Colorado Healthcare Affordability and Sustainability Enterprise Annual Report

January 17, 2023

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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I. Executive Summary

From October 2021 through September 2022, the CHASE has:

- **Provided $457 million in increased reimbursement to hospital providers**

  Hospitals received more than $1.6 billion in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed with health care affordability and sustainability fees, including $104 million in hospital quality incentive payments (HQIP). This funding increased hospital reimbursement by $457 million for care provided to Health First Colorado and CICP members with no increase in General Fund expenditures. In addition, of the $2.9 billion in claims paid for CHASE coverage expansion Health First Colorado members, approximately 42% or more than $1.2 billion were paid to hospitals.

- **Transferred $153.5 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 novel coronavirus (COVID-19) pandemic, the federal government has funded $153.5 million of the state's medical assistance program expenditures normally funded through the state General Fund since January 2020 as part of House Bill (H.B.) 20-1385.

- **Saved hospitals $152 million in health care 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 $152 million more in health care affordability and sustainability fees to receive the same $1.6 billion supplemental payments. This increased net benefit is to support hospitals' Hospital Transformation Program efforts.

- **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.

  - ✓ From 2009 to 2021, the payment for care provided to Health First Colorado members has improved overall, increasing coverage from 54% to 81% of costs[1].
  - ✓ In 2021, the amount of bad debt and charity care decreased by more than 40% 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

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

(ACA). However, 2021 total bad debts and charity care haves increased 10.0% from 2019 and by $154.0 million since 2015 or by 58.4%.

- ✓ A positive impact on cost shifting to private payers is not apparent with private insurance payments less cost per patient increasing by approximately 111% since 2009.
- ✓ Federal stimulus in 2020, which amounted to $1.2 Billion, helped support hospitals for bridged the gap between 2019 and 2021, and more than covered losses of revenue and increased expenses due to the COVID-19 pandemic.

- **Provided health care coverage through Health First Colorado and Child Health Plan *Plus* for more than 668,000 Coloradans**

  As of September 30, 2022, the Department has enrolled approximately 110,000 Health First Colorado parents ranging from 61% to 133% of the federal poverty level (FPL), 25,000 CHP+ children and pregnant women ranging from 206% to 250% of the FPL, 17,000 Health First Colorado working adults up to 450% of the FPL and children with disabilities up to 300% of the FPL, and 516,000 Health First Colorado adults without dependent children up to 133% of the FPL with no increase in General Fund expenditures.

- **Launched the Hospital Transformation Program (HTP)**

  The Hospital Transformation Program (HTP) was the first major Value Based Payment (VBP) effort for hospitals in Colorado Medicaid, goals of quality and affordability, through the implementation of statewide and local measures. Along with the hospital quality incentive payments with the implementation of HTP, more than 97% of CHASE supplemental Medicaid payments are Value Based.

- **Maintained low administrative expenditures**

  Administrative costs are limited in statute to 3% of the total CHASE expenditures. However, the remained low in SFY 2021-22, CHASE operated below that cap at approximately 1.9%. This is well below the cap, and benefits of CHASE go to hospitals and coverage.

II. Colorado Healthcare Affordability and Sustainability Enterprise Overview

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

The CHASE is a government-owned business operating within the Department. Its purpose is to charge and collect the health care affordability and sustainability fee to obtain federal matching funds. The health care 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)(H)(V)(e), C.R.S., this report includes:

- The recommendations made by the CHASE Board to the Medical Services Board regarding the health care affordability and sustainability fee;
- A description of the formula for how the health care affordability and sustainability fee is calculated and the process by which the health care affordability and sustainability fee is assessed and collected;

- An itemization of the total amount of the health care 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 health care 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. Health Care Affordability and Sustainability Fee and Supplemental Payments

- *The recommendations made by the CHASE Board to the Medical Services Board regarding the health care affordability and sustainability fee*
- *A description of the formula for how the health care affordability and sustainability fee is calculated and the process by which the health care affordability and sustainability fee is assessed and collected*
- *An itemization of the total amount of the health care 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 health care affordability and sustainability fee. Information about the CHASE Board and its meetings is available at www.colorado.gov/pacific/hcpf/colorado-healthcare-affordability-and-sustainability-enterprise-chase-board.

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

For terms expiring May 15, 2023:

- Scott Lindblom of Thornton, representing the Department.
- George Lyford of Boulder, representing a statewide organization of health insurance carriers.
- Robert Morasko of Salida, representing a rural hospital.
- Jeremy Springston of Highlands Ranch, representing a hospital.

For terms expiring May 15, 2024:

- Janie Wade of Lafayette, representing a hospital.
- Dr. Kimberley E. Jackson of Windsor, representing persons with disabilities, serving as Vice Chair.

For terms expiring May 15, 2025:

- Barbara Carveth of Aurora, representing a safety net hospital
- Mathew Stephen Colussi of Aurora, representing the Department
- Heather Lafferty of Denver, representing a business that purchases health insurance
- Dr. Claire Reed of Pueblo, representing the health care industry and who does not represent a hospital or a health insurance carrier
- Robert John Vasil of Larkspur, representing a hospital
- Ryan Westrom of Aurora, representing a statewide organization of hospitals

The Medical Services Board, with the recommendation of the CHASE Board, promulgated rules related to the health care 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 health care 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~~Table 1~~ outlines the FFY 2021-22 health care affordability and sustainability fee and payment amounts. Table 16~~Table 16~~ and Table 17~~Table 17~~ (in the Appendix) detail hospital specific FFY 2021-22 health care affordability and sustainability fee and payment amounts. Health care affordability and sustainability fees are collected and resulting hospital payments are made monthly by electronic funds transfer for each hospital.

Table 1. FFY 2021-22 CHASE Fee and Supplemental Payments

Item	Amount
Inpatient Fee	$528,010,052
Outpatient Fee	$610,430,960
Total Health Care Affordability and Sustainability Fee	**$1,138,441,832**
Inpatient Supplemental Payment	$596,360,076
Outpatient Supplemental Payment	$637,087,863
Essential Access Supplemental Payment	$19,500,005
Rural Support Supplemental Payment	$11,999,997
Hospital Quality Incentive Supplemental Payment	$104,089,834
Disproportionate Share Hospital Supplemental Payment	$226,610,302
Total Supplemental Payments	**$1,595,648,077**
Net Reimbursement to Hospitals	**$457,206,245**

For an overview of the fee assessment and payment methodologies recommended by the CHASE Board for October 2021 through September 2022, see the sections below. While individual hospitals may not be eligible for all payments, all methodologies are described.

A. Health Care Affordability and Sustainability Fee

The total health care affordability and sustainability fee collected during FFY 2021-22 was $1,138,441,832, with the inpatient fee comprising 46.4% of total fees and the outpatient fee comprising 53.6% 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 was 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 health care 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: health care affordability and sustainability fees and federal matching funds, calculated pursuant to the federal medical assistance percentage (FMAP). Historically, the FMAP for supplemental payments was 50%. For every supplemental payment dollar, 50 cents were health care affordability and sustainability fees and 50 cents were federal matching funds. Effective FFY 2019-20 and onward, the Department is approved to utilize an enhanced FMAP to make supplemental payments to hospitals. With the enhanced FMAP, the Department 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 Health First Colorado expansion occurred, the individuals that 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 $420 million in health care affordability and sustainability fees over the last three years. That is $127 million in FFY 2019-20, $141 million in FFY 2020-21, and $152 million in FFY 2021-22.

C. COVID 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 increases the base Medicaid FMAP from 50% to 56.2% during the COVID-19 public health emergency. The temporary increase in base FMAP is effective beginning January 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 the Department 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 H.B. 20-1385, allowing the Department to utilize the increase in base FMAP to offset General Fund expenditures for medical service premiums. So far, the Department has been able to draw down an additional $153.5 million in federal funds for the period January 1, 2020 through September 30, 2022[2].

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] 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.

2. Outpatient Supplemental Payment

For qualified hospitals, this payment equals Health First Colorado outpatient billed costs, adjusted for utilization and inflation, multiplied by an outpatient adjustment factor. Outpatient adjustment factors may vary by hospital. The outpatient adjustment factor for each hospital is published annually in the Provider Bulletin.

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 $19,500,000.

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 Hospital Transformation Program that will enable critical access and rural hospitals to be successful for future value-based payment environments. Some rural hospitals have a difficult time layering quality-based initiatives on top of insufficient operational strategies. Additionally, infrastructure may not allow the hospitals to prepare for 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 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.

The payment equals $12,000,000 divided by the total number of qualified hospitals that submit an acceptable attestation.

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

5. Hospital Quality Incentive Supplemental Payment

As part of our Value Based Payment effort for hospitals, CHASE includes a provision to establish Hospital Quality Incentive Payments (HQIP) funded by the health care 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 October 1, 2021, 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 was a total of 15 measures separated into three measure groups. The measures for 2021 HQIP are presented below.

1) Maternal Health and Perinatal Care Measure Group
    i. Exclusive Breast Feeding
    ii. Cesarean Section
    iii. Perinatal Depression and Anxiety
    iv. Maternal Emergencies
    v. Reduction of Peripartum Racial and Ethnic Disparities
    vi. Reproductive Life/Family Planning
2) Patient Safety Measure Group
    i. Zero Suicide
    ii. Clostridium Difficile
    iii. Sepsis
    iv. Antibiotics Stewardship

v. Adverse Event
vi. Culture of Safety Survey
vii. Handoff and Signouts

3) Patient Experience Measure Group
   i. Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS)
   ii. Advance Care Plan

Payment Calculation

The payments earned for each of the FFY 2021-22 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~~.

Table 2. FFY 2021-22 HQIP Dollars Per Adjusted Discharge Point

Tier	Quality Points Awarded	Dollars Per Adjusted Discharge Point
0	0-19	$0.00
1	20-39	$2.82
2	40-59	$5.64
3	60-79	$8.46
4	80-100	$11.28

During the FFY 2021-22 timeframe, HQIP payments totaled over $104 million with 80 hospitals receiving payments. HQIP payments, Health First Colorado adjusted discharges, and quality points awarded by hospital are listed in Table 3~~Table 3~~.

Table 3. FFY 2021-22 Hospital Quality Incentive Payments

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
Animas Surgical Hospital	54	81	$5.64	$24,669
Arkansas Valley Regional Medical Center	42	739	$5.64	$175,054
Aspen Valley Hospital	64	120	$8.46	$64,973
Avista Adventist Hospital	65	2,399	$8.46	$1,319,210
Banner Fort Collins Medical Center	96	645	$11.28	$698,458
Broomfield Hospital	92	357	$11.28	$370,480
Castle Rock Adventist Hospital	66	1,073	$8.46	$599,120
Children's Hospital Anschutz	82	6,864	$11.28	$6,348,925
Children's Hospital Colorado Springs	78	1,902	$8.46	$1,255,092
Colorado Canyons Hospital & Medical Center[3]	67	25	$8.46	$14,171
Colorado Plains Medical Center	50	831	$5.64	$234,342
Community Hospital	62	577	$8.46	$302,648
Conejos County Hospital	83	138	$11.28	$129,201
Craig Hospital	39	67	$2.82	$7,369
Delta County Memorial Hospital	56	850	$5.64	$268,464
Denver Health Medical Center	84	11,086	$11.28	$10,504,207
East Morgan County Hospital	91	586	$11.28	$601,517
Foothills Hospital	47	1,546	$5.64	$409,814
Good Samaritan Medical Center	54	2,061	$5.64	$627,698
Grand River Health	69	163	$8.46	$95,150
Grandview Hospital	92	648	$11.28	$672,468
Greeley Hospital	85	1,806	$11.28	$1,731,593
Gunnison Valley Health	67	197	$8.46	$111,664
Highlands Ranch Hospital	87	814	$11.28	$798,827
Keefe Memorial Hospital	42	25	$5.64	$5,922
Kit Carson County Memorial Hospital	63	247	$8.46	$131,646
Lincoln Community Hospital	29	75	$2.82	$6,134
Littleton Adventist Hospital	70	1,480	$8.46	$876,456
Longmont United Hospital	66	1,596	$8.46	$891,143
Longs Peak Hospital	83	1,891	$11.28	$1,770,430
Lutheran Medical Center	58	4,755	$5.64	$1,555,456
McKee Medical Center	88	1,619	$11.28	$1,607,084
Medical Center of the Rockies	84	1,921	$11.28	$1,820,186
Melissa Memorial Hospital	58	38	$5.64	$12,431
Memorial Hospital	80	12,534	$11.28	$11,310,682
Mercy Regional Medical Center	73	1,912	$8.46	$1,180,813

[3] Name changed to St. Elizabeth Hospital when it was acquired by Centura Health on May 1, 2022.

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
Middle Park Medical Center	51	50	$5.64	$14,382
Montrose Regional Health	82	665	$11.28	$615,098
Mt. San Rafael Hospital	45	639	$5.64	$162,178
National Jewish Health	47	81	$5.64	$21,471
North Colorado Medical Center	78	4,484	$8.46	$2,958,902
North Suburban Medical Center	54	5,284	$5.64	$1,609,295
Pagosa Springs Medical Center	95	181	$11.28	$193,960
Parker Adventist Hospital	64	1,744	$8.46	$944,271
Parkview Medical Center	83	7,957	$11.28	$7,449,662
Penrose-St. Francis Health Services	67	7,187	$8.46	$4,073,735
Pikes Peak Regional Hospital	81	325	$11.28	$296,946
Pioneers Medical Center	24	26	$2.82	$1,760
Platte Valley Medical Center	68	2,213	$8.46	$1,273,095
Porter Adventist Hospital	67	1,410	$8.46	$799,216
Poudre Valley Hospital	82	5,463	$11.28	$5,053,056
Presbyterian-St. Luke's Medical Center	67	3,418	$8.46	$1,937,391
Prowers Medical Center	56	817	$5.64	$258,041
Rehabilitation Hospital of Colorado Springs	55	365	$5.64	$113,223
Rehabilitation Hospital of Littleton	45	246	$5.64	$62,435
Rio Grande Hospital	68	444	$8.46	$255,424
Rose Medical Center	55	3,503	$5.64	$1,086,631
San Luis Valley Health Regional Medical Center	72	2,186	$8.46	$1,331,536
Sedgwick County Health Center	24	106	$2.82	$7,174
Sky Ridge Medical Center	56	2,149	$5.64	$678,740
Southeast Colorado Hospital	55	124	$5.64	$38,465
Southwest Health System	55	997	$5.64	$309,269
Spanish Peaks Regional Health Center	53	88	$5.64	$26,305
St. Anthony Hospital	65	2,439	$8.46	$1,341,206
St. Anthony North Health Campus	79	3,252	$8.46	$2,173,442
St. Anthony Summit Medical Center	75	732	$8.46	$464,454
St. Joseph Hospital	48	4,748	$5.64	$1,285,379
St. Mary-Corwin Medical Center	59	1,664	$5.64	$553,713
St. Mary's Medical Center	58	1,768	$5.64	$578,348
St. Thomas More Hospital	61	1,315	$8.46	$678,619
Sterling Regional MedCenter	75	966	$8.46	$612,927
Swedish Medical Center	59	5,001	$5.64	$1,664,133
The Medical Center of Aurora	45	5,212	$5.64	$1,322,806
University of Colorado Hospital	82	12,629	$11.28	$11,681,320
Vail Health Hospital	66	596	$8.46	$332,783

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Payment
Valley View Hospital	68	718	$8.46	$413,051
Weisbrod Memorial County Hospital	30	6	$2.82	$508
Wray Community District Hospital	79	287	$8.46	$191,814
Yampa Valley Medical Center	92	580	$11.28	$601,901
Yuma District Hospital	74	141	$8.46	$88,272
Total	**-**	**157,874**	**-**	**$104,089,834**

6. Disproportionate Share Hospital Supplemental Payment

The Disproportionate Share Hospital (DSH) payment equals $226,610,302 in total. To qualify for the DSH Supplemental Payment a Colorado hospital must meet either of the following criteria:

- Be a CICP provider and has 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 has 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

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

Administrative expenditures are reported on a state fiscal year basis. In SFY 2021-22 CHASE collected $1,129,598,038 in fees from hospitals[4], which, with federal matching funds, funded health coverage expansions, payments to hospitals, and the CHASE's administrative expenses. Of the $2,965,256,856 in claims paid for health coverage expansions, approximately 42% or more than $1.2 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. They are limited in statute to 3% of the total CHASE expenditures. In SFY 2021-22, CHASE operated below that cap at approximately 1.9%. Of note, only 0.18% of total CHASE expenditure for the fiscal year were for the personal services costs for the full time equivalent (FTE) staff that administer the program.

