COLORADO
Colorado Healthcare Affordability
& Sustainability Enterprise

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

January 15, 2018

Christy Blakely
President, Medical Services Board
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Blakely:

Enclosed please find a legislative report to the Governor 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 total amount of fee paid by each hospital and any projected revenue that each hospital is expected to receive; an itemization of the costs incurred by the enterprise; 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 enterprise 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, David DeNovellis, at David.Denovellis@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 Health Care Affordability and Sustainability Enterprise Act Annual Report

Cc: Amanda Moorer, Vice President, Medical Services Board

Cecile Fraley, Medical Services Board
Patricia Givens, Medical Services Board
Simon Hambidge, Medical Services Board
Bregitta Hughes, Medical Services Board
Jessica Kuhns, Medical Services Board
Charolette Lippolis, Medical Services Board
An Nguyen, Medical Services Board
David Potts, Medical Services Board
Donna Roberts, RN, BSN, DTR, BA, Medical Services Board
Chris Sykes, Medical Services Board Coordinator
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Laurel Karabatsos, Interim Health Programs Office Director & Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Interim Community Living Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control and Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF

Colorado Healthcare Affordability and Sustainability Enterprise Annual Report

January 15, 2019

COLORADO
Colorado Healthcare Affordability & Sustainability Enterprise

Table of Contents

Table of Tables

I. Colorado Healthcare Affordability and Sustainability Enterprise Overview

This legislative report is presented by the Department of Health Care Policy and 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 that operates within the Department. Its purpose is to charge and collect the healthcare affordability and sustainability fee to obtain federal matching funds that 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 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 2017 through September 2018, the CHASE has:

- **Provided $407 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 $97.6 million in hospital quality incentive payments. This funding increased hospital reimbursement by $407 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 2017, which includes data from the former Colorado Health Care Affordability Act (CHCAA), the payment for care provided to Medicaid members has improved overall, increasing coverage from 54% to 69% of costs. In 2017, the amount of bad debt and charity care decreased by more than 59% 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 nearly 63% since 2009. Determining the extent to which the 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 450,000 Coloradans**
  As of September 30, 2018, the Department has enrolled approximately 75,000 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, 8,700 Health First Colorado working adults up to 450% of the FPL and children with disabilities up to 300% of the FPL, and 342,000 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.

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:

For terms expiring May 15, 2019:

- Peg Burnette of Denver, representing a hospital
- William Heller of Denver, representing the Department
- Kimberly Monjesky of Woodland Park, representing a rural hospital
- Thomas Rennell of Castle Rock, representing a health insurance organization

For terms expiring May 15, 2020:

- Dan Enderson of Castle Rock, representing a hospital
- George O'Brien of Pueblo, representing persons with disabilities

For terms expiring May 15, 2021:

- Kathryn Ashenfelter of Denver, representing a hospital
- Dr. Lesley Clark Brooks of Greeley, representing the health care industry
- Matthew Colussi of Aurora, representing the Department
- Allison Neswood of Denver, representing a consumer of health care
- 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 hospital organization

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 2017-18 fee and payment amounts. Table 15 and Table 16 (in the Appendix) detail hospital specific FFY 2017-18 fee and payment amounts. Fees are collected and resulting hospital payments are made monthly by electronic funds transfer for each hospital.

Table 1 FFY 2017-18 CHASE Fee and Supplemental Payments

Item	Amount
Inpatient Fee	$423,596,263
Outpatient Fee	$470,945,327
Total Healthcare Affordability and Sustainability Fee	**$894,541,590**
Inpatient Base Rate Supplemental Payment	$457,639,032
Outpatient Supplemental Payment	$428,022,036
Uncompensated Care Supplemental Payment	$110,480,176
Disproportionate Share Hospital Supplemental Payment	$207,938,060
Hospital Quality Incentive Supplemental Payment	$97,553,767
Total Supplemental Payments	**$1,301,633,071**
Net Reimbursement to Hospitals	**$407,091,481**

For an overview of the fee assessment and payment methodologies recommended by the CHASE Board for October 2017 through September 2018, 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 2017-18 was $894,541,590, with the inpatient fee comprising 47% of total fees and the outpatient fee comprising 53% 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 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 30,000 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 $95,480,176.

