CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

January 15, 2020

Governor Jared Polis
136 State Capitol
Denver, CO 80203

Dear Governor Polis:

Enclosed please find a legislative report from the Department of Health Care Policy and Financing and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board on the Colorado Health Care Affordability and Sustainability Enterprise Act of 2018.

Section 25.5-4-402 4(e) states that on or before January 15,2018, the enterprise board shall submit a written report to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor and the state board. The report shall include, but need not be limited to: the recommendations made to the state board; a description of the formula for how the healthcare affordability and sustainability fee is calculated; an itemization of the costs incurred by the enterprise; estimates of the differences between the cost of case provided and the payment received by hospitals on a per-patient basis, aggregated or all hospitals, for patients covered by Medicaid Medicare; and all other payers; and a summary of the efforts made by the enterprise to seek any federal waiver necessary to fund and support the implementation of a health care delivery system reform incentive payments program.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

Shepard Nevel
Chair, Colorado Healthcare Affordability and Sustainability Enterprise Board

KB/nad

Enclosure(s): Colorado Healthcare Affordability and Sustainability Enterprise Act Annual Report

Cc: Elisabeth Arenales, Senior Health Policy Advisor, Governor's Office
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John Bartholomew, Finance Office Director, HCPF
Tracy Johnson, Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Community Living Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control and Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

January 15, 2020

The Honorable Daneya Esgar
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Esgar:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board on the Colorado Health Care Affordability and Sustainability Enterprise Act of 2018.

Section 25.5-4-402 4(e) states that on or before January 15,2018, the enterprise board shall submit a written report to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor and the state board. The report shall include, but need not be limited to: the recommendations made to the state board; a description of the formula for how the healthcare affordability and sustainability fee is calculated; an itemization of the costs incurred by the enterprise; estimates of the differences between the cost of case provided and the payment received by hospitals on a per-patient basis, aggregated or all hospitals, for patients covered by Medicaid Medicare; and all other payers; and a summary of the efforts made by the enterprise to seek any federal waiver necessary to fund and support the implementation of a health care delivery system reform incentive payments program.

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Shepard Nevel
Chair, Colorado Healthcare Affordability and Sustainability Enterprise Board

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Enclosure(s): Colorado Healthcare Affordability and Sustainability Enterprise Act Annual Report

Cc: Senator Dominick Moreno, Vice-Chair, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
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Nina Schwartz, Legislative Liaison, HCPF

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise
1570 Grant Street
Denver, CO 80203

January 15, 2020

The Honorable Susan Lontine, Chair
House Health and Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Lontine:

Enclosed please find a legislative report to the House Health and Insurance Committee from the Department of Health Care Policy and Financing and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board on the Colorado Health Care Affordability and Sustainability Enterprise Act of 2018.

Section 25.5-4-402 4(e) states that on or before January 15,2018, the enterprise board shall submit a written report to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor and the state board. The report shall include, but need not be limited to: the recommendations made to the state board; a description of the formula for how the healthcare affordability and sustainability fee is calculated; an itemization of the costs incurred by the enterprise; estimates of the differences between the cost of case provided and the payment received by hospitals on a per-patient basis, aggregated or all hospitals, for patients covered by Medicaid Medicare; and all other payers; and a summary of the efforts made by the enterprise to seek any federal waiver necessary to fund and support the implementation of a health care delivery system reform incentive payments program.

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Sincerely,

Kim Bimestefer
Executive Director

Shepard Nevel
Chair, Colorado Healthcare Affordability and Sustainability Enterprise Board

KB/nad

Enclosure(s): Colorado Healthcare Affordability and Sustainability Enterprise Act Annual Report

Cc: Representative Yadira Caraveo, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Susan Beckman, Health and Insurance Committee
Representative Janet Buckner, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
Representative Kerry Tipper, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
Representative Matt Soper, Health and Insurance Committee
Representative Brianna Titone, Health and Insurance Committee
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Nina Schwartz, Legislative Liaison, HCPF

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

January 15, 2020

The Honorable Jonathan Singer, Chair
House Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

Enclosed please find a legislative report to the House Public Health Care and Human Services Committee from the Department of Health Care Policy and Financing and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board on the Colorado Health Care Affordability and Sustainability Enterprise Act of 2018.

Section 25.5-4-402 4(e) states that on or before January 15,2018, the enterprise board shall submit a written report to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor and the state board. The report shall include, but need not be limited to: the recommendations made to the state board; a description of the formula for how the healthcare affordability and sustainability fee is calculated; an itemization of the costs incurred by the enterprise; estimates of the differences between the cost of case provided and the payment received by hospitals on a per-patient basis, aggregated or all hospitals, for patients covered by Medicaid Medicare; and all other payers; and a summary of the efforts made by the enterprise to seek any federal waiver necessary to fund and support the implementation of a health care delivery system reform incentive payments program.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

Shepard Nevel
Chair, Colorado Healthcare Affordability and Sustainability Enterprise Board

KB/nad

Enclosure(s): Colorado Healthcare Affordability and Sustainability Enterprise Act Annual Report

Cc: Representative Dafna Michaelson Jenet, Vice Chair, Public Health Care and Human Services Committee
Representative Yadira Caraveo, Public Health Care and Human Services Committee
Representative Lisa Cutter, Public Health Care and Human Services Committee
Representative Serena Gonzales-Gutierrez, Public Health Care and Human Services Committee
Representative Sonya Jacquez Lewis, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Kyle Mullica, Public Health Care and Human Services Committee
Representative Rod Pelton, Public Health Care and Human Services Committee
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Nina Schwartz, Legislative Liaison, HCPF

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

January 15, 2020

The Honorable Rhonda Fields, Chair
Senate Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

Enclosed please find a legislative report to the Senate Health and Human Services Committee from the Department of Health Care Policy and Financing and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board on the Colorado Health Care Affordability and Sustainability Enterprise Act of 2018.

Section 25.5-4-402 4(e) states that on or before January 15,2018, the enterprise board shall submit a written report to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor and the state board. The report shall include, but need not be limited to: the recommendations made to the state board; a description of the formula for how the healthcare affordability and sustainability fee is calculated; an itemization of the costs incurred by the enterprise; estimates of the differences between the cost of case provided and the payment received by hospitals on a per-patient basis, aggregated or all hospitals, for patients covered by Medicaid Medicare; and all other payers; and a summary of the efforts made by the enterprise to seek any federal waiver necessary to fund and support the implementation of a health care delivery system reform incentive payments program.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

Shepard Nevel
Chair, Colorado Healthcare Affordability and Sustainability Enterprise Board

KB/nad

Enclosure(s): Colorado Healthcare Affordability and Sustainability Enterprise Act Annual Report

Cc: Senator Brittany Pettersen, Vice Chair, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Faith Winter, Health and Human Services Committee
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Nina Schwartz, Legislative Liaison, HCPF

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

January 15, 2020

Amanda Moorer, President
1570 Grant Street
Denver, CO 80211

Dear Ms. Moorer:

Enclosed please find a legislative report from the Department of Health Care Policy and Financing and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board on the Colorado Health Care Affordability and Sustainability Enterprise Act of 2018.