Table 4~~Table 4~~ outlines the health care affordability and sustainability fee expenditures in SFY 2021-22.

Table 4. SFY 2021-22 CHASE Expenditures

Item	Total Fund
Supplemental Payments	$1,465,075,472
CHASE Administration (Table 5)	$89,062,893
Expansion Populations	$2,965,256,856
25.5-4-402.4(5)(b)(VIII) – Offset Revenue Loss	$15,700,000
Subtotal Expenditures	**$4,535,095,221**
H.B. 20-1385 Use of Increased Medicaid Match	$52,864,196
S.B. 21-286 ARPA Transfer	$14,211,679
Total Expenditures	**$4,602,171,096**

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 state General Fund to be used as an offset against Health First Colorado's budget. H.B. 20-1385 authorized the transfer of additional federal financial participation that was provided by the federal government during the COVID-19 pandemic. Senate Bill (S.B.) 21-286 authorized the Department to 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 for older adults and people with disabilities.

[4] In addition, $1,782,611 was recorded as earned interest.

Funding in SFY 2021-22 was appropriated for the CHASE administrative expenses through the normal budget process. For SFY 2021-22, there were approximately 79 regular full-time equivalent (FTE) positions for the administration of the CHASE. The expenditures reflected in Table 5~~Table 5~~ are funded entirely by the health care affordability and sustainability fee and federal funds.

Table 5. SFY 2021-22 CHASE Administrative Expenditures

Item	Total Fund
General Administration	**$14,723,009**
Personal Services	$8,300,007
PERA Direct Distribution	$125,919
Worker's Compensation	$21,105
Operating Expenses	$371,640
Legal Services	$257,657
Administrative Law Judge Services	$104,721
Payments to Risk Management and Property Funds	$22,491
Leased Space	$349,402
Capitol Complex Leased Space	$83,224
Payments to OIT	$1,270,015
CORE Operations	$12,340
General Professional Services and Special Projects	$3,804,488
Information Technology Contracts and Projects	**$36,291,763**
MMIS Maintenance and Projects	$20,893,528
CBMS Operating and Contract Expenses	$14,769,381
CBMS Health Care & Economic Security Staff	$628,854
Eligibility Determinations and Client Services	**$32,574,143**
Disability Determination Services	$686,724
County Administration	$22,547,514
Medical Assistance Sites	$825,542
Customer Outreach	$637,902
Returned Mail Processing	$353,252
Work Number Verification	$494,734
Eligibility Overflow Processing Center	$296,783
Centralized Eligibility Vendor Contract Project	$6,731,692
Recoveries Contracts	**$1,691,482**
Acute Care Utilization Review	**$3,129,846**
Professional Audit Contracts	**$477,600**
Indirect Cost Assessment	**$162,130**
Children's Basic Health Plan Administration	**$12,920**
Total Administrative Expenditures	**$89,062,893**

More than $74.3 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 $36.3 million and were for the CHASE's share of expenses for the Colorado Benefits Management System (CBMS, the eligibility determination system for the 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 $22.5 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

- *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 2021.[5] In the most recent cost shift data, specifically from 2021 and 2022, 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.[6] Additionally, nursing shortages have led to substantial increases in labor costs since the COVID-19 pandemic.[7] In sum, inflation, wage pressure and a tightening labor market are important financial challenges to acknowledge.

Since the inception of the CHCAA and through the implementation of the CHASE, the hospital provider fee and the hospital affordability and sustainability fee increased hospital reimbursement an average of more than $410 million per year and substantially increased enrollment in Health First Colorado and CHP+.

Overall, the cost shift analysis that follows shows hospital reimbursement compared to patient costs and bad debt and charity care write off costs have all substantially improved from 2009 to 2021. Some major findings of the Department's analysis are:

- In almost all instances, the Department is seeing a return to pre-pandemic levels for numerous hospital metrics.
- 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, with no federal stimulus fund included. From 2020 to 2021, hospital payment less cost increased by $644.7 million, or a 158.5% increase. Hospital payment less cost has returned to levels more comparable to a pre-pandemic state. However, if compared to pre-pandemic amounts, the 2021 payment less cost is the lowest it has been since 2015 as shown in tables 6 and 7. Also shown in tables 22 and 23, the 2021 payment to cost amounts decreased 8.0% from 2019 and 23.4% from 2018.

[5] 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.

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

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

- 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 reserved itself, when hospital payment less cost per patient increased by $692, or a 141.4%, and have returned to levels comparable to pre-pandemic. Payment less cost per patient grew less than one percent between 2019 and 2021. Additionally, payment less costs per patient has decreased 23% from 2018.
- 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. Comparing 2021 total uncompensated care costs to 2020 numbers one sees that these numbers have stabilized (see Figure 4~~Figure 4~~). The Department will continue to watch the trends of uncompensated care costs and whether they will continue at this level or decline to previous lows. Overall, from 2013 to 2021 bad debt and charity care write off costs declined by ($281.8 million) or (40.3%).

~~This section reports cost shift data from calendar year 2009 through calendar year 2021 and 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.~~

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 2021.[8]

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 6~~, Table 7~~Table 7~~, and Figure 1~~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.

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

As shown below, in 2009, prior to the implementation of the CHCAA, Health First Colorado reimbursement to Colorado hospitals was approximately 54% of costs, while in 2021, the payment to cost ratio for Health First Colorado was 81% of costs. Reimbursement for Health First Colorado has continued to growth in recent years, and through the pandemic has been able to maintain itself above an 80% of cost reimbursement rate. The payment to cost ratio for the CICP/Other payer group was 99% of costs in 2021[9], whereas the Self Pay payer group was reimbursed at 35% of costs.[10] Between 2009 and 2021, the payment to cost ratio for private sector insurance increased from 155% to 172% of costs. Between 2020 and 2021 the payment to cost ratio for private sector insurance increased from 166% to 172% of costs. CHA Comment: However, compared to pre-pandemic figures, the private insurance sector decreased from 185% to 172%. Excluding the 2020 pandemic year, the payment to cost ratio is the lowest it has been since 2013 and decreased from 1.07 in 2019 to 1.06 in 2021.The Department found:

- Payments from private insurance payers grew more than their costs leading to an increase in payment less cost of $512.3 million or an increase of 13.9% between 2020 and 2021. This represents an increase in hospital profits on privately insured patients, which is funded by employers and consumers.
  - ✓ Between 2020 and 2021, private insurance payers saw an increase in payments of 8.0% or an increase of $739.0 million.[11]
- Although costs did grow, private insurance payers did not see an above average increase in costs between 2020 and 2021. In fact private insurance payers' costs was one of the lowest increases of all payers with 4.1% growth, or an increase of $226.7 million.
- However, when compared to pre-pandemic figures the 2021 private insurance payments grew by 2.9% compared to 2019, while private insurance costs increased over 10%. This has led to a 6.9% reduction in the private insurance payment to cost ratio which decreased from 1.85 to 1.72 between 2019 and 2021, this marks the first reduction in the private insurance payment to cost ratio since 2015.

[9] The Department would like to continue to watch how reimbursement for CICP/Other as it does appear higher than usual. This may be due to better reporting of supplemental payments and a break out of DSH payments from total supplemental payments in 2020 and 2021.
[10] 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.
[11] Total charges increased more than write-off costs such as contractual allowances and uncompensated care thus resulting in an increase in payments from private insurance payers to hospitals. Overall, total charges eclipsed the cost of care.

- Between 2019 and 2021 overall costs have increased by 14.4%, while payments have increased 13.0%, these trends have decreased the overall payment to cost ratio during the same time period. Since 2009, Medicare costs have increased 159% and Medicaid Costs have increased 292% while private insurance costs have increased 48%.

~~To reiterate, the change in payment to cost ratio for private insurance was primarily driven by an increase in payments, which, in turn, was driven by an increase in total charges. The Department will watch this trend to see if it continues in coming years.~~

~~Overall, hospital payment to cost ratios have returned to pre-2020 levels and hospitals have recovered in 2021 in aggregate.~~ Note, in Table 7~~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 H.B. 19-1001[12]

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	0.81	1.72	0.35	0.99	1.06

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 and others. Colorado hospitals have accepted approximately $1.2 billion in financial

[12] Increases for Health First Colorado's reimbursement between 2019 and 2020 were most likely driven by increased reporting efforts of supplemental payments from hospitals to the Department and the Federal increase to the FMAP in response to the COVID-19 Pandemic.

assistance.[13] Federal stimulus improved hospitals financial position for the year and increased the overall payment-to-cost ratio, but the scale of this improvement is uncertain due to several factors. Stimulus can be used to make up for lost revenue, or to cover COVID-19 related expenses.[14] A portion of these COVID-19 related expenditures is reflected in the payment to cost ratio e.g., supplies, payroll, etc., and 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.) and 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 future reports to focus on true patient revenues and costs. Without stimulus the overall payment-to-cost ratio for 2020 was 1.02 as seen above, and with all $1.2 billion in federal stimulus, but not all the above costs, it would be 1.09. Given what is known to date, the appropriate ratio likely falls somewhere between 1.02 and 1.09.

Between 2020 and 2021, the payer mix primarily stayed the same (see Figure 1~~Figure 1~~). Medicare and Medicaid payer mix increased by 0.9% and 0.5%, respectively; and private insurance reduced by 0.9%. Between 2020 and 2021, CICP/Other grew by 0.2% and Self Pay reduced by 0.8%.

[13] For more information on federal stimulus see the Departments *COVID-19's Impact on Colorado Hospitals' Finances* (2021). https://hcpf.colorado.gov/sites/hcpf/files/COVID19%20Impact%20on%20Colorado%20Hospitals%20Finances-f.pdf

[14] "Provider Relief Fund." *Official Web Site of the U.S. Health Resources & Services Administration*, 28 May 2021, https://www.hrsa.gov/provider-relief.

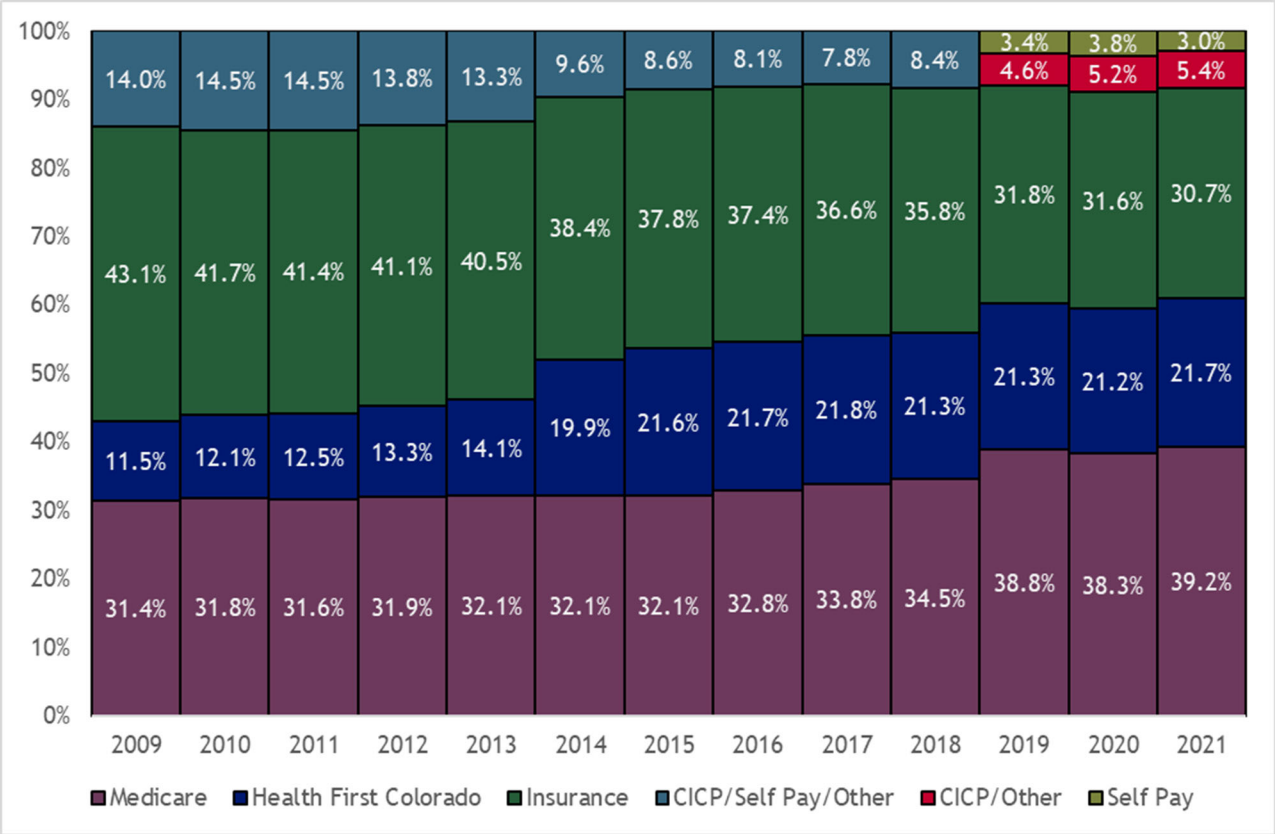

Figure 1. Payer Mix

Payer type payments are available within Figure 10~~Figure 10~~, Table 18~~Table 18~~, and Table 19~~Table 19~~. From 2020 to 2021, payment increased for Health First Colorado by 6.8%, or a $209.5 million increase. Payments for the CICP/Other category increased by 16.8%, or a $144.1 million increase[15]. Medicare payments increased by $861.3 million, or a 19.0% increase. As mentioned above, private insurance payments increased in 2021 by 8.0%, or a $739.0 million increase. Overall, hospital payments have grown an average of 6.4% every year from 2009 through 2021.

