# Improving the Hospital Transformation Program:

**Participant recommendations for the next iteration of HTP**

## Background

The Hospital Transformation Program (HTP) is a Health Care Policy and Financing (HCPF)-led initiative with statutory goals of improving access, quality, efficiency, and integration across the health care continuum for beneficiaries of Health First Colorado, the state's Medicaid program. The five-year, value-based program began in 2021 and will conclude in October 2026. Hospitals work from a menu of over 30 measures, some mandatory and others optional. Over 85 acute care hospitals in Colorado participate in HTP. More than $1 billion is at risk for Colorado hospitals throughout the course of the program, which distributes funds based on the performance of individual hospitals. The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board oversees the program.

## Survey Purpose and Methodology

In preparation for the conclusion of HTP's fifth and final programmatic year in 2026, HCPF plans to initiate a stakeholder process in the first quarter of 2025 to determine the future of the program. Colorado Hospital Association (CHA) is the leading voice of the Colorado hospital and health system community, representing all hospitals participating in HTP. CHA administered a survey in late fall of 2024 to better understand member experiences related to HTP and had 100 percent participation. Staff within CHA's Center for Clinical Leadership and Excellence analyzed the data and identified themes as follows:

## What's Going Well

### Fostering Relationships

Respondents indicated that HTP's emphasis on improving relationships has ultimately established a "ripple effect" with community-based organizations, regional accountable entities (RAEs), and other acute care facilities. Several initiatives have extended beyond the walls of hospitals to address complex patient needs and lay the groundwork for future collaboration. Respondents also shared that HTP has been helpful in bolstering cross-department teamwork internally, especially related to care coordination efforts. Finally, over 75 percent of respondents reported establishing meaningful relationships and collaborative engagement with HTP staff at HCPF.

### Health-Related Social Needs and Health Equity

A clear highlight of the program has been the spurring of statewide innovation in the areas of social determinants of health and health equity. The implementation of social needs screening by many hospitals has helped in starting to quantify and address this critical area of opportunity, far ahead of new requirements put in place by the Centers for Medicare and Medicaid Services.

### Data and IT Integration

For facilities with appropriate resources, the program has meaningfully demonstrated how electronic health records and population health data can be effectively used to improve care, outcomes, and coordination.

### Patient Care Improvement

HTP has promoted innovations that address core health challenges and the needs of Medicaid beneficiaries, especially within certain patient populations such as those experiencing mental illness and substance use disorder.

# Challenges and Opportunities

### Claims-Based vs. Self-Reported Data

Most respondents noted major challenges with access to timely, clear, and consistent data. As the majority of HTP measures are self-reported by individual hospitals, the lack of meaningful baseline and benchmark data across all participating hospitals severely limits decision making, appropriate resource allocation, and the overall effectiveness of the program. Conversely, respondents noted that the minimal use of claims-based measures, especially where such infrastructure already exists, is difficult to understand.

### Measure Complexity and Federal Alignment

While most HTP measures were originally based on national standards and guidelines similar to those found in federal quality programs, many measures were ultimately modified to meet HTP and HCPF goals. These modifications have complicated implementation, created significant misalignment with federal quality programs, and resulted in redundant reporting requirements. Measures have changed numerous times since the program's inception, which makes implementation even more challenging.

### Administrative and Reporting Burdens

A majority of respondents highlighted the massive administrative undertaking needed to comply with program requirements, especially among rural hospitals. Facilitating the program is extremely demanding, resources are limited, and no "net new" funding is provided to support hospitals. Reporting requirements are perceived to lack meaning and value and are considered by most respondents to be "busy work" that divert vital resources away from the core focus of the program, which is to improve care. The frequency and scope of reporting required for each program year, along with the reporting for numerous quality measures for each hospital, has posed significant challenges. In addition, manual extraction from electronic health records adds to the burden of program participation. While most respondents indicated this as a major issue, rural and critical access hospitals especially emphasized these challenges.

### Program Governance, Subject Matter Expertise, and Technical Assistance

Respondents felt that while HCPF staff have been available for discussion about HTP and encourage feedback through collaborative workgroups, the program lacks transparency and clear governance. Respondents were unclear on who is involved in decision-making and the process by which critical decisions are made. Concern was also raised about minimal ongoing input from individuals with explicit experience and expertise in implementing/scaling quality improvement work in acute care hospitals. These subject matter experts are not currently involved in program development and decision-making processes in any meaningful capacity.

### RAE and Care Coordination

A goal of HTP is improving care coordination between hospitals and RAEs. Respondents largely agreed that progress has been made in this area. However, a recurring concern is that RAEs face challenges in providing holistic care coordination and in fully leveraging the comprehensive datasets provided by hospitals as part of HTP. Additionally, respondents expressed that while hospitals are being held accountable for certain outcomes, there is a perception that RAEs are not being held to comparable standards, which places additional burdens on hospitals. It is important to note that despite major improvement in social needs screenings, RAEs and communities lack many of the same resources needed to drive systematic changes in areas such as housing instability and access to outpatient behavioral health.

# Next Steps

Based on robust member feedback and understanding of best practices, CHA's Center for Clinical Leadership and Excellence recommends future solutions be centered on the following principles:

### Program Governance

- Establish a clear governance framework for HTP, including HCPF, hospitals, and RAEs. This shared governance structure should be accountable for final decisions about measure requirements, timelines, modifications, and scoring disputes.
- Clinical and quality subject matter experts should have direct and collaborative decision-making authority in all aspects of the program.

### Subject Matter Expertise and Programmatic Support

- Establish robust technical assistance (TA) and quality improvement infrastructure to support hospitals in implementing measures, enhancing data collection and analysis, and supporting collaboration across stakeholder groups. At minimum, such TA should actively engage hospitals, RAEs, and health information exchanges, and should support information technology initiatives.
- Build on opportunities for hospitals with similar measures to collaborate and share best practices. This includes facilitating a regularly occurring, expert-led learning community that reduces duplication of effort, promotes innovation, and accelerates progress toward shared goals.
- Financial resources should be made available to support hospitals in implementing interventions.

### Measure Alignment

- Reduce the number of mandatory quality measures included in the program and limit the number of metrics to those with evidence-based impact on patient care and outcomes. The focus should remain on making meaningful clinical and patient-centered improvements that are within the scope of acute care hospitals.
- Whenever possible, HTP measures should explicitly align with federal quality programs. While having a menu of options can be meaningful in incorporating the local context into quality improvement, having numerous quality measures at a state level in addition to robust federal quality programs can be distracting and lead to diminishing returns.

- Avoid one-size-fits-all program mandates by considering the population size, patient demographics, and resource limitations of individual facilities, especially among rural facilities.

### Data, Reporting, and Administrative Burden

- Provide real-time, transparent, and actionable data including monthly statewide summaries of both claims-based and self-reported measures to participants. Such dashboards and information will empower data-driven decision making and process improvements.
- Clear, consistent, and meaningful benchmarks should be established to ensure fairness and improve hospitals' ability to meet program goals effectively.
- Baselines and benchmarks should be analyzed and decided on by the governing body, with stakeholder input, prior to final measure decisions being made for the next iteration of the program.
- Ensure that all reporting activity is truly meaningful in fulfilling the program's statutory goals. When reporting is required, data collected on implementation challenges and achievements should be made publicly available in aggregate to support continuous improvement across the state.