Section 25.5-4-402 4(e) states that on or before January 15,2018, the enterprise board shall submit a written report to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor and the state board. The report shall include, but need not be limited to: the recommendations made to the state board; a description of the formula for how the healthcare affordability and sustainability fee is calculated; an itemization of the costs incurred by the enterprise; estimates of the differences between the cost of case provided and the payment received by hospitals on a per-patient basis, aggregated or all hospitals, for patients covered by Medicaid Medicare; and all other payers; and a summary of the efforts made by the enterprise to seek any federal waiver necessary to fund and support the implementation of a health care delivery system reform incentive payments program.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

Shepard Nevel
Chair, Colorado Healthcare Affordability and Sustainability Enterprise Board

KB/nad

Enclosure(s): Colorado Healthcare Affordability and Sustainability Enterprise Act Annual Report

Cc: David Pump, Vice-President, Medical Services Board
Christy Blakely, Medical Services Board
Martha Cecile Fraley, Medical Services Board
Patricia Lynn Givens, Medical Services Board
Simon Hambidge, Medical Services Board
Bregitta Hughes, Medical Services Board
Jessica Hughes, Medical Services Board
Charolette Lippolis, Medical Services Board
An Nguyen, Medical Services Board
Donna M. Roberts, Medical Services Board
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Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

Colorado Healthcare Affordability and Sustainability Enterprise Annual Report

January 15, 2020

CHASE

Colorado Healthcare Affordability and Sustainability Enterprise

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I. Colorado Healthcare Affordability and Sustainability Enterprise Overview

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

The CHASE is a government-owned business operating within the Department. Its purpose is to charge and collect the healthcare affordability and sustainability fee to obtain federal matching funds 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 the 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.

From October 2018 through September 2019, the CHASE has:

- **Provided $410 million in increased reimbursement to hospital providers**

  Hospitals received more than $1.3 billion in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed with healthcare affordability and sustainability fees, including $90.4 million in hospital quality incentive payments. This funding increased hospital reimbursement by $410 million for care provided to Medicaid and CICP members with no increase in General Fund expenditures.

- **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 2018, the payment for care provided to Medicaid members has improved overall, increasing coverage from 54% to 77% of costs[1]. In 2018, the amount of bad debt and charity care decreased by more than 56% compared to 2013. This sharp reduction in hospitals' uncompensated care follows the increased reimbursement to hospitals under CHASE and the reduction in the number of uninsured Coloradans due to the CHASE and the federal Affordable Care Act (ACA). However, a positive impact on cost shifting to private payers is not apparent with payments in excess of cost per patient increasing by approximately 182% since 2009. Determining the extent to which hospitals reduced the cost shift requires additional data and analysis.

- **Provided health care coverage through Health First Colorado and the Child Health Plan Plus (CHP+) for more than 421,000 Coloradans**

  As of September 30, 2019, the Department has enrolled approximately 65,000 Health First Colorado parents ranging from 61% to 133% of the federal poverty level (FPL), 27,000 CHP+ children and pregnant women ranging from 206% to 250% of the FPL, 9,600 Health First Colorado working adults up to 450% of the FPL and children with disabilities up to 300% of the FPL, and 320,000 Health First Colorado adults without dependent children up to 133% of the FPL with no increase in General Fund expenditures.

A. CHASE Annual Report

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

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

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

II. Healthcare Affordability and Sustainability Fee and Supplemental Payments

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

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

For terms expiring May 15, 2020:

- Dan Enderson of Castle Rock, representing a hospital
- Kimberley Jackson of Windsor, representing persons with disabilities

For terms expiring May 15, 2021:

- Shepard Nevel of Denver, representing a business that purchases health insurance, to serve as chair
- Dan Rieber of Castle Rock, representing a safety-net hospital
- Ryan Westrom of Aurora, representing a statewide organization of hospitals
- Kathryn Ashenfelter of Denver, representing an urban hospital
- Matthew Colussi of Aurora, representing the Department
- Allison Neswood of Denver, representing a consumer of health care

For terms expiring May 15, 2023:

- Brent Bowman of Denver, representing a statewide organization of health insurance carriers
- Scott Lindblom of Thornton, representing the Department
- Peg Burnette of Denver, representing a hospital
- Robert Morasko of Salida, representing a rural hospital

The Medical Services Board, with the recommendation of the CHASE Board, promulgated rules related to the healthcare affordability and sustainability fee, including the calculation, assessment, and timing of the fee, the reports that hospitals will be required to report to the

CHASE, and other rules necessary to implement the healthcare affordability and sustainability fee. Those rules are located at 10 CCR 2505-10, Section 8.3000.

The CHASE operates on a federal fiscal year (FFY) basis, from October to September. Table 1 outlines the FFY 2018-19 fee and payment amounts. Table 14 and Table 15 (in the Appendix) detail hospital specific FFY 2018-19 fee and payment amounts. Fees are collected and resulting hospital payments are made monthly by electronic funds transfer for each hospital.

Table 1. FFY 2018-19 CHASE Fee and Supplemental Payments

Item	Amount
Inpatient Fee	$453,264,832
Outpatient Fee	$464,614,608
Total Healthcare Affordability and Sustainability Fee	**$917,879,440**
Inpatient Base Rate Supplemental Payment	$471,932,536
Outpatient Supplemental Payment	$444,811,120
Uncompensated Care Supplemental Payment	$107,980,172
Disproportionate Share Hospital Supplemental Payment	$212,928,574
Hospital Quality Incentive Supplemental Payment	$90,445,983
Total Supplemental Payments	**$1,328,098,385**
Net Reimbursement to Hospitals	**$410,218,945**

For an overview of the fee assessment and payment methodologies recommended by the CHASE Board for October 2018 through September 2019, see the sections below. While individual hospitals may not be eligible for all payments, all methodologies are described.

A. Healthcare Affordability and Sustainability Fee

The total healthcare affordability and sustainability fee collected during FFY 2018-19 was $917,879,440, with the inpatient fee comprising 49.4% of total fees and the outpatient fee comprising 50.6% of total fees. In addition to the fee collected, $13.5 million was used from the cash fund reserve.

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 Medicaid members, are CICP providers, or are Essential Access providers are eligible to receive a discount on the fee. High Volume Medicaid and CICP providers are those providers with at least 27,500 Medicaid inpatient days per year that provide over 30% of their total days to Medicaid and CICP clients. The inpatient fee calculation for high-volume Medicaid and CICP providers was discounted by

47.79%. The outpatient fee for high-volume Medicaid 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% for these providers.

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

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

B. Supplemental Payments

1. Inpatient Base Rate Supplemental Payment

For qualified hospitals, this payment equals Medicaid estimated discharges multiplied by average Medicaid case mix multiplied by the Medicaid base rate multiplied by an inpatient percent adjustment factor. Inpatient percent adjustment factors may vary by hospital. The inpatient percent adjustment factor for each hospital is published annually in the Colorado Medicaid Provider Bulletin.

State licensed psychiatric hospitals are not qualified for this payment.

2. Outpatient Supplemental Payment

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

State licensed psychiatric hospitals are not qualified for this payment.

3. Uncompensated Care 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 $15,000,000. The Uncompensated Care Supplemental Payment for qualified non-Essential Access hospitals is the hospital's percent of uninsured costs compared to total uninsured costs for all qualified non-Essential Access hospitals multiplied by $92,980,176.

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

4. Disproportionate Share Hospital Supplemental Payment

The Disproportionate Share Hospital (DSH) payment equals $212,928,574 in total. To qualify for the DSH Supplemental Payment a Colorado hospital must meet either of the following criteria:

- Is 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
- Has a Medicaid Inpatient Utilization Rate 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.

5. Hospital Quality Incentive Supplemental Payment

The CHASE includes a provision to establish Hospital Quality Incentive Payments (HQIP) funded by healthcare affordability and sustainability fees 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 sought 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, 2018, the HQIP subcommittee recommended, and the CHASE Board approved, the following measures for HQIP payments. A hospital was scored on the first five measures for which it was eligible (in the order presented below) for a maximum possible score of 80 points.