As displayed in Figure 11~~Figure 11~~, Table 20~~Table 20~~, and Table 21~~Table 21~~, overall costs grew by 7.0%, or a $1,227.6 million increase between 2020 and 2021. CICP/Other saw the highest cost growth between 2020 and 2021 with 10.7% or a $97.8 million increase; followed by Health First Colorado and Medicare with an increase of 9.6% ($357.7 million) and 9.5% ($639.0 million), respectively. Private insurance saw the lowest increase in costs with 4.1% or a $226.7 million increase. Self Pay, unlike the other payer types actually saw a decrease in costs of 14.2% or a $93.6 million decrease.

[15] Between 2019 and 2021, the Department has worked with hospitals to more accurately report DSH payments to the Department through H.B. 19-1001, Hospital Transparency Measures to Analyze Efficacy, contributing to this increase. Therefore, increased in CICP/Other from 2019 are heavily influenced by increased reporting efforts.

Figure 2~~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 non-commercial 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 a decrease of 8.0%.
  - ✓ Before including federal stimulus in 2020, total payment less cost equals $406.7 million. Between 2020 and 2021, overall payment less cost increased by 158.5%, or a $644.7 million increase.
  - ✓ Considering the limitations of factoring in the federal stimulus, including it in payments when comparing 2020 and 2021, overall payment less cost decreased by a maximum of 28.7%.

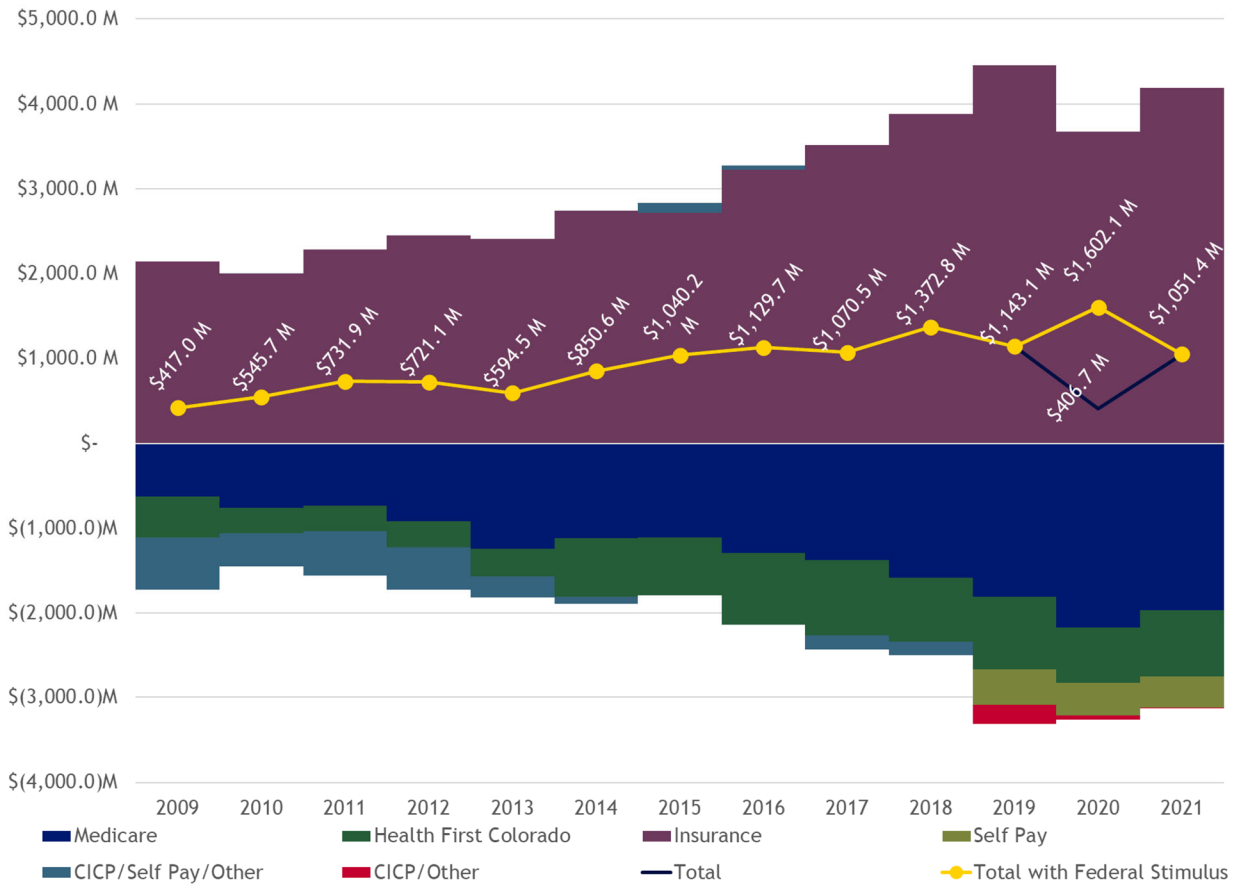

Figure 2. Payment Less Cost

Reflecting the impact of the pandemic, all payers saw a reduction in patient volume between 2019 and 2020 (see Figure 13~~Figure 13~~). Between 2020 and 2021, patient volume has begun to rise again. Overall, patient volume increased by 7.1%. Health First Colorado volume increased the most (10.6%), followed by private insurance (8.2%) and Medicare (8.1%). Both Self Pay and CICP/Other saw a reduction in patient volume between 2020 and 2021 (a reduction of 12.2% and 1.5%, respectively); however, compared to the reductions in volumes of the previous year, this has slowed considerably. Overall, between 2019 and 2021 patient volumes have declined (84 thousand patients or a 8.7% reduction), no payer type has increased beyond its 2019 volume. Even though there has been a decrease in patient volume 2021 volumes are returning to more typical pre-pandemic levels.

Figure 3~~Figure 3~~, shows the difference between total payments and total costs on a per patient basis, whereas Table 22~~Table 22~~ and Table 23~~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 a 141.4% increase. Considering the limitations of adding total federal stimulus to the numbers,

overall payment less cost per patient would have a maximum of a 38.7% decrease between 2020 and 2021.

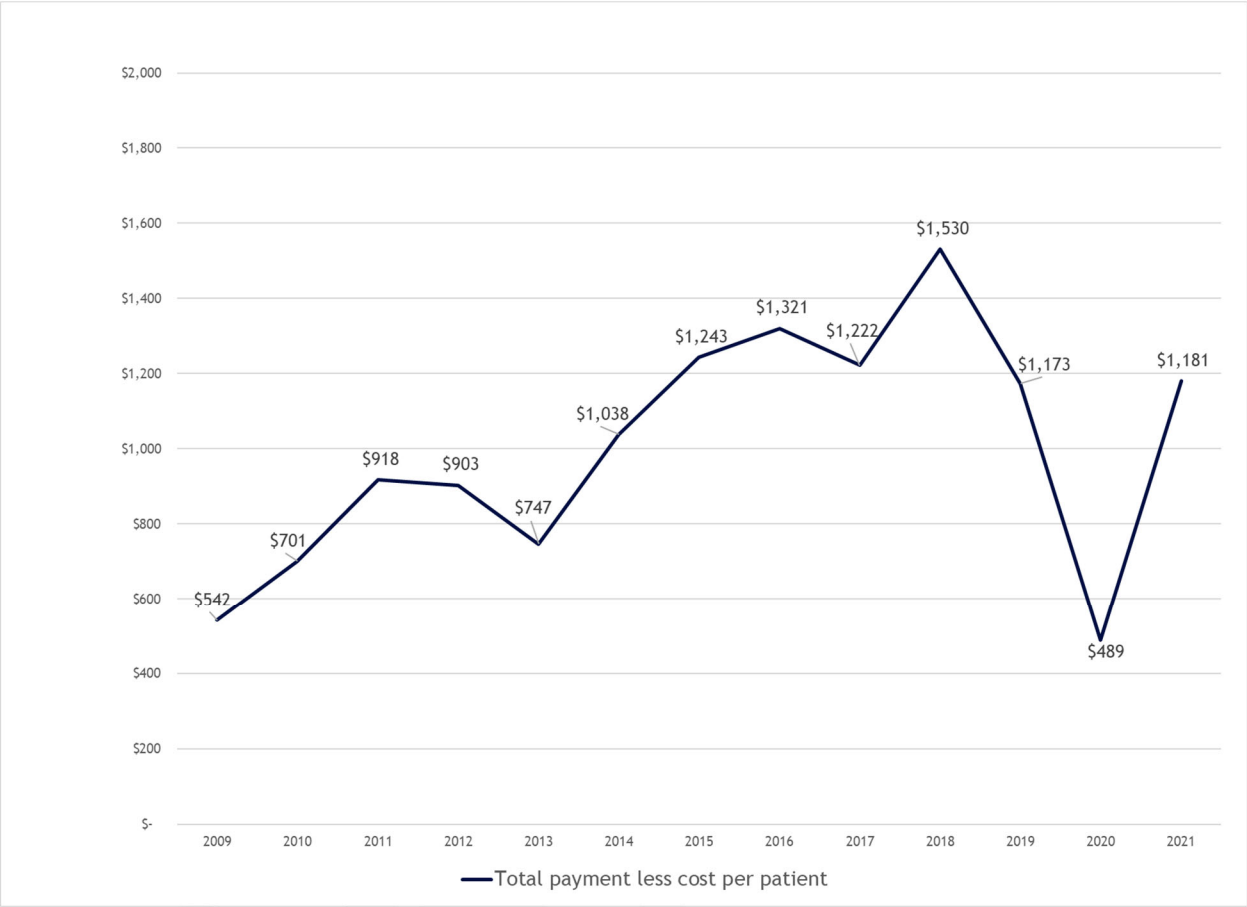

Figure 3. Total Payment Less Cost per Patient

Table 8. Payment Less Cost per Patient by Payer Group[16]

Year	Medicare	Health First Colorado	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 9. Payment Less Cost Per Patient by Payer Group, Post H.B. 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	($6,357)	($3,708)	$14,366	($10,270)	($217)	$1,181

Table 8~~Table 8~~ displays payment less cost per patient between 2009 and 2018 and then post HB19-1001, 2019 through 2021, is displayed in Table 9~~Table 9~~. Table 10~~Table 10~~ presents overall hospital payments, costs, and payment less cost on a per patient basis from 2009 to 2021. While costs have increased at an annual average rate of 5.2% over the 12-year period, payments have increased an average of 5.2% per year resulting in an average annual increase in payment less cost of 15.4%. Table 10~~Table 10~~'s averages do not include stimulus funds and therefore the 15.4% average annual increase is inflated do to the above average increase between 2020 and 2021 payment less cost. When stimulus is included in 2020 figures the average annual increase would be 10.6%.

[16] 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. All-Payer Payment, Cost and Profit

Year	Payment Per Patient	Cost Per Patient	Profit 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
Average Annual Change	5.2%	5.2%	15.4%

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~~Figure 4~~ and Table 11~~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 2020 and 2021 there was an increase in charity care costs of $12.6 million, or a 5.0% increase. Between 2020 and 2021, bad debt costs decreased by $12.9 million, or a 7.7% decrease. Total uncompensated care costs decreased by $292.2 thousand, or an 0.1% decrease. However, 2021 total bad debts and charity care has increased 8.0% from 2019 and by $154.0 million since 2015 or by 58.4%.

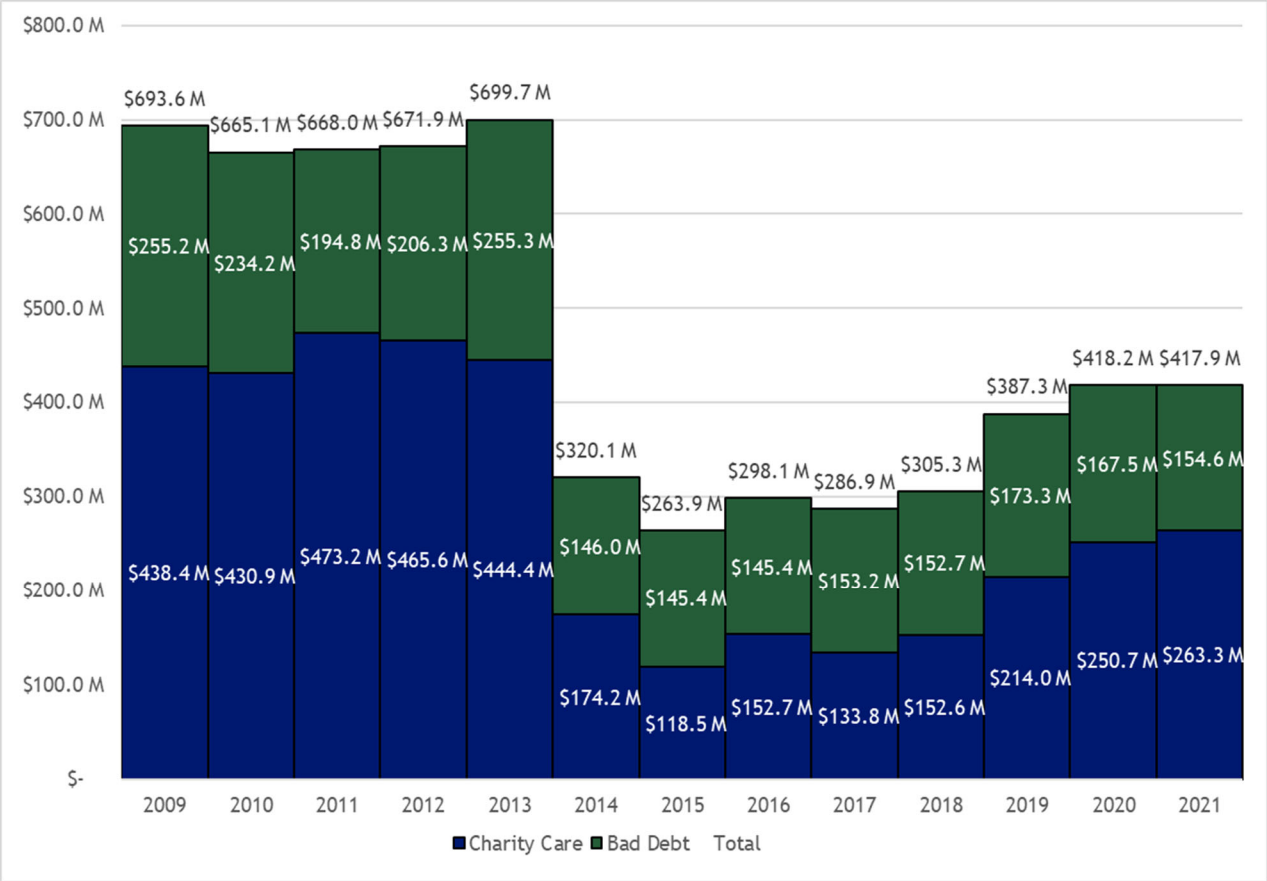

Figure 4. Bad Debt and Charity Care Costs

Table 11. 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

VI. Delivery System Reform Incentive Payment Program

- *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 two of the five-year program and hospitals have received evaluations on their program year one, quarter ending in September 2022 interim activity and Community Health & Neighborhood Engagement (CHNE) progress. Within HTP, hospitals select statewide and local measures to be evaluated on over the course of the program. Not all measures are required statewide, which allows hospitals to address local community needs. Such that, large hospitals (91+ beds) must select 6 statewide measures plus at least 4 local measures. Medium hospitals (26-90 beds) must select 6 statewide measures plus at least 2 local measures. Small hospitals (25 or fewer beds) along with critical access hospitals must select 6 measures that may consist of either statewide or local measures. Below is a list of HTP focus areas and statewide measures that include emphasis on both affordability and quality of care. Statewide measures are bolded and included first under each focus area; local measures are listed subsequently.

