840	$3,008,865	$0	$0	$656,525	$3,607,686	$8,876,916	-$15,238
Conejos County Hospital	Conejos	$334,596	$77,000	$2,347,903	$588,235	$521,739	$134,552	$0	$3,669,429	$3,334,833
Delta County Memorial Hospital	Delta	$4,427,246	$1,786,275	$7,323,112	$0	$0	$463,612	$0	$9,572,999	$5,145,753
Denver Health Medical Center	Denver	$40,642,422	$74,662,920	$6,320,069	$0	$0	$7,047,096	$43,452,837	$131,482,922	$90,840,500
East Morgan County Hospital	Morgan	$903,238	$772,650	$3,625,875	$588,235	$521,739	$921,339	$0	$6,429,838	$5,526,600
Estes Park Health	Larimer	$1,157,646	$316,200	$3,641,324	$588,235	$0	$0	$0	$4,545,759	$3,388,113
Family Health West	Mesa	$1,645,768	$14,000	$2,983,520	$588,235	$0	$28,979	$5,293	$3,620,027	$1,974,259
Foothills Hospital	Boulder	$24,996,987	$8,646,400	$16,195,193	$0	$0	$924,382	$0	$25,765,975	$768,988
Good Samaritan Medical Center	Boulder	$21,496,814	$4,701,200	$3,846,329	$0	$0	$1,988,123	$0	$10,535,652	-$10,961,162
Grand River Health	Garfield	$1,853,018	$210,375	$2,418,717	$588,235	$0	$159,762	$3,202,919	$6,580,008	$4,726,990
Grandview Hospital	El Paso	$2,842,944	$284,480	$2,485,453	$0	$0	$786,688	$0	$3,556,621	$713,677
Greeley Hospital	Weld	$8,593,117	$2,239,054	$4,083,727	$0	$0	$1,767,264	$5,920,404	$14,010,449	$5,417,332
Gunnison Valley Health	Gunnison	$1,483,217	$141,525	$1,597,439	$588,235	$0	$167,280	$857,853	$3,352,332	$1,869,115
Haxtun Health	Phillips	$151,897	$33,150	$685,269	$588,235	$521,739	$0	$0	$1,828,393	$1,676,496
Heart of the Rockies Medical Center	Chaffee	$2,821,799	$1,049,325	$6,359,272	$588,235	$0	$66,263	$0	$8,063,095	$5,241,296

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Highlands Ranch Hospital	Adams	$8,128,135	$4,214,050	$9,098,913	$0	$0	$984,344	$0	$14,297,307	$6,169,172
Keefe Memorial Hospital	Cheyenne	$107,754	$72,675	$698,863	$588,235	$521,739	$11,562	$0	$1,893,074	$1,785,320
Kit Carson County Memorial Hospital	Kit Carson	$539,375	$260,100	$1,930,907	$588,235	$521,739	$203,540	$0	$3,504,521	$2,965,146
Lincoln Community Hospital	Lincoln	$415,597	$126,225	$1,581,590	$588,235	$521,739	$9,978	$0	$2,827,767	$2,412,170
Longs Peak Hospital	Weld	$9,439,898	$2,501,520	$3,616,097	$0	$0	$1,805,296	$5,638,663	$13,561,576	$4,121,678
Lutheran Medical Center	Jefferson	$35,954,512	$23,316,840	$26,109,007	$0	$0	$3,750,378	$0	$53,176,225	$17,221,713
McKee Medical Center	Larimer	$8,896,054	$1,620,640	$4,689,414	$0	$0	$896,685	$3,091,260	$10,297,999	$1,401,945
Medical Center of the Rockies	Larimer	$28,544,714	$5,148,640	$6,831,554	$0	$0	$1,798,536	$10,838,669	$24,617,399	-$3,927,315
Melissa Memorial Hospital	Phillips	$434,688	$112,200	$1,293,689	$588,235	$521,739	$66,199	$0	$2,582,062	$2,147,374
Memorial Hospital	El Paso	$62,572,701	$25,052,500	$6,398,024	$0	$0	$8,280,116	$33,512,307	$73,242,947	$10,670,246
Middle Park Medical Center	Grand	$918,524	$94,350	$3,458,766	$588,235	$521,739	$30,022	$0	$4,693,112	$3,774,588
Montrose Regional Health	Montrose	$7,599,023	$1,528,725	$5,356,688	$0	$0	$1,130,911	$3,387,027	$11,403,351	$3,804,328
Mt. San Rafael Hospital	Las Animas	$1,123,721	$280,000	$4,766,283	$588,235	$0	$268,115	$0	$5,902,633	$4,778,912