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 $207,938,060[1] 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.

[1] Originally, the DSH payment was equal to $172,633,510 in anticipation of DSH allotment reductions. Fees were collected and payments were made using that figure. However, on November 2, 2017, the U.S. House of Representatives passed H.R. 3922. The passage of this bill delayed the DSH allotment reductions, meaning Colorado hospitals were now eligible for the $35,304,550 difference. This difference will be paid to the hospitals that were qualified for DSH (and below their DSH limit) for the FFY 2017-18 period in early 2019.

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 (VBP) 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, 2017, 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. Each measure was scored out of ten possible points.

2017 Measures

1. Culture of Safety
2. Active Participation in RCCOs
3. Cesarean Section
4. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
5. 30 Day All-Cause Readmission
6. Emergency Department Process
7. Advance Care Planning
8. Tobacco Screening and Follow-Up

Payment Calculation

The HQIP payments earned for each of the FFY 2017-18 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 had less than 200 Medicaid discharges, those discharges were 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 the table below.

Table 2 FFY 2017-18 HQIP Dollars Per Adjusted Discharge Point

Tier	Quality Points Awarded	Dollars Per Adjusted Discharge Point
1	1-10	$5.69
2	11-20	$8.54
3	21-30	$11.38
4	31-40	$14.23
5	41-50	$17.07

During the FFY 2017-18 timeframe, HQIP payments totaled $97.6 million with 79 hospitals receiving payments. HQIP payments, Medicaid adjusted discharges, and quality points awarded by hospital are listed in the following table.

Table 3 FFY 2017-18 Hospital Quality Incentive Payments

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	HQIP Supplemental Payment
Animas Surgical Hospital	46	213	$167,252
Arkansas Valley Regional Medical Center	25	1,472	$418,784
Aspen Valley Hospital	29	246	$81,185
Avista Adventist Hospital	46	2,104	$1,652,103
Banner Fort Collins Medical Center	38	899	$486,125
Boulder Community Health	39	2,239	$1,242,578
Castle Rock Adventist Hospital	43	1,018	$747,222
Children's Hospital Colorado	50	10,329	$8,815,802
Colorado Canyons Hospital and Medical Center	46	75	$58,892
Colorado Plains Medical Center	23	1,328	$347,591
Community Hospital	34	505	$244,329
Craig Hospital	43	64	$46,977
Delta County Memorial Hospital	13	1,358	$150,765
Denver Health Medical Center	38	14,671	$7,933,197
East Morgan County Hospital	46	488	$383,187
Estes Park Health	30	447	$152,606
Good Samaritan Medical Center	30	2,501	$853,841
Grand River Hospital District	38	175	$94,630
Gunnison Valley Health	46	301	$236,351
Haxtun Hospital District	16	5	$683
Heart of the Rockies Regional Medical Center	43	922	$676,757
Keefe Memorial Health Service District	41	44	$30,794

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	HQIP Supplemental Payment
Kindred Hospital - Aurora	21	50	$11,949
Kindred Hospital - Denver	9	16	$819
Lincoln Community Hospital	29	88	$29,042
Littleton Adventist Hospital	46	1,832	$1,438,523
Longmont United Hospital	34	2,964	$1,434,042
Lutheran Medical Center	25	7,087	$2,016,252
McKee Medical Center	41	2,698	$1,888,249
Medical Center of the Rockies	38	3,333	$1,802,286
Melissa Memorial Hospital	40	25	$14,230
Memorial Hospital Central	34	18,441	$8,922,125
Memorial Regional Health	16	685	$93,598
Mercy Regional Medical Center	50	1,980	$1,689,930
Middle Park Medical Center	33	88	$41,324
Montrose Memorial Hospital	30	1,112	$379,637
Mt. San Rafael Hospital	13	644	$71,497
National Jewish Health	34	100	$48,382
North Colorado Medical Center	29	7,378	$2,434,888
North Suburban Medical Center	25	7,234	$2,058,073
Pagosa Springs Medical Center	46	531	$416,952
Parker Adventist Hospital	25	2,388	$679,386
Parkview Medical Center	41	8,978	$6,283,433
Penrose-St. Francis Health Services	43	8,975	$6,587,740
Pikes Peak Regional Hospital	50	438	$373,833
Pioneers Medical Center	16	63	$8,608
Platte Valley Medical Center	29	2,879	$950,128
Porter Adventist Hospital	46	2,006	$1,575,151
Poudre Valley Hospital	34	6,746	$3,263,850
Presbyterian/St. Luke's Medical Center	16	4,027	$550,249
Prowers Medical Center	34	1,140	$551,555
Rangely District Hospital	13	19	$2,109
Rehabilitation Hospital of Colorado Springs	29	330	$108,907
Rehabilitation Hospital of Littleton	41	275	$192,464
Rio Grande Hospital	31	475	$209,537
Rose Medical Center	21	4,012	$958,788
San Luis Valley Health Conejos County Hospital	34	106	$51,285
San Luis Valley Health Regional Medical Center	38	2,374	$1,283,717
Sky Ridge Medical Center	25	2,083	$592,614
Southeast Colorado Hospital District	29	119	$39,272
Southwest Health System, Inc.	13	1,329	$147,546
Spanish Peaks Regional Health Center	43	106	$77,805
St. Anthony Hospital	34	3,422	$1,655,632