- Reducing avoidable hospitalization utilization
  - ✓ **30-day all cause risk adjusted hospital readmissions**
  - ✓ **Pediatric all-condition readmission measure**
  - ✓ Follow up prior to discharge and notification to the 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**
  - ✓ 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
- ✓ Increase access to specialty care

- Behavioral health/ Substance use disorder
  - ✓ **Collaborate discharge planning and notifications with Regional Accountable Entities (RAE)**
  - ✓ **Pediatric Screening for depression in inpatient and ED including suicide risk**
  - ✓ **Using alternative to opioids in ED**
  - ✓ 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**
  - ✓ Increase the successful transmission of a summary of care record to a patient's primary care physician
  - ✓ Implementation/expansion of telemedicine visits
  - ✓ Implementation/expansion of e-Consults
  - ✓ Energy Star Certification achievement and score improvement for hospitals
- Population health/Total cost of care
  - ✓ **Severity adjusted length of stay**
  - ✓ 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) hospitals will be using for HTP has a public dashboard 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

The Department is pleased to report robust progress and engagement thus far from hospitals in the HTP. Such that, all 83 hospitals submitted their Interim Activity on time, and 82 hospitals submitted their CHNE Activity on time. This trend should continue with 94% of hospitals reporting they are on track to hit all of their milestones for program year 2. So far, hospitals are making progress toward **1,479 different interim activities** across all hospital interventions. Hospitals have also made a lot of Community Health & Neighborhood Engagement (CHNE) progress under the HTP. Hospitals have reported having 548 consultations with key stakeholders, 101 community advisory meetings, and 53 public engagement meetings. Overall, this makes up **over 700 unique CHNE activities** and illustrates that hospitals are making strides in connecting with their community and partner organizations on pertinent HTP topics. On average, hospitals are conducting just under seven key stakeholder meetings for program year 1, quarter ending Sept. 30, 2022.

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. There will be challenges but there will continue to be shared learning opportunities and technical assistance to hospitals regarding their 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 2 interventions.** Although it is still early in the five-year program, there are exciting results that highlight hospitals commitment to improve the quality of hospital care and engage 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 who 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 each intervention(s) outlined in their applications.

Summary of current HTP activities:

- 83 Hospitals have submitted interim activity on time

- 94% of hospitals on track to hit **all** their year 2 milestones
- Over 1,479 interim activities across hospital interventions
- Over 700 unique Community Health & Neighborhood Engagement (CHNE) activities
- Over 548 consultations with key stakeholders
- Over 101 community advisory meetings
- 53 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 the Department, 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 can be found at https://hcpf.colorado.gov/colorado-hospital-transformation-program.

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:

- 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 the Department's SPA for the pay-for-reporting component of Hospital Transformation Program (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 as well as HTP outcomes and deliverables to date. These sections provide an overview of the HTP while also expanding on hospital's achievement status and Community Health Neighborhood Engagement progress.

C. HTP Application Process

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

Following technical assistance by the Department 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 can be found at https://hcpf.colorado.gov/sites/hcpf/files/2020%20February%20HTP%20Application%20Background%20and%20Instructions%20%20.pdf.

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

Since the implementation plan process in late 2021, hospitals in the HTP program have made substantial progress as HTP continues into program year 2, which began in October 2022. The subsequent sections of outline deliverables and progress to date.

E. Outcome of Deliverables & Progress to Date

As of October 3, 2022, hospitals were notified via email that the Quarter ending September 2022, Interim Activity and CHNE Quarterly Reporting scores for timeliness and completeness were finalized. All 83 hospitals17 in this reporting quarter were considered timely; 83 hospitals were considered complete for their Interim Activity reporting; and 82 hospitals were considered complete for their CHNE Activity reporting. Therefore, 82 hospitals earned the available 0.5% of at-risk funds for this quarter of reporting. 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.

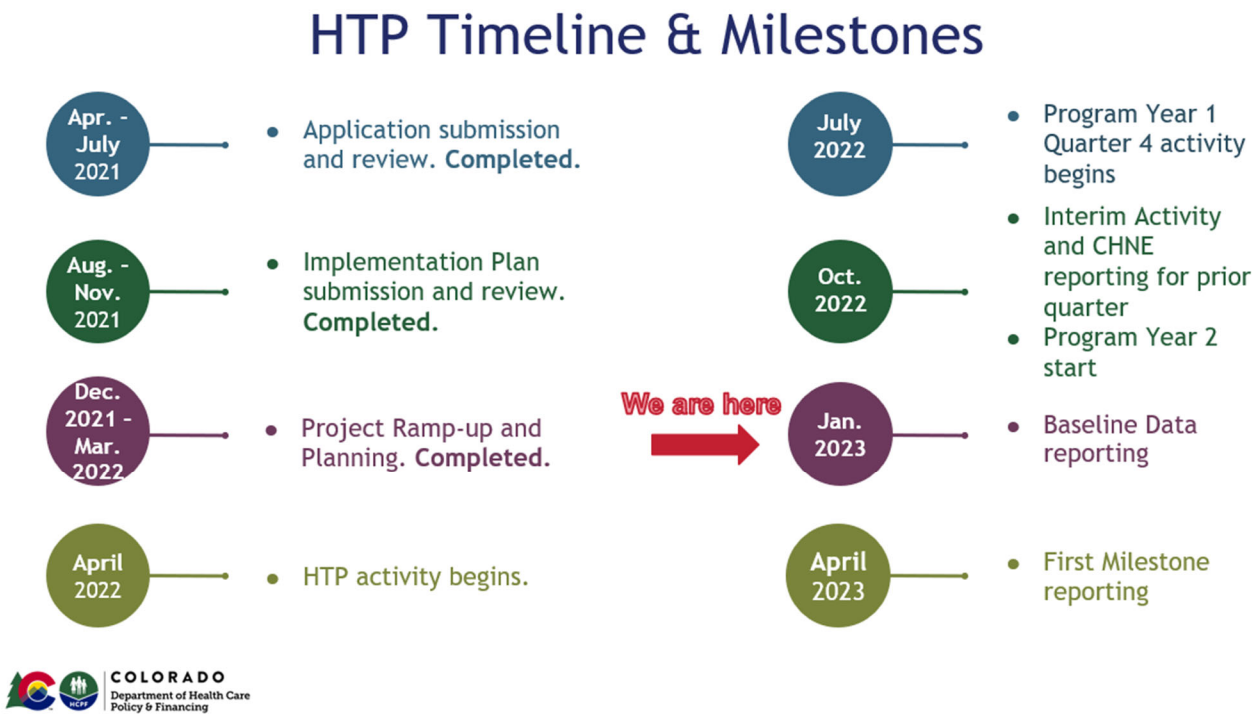

Figure 5. *Hospital Transformation Program Timeline*

[17] During this HTP reporting period only 83 hospitals were due to report however, there are 84 hospitals that are part of the HTP with OrthoColorado joining at a later date.

Table 12. Year 1 Quarter ending Sept. 30, 2022, Interim and CHNE Activity Submission Achievement

Components	Scoring Criteria	Number of Hospitals
Year 1 Quarter ending Sept. 30, 2022, Reporting Submission	On Time	83
Year 1 Quarter ending Sept. 30, 2022, Reporting Submission	Late	0
Year 1 Quarter ending Sept. 30, 2022, Reporting – Interim Activity Completeness	Complete	83
Year 1 Quarter ending Sept. 30, 2022, Reporting – Interim Activity Completeness	Incomplete	0
Year 1 Quarter ending Sept. 30, 2022, Reporting – CHNE Activity Completeness	Complete	82
Year 1 Quarter ending Sept. 30, 2022, Reporting – CHNE Activity Completeness	Incomplete	1
Achievement Status	**At-risk earned**	**82**
Achievement Status	**At-risk unearned**	**1**

1. **HTP Quarter Ending September 2022 Activity Summary**

During the project ramp-up and planning period of HTP, there are Interim Activity reporting periods prior to hospitals' first Milestone Activity reporting period in PY2Q2 (January to March 2023).

While payment is not tied to successful completion of milestones during interim activity reporting, this reporting period provides insight into whether hospitals are on target to complete the upcoming milestones for all interventions designated in their Implementation Plans. Hospitals collectively reported they are **on track** with the vast majority of their interventions (**99% of interventions** reported on target).

Table 13. Interim Activity Summary – Intervention Progress

Interim Activity Progress	Number of Interventions
Number of Interventions that Hospitals Reported Were on Track to Complete Program Year 2, Quarter ending June 2023 Milestones	630
Total Number of Interventions during Program Year 1, Quarter ending Sept. 30, 2022 Reporting	636

Similarly, 78 out of 83 hospitals (**94% of hospitals**) report they are **on track** to complete all of their upcoming milestones for Program year 2, Quarter ending June 30, 2023.

Table 14. Interim Activity Progress

Interim Activity Progress	Number of Hospitals
Number of Hospitals that Reported Being on Track to Complete All Upcoming Program Year 2, Quarter ending June 2023, Milestones	78
Total Number of Reporting Hospitals	83

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. So far hospitals are making progress toward **1,479 different interim activities attributed to the four functional areas** across all hospital interventions.[18]

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 impacts patient care. Through the Interim Activity reporting survey, hospitals can document updates on these improvement activities, as categorized by the four functional area types.

2. Program Year 1 Quarter ending September 30, 2022, 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 1 Quarter ending September 30, 2022, Submissions of Excellence demonstrated the following criteria:

[18] Note, the interim activities summarized during Quarter ending Sept 30, 2022 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.

- ***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 People and Technology functional area. During the Quarter ending September 30, 2022 Interim Activity Reporting, the hospital provided sufficient detail and addressed both People 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 effort above and beyond program requirements. While hospitals were minimally required to report some type of ongoing CHNE activities this quarter (whether key stakeholder engagements, community advisory meetings, and/or public engagements), some hospitals reported multiple engagements this quarter, therefore, 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, the hospital can better understand, and therefore, serve the broad interests of the community.
  - ✓ Hospitals documented detailed feedback 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 required on an ongoing basis for program participants. Before hospitals submitted their application to the program, they participated in a Community and Health Neighborhood Engagement (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 the figure below, hospitals **surpassed reporting requirements** for Quarter ending September 30, 2022, CHNE Reporting. Additionally, they are making progress towards meeting their Program Year One annual reporting requirements. With **over 700 unique CHNE activities conducted and captured this quarter**, this shows that hospitals are making strides in connecting with their community and partner organizations on pertinent HTP topics.

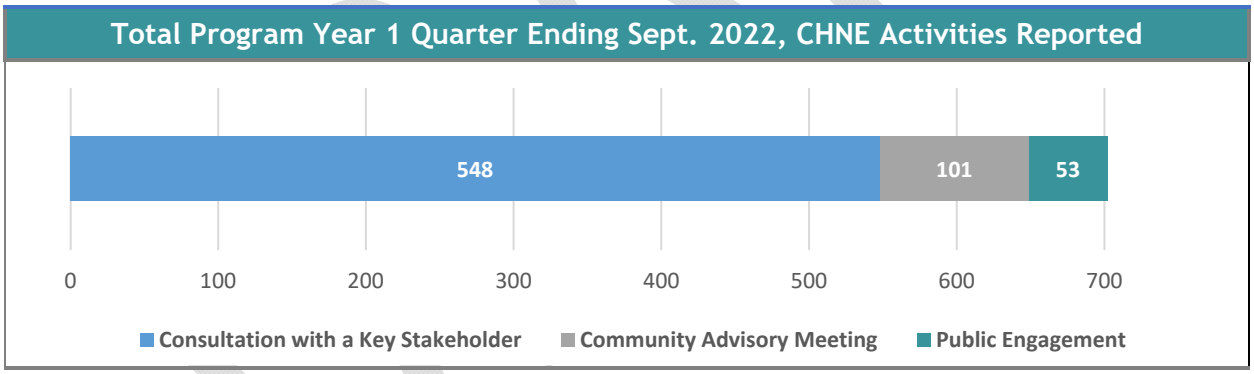

Figure 6. Program Year 1 Quarter Ending Sept. 2022, CHNE Activities

Table 15. Average CHNE Engagement Reported per Hospital

CHNE Component	Average CHNE Engagement Reported per Hospital
Consultation with Key Stakeholder	6.77
Community Advisory Meeting	1.77
Public Engagement	1.06

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 PY1Q3 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** (LPHAs), such as Rio Blanco County Public Health, Eagle County Public Health, Pitkin County Public Health, and Boulder County Public Health/Family Connects
- **Behavioral Health Providers**, such as Mind Springs Health, Aspen Hope Center, Jefferson Center for Mental Health, and SouthWEST Opioid Response District (SWORD)
- **Community Health Centers** (including Federally Qualified Health Centers and rural health centers), such as High Plains Community Health Center and Mountain Family Health Center
- **Primary Care Medical Providers** (PCMPs), such as Swedish Family Medicine, Building Hope Summit County, and Southeast Health Group
- **Regional Emergency Medical and Trauma Services Advisory Councils** (RETACs), such as Metro Denver Homeless Initiative, Foothills RETAC, and Colorado Coalition for the Homeless
- **Long-Term Service and Support** (LTSS) Providers, such as Vibra, Developmental Pathways-Intellectual & Developmental Disabilities (IDD)-Community Centered Boards, and Team Select
- **Consumer advocates or advocacy organizations**, such as TMCA Patient Family Advisory Committee, Open Heart Advocates, Club 20, and Peer Assistance Services
- **Health alliances**, such as Gunnison Valley Health Coalition, West Mountain Regional Health Care (WMRHC), and Mile High Health Alliance
- **Community organizations addressing social determinants of health**, such as MDPH S-HIE Implementation Workgroup, Denver Regional Council of Governments (DRCOG), JeffCo Food Task Force, FindHelp, and Vivage
- **Other**, such as Rangely Fire Department and Aurora Police

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 key stakeholder this quarter.[19]

During the Quarter ending Sept. 30, 2022

- 81 out of 83 hospitals reported at least one consultation with a key stakeholder
- In total, hospitals reported 548 consultations with key stakeholders
- There was stakeholder engagement with over 200 unique organizations [20]

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: Parker Adventist Hospital, 20; Longmont United Hospital, 16; Platte Valley Medical Center, 16; Avista Adventist Hospital, 15; and St. Anthony Hospital, 15.

