



CHASE

Colorado Healthcare Affordability and
Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

December 31, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: State of Colorado Proposed Section 1115 HTP Demonstration

Dear Administrator Verma:

I am pleased to submit the enclosed Section 1115 Hospital Transformation Program (HTP) Demonstration Waiver application for your approval. The Colorado HTP is an initiative under development by the Colorado Department of Health Care Policy & Financing (the Department) in concert with the Colorado Health Care Affordability and Sustainability Enterprise (CHASE) and in collaboration with the hospital community and other stakeholders with an interest in Colorado's health care delivery system.

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

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

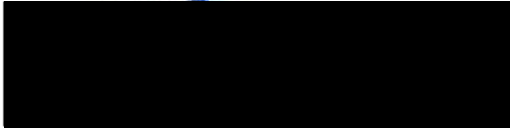
For the incentive payments, Colorado will leverage hospital supplemental payment funding generated through the existing healthcare affordability and sustainability fees assessed on hospitals, for which the state has submitted a State Plan Amendment. The proposed demonstration makes no other changes to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

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.
www.colorado.gov/hcpf



We look forward to collaborating closely with our partners at Centers for Medicare & Medicaid Services as the state implements its demonstration. If you have any questions or require additional information regarding the proposed demonstration, please contact Nancy Dolson, Special Financing Division Director, at 303-866-3698 or Nancy.Dolson@state.co.us.

Sincerely,



John Bartholomew
Finance Office Director

Attachments: Colorado Section 1115 HTP Demonstration Waiver Application
Appendix A Colorado 1115 Demonstration Checklist



Colorado Hospital Transformation Program: Delivery System Reform Incentive Payment Demonstration

*Application for Federal Section 1115 Medicaid
Demonstration to the Centers for Medicare and
Medicaid Services by Colorado Department for Health
Care Policy & Financing*

December 31, 2019

Submitted to: The Centers for Medicare and Medicaid Services
by the Colorado Department of Health Care Policy &
Financing



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Sustainability Enterprise

Contents

I.	PREFACE.....	5
II.	Description of Hospital Transformation Program.....	6
	A. Summary of Demonstration Program and Role in the Furthering Objectives of Title XIX	6
	B. Rationale for Proposed Demonstration Program	6
	C. Goals and Objectives for the Proposed Demonstration Program	7
	D. Statewide Operation and Affected Medicaid Stakeholders.....	9
	E. Effects on Current Colorado Medicaid State Plan Policies and Waivers.....	9
	F. Proposed Timeline for Demonstration Implementation and Operation	11
	G. Compliance with Application Content Requirements	13
III.	Hospital Delivery System Reform Incentive Payments	14
	A. Scope of Delivery Reforms and Incentive Payments.....	14
	1. Pay for Reporting and Activity, Pay for Achievement, Performance and Improvement (Downside Risk)	15
	2. Redistribution of Dollars, and Medicaid Savings Bonds (Upside Risk).....	16
	3. Pay for Reporting and Activity.....	17
	4. Pay for Achievement, Performance, and Improvement	18
	5. Benchmarking and Achievement Thresholds	19
	H. Measuring Scoring	20
	I. Statewide Measures, Local Measures, State Priorities, and Complementary Efforts.....	22
	1. Statewide Measures	22
	2. Local Measures	23
	3. Statewide Priorities	25
	4. Complementary Statewide Efforts	25
	5. Rural Hospital Support Program	26
	J. Overview of Colorado Value-Based Purchasing and Delivery Reform Initiatives to Date	27

K.	Expected Impact on Outcomes, Quality, Access and Cost Efficiency.....	29
L.	Hospital Participation and Hospital Applications and Implementation Plans ...	30
M.	Protocols for Application Review, Project Assessment, and Payments	33
1.	Application Review and Project Assessment Protocol	33
2.	Hospital Incentive Payments	33
3.	Performance Measurement and Reporting.....	34
N.	Post-Demonstration Sustainability	34
IV.	Implementation of Demonstration.....	35
A.	Approach to Implementation.....	35
B.	Timeline for Implementation	35
C.	Other Implementation.....	36
V.	Demonstration Financing and Budget Neutrality	37
A.	Description of Demonstration Financing	37
1.	Source of Non-Federal Share for Demonstration.....	37
2.	Other Sources of Non-Federal Share Not Used	37
3.	Same Effective Federal Medical Assistance Percentage	37
4.	Other Payment Methodologies.....	38
5.	Upper Payment Limit Not Applicable.....	38
6.	Hospital Receipt and Retention of Payments.....	39
7.	Publicly Owned Providers.....	39
D.	Historical Expenditures	40
E.	Projected Expenditures	40
F.	Federal Budget Neutrality Methodology.....	40
1.	Background Information for the Public.....	40
2.	Methodology for Demonstrating Federal Budget Neutrality.....	41
3.	Demonstration Financing Form and Budget Neutrality Spreadsheet.....	41
VI.	Proposed Waiver and Expenditure Authorities	42
A.	List of Proposed Waiver and Expenditure Authorities for the Demonstration...	42
B.	Rational and Planned Use of Proposed Waiver and Expenditure Authorities ...	42
1.	Rational for Waiver Authority.....	42

2. Planned Use of Requested Waiver and Expenditure Authority	43
VII. Demonstration Hypothesis and Evaluation.....	45
A. Hypothesis for Testing.....	45
B. Approach to Evaluation Design.....	46
C. Data Sources	47
D. Evaluation Plan and Reporting	48
VIII. Public Comment and Stakeholder Consultation.....	49
A. Overview of Stakeholder Engagement	49
B. Public Notice and Comment.....	50
C. Certification of Public Notice	50
D. Public Hearings.....	51
E. Other Mechanisms Used to Notify the Public	51
F. Tribal Consultation	52
G. Public Comments and State Responses	52
IX. Demonstration Contact	55
X. Appendix A - Waiver Application Check List	56
XI. Appendix B - Completed CMS Demonstration Financing Form.....	57
XII. Appendix C - Budget Neutrality Spreadsheet	61
XIII. Appendix D - Copy of Public Notice	70
XIV. Appendix E - Summary of Public Comments and State Responses on Draft Application	77
XV. Appendix F: Tribal Notice: Programmatic Log (November 8, 2019).....	92

I. PREFACE

The Colorado Hospital Transformation Program is an initiative under development by the Colorado Department of Health Care Policy & Financing (the Department) in concert with the Colorado Health Care Affordability and Sustainability Enterprise (CHASE) and in collaboration with the hospital community and other stakeholders with an interest in Colorado's health care delivery system.

This document is the Department's application to the federal Centers for Medicare and Medicaid Services (CMS) to implement and operate the Hospital Transformation Program (HTP) as an 1115 demonstration.

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

- Improve patient outcomes through care redesign and integration of inpatient and outpatient hospital services with community-based providers.
- Lower Health First Colorado (Colorado's Medicaid Program) costs through reductions in avoidable care and increased efficiency and effectiveness of care delivery systems.
- Accelerate hospitals' organizational, operational, and systems readiness for value-based payment.

Increase collaboration between hospitals and other providers, particularly Accountable Care Collaborative (ACC) participants, on data sharing and performance analytics and on evidenced-based initiatives in care coordination and care transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health.

The program will operate as a five-year demonstration and requires a federal Medicaid waiver(s) under section 1115 of the Social Security Act.

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

II. Description of Hospital Transformation Program

A. Summary of Demonstration Program and Role in the Furthering Objectives of Title XIX

Consistent with the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Act of 2017, the Colorado Health Care Affordability and Sustainability Enterprise in concert with the State of Colorado Department of Health Care Policy and Financing (the Department), seeks approval from the federal Centers for Medicare and Medicaid Services (CMS) for the federal authority necessary to embark on a five-year program to implement hospital-led strategic initiatives through the establishment of an alternative payment incentive program. The state will leverage hospital supplemental payment funding generated through existing healthcare affordability and sustainability fees (commonly referred to as hospital provider fees) authorized under CHASE. These payments will be used as incentives in a statewide Hospital Transformation Program (HTP) designed to improve patient outcomes through care redesign and integration with community-based providers, optimize Medicaid costs through reductions in avoidable care, and prepare the state's hospitals for future value focused, alternative payment arrangements.

B. Rationale for Proposed Demonstration Program

The state of Colorado is at the forefront of health care innovation and is focused on the quadruple aim's goals of better patient experience, improved health outcomes, improved provider experience, and reduced cost. Colorado is focused on leading and implementing delivery system reforms through its innovative Accountable Care Collaborative (ACC) and through participation in the Comprehensive Primary Care (CPC+) Initiative, with both efforts focused on integrating ambulatory care, as well as through the State Innovation Model (SIM) initiative that helped primary care practice sites integrate behavioral and physical health in primary care settings and set the stage for value based payments that evolved into the current Advanced Primary Care Alternative Payment Model (APM). By aligning and building upon these efforts to develop a more integrated system, Colorado is now expanding its reform efforts to further encompass the role hospitals play in service delivery transformation and quality.