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
National Jewish Health	Denver	$5,033,410	$25,200	$6,933,740	$0	$0	$66,708	$1,074,116	$8,099,764	$3,066,354
North Colorado Medical Center	Weld	$24,652,728	$11,217,360	$10,073,760	$0	$0	$4,314,387	$14,921,208	$40,526,715	$15,873,987
North Suburban Medical Center	Adams	$30,817,233	$9,313,360	$8,407,146	$0	$0	$1,788,125	$9,367,256	$28,875,887	-$1,941,346
OrthoColorado Hospital	Jefferson	$3,557,529	$0	$465,204	$0	$0	$0	$0	$465,204	-$3,092,325
Pagosa Springs Medical Center	Archuleta	$987,795	$186,150	$2,819,612	$588,235	$521,739	$171,806	$0	$4,287,542	$3,299,747
Parkview Medical Center	Pueblo	$48,656,503	$36,915,200	$30,347,673	$0	$0	$4,263,574	$0	$71,526,447	$22,869,944
Pikes Peak Regional Hospital	Teller	$1,052,341	$133,000	$3,491,752	$588,235	$521,739	$201,518	$0	$4,936,244	$3,883,903
Pioneers Medical Center	Rio Blanco	$431,075	$66,300	$469,948	$588,235	$521,739	$2,460	$0	$1,648,682	$1,217,607
Platte Valley Medical Center	Adams	$8,441,483	$3,529,120	$5,122,871	$0	$0	$1,600,788	$6,256,629	$16,509,408	$8,067,925
Poudre Valley Hospital	Larimer	$39,864,610	$8,823,650	$2,757,779	$0	$0	$4,525,692	$13,748,806	$29,855,927	-$10,008,683
Presbyterian -St. Luke's Medical Center	Denver	$44,426,744	$37,568,730	$28,269,581	$0	$0	$2,059,374	$0	$67,897,685	$23,470,941
Prowers Medical Center	Prowers	$942,554	$877,200	$6,006,621	$588,235	$0	$955,503	$0	$8,427,559	$7,485,005

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Rangely District Hospital	Rio Blanco	$136,328	$10,200	$738,932	$588,235	$521,739	$0	$0	$1,859,106	$1,722,778
Rio Grande Hospital	Rio Grande	$733,553	$201,600	$2,206,414	$588,235	$521,739	$31,151	$0	$3,549,139	$2,815,586
Rose Medical Center	Denver	$34,837,837	$17,128,555	$16,012,108	$0	$0	$2,131,314	$0	$35,271,977	$434,140
San Luis Valley Health Medical Center	Alamosa	$5,387,723	$2,045,400	$10,899,353	$0	$0	$1,256,666	$0	$14,201,419	$8,813,696
Sedgwick County Health Center	Sedgwick	$284,733	$77,775	$878,810	$588,235	$521,739	$7,041	$0	$2,073,600	$1,788,867
Sky Ridge Medical Center	Douglas	$46,553,115	$11,551,375	$10,631,118	$0	$0	$1,372,104	$0	$23,554,597	-$22,998,518
Southeast Colorado Hospital	Baca	$306,448	$110,925	$1,331,412	$588,235	$521,739	$70,575	$0	$2,622,886	$2,316,438
Southwest ystem	Montezuma	$1,874,758	$1,923,975	$7,612,883	$588,235	$521,739	$736,465	$0	$11,383,297	$9,508,539
Spanish Peaks Regional Health Center	Huerfano	$252,285	$141,525	$2,413,663	$588,235	$521,739	$35,985	$0	$3,701,147	$3,448,862
St. Joseph Hospital	Denver	$37,480,146	$29,135,935	$20,934,218	$0	$0	$5,501,387	$0	$55,571,540	$18,091,394
St. Mary's Medical Center	Mesa	$30,442,412	$14,900,935	$11,852,999	$0	$0	$1,864,700	$12,285,581	$40,904,215	$10,461,803
St. Vincent Hospital	Lake	$232,445	$87,975	$1,505,654	$588,235	$521,739	$0	$0	$2,703,603	$2,471,158
Sterling Regional MedCenter	Logan	$2,235,668	$751,100	$5,775,018	$588,235	$521,739	$1,164,072	$0	$8,800,164	$6,564,496

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Swedish Medical Center	Arapahoe	$65,622,460	$38,591,755	$28,662,205	$0	$0	$2,407,681	$0	$69,661,641	$4,039,181
The Medical Center of Aurora	Arapahoe	$52,057,742	$29,576,940	$31,513,190	$0	$0	$1,343,406	$0	$62,433,536	$10,375,794
The Memorial Hospital	Moffat	$1,382,644	$559,725	$6,173,980	$588,235	$521,739	$0	$0	$7,843,679	$6,461,035
University of Colorado Hospital	Adams	$120,652,721	$63,086,620	$62,417,830	$0	$0	$11,799,341	$28,376,590	$165,680,381	$45,027,660
Vail Health Hospital	Eagle		$747,600	$7,071,716	$0	$0	$347,509	$0	$8,166,825	$2,224,518
Valley View Hospital	Garfield	$8,631,645	$2,610,300	$4,516,964	$0	$0	$579,566	$10,641,359	$18,348,189	$9,716,544
Weisbrod Memorial County Hospital	Kiowa	$85,109	$7,650	$600,837	$588,235	$521,739	$0	$0	$1,718,461	$1,633,352
Wray Community District Hospital	Yuma	$549,143	$462,825	$2,180,380	$588,235	$521,739	$298,920	$0	$4,052,099	$3,502,956
Yampa Valley Medical Center	Routt	$3,169,863	$717,500	$5,956,802	$0	$0	$609,529	$559,681	$7,843,512	$4,673,649
Yuma District Hospital	Yuma	$478,181	$163,200	$2,334,387	$588,235	$521,739	$133,824	$0	$3,741,385	$3,263,204
Total	-	$1,230,051,582	$631,192,033	$667,484,681	$19,999,990	$11,999,997	$118,229,822	$244,068,958	$1,692,975,481	$462,923,899

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Total (All Hospitals)	-	$1,230,051,582	$631,995,568	$667,614,563	$19,999,990	$11,999,997	$118,510,744	$244,068,958	$1,694,189,820	$464,138,238

B. Cost Shift

1. Payment to Cost Ratio by Payer Group

Figure 9 is a visual display of payment to cost ratios by payer group from 2009 to 2022.