2019 Measures

1. Regional Care Collaborative Organization and Behavioral Health Organization Engagement
2. Culture of Safety and Patient Safety
3. Advanced Care Planning and Care Transition Activities
4. Cesarean Section
5. Breastfeeding Practices
6. Tobacco and Substance Use Screening and Follow-Up
7. Emergency Department Process
8. Hospital Consumer Assessment of Healthcare Providers and Systems
9. 30 Day All-Cause Readmissions

Payment Calculation

The HQIP payments earned for each of the FFY 2018-19 measures are based on points per Medicaid adjusted discharge. Medicaid adjusted discharges are calculated by multiplying total Medicaid discharges by an adjustment factor. The adjustment factor is calculated by dividing total Medicaid gross charges by Medicaid inpatient service charges and multiplying the result by the total Medicaid discharges. The adjustment factor is limited to 5.0. For purposes of calculating Medicaid adjusted discharges, if a hospital has less than 200 Medicaid 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 Medicaid adjusted discharges multiplied by dollars per adjusted discharge point.

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

Table 2. FFY 2018-19 HQIP Dollars Per Adjusted Discharge Point

Tier	Quality Points Awarded	Dollars Per Adjusted Discharge Point
0	0-19	$0.00
1	20-35	$3.13
2	36-50	$6.26
3	51-65	$9.39
4	66-80	$12.52

During the FFY 2018-19 timeframe, HQIP payments totaled $90.4 million with 76 hospitals receiving payments. HQIP payments, Medicaid adjusted discharges, and quality points awarded by hospital are listed in Table 3.

Table 3. FFY 2018-19 Hospital Quality Incentive Payments

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Supplemental Payment
Animas Surgical Hospital	59	113	$9.39	$62,603
Arkansas Valley Regional Medical Center	60	985	$9.39	$554,949
Aspen Valley Hospital	55	157	$9.39	$81,083
Avista Adventist Hospital	58	2,009	$9.39	$1,094,142
Banner Fort Collins Medical Center	70	636	$12.52	$557,390
Boulder Community Health	59	1,859	$9.39	$1,029,905
Castle Rock Adventist Hospital	56	909	$9.39	$477,989
Children's Hospital Colorado	62	9,568	$9.39	$5,570,298
Colorado Canyons Hospital and Medical Center	51	75	$9.39	$35,917
Colorado Plains Medical Center	55	1,030	$9.39	$531,944
Community Hospital	49	586	$6.26	$179,750
Craig Hospital	49	63	$6.26	$19,325
Delta County Memorial Hospital	56	1,108	$9.39	$582,631
Denver Health Medical Center	64	12,565	$9.39	$7,551,062
East Morgan County Hospital	65	475	$9.39	$289,916
Estes Park Health	48	278	$6.26	$83,533
Good Samaritan Medical Center	55	2,033	$9.39	$1,049,943
Grand River Hospital District	55	263	$9.39	$135,826
Gunnison Valley Health	51	192	$9.39	$91,947
Heart of the Rockies Regional Medical Center	57	715	$9.39	$382,689
Keefe Memorial Health Service District	59	56	$9.39	$31,025
Kit Carson County Health Service District	67	181	$12.52	$151,830
Lincoln Community Hospital	55	44	$9.39	$22,724
Littleton Adventist Hospital	58	1,483	$9.39	$807,671
Longmont United Hospital	66	2,418	$12.52	$1,998,042
Lutheran Medical Center	50	5,180	$6.26	$1,621,340
McKee Medical Center	71	1,858	$12.52	$1,651,613
Medical Center of the Rockies	55	2,696	$9.39	$1,392,349
Melissa Memorial Hospital	50	31	$6.26	$9,703
Memorial Hospital Central	68	14,564	$12.52	$12,399,207
Mercy Regional Medical Center	59	1,723	$9.39	$954,559
Middle Park Medical Center	69	113	$12.52	$97,618
Montrose Memorial Hospital	54	875	$9.39	$443,678
Mt. San Rafael Hospital	48	781	$6.26	$234,675
National Jewish Health	50	125	$6.26	$39,125
North Colorado Medical Center	64	5,080	$9.39	$3,052,877
North Suburban Medical Center	63	5,831	$9.39	$3,449,445
Pagosa Springs Medical Center	78	331	$12.52	$323,241
Parker Adventist Hospital	51	1,776	$9.39	$850,509
Parkview Medical Center	72	6,743	$12.52	$6,078,410

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	Dollars Per Adjusted Discharge Point	HQIP Supplemental Payment
Penrose-St. Francis Health Services	68	7,213	$12.52	$6,140,860
Pikes Peak Regional Hospital	76	388	$12.52	$369,190
Pioneers Medical Center	29	49	$3.13	$4,448
Platte Valley Medical Center	46	2,052	$6.26	$590,894
Porter Adventist Hospital	62	1,595	$9.39	$928,577
Poudre Valley Hospital	65	6,060	$9.39	$3,698,721
Presbyterian/St. Luke's Medical Center	43	3,563	$6.26	$959,088
Prowers Medical Center	43	821	$6.26	$220,997
Rangely District Hospital	35	44	$3.13	$4,820
Rehabilitation Hospital of Colorado Springs	37	426	$6.26	$98,670
Rio Grande Hospital	66	506	$12.52	$418,118
Rose Medical Center	48	3,400	$6.26	$1,021,632
San Luis Valley Health Conejos County Hospital	54	69	$9.39	$34,987
San Luis Valley Health Regional Medical Center	64	1,732	$9.39	$1,040,863
Sedgwick County Health Center	22	81	$3.13	$5,578
Sky Ridge Medical Center	49	2,078	$6.26	$637,406
Southeast Colorado Hospital District	38	113	$6.26	$26,880
Southwest Health System, Inc.	32	869	$3.13	$87,039
Spanish Peaks Regional Health Center	57	144	$9.39	$77,073
St. Anthony Hospital	55	2,779	$9.39	$1,435,215
St. Anthony North Health Campus	53	3,634	$9.39	$1,808,533
St. Anthony Summit Medical Center	63	657	$9.39	$388,661
St. Joseph Hospital	38	4,744	$6.26	$1,128,503
St. Mary-Corwin Medical Center	57	3,397	$9.39	$1,818,176
St. Mary's Hospital & Medical Center, Inc.	70	2,003	$12.52	$1,755,429
St. Thomas More Hospital	49	1,316	$6.26	$403,670
Sterling Regional MedCenter	66	802	$12.52	$662,709
Swedish Medical Center	34	5,102	$3.13	$542,955
The Medical Center of Aurora	34	5,859	$3.13	$623,515
University of Colorado Hospital	57	11,320	$9.39	$6,058,804
Vail Health Hospital	59	505	$9.39	$279,775
Valley View Hospital	71	827	$12.52	$735,137
Weisbrod Memorial County Hospital	64	6	$9.39	$3,606
Wray Community District Hospital	70	220	$12.52	$192,808
Yampa Valley Medical Center	52	471	$9.39	$229,980
Yuma District Hospital	49	131	$6.26	$40,183
Total	**4,290**	**163,015**		**$90,445,983**

III. Administrative Expenditures

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

Administrative expenditures are reported on a state fiscal year basis. In State Fiscal Year (SFY) 2018-19 CHASE collected $912 million in fees from hospitals, which, with federal matching funds, funded health coverage expansions, payments to hospitals, and the CHASE's administrative expenses. Table 4 outlines the healthcare affordability and sustainability fee expenditures in SFY 2018-19.

Table 4. SFY 2018-19 CHASE Fee Expenditures

Item	Total Fund
Supplemental Payments	$1,509,351,000
CHASE Administration (Table 5)	$79,490,000
Expansion Populations	$1,854,362,000
25.5-4-402.4 (5)(b)(VIII) - Offset Revenue Loss	$15,700,000
Total Expenditures	**$3,458,903,000**

Funding in SFY 2018-19 was appropriated for the CHASE administrative expenses through the normal budget process. For SFY 2018-19, there were approximately 78 regular full-time equivalent (FTE) positions for the administration of the CHASE. The expenditures reflected in Table 5 are funded entirely by the healthcare affordability and sustainability fee and federal funds.