Hospitals are a major source of care delivery and point of entry to care across the state. In addition to serving the medically and socially complex day-to-day needs of their patients, they are also engaged in making an array of clinical, operational, and system improvements that directly impacts patient care. These improvements are key to developing and maintaining a comprehensive, high-quality, population-based health delivery system for Health First Colorado members. A growing body of economic analysis indicates the total dollars lost through inefficient care transitions from hospitals to post-acute settings is oftentimes the primary driver of variation in a patient's total annual medical expense ("Health Policy Brief: Care Transitions," Health Affairs, September 13, 2012). Additionally, the prevalence of mental health and substance use disorders across the population continues to represent a major determinant of a health care system's ability to control population health and ensure patients' adherence to medication administration and other primary and preventive health services. Hospitals play a vital role in controlling and coordinating patient care across these critical areas, and their collaboration and coordination with care providers outside their four walls remains fundamental to successfully navigating these difficult delivery relationships.

The HTP will engage Colorado's general and critical access hospitals by pairing the flexibility to implement innovative interventions with financial incentives designed to encourage regional collaboration and improve access, quality and appropriateness of service delivery, and patient outcomes across vital areas of care. The HTP will be the state's first major effort to significantly redirect hospital supplemental payments toward major delivery model growth, maturity, and evolution. Colorado currently has a limited pay for performance effort underway known as the Hospital Quality Improvement Payment (HQIP) program. It is a voluntary supplemental payment program that pays participating hospitals based on reporting on six measures groups comprising 18 selected measures in 2019. The HQIP program represents approximately less than 10 percent of total supplemental payments received by hospitals throughout the year.

C. Goals and Objectives for the Proposed Demonstration Program

The Colorado HTP is designed to achieve four strategic, statewide objectives for hospital delivery reform:

1. Improve patient outcomes through care redesign and integration of care across delivery settings.
2. Lower Health First Colorado costs through reductions in avoidable care and increased effectiveness and efficiency in care delivery.
3. Accelerate hospitals' organizational, operational, and systems readiness for value-based payment.
4. Increase collaboration between hospitals and other providers, particularly ACC participants, in data sharing and analytics and evidence-based care coordination and care transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health and disparities reduction efforts.

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

- Care Coordination and Care Transitions
- Complex Care Management for Core Populations
- Behavioral Health and Substance Use Disorder (SUD) Coordination
- Maternal Health, Perinatal Care and Improved Birth Outcomes
- Social Needs
- Total Cost of Care

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

Within these priority areas, the delivery system reform incentive payment (DSRIP) program will be used to incentivize hospital-led activities to:

- Build the necessary organizational, workforce, and technology infrastructure for delivery system reform and accelerated readiness for value-based payment.
- Implement evidence-based interventions to improve care transitions, help address unmet needs of high-risk, high-cost populations and advance integration across the care delivery spectrum.

- Support data-driven accountability and outcome measurement through the collection, sharing, and monitoring of information among providers.

D. Statewide Operation and Affected Medicaid Stakeholders

The HTP will operate on a statewide basis. Any state-licensed general or critical access hospital participating in Colorado Medicaid may apply to participate in the demonstration. Free-standing psychiatric hospitals, long term acute care (LTAC) hospitals, and rehabilitation hospitals will be exempt from the program. The Department anticipates all non-exempt hospitals will participate.

While only hospitals will be eligible for delivery system reform payments, the demonstration is designed to strongly encourage partnerships, collaboration, and integration among primary, acute, and specialty providers, particularly between hospitals and ACC participants. Additional operational guidance on an appropriate strategy will be developed by the Department, in consultation with DSRIP stakeholders, and shared with all participating hospitals in the coming months.

Since the demonstration is intended to improve care delivery, many of Colorado's 1.2 million Health First Colorado and CHP+ members are expected to benefit over time. However, as noted in section 1.5, the proposed demonstration makes no changes to Health First Colorado or CHP+ eligibility requirements, benefit coverage, cost sharing, or freedom of choice and will not affect enrollment.

E. Effects on Current Colorado Medicaid State Plan Policies and Waivers

The proposed demonstration would make one substantive change in current Colorado Medicaid policies. Specifically, inpatient and outpatient hospital supplemental payments for uncompensated care currently made under the State Plan will be redistributed by delivery system reform incentive payments to hospitals under the demonstration. The source of the non-federal share of Medicaid expenditures for delivery reform incentive payments will be the hospital provider fee now used to finance the non-federal share of the supplemental payments.

Otherwise, this application proposes no changes to any of the following areas of the Health First Colorado or CHP+ programs:

Enrollment: The demonstration will not increase or decrease annual enrollment.

Eligibility requirements: The demonstration will not affect eligibility requirements or processes. The demonstration will not change eligibility groups or financial and non-financial eligibility criteria.

Benefit coverage: The demonstration will not change covered services and proposes no changes or reductions in the amount, duration, or scope of services available to beneficiaries. The proposed demonstration provides no additional benefits beyond those already provided through the State Plan.

Cost sharing: The demonstration will not change beneficiary cost sharing (premiums, deductibles, co-payments, or co-insurance).

Managed delivery systems: The demonstration does not involve the use of risk-based managed care arrangements and will not affect beneficiary freedom of choice in the selection of their health care providers.

Long-term services and supports: The demonstration does not make any changes to Medicaid long-term services and supports (LTSS).

Payment methods: At the start of this demonstration, the current inpatient and outpatient hospital supplemental payments to hospitals for uncompensated care provided under the State Plan will continue and the hospital delivery system reform incentive payments through the demonstration will further complement that reimbursement. No other Medicaid or CHP+ payment methodologies are changed. The demonstration will not change the relative distribution of Medicaid payments to publicly owned providers.

Waivers: This proposed demonstration requires no changes to any of Colorado's other waiver-based programs under sections 1115, 1915(b), or 1915(c) of the Social Security Act.

Financing: The demonstration will not change how Health First Colorado or CHP+ are financed. Unlike most other state demonstration programs involving delivery system reform incentive payments, the Colorado HTP demonstration will redirect existing hospital supplemental payment funds to support transformation. In addition:

- No Designated State Health Program (DSHP) is involved in this demonstration.
- The demonstration will not change the existing hospital provider fee. The state's existing waivers under section 1903(w) are not affected.
- The demonstration does not involve the use of intergovernmental transfers or certified public expenditures as a source of non-federal share.
- The only source of federal funding is Medicaid federal financial participation (FFP) under sections 1903 and 1905 of the Social Security Act. No other sources of federal funding, whether from CMS or another federal agency, are used in the proposed demonstration.

F. Proposed Timeline for Demonstration Implementation and Operation

This 1115 Demonstration would provide authority for the HTP DSRIP program over five-years. with the first year of the DSRIP program commencing as of October 1, 2020. However, the HTP hospital supplemental payment program is authorized under State Plan authority, and begins as of October 1, 2019, and runs through September 30, 2020. Because of the operational planning and framework needed for a successful implementation of the HTP DSRIP program, a program year zero is used below. For the purposes of this proposed application, program years (PY) and demonstration years (DY) maybe used interchangeably, although for CMS reporting purposes only demonstration years one through five will be included in any formal reporting to CMS. Below is a timeline displaying demonstration timeframes through September 30, 2025.

Program Year Zero: October 1, 2019 to September 30, 2020

- State Plan Amendment effective.
- Hospitals submit program applications.
- Hospital submit implementation plans.
- 1115 demonstration waiver approved.

Demonstration Year One: October 1, 2020 to September 30, 2021

- Baseline period for benchmarks and achievement starts.

Demonstration Year Two: October 1, 2021 to September 30, 2022

- Performance period begins.
- Hospitals focus on initiatives with measurable impacts.
- Begin to shift the payment structure from a pay-for-reporting to a pay-for-quality methodology based on state defined metrics with the percentage of hospital risk increasing incremental each year.

Demonstration Year Three: October 1, 2022 to September 30, 2023

- Hospitals continue to focus on initiatives with measurable impacts.

Demonstration Year Four: October 1, 2023 to September 30, 2024

- The Department to continue focusing on incentivizing the infrastructure changes needed across participating hospitals and will also reward hospitals based on the performance on improvement measures.

Demonstration Year Five: October 1, 2024 to September 30, 2025

- Shifting to value-based payments with a greater focus on implementing the care process redesign needed to thrive under an alternative payment reimbursement environment with successfully implemented interventions driving improvements in patient outcomes.
- Colorado HTP expires (unless an extension is submitted) at the end of demonstration year five. HTP will operate on a statewide basis. Any state-licensed general or critical access hospital participating in Colorado Medicaid may apply to participate in the demonstration. Free-standing psychiatric hospitals, long term acute care (LTAC) hospitals, and rehabilitation hospitals will be exempt from the program. The Department anticipates all non-exempt hospitals will participate.

While only hospitals will be eligible for delivery system reform incentive payments, the demonstration is designed to strongly encourage partnerships, collaboration, and integration among primary, acute, and specialty providers, particularly between hospitals and ACC participants.

Since the demonstration is intended to improve care delivery, many of Colorado's 1.2 million Health First Colorado and CHP+ members are expected to benefit over time. However, as noted in section 1.5, the proposed demonstration makes no changes to Health First Colorado or CHP+ eligibility requirements, benefit coverage, cost sharing, or freedom of choice and will not affect enrollment.

G. Compliance with Application Content Requirements

This application provides all content required under 42 CFR 431.412(1) and recommended in the CMS template for section 1115 waiver applications, except where not applicable to this proposed demonstration. As a result of the concentrated focus of the HTP and the use of existing funding only, many of the standard questions and recommended content identified in the template do not apply to this application.