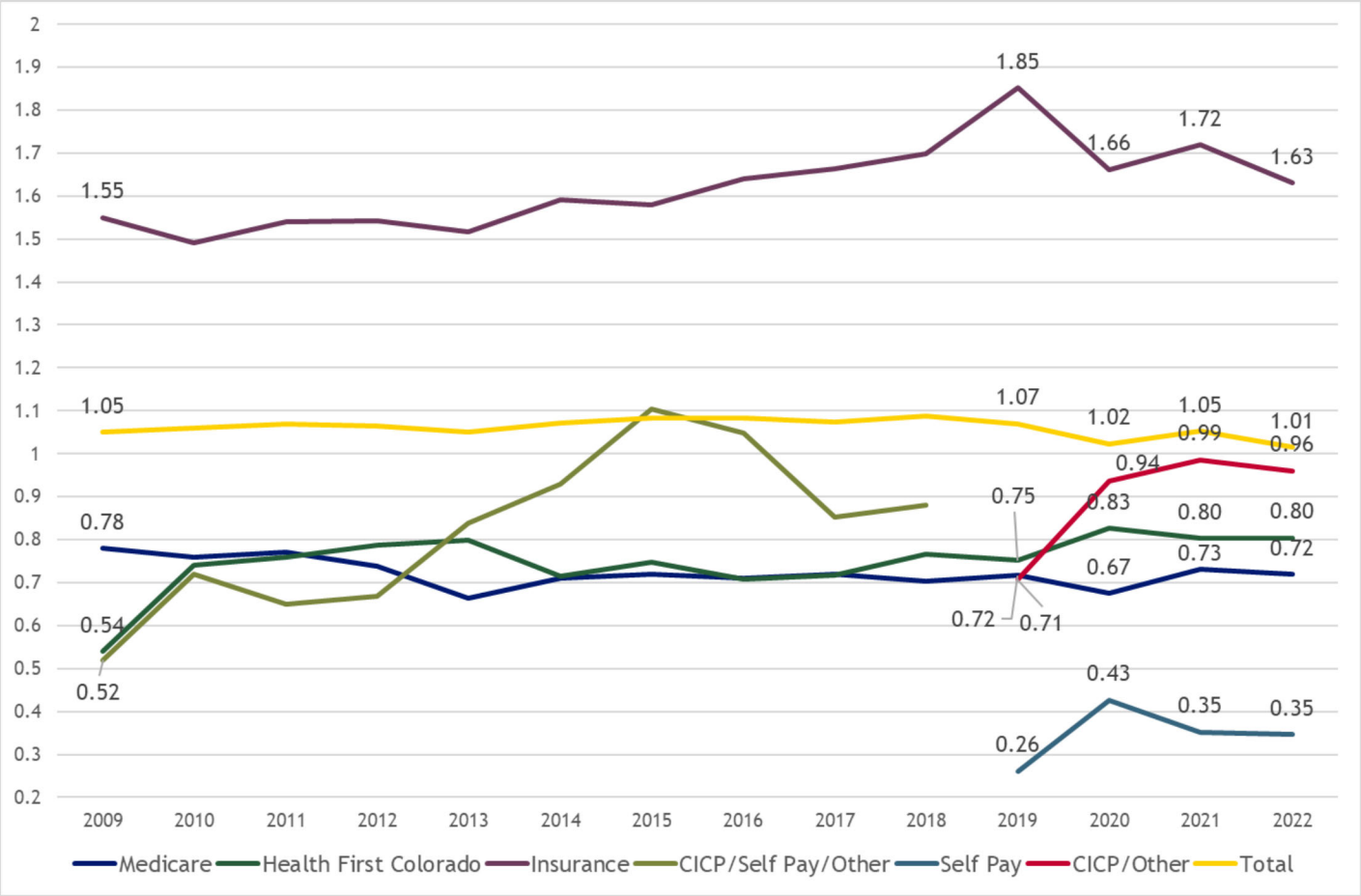


Figure 9. Payment to Cost Ratio by Payer Group

2. Payment, Cost by Payer Group

Figure 10 shows the total payments by payer from 2009 to 2022. The figure highlights figures from the first year and the two most recent years. Table 18 and Table 19 displays the total hospital payments by payer group from 2009 to 2022.