Table 5. SFY 2018-19 CHASE Administrative Expenditures

Item	Total Fund
General Administration	**$10,422,628**
Personal Services	$6,260,343
Worker's Compensation	$12,384
Operating Expenses	$401,984
Legal Services	$269,444
Administrative Law Judge Services	$73,842
Payments to Risk Management and Property Funds	$11,644
Leased Space	$314,758
Capitol Complex Leased Space	$76,628
Payments to OIT	$694,650
CORE Operations	$172,384
General Professional Services and Special Projects	$2,134,567
Information Technology Contracts and Projects	**$37,047,817**
MMIS Maintenance and Projects	$19,744,439
CBMS Operating and Contract Expenses	$16,785,414

Item	Total Fund
CBMS Health Care & Economic Security Staff	$517,964
Eligibility Determinations and Client Services	**$28,758,981**
Medical Identification Cards	$24,570
Hospital Out-Stationing	$0
Disability Determination Services	$5,428,794
Provider Fee County Administration	$18,217,397
Medical Assistance Sites	$868,269
Customer Outreach	$673,240
Centralized Eligibility Vendor Contract Project	$3,546,711
Utilization and Quality Review Contracts	**$2,180,647**
Acute Care Utilization Review	$1,373,688
External Quality Review	$763,042
Drug Utilization Review	$43,917
Provider Audits and Services - Professional Audit Contracts	**$553,351**
Indirect Cost Recoveries - Indirect Cost Assessment	**$519,098**
Children's Basic Health Plan Administration	**$7,905**
Total Administrative Expenditures (Total Funds)	**$79,490,424**

Administrative expenditures are for CHASE-related activities, including expenditures related to the CHASE-funded expansion populations, and these expenditures do not supplant existing Department administrative funds.

More than $70 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 $36.5 million and were for CHASE's share of expenses for the Colorado Benefits Management System (CBMS, the eligibility determination system for the Medicaid and CHP+ programs), the Medicaid Management Information System (MMIS, the claims system for the Medicaid 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 CHASE were county administration contracts for eligibility determinations totaling approximately $18 million and a utilization management contract for approximately $2.2 million. CHASE, as a government-owned business within 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 CCR §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 CHASE to receive federal matching funds for services procured.

CHASE includes a 3% limit on administrative expenditures, and CHASE's administrative expenditures are below that cap. Approximately 2.3% of total CHASE expenditures were for administrative expenses, while 0.18% of total CHASE expenditures were for the personal services costs for the FTE administering the program.

IV. 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 Medicaid, Medicare, and all other payers*

This section reports cost shift data from calendar year 2009 through calendar year 2018 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.

Since the inception of the CHCAA and through the implementation of CHASE, the hospital provider fee and the hospital affordability and sustainability fee increased hospital reimbursement an average of more than $210 million per year and substantially increased enrollment in Health First Colorado and CHP+. Overall reimbursement compared to cost per patient improved by 182% since 2009, including a reduction to hospitals' bad debt/charity care write off costs by 56%. Additional analysis should be undertaken to explore the extent to which the hospitals reduced the cost shift as a positive impact on cost shifting to private payers has not been apparent for the past several years.

Historically the impact on the cost shift has been evaluated by trending the difference between hospital payments and costs for each of the four major payer groups - Medicare, Medicaid, private insurance, and CICP/Self Pay/Other. The Colorado Hospital Association (CHA) DATABANK[2] and survey data are used as the data source as information at this level of detail is not available from public sources. The trending starts with 2009 data as it shows payment to cost ratios prior to the implementation of the CHCAA, while changes due to the CHCAA are captured with data from 2010 to midway through 2017, with CHASE beginning in July 2017. The 2014 data is the first year of data that includes the expansion of Medicaid under the ACA.

When the DATABANK data was provided to the Department for this report, CHA explained that there was an issue with prior year data that had been discovered while verifying figures in the CICP/Self Pay/Other payer group for calendar year (CY) 2018. The issue was corrected, and the DATABANK data was reissued to the Department for CY 2017 along with the most recent data for CY 2018. As such, the figures in the following tables have been updated for CY 2017 in comparison to the 2019 CHASE Annual Report.

[2] CHA DATABANK is an online program available to Colorado Hospital Association members and serves as a centralized location for the collection and analysis of hospital utilization and financial data.

A. Payment, Cost, and Payment Less Cost by Payer Group

Table 6 displays the total hospital payments by payer group. Overall, hospital payments have grown an average of 6.7% every year from 2009 through 2018.

Table 6. Total Payments by Payer Group

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

Table 7 shows the total costs by payer from 2009 through 2018. The average overall growth in cost for providing hospital care to Coloradans was 6.2% every year. If costs had grown in line with the national cost trend from hospitals' Medicare cost reports, the cost growth would have been approximately 4.3%[3], which may have lowered the cost shift to commercial payers.

Table 7. Total Costs by Payer Group

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

The disparity between actual Colorado hospital cost growth and these national trends bears further research.

[3] Calculated from the average annual increase in hospital only operating expenses as reported in each hospital's Medicare cost report.

Table 8 shows the total payments less total costs by payer, or total margin. The total margin for hospitals grew by 229% since 2009.

Table 8. Payment Less Cost by Payer Group

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

Table 9 displays the difference between total payments and total costs on a per patient basis for the Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups. Negative values indicate that costs exceed payments, while positive values indicate that payments exceed costs.

The data show that the under-compensation for the Medicaid and CICP/Self Pay/Other payer groups improved significantly. From 2009 to 2018, the payment shortfall improved by $906 per patient for Medicaid patients. For uninsured patients (i.e., CICP/Self Pay/Other), the payment below cost improved by more than $2,600 per patient[4].

Table 9. Payment Less Cost per Patient by Payer Group

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

[4] 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.

B. Patient Mix by Payer

Table 10 shows the relative patient mix by payer. Over the ten-year timeframe, the patient mix for Medicare is relatively constant, while the payer mix figures for Medicaid increased and CICP/Self Pay/Other decreased significantly beginning in 2014 when the full Medicaid expansion under the ACA occurred. During this same period the insurance payer mix decreased as well.

Table 10. Patient Mix by Payer

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

C. Payment to Cost Ratio

Another way to view the impact of cost shifting is through the ratio of total payments to total costs for Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups.

In Table 11, ratios below 1 mean that costs exceed payments, which is generally the case for Medicare and Medicaid. Values greater than 1 mean that payments exceed costs, as is the case for the private sector insurance group.

As shown below, in 2009, prior to the implementation of the CHCAA, Medicaid reimbursement to Colorado hospitals was approximately 54% of costs, while in 2018, the payment to cost ratio for Medicaid was 77% of costs. The payment to cost ratio for the CICP/Self Pay/Other payer group has also increased from 52% in 2009 to 88% in 2018[5]. However, the payment to cost ratio for private sector insurance and the overall payment to cost ratio have also increased, making it counterintuitive to a cost shift reduction.

[5] 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. More analysis is needed to understand the change in payment less cost per patient for the CICP/Self Pay/Other payer group.