Hospital Name	Quality Points Awarded	Medicaid Adjusted Discharges	HQIP Supplemental Payment
St. Anthony North Health Campus	25	4,821	$1,371,575
St. Anthony Summit Medical Center	39	810	$449,526
St. Joseph Hospital	41	5,591	$3,912,973
St. Mary-Corwin Medical Center	38	4,759	$2,573,382
St. Mary's Hospital & Medical Center, Inc.	38	2,271	$1,228,021
St. Thomas More Hospital	25	1,493	$424,759
Sterling Regional MedCenter	33	1,088	$510,914
Swedish Medical Center	13	6,124	$679,886
The Medical Center of Aurora	25	6,911	$1,966,180
University of Colorado Hospital	38	13,930	$7,532,508
Vail Health Hospital	30	725	$247,515
Valley View Hospital	38	1,090	$589,407
Vibra Hospital	13	8	$888
Wray Community District Hospital	16	283	$38,669
Yampa Valley Medical Center	25	641	$182,365
Yuma District Hospital	38	163	$88,141
Total	**2,556**	**200,688**	**$97,553,767**

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) 2017-18 CHASE collected $867 million in fees from hospitals, which, with federal matching funds, funded health coverage expansions, payments to hospitals, and the CHASE's administrative expenses. The following table outlines the healthcare affordability and sustainability fee expenditures in SFY 2017-18.

Table 4 SFY 2017-18 CHASE Fee Expenditures

Item	Total Fund
Supplemental Payments	$1,217,437,000
CHASE Administration (**Table 5**)	$68,467,000
Expansion Populations	$1,994,705,000
25.5-4-402.4 (5)(b)(VIII) - Offset Revenue Loss	$15,700,000
Total Expenditures	**$3,296,309,000**

Funding in SFY 2017-18 was appropriated for the CHASE administrative expenses through the normal budget process. For SFY 2017-18, there were approximately 77.42 regular full-time equivalent (FTE) positions for the administration of the CHASE. The expenditures reflected in the following table are funded entirely by the healthcare affordability and sustainability fee and federal funds.

Table 5 SFY 2017-18 CHASE Administrative Expenditures

Item	Total Fund
(1) Executive Director's Office; (A) General Administration; (A) Personal Services	$6,052,866
(1) Executive Director's Office; (A) General Administration; (A) Salary Survey	$0
(1) Executive Director's Office; (A) General Administration; (A) Merit Pay	$0
(1) Executive Director's Office; (A) General Administration; (A) Operating Expenses	$122,552
(1) Executive Director's Office; (A) General Administration; (A) Legal Services	$247,622
(1) Executive Director's Office; (A) General Administration; (A) Administrative Law Judge Services	$144,338
(1) Executive Director's Office; (A) General Administration; (A) Payments to OIT	$860,880
(1) Executive Director's Office; (A) General Administration; (A) CORE Operations	$296,290
(1) Executive Director's Office; (A) General Administration; (A) Leased Space	$494,730
(1) Executive Director's Office; (A) General Administration; (A) General Professional Services and Special Projects	$2,437,580