For the convenience of CMS in reviewing this application for completeness under 42 CFR 431.412, Appendix A provides a checklist using the CMS template for section 1115 waiver applications. For each content element or question in the template, Appendix A indicates the primary pages where the relevant content or answers may be found or when template content or questions are not applicable to this demonstration.

III. Hospital Delivery System Reform Incentive Payments

A. Scope of Delivery Reforms and Incentive Payments

As part of the HTP, hospitals will receive supplemental payments based on their activity and performance on certain collaboratively developed measures. For each intervention and measure, hospitals will be asked to develop improvement plans with clear milestones for the first two years of the program and improve performance in years three through five across a series of measures important to improved processes of care, improved health outcomes, and reducing avoidable utilization and costs. In addition, hospitals will be asked to produce a plan for sustainability of projects and performance after the final year of the demonstration. The Department is recommending measure scoring for the HTP that includes a combination of statewide and local measures selected by each individual hospital to align with their improvement priorities and community needs.

The Department established expert measure specification and clinical workgroups to review preliminary measures selected for inclusion in the HTP. These groups determined measure feasibility and developed specifications for measures appropriate for final inclusion in the HTP. The purpose of both workgroups was to guide the course of converting a measure topic to measure specifications that can be executed. Due to the level of involvement and complexity required to develop specifications, the workgroups required a group of multidisciplinary experts. Throughout the process, the needs of the Medicaid population in Colorado drove the measure selection development.

During the pre-program period, qualified hospitals were tasked with conducting a Community and Health Neighborhood Engagement (CHNE) process to inform the hospitals' HTP projects and cultivate the meaningful partnerships that will be critical to the success of the overall program. It is mandatory that every hospital participating in the HTP complete all components of the CHNE process.

The first year of the HTP—referred to as PY1 or Demonstration Year 1 (DY1)—will be the first of year of the program. Throughout the program period, the Department seeks to continue its efforts to increase transparency through public reporting on quality measures and hospital utilization. As the HTP evolves, the payment structure will shift from pay-for-reporting and pay-for-

action in PY1 and PY2 to pay-for-quality and pay-for-performance beginning in PY3, with the percentage of hospital risk increasing incrementally each year.

As the program matures into the post-program time period, the Department anticipates efforts will be sustained or enhanced with the adoption of value-based payments and/or APMs, and efforts will be undertaken to define, evaluate, and identify centers of excellence.

1. Pay for Reporting and Activity, Pay for Achievement, Performance and Improvement (Downside Risk)

Hospitals will be at-risk for a sequentially increasing percentage of their payments. Pay for reporting at-risk dollars will operate under the authority of State Plan beginning in program year zero (PY0) (October 1, 2019). SPAs 19-0031 and 19-0032 will be submitted no later than December 31, 2019, with an effective date of October 1, 2019, and will contain more details pertaining to pay for reporting at risk payments. The schedule for at-risk dollars is as follows:

In PY1/DY1, 3% of payments will be at-risk, with 1.5% at risk each for hospital applications and implementation plans.

In PY2/DY2, 6% of payments will be at-risk, with 2% at risk for timely reporting, and 4% at risk for meeting major project milestones. For hospitals who miss their milestones, 50% of the at-risk dollars can be earned back by submitting a course correction plan in Q3. Each hospital may submit a course correction plan once per intervention.

In PY3/DY3, 15% of payments will be at-risk, with 2% at risk for timely reporting, 8% at risk for meeting major project milestones, and up to 5% at risk for not meeting or exceeding benchmarks or achievement thresholds. For hospitals who miss their milestones, 50% of the at-risk dollars can be earned back by submitting a course correction plan in Q1 or Q3. Each hospital may submit a course correction plan once per intervention.

In PY4/DY4, 20% of payments will be at-risk, with 2% at risk for timely reporting and up to 18% at risk for not meeting or exceeding benchmarks or achievement thresholds.

In PY5/DY5, 30% of payments will be at-risk, with 2% at risk for timely reporting, 8% at risk for submission and approval of the sustainability plan, and up to 20% at risk for not meeting or exceeding benchmarks or achievement thresholds.

2. Redistribution of Dollars, and Medicaid Savings Bonds (Upside Risk)

While hospital payments will be at-risk for certain activities, high performing hospitals, defined as those in the top 10%, will also be able to receive an upside risk payment comprised of a redistribution of at-risk dollars. For PY1 through PY3, this upside risk will comprise only a redistribution of unearned at-risk dollars. For each statewide measure, unearned at-risk dollars for that measure will be distributed to hospitals who scored in the top 10% on the measure.

Unearned at-risk dollars for local measures will be pooled together and distributed to hospitals whose average performance, as a percent of benchmark, for their local measures is in the top 10% of all hospitals. The percentage of benchmark a hospital receives on each of its local measures will be calculated and then the average percentage of benchmark across these measures will be determined. This average will be used to rank each hospital and the distribution will be awarded to the top 10%.

Table A: Hospital Examples

Hospital A	Hospital B
4 local measures	2 local measures
Measure 1 = 90% of benchmark = .9	Measure 1 = 120% of benchmark = 1.2
Measure 2 = 110% of benchmark = 1.1	Measure 2 = 105% of benchmark = 1.05
Measure 3 = 105% of benchmark = 1.05	
Measure 4 = 120% of benchmark = 1.2	
Average = 1.0625	Average = 1.125

Dollar distribution for each eligible hospital will be weighted by their total dollars at-risk.

In addition, in PY4 and PY5 hospitals will be eligible for savings bonuses included in the upside opportunity. The savings bonuses are comprised of dollars saved as a result of the program’s hospital utilization changes attributable to HTP efforts. A portion of the savings will be shared with all hospitals based on their relative proportion of Medicaid hospital utilization

adjusted by their average performance on HTP measures. Savings will be determined based on a comparison of actual hospital-based services payments to expected payments for the same period, adjusted for utilization. The pool of hospital savings will be capped by the lesser of hospital savings and total program payment savings, such that, if there is no overall savings, then there will be no savings bonuses. These savings will be evaluated for PY3, PY4, and PY5 with calculation at the end of each performance year and savings shared in the subsequent year in accordance with timely filing limits. For example, savings calculated in PY3 will be shared in PY4.

The 30% at-risk in PY5 will be reconciled along with the savings bonus for payment following the end of program year 5. It is required to have a 6-month lag to produce the report for the last program year of the demonstration. The Department will have Q3 of payment year 6 to receive and accept sustainability plans and reconcile payments in Q4 of payment year 6.

3. Pay for Reporting and Activity

Hospitals will be asked to implement interventions that will impact HTP measures. In PY1, the timely approval of the application and the implementation plans for the interventions each carry a 1.5% downside risk.

Throughout the HTP, hospitals will be asked to document and report on the activities they are undertaking with the implementation, management, execution, and monitoring of the interventions they have committed to in their applications. Failure to report completely and on time for any quarter will result in complete forfeiture of at-risk reporting funds for that quarter. These quarterly reporting requirements and associated at-risk funds will continue through the entirety of the program.

Additionally, hospitals will be asked to report on ongoing community engagement activities. This information, along with any self-reported data associated with HTP measures as a requirement of the program each year, carries a 2% risk for failure to report in a timely and consistent fashion according to established reporting deadlines beginning in PY2.

Hospitals will have the opportunity to earn back 50% of milestone penalties for an intervention by submitting a course correction plan. Each hospital may submit a course correction plan once per intervention. Course correction plans may be submitted as part of quarterly reporting in the third quarter of PY2, as well as the first or third quarter of PY3.

After the completion of the demonstration, hospitals will be required to submit a sustainability plan demonstrating how the transformation efforts will be maintained after the five-year demonstration period. Failure to submit and gain approval of sustainability plans will result in complete forfeiture of the associated at-risk funds.

4. Pay for Achievement, Performance, and Improvement

There are two areas of accomplishment within the HTP:

Achievement of Project Milestones. Hospitals will be asked to establish milestones associated with each implemented intervention and the measures they are impacting. These are process measures essential to achieving successful outcomes they will be held to as they implement and execute on their plans. The at-risk percentage will be tied to the successful completion of milestones. The percent of credit toward milestones for each intervention will equal the number of milestones achieved divided by the total number of milestones for the intervention. The at-risk percentage for each intervention will equal the at-risk percentage divided by the number of interventions.

Performance or Improvement on Outcome Measures. Hospitals will be asked to select measures as outlined in the Measurement Scoring section below. Beginning in PY3, hospitals will have an established percentage at risk for a given program year based on whether they:

- Achieve or exceed the benchmarks for their measures; or,
- Show marked improvement in their measures.

If a hospital achieves or exceeds the benchmark for a measure, the full point value for that measure is earned.

If a hospital performs at or above the achievement threshold on a measure, but does not meet the benchmark, the following improvement factor will be applied to the hospital's possible points for the given measure, based on the relative percentage of improvement towards the benchmark according to the formula below:

$$\text{Improvement Factor} = \frac{(\text{Hospital Performance} - \text{Achievement Threshold})}{(\text{Benchmark} - \text{Achievement Threshold})}$$

Those that fail to do either a. or b. for a measure will receive no points for that measure.