Table 11. Payment to Cost Ratio

Year	Medicare	Medicaid	Insurance	CICP/Self Pay/Other	Overall
CY 2009	0.78	0.54	1.55	0.52	1.05
CY 2010	0.76	0.74	1.49	0.72	1.06
CY 2011	0.77	0.76	1.54	0.65	1.07
CY 2012	0.74	0.79	1.54	0.67	1.07
CY 2013	0.66	0.8	1.52	0.84	1.05
CY 2014	0.71	0.72	1.59	0.93	1.07
CY 2015	0.72	0.75	1.58	1.11	1.08
CY 2016	0.71	0.71	1.64	1.08	1.09
CY 2017	0.72	0.72	1.66	0.85	1.07
CY 2018	0.70	0.77	1.70	0.88	1.09

D. Bad Debt and Charity Care

Total bad debt and charity care is collected in aggregate from the CHA DATABANK. Bad debt and charity care are costs hospitals typically write-off as uncompensated care. As shown in Table 12, total bad debt and charity care decreased significantly from 2013 to 2014 – the year health coverage expansion under the ACA was fully implemented – and continued through 2018. Total bad debt and charity care are approximately $394 million lower in 2018 compared to 2013, decreasing by 56%.

Table 12. Bad Debt and Charity Care Cost

Year	Bad Debt	Charity	Total
CY 2009	$255,161,427	$438,432,609	$693,594,036
CY 2010	$234,216,738	$430,871,543	$665,088,281
CY 2011	$194,825,791	$473,157,782	$667,983,573
CY 2012	$206,347,067	$465,558,867	$671,905,934
CY 2013	$255,306,707	$444,436,807	$699,743,514
CY 2014	$145,964,802	$174,150,188	$320,114,990
CY 2015	$145,358,187	$118,526,410	$263,884,597
CY 2016	$145,381,741	$147,180,251	$292,561,992
CY 2017	$153,155,478	$133,783,564	$286,939,042
CY 2018	$152,713,948	$152,595,060	$305,309,008

E. All-Payer Cost, Revenue, and Margin

Table 13 presents overall hospital payments, costs, and margins on a per patient basis over the last ten years. While costs have increased at an annual average rate of 4.4% over the ten-year period, payments have increased an average of 4.8% per year resulting in an average annual increase in margin of 13.8%.

Table 13. All-Payer Cost, Revenue, and Margin

Year	Payment Per Patient	Cost Per Patient	Margin Per Patient
CY 2009	$12,313	$11,771	$542
CY 2010	$13,285	$12,584	$701
CY 2011	$13,786	$12,868	$918
CY 2012	$14,663	$13,760	$903
CY 2013	$15,224	$14,477	$747
CY 2014	$15,766	$14,727	$1,039
CY 2015	$16,045	$14,802	$1,243
CY 2016	$17,126	$15,779	$1,347
CY 2017	$17,777	$16,555	$1,222
CY 2018	$18,816	$17,286	$1,530
Average Annual Change	4.8%	4.4%	13.8%

V. Delivery System Reform Incentive Payment Program

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

Pursuant to 25.5-4-402.4 (8), C.R.S., the CHASE, acting in concert with the Department, will seek a federal waiver to fund and support the implementation of a health care delivery system reform incentive payments program to improve health care access and outcomes for Health First Colorado members no earlier than October 2019.

The planned delivery system reform incentive payments (DSRIP) program is referred to as the Hospital Transformation Program (HTP). The HTP will engage Colorado's general and critical access hospitals by pairing the flexibility to implement innovative interventions with financial incentives designed to encourage regional collaboration and improve access, quality and appropriateness of service delivery, and patient outcomes across vital areas of care. The HTP will be the state's first major effort to significantly redirect hospital supplemental payments toward major delivery model growth, maturity, and evolution. The HTP envisions transforming care across care coordination and transitions, complex care management for targeted populations, behavioral health and substance use disorder coordination, and perinatal care and improved birth outcomes, all while recognizing and addressing social determinants of health and reducing total cost of care.

The HTP will use delivery system reform incentive payments to support hospital-led projects to:

- Improve patient outcomes through care redesign and integration of inpatient and outpatient hospital services with community-based providers.
- Lower Health First Colorado (Colorado's Medicaid Program) costs through reductions in avoidable care and increased efficiency and effectiveness of care delivery systems.
- Accelerate hospitals' organizational, operational, and systems readiness for value-based payment.
- Increase collaboration between hospitals and other providers, particularly Accountable Care Collaborative (ACC) participants, on data sharing and performance analytics and on evidenced-based initiatives in care coordination and care transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health.

A State Plan Amendment (SPA) will be utilized for the initial implementation of the developed HTP components. The Centers for Medicare and Medicaid Services (CMS) guidance to the state is to utilize existing federal authority where possible. The majority of the program's recommended framework can be accomplished under the State Plan authority; the Department will seek to utilize a federal Medicaid waiver under section 1115 of the Social Security Act for more targeted areas of the program that cannot be accomplished under State Plan authority. For the incentive payments, Colorado will leverage hospital supplemental payment funding

generated through the existing healthcare affordability and sustainability fees assessed on hospitals, for which the state has submitted a State Plan Amendment. The proposed demonstration makes no other changes to provider reimbursement and makes no changes to Health First Colorado or Child Health Plan Plus (CHP+, Colorado's Children's Health Insurance Program) enrollment, eligibility, covered benefits, cost sharing, or beneficiary freedom of choice in providers.

To achieve these objectives, the Colorado HTP will use delivery reform incentive payments to support hospital-led projects designed to make significant, evidence-based improvements to Colorado Medicaid's health care delivery in population health and total cost of care in critical priority areas:

- Care coordination and care transitions;
- Complex care management for core populations;
- Behavioral health (BH) and substance use disorder (SUD) coordination;
- Maternal health, perinatal care and improved birth outcomes;
- Social needs screening and notification; and
- Total cost of care.

Implementation of the HTP is a signal of Colorado's shift toward total medical expense delivery models, population health, and other alternative payment methodologies (APMs) such as shared savings for the future of reimbursement.

Within these priority areas, the DSRIP program will be used to incentivize hospital-led activities to:

- Build the necessary organizational, workforce, and technology infrastructure for delivery system reform and accelerated readiness for value-based payment;
- Implement evidence-based interventions to improve care transitions, help address unmet needs of high-risk, high-cost populations; and advance integration across the care delivery spectrum; and
- Support data-driven accountability and outcome measurement through the collection, sharing, and monitoring of information among providers.

The Department is committed to collaborating with hospitals to ensure the goals and priorities of the HTP are achievable and can be implemented effectively within required timeframes.

A. Program and Waiver Development

The Department remains committed to a development process that is open, transparent, and inclusive of stakeholder and community input and feedback. To date, the Department has maintained a robust stakeholder engagement process, which includes convening workgroups with the Colorado Hospital Association (CHA) and hospitals, as well as targeted and regular engagement with Department subject matter experts, Regional Accountable Entities (RAEs), health alliances and other provider organizations, and other community

organizations such as community health centers, community mental health centers, public health agencies, and client and consumer advocacy organizations. Additionally, the Community Advisory Council (council) was formed as a result of recommendations from the CHASE Board to cast a wider net to obtain feedback from health care consumers and the broader community impacted by HTP. Monthly council meetings provide valuable community input to all program aspects of the HTP.

Multiple hospital workgroups were formed and engaged working on components of the program: rural hospital and urban hospital workgroups, and quality/clinical measures workgroups including a pediatric measures workgroup. The measures workgroups worked with Department staff to develop and refine measures hospitals would be held accountable to throughout HTP. The rural and urban hospital workgroups work collaboratively with the Department to balance the interests of stakeholders to design the overall framework and structure of the program. This includes identifying the goals of the HTP and developing the operational components of the program. These workgroups played a vital part in informing how the draft waiver was developed.

Statewide metrics, project-specific metrics, and financing approach were developed for HTP for CHASE Board and stakeholder consideration. The development of specifications for each measure has been a collaborative process involving workgroups, clinical experts, stakeholder feedback, and Department subject matter experts.