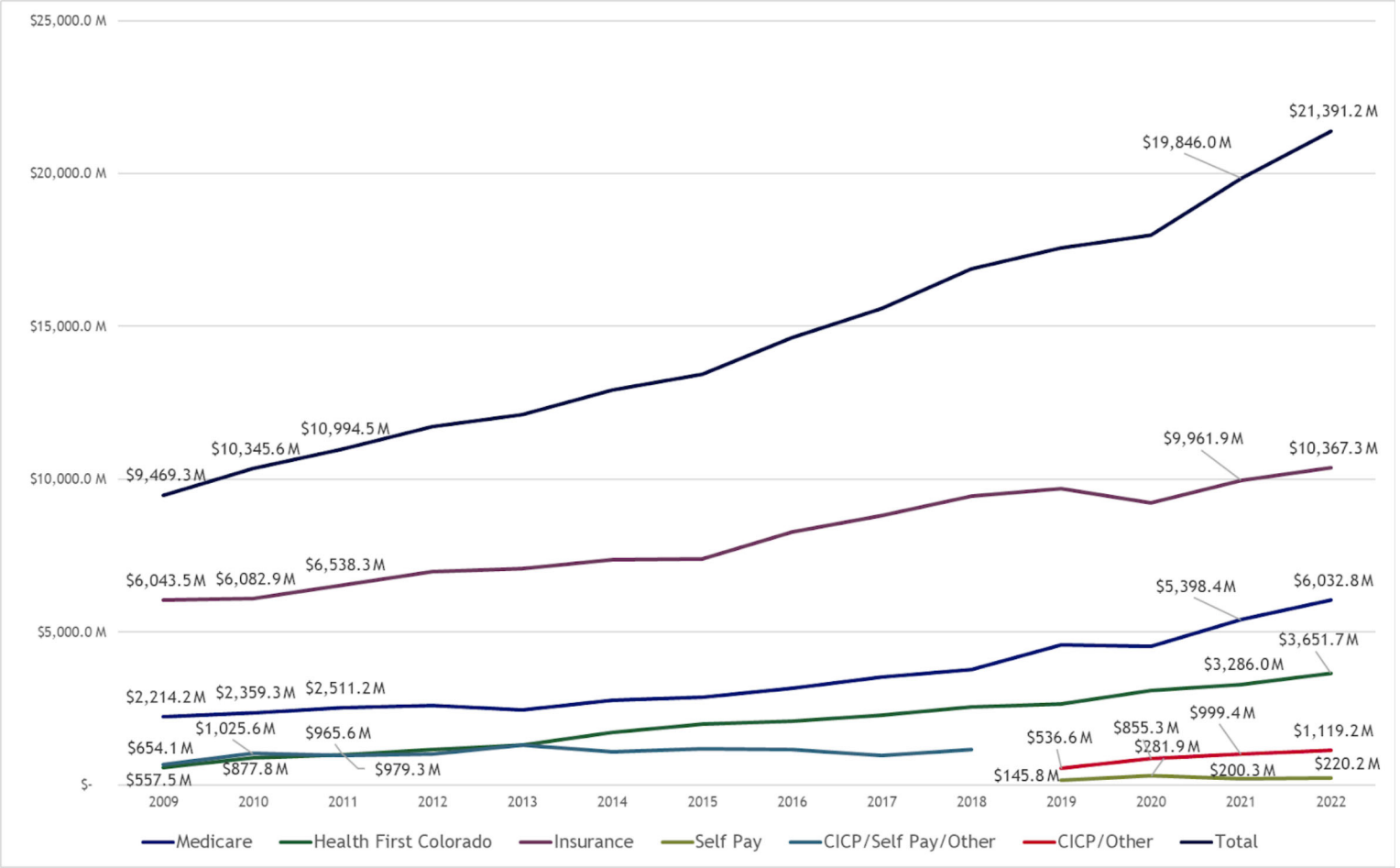


Figure 10. Total Payments by Payer Group

Table 20. 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 21. 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	$6,032,799,151	$3,651,662,572	$10,367,338,446	$220,204,167	$1,119,236,382	$21,391,240,717

Figure 11 shows costs from 2009 to 2022. Table 20 and Table 21 show the total costs by payer from 2009 through 2022.