Item	Total Fund
(1) Executive Director's Office; (C) Information Technology Contracts and Projects; (C) MMIS Maintenance and Projects	$11,589,382
(1) Executive Director's Office; (C) Information Technology Contracts and Projects; (C) MMIS Re-Procurement Contracts	$5,960,452
(1) Executive Director's Office; (C) Information Technology Contracts and Projects; (C) CBMS Operating and Contract Expenses	$7,246,958
(1) Executive Director's Office; (C) Information Technology Contracts and Projects; (C) CBMS Health Care & Economic Security Staff	$298,894
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services; (D) Medical Identification Cards	$39,640
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services; (D) Hospital Out-Stationing	$4,834,072
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services; (D) Disability Determination Services	$1,102,956
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services; (D) Hospital Provider Fee County Administration	$18,922,186
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services; (D) Medical Assistance Sites	$1,531,968
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services; (D) Customer Outreach	$673,242
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services; (D) Centralized Eligibility Vendor Contract Project	$3,445,137
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts; (E) Acute Care Utilization Review	$1,003,181
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts; (E) External Quality Review	$105,603
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts; (E) Drug Utilization Review	$71,708
(1) Executive Director's Office; (F) Provider Audits and Services; (F) Professional Audit Contracts	$500,000
(1) Executive Director's Office; (H) Indirect Cost Recoveries; (H) Indirect Cost Assessment	$477,038
Total Executive Director's Office Expenditures	**$68,459,275**
(4) Children's Basic Health Plan Administration	$7,904
Total Administrative Expenditures (Total Funds)	**$68,467,179**

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.

Significant contracted expenditures funded by CHASE totaled approximately $35.4 million. Of that amount, information technology contract expenditures were approximately $24 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 $14 million and a utilization management contract for approximately $1.1 million. CHASE, as a government-owned business within the Department of Health Care Policy and 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 2.08% 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 2017 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 HAS fee increased hospital reimbursement an average of more than $200 million per year and substantially increased enrollment in Health First Colorado and CHP+. Overall reimbursement compared to cost per patient improved by 153% since 2009, including a reduction to hospitals' bad debt/charity care write off costs by 59%. However, a positive impact on cost shifting to private payers is not apparent with payments in excess of cost per patient increasing by nearly 63% since 2009. Determining the extent to which the hospitals reduced the cost shift requires additional data and analysis.

Historically the impact on the cost shift has been evaluated by trending the difference between hospital payments and costs for each of 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.

[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 9.4% from 2009 through 2017.

Table 6 Total Payments by Payer Group

Year	Medicare	Medicaid	Insurance	CICP/Self	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	$3,368,072,326	$2,150,865,794	$8,787,800,429	$1,402,593,552	$15,709,332,101

Table 7 shows the total costs by payer, which grew by an average of 7.5% between 2009 and 2017.

Table 7 Total Costs by Payer Group

Year	Medicare	Medicaid	Insurance	CICP/Self	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	$4,863,199,944	$3,133,068,710	$5,278,031,995	$1,232,290,381	$14,506,591,031

From 2009 through 2016, the seven-year average overall growth in cost for providing hospital care to Coloradans grew by 7.0%. If costs had grown in line with the Medicare Market Basket for Inpatient Prospective Payment Systems (MMB IP PPS) or with the national cost trend from hospitals' Medicare cost reports, the cost growth would have been approximately 4.4%, which may have lowered the cost shift to commercial payers (see Table 8).

The disparity between actual Colorado hospital cost growth and these national trends bears further research. The Department and CHA are assessing the drivers of hospital cost growth, and the Department plans to issue a report on the findings in January 2019.

Table 8 Average Cost Growth

Source	Average Cost Growth
DATABANK	7.0%
MMB IP PPS	4.4%
Cost Report - National	4.3%

Table 9 shows the total payments less total costs by payer, or total margin. The total margin for hospitals grew by an average of 23.5% in the eight years between 2009 and 2017.