1. Waiver submission Process

In accordance with section 10201(i) of the ACA that set forth transparency and public notice requirements for section 1115 waiver demonstrations, the Department submitted its section 1115 waiver demonstration application to CMS on December 31, 2019.

The application included all the requirements for the purpose of initiating federal review including:

- A comprehensive program description of the demonstration, including the goals and objectives to be implemented under the demonstration project;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act;
- An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable;
- Current enrollment data, if applicable, and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration;

- Other program features that the demonstration would modify in the state's Medicaid program and/or CHP+;
- The specific waiver and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives; a plan for testing the hypotheses in the context of an evaluation; and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators; and
- Written documentation of the state's compliance with the public notice requirements, with a report of the issues raised by the public during the comment period, which shall be no less than 30 days, and how the state considered those comments when developing the demonstration application.

2. Public Comment and Stakeholder Consultation

The ACA requires opportunity for public comment and greater transparency of the section 1115 demonstration waivers, setting standards for making information about Medicaid and CHP+ demonstration waiver applications and approved demonstration waiver projects publicly available at the state and federal levels. This process ensures the public will have an opportunity to provide comments on a demonstration while it is under review at CMS.

The public notice pertaining to the HTP was published on November 10, 2019 to the Colorado Register. Upon publication, the Department alerted stakeholders via email and began accepting comments and inquiries until Sunday, December 15, 2019 at 5 p.m. MST. Due to the importance of fully engaging with stakeholders, the Department provided additional time to the federally required 30-day public notice and comment period. During the public comment period, stakeholders were instructed to submit comments to COHTP@state.co.us and via the United States Postal Service.

The Department invited stakeholders to attend public hearings in person or to join by teleconference/webinar to learn more about Colorado's 1115 Demonstration application and provide comments.

In addition to the required meetings, the Department collected comments from stakeholders during the public notice and comment period via two Community Advisory Council meetings which took place on November 22, 2019 and December 19, 2019. Feedback from these meetings were submitted to CMS with the application.

Stakeholder engagement and consultation has been a crucial component of HTP since groundwork for the program began in January 2016. A 31-page document titled "Hospital Transformation Program: Stakeholder Engagement and Activities, January 2016 to November 10, 2019" posted on the HTP webpage at

www.colorado.gov/pacific/hcpf/colorado-hospital-transformation-program includes a detailed breakdown of stakeholder and hospital engagement.

B. Community and Health Neighborhood Engagement

Hospitals seeking to participate in HTP extensively engaged with community organizations and health neighborhoods as they planned for their participation in the program, called the Community and Health Neighborhood Engagement (CHNE) process. Specifically, hospitals conducted an environmental scan informed by external feedback and sought meaningful input on their project development and applications during the pre-waiver period. The goal of CHNE is to inform the selection of HTP projects based on a solid understanding of the health needs of the population and the resources available to address them in order to help achieve the quadruple aim: better patient experience, improved health outcomes, improved provider experience, and reduced cost. Furthermore, this engagement at the outset is critical to ensuring successful collaborations and delivery system impacts throughout and following the HTP.

Hospitals were required to demonstrate they had solicited and incorporated into their planning and applications input from a broad cross-section of the community and Health Neighborhood, including clinical providers and organizations that serve and represent the broad interests of the community. Health Neighborhood providers include but are not limited to specialty care, long term services and supports (LTSS) providers, Managed Service Organizations and their networks of substance use disorder providers, local public health agencies, mental health centers, Community Health Centers (including federally qualified health centers and rural health centers), primary care medical providers, regional emergency medical and trauma services advisory councils, consumer advocates/advocacy organizations, pharmacists, dental, non-emergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers such as Colorado Crisis Services vendors. Hospitals were encouraged to leverage existing forums and collaborations to help maximize community participation and align their engagement activities with advisory groups, existing programs and alliances, and statewide initiatives designed to strengthen the health care system. Hospitals across the state convened groups at regular intervals to ensure their engagement and inform their program application

1. Reporting

Hospitals were required to submit CHNE Action Plans to outline how they will conduct the CHNE process. They were asked to review the requirements for CHNE outlined in the Requirements document and the Hospital Guidebook to ensure compliance. Letters from their local RAE and at least two other community organizations, as well as letters from the coordinators of coalitions and meetings they intend to leverage, were required expressing that they were aware of the Action Plan and they intend to participate in the

CHNE process. On November 30, 2018 CHNE Action Plans were submitted to the Department for evaluation and feedback. Guidance and support were provided by the Department to hospitals following submission for those who required additional assistance.

The HTP required hospitals to report on the progress made in the first phase of the CHNE process in their Midpoint Reports, including updates on community engagement and results of their environmental scan of community characteristics, needs, and resources. To assist hospitals in compiling accurate reports, the Department provided several data resources to support providers as they put together their Midpoint Reports. In addition to the data resource links on the HTP website, which include data from the Colorado Department of Public Health & Environment and the Colorado Health Institute, the Department sent each hospital a series of Health First Colorado data reports, and links to health literacy resources.

On April 19, 2019, hospitals submitted their Midpoint Reports. Department staff were impressed by efforts not only throughout the CHNE process, but in the detail contained in submitted reports. On May 20, the Department and consultants from Public Consulting Group (PCG) completed reviews of Midpoint Reports and shared findings and questions with hospitals. In addition to the Department and consultations from PCG, a qualitative research analyst from University of Colorado Denver was brought on to analyze Midpoint Reports. The review process was primarily to ensure the Department had the most complete picture of how the CHNE process was progressing for each hospital before Midpoint Reports were made available to external stakeholders and the public. During the review process, the Department looked for missing information or areas of clarification, as well as provided feedback and allowed for any revisions. Midpoint Report were reviewed against the requirements found in the Guidebook, Midpoint Report template and Midpoint Report review criteria. On May 31, hospitals made the necessary revisions to their Midpoint Reports and on June 10, reports were made available to the public.

Midpoint Reports informed the second half of hospitals' CHNE process. On September 20, 2019, Final Reports were submitted by hospitals to the Department. In the Final Report, hospitals explained decisions regarding prioritizing community needs and selecting target populations and initiatives. Hospitals determined mechanisms for engagement in all-provider collaboratives and consensus quality metrics. Hospital identified cost drivers, shared platforms for efficient clinical pathways such as e-consults and telehealth, features and attributes to create a shared prescription tool. Following the submission, the Department reviewed the and worked collaboratively with participants as they worked on their applications to address any questions or concerns that may arise from the Final Report.

VI. Appendix

Table 14. Fee-Exempt Hospitals: Psychiatric, Long-Term Care, and Rehabilitation Hospitals