The percent earned of the total at-risk dollars for measure performance for each hospital will be based on the sum of the total points earned for the measures they are working on. That total will be divided by the total possible measure points (100) to determine the percent earned of at-risk dollars as below:

$$\text{Percent earned of at-risk dollars} = \frac{\text{Measure Points Achieved}}{100}$$

Example: Medium Size Hospital working on 6 statewide measures each 12.5 points and two local measures each 12.5 points:

- Four statewide measures and one local measure better than benchmark = $(4 \times 12.5) + (1 \times 12.5) = 62.5$ points
- Two statewide and one local measure above achievement threshold at 80% improvement (improvement factor = 0.8) = $(2 \times .8 \times 12.5) + (1 \times .8 \times 12.5) = 30$ points
- Total Points = 92.5 = 92.5% earned of at-risk dollars

5. Benchmarking and Achievement Thresholds

After the baseline period of PY1, benchmarks and achievement thresholds will be set in PY2 based on the prior year's performance. Benchmarks will vary based on availability of data and type of measure. These are relative improvements.

Where benchmarks are available either nationally or statewide, the benchmark may be set consistent with that benchmark.

Where data is available from more than ten hospitals and no standard benchmark is used:

- The benchmark for all hospitals for PY3 will be the average performance of the top 75% of hospitals during PY1

For all measures with more than ten hospitals:

- The benchmark for all hospitals for PY4 will be a 5% improvement of PY3 benchmark
- The benchmark for all hospitals for PY5 will be a 5% improvement of PY4 benchmark
- The achievement threshold will be set at the 50th percentile (median) of hospital's performance during PY1.

For select process rate measures where there is **not** data available nationally, statewide, or from ten or more hospitals the expectation is that the process will be implemented across all eligible patients:

- The benchmark for all hospitals for PY3 will be 80%
- The benchmark for all hospitals for PY4 will be 85%
- The benchmark for all hospitals for PY5 will be 90%
- The achievement threshold will be set at (individual) hospital's performance from the prior year.

For all other measures where there are less than ten hospitals:

- The benchmark for PY3 will be 5% improvement of (individual) hospital's PY1 performance
- The benchmark for PY4 will be 5% improvement of (individual) hospital's PY3 benchmark
- The benchmark for PY5 will be 5% improvement of (individual) hospital's PY4 benchmark
- The achievement threshold will be set at (individual) hospital's PY1 performance.

H. Measuring Scoring

Data obtained from multiple sources to assess hospital performance were used to inform measures creation. Such sources of data include but are not limited

to Medicaid claims data and hospital data self-reported to the Department on selected measures subject to review.

The proposal for calculating the total required effort for measures is that each hospital will be required to work on a set of measures equal to 100 points, apart from critical access hospitals who will be required to reach a total of 60 points achieved by working on six measures each worth 10 points. Moreover, the number, mix, and points per measure will vary according to hospital size, defined by bed count or specialty type. Hospitals have the option to work on local measures beyond the required minimum. This would spread the local measure risk by reducing the points per local measure.

Large hospitals (91+ beds) will be accountable for six statewide measures, totaling 60 points and a minimum of four local measures, which will account for 40 points. Points per local measure will equal 40 divided by the number of local measures selected.

Medium hospitals (26-90 beds) will be accountable for six statewide measures and a minimum of two local measures. If two local measures are selected, statewide measures will total 75 points, and local measures will account for 25 points. If three local measures are selected, then statewide measures will total 67 points and local measures will account for 33 points. If four or more local measures are selected, then statewide measures will then total 60 points and local measures will account for 40 points. Points per local measure will equal 40 divided by the number of local measures selected for four or more local measures.

Small hospitals (<26 beds) excluding critical access hospitals will be accountable for six measures (statewide or local) to account for 100 points. Points per each measure will equal 100 divided by the number of measures selected.

Critical access hospitals (CAH) will be accountable for six measures (statewide or local) and will have their risk for measures reduced by 40%.

Pediatric hospitals will be accountable for five statewide measures, totaling 50 points and a minimum of five local measures, which will account for 50 points.

Points per local measure will equal 50 divided by the number of local measures selected for five or more local measures.

Respiratory specialty hospitals will be accountable for four statewide measures and a minimum of four local measures. If four measures are selected, then statewide measures will total 56 points and local measures will account for 44 points. If five or more measures are selected, then statewide measures will total 50 points and local measures will total 50 points. Points per local measure will equal 50 divided by the number of local measures selected for five or more local measures.

As noted above, most hospitals will be accountable for certain statewide measures, including at least one in each of the following areas:

- Reducing avoidable hospital utilization
- Core populations
- Behavioral health and substance use disorder
- Clinical and operational efficiencies
- Population health and total cost of care.

As noted in Section III.A, above, the projects and measures will be risk-scored as follows based on milestones and achievement and their relative points:

- PY1: 1.5% at risk for performance-improvement plan with milestones in PY2 and PY3 and outcome improvement in PY3 to PY5
- PY2: 4% risk for achievement of milestones
- PY3: 8% risk for milestones and 5% risk for measures (3% for CAH)
- PY4: 18% risk for measures (10.8% for CAH)
- PY5: 20% risk for measures (12% for CAH) and 8% risk for sustainability plan.

I. Statewide Measures, Local Measures, State Priorities, and Complementary Efforts

1. Statewide Measures

For each focus area, there will be at least one statewide measure required for most HTP-participating hospitals. Below are the statewide measures for the program.

- Reducing Avoidable Hospital Utilization.
- Adult 30-day all cause risk adjusted readmission rate.
- Pediatric all condition readmission measure.
- Core Populations.
- Social needs screening and notification.
- Behavioral Health and Substance Use Disorder (SUD)
- Collaboratively develop and implement a mutually agreed upon discharge planning and notification process with the appropriate Regional Accountable Entity (RAE) for eligible patients with a diagnosis of mental illness or SUD discharged from the hospital or emergency department.
- Pediatric screening for depression in inpatient and emergency department including suicide risk.
- Using alternatives to opioids (ALTOs) in hospital emergency departments - Decrease opioid use and increase use of ALTOs.
- Clinical and Operational Efficiencies.
- Hospital index.
- Population Health and Total Cost of Care.
- Severity adjusted length of stay.

2. Local Measures

Hospitals will be asked to select from a list of local measures to comprise the remainder of their measurement score. The combination of local measures selected should be reflective of the community needs identified in the Community and Health Neighborhood Engagement (CHNE) process. The Department has worked with quality measures workgroups to identify local measures for the program. These measures include:

- Reducing Avoidable Hospitalizations:
 - ✓ Connection to primary care medical provider (PCMP) prior to discharge and initial appointment made and notification to the RAE within one business day.
 - ✓ Emergency department visits for which the member received follow-up within 30 days of the emergency department visit.
 - ✓ Home management plan of care document given to pediatric asthma patient/caregiver.

- ✓ Percentage of patients with ischemic stroke who are discharged on statin medication.
- Core Populations:
 - ✓ Readmission rate for a high frequency chronic condition - 30 day adult/30 day pediatric.
 - ✓ Pediatric bronchiolitis - appropriate use of testing and treatment.
 - ✓ Pediatric sepsis - time to first intravenous antibiotics in the emergency department, early identification.
 - ✓ Screening for transitions of care supports in adults with disabilities.
 - ✓ Reducing neonatal complications.
 - ✓ Screening and referral for perinatal and post-partum depression and anxiety, and notification of positive screens to the RAE.
 - ✓ Increase access to specialty care.
- Behavioral Health/Substance Use Disorder:
 - ✓ Screening, Brief Intervention and Referral to Treatment (SBIRT) in the emergency department.
 - ✓ Initiation of Medication Assisted Treatment (MAT) in the emergency department or hospital owned certified provider based rural health center.
- Clinical and Operating Efficiencies:
 - ✓ Increase the successful transmission of a summary of care record to a patient's primary care physician or other health care professional within one business day of discharge from an inpatient facility to home.
 - ✓ Implementation/expansion of telemedicine visits.
 - ✓ Implementation/expansion of e-consults.
 - ✓ Energy Star Certification achievement and score improvement for hospitals.
- Population Health and Total Cost of Care:
 - ✓ Increase the percentage of patients who had a well visit within a rolling 12-month period.
 - ✓ Increase the number of patients seen by co-responder hospital staff.

- ✓ Improve leadership diversity.

The Department is considering the inclusion of a local measure related to alcohol and will make updates accordingly.

3. Statewide Priorities

In addition, hospitals have the option to replace a local measure with a statewide priority. Each statewide priority will be worth 20 points and if selected the points for each remaining local measure will be equal to the remaining total required local measure points divided by the number of local measures, greatly reducing the risk associated with those measures. Statewide priorities in the program are:

- Conversion of hospital-owned free-standing emergency departments to address community needs.
- The creation of dual-track emergency departments.

4. Complementary Statewide Efforts

Within certain focus areas, there will be some complementary statewide efforts HTP-participating hospitals will be asked to align with or engage in, along with HTP efforts. These complementary efforts will correspond with the CHNE process, core populations, and behavioral health and SUD coordination.

