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Colorado Hospital Association

Feb. 14, 2019

The Honorable Jared Polis
Governor, State of Colorado
136 State Capitol
Denver, CO 80203

Dear Governor Polis:

Congratulations on your recent inauguration and completing your first full month in office. We are honored to have you serving as Colorado's 43rd Governor.

The information below is provided in the spirit of partnership with your administration in response to a letter to the Association from Director Bimestefer dated Jan. 23rd. We value Director Bimestefer's role in shepherding shared health policy priorities during the Hickenlooper-Polis transition and appreciate her detailed response to the Association's request to develop statewide hospital affordability targets by detailing the many existing areas of partnership between Colorado hospitals and the state.

CHA and its member hospitals and health systems share your administration's commitment to improve health care affordability for Coloradans and stand ready to partner with you and your team to develop and implement bold solutions to Colorado's health care affordability challenges. With roughly $18 billion flowing through Colorado hospitals annually – roughly 34 percent of Colorado's annual health care spending – hospitals must be an active part of the solution.[1]

Attached is a compilation of the Association's immediate and long-term affordability focal points developed in partnership with our 110 member hospitals and health systems. These represent commitments all Colorado hospitals have already made in partnership with CHA to improve health care affordability and value for Coloradans, but it is not an exhaustive list of the efforts individual hospitals and health systems are taking to improve efficiency, value and affordability. Each of the areas detailed below meet the Association's threshold criteria of improving access to affordable, high-quality health care and aligning payment incentives to deliver high-value care at a lower cost.

We have also identified the cost-saving potential and investment impact of these initiatives, which collectively reach between $1.5 and $2.5 billion on an annual basis over the next several years.

At the outset, we acknowledge that many of these efforts create a long-term return on investment (ROI) and may not provide an immediate, meaningful impact on consumer pocketbooks. However, these efforts are sustainable and will substantially move Colorado's health care delivery system in the right direction – toward value and away from volume-based payments. That said, the affordability crisis is such that we cannot delay, and we must progress on several fronts simultaneously: one immediate and one long-term; one collective and one tailored to specific needs of unique organizations and the communities they serve.

Additionally, while affordability is justifiably an urgent concern for many Coloradans, the focus on cost must be balanced with the importance of ensuring access to health care services, maintaining and

[1] Colorado Health Institute, Affordability in Colorado: Answers About Health Care Costs, December 2018, https://cha.com/wp-content/uploads/2018/12/Affordability-in-Colorado-Report.pdf

improving quality of care and efforts that present a longer-term ROI, including preventive care and social determinants of health.

Further, we know our work does not stop here. CHA is supportive of some of this year's early legislative efforts to tackle health care affordability – including House Bill 19-1001 "Hospital Transparency" – and is actively seeking opportunities to support additional ideas consistent with our strategic objectives and the ongoing efforts discussed below. CHA is also working on new cost control measures with our members, which we hope will increase the value of health care in Colorado. We look forward to collaborating with you over the next several months when these ideas are shaped out a bit further. Colorado hospitals will need to balance this work with what is being asked of them by the legislature this year.

Equally important as looking inward as a hospital community is our work with other stakeholders, including industry partners, patients and families, policymakers, consumer advocates and our workforce. CHA and our member hospitals and health systems fervently believe that in order for Colorado to achieve the shared goal of improving health care affordability, we must collectively establish objectives across the health care industry that engage all stakeholders and provide accountability. Anything less will lead to fragmented work that will at best fail to achieve savings targets, or at worst, lead to potentially devastating and unintended consequences to our health system. As a reflection of the importance of consensus-driven and evidence-based policy, we ask that you join with us in championing the development of a statewide health care affordability scorecard that can guide Colorado toward collectively holding all stakeholders accountable as we transform Colorado's health care system to provide the best care at the lowest cost. Other states, including Massachusetts, Delaware, and Rhode Island have embarked upon similar work as an effort to develop consensus, set benchmarks and track progress toward improving health care affordability.

We welcome your engagement on the considerable work in front of us to achieve our shared goal of improving health care affordability for Coloradans, and we welcome the opportunity to meet with you to discuss the best ways to proceed.