Hospital Name	County	Fee	Inpatient Payment	Outpatient Payment	Uncompensated Care Payment	DSH Payment	HQIP Payment	Total Payment	Net Benefit
Kindred Hospital - Aurora	Adams	$0	$300,503	$0	$0	$0	$0	$300,503	$300,503
Spalding Rehabilitation Hospital	Adams	$0	$41,383	$0	$0	$0	$0	$41,383	$41,383
Vibra Hospital	Adams	$0	$16,727	$120	$0	$0	$0	$16,847	$16,847
Craig Hospital	Arapahoe	$0	$124,173	$29,338	$0	$0	$19,325	$172,836	$172,836
Denver Springs	Arapahoe	$0	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Hospital of Littleton	Arapahoe	$0	$228,521	$3,283	$0	$0	$0	$231,804	$231,804
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0	$0	$0	$0	$0
Colorado Acute Long Term Hospital	Denver	$0	$51,387	$0	$0	$0	$0	$51,387	$51,387
Colorado Mental Health Institute Fort Logan	Denver	$0	$0	$0	$0	$0	$0	$0	$0
Eating Recovery Center	Denver	$0	$0	$0	$0	$0	$0	$0	$0
Kindred Hospital - Denver	Denver	$0	$6,980	$0	$0	$0	$0	$6,980	$6,980
Kindred Hospital - Denver South[6]	Denver	$0	$673	$0	$0	$0	$0	$673	$673
Highlands Behavioral Health System	Douglas	$0	$0	$0	$0	$0	$0	$0	$0
Cedar Springs Hospital	El Paso	$0	$0	$0	$0	$0	$0	$0	$0
Peak View Behavioral Health	El Paso	$0	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Hospital of Colorado Springs	El Paso	$0	$224,376	$2,609	$0	$0	$98,670	$325,655	$325,655
Clear View Behavioral Health	Larimer	$0	$0	$0	$0	$0	$0	$0	$0
Northern Colorado Long Term Acute Hospital	Larimer	$0	$3,492	$0	$0	$0	$0	$3,492	$3,492
Northern Colorado Rehabilitation Hospital	Larimer	$0	$81,727	$1,768	$0	$0	$0	$83,495	$83,495
West Springs Hospital	Mesa	$0	$0	$0	$0	$0	$0	$0	$0
Colorado Mental Health Institute Pueblo	Pueblo	$0	$0	$0	$0	$0	$0	$0	$0
Total		**$0**	**$1,079,942**	**$37,118**	**$0**	**$0**	**$117,995**	**$1,235,055**	**$1,235,055**

[6] Hospital closed in March 2019. Payments reflect prorated amounts.

Table 15. Fee-Paying Hospitals: General and Acute Care Hospitals

Hospital Name	County	Fee	Inpatient Payment	Outpatient Payment	Uncompensated Care Payment	DSH Payment	HQIP Payment	Total Payment	Net Benefit
Children's Hospital Colorado	Adams	$29,808,495	$6,110,239	$10,476,332	$4,432,351	$34,514,993	$5,570,298	$61,104,213	$31,295,718
North Suburban Medical Center	Adams	$21,390,374	$6,144,779	$7,247,903	$2,246,278	$0	$3,449,445	$19,088,405	-$2,301,969
Platte Valley Medical Center	Adams	$5,930,562	$2,234,331	$4,699,915	$1,206,501	$11,691,026	$590,894	$20,422,667	$14,492,105
University of Colorado Hospital	Adams	$74,367,077	$23,785,542	$39,951,039	$8,451,254	$15,057,244	$6,058,804	$93,303,883	$18,936,806
San Luis Valley Health Regional Medical Center	Alamosa	$3,966,001	$4,761,410	$5,830,268	$342,416	$0	$1,040,863	$11,974,957	$8,008,956
Littleton Adventist Hospital	Arapahoe	$20,467,598	$10,341,583	$6,341,949	$898,030	$0	$807,671	$18,389,233	-$2,078,365
Swedish Medical Center	Arapahoe	$49,426,501	$34,747,385	$16,528,623	$3,130,713	$0	$542,955	$54,949,676	$5,523,175
The Medical Center of Aurora	Arapahoe	$39,530,792	$25,809,766	$17,187,910	$3,058,906	$0	$623,515	$46,680,097	$7,149,305
Pagosa Springs Medical Center	Archuleta	$716,678	$331,708	$2,196,214	$231,092	$0	$323,241	$3,082,255	$2,365,577
Southeast Colorado Hospital District	Baca	$197,085	$130,542	$645,877	$483,193	$0	$26,880	$1,286,492	$1,089,407
Avista Adventist Hospital	Boulder	$7,919,572	$5,477,944	$4,565,982	$636,152	$0	$1,094,142	$11,774,220	$3,854,648
Boulder Community Health	Boulder	$22,956,477	$9,431,892	$6,488,347	$1,550,652	$2,850,449	$1,029,905	$21,351,245	-$1,605,232
Good Samaritan Medical Center	Boulder	$18,868,579	$3,589,052	$3,748,711	$933,339	$0	$1,049,943	$9,321,045	-$9,547,534
Longmont United Hospital	Boulder	$12,083,562	$2,944,425	$4,813,140	$613,846	$7,770,252	$1,998,042	$18,139,705	$6,056,143
St. Anthony North Health Campus	Broomfield	$12,317,902	$3,908,184	$7,441,118	$1,198,064	$0	$1,808,533	$14,355,899	$2,037,997
Heart of the Rockies Regional Medical Center	Chaffee	$1,802,167	$1,062,133	$3,915,152	$525,210	$0	$382,689	$5,885,184	$4,083,017
Keefe Memorial Health Service District	Cheyenne	$116,674	$33,885	$626,731	$525,210	$0	$31,025	$1,216,851	$1,100,177
San Luis Valley Health Conejos County Hospital	Conejos	$227,628	$103,979	$1,400,927	$357,143	$0	$34,987	$1,897,036	$1,669,408
Delta County Memorial Hospital	Delta	$3,845,845	$1,439,032	$4,640,076	$306,619	$0	$582,631	$6,968,358	$3,122,513
Denver Health Medical Center	Denver	$31,970,468	$2,629,993	$1,756,605	$22,032,845	$79,153,178	$7,551,062	$113,123,683	$81,153,215
National Jewish Health	Denver	$3,997,387	$3,913	$1,617,473	$154,520	$8,729,020	$39,125	$10,544,051	$6,546,664
Porter Adventist Hospital	Denver	$21,999,097	$4,388,624	$4,359,488	$939,817	$0	$928,577	$10,616,506	-$11,382,591
Presbyterian/St. Luke's Medical Center	Denver	$35,257,741	$34,248,401	$15,560,225	$1,229,159	$0	$959,088	$51,996,873	$16,739,132
Rose Medical Center	Denver	$26,244,143	$15,106,857	$10,294,593	$923,513	$0	$1,021,632	$27,346,595	$1,102,452
St. Joseph Hospital	Denver	$32,546,287	$10,671,334	$9,117,767	$5,308,885	$0	$1,128,503	$26,226,489	-$6,319,798
Castle Rock Adventist Hospital	Douglas	$5,025,309	$789,109	$1,867,991	$390,219	$0	$477,989	$3,525,308	-$1,500,001
Parker Adventist Hospital	Douglas	$16,909,535	$9,138,588	$8,115,827	$1,066,448	$0	$850,509	$19,171,372	$2,261,837
Sky Ridge Medical Center	Douglas	$27,917,263	$10,890,735	$5,270,315	$788,629	$0	$637,406	$17,587,085	-$10,330,178
Vail Health Hospital	Eagle	$4,547,885	$3,414,282	$3,636,038	$1,487,049	$0	$279,775	$8,817,144	$4,269,259
Grandview Hospital	El Paso	$2,580,270	$129,112	$728,822	$629,164	$0	$0	$1,487,098	-$1,093,172
Memorial Hospital Central	El Paso	$40,718,628	$24,847,608	$28,544,048	$4,336,936	$0	$12,399,207	$70,127,799	$29,409,171
Penrose-St. Francis Health Services	El Paso	$46,363,662	$36,958,372	$30,409,565	$1,650,907	$0	$6,140,860	$75,159,704	$28,796,042
St. Thomas More Hospital	Fremont	$2,536,422	$4,711,964	$4,107,299	$525,210	$0	$403,670	$9,748,143	$7,211,721
Grand River Hospital District	Garfield	$1,510,007	$247,649	$2,724,154	$525,210	$534,031	$135,826	$4,166,870	$2,656,863
Valley View Hospital	Garfield	$7,943,044	$5,492,907	$3,683,821	$1,665,754	$5,376,234	$735,137	$16,953,853	$9,010,809
Middle Park Medical Center	Grand	$604,549	$75,281	$2,237,227	$483,193	$0	$97,618	$2,893,319	$2,288,770
Gunnison Valley Health	Gunnison	$1,006,073	$321,889	$868,799	$504,202	$0	$91,947	$1,786,837	$780,764
Spanish Peaks Regional Health Center	Huerfano	$391,710	$125,564	$1,631,659	$420,168	$0	$77,073	$2,254,464	$1,862,754
Broomfield Hospital	Jefferson	$755,671	$40,611	$186,610	$506,674	$0	$0	$733,895	-$21,776
Lutheran Medical Center	Jefferson	$30,503,693	$24,749,483	$19,412,949	$1,897,265	$0	$1,621,340	$47,681,037	$17,177,344
OrthoColorado Hospital	Jefferson	$2,000,382	$0	$0	$0	$0	$0	$0	-$2,000,382