- A discussion of hospital inventory and capacity will be a part of the CHNE.
- Engagement with a multi-provider consensus quality measure and APM collaborative.
- Use of the Advanced Care Plan Repository and Education Tools.
- Use of the Medication (Rx) Prescribing Tool (which is being expanded to include health improvement program and opioid addiction prevention insights for prescribers).
- Real time data sharing and admission, discharge, and transfer (ADT) standards.
- Defining and identifying centers of excellence.
- Where capacity and need align, obtain necessary enrollment to provide beds for residential and inpatient SUD services following approval of the Department's SUD Waiver.

- Participation in a rural hospital support program for certain qualified hospitals.

5. Rural Hospital Support Program

The proposed Rural Support Fund provides additional support payments to select rural hospitals to meet the goals and milestones of the program.

Under the HTP, hospitals will be required to implement quality-based initiatives and projects to receive supplemental payments and demonstrate meaningful community engagement and improvements in health outcomes over time. For some rural hospital communities, layering quality-based efforts on top of insufficient operational strategies or infrastructure may not allow the hospitals to prepare for the needs of the communities they serve or the payment methodologies of the future.

Select rural hospitals will be eligible to receive additional support payments to prepare rural hospitals for alternative payment methodologies in the future through strategic planning and financial modeling, and then to operationalize those strategies. Critical access hospitals may apply. Hospitals will be evaluated based on responses to an application and financial resource analysis.

Funding is expected to be available each of the five years through the HTP. The funding may be used for services to prepare the hospital for future value-based or alternative payment methodologies, including:

- Technical capacity.
- Health Information Exchange (HIE) connectivity, such as the Colorado Regional Health Information Organization (CORHIO) fees.
- Strategic planning and consulting.
- Data analytics.
- Actuarial services and financial modeling for alternative payment methodologies.
- Transformation capital to operationalize the strategic plan
- Establish or augment service lines, such as funding shared clinical resources for behavioral health or substance use disorder.

- Physical plant changes, such as the conversion of intensive beds to ambulatory health or creating behavioral health capacity.
- Hospital's projects may not be for land or real estate investments for the sole purpose of future financial benefit, to finance or satisfy any existing debt, or to establish service lines that do not serve the community's needs.

J. Overview of Colorado Value-Based Purchasing and Delivery Reform Initiatives to Date

The Accountable Care Collaborative (ACC) program is the core of the state's Medicaid program. Launched in 2011, it is the primary vehicle for delivering health care to Health First Colorado members. The program represents an innovative way to accomplish the Department's goals for Medicaid reform. The fundamental premise of the program is that regional communities are in the best position to make the changes that will cost-effectively optimize the health and quality of care for all members.

The ACC was designed with a long-term vision in mind, and the understanding that to meet members' complex health needs, delivery system change must be iterative to keep up with an evolving health care system. Fiscal year 2018-19 began the second phase of the ACC. For Phase II, one entity, the Regional Accountable Entity (RAE), is responsible for promoting physical and behavioral health in each of seven regions. In order to promote comprehensive and coordinated care for members, the RAEs contract with a network of primary care medical providers (PCMPs) to serve as members' central point of care. The RAE also provides or arranges for the delivery of mental health and substance use disorder services as the administrator of the Department's capitated behavioral health benefit. Combining these responsibilities under one entity improves the member experience and member health by establishing one point of contact and clear accountability for treating the whole person.

The implementation of Phase II of the ACC has set the stage for the Department to pursue both targeted and structural approaches to controlling Medicaid costs in alignment with state priorities. The unique design of the ACC provides a flexible delivery system within which the Department can innovate and expand efforts to improve the affordability of health care. For example, the RAEs have a primary role in implementing the Department's new statewide

approach for clinical management of members with complex health needs and members with one of the Department's top ten health conditions by total expenditure. Through enhanced care coordination, leveraging existing community-based programs, and the delivery of preventive and supportive services, the Department expects to prevent disease progression, promote members' ongoing health, and reduce costs.

For Phase II of the ACC, the Department implemented mandatory enrollment into the program for all full-benefit Health First Colorado members, excluding those members enrolled in the Program of All-Inclusive Care for the Elderly (PACE). In FY 2018-19, average monthly enrollment in the Accountable Care Collaborative was 1,200,082. This enrollment number includes members participating in the Accountable Care Collaborative limited managed care capitation initiatives: Rocky Mountain Health Plans Prime (36,219 members) and Denver Health Medicaid Choice (78,909 members). FY 2018-19 enrollment reflects an increase from FY 2017-18 of 198,303 (19.8 percent).

Most of the state's Medicaid reimbursement to providers is based on fee-for-service (FFS) payments, though over 95 percent of Health First Colorado members are enrolled in the ACC's care management model. This model has proven successful in aligning patient care with needs and eliminating some unnecessary care among participants. The HTP will continue Colorado Medicaid's commitment to delivery and payment system transformation by bringing hospitals more purposefully into these arrangements and preparing them for expanded use of value-based payments. Since 2010, a significant amount of funding for hospitals participating in Colorado's Medicaid program has come from supplemental payments funded with fees assessed on hospitals and matching federal funds. Of these supplemental payments, approximately less than 10 percent are currently based on performance.

The Department's recent major initiatives have been aimed at building a robust, integrated Medicaid delivery system but their emphasis have been largely on the ambulatory and primary care setting. Hospitals, however, are a major source of care delivery and point of entry to care across the state. To create a fully integrated system, Colorado must align the state's hospitals with its other ongoing payment and delivery system transformation efforts. By leveraging supplemental payments made to hospitals, the state envisions

creating a Hospital Transformation Program which will serve as the vehicle through which the priorities for integration and alignment are achieved through clearly defined goals and financial incentive structures. The Hospital Transformation Program will focus on driving the infrastructure development, partnerships, data sharing, and operational changes needed to ensure the state's acute care hospitals are fully aligned with the priorities of ongoing ambulatory reform efforts.

Colorado benefits from the strong dedication of all hospitals throughout the state in serving the health care needs of individuals, families, and their communities. Hospitals' commitment to the goals of improved, accessible, and cost-effective health care is further evidenced by the historical and ongoing collaboration among rural and urban hospitals, the Colorado Hospital Association, and the Department. The HTP will serve to foster and expand upon these efforts.

K. Expected Impact on Outcomes, Quality, Access and Cost Efficiency

The HTP demonstration is designed to improve outcomes, quality of care, access to care, and cost efficiency over the five-year period and sustain and build upon the increased performance, integration, and care delivery reforms following the demonstration.

The HTP will focus hospital efforts on key processes and populations representing the most fragile, medically needy and at-risk beneficiaries:

- High utilizers.
- Core populations.
- Behavioral health and substance use disorders diagnoses.
- Clinical and operational efficiencies.
- Population health and total cost of care.