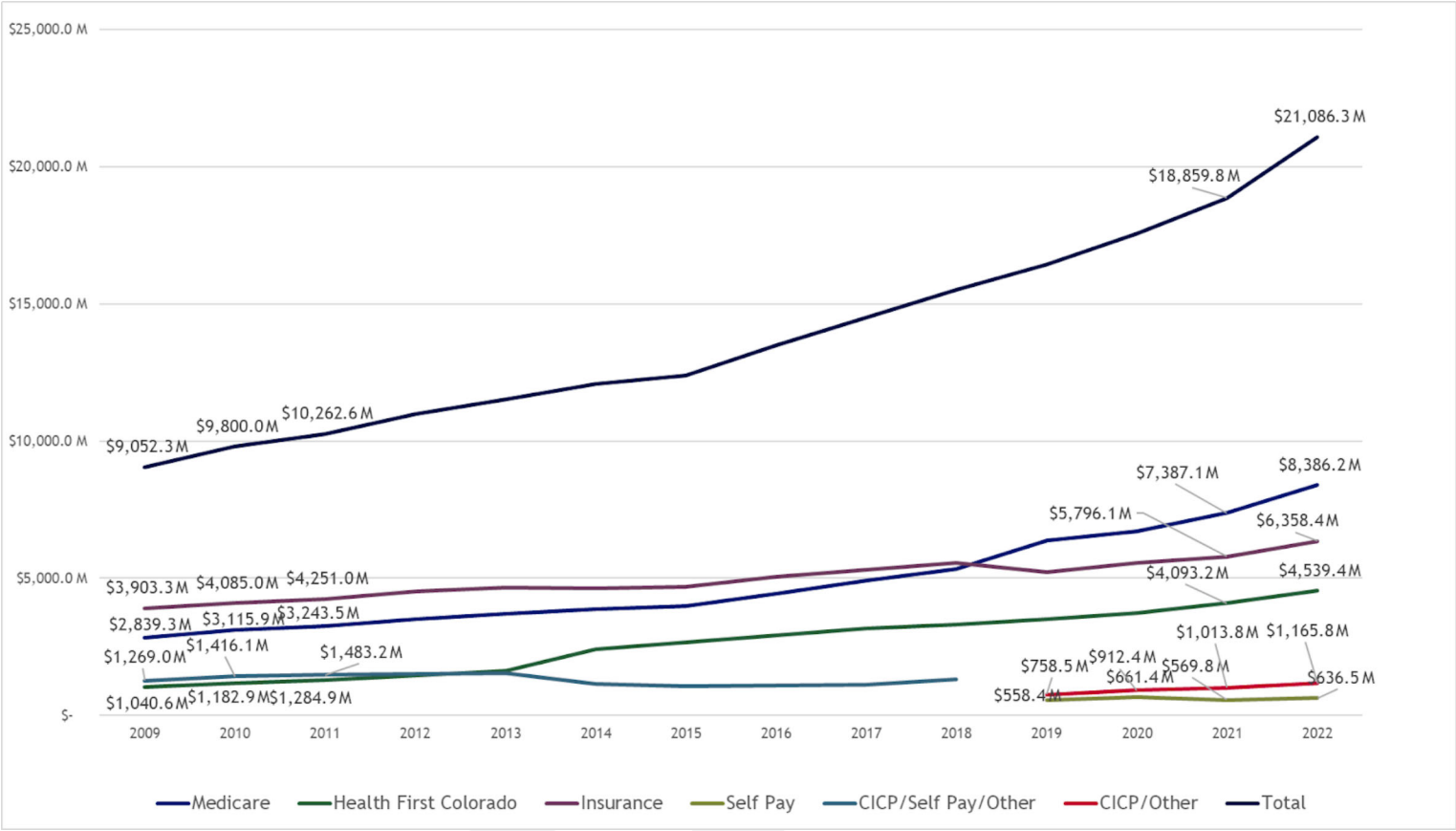


Figure 11. Total Costs by Payer Group

Table 22. 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 23. Total Costs by Payer Group, Post HB 19-1001

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	$7,361,512,667	$4,079,013,236	$5,776,011,485	$567,825,290	$1,010,247,637	$18,794,610,315
2022	$8,386,215,775	$4,539,380,455	$6,358,422,706	$636,492,546	$1,165,778,896	$21,086,290,378

Table 24. 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 25. Payment Less Cost by Payer Group, Post HB 19-1001

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
2021	($1,963,141,570)	($792,968,174)	$4,185,878,245	($367,525,797)	($10,853,575)	$1,051,389,128
2022	($2,353,416,624)	($887,717,883)	$4,008,915,740	($416,288,379)	($46,542,514)	$304,950,340