Sincerely,

Steven J. Summer
President and Chief Executive Officer
Colorado Hospital Association

cc: Members, CHA Board of Trustees
Chief Executive Officers, Member Hospitals and Health Systems
Lt. Gov. Dianne Primavera
Lisa Kauffman, Chief of Staff, Office of Gov. Polis
Eve Lieberman, Deputy Chief of Staff, Office of Gov. Polis
Wade Buchanan, Policy Director, Office of Gov. Jared Polis
Elisabeth Arenales, Senior Health Policy Advisor, Office of Gov. Jared Polis
Kacey Wulff, Deputy Chief of Staff to Lt. Gov. Primavera
Kim Bimestefer, Executive Director, Colorado Department of Health Care Policy and Financing
Michael Conway, Commissioner of Insurance
Jerene Petersen, Acting Executive Director, Colorado Department of Human Services
Jill Ryan, Executive Director, Colorado Department of Public Health and Environment
Dr. Robert Werthwein, Director, Office of Behavioral Health, Department of Human Services

Colorado Hospital Efforts to Improve Health Care Affordability & Value[2]

February 2019

Hospital Transformation Program

Jan. 23 letter reference: page 2, item 1; page 4, item 6

The Hospital Transformation Program (HTP) will leverage the $1 billion per year in Medicaid funding that flows through the Colorado Hospital Sustainability and Affordability Enterprise (CHASE) to pay hospitals for value and outcomes over a five-year period. The premise behind HTP is that it will transform care for all populations, not just Medicaid patients. However, it is important to note that while HTP will change *how* Medicaid pays for care, it does not include additional funds, and thus will not change *what* Medicaid pays for care – Medicaid will continue to pay significantly below the cost of providing care.

While HTP will require significant time and resource investments from hospitals, CHA has been an ardent champion of HTP since 2015, a full two years' prior to when it received statutory authority from the General Assembly. CHA and our member hospitals and health systems have engaged three years' worth – and thousands of hours' worth – of working groups to refine the program and are actively working on Community Health Neighborhood Engagement (CHNE) planning in anticipation of the program's formal launch in fall 2019. As conceived by the Department of Health Care Policy and Financing (HCPF) and developed in partnership with hospitals, this is the HTP and hospital-specific complement to Community Health Needs Assessments to ensure hospitals align infrastructure and investments with community interests and needs.

We are anxiously awaiting further details from HCPF on HTP metrics, funding details and other specifics that need to be developed, negotiated and vetted through the HTP workgroups and community stakeholders before the federal waiver application can be submitted and the program can formally launch in October 2019.[3]

Work Term[4]	ROI Term	Investment or Savings[5]	Annual Financial Scale[6]
2015-2025	<1 year - ongoing	Investment	$$$$$

[2] There were several hospital-focused ideas included in Director Bimestefer's letter not addressed in this response. In general, these have merit and warrant further discussion, but we focused our attention first on ideas that meet the criteria of improving access to affordable, high-quality health care and aligning payment incentives to deliver high-value care at a lower cost. Out of respect for the requests, CHA will work with our members to consider these ideas for the future.

[3] HCPF, HTP Concept Paper, January 2019, https://www.colorado.gov/pacific/sites/default/files/2019%20January-Hospital%20Transformation%20Program%20Concept%20Paper.pdf

[4] Identifiable duration of the current project is either based on project plans or proposed legal authorities (eg, federal waivers). Many concepts have potential to be ongoing and/or continuous improvement activities; however, their efficacy should be periodically assessed.

[5] Assessment of the initiative's ROI potential. "Investment" is indicated where the initiative has a significant hospital up-front or ongoing investment required and/or where the documented evidence is lacking on ROI potential. "Savings" is indicated where the up-front investment is borne by a third party (eg, HCPF or General Fund). "Both" indicated where there is an evidence base to support a strong ROI.

[6] Annual financial scale estimated as follows: $=$0-50 million; $$=$51-100 million; $$$=$101-500 million; $$$$=$501-1 billion; $$$$=>$1 billion

Reduce Unwarranted Care Variation

Jan. 23 letter reference: page 3, item 3 ("direct care to lower cost/higher quality")

CHA is building out a platform to help Colorado hospitals identify and pursue these opportunities, which will require strong partnerships across hospital administrative leadership, clinicians and patients. Recent national research has proven that hospitals can achieve better quality and significantly reduce costs targeting wasteful testing and unnecessary clinical variations in care (also called "unwarranted care variation," or UCV).[7] While the potential for savings varies, researchers suggest a minimum of $4 million per year for a typical hospital – without sacrificing a commitment to high-quality care.