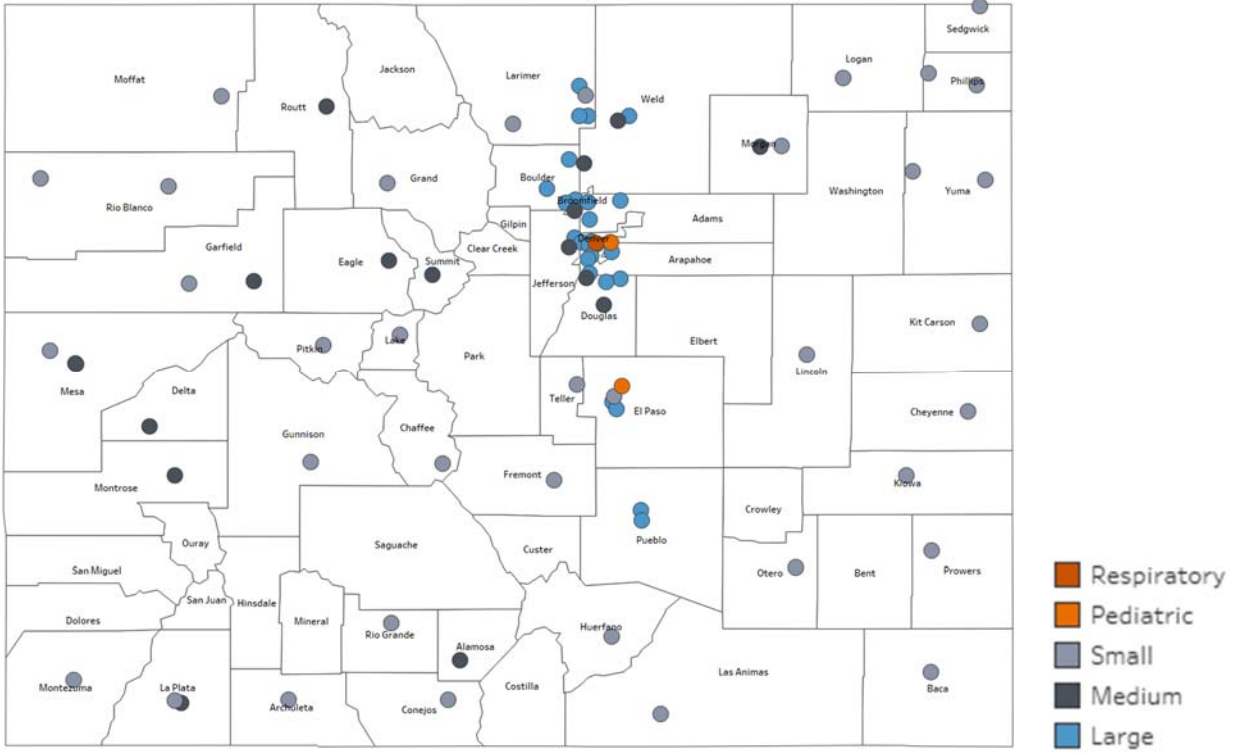
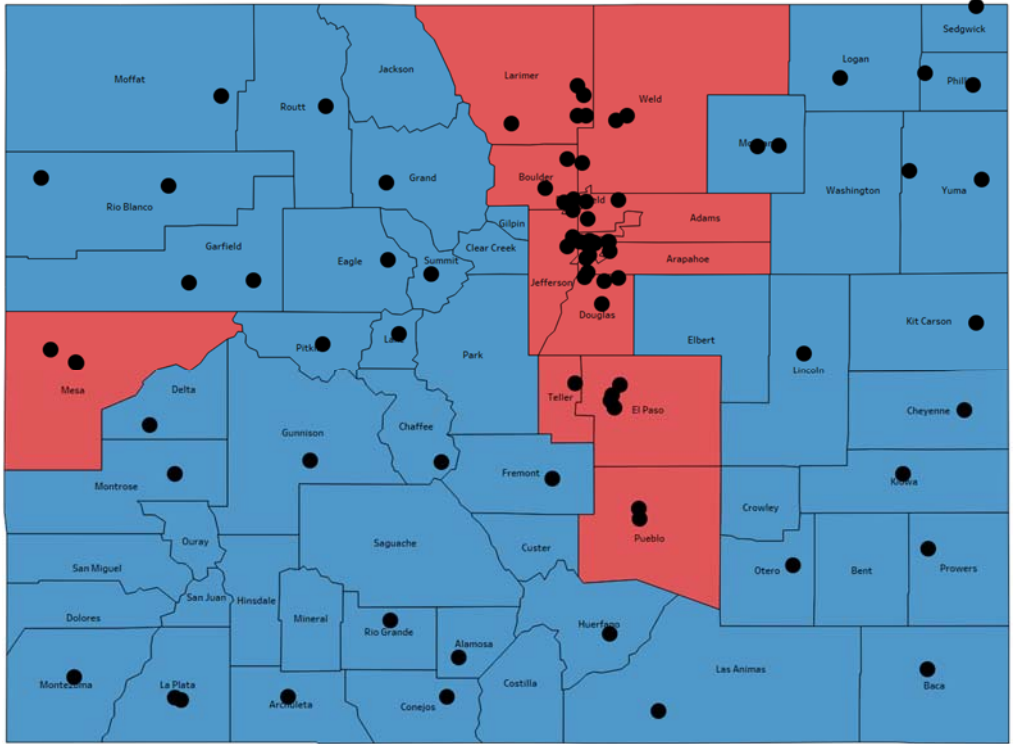
The incentive payments will support delivery system reforms through hospital-led and independently assessed projects specifically designed to achieve significant, measurable, and sustainable improvements in clinical outcomes and quality, patient experience, and efficiency in service use and provider operations. The expected improvements include:

- Reduction in avoidable costs and potentially preventable events.

- Increasing the degree of integrated care delivery in urban and rural services areas.
- Increasing integration of physical and behavioral health care delivery.
- Increasing the degree of evidence-based care coordination, care transitions, population health, and chronic care management within Colorado Medicaid.
- Increasing hospitals' clinical, organizational, and operational alignment with the objectives of ACC Phase II.
- Increasing clinical care collaboration and data sharing between hospitals, ACC participating providers, behavioral health providers, and local public health agencies.
- Increasing the capabilities and readiness of Colorado hospitals to participate successfully in value-based payment.

L. Hospital Participation and Hospital Applications and Implementation Plans

Any state-licensed general or critical access hospital participating in Colorado Medicaid may participate in the HTP, provided that the hospital completed the pre-waiver Community and Health Neighborhood Engagement process. Free-standing psychiatric hospitals, long-term acute care (LTAC) hospitals, and rehabilitation hospitals will be exempt from the program. There are 104 hospitals in Colorado. Of these, 10 are free-standing psychiatric hospitals, six are LTAC hospitals, and four are rehabilitation hospitals. The remaining 84 hospitals are eligible for participation in the HTP. The Department anticipates all 84 non-exempt hospitals will participate. The maps below show the spread of eligible hospitals in the state. The first map depicts if a hospital is located in a rural or urban area. The counties shaded in red are urban and those shaded in blue are rural. Nearly half of all eligible hospitals, 40 total, are located in rural counties while the remaining 44 eligible hospitals are located in urban areas. The second map depicts each hospital and its respective category for the HTP (respiratory, pediatric, small, medium, or large). These categories are defined in section 2.2 of this document. There is one respiratory hospital, two pediatric hospitals, 36 small hospitals, 16 medium hospitals, and 29 large hospitals.



In order to receive delivery system reform payments, each hospital must first apply to the HTP and propose specific initiatives. Hospitals may collaborate with each other on a regional or statewide basis in individual initiatives, but each hospital must submit its own application. Depending on the clinical, geographic, and operational focus a given project, hospitals will be expected to collaborate with RAEs, local public health agencies, and community-based organizations whenever possible to share data, strengthen relationships, integrate care delivery, and maximize use of core competencies and patient connections.

In consultation with hospitals and other stakeholders, the Department has developed a draft hospital application and a draft implementation plan template. The state has provided guidance and will provide trainings that specify the hospital application process and instructions and the implementation plan submission process and instructions. The state will provide an application and implementation plan template and question-specific review criteria and trainings for each.,

The due date for submission applications and implementation plans will be specified as soon as SPA approval is received.

Hospitals agreeing to participate in the HTP and commit resources to meet their initiative milestones will be eligible to receive supplemental payments and must complete initiatives and achieve milestones.

The Department anticipates it will require hospitals to implement initiatives focused on care coordination and transitions of care and on physical and behavioral health integration to ensure alignment with the goals of the ACC and other Department initiatives. Each hospital will also be required to identify initiatives focused on population health and chronic condition management. Initiatives must address needs identified during the hospital's Community and Health Neighborhood Engagement process.

The Department will collect and analyze data showing the impact of each transformation initiative, beginning with baseline data and continuing over the course of the HTP to identify opportunities for improvement and allow for course corrections with hospitals. To the extent possible, the Department will

leverage its data platforms, such as the ACC Data and Analytics Portal and the Business Intelligence and Data Management system for this effort, with an ultimate goal of moving hospitals and other providers toward a common performance data platform. The metrics used to measure projects will be informed by and aligned with metrics used to track progress and performance in the state's other major current and recent initiatives, such as the ACC, SIM, and CPC+ initiatives.

Coordination, reciprocal data sharing, and ongoing collaboration among participating hospitals and others in the community, including RAEs, will be important for application development, initiative implementation and operation, and achievement of program goals. This includes access to decision-relevant data in useable and secure formats. The Department is committed to facilitating this throughout implementation and operation of the program.

M. Protocols for Application Review, Project Assessment, and Payments

During the implementation phase and in consultation with the hospital community and other stakeholders, the Department will develop the following operational protocols for CMS review and approval. The STCs will define the required content and due dates for the protocols:

1. Application Review and Project Assessment Protocol

This protocol will detail the process for the assessment and scoring of initiative proposals, including project descriptions and justifications. The protocol will be used to review and assess hospital projects. The protocol will also describe the Department's process for approving applications and implementation plans, requiring changes or clarifications, and approving exceptions requests.

2. Hospital Incentive Payments

This protocol will describe the methodology for making incentive payments at various stages of demonstration and project implementation and operations. The protocol will specify withholds or penalties for late or incomplete project implementations and reporting problems. The protocol will specify the process the Department will use to redistribute unearned at-risk dollars to reward hospitals for exceptional performance in project implementation and effectiveness.

3. Performance Measurement and Reporting

This protocol will specify the statewide, hospital specific, and project specific performance metrics and the plan for measuring and reporting performance. The Evaluation Design described in sections 6.2 and 6.3 will inform this protocol design.

N. Post-Demonstration Sustainability

The demonstration is designed to achieve significant, measurable, and sustainable improvements in care delivery, in integration of care, in program-wide and hospital-specific cost efficiency, and readiness of hospitals to perform well under the value-based payment environment. In this way, the demonstration is intended to position the Medicaid program and local delivery systems for greater use of value-based payment to sustain and expand upon the capabilities and interventions built during the demonstration. Since this application requests no additional federal funding, the demonstration does not create a funding gap at the end of the demonstration.

After the five-year demonstration, Colorado plans to transition from (a) the use of DSRIP to (b) expanded use of value-based payments for hospital services through a State Plan Amendment (SPA). At that time, hospital provider fee revenues used for the non-federal share of the DSRIP program in the demonstration would instead be used to finance the non-federal share of expanded value-payment payments to hospitals made under the State Plan. Therefore, preserving the state's ability to use these funds as non-federal share both during and after the demonstration is critically important.

IV. Implementation of Demonstration

A. Approach to Implementation

Colorado plans to implement the HTP on a statewide basis following CMS approval of the waiver and SPA. The State plan Amendment (SPA 19-0031) submitted December 31, 2019 has an effective date of October 1, 2019, and requests CMS authority to implement pay for reporting payments, which will begin in PY0 and continue through PYs 1-5. This waiver, with a target effective date of October 1, 2020, requests CMS authority to implement the remaining elements of HTP.