Table 9 Payment Less Cost by Payer Group

Year	Medicare	Medicaid	Insurance	CICP/Self	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	($1,495,127,619)	($982,202,916)	$3,509,768,434	$170,303,171	$1,202,741,070

Table 10 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 2017, the payment shortfall improved by $26 per patient for Medicaid patients. For uninsured patients (i.e., CICP/Self Pay/Other), the payment below cost improved by more than $6,500 per patient[3].

Table 10 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

[3] The payment less cost per patient for the CICP/Self Pay-Other payer group may show a positive result in calendar years 2015 through 2017 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.

Year	Medicare	Medicaid	Insurance	CICP/Self Pay/Other	Overall
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	($5,660)	($4,454)	$11,110	$2,011	$1,373

B. Patient Mix by Payer

Table 11 shows the relative patient mix by payer. Over the eight-year time-frame, 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 11 Patient Mix by Payer

Year	Medicare	Medicaid	Insurance	CICP/Self Pay/Other	Total
CY 2009	31.4%	11.5%	43.1%	14.0%	100%
CY 2010	31.8%	12.1%	41.7%	14.5%	100%
CY 2011	31.6%	12.5%	41.4%	14.5%	100%
CY 2012	31.9%	13.3%	41.1%	13.8%	100%
CY 2013	32.1%	14.1%	40.5%	13.3%	100%
CY 2014	32.1%	19.9%	38.4%	9.6%	100%
CY 2015	32.1%	21.6%	37.8%	8.6%	100%
CY 2016	32.8%	21.7%	37.4%	8.1%	100%
CY 2017	33.5%	21.6%	36.4%	8.5%	100%

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 12, 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 2017, the payment to cost ratio for Medicaid is 69% of costs. The payment to cost ratio for the CICP/Self Pay/Other payer group has also increased from 52% in 2009 to 114% in 2017[4]. 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.

Table 12 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	0.69	0.69	1.66	1.14	1.08

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 that hospitals typically write-off as uncompensated care. As shown below, total bad debt and charity care have decreased significantly from 2013 to 2014 – the year when health coverage expansion under the ACA was fully implemented – and continued through 2017. On the other hand, total bad debt and charity care are approximately $413 million lower in 2017 compared to 2013, decreasing by 59%.

Table 13 Bad Debt and Charity Care

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	$152,801,781	$133,474,605	$286,276,386

[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 2017 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.

E. All-Payer Cost, Revenue, and Margin

Table 14 presents overall hospital payments, costs, and margins on a per patient basis over the last eight years. While costs have increased at an annual average rate of 5.1% over the eight-year period, payments have increased an average of 5.7% per year resulting in an average annual increase in margin of 19.2%.

Table 14 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	$17,930	$16,557	$1,373
Average Annual Change	5.7%	5.1%	19.2%

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 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 program is referred to as the Hospital Transformation Program (HTP). 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 program goals of the HTP are as follows:

- Improve patient outcomes through redesign and integration of care across settings;
- Improve the patient experience in 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 hospital's organization, operational, and system readiness for value-based payment;
- Increase collaboration between hospitals and other providers, particularly Accountable Care Collaborative (ACC) participants; and
- Add value to the system through an evidence-based and quality measure driven approach.

Colorado's hospitals have a critical role to play in the HTP, and will be asked to:

- Engage meaningfully with community partners, including Regional Accountable Entity (RAE) engagement to improve care coordination and transitions of care;
- Recognize and address the social determinants of health;
- Prevent avoidable hospital utilization;
- Ensure access to appropriate care and treatment;
- Improve patient outcomes; and
- Reduce costs and contribute to reductions in total cost of care.

The HTP is built upon a framework that addresses five focus areas:

- High utilizers;
- Vulnerable populations, including pregnant women and end of life;
- Individuals with behavioral health conditions and substance use disorders;
- Clinical and operational efficiencies; and
- Community development efforts to address population health and total cost of care.

In an effort to achieve these goals, hospitals will implement programs using the following guidelines:

- A set of required statewide metrics, as well as program-specific metrics reflecting the HTP's focus populations and goals that measure program progress and success;
- State guidance regarding the types of activities that must be executed within each program; and
- Action reports and programs they intend to implement.

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

A. Program and Waiver Development

To date the Department has maintained a robust stakeholder engagement process, which includes convening workgroups with the CHA and hospitals, and targeted and regular engagement with Department subject matter experts, 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.