Our work in this area targeting the opioid crisis is addressed below on page 5. Another example of this effort is a CHA/UCHealth study on pre-surgical, low-value cardiac testing for low-risk surgery, which will determine if pre-surgical cardiac testing can be safely eliminated - with no change in outcome - for specific low-risk procedures, thereby reducing utilization and cost of care.

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
2018 – 2022	1-3 years	Both	$$$

Centers of Excellence & Capacity Analysis

Jan. 23 letter reference: page 3, item 3 ("direct care to lower cost/higher quality") and item 4; page 4, item 6

Assessing adequate capacity and developing the "Centers of Excellence" concept go hand-in-hand. Despite the assertion that hospitals are creating oversupply or engaging in an "arms race," many hospitals along the Front Range have experienced frequent high-capacity demands in recent years. Further, increased competition among providers applies a downward pressure on prices in Colorado's health care market.[8] Identifying measures by which capacity can be assessed and tracked – particularly among traditionally under-resourced services such as behavioral health – is an activity in which we welcome the administration's partnership and collaboration, preferably without the express bias and predetermination that there is currently an "oversupply."

CHA has been actively working to build models that support the Centers of Excellence concept articulated in Director Bimestefer's letter, and later in 2019, we welcome the administration's partnership in developing partnerships with private and public payers, ensuring a sustainable financing plan, addressing legal and regulatory challenges and implementing pilot projects to prove the concept.

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
2020 - 2022	1-3 years	Both	$$

[7] The Advisory Board, October 2018, https://www.unitedhealthgroup.com/newsroom/2018/2018-10-03-hospitals-lower-cost-care.html

[8] Colorado Health Institute, December 2017, https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/Competition_HIHC%202017_For%20Web.pdf

New Technologies that Drive Affordability and Quality

Jan. 23 letter reference: page 4, item 7

CHA and Colorado hospitals have long been supporters and early adopters of technologies to drive affordability and quality, most prominently through our institutional support of the Colorado Telehealth Network (CTN), health information exchange through Quality Health Network (QHN) and the Colorado Regional Health Information Network (CORHIO), the Colorado All Payer Claims Database and the Center for Improving Value in Health Care (CIVHC) and the Governor's Office of e-Health Innovation (OeHI). We have championed legislation to improve access to telehealth services in both urban and rural Colorado (House Bill 17-1094), and our hospitals continue to develop partnerships to improve access to care via telehealth, especially in rural Colorado. This year, CHA is the chief proponent of Senate Bill 19-073 to create a statewide advanced directives registry, which has strong support from our members in our efforts to simplify the health care system and facilitate opportunities to better respect patient wishes.

While CHA is proud of the work Colorado hospitals have done in this area, there is ever-present opportunity, and unfortunately little post-market analysis documenting its "real life" cost-saving achievements.

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
2010 - ongoing	Undetermined	Investment	$$

Inpatient Hospital Review Program

Jan. 23 letter reference: not included

In the 2018 legislative session, CHA supported Senate Bill 18-266, authorizing HCPF to pursue cost-control strategies, value-based payments and other efforts to reduce the rate of growth in the Medicaid program. One of the first initiatives under this legislation was the creation of the inpatient hospital review program, which will launch this year. This additional level of review will result in financial losses to hospitals, but hospitals know these efforts align with our priority to modernize Colorado's Medicaid program to function consistent with other commercial payers.[9,10]

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
2019 - ongoing	<1 year - ongoing	Savings	$

Invest in Workforce Development

Jan. 23 letter reference: page 4, item 5

CHA has been a consistent and enthusiastic supporter of our employed and affiliated health care workforce, including physicians, nurses and other allied health professions. In the legislative arena, we have advocated for expanded scopes of practice to ensure professionals are allowed to practice to the full extent of their training and experience; for interstate transfer of licenses for physicians, nurses and others; for financial support of preceptors in rural areas; for funding for family medicine residency programs; for nurse anesthetists to have full independent practice in rural areas; and many other initiatives. CHA has a very active Workforce Council that provides recommendations and toolkits to

[9] HCPF, SFY 2018-19 Budget Amendment BA-16, https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20BA-16%20Comprehensive%20Claim%20Cost%20Control.pdf

[10] In November 2018, the CHA Board of Trustees reaffirmed the Association's policies and priorities, a summary of which is included as an attachment to this document.

members regarding workforce development programs. CHA is also a state co-lead (along with the Colorado Center for Nursing Excellence) of the Future of Nursing Campaign for Action, sponsored by AARP and the Robert Wood Johnson Foundation.