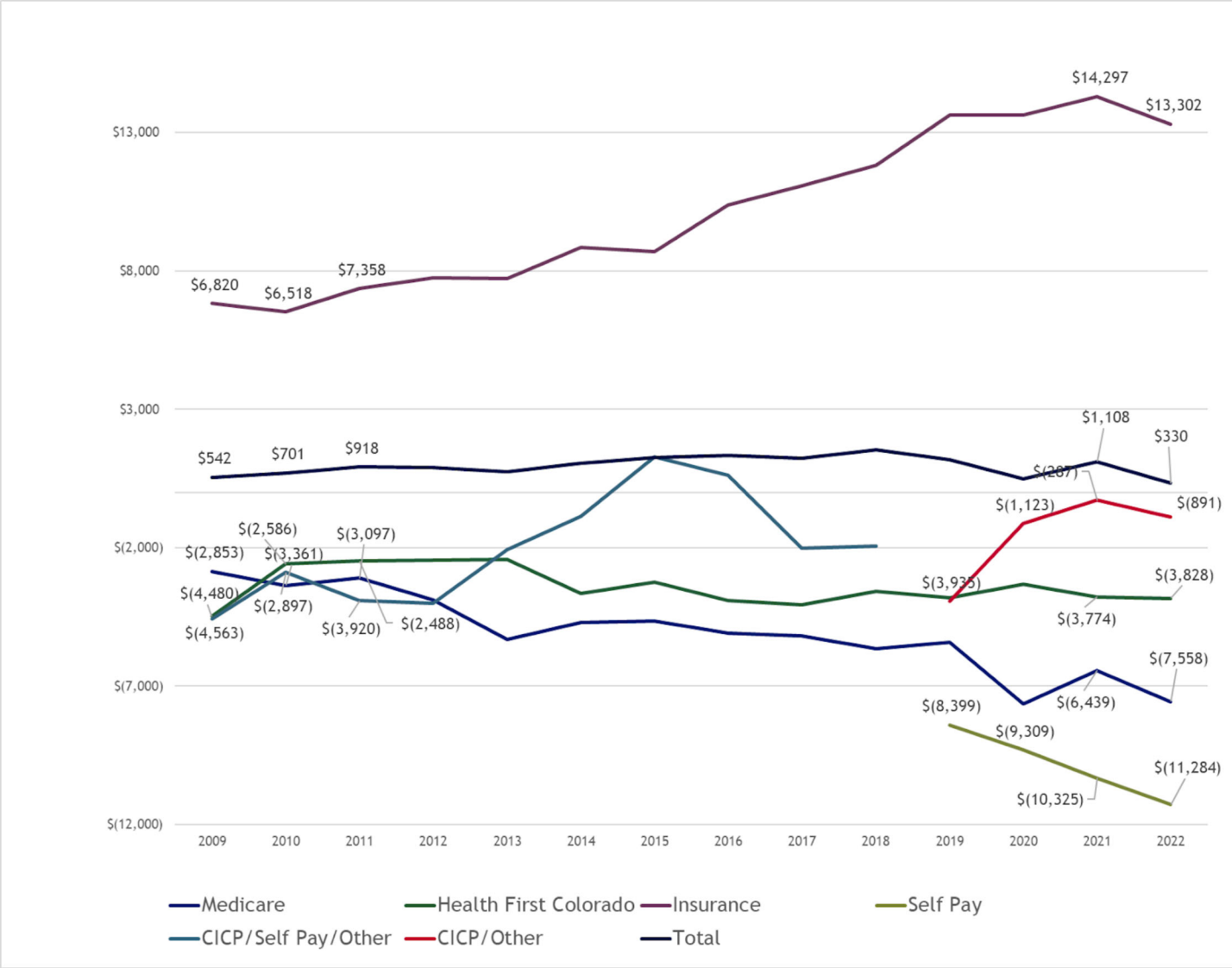


Figure 12. Payment less cost per patient by Payer Type

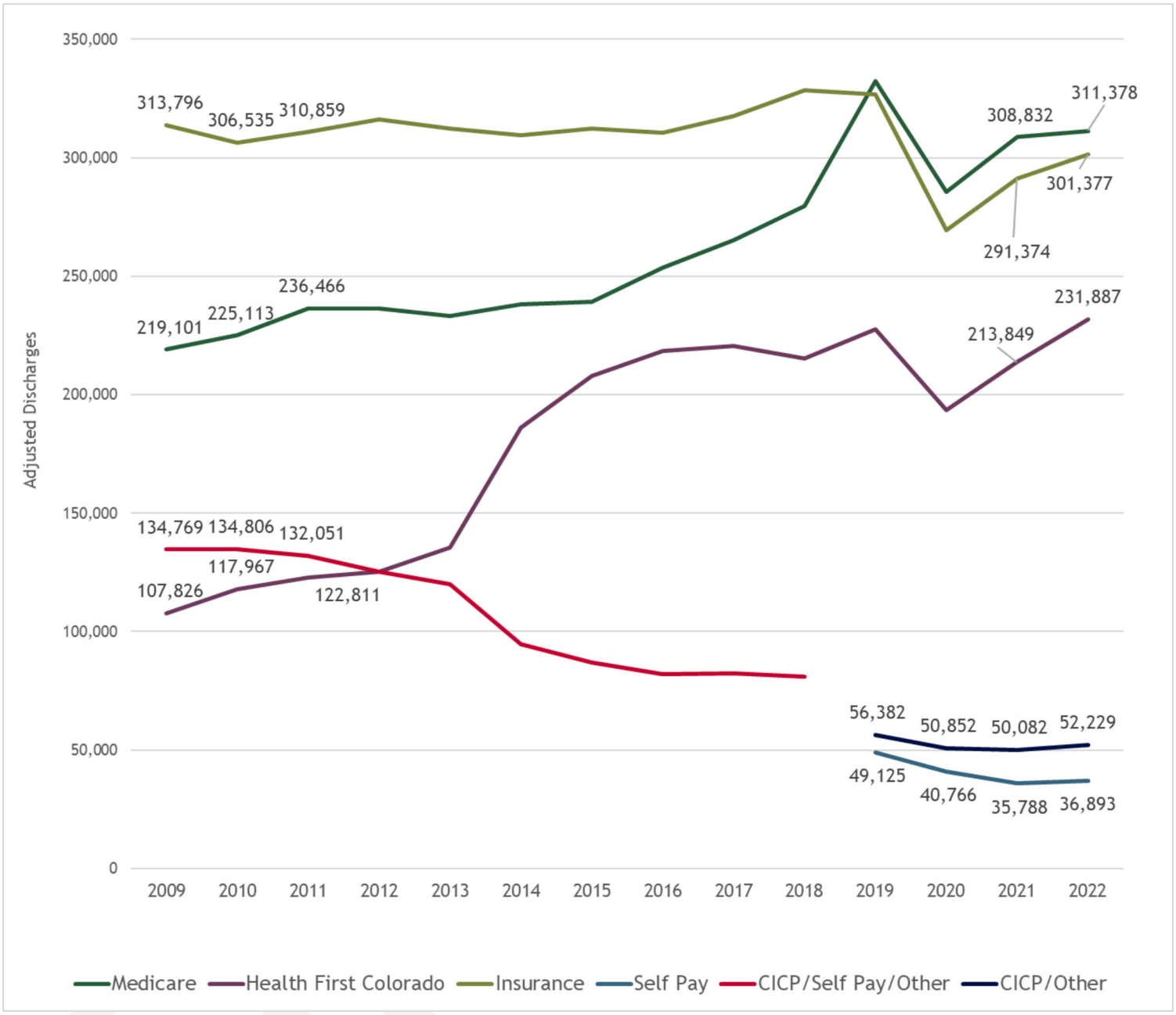


Figure 13. Patient Volume

Table 26. 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 27. 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	39.8%	21.5%	30.2%	3.0%	5.5%

C. Program Year Two Rural Support Fund Attestation Summaries

The following are summaries of excerpts from year two 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 and care coordination.
- Evaluation, modification, and standardization of discharge process and discharge rounds.
- Updated the policy and trained hospital staff to schedule follow-up appointments with the patient's primary care provider and provide timely care information with community partners.
- Scheduling improvements that increase access to care through the patient portal.
- Completed the build on the interface with CommonWell to connect to the regional health information exchange.
- In collaboration with a federally qualified health center, purchased a vehicle suited for handicapped accessibility to transport patients for medical and other human services.