In anticipation of the implementation, the Department began meeting with hospitals and other interested stakeholders in 2016. The timelines below provide an overview of HTP's approach to implementation.

B. Timeline for Implementation

Waiver Development and CMS Approval: June 27, 2019 to October 1, 2020

- Waiver Development Process: June 27, 2019 to October 30, 2019
- Community Engagement / Stakeholder Feedback: August 28, 2019 to December 15, 2019. The community engagement and stakeholder feedback referenced here pertains only to the development of this demonstration application. The Department and the CHASE Board has conducted extensive community engagement activities in anticipation of this demonstration and plans to continue these efforts through the demonstration lifespan.
- ✓ Stakeholder Outreach
 - State Medical Assistance and Services Advisory Council
 - HTP Community Advisory Council
 - Hospital Workgroup Meetings
 - CHASE Board
 - Rural Health Center Conference
 - Eastern Plains Healthcare Consortium
 - Western Healthcare Alliance
 - BridgeCare
 - Colorado Health Network

- 1115 Demonstration Waiver published in Colorado Register: November 10, 2019
- Public Notice and Comment Period: November 10, 2019 to December 15, 2019
 - ✓ Public Hearings
 - CHASE Board Meeting: November 19, 2019
 - State Medical Assistance and Services Advisory Council: November 20, 2019
 - Online Webinar: December 3, 2019
- 1115 Demonstration Waiver submitted to CMS: December 31, 2019
- Federal Public Notice: January 1, 2020 to January 31, 2020
- Federal Decision-Making Period: January 16, 2020 to March 18, 2020
- Federal negotiations with CMS: April 15, 2020 to August 17, 2020
- CMS approval and waiver effective date: October 1, 2020

C. Other Implementation

The Department is aware of CMS' commitment to a transparent and comprehensive stakeholder engagement process and is already engaging with hospitals to ensure a seamless demonstration implementation. A description of the stakeholder engagement process can be found in Section 7 of this application. The stakeholder engagement process will continue throughout the demonstration negotiation period and the Department anticipates providing a comprehensive implementation plan as part of the negotiated terms of this demonstration.

V. Demonstration Financing and Budget Neutrality

A. Description of Demonstration Financing

1. Source of Non-Federal Share for Demonstration

Under this demonstration, at-risk inpatient and outpatient hospital supplemental payments for uncompensated care costs currently made under the State Plan will now be considered part of the DSRIP program. Hospital provider fee revenues now used to fund the non-federal share of the inpatient and outpatient hospital supplemental payments will instead be used to finance the non-federal share of the hospital DSRIP made under the demonstration.

Using the hospital provider fee revenues, the non-federal share of the delivery system reform incentive payments will be made available through the state's General Fund appropriation process through an enterprise account established for the hospital provider fee.

The proposed demonstration does not change the hospital provider fee and does not affect the CMS waivers in effect under section 1903(w) of the Social Security Act.

2. Other Sources of Non-Federal Share Not Used

The hospital provider fee is the sole source of the non-federal share of the delivery system reform incentive payments under the demonstration. Intergovernmental transfers (IGTs) and certified public expenditures (CPEs) will not be used for the non-federal share of DSRIP program under this demonstration. Also, the DSRIP program will not duplicate other federal funding.

3. Same Effective Federal Medical Assistance Percentage

Colorado claiming for federal matching funds for delivery system reform incentive payment expenditures will use an effective Federal Medical Assistance Percentage (FMAP) which is the product of the relative proportions of standard FMAP and enhanced FMAP claimed for regular inpatient and outpatient hospital payments (exclusive of disproportionate share hospital payments). Specifically, the effective FMAP used for claiming federal match on the DSRIP will equal the equivalent effective FMAP

claimed in the aggregate on the regular non-DSH hospital payments after accounting for the proportion of hospital services received by group VIII (Affordable Care Act Medicaid expansion) eligible members compared to that received by all other eligible members. This effective FMAP for use in claiming federal share on the DSRIP will be updated annually or quarterly based on claims experience as specified in the negotiated STCs.

4. Other Payment Methodologies

As noted above, inpatient and outpatient hospital supplemental payments for uncompensated care costs currently made under the State Plan will continue under the DSRIP demonstration.

No other provider payment methodologies, whether fee-for-service, capitated, or otherwise, are changed under this demonstration.

At the conclusion of this demonstration, Colorado intends to expand the use of value-based payments to hospitals. At that time, the DSRIP program could be replaced by an expanded value-based payment program through the State Plan. The necessary State Plan Amendment(s) will be developed as appropriate prior to the end of the demonstration, in consultation with stakeholders. This will be informed by the evaluation, experience, and priorities and opportunities for access, quality, outcomes, and efficiency improvement at the time.

5. Upper Payment Limit Not Applicable

The redistributed DSRIP are non-service payments and therefore will be excluded when (a) estimating Medicaid hospital payments compared to the applicable upper payment limits (UPL) and (b) costs for purposes of calculating disproportionate share hospital (DSH) payments under the State Plan.

Medicare Part A inpatient and Part B outpatient payment principles must be used in calculating the hospital-based upper limits for use in the Medicaid program. However, by their nature, DSRIP program payments are not direct reimbursement for inpatient or outpatient hospital services. DSRIP program payments are not recognized in the Medicare Part A and Part B payment methodologies under 42 CFR 412 and 42 CFR 419, respectively, and are not

relevant to the intent or function of federal upper payment limit policies or to guidance on upper limit calculations and the comparison of aggregate Medicaid hospital payments to the applicable Medicare-based upper payment limits.

Therefore, as proposed below regarding federal waiver and expenditure authorities, DSRIP incentive expenditures made under this demonstration would not be considered in determining the state's adherence to the applicable hospital upper payment limits under 42 CFR Part 447. However, under the proposed budget neutrality methodology, the aggregate federal expenditures for the demonstration will not exceed the aggregate federal expenditures that would otherwise be made, absent the demonstration for the current hospital supplemental payments and application of the upper payment limit ceiling.

6. Hospital Receipt and Retention of Payments

Providers will receive and retain all payments made under the demonstration, including both the federal and non-federal shares of those payments. No portion of payments will be returned to the State, except as required due to a hospital's non-compliance with program requirements. In the event some DSRIP incentives are returned to or recouped by the Department for whatever reason, Colorado will use the standard process for returning the federal share of the excess to CMS in the quarterly expenditure report process.

7. Publicly Owned Providers

No publicly owned provider receives payments that in the aggregate exceed their reasonable costs of providing services.

Further, incentive payments made under the demonstration will not significantly affect the distribution of aggregate Medicaid payments to individual hospitals or to hospitals of different ownership types compared to that under the current inpatient and outpatient supplemental payments for uncompensated care. Under the demonstration, state owned and other publicly owned hospitals are treated the same as private or non-profit facilities.

D. Historical Expenditures

The following table shows recent Colorado Medicaid expenditures for hospital supplemental payments, with non-federal share financed through the existing hospital fee:

Table C: Inpatient and Outpatient Payments (HTP) for SFY 2014-15 through 2018-19

Payment Type	SFY 2014-15	SFY 2015-16	SFY 2016-17	SFY 2017-18	SFY 2018-19
Inpatient Payment (HTP)	\$677,631,688	\$609,774,826	\$556,025,018	\$563,792,965	\$576,982,657
Outpatient Payment (HTP)	\$190,303,954	\$251,062,723	\$306,240,955	\$403,307,956	\$441,393,514
Combined HTP Payments	\$867,935,642	\$860,837,549	\$862,265,973	\$967,100,921	\$1,018,376,171

E. Projected Expenditures

The following table shows projected at-risk DSRIP payments during the proposed five-year demonstration. These are the total dollars at-risk that if unearned, would be redistributed to hospitals meeting program milestones

Table D: At-risk DSRIP Payments and Trend by Demonstration Year.

Demonstration Year	Trend Rate	Total Expenditures, in Dollars (\$)
DY 1	5.98%	\$36,565,989
DY 2	3.80%	\$75,911,864
DY 3	4.04%	\$197,444,594
DY 4	4.02%	\$273,845,665
DY 5	4.00%	\$427,215,726

F. Federal Budget Neutrality Methodology

1. Background Information for the Public

Under long-standing federal policy, Medicaid demonstrations under section 1115 of the Social Security Act must be "budget neutral" to the federal government. The objective is to ensure that during the demonstration, federal Medicaid expenditures would not exceed federal spending without the demonstration.

The "without demonstration" (or "without waiver") budget ceiling is calculated using a methodology with growth trends that estimate what the cost of Medicaid services would be, absent the demonstration. For a demonstration to be budget neutral, the federal share of actual Medicaid benefit expenditures - plus the federal cost of any expenditure authorities authorized under the demonstration - may not be greater than the projected "without waiver" expenditures.

2. Methodology for Demonstrating Federal Budget Neutrality

The Hospital Transformation Program demonstration will maintain federal budget neutrality by establishing DSRIP incentive-based hospital transformation expenditures for the term of the waiver within the maximum federal expenditures projected to be spent otherwise, without the waiver. The source of the non-federal match remains unchanged and the DSRIP incentive-based expenditures will replace current hospital inpatient and outpatient supplemental payments for uncompensated care. Therefore, demonstrating federal budget neutrality is straightforward.