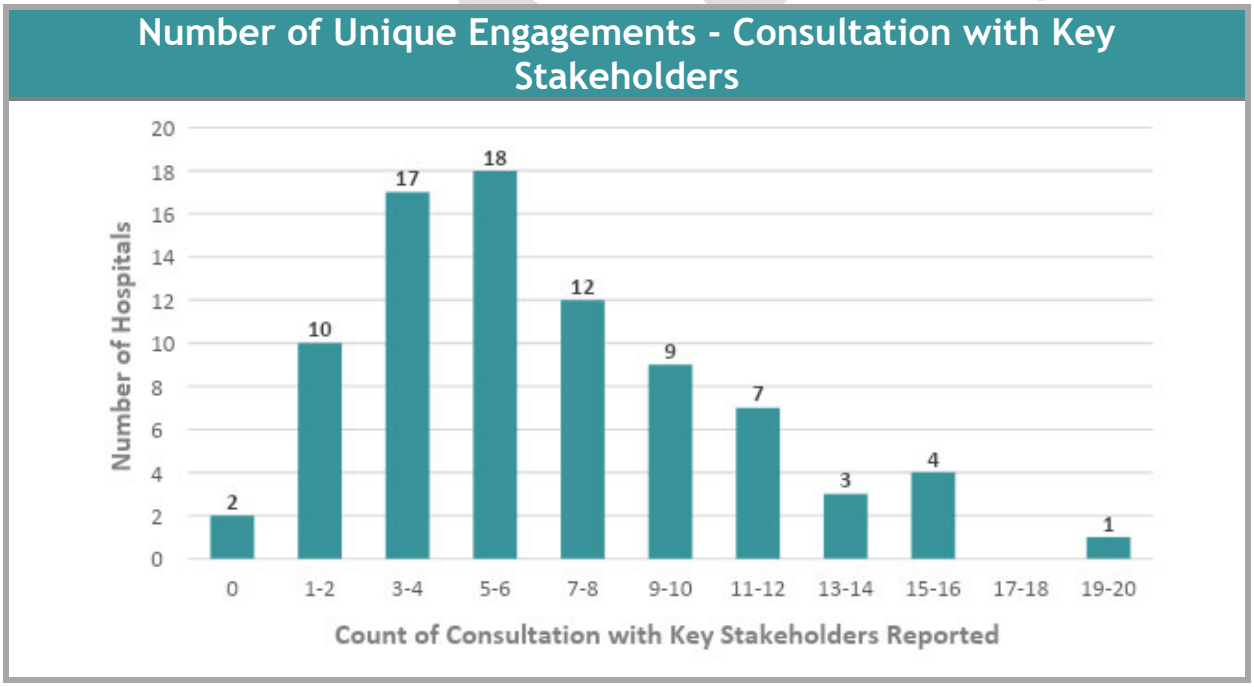

Figure 7. Number of Unique Engagements Reported by Each Hospital- Consultation with Key Stakeholders

[19] Two hospitals did not report a consultation with key stakeholder this quarter: Middle Park Medical Center and Animas Surgical Hospital. Middle Park Medical Center met its reporting requirements by conducting a community advisory meeting; however, Animas Surgical Hospital did not report any CHNE this quarter, and therefore were deemed incomplete for CHNE reporting.
[20] Since several consultations were noted to be reoccurring, the actual number of meetings held this quarter may be far greater.

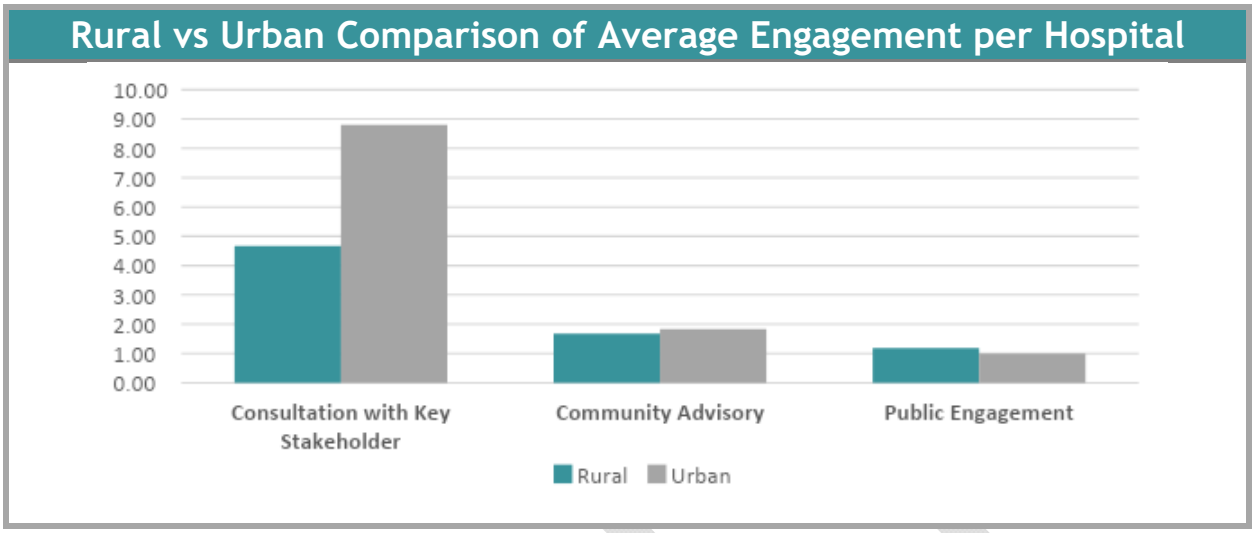

Figure 8. Rural vs Urban Comparison of Average Engagement per Hospital

Hospitals are also expected to engage key stakeholders in a group setting through either convening of **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, 2022

- Hospitals reported 101 community advisory meetings
- 57 out of 83 hospitals reported at least one community advisory meeting[21]

This speaks to hospitals' commitment to maximizing their engagement with their community and critical partners, as community advisory meetings were not a requirement for HTP Year One CHNE reporting. Hospitals are leveraging stakeholder input to make progress in addressing their interventions and making informed choices.

[21] 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.

H. Public Engagements

Continued CHNE should also allow for periodic engagement with the public more broadly. This could be achieved via public forum, 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 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, 2022

- Hospitals report 53 public engagements
- 50 out of 83 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 discussed their experience hosting informational booths at a health fair that were staffed with trained individuals to discuss HTP and its updates. The hospital also provided informational handouts regarding HTP. Through its reporting, the hospital noted the minimal feedback received, "Although the concept behind HTP is good information overall, HTP interventions is a lot to take in and understand for those who are not working in the healthcare environment.
- Many of the community members in attendance were polite and attentive but were not overly interested in the topic."
- Other feedback received helped hospitals better understand their community's focus areas and priorities surrounding the following:
  - ✓ Access to Mental and Behavioral Health Care Services and Providers, including increasing the availability for follow up or outpatient behavioral health services and increasing training to 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

- ✓ Continued focus on COVID-19 Prevention and Response, as well as the end to the public health emergency
- ✓ 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 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 Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board created the Community Advisory Council. Community Advisory Council (CAC) meetings provide valuable consumer input to all parts of the HTP.

The Community Advisory Council provided impactful feedback and suggestions during the creation of HTP. However, since HTP has entered the reporting stage, CAC membership has declined. The CAC has taken action to increase membership and informed the CHASE board during the August 23, 2022, meeting to seek guidance and feedback for increasing membership and contribute meaningful feedback for community engagement measures within HTP.

The Community Advisory Council has sent out letters to various organizations across the state to recruitment 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. Once membership has increased the CAC will host internal discussions about potential action plans to ensure the needs of individuals in communities are being heard and best served by HTP initiatives.

Additional information about the Community Advisory Council can be found in a Department memo[22] and on the council's webpage[23].

[22] https://hcpf.colorado.gov/sites/hcpf/files/2019%20September%20HTP%20Consumer%20engagement%20memo.pdf
[23] 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. Starting with Program Year 1, in the Quarter ending June 2022, hospitals were asked to submit ongoing interim activity reports that indicate the hospitals' progress on the activities they are undertaking with the implementation, management, execution, and monitoring of the interventions they have committed to in their implementation plans.[24] This report also contains information about the hospital's CHNE activities during the quarter. All reports are then reviewed by the Department and are evaluated based on established scoring criteria described within this document to determine payment of at-risk dollars.

In ongoing support efforts, the Department and partners have worked to compile and share learning opportunities and submissions of excellence (as documented earlier in the **HTP Quarter Ending September 2022 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, the Department will continue to provide regular FAQ updates, Office Hours, hospital workgroups, and one-one-one technical assistance, to ensure more seamless reporting and to build hospitals' confidence in their ongoing Interim Activity and CHNE requirements.

Overall, the number of hospitals on target to complete their future milestones is extremely encouraging. Yet, some hospitals have indicated they are not on target to complete some of their Program Year 2, Second Quarter (January – March 2023) milestones. The Department is aware that some hospitals have noted several setbacks and are already considering different mitigation strategies. While the goal is for all hospitals to be on target, the Department 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. The Department anticipates that

[24] In the first program year, hospitals are required to submit an Interim and CHNE Activity report in both Q3 (April – June 2022) and Q4 (July – September). Starting PY2 through the end of the program, hospitals will submit biannual reports during Q1 and Q3 Interim and CHNE Activity reports and biannual Q2 and Q4 Milestone and CHNE reports. This information, along with any hospital self-reported data associated with HTP measures, are a requirement of the program each year.

delivery system changes on this scale will continue to be met with unforeseen challenges. In addition, one hospital (Animas Surgical Hospital) did not meet minimum requirements for its CHNE Activity reporting, and therefore did not earn the available 0.5% of at-risk funds for this component of the program. 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. The Department may wish to track these challenges reported, monitor the prevalence, and potentially address them through legislative or rule-making channels.

In Program Year 2, the Department is planning to hold the first HTP learning symposium for HTP hospitals and stakeholders. The HTP learning symposium will be a mandatory two-day event for hospitals and key stakeholders with strong connections to the HTP program. The HTP learning symposium will celebrate hospital achievements to date, provide resources, peer learning and panels of how to be successful within the HTP program. The HTP learning symposium is another avenue for the Department to ensure success in the HTP program.

One way to help hospitals through the learning symposium was to survey and have conversations around the most critical aspects of HTP. Therefore, hospitals were surveyed about what content they would like to see presented and covered at the HTP learning symposium. Based on hospital survey results, the content covered at the learning symposium will include the following topics.

- Data and IT Reporting
  - ✓ Specifically for Clinicians, Quality Workers, IT Workers
  - ✓ Reporting to Regional Accountable Entities (RAE)
- Hospital Interventions
  - ✓ Social Determinants of Health
  - ✓ Behavioral Health
  - ✓ 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

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. 23 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 (approximately $523k per hospital). Rural Support Funds for FFY 2021-22 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 first program year which ran from October 2021 through September 2022. Attestation will be required for each subsequent year summarizing how the funds were utilized and how future funds will be allocated.

VII. Appendix

A. CHASE Fee, Supplemental Payments and Net Benefit

Table 16. 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
Craig Hospital	Arapahoe	$0	$83,936	$222,974	$0	$0	$7,369	$0	$314,279	$314,279
Kindred Hospital - Aurora	Adams	$0	$259,008	$0	$0	$0	$0	$0	$259,008	$259,008
Kindred Hospital - Denver	Denver	$0	$7,616	$0	$0	$0	$0	$0	$7,616	$7,616
Northern Colorado Long Term Acute Hospital	Larimer	$0	$0	$0	$0	$0	$0	$0	$0	$0
Northern Colorado Rehabilitation Hospital	Larimer	$0	$33,472	$8,316	$0	$0	$0	$0	$41,788	$41,788
PAM Specialty Hospital of Denver	Denver	$0	$21,504	$0	$0	$0	$0	$0	$21,504	$21,504
Rehabilitation Hospital of Colorado Springs	El Paso	$0	$133,600	$20,725	$0	$0	$113,223	$0	$267,548	$267,548
Rehabilitation Hospital of Littleton	Arapahoe	$0	$73,504	$0	$0	$0	$62,435	$0	$135,939	$135,939
Spalding Rehabilitation Hospital	Adams	$0	$69,504	$12,395	$0	$0	$0	$0	$81,899	$81,899
Vibra Hospital of Denver	Adams	$0	$55,808	$0	$0	$0	$0	$0	$55,808	$55,808
Vibra Rehabilitation Hospital	Adams	$0	$83,200	$0	$0	$0	$0	$0	$83,200	$83,200
Total		**$0**	**$821,152**	**$264,410**	**$0**	**$0**	**$183,027**	**$0**	**$1,268,589**	**$1,268,589**

Table 17. 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	$1,429,935	$38,556	$1,904,962	$324,100	$0	$24,669	$0	$2,292,287	$862,352
Arkansas Valley Regional Medical Center	Otero	$1,362,500	$2,375,000	$4,994,466	$675,208	$0	$175,054	$0	$8,219,728	$6,857,228
Aspen Valley Hospital	Pitkin	$1,643,755	$378,100	$1,434,149	$675,208	$0	$64,973	$285,546	$2,837,976	$1,194,221
Avista Adventist Hospital	Boulder	$10,813,338	$7,507,276	$9,194,042	$0	$0	$1,319,210	$0	$18,020,528	$7,207,190
Banner Fort Collins Medical Center	Larimer	$2,055,129	$1,182,584	$2,011,784	$0	$0	$698,458	$1,093,968	$4,986,794	$2,931,665
Broomfield Hospital	Jefferson	$1,803,169	$1,022,294	$1,867,051	$0	$0	$370,480	$0	$3,259,825	$1,456,656
Castle Rock Adventist Hospital	Douglas	$7,741,538	$2,033,902	$2,451,102	$0	$0	$599,120	$0	$5,084,124	-$2,657,414
Children's Hospital Anschutz	Adams	$41,149,030	$33,403,820	$11,341,638	$0	$0	$6,348,925	$23,044,926	$74,139,309	$32,990,279
Children's Hospital Colorado Springs	El Paso	$12,366,166	$5,482,740	$2,047,549	$0	$0	$1,255,092	$2,261,983	$11,047,364	-$1,318,802
Colorado Canyons Hospital & Medical Center[25]	Mesa	$1,373,271	$40,698	$2,828,735	$675,208	$0	$14,171	$0	$3,558,812	$2,185,541
Colorado Plains Medical Center	Morgan	$3,884,459	$1,082,781	$4,353,878	$0	$0	$234,342	$0	$5,671,001	$1,786,542
Community Hospital	Mesa	$7,989,126	$817,950	$2,980,020	$0	$0	$302,648	$5,201,366	$9,301,984	$1,312,858
Conejos County Hospital	Conejos	$258,506	$71,757	$2,137,844	$459,141	$521,739	$129,201	$0	$3,319,682	$3,061,176
Delta County Memorial Hospital	Delta	$4,329,063	$1,854,400	$6,702,399	$0	$0	$268,464	$0	$8,825,263	$4,496,200
Denver Health Medical Center	Denver	$38,092,661	$46,796,556	$9,370,922	$0	$0	$10,504,207	$49,476,851	$116,148,536	$78,055,875
East Morgan County Hospital	Morgan	$817,533	$636,500	$3,318,545	$675,208	$521,739	$601,517	$0	$5,753,509	$4,935,976
Estes Park Health	Larimer	$1,108,023	$535,800	$3,332,682	$621,191	$0	$0	$0	$4,489,673	$3,381,650
Foothills Hospital	Boulder	$23,598,546	$7,140,675	$16,039,937	$0	$0	$409,814	$0	$23,590,426	-$8,120
Good Samaritan Medical Center	Boulder	$20,017,902	$5,774,002	$3,965,833	$0	$0	$627,698	$0	$10,367,533	-$9,650,369
Grand River Health	Garfield	$1,652,545	$186,200	$2,213,705	$675,208	$0	$95,150	$3,276,717	$6,446,980	$4,794,435

[25] Name changed to St. Elizabeth Hospital when it was acquired by Centura Health on May 1, 2022.