East Morgan County Hospital

- Hired two case managers to partner with a case manager and social worker to prevent readmissions through discharge planning and identifying social determinants of health needs at the point of care.
- Implemented the Alternatives to Opioid (ALTO) program that targets substance use disorders. The hospital has been successful in decreasing opioid usage in 2019.
- Community involvement and input.
- Partnership with the Regional Accountable Entity (RAE) on high-risk and high-utilizer patients for interventions and collaboration of care.
- Planned emergency department improvements that align with increased patient needs and provider satisfaction, regulatory compliance, and increased operational efficiency. Plans include a dedicated safe behavioral health room adjacent to the new nurse's station with additional features for the safety and comfort of patients.

Haxtun Hospital District

- Weekly meetings with the RAE and ongoing coordination of care.
- Implemented the ALTO program and used an electronic medical records system to track our emergency room opioid and ALTO patients.
- Reflecting partnership with the RAE for our region and their mental health partner Centennial Mental Health, added a counseling room to provide a space for Centennial Mental Health to provide counseling and outpatient services.
- Relocating our Haxtun Clinic to Main Street in town and will also build out counseling rooms in that space. At the request of Centennial Mental Health, both new spaces will be embedded within our outpatient clinic to reduce stigma and for real-time referrals.
- Staffing and data analysis through the employment of the Director of Quality position, data analysts, and software systems.

Keefe Memorial Health Service District

- Expansion of telehealth services for local providers.
- Implemented the ALTO program and monthly monitoring of ALTO data.
- Implementation stage of adding Integrated Health Center services, a telehealth behavioral health service provider.
- Partnership with Holistic Pain Management (HPM). HPM collaborates with hospital and physician partners to provide alternative pain options.
- Utilizing Telestroke, additional resources for acute neurology and psychiatry services for all emergency room and inpatient needs.
- Hired a Nurse Navigator and Clinic Nurse.
- Reimplemented the Cross TX Chronic Care Management system.
- Installed a modern Siemens 3D mammography system.
- Ambry Genetics partnership and patient evaluation.
- Staff time and training for data collection and analysis.
- Increase access to local endoscopies and colonoscopies care through the future purchase of endoscopy equipment and bringing in providers for endoscopy services at the hospital.

Kit Carson County Health Service District

- Providing behavioral health services through a behavioral health professional licensed as a Licensed Clinical Social Worker.
- Broadened behavioral health services with Rocky Mountain Crisis Partners offering additional resources to our patients.
- Implemented i2i Population Health software data collection.
- Introduced Avel eCare telemedicine system for emergency room and behavioral health patients.
- Staffing the Director of Quality position to abstract data and report metrics.
- Future additional staffing for patient navigation support and case management.

Lincoln Community Hospital

- Implementation of the Cerner CommunityWorks Foundations electronic medical records platform.
- Contracted a project manager for the implementation of the EHR.
- Implemented i2i Population Health software data collection.
- Staff training on new tools and technologies.
- Piloting an in-home monitoring program for diabetes patients.
- Providing telemedicine and researching other ways to increase use.

Melissa Memorial Hospital

- Providing educational opportunities, specifically aimed towards health care transformation, to two of the members of our hospital staff.
- Transformation of the facility's informational technologies infrastructure including implementing a data analytics platform.
- Hiring a data analyst.
- Creating partnerships with the community.

The Memorial Hospital

- Supported three members to get additional training to grow their clinical informatics analyst skills.

- Increased service agreement with Intermountain Health to receive training and support at the management and technical support level.
- Ensuring data input and extraction from the electronic medical record platform is clean, accurate, and reliable before communication.
- Host daily morning alignments for daily emergency department and inpatient census, patient satisfaction, safety updates, and employee engagement opportunities.
- Hired a cultural ambassador to support employee development.
- Conducted a pro forma to determine the viability of establishing a Crisis Stabilization Unit or detox facility in Northwest Colorado.

Middle Park Medical Center

- Hired a case manager and behavioral health navigator to help reduce barriers and connect patients to care.
- Processing report extractions from the electronic medical records platform and reporting of readmissions and chronic conditions.
- Implemented care coordination with the RAE and ensuring that data is being sent to the RAE correctly.
- Hired a patient financial navigator to help patients with financial need and plans to implement a patient navigator program.
- Plans to hire two clinical case coordinators to help with care coordination.
- Implemented the ALTO program including training and education for providers, as well as analysis and reporting.
- Policies to increase and standardize suicide screenings in the emergency department for patients twelve and older with the use of the Columbia Suicide Severity Rating Scale tool.
- Implementing the standardization of similar processes in the primary care setting.
- Continue to provide telemedicine and will work on expanding services, especially for nurse-managed visits.

Pagosa Springs Medical Center

- Utilizing the Performance Improvement Committee for HTP spending decisions.
- Chartered HTP workgroup teams that are evaluating software, education, training, staffing, and other resource needs.
- Training and education of our hospital and clinic staff.
- Supporting additional staffing needs.
- Hired a Director of Clinic Operations for our rural health clinic and a Quality and Performance Improvement Manager.
- Posted job posting for a Registered Nurse Care Manager.

Pikes Peak Regional Hospital

- Planning and purchasing orders for technology and equipment to support the procurement of new technology platforms, equipment, and instrumentation for surgeons and operating rooms.
- Revising behavioral health processes including tele-behavioral health processes and the ability to collaborate with community partners for coordinated care delivery.
- Evaluation and engagement with the UCHealth Design and Construction Team for the emergency department improvement project to support process modifications.