There are currently three different hospital workgroups working on components of the program: rural hospital and urban hospital workgroups and a quality measures workgroup. 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 will also play a role as the draft waiver is developed. There is also a quality measures workgroup comprised of subject matter experts and clinical professionals that is meeting in collaboration with the Department on the development of the HTP quality measures and measures specifications.

Statewide metrics, project-specific metrics, and financing approach are currently under development for CHASE Board and stakeholder consideration. In the pursuit of a waiver with CMS, these components of the program must be developed, and there are several

formal steps that must be accomplished before the Department can submit a draft waiver application.

1. Waiver submission Process

Effective April 27, 2012, in accordance with section 10201(i) of the ACA that set forth transparency and public notice requirements for section 1115 waiver demonstrations, states need to include the following components in demonstration applications for the Centers for Medicare and Medicaid Services (CMS) to consider the application submission complete for the purpose of initiating federal review:

- 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 that the public will have an opportunity to provide comments on a demonstration while it is under review at CMS.

States must provide at least a 30-day public notice and comment period for applications for new waiver demonstrations and extensions of existing demonstrations. Once a state's 30-day public comment period has ended, the state will submit an application to CMS. Within 15 days of receipt of the application, CMS will determine whether the application is complete. CMS will send the state written notice informing the state of receipt of the complete application, the date on which the Secretary of Health and Human Services received the application, and the start date of the 30-day federal public notice period. If CMS determines that the application is not complete, CMS will notify the state of any missing elements in the application.

After the state is notified that their application is complete, there will be a 30-day federal comment period for the general public and stakeholders to submit comments. CMS will not act on the demonstration request until 15 days, at a minimum, after the conclusion of the public comment period.

B. Community and Health Neighborhood Engagement

Hospitals seeking to participate in the HTP are required to engage with community organizations and health neighborhoods as they plan for their HTP participation. Specifically, beginning in fall 2018, hospitals must conduct an environmental scan that is informed by external feedback and seek meaningful input on their project development and program applications during the pre-waiver period. The goal of the required community engagement process – including the environmental scan - is to inform the selection of HTP projects that are based on a solid understanding of the health needs of the population and the resources available to address them that will help achieve the Quadruple Aim: better patient experience, improved health outcomes, improved provider experience, and reduced cost. Furthermore, this engagement at the outset of the HTP will be critical to ensuring successful collaborations and delivery system impacts throughout and following the HTP.

This pre-waiver year dedicated to the Community and Health Neighborhood Engagement process is seen as a cornerstone of the program.

For more information about the Hospital Transformation Program visit: www.colorado.gov/pacific/hcpf/colorado-hospital-transformation-program.

VI. Appendix

Table 15 Fee-Exempt Hospitals:
Psychiatric, Long-Term Care, and Rehabilitation Hospitals

Hospital Name	County	Fees	Payments	Net Reimbursement
Kindred Hospital - Aurora	Adams	$0	$257,620	$257,620
Spalding Rehabilitation Hospital	Adams	$0	$59,387	$59,387
Vibra Hospital	Adams	$0	$12,621	$12,621
Craig Hospital	Arapahoe	$0	$237,565	$237,565
Denver Springs	Arapahoe	$0	$0	$0
Rehabilitation Hospital of	Arapahoe	$0	$516,536	$516,536
Centennial Peaks Hospital	Boulder	$0	$0	$0
Colorado Acute Long-Term	Denver	$0	$79,184	$79,184
Colorado Mental Health Institute	Denver	$0	$0	$0
Eating Recovery Center	Denver	$0	$0	$0
Kindred Hospital - Denver	Denver	$0	$24,271	$24,271
Kindred Hospital - Denver South	Denver	$0	$14,416	$14,416
Highlands Behavioral Health	Douglas	$0	$0	$0
Cedar Springs Hospital	El Paso	$0	$0	$0
Peak View Behavioral Health	El Paso	$0	$0	$0
Rehabilitation Hospital of	El Paso	$0	$371,491	$371,491
Clear View Behavioral Health	Larimer	$0	$0	$0
Northern Colorado Long Term	Larimer	$0	$9,336	$9,336
West Springs Hospital	Mesa	$0	$0	$0
Colorado Mental Health Institute	Pueblo	$0	$0	$0
Northern Colorado	Weld	$0	$120,785	$120,785
Total		**$0**	**$1,703,212**	**$1,703,212**