Collectively, Colorado hospitals directly employ more than 75,000 people generating direct economic impact of more than $15 billion and total impact of $33 billion. On an individual basis, Colorado hospitals also make significant investments in the nursing workforce, especially in the areas of training and professional development. Based on a 2017 CHA member survey, 56 percent of respondents have pipeline-based training programs, 37 percent offer internships, 22 percent have specialty training programs, and 7 percent offer apprenticeships.[11] While personnel expense is the largest expense category for hospitals (employee wages and benefits constitute 59 percent of costs for inpatient services nationally), Colorado hospitals recognize that investing in human capital is a necessity that pays dividends in improved care quality and patient experience.[12]

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
Historic - ongoing	Undetermined	Investment	$$

Drive Appropriate Use of Emergency Care

Jan. 23 letter reference: page 5, item 8

Colorado hospitals agree that there is significant potential for cost savings in driving toward "right care, right time, right place" approaches, particularly when it comes to emergency care; estimates from national research estimate that anywhere from 3.3 to 27 percent of ER visits are potentially avoidable.[13] We further agree that investing in Colorado's primary care infrastructure can improve avoidable emergency department use, and CHA is proud to have supported a number of recent legislative efforts to bolster primary care, such as the rural preceptor tax credit, increased primary care reimbursements and alternative payment models for primary care providers.[14]

At the same time, hospitals play an important role in ensuring emergency care is available to Colorado communities 24/7/365 regardless of an individual's ability to pay, and we support individuals' right to make informed decisions about where they access care. We have actively engaged in legislative conversations regarding Freestanding Emergency Departments (FSEDs) working to improve the information available to consumers (Senate Bill 18-146) and leading the effort for a new state licensure category (House Bill 19-1010) that reflects this new model of delivering emergency services while ensuring proper state oversight for patient safety and integration with the continuum of care. We have also partnered with the Department of Public Health and Environment (CDPHE) in attempts to gain further clarification from federal officials regarding permissive activities under the Emergency Medical Treatment and Labor Act (EMTALA) to better educate consumers about emergency services. At the same time, in response to community needs, some health systems are converting FSEDs into primary or urgent care locations.

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[11] Colorado Hospital Association, Workforce Pipeline Report, 2017, https://cha.com/wp-content/uploads/2017/09/CHA.073-2017-Workforce-Council-Report_web.pdf

[12] Colorado Hospital Association, Financial Health of Colorado Hospitals, 2017, https://cha.com/wp-content/uploads/2017/10/Financial-Health-of-Colorado-Hospitals-10-6-2017-S.pdf

[13] https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html; https://academic.oup.com/intqhc/article/29/5/642/4085442

[14] For example, CHA supported continuing increased primary care reimbursement initially included in the ACA (the "1202 bump") using General Fund, supported House Bill 16-1142 creating a tax credit for rural preceptors, and inclusion of an alternative payment model approach starting in the state's 2017-18 budget.

In 2017, CHA launched the "Where for Care" campaign, an effort to educate the public about when to seek emergency services and when to seek care at another location, such as an urgent care center or primary care provider's office. And Coloradans are responding: non-emergency ED visits have declined 7.3 percent since 2009.[15] However, CHA data shows that ED visits for illnesses that could have been treated in primary care are 35% larger for Medicaid than commercial patients; the proportion of mental health related diagnoses is 47% larger. The Association views these as opportunities ripe for partnership with HCPF as capturing cost savings available through appropriate emergency utilization will require a shared effort to further educate consumers and ensure Colorado communities have the appropriate alterative services such as primary and urgent care available outside of traditional "office hours". The Colorado Health Institute recently found that 72 percent of Coloradans with non-emergency ER visits chose the ER because care was needed at night or over the weekend.[16] Further, roughly 60 percent of non-emergency ER visits occur because the ER is more convenient, or a primary care appointment wasn't available soon enough.[17]

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
2017 - ongoing	<1 year - ongoing	Both	$$

Effective Prescription Medication Management

Jan. 23 letter reference: page 4, item 7; page 5, item 9

CHA strongly supports the concept behind HCPF's new prescription drug prescribing efficacy and health improvement prescribing tools, both of which were key components of Senate Bill 18-266, a bill that garnered CHA support last year. We look forward to continuing to work with the Department moving forward.