Pioneers Medical Center

- Implementing, training, and sustaining 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.
- Implemented standard screening processes.
- Auditing and tracking of compliance.
- Participation in multiple resource advisory committees.
- Formed two regional collaborations.
- HTP team formation.
- Contracting health information exchange services.

Rangely District Hospital

- Engagement and implementation with Quality Health Network for one-day notifications and clinical information
- Created a subcommittee.
- Electronically accessible screening for social needs using the Community Resource Network screening form.
- Through a care coordinator, care coordination processes for patients after discharge to connect them to resources.
- Report build-out for opioid administration and ALTOs, as well as ALTO processes.
- Automatic exchange of Continuity of Care documents to the patient's primary care provider or discharge facility.
- Implementation of Senior Life Solution, an intensive, almost entirely telehealth, outpatient behavioral health program for seniors.
- Partnership with Fitz Ilias Inc. who provides behavioral health telehealth services to non-senior patients and provides no cost care to students at the local community college.
- Staff training.

Rio Grande Hospital

- Upload patient summaries to Colorado State Health Information Exchange for transitions of care.
- Hired a person to organize and lead several Community Health Needs Assessment meetings.
- Met with schools in the area to provide athletic physicals and requested that parents consider having students go to clinics for annual preventive exams.
- Clinic participation with an Accountable Care Organization.
- Will be part of Community Care Alliance, which is a rural clinically integrated network offering population health services and incentives for meeting key performance indicators.
- Partnership with the Center for Restorative Program to provide intensive care management to patients with unmet social determinants of health.
- Partnership with San Luis Valley Area Health Education Center to provide a mobile childcare unit available during Recovery Clinic hours.
- Engagement with two Baylor College honor pre-med students to determine ways to promote wellness and reduce risks for the migrant community.

Sedgwick County Health Center

- Updated infrastructure to increase opportunities via telehealth.
- Implementation of Senior Life Solution, a hospital-based geriatric outpatient behavioral health care system.

- Implemented i2i Population Health software, including Quality Director training.
- Covering the cost to connect the current electronic medical record platform to i2i Population Health and Colorado Regional Health Information Organization.

Southeast Colorado Hospital District

- Researching and staffing for home health delivery and collective efforts to develop efficiency and improve customer care and efficiency.
- Electronic medical record platform enhancements.
- Efficiency enhancements.
- Staff recruitment and training.
- Information technology and investments to provide remote and distant primary care, telepsychology, telestroke, and home health services.
- Utilizing Critical Access Hospital Measurement & Performance Assessment System to benchmark, improve care, develop efficiencies, control, and reduce care costs.
- Increasing access to dental services.
- Educate and train staff on new care models.
- Engagement with community entities to support HTP initiatives through education, meetings, and stakeholder functions.

Southwest Health System, Inc.

- Purchased an ambulatory electronic health records platform (Cerner Community Works).
- Engaging with i2i Population Health and built to complement Cerner for current hospital and future clinic use.
- Filled the Patient Navigator position as a dual role with the Quality Project Navigator position.
- Posted positions for a Quality Specialist and an Emergency Department Case Management.
- Purchases and upgrades of computers, equipment, software, servers, and licenses.

Spanish Peaks Regional Health Center

- Social determinants of health screening and reporting to RAE.
- Development and deployment of a new electronic health record, Meditech Expanse.
- Electronic health record platform abilities including ALTO data extraction and reporting.
- Staff education regarding ALTO medications.
- Process collaboration between the clinic and medication assistance treatment resources in the community.
- Partnership with a third-party vendor to enable transmission and receipt of records electronically.

Sterling Regional MedCenter

- Community engagement and collaboration.
- Staff investment.
- Added corporate leadership support from our division that handles population health.
- Implemented the ALTO Program.
- Expansion of a specialized behavioral health room in the emergency department.

- Establishing relationships with specialists via telehealth services.
- Acquired equipment and software for data interfaces.
- Vetting partnerships.

Weisbrod Memorial County Hospital

- Strategic planning and consultation.
- Completed a community health needs assessment.
- Contractual services with various groups: Haugen Group for health information management, Community Hospital Consulting to review payor contracts, and Trisource Health to ensure clinical services are at industry standards.
- Implement and train all staff on the Strategic Quality Support System for HTP compliance.
- Building capacity and partnership for behavioral health continuum of care with UCHealth.
- Purchased two medication units.
- Technology enhancements including two-factor authentication, implementation of i2i Population Health software, and server upgrades.
- Staff training.

Wray Community District Hospital

- Participated with Barbara Davis Center for Childhood Diabetes to provide telemedicine for young patients in the northeast Colorado region.
- Engaged Halsa Advisors, LLC to evaluate its current services in northeast Colorado.
- Architectural planning for renovation and expansion.
- Completed the Comprehensive Primary Care Plus and introduction of the Primary Care First program.
- Employment of a full-time general surgeon, two full-time primary care physicians, a physician's assistant, and a pulmonologist.
- Engaged with i2i Population Management services and explored extensions to increase facility and patient communication.
- Community engagement.

Yuma District Hospital

- Partnered with the City of Yuma Task Force to bring Mike Donahue from the Value-Up program.
- Various equipment purchases.
- Hired a social worker to help with care coordination services and the development of workflows between the hospital, clinics, and the RAE.
- Funds covered the salary of the registered nurse project managing the HTP project.
- Monetary donations to our community partners.
- Staff education and training.
- Engaging and onboarding with i2i Population Health and consulting Merakinos for implementation.
- Investments in other technological interfaces and infrastructure.
- Strategic planning.