Table 16 Fee-Paying Hospitals:
General and Acute Care

Hospital Name	County	Fees	Payments	Net Reimbursement
Children's Hospital Colorado	Adams	$30,271,356	$64,486,521	$34,215,165
North Suburban Medical Center	Adams	$20,156,255	$30,999,410	$10,843,155
Platte Valley Medical Center	Adams	$5,846,483	$12,977,617	$7,131,134
University of Colorado Hospital	Adams	$72,137,953	$91,833,445	$19,695,492
San Luis Valley Health Regional Medical Center	Alamosa	$3,635,875	$10,962,227	$7,326,352
Littleton Adventist Hospital	Arapahoe	$20,655,494	$18,808,354	($1,847,140)
Swedish Medical Center	Arapahoe	$47,908,672	$57,576,173	$9,667,501
The Medical Center of Aurora	Arapahoe	$38,831,334	$28,108,573	($10,722,761)
Pagosa Springs Medical Center	Archuleta	$715,750	$2,829,089	$2,113,339
Southeast Colorado Hospital District	Baca	$263,409	$1,548,723	$1,285,314
Avista Adventist Hospital	Boulder	$7,386,321	$14,263,246	$6,876,925
Boulder Community Health	Boulder	$22,502,793	$20,738,521	($1,764,272)
Good Samaritan Medical Center	Boulder	$18,772,304	$10,994,397	($7,777,907)
Longmont United Hospital	Boulder	$12,258,149	$17,351,205	$5,093,056
St. Anthony North Health Campus	Broomfield	$12,276,567	$18,179,772	$5,903,205
Heart of the Rockies Regional Medical Center	Chaffee	$1,777,790	$5,707,528	$3,929,738
Keefe Memorial Health Service District	Cheyenne	$121,922	$637,254	$515,332
San Luis Valley Health Conejos County Hospital	Conejos	$252,197	$2,742,082	$2,489,885
Delta County Memorial Hospital	Delta	$3,737,347	$6,847,269	$3,109,922
Denver Health Medical Center	Denver	$31,055,137	$112,097,476	$81,042,339
National Jewish Health	Denver	$3,308,431	$10,403,801	$7,095,370
Porter Adventist Hospital	Denver	$22,654,208	$13,501,915	($9,152,293)
Presbyterian/St. Luke's Medical Center	Denver	$32,742,889	$55,490,855	$22,747,966
Rose Medical Center	Denver	$26,599,845	$30,317,269	$3,717,424
St. Joseph Hospital	Denver	$30,894,502	$48,921,535	$18,027,033
Castle Rock Adventist Hospital	Douglas	$4,872,570	$4,605,103	($267,467)
Parker Adventist Hospital	Douglas	$15,444,267	$10,181,951	($5,262,316)
Sky Ridge Medical Center	Douglas	$25,610,969	$8,217,833	($17,393,136)
Vail Health Hospital	Eagle	$4,705,905	$9,868,163	$5,162,258