CHA was an early partner in the state's effort to combat opioid misuse in Colorado and continues to work in collaboration with the Colorado Consortium for Prescription Drug Abuse Prevention. In 2017, CHA partnered with the Colorado Chapter of the American College of Emergency Physicians to implement a set of guidelines to inform emergency departments on how to holistically address the opioid epidemic. In a six-month pilot study, hospital emergency department opioid administration dropped by 36 percent and the use of ALTOs – alternatives to opioids – increased 31 percent. By the end of 2018, our 10 pilot sites had decreased the administration of opioids by 62 percent. The pilot has since rolled out across the state and recognized as a best practice by national and federal partners, most prominently through the inclusion of a federally-funded pilot program modeled on Colorado's experience in the bipartisan SUPPORT for Patients and Communities Act, which was signed into law in October 2018.[18]

[15] Colorado Health Institute, Colorado Health Access Survey 2017, https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf

[16] Colorado Health Institute, Colorado Health Access Survey 2017, https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf

[17] Colorado Health Institute, Colorado Health Access Survey 2017, https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf

[18] Pub. Law. 115-271

Just last month, CHA, in partnership with the Colorado Medical Society, medical specialty groups and the Colorado Consortium for Prescription Drug Abuse Prevention, launched the Colorado's CURE initiative, designed to reduce opioid administrations in the inpatient hospital setting. The Association is again partnering with physician specialties to develop prescribing guidelines tailored to the nuances of patient populations based on the care they need.

These initiatives are just a portion of the Association's effort to tackle unwarranted care variation, discussed above on page 2.

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
2017 - ongoing	<1 year - ongoing	Both	$$

Hospital Governance & Business Decisions

Jan. 23 letter reference: not included; referenced at page 2, item 2; page 4, item 5; page 5, item 10; page 5, item 11

More than 80 percent of Colorado hospitals are public or nonprofit institutions, with community-based governing boards and considerable federal obligations to fulfill their mission and support their communities. The remaining private hospitals and health systems also have governing boards and work to improve operational efficiencies and achieve performance goals in partnership with their communities.

There are currently no uniform standards for classifying hospital expenditures as administrative or patient care-related. For example, an electronic health records system may seem like – and be classified as – an administrative expense, but it is vital to making sure patients get the highest quality care. Nurse Managers may have no patients of their own but instead make sure that an entire unit of patients is appropriately cared for. This ambiguity makes it difficult to determine exactly how much of hospital's expenditures are related to patient care versus administration, but patient care expenses should account for both direct and indirect patient care.

CHA also hopes to partner with your administration to develop a shared affordability scorecard, as described below, which would enable us to have common, standardized metrics and an understanding of key drivers of health care cost and affordability.

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
2019 - ongoing	1-3 years	Both	$

Strengthening Vulnerable Rural Hospitals

Jan. 23 letter reference: not included

Ensuring the sustainability of Colorado's small rural hospitals – particularly critical access hospitals – is a top priority of CHA. The Association's efforts culminating in the creation of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) in 2017 is the chief embodiment of this priority. Throughout 2018, CHA worked closely with a stakeholder group facilitated by Governor Hickenlooper's administration to examine the feasibility of a global budget program for rural hospitals, which would provide needed budget certainty and needed regulatory relief.

CHA and our rural hospital members will continue to engage with CMMI on the possibility of a multi-state rural global budget program, and we welcome your administration's support to ensure the sustainability and viability of hospitals and health care services in Colorado's rural communities.

Work Term	ROI Term	Investment or Savings	Annual Financial Scale
2017 - ongoing	1-3 years	Investment	$$$

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Colorado Hospital Association

CHA Medicaid Principles and Priorities

November 2018

The following principles and priorities were proposed to the CHA Board of Trustees by the CHA Payment Reform Task Force and ratified in November 2018. We welcome the administration's partnership on modernizing Colorado's Medicaid program and engaging in a dialogue with CHA on any topics addressed below.

As Medicaid grows and changes and is both the subject of reform and a driver for private-market reform, general policy principles are helpful to maintain longitudinal consistency with the Association's Medicaid activities and provide overall guardrails as new ideas are advanced.