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Grandview Hospital	El Paso	$2,279,529	$500,461	$2,461,084	$0	$0	$672,468	$0	$3,634,013	$1,354,484
Greeley Hospital	Weld	$9,779,644	$2,675,953	$5,416,047	$0	$0	$1,731,593	$5,462,030	$15,285,623	$5,505,979
Gunnison Valley Health	Gunnison	$1,292,078	$317,300	$1,462,039	$648,199	$0	$111,664	$0	$2,539,202	$1,247,124
Haxtun Health	Phillips	$122,526	$24,700	$627,185	$675,208	$521,739	$0	$0	$1,848,832	$1,726,306
Heart of the Rockies Regional Medical Center	Chaffee	$2,378,843	$1,311,000	$5,820,256	$675,208	$0	$0	$0	$7,806,464	$5,427,621
Highlands Ranch Hospital	Adams	$12,248,786	$3,541,272	$11,069,385	$0	$0	$798,827	$13,243	$15,422,727	$3,173,941
Keefe Memorial Hospital	Cheyenne	$118,421	$26,600	$639,626	$675,208	$521,739	$5,922	$0	$1,869,095	$1,750,674
Kit Carson County Memorial Hospital	Kit Carson	$494,421	$416,100	$1,767,242	$513,158	$521,739	$131,646	$0	$3,349,885	$2,855,464
Lincoln Community Hospital	Lincoln	$399,850	$83,600	$1,447,533	$405,125	$521,739	$6,134	$0	$2,464,131	$2,064,281
Littleton Adventist Hospital	Arapahoe	$22,418,186	$8,082,319	$10,750,047	$0	$0	$876,456	$0	$19,708,822	-$2,709,364
Longmont United Hospital	Boulder	$11,040,722	$4,954,742	$4,386,016	$0	$0	$891,143	$4,964,194	$15,196,095	$4,155,373
Longs Peak Hospital	Weld	$7,007,632	$2,610,946	$3,580,641	$0	$0	$1,770,430	$3,739,467	$11,701,484	$4,693,852
Lutheran Medical Center	Jefferson	$31,905,642	$20,603,639	$24,115,960	$0	$0	$1,555,456	$0	$46,275,055	$14,369,413
McKee Medical Center	Larimer	$7,382,275	$2,304,614	$4,835,114	$0	$0	$1,607,084	$3,054,740	$11,801,552	$4,419,277
Medical Center of the Rockies	Larimer	$29,371,199	$7,782,970	$6,764,574	$0	$0	$1,820,186	$8,909,408	$25,277,138	-$4,094,061
Melissa Memorial Hospital	Phillips	$324,085	$150,100	$1,184,036	$405,125	$521,739	$12,431	$0	$2,273,431	$1,949,346
Memorial Hospital	El Paso	$54,243,252	$24,420,430	$4,100,075	$0	$0	$11,310,682	$21,172,586	$61,003,773	$6,760,521
Mercy Regional Medical Center	La Plata	$11,301,889	$3,927,357	$12,185,268	$0	$0	$1,180,813	$0	$17,293,438	$5,991,549
Middle Park Medical Center	Grand	$896,144	$100,700	$3,165,600	$675,208	$521,739	$14,382	$0	$4,477,629	$3,581,485
Montrose Regional Health	Montrose	$6,585,094	$1,280,600	$4,902,652	$0	$0	$615,098	$1,971,583	$8,769,933	$2,184,839
Mt. San Rafael Hospital	Las Animas	$1,203,409	$366,282	$4,519,005	$675,208	$0	$162,178	$0	$5,722,673	$4,519,264
National Jewish Health	Denver	$4,204,172	$55,211	$6,865,756	$0	$0	$21,471	$670,144	$7,612,582	$3,408,410
North Colorado Medical Center	Weld	$24,593,556	$14,393,152	$10,386,748	$0	$0	$2,958,902	$10,322,673	$38,061,475	$13,467,919
North Suburban Medical Center	Adams	$27,493,215	$11,997,707	$8,668,354	$0	$0	$1,609,295	$8,968,687	$31,244,043	$3,750,828
OrthoColorado Hospital	Jefferson	$2,765,286	$151,385	$599,140	$0	$0	$0	$0	$750,525	-$2,014,761
Pagosa Springs Medical Center	Archuleta	$827,168	$376,200	$2,580,620	$297,091	$521,739	$193,960	$0	$3,969,610	$3,142,442
Parker Adventist Hospital	Douglas	$19,562,145	$8,232,630	$14,227,739	$0	$0	$944,271	$0	$23,404,640	$3,842,495
Parkview Medical Center	Pueblo	$46,171,528	$35,210,325	$28,865,212	$0	$0	$7,449,662	$0	$71,525,199	$25,353,671
Penrose-St. Francis Health Services	El Paso	$56,143,315	$38,187,268	$41,672,323	$0	$0	$4,073,735	$0	$83,933,326	$27,790,011
Pikes Peak Regional Hospital	Teller	$795,581	$267,750	$3,179,356	$405,125	$521,739	$296,946	$0	$4,670,916	$3,875,335
Pioneers Medical Center	Rio Blanco	$343,651	$70,300	$430,115	$432,133	$521,739	$1,760	$0	$1,456,047	$1,112,396
Platte Valley Medical Center	Adams	$7,228,845	$3,535,285	$5,282,037	$0	$0	$1,273,095	$5,935,042	$16,025,459	$8,796,614
Porter Adventist Hospital	Denver	$22,371,511	$6,706,356	$4,928,106	$0	$0	$799,216	$0	$12,433,678	-$9,937,833
Poudre Valley Hospital	Larimer	$38,156,428	$9,080,115	$1,767,280	$0	$0	$5,053,056	$9,991,561	$25,892,012	-$12,264,416
Presbyterian-St. Luke's Medical Center	Denver	$41,970,600	$38,966,403	$25,420,341	$0	$0	$1,937,391	$0	$66,324,135	$24,353,535
Prowers Medical Center	Prowers	$888,004	$1,499,100	$5,497,496	$675,208	$0	$258,041	$0	$7,929,845	$7,041,841
Rangely District Hospital	Rio Blanco	$120,523	$9,500	$676,300	$675,208	$521,739	$0	$0	$1,882,747	$1,762,224
Rio Grande Hospital	Rio Grande	$715,777	$283,815	$2,091,943	$459,141	$521,739	$255,424	$0	$3,612,062	$2,896,285
Rose Medical Center	Denver	$32,502,255	$13,865,845	$14,789,814	$0	$0	$1,086,631	$0	$29,742,290	-$2,759,965
San Luis Valley Health Regional Medical Center	Alamosa	$4,956,094	$2,827,440	$9,924,224	$0	$0	$1,331,536	$0	$14,083,200	$9,127,106
Sedgwick County Health Center	Sedgwick	$251,546	$178,600	$804,322	$405,125	$521,739	$7,174	$0	$1,916,960	$1,665,414
Sky Ridge Medical Center	Douglas	$40,079,826	$9,955,001	$9,430,310	$0	$0	$678,740	$0	$20,064,051	-$20,015,775
Southeast Colorado Hospital	Baca	$300,325	$218,500	$1,218,561	$621,191	$521,739	$38,465	$0	$2,618,456	$2,318,131

Hospital Name	County	CHASE Fee	Inpatient Payment	Outpatient Payment	Essential Access Payment	Rural Support Payment	HQIP Payment	DSH Payment	Total Payment	Net Benefit
Southwest Health System	Montezuma	$1,766,021	$2,004,500	$6,967,611	$675,208	$521,739	$309,269	$0	$10,478,327	$8,712,306
Spanish Peaks Regional Health Center	Huerfano	$362,200	$378,100	$2,209,081	$540,166	$521,739	$26,305	$0	$3,675,391	$3,313,191
St. Anthony Hospital	Jefferson	$30,116,437	$13,947,011	$6,518,997	$0	$0	$1,341,206	$0	$21,807,214	-$8,309,223
St. Anthony North Health Campus	Broomfield	$14,999,225	$5,901,344	$6,982,920	$0	$0	$2,173,442	$0	$15,057,706	$58,481
St. Anthony Summit Medical Center	Summit	$3,930,340	$1,251,999	$4,538,715	$0	$0	$464,454	$0	$6,255,168	$2,324,828
St. Joseph Hospital	Denver	$36,596,741	$29,556,107	$24,480,998	$0	$0	$1,285,379	$0	$55,322,484	$18,725,743
St. Mary-Corwin Medical Center	Pueblo	$10,306,822	$2,181,725	$7,964,683	$0	$0	$553,713	$0	$10,700,121	$393,299
St. Mary's Medical Center	Mesa	$30,716,550	$13,173,587	$10,948,193	$0	$0	$578,348	$10,549,920	$35,250,048	$4,533,498
St. Thomas More Hospital	Fremont	$2,937,343	$2,304,792	$6,683,523	$675,208	$0	$678,619	$0	$10,342,142	$7,404,799
St. Vincent Hospital	Lake	$203,922	$79,800	$1,378,033	$675,208	$521,739	$0	$0	$2,654,780	$2,450,858
Sterling Regional MedCenter	Logan	$1,853,174	$1,098,846	$5,475,407	$675,208	$521,739	$612,927	$0	$8,384,127	$6,530,953
Swedish Medical Center	Arapahoe	$59,265,958	$33,684,833	$25,954,010	$0	$0	$1,664,133	$0	$61,302,976	$2,037,018
The Medical Center of Aurora	Arapahoe	$48,385,067	$26,525,065	$29,107,611	$0	$0	$1,322,806	$0	$56,955,482	$8,570,415
The Memorial Hospital at Craig	Moffat	$1,244,450	$1,168,500	$5,650,669	$675,208	$521,739	$0	$0	$8,016,116	$6,771,666
University of Colorado Hospital	Adams	$109,514,896	$53,764,493	$61,960,864	$0	$0	$11,681,320	$38,589,155	$165,995,832	$56,480,936
Vail Health Hospital	Eagle	$5,408,391	$1,246,644	$6,616,923	$0	$0	$332,783	$0	$8,196,350	$2,787,959
Valley View Hospital	Garfield	$8,288,299	$5,286,456	$4,282,621	$0	$0	$413,051	$7,654,512	$17,636,640	$9,348,341
Weisbrod Memorial County Hospital	Kiowa	$74,655	$9,500	$549,909	$675,208	$521,739	$508	$0	$1,756,864	$1,682,209
Wray Community District Hospital	Yuma	$564,299	$843,600	$1,995,571	$405,125	$521,739	$191,814	$0	$3,957,849	$3,393,550
Yampa Valley Medical Center	Routt	$2,738,233	$1,068,858	$5,423,866	$0	$0	$601,901	$0	$7,094,625	$4,356,392
Yuma District Hospital	Yuma	$447,636	$152,000	$2,136,523	$405,125	$521,739	$88,272	$0	$3,303,659	$2,856,023
Total	**-**	**$1,138,441,83**	**$595,538,924**	**$636,823,453**	**$19,500,005**	**$11,999,997**	**$103,906,807**	**$226,610,302**	**$1,594,379,488**	**$455,937,656**
Total (all hospitals)	**-**	**$1,138,441,83**	**$596,360,076**	**$637,087,863**	**$19,500,005**	**$11,999,997**	**$104,089,834**	**$226,610,302**	**$1,595,648,077**	**$457,206,245**

B. Cost Shift

1. Payment to Cost Ratio by Payer Group

Figure 9~~Figure 9~~ is a visual display of payment to cost ratios by payer group from 2009 to 2021.

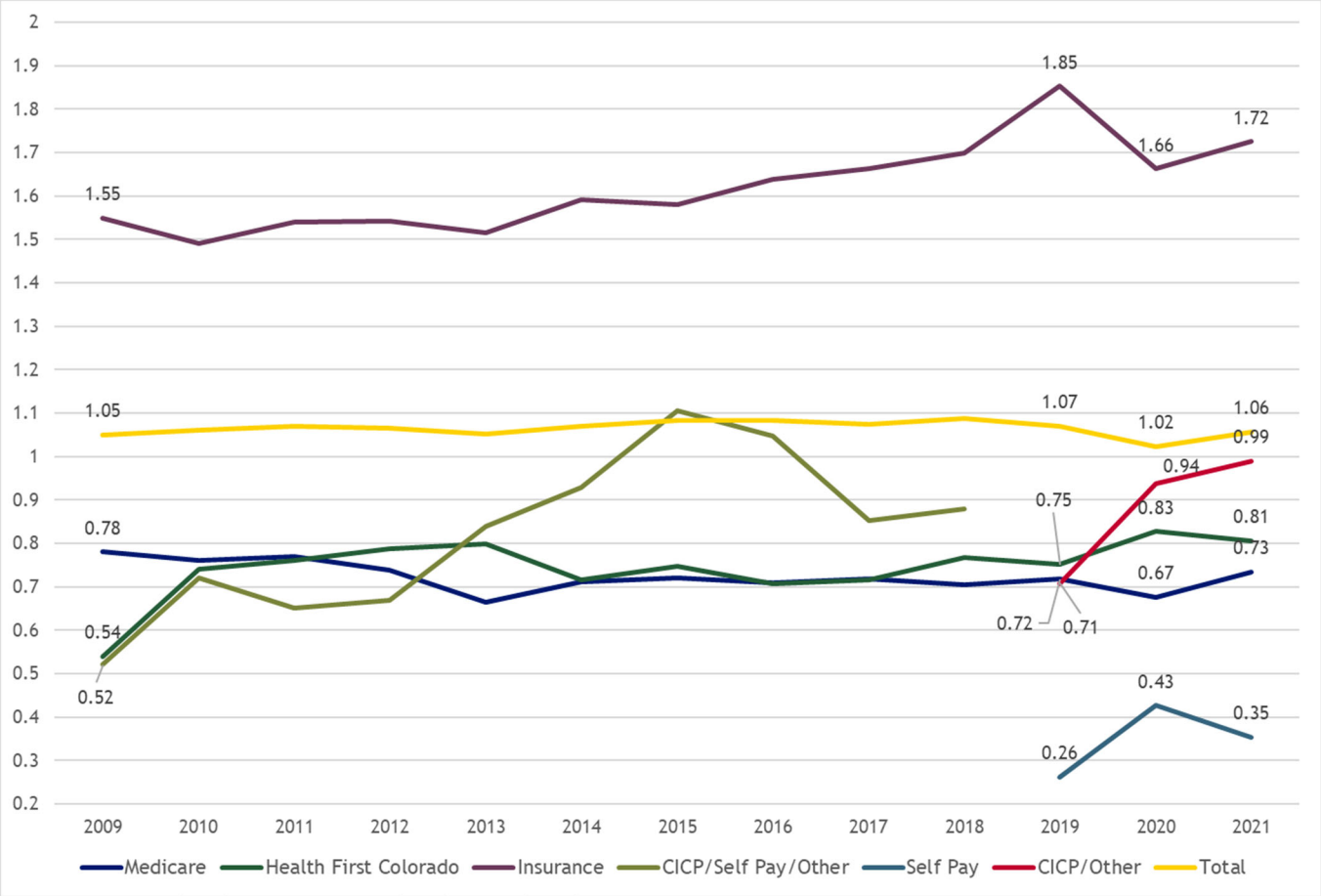

Figure 9. Payment to Cost Ratio by Payer Group

2. Payment, Cost by Payer Group

Figure 10~~Figure 10~~ shows the total payments by payer from 2009 to 2021. The figure highlights figures from the first year and the two most recent years. Table 18~~Table 18~~ and Table 19~~Table 19~~ displays the total hospital payments by payer group from 2009 to 2021.