Hospital Name	County	Fees	Payments	Net Reimbursement
Grandview Hospital	El Paso	$3,482,467	$0	($3,482,467)
Memorial Hospital Central	El Paso	$36,616,389	$67,342,866	$30,726,477
Penrose-St. Francis Health Services	El Paso	$45,945,157	$50,889,209	$4,944,052
St. Thomas More Hospital	Fremont	$2,597,081	$8,940,240	$6,343,159
Grand River Hospital District	Garfield	$1,454,248	$4,444,138	$2,989,890
Valley View Hospital	Garfield	$7,212,223	$17,215,066	$10,002,843
Middle Park Medical Center	Grand	$552,785	$2,938,643	$2,385,858
Gunnison Valley Health	Gunnison	$915,854	$1,957,266	$1,041,412
Spanish Peaks Regional Health Center	Huerfano	$381,830	$1,812,025	$1,430,195
Broomfield Hospital	Jefferson	$4,937,216	$0	($4,937,216)
Lutheran Medical Center	Jefferson	$29,000,621	$25,744,974	($3,255,647)
OrthoColorado Hospital	Jefferson	$1,636,050	$0	($1,636,050)
St. Anthony Hospital	Jefferson	$28,017,531	$26,002,632	($2,014,899)
Weisbrod Memorial County Hospital	Kiowa	$49,334	$807,991	$758,657
Kit Carson County Health Service District	Kit Carson	$431,031	$1,904,763	$1,473,732
Animas Surgical Hospital	La Plata	$1,290,470	$1,991,251	$700,781
Mercy Regional Medical Center	La Plata	$8,718,186	$16,074,324	$7,356,138
St. Vincent General Hospital District	Lake	$139,904	$1,625,711	$1,485,807
Banner Fort Collins Medical Center	Larimer	$1,106,195	$5,105,843	$3,999,648
Estes Park Health	Larimer	$1,005,806	$2,271,477	$1,265,671
McKee Medical Center	Larimer	$7,919,623	$12,492,774	$4,573,151
Medical Center of the Rockies	Larimer	$21,889,481	$32,406,485	$10,517,004
Poudre Valley Hospital	Larimer	$28,738,328	$39,185,876	$10,447,548
Mt. San Rafael Hospital	Las Animas	$1,223,552	$5,082,174	$3,858,622
Lincoln Community Hospital	Lincoln	$304,468	$1,004,753	$700,285
Sterling Regional MedCenter	Logan	$1,751,115	$6,024,309	$4,273,194
Colorado Canyons Hospital and Medical Center	Mesa	$1,088,245	$1,733,700	$645,455
Community Hospital	Mesa	$4,622,782	$4,597,331	($25,451)
St. Mary's Hospital & Medical Center, Inc.	Mesa	$26,148,653	$36,641,671	$10,493,018
Memorial Regional Health	Moffat	$1,055,785	$5,625,232	$4,569,447
Southwest Health System, Inc.	Montezuma	$1,586,107	$6,404,744	$4,818,637

Hospital Name	County	Fees	Payments	Net Reimbursement
Montrose Memorial Hospital	Montrose	$5,391,960	$9,317,380	$3,925,420
Colorado Plains Medical Center	Morgan	$4,162,041	$6,307,991	$2,145,950
East Morgan County Hospital	Morgan	$797,402	$3,075,543	$2,278,141
Arkansas Valley Regional Medical Center	Otero	$1,432,543	$7,819,316	$6,386,773
Haxtun Hospital District	Phillips	$78,878	$781,232	$702,354
Melissa Memorial Hospital	Phillips	$230,376	$1,015,131	$784,755
Aspen Valley Hospital	Pitkin	$1,729,963	$2,104,140	$374,177
Prowers Medical Center	Prowers	$900,283	$5,105,613	$4,205,330
Parkview Medical Center	Pueblo	$37,891,987	$57,572,815	$19,680,828
St. Mary-Corwin Medical Center	Pueblo	$16,653,126	$31,283,136	$14,630,010
Pioneers Medical Center	Rio Blanco	$220,856	$531,653	$310,797
Rangely District Hospital	Rio Blanco	$129,529	$1,122,814	$993,285
Rio Grande Hospital	Rio Grande	$523,995	$2,151,619	$1,627,624
Yampa Valley Medical Center	Routt	$2,720,641	$6,966,947	$4,246,306
Sedgwick County Health Center	Sedgwick	$226,745	$2,469,261	$2,242,516
St. Anthony Summit Medical Center	Summit	$2,601,379	$4,518,079	$1,916,700
Pikes Peak Regional Hospital	Teller	$891,656	$2,563,530	$1,671,874
Longs Peak Hospital	Weld	$5,017,035	$2,883,831	($2,133,204)
North Colorado Medical Center	Weld	$22,842,297	$39,024,460	$16,182,163
Wray Community District Hospital	Yuma	$329,378	$1,670,243	$1,340,865
Yuma District Hospital	Yuma	$554,309	$2,180,350	$1,626,041
Total		**$894,541,590**	**$1,299,929,589**	**$405,388,269**
Total All Hospitals		**$894,541,590**	**$1,301,633,071**	**$407,091,481**