Policy Principles:

- *Medicaid spending is an appropriate subject for public scrutiny, given the significant expense to taxpayers in funding health care for Medicaid recipients*
- *Effective leadership, a collaborative organizational culture, and sufficient expertise are essential to efficiently manage core functions of administering public coverage programs and ensuring access to care*
- *Decisions made by HCPF are high-stakes: patients' health and providers' livelihoods are often on the line. As such, the following are essential core competencies for HCPF leadership and organizational culture:*
    - *Commitment to transparency in intent, process, and methodology*
    - *Commitment to collaboration and inclusiveness in policy development and decision making*
    - *Commitment to thoughtfully evaluating and incorporating stakeholder feedback, as well as communicating results and building buy-in prior to taking action*
- *The guiding principles outlined in the Association's Vision for Medicaid (2014) remain relevant and should continue to guide CHA activities:*
    - *Patient Centered: The Medicaid program must be patient-centered and support the whole person by promoting wellness and addressing behavioral and physical health needs across the continuum of care. The program should engage patients as partners in their plan of care.*
    - *High-Performing: Beneficiaries must receive care that is high-quality and safe.*
    - *Efficient: Reforms must reduce growth in Medicaid costs through improved administrative efficiency and better resource management.*
    - *Equitable: All beneficiaries, particularly those in rural Colorado, must have access to high quality care.*
    - *Evidence-based: Solutions must be evidence-based to the extent possible with timely and accurate data available at the point-of-care as well as at the state and regional levels.*
    - *Accountable: Providers must be accountable to beneficiaries and the state for meeting quality and health outcomes standards.*
    - *Inclusive: All stakeholders critical to the success of reforms must have the opportunity to participate in the development and implementation of Medicaid reforms.*

- *Sustainable: Providers must receive adequate payment to ensure beneficiaries have access to high-quality care.*

Medicaid Cost Control Unit (Senate Bill 18-266)

As this effort is already underway, the Task Force recommends the following operating principles in addition to the general principles above:

- *The Cost Control Unit when conceived was to modernize the Medicaid program and enhance Medicaid functions to meet modern private payer standards*
  - *The Task Force expressed concern that Unit leadership has shown an interest in acting more like a market regulator than a payer, and that the Unit should focus first and foremost on cost controls that involve Medicaid's role as a payer*
- *HCPF should proactively engage CHA and member hospitals when evaluating cost control mechanisms related to hospitals to ensure activities are developed and executed appropriately*
  - *Cost containment efforts being implemented through HTP (e.g., the "Waste Calculator") should be evaluated by this Unit for application across all Medicaid services, especially physician services*
- *CHA should evaluate the need for an impartial "watchdog" entity outside of HCPF for the work of this Unit to ensure the agency continues to work with providers in a collaborative fashion*
  - *Future legislative action should be considered to establish an advisory or management board for the activity of this Unit or an independent "watchdog"*

Hospital Transformation Program

As this effort is already underway, the Task Force recommends the following operating principles for the Hospital Transformation Program (HTP):

- *CHA is supportive of the premise and program goals of HTP; however, hospitals have concerns that the program has shifted significantly under new leadership, disregarding over three years of thorough stakeholder engagement and collaboration*
- *HTP should focus exclusively on the established program goals:*
  - *Improve patient outcomes through care redesign and integration across care settings*
  - *Improve delivery system performance by ensuring appropriate care in appropriate settings*
  - *Lower Medicaid costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery*
  - *Accelerate hospitals' operational and systems readiness for value-based payment*
  - *Increase collaboration between hospitals and other providers*
- *HTP should maximize federal matching funds coming into Colorado, and funds must not be diverted to purposes outside of HTP or recipients other than hospitals*
- *As previously agreed, program design decisions should flow through CHA-HCPF Workgroups, or their successor groups*
- *Hospitals must be empowered to voluntarily select from a "menu" of metrics that align with goals and requirements of other HCPF efforts (e.g., Accountable Care Collaborative)*
- *HCPF must provide comprehensive training, data, and technical support to hospitals to assist in pre-waiver, implementation and review of the HTP program*

As part of an ongoing effort, the CHA Payment Reform Task Force also discussed the importance of documenting and communicating significant key concerns regarding HTP, including:[19]

- *Lack of a comprehensive stakeholder process on details of the HTP that extends beyond hospitals*
- *Failure to comply with agreement to discuss HTP program design concepts with the established CHA-HCPF hospital workgroups*
- *Despite three years' worth of work, there remains lack of clarity on key program components hospitals need to assess to determine their level of support for the program, including:*
  - *Financial model for HTP overall and potential financial risk to individual hospitals*
  - *Metrics for HTP initiatives and weighting system for non-mandatory program components*
- *Lack of communication and agreement on the waiver development and implementation timeline*

[19] While this position was a "point in time" perspective as of November 2018, several concerns regarding HTP remain relevant as of February 2019 and are therefore also included here.