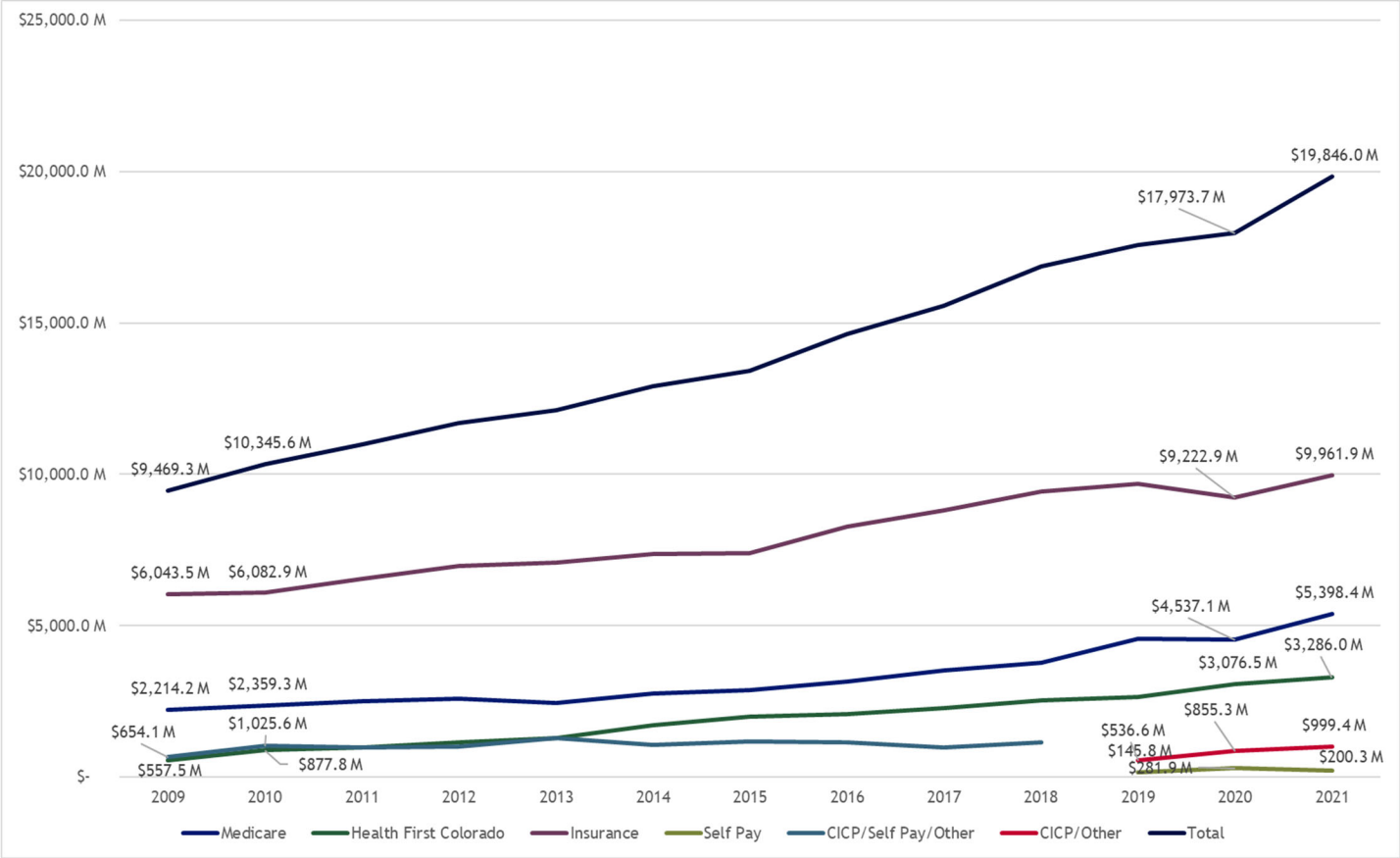

Figure 10. Total Payments by Payer Group

Table 18. 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 19. Total Payments by Payer Group, Post H.B. 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

Figure 11~~Figure 11~~ shows costs from 2009 to 2021. Table 20~~Table 20~~ and Table 21~~Table 21~~ show the total costs by payer from 2009 through 2021.

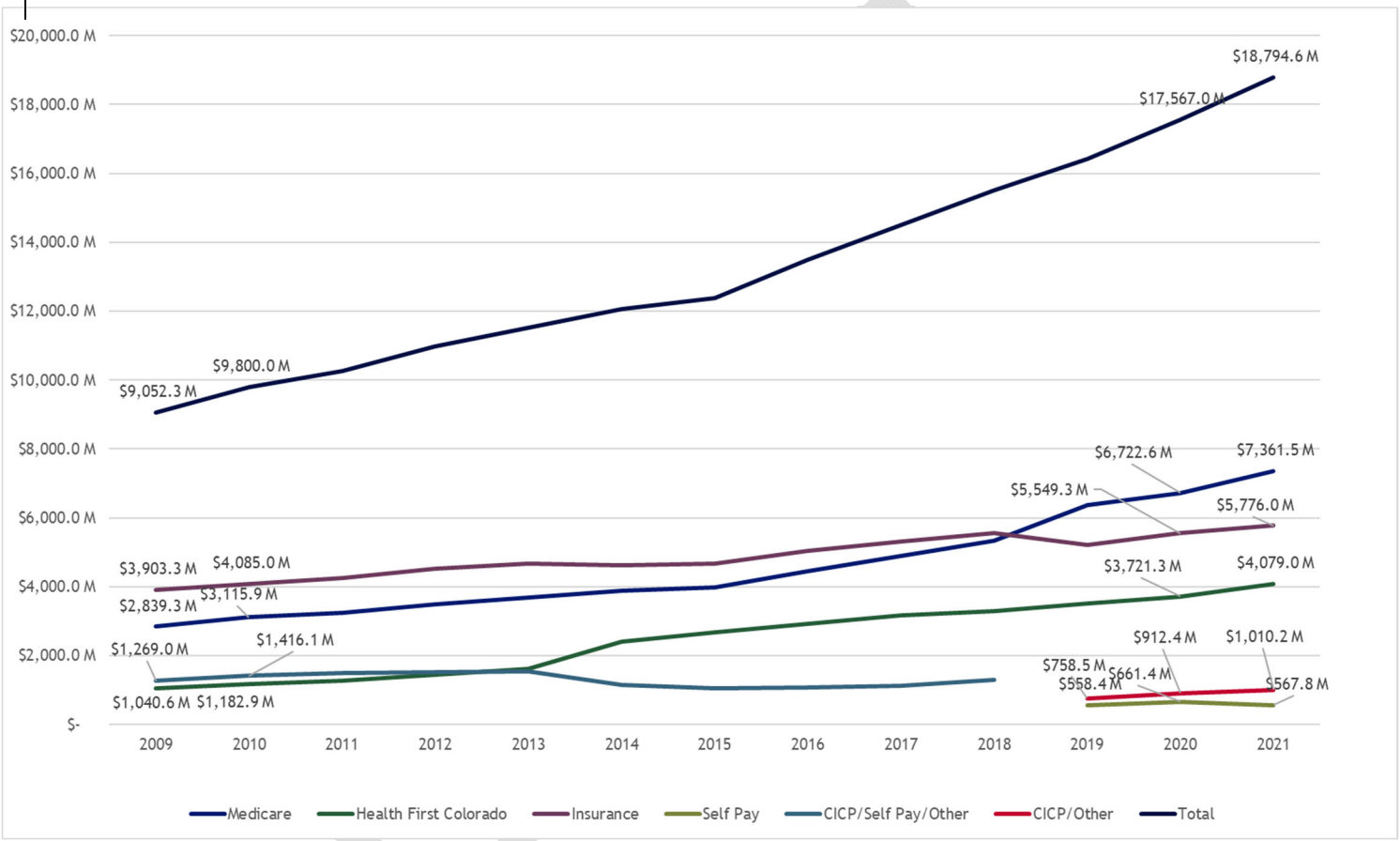

Figure 11. Total Costs by Payer Group

Table 20. 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 21. Total Costs by Payer Group, Post H.B. 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

Table 22. 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 23. Payment Less Cost by Payer Group, Post H.B. 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