Hospital Name	County	Fee	Inpatient Payment	Outpatient Payment	Uncompensated Care Payment	DSH Payment	HQIP Payment	Total Payment	Net Benefit
St. Anthony Hospital	Jefferson	$29,207,182	$8,758,435	$6,918,404	$1,634,153	$0	$1,435,215	$18,746,207	-$10,460,975
Weisbrod Memorial County Hospital	Kiowa	$35,537	$14,825	$244,435	$525,210	$0	$3,606	$788,076	$752,539
Kit Carson County Health Service District	Kit Carson	$410,260	$106,956	$1,314,127	$399,160	$0	$151,830	$1,972,073	$1,561,813
Animas Surgical Hospital	La Plata	$1,305,521	$213,142	$1,406,519	$252,101	$0	$62,603	$1,934,365	$628,844
Mercy Regional Medical Center	La Plata	$9,114,552	$8,981,690	$6,616,421	$954,206	$0	$954,559	$17,506,876	$8,392,324
St. Vincent General Hospital District	Lake	$132,659	$7,071	$1,634,344	$525,210	$0	$0	$2,166,625	$2,033,966
Banner Fort Collins Medical Center	Larimer	$1,360,030	$645,585	$2,118,575	$264,226	$3,344,654	$557,390	$6,930,430	$5,570,400
Estes Park Health	Larimer	$972,627	$149,902	$1,642,591	$483,193	$0	$83,533	$2,359,219	$1,386,592
McKee Medical Center	Larimer	$7,357,817	$1,682,168	$4,503,754	$602,472	$3,904,951	$1,651,613	$12,344,958	$4,987,141
Medical Center of the Rockies	Larimer	$22,052,760	$17,777,470	$8,616,369	$2,893,160	$0	$1,392,349	$30,679,348	$8,626,588
Poudre Valley Hospital	Larimer	$29,507,799	$16,105,552	$17,140,376	$2,526,595	$0	$3,698,721	$39,471,244	$9,963,445
Mt. San Rafael Hospital	Las Animas	$1,176,391	$910,703	$3,002,319	$525,210	$0	$234,675	$4,672,907	$3,496,516
Lincoln Community Hospital	Lincoln	$307,933	$8,124	$834,691	$315,126	$0	$22,724	$1,180,665	$872,732
Sterling Regional MedCenter	Logan	$1,698,239	$2,400,502	$3,270,871	$525,210	$0	$662,709	$6,859,292	$5,161,053
Colorado Canyons Hospital and Medical Center	Mesa	$995,640	$78,433	$1,341,672	$525,210	$0	$35,917	$1,981,232	$985,592
Community Hospital	Mesa	$5,301,347	$102,181	$1,471,644	$573,639	$3,076,524	$179,750	$5,403,738	$102,391
St. Mary's Hospital & Medical Center, Inc.	Mesa	$27,049,093	$16,224,382	$7,884,116	$2,446,517	$6,927,366	$1,755,429	$35,237,810	$8,188,717
Memorial Regional Health	Moffat	$873,260	$1,183,826	$3,426,549	$525,210	$1,635,846	$0	$6,771,431	$5,898,171
Southwest Health System, Inc.	Montezuma	$1,680,407	$1,312,942	$5,586,690	$525,210	$0	$87,039	$7,511,881	$5,831,474
Montrose Memorial Hospital	Montrose	$5,362,511	$1,180,146	$4,178,637	$863,098	$1,088,999	$443,678	$7,754,558	$2,392,047
Colorado Plains Medical Center	Morgan	$4,223,659	$2,401,943	$2,609,552	$223,419	$0	$531,944	$5,766,858	$1,543,199
East Morgan County Hospital	Morgan	$781,240	$504,641	$2,182,993	$525,210	$0	$289,916	$3,502,760	$2,721,520
Arkansas Valley Regional Medical Center	Otero	$1,310,620	$2,020,078	$4,123,458	$525,210	$0	$554,949	$7,223,695	$5,913,075
Haxtun Hospital District	Phillips	$110,460	$15,518	$263,312	$525,210	$0	$0	$804,040	$693,580
Melissa Memorial Hospital	Phillips	$230,818	$34,256	$891,888	$315,126	$0	$9,703	$1,250,973	$1,020,155
Aspen Valley Hospital	Pitkin	$1,567,965	$255,298	$1,432,485	$525,210	$208,883	$81,083	$2,502,959	$934,994
Prowers Medical Center	Prowers	$870,571	$1,085,076	$3,162,351	$525,210	$0	$220,997	$4,993,634	$4,123,063
Parkview Medical Center	Pueblo	$40,020,901	$41,027,280	$13,817,750	$993,812	$0	$6,078,410	$61,917,252	$21,896,351
St. Mary-Corwin Medical Center	Pueblo	$16,948,900	$5,055,631	$7,335,668	$728,610	$0	$1,818,176	$14,938,085	-$2,010,815
Pioneers Medical Center	Rio Blanco	$277,571	$35,902	$463,478	$210,084	$0	$4,448	$713,912	$436,341
Rangely District Hospital	Rio Blanco	$122,835	$3,132	$661,653	$525,210	$0	$4,820	$1,194,815	$1,071,980
Rio Grande Hospital	Rio Grande	$517,566	$767,252	$1,350,687	$357,143	$0	$418,118	$2,893,200	$2,375,634
Yampa Valley Medical Center	Routt	$2,694,201	$2,501,325	$3,683,314	$694,531	$0	$229,980	$7,109,150	$4,414,949
Sedgwick County Health Center	Sedgwick	$198,967	$55,510	$461,682	$315,126	$1,187,924	$5,578	$2,025,820	$1,826,853
St. Anthony Summit Medical Center	Summit	$2,691,447	$1,718,105	$2,313,989	$492,876	$0	$388,661	$4,913,631	$2,222,184
Pikes Peak Regional Hospital	Teller	$920,357	$432,859	$1,749,256	$315,126	$0	$369,190	$2,866,431	$1,946,074
Longs Peak Hospital	Weld	$5,472,905	$974,081	$3,567,859	$1,122,192	$1,145,645	$0	$6,809,777	$1,336,872
North Colorado Medical Center	Weld	$22,894,682	$2,148,888	$3,927,989	$1,953,763	$24,731,355	$3,052,877	$35,814,872	$12,920,190
Wray Community District Hospital	Yuma	$347,250	$454,020	$1,038,196	$315,126	$0	$192,808	$2,000,150	$1,652,900
Yuma District Hospital	Yuma	$506,165	$147,677	$1,705,849	$315,126	$0	$40,183	$2,208,835	$1,702,670
Totals		**$917,879,440**	**$470,852,594**	**$444,774,002**	**$107,980,172**	**$212,928,574**	**$90,327,988**	**$1,326,863,330**	**$408,983,890**
Totals (all hospitals)		**$917,879,440**	**$471,932,536**	**$444,811,120**	**$107,980,172**	**$212,928,574**	**$90,445,983**	**$1,328,098,385**	**$410,218,945**