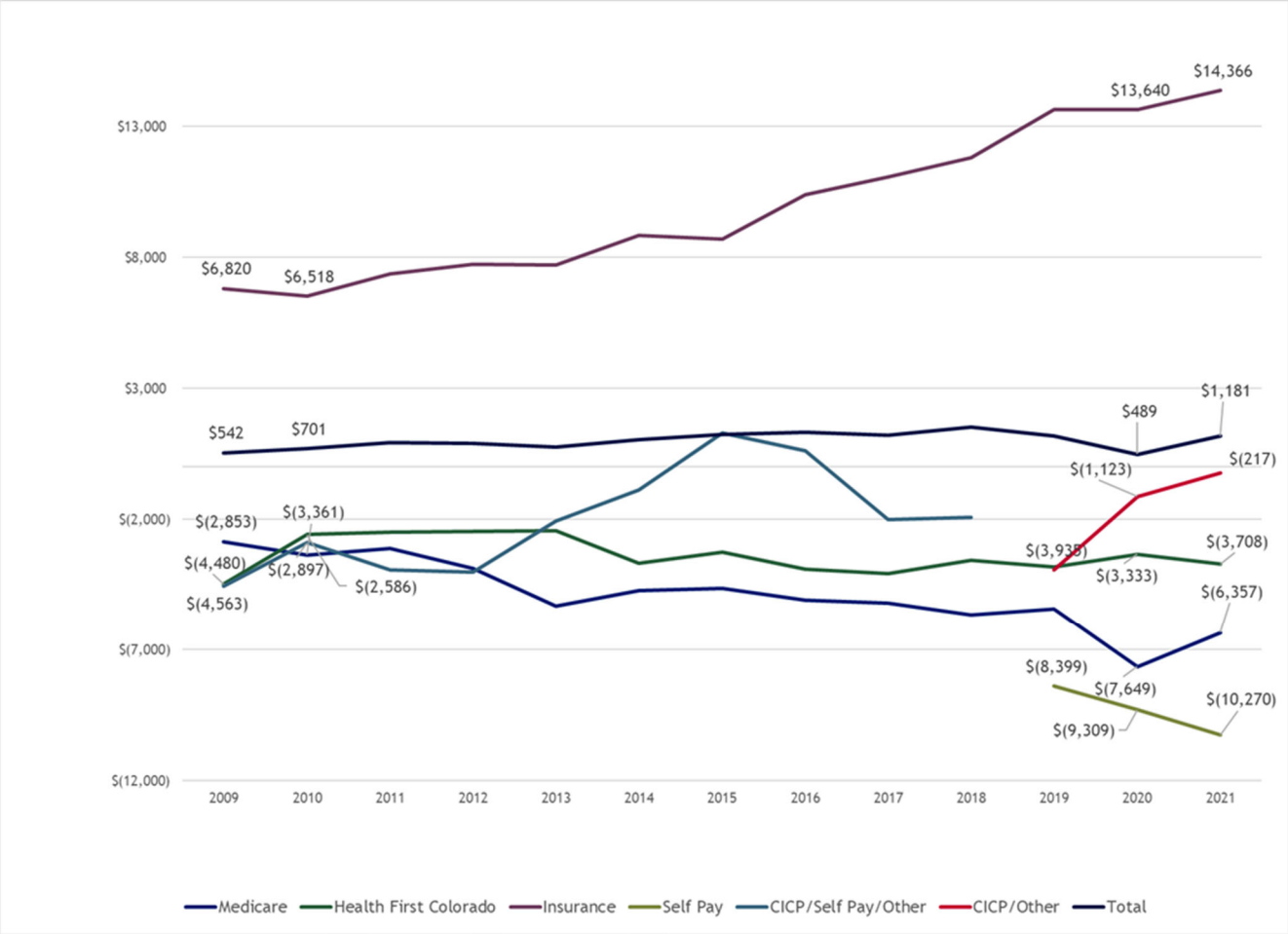

Figure 12. Payment less cost per patient by Payer Type

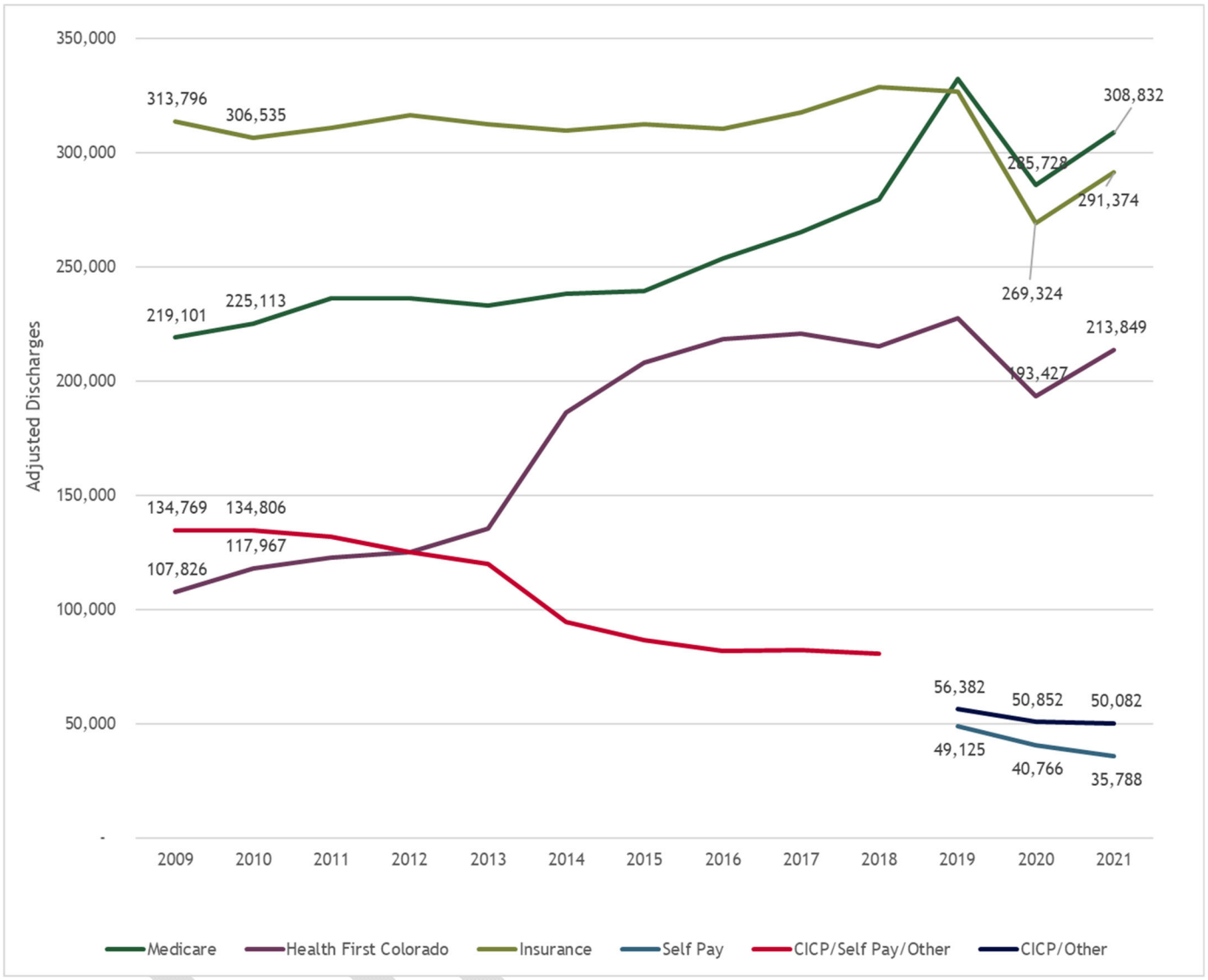

Figure 13. Patient Volume

3. Patient Mix by Payer

Table 24. 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 25. Patient Mix by Payer Group, Post H.B. 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%

C. Program Year 1 Rural Support Fund Attestation Summaries

Conejos County Hospital

- Increase Care Coordination staffing 0.5 to 1 FTE in Antonio clinic
- Increase Care Coordination and Discharge Planning @ CCH and LaJara clinic
- Develop standardized processes for transitions of care
- Standardize hand off communication
- Standardize PCP selection process; train staff on PCP Workflow
- Increase technology competence (MEDITECH patient portal, health information exchange, automate chart/schedule scrubbing process, surveillance tools for high-risk health conditions, electronic support for wound care)
- Participate in SLVH strategy planning process, develop transportation assistance resources and access through local partnerships

East Morgan County Hospital

- Addition of 2 RN case managers to assist in ambulatory setting
- Data analytics staffing and partnerships
- Acquire equipment/software for data interfaces
- Education, training, and marketing (Strategic Planning, Community Partners)
- Maternal Care (prenatal care and education, breast feeding class, decreased c-sections)
- Behavioral health and partnerships (telemedicine, emergency room remodel/expansion, Zero Suicide program, transportation partnerships)
- HME and Home Care Expansion
- Continued focus on Women's Health Service line and perinatal care

Haxtun Hospital District

- Add counseling room to provide a space for Centennial Mental Health
- Relocate Haxtun Clinic; add new counseling rooms to new location
- Using ALTOs in EDS; need to eliminate cost barriers to 1) educate clinical team on ALTOs and 2) purchase interface to better collect/report data
- Engage either a Clinical Informaticist or Consultant to identify a resource/product to achieve multiple district measures (SW-CP1, CP-6, RAH-1, RAH-2, COE1)
- Implement telemedicine
- Hire Actuary or Data Analyst; find right data processing tool
- Keep Director of Quality position to improve patient safety

Keefe Memorial Health Service District

- Expand Telehealth platform; maintain access to HealthOne for psychiatric consults
- Bring in partners to extract data from EMR; train staff on data entry requirements and entering screenings
- Upgrade to a 3D mammography unit; more patient outreach efforts for breast cancer awareness
- Purchase endoscope and engage a provider to perform endoscopies and colonoscopies for patients to have access to local screening/care
- Continued use of Chronic Care Management program
- Expand specialty doctor visits through HealthOne telerobot program

Kit Carson County Health Service District

- Administrative and operations efficiencies (effective data analytics processes)
- Development and offering innovative programs and collaboration with area services; community initiatives aimed at improving community health
- Promote existing services; develop additional specialty clinics
- Review and develop operations effectiveness and efficiency
- Acquisition of private and public funding for capital and operational needs
- Link diagnostic, therapeutic, and rehabilitative services with partners in health care systems
- Obtain access to contracts that maximize potential and minimize expenses
- Link resources between District personal and systems such as CHN, MSSP, HMOs, and PPOs

Lincoln Community Hospital

- Robust data system (work towards having a single platform to optimize Electronic Health Records)
- Improve provider utilization, improve revenue cycle management processes, efficiently and effectively extract data to improve all operation levels
- Possible addition of an interface engine to also help integrate HER
- Enhance telemedicine capabilities
- Improve community health education and access (tele-health services, para-medicine services, expanding catchment area to reach more people)
- Establish Centers of Excellence across EPHC to improve patient access

Melissa Memorial Hospital

- Select and implement a data analytics platform by Q3 of 2021

- Hire Data Analyst and Educator by Q2 of 2021
- Secure auditor and get bids for financial modeling by Q2 of 2021
- Develop benchmarks to support HTP goals by Q2 for baseline measures
- Strategic meetings in Q2-4 of 2021
- Leadership development and employee training Q2-4 of 2021
- Community partnering by Q3 of 2021
- Develop project management timeline by Q2-4 of 2021 including prioritizing and alignment of work

The Memorial Hospital

- Dedicated EPIC (EHR system) Systems Trainer/Data Analyst to assist in building reports and dashboards
- Implement Tableau for better data communication
- Invest in employee development and training (goal to become a 4-star hospital)
- Research to determine viability/sustainability of implementing mental and behavioral health services (external expertise needed)

Middle Park Medical Center

- Implement patient navigator program within system to assist in prevention of readmissions/initial acute admissions
- Start analyzing/stratifying data into high frequency chronic conditions (help prioritize patient navigator program focus)
- Start reporting 30-day readmissions to QHi (software managed by CO Rural Health Centers)
- Partner with behavioral health navigator to build brief intervention and referral segment (integrate hospital services with primary care services)
- Expand telemedicine service line to include more specialty services (specifically neurology) by end of 2021

Pagosa Springs Medical Center

- Use existing Electronic Health Record to better support chronic care management and care coordination
- Purchase modules from Cerner to facilitate management of above services
- Staff training in Medication Assisted Treatment; RN staff training in care coordination and chronic disease management
- Procure patient facing materials that explain and promote chronic disease management, behavioral health services (Medication Assisted Treatment), and care coordination

- Find and contract with organization that provides patient education and support for chronic disease conditions
- Possible addition of more telemedicine equipment
- Add additional staff as necessary to support initiatives such as Licensed Clinical Social Workers and Registered Nurses
- Use Rural Support Payment to offset costs associated with overall project management team

Pikes Peak Regional Hospital

- New technology platform that includes enhanced visualization modalities for surgical use
- Further employ Enhanced Recovery After Surgery; need for rehabilitation equipment
- Convert perioperative space adjacent to ED to multipurpose beds
- Medication management program expansion
- Improve facility and IT infrastructure
- Hire specially trained clinicians that can provide care, provider staff education/training, and facilitate assessment/placement of Behavioral Health patients

Pioneers Medical Center

- Increase staff; involve more frontline staff to bolster work
- Explore new avenues of technology use i.e. virtual meetings
- Explore vendor options for interfaces and data analysis
- Facilitate expanded use of current relationships/collaboratives

Rangely District Hospital

- Increase use of telemedicine
- Expansion of use of e-consults (increase patients that use service; add specialty services to e-consults as needed)
- Increase aftercare from hospital discharge; improve primary care patient relationship
- Ensure every patient seen in Emergency Room and hospital receives social needs screening within 12 months of admission
- Design workflows to reduce labor intensity and screening fatigue
- Follow up appointment made with clinician before discharge and notification to RAE within one business day
- Implement use of opioid risk assessment tool; provide opioid education to respective patients; staff training on ALTO

Rio Grande Hospital

- Increase/improve ability to report clinical information through CORHIO
- Continue to build relationships with downstream providers (meeting spaces, food, breaks, agenda planning)
- Hire an Event Planner/Organizer to lead Community Health Needs Assessment (CHNA) event
- Increase number of wellness visits at Rural Health Clinics; increase MAT testing to include ER inductions
- Hire Case Manager/Care Coordinator; hire a patient navigator; possibly share behavioral health counsellor with local Behavioral Health Organization
- Training in readiness for value-based improvements
- Train managers on dashboard development basics; learn more about population health data analytics

Sedgwick County Health Center

- Update infrastructure and equipment to improve telehealth services
- Add specialist services to telehealth program
- Focus on mental health of aging community
- Hire staff and purchase new equipment for newly established pain clinic
- New equipment in general (new CT machine)
- Expand facility space to accommodate growing staff and growing equipment needs

Southeast Colorado Hospital District

- Explore data extraction services/partnerships for improving and increasing technical capacity
- Expand telehealth modalities
- Explore resources to improve data analytics, actuarial service, and financial modeling means
- Recruit staff with skill sets to accomplish HTP key performance indicators

Southwest Health System, Inc.

- Electronic Health Record (EHR) Ambulatory purchase, monitoring, and report building
- Need Electronic Health Record interfaces with information exchanges
- Interface connection to CORHIO (to report to RAE; info sharing for discharge planning/transition of care and patient)
- Education and training for established positions on report training
- Patient Navigator position (data extraction, care coordination)
- Computer/equipment upgrades

- Software additions (Electronic Health Record for clinic portions)
- Cybersecurity; server upgrades

Spanish Peaks Regional Health Center

- Create designated observation room within emergency dept for mental health/suicidal patients
- Partner with Health Solutions or invest in 0.5 or 1.0 FTE to provide evaluations, care, and care coordination
- Enhance MAT program inductions
- Training and education for staff (SBIRT certification; Health Stream implementation; Mental Health First Aid Colorado certification)
- Enhance/increase patient portal usage
- Enhance telehealth
- Enhance data analytics and tracking through increased training for appropriate staff; new EMR

St. Vincent General Hospital District

- Repurpose old building as inpatient unit and outpatient treatment rooms (renovation)
- Telehealth equipment for mental health providers; additional upgrades to Electronic Health Record
- Design policies and procedures for ER triage
- Create an Urgent Care dept within ED for non-emergent patients
- Physician recruitment; succession planning for one local family practice provider
- Community education on available health services (monthly meetings with various community organizations)
- Improve connection to Latino population
- Integration of substance abuse administration and follow up
- Need two cultural navigators to assist patients with care coordination
- Create service agreement and pay for travel or other support for Arch Valley Recovery life coaches to support Lake County patients
- Pay for training for providers on suboxone therapy
- Creation of outpatient behavioral health counseling program (building renovation, hiring clinicians, contracting with psychiatrist and psychologist for telehealth visits)
- Partner with local school counselors and school-based health clinic
- Creation of an inpatient behavioral health and substance abuse wing

Sterling Regional MedCenter

- Add/enhance technology: interfaces, telehealth partnerships, data analytics, staff time/training
- Support behavioral healthcare: Acute Response Teams, care coordination, and shared clinical resources for behavioral and substance use
- Support correctional healthcare: enhancing capacity and coordination of care within ED
- Provide supplemental intrahospital and ground transport
- Enhance HME availability to support discharge needs
- Enhance social work support and ambulatory care coordination
- Support local transportation needs of patients (clinic/ambulatory visits)
- Provide consultation and strategic planning support
- Enhance community partnerships, involvement, and resources
- Purchase equipment to implement, expand, or enhance resources/service lines
- Provide training and education for patients, providers, team members, and partners
- Develop and enhance Maternal Fetal Medicine community opportunities

Weisbrod Memorial County Hospital

- Complete interfaces (CORHIO) within 6 months after receiving funds; pay for monthly fees associated with interfaces
- Place an individual in data analytics position
- Strategic planning and consulting event by end of 2021
- Technology enhancements (upgrade server, computer equipment, and software)
- By end of year 2 will have purchased two medication dispense units to interface with Electronic Health Record
- By end of year two upgrade x-ray unit with C-arm
- Add additional security through partnering with local Sheriff dept for behavioral health patients; partner with Southeast Health Group to provide behavioral health sitters

Wray Community District Hospital

- Telemedicine expansion within Specialties and Clinical Service lines
- Behavioral Health/Substance Use Disorder coordination and facilitation
- Enhance downstream communications and projects; potential 2021 projects: promoting well-being in schools, partnering with local EMS to provide in-home services
- Have an appropriate consultation service conduct analysis of existing and new services provided by WCDH in the market area
- Complete Comprehensive Primary Care Plus (CPC+) in 2021
- Ensure CHNE process continues

- Continue to increase total Provides/Specialist to meet expanding capacity in specialty clinics

Yuma District Hospital

- Bring Value-Up program to schools and community to focus on improving mental health for children and adults
- Implement programs that offer "self-management" for chronic disease and diabetes
- Assist foundation for Autistic Center in purchase of specialized equipment
- Invest in placement of a hospital based Social Worker
- Donate to Community Partners; sponsor own events to raise mental health awareness
- Acquire two mobile UVDI ultraviolet sanitation lights, one wall mounted unit
- Invest in BioVigil Hand Hygiene Monitoring System
- Implement Avera eCare Emergency and Avera eCare Hospitalist services (telehealth)
- Invest in patient educational channel (interfaces)
- iPad tablets for patients
- Potential hospital-based patient transportation assistance program
- Expand rehabilitation services: Freemotion Genesis, push/pull dynamometer, Total Gym
- Expand home health: Lifeline program, purchase Wound Camera
- New digital portable for radiology department
- X-ray room replacement
- Upgrade to full Digital Fluoroscopy; new full digital MRI; larger C-arm for surgery
- Support funds for patients with chronic conditions
- Bladder scanner; electronic double doors for patient care unit and surgery
- Staff educational needs