Over the initial five-year life of the demonstration, the projected federal expenditures without the waiver are equal to or less than projected maximum federal expenditures under the demonstration. The same funding levels based on the equivalent of 100 percent of the hospital upper payment limits, the appropriate effective federal matching rate for Colorado hospital payments, and trend factors are used for both the with-waiver and without-waiver projections.

The budget neutrality model is highly conservative and does not assume any federal savings from the delivery system during the five-year demonstration. Of course, it is reasonable to project federal savings from the transformation efforts of hospitals and the positive effects on outcomes and efficiency. During negotiations with CMS on the STCs for the demonstration, Colorado wishes to discuss the possibility of incorporating a reasonable projection of likely federal savings into demonstration financing in order to increase the funding available to support hospital transformation projects and thus further accelerate DSRIP incentive reform.

3. Demonstration Financing Form and Budget Neutrality Spreadsheet

Please see Appendix B for the completed CMS Demonstration Financing Form for this demonstration.

Please see Appendix C for the budget neutrality spreadsheet showing the projected with-waiver and without waiver federal expenditures for the five-year demonstration period.

VI. Proposed Waiver and Expenditure Authorities

A. List of Proposed Waiver and Expenditure Authorities for the Demonstration

Health First Colorado, the Colorado Medicaid program, currently operates under the State Plan and waivers under sections 1115 and 1915 of the Social Security Act. Under section 1115(a) of the Social Security Act, Colorado requests the federal waiver and expenditure authorities necessary for this proposed demonstration. These include:

- Waiver of hospital inpatient and outpatient-related rate setting, payment methods, and payment limitation requirements per sections 1902(a)(13) and 1902(a)(30) of the Social Security Act and 42 CFR Part 447.
- Expenditure authority under section 1115(a)(2) of the Social Security Act to regard delivery system reform incentive payments made by Colorado to hospitals under this demonstration, which are not otherwise included as expenditures under section 1903 of the Act, as permissible benefit expenditures under state's Title XIX State Plan.
- Such other waiver and expenditure authorities CMS determines are necessary for the demonstration.

B. Rational and Planned Use of Proposed Waiver and Expenditure Authorities

1. Rational for Waiver Authority

Waiver of hospital-related rate setting, payment methods, and payment limitation requirements per sections 1902(a)(13) and 1902(a)(30) of the Social Security Act and 42 CFR Part 447 are necessary to make delivery system reform incentive payments to hospitals and exclude DSRIP expenditures from the inpatient and outpatient hospital upper payment limits during the demonstration.

By express design, DSRIP programs are fully consistent with economy, efficiency, and quality within the intent of 1902(a)(30) of the Social Security Act. The DSRIP program will be determined through the public processes described in this application, including the hospital application, review, and approval process. Therefore, a separate process under 1902(a)(13) is duplicative.

Payments under the DSRIP program will be made to hospitals based on their participation in the Hospital Transformation Program and their achievement

of specific milestones and metrics related to transformation projects undertaken to support the demonstration vision.

Payments under the DSRIP program are not direct reimbursement for inpatient or outpatient hospital services under either Medicaid or Medicare. Medicare Part A and Part B payment principles must be used in calculating upper limits for use in the Medicaid program. However, DSRIP program payments are not recognized in those Medicare methodologies and are not relevant to the intent of federal upper payment limit policies or guidance on upper limit calculations. Therefore, DSRIP expenditures made under this demonstration should not be considered in determining the state's adherence to the applicable upper payment limits under 42 CFR Part 447.

Further, the waiver authority and associated DSRIP program payments will not materially affect the distribution of Medicaid payments to state-owned or other non-state publicly owned hospitals than would otherwise be made under the State Plan absent the waiver.

2. Planned Use of Requested Waiver and Expenditure Authority

The requested waiver and expenditure authority will be used under the demonstration to:

- Make the DSRIP program payments under the demonstration.
- Ensure continued compliance with upper payment limits as they pertain to payments for patient services and exclude DSRIP expenditures when determining inpatient and outpatient hospital expenditures relative to the inpatient and outpatient upper limits.
- Ensure FFP for DSRIP to hospitals and ensure this FFP on DSRIP program payments is at the State's effective FMAP for benefits. Through the special terms and conditions, Colorado wishes to ensure that FMAP is available for DSRIP expenditures under the demonstration and at the same effective FMAP rate received on hospital claims payments made under the State Plan, in the aggregate and updated annually or quarterly during the demonstration, based on the proportion of those regular inpatient and outpatient hospital claims (excluding DSH payments) applicable

to the State's regular FMAP and the enhanced FMAP as described in section 1905(y)(2) of the Act, respectively.

- Ensure federal financial participation for demonstration administrative costs at the appropriate administrative FMAP.

VII. Demonstration Hypothesis and Evaluation

Colorado will partner with an independent evaluator to develop a comprehensive monitoring and evaluation plan to assess the implementation and impact of this demonstration. The evaluation will be supported by standardized metrics measuring the impact of the demonstration, incentivizing delivery system transformation. The evaluation plan will use standardized metrics, including performance measures, quality improvement, access to care, value-based payments, population health outcomes and informatics infrastructure including the health information exchange.

Colorado expects that the emphasis on value focused incentives will lead to improvements in the overall population health and quality of care provided to Health First Colorado members. Similarly, the Department anticipates these incentives as a glide path for hospitals to move toward a future value-based reimbursement structure. In addition to the metrics used to determine payment, Department staff will work with evaluators to ensure the metrics selected for evaluations represent a holistic view of the entire delivery system.

A. Hypothesis for Testing

Based on the demonstration's core objectives and the focus of transformation project activities, Colorado proposes the following hypotheses for testing the effectiveness and overall impact of the demonstration:

- Hypothesis 1: Demonstration will improve patient outcomes through care redesign and integration of care across care settings.
- Hypothesis 2: Demonstration will improve the patient experience in the care delivery system and increase appropriate care in appropriate settings.
- Hypothesis 3: Demonstration will lower Health First Colorado costs through reductions in avoidable care and increased effectiveness and efficiency in care delivery.
- Hypothesis 4: Demonstration will accelerate hospitals' organizational, operational, and systems readiness for value-based payment.
- Hypothesis 5: Demonstration will increase coordination and collaboration between hospitals and other providers, including ACC participants, in care coordination and transitions, data sharing, integrated physical and behavioral health care, population health, and chronic care management.

B. Approach to Evaluation Design

Title XIX of the Social Security Act (the Act) requires an evaluation of every 1115 demonstration. At a minimum, the draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested. The draft design will discuss:

- The outcome measures to be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;
- The data sources and sampling methodology for assessing these outcomes; and
- A detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.

The evaluator will be responsible for selecting measures to test each of the hypotheses. The hypothesis testing will include, where possible, assessment of both process and outcome measures. Proposed measures will be selected from nationally recognized sources and national measures sets, where possible. Measures sets may include measures from CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

At this time, the Department anticipates an evaluation approach based on the following:

- The selected evaluator will be required to evaluate each component of the waiver separately and then submit an integrated programmatic summary describing whether the state met the demonstration goal, with recommendations for future efforts regarding all components.
- A longitudinal, mixed-method research design using both quantitative and qualitative methods, including, as appropriate, analysis of claims and other administrative data, surveys, site visits, focus groups, key informant interviews, analysis of hospital project reports, observational information, other secondary data, and modeling.

- The evaluative efforts will be used to assess the demonstration’s impact on delivery system performance, integrated care delivery, hospital readiness for value-based payment, provider collaboration and data sharing, use of evidence-based practices, clinical outcomes, reduction in potentially preventable events, cost and utilization, hospital operational efficiency, beneficiary access and care experiences, and provider experiences.
- A formative, mid-course evaluation of the demonstration between Demonstration Year 2 and Demonstration Year 3
- A summative evaluation is due at the end of Demonstration Year 5.

C. Data Sources

To support the evaluation, the Department will leverage existing fee-for-service data resources as well as hospital reported data. Hospitals are expected to report on their actions and coordinate with community partners to build an understanding of the processes. The Department will collect and analyze data showing the impact of each transformation initiative, beginning with baseline data and continuing over the course of the HTP to identify improvement and provide opportunities to enhance efforts or make improvements as needed.

To the extent possible, the Department will leverage its data platforms such as the ACC Data Analytics Portal and the Business Intelligence and Data Management system for this effort, with a goal of moving hospitals toward a common performance data platform.

The metrics used to measure initiatives were informed by and are aligned with metrics used to track progress and performance in the State’s other significant current and recent efforts such as the ACC, SIM, APM, and the CPC+ initiatives. National best practices and the experience of similar programs throughout the country have been used in developing these metric sets. Coordination, reciprocal data sharing, and ongoing collaboration among participating hospitals and others in the community, including RAEs, will be essential for project implementation and operation, and achievement of program goals. This includes access to decision-relevant data in useable and secure formats. The Department is committed to facilitating this throughout the implementation and operation of the program.

D. Evaluation Plan and Reporting

The specific evaluation design will be developed by the Department and a designated independent evaluation contractor. Following federal approval of the demonstration and during the implementation phase, the Department will submit the research design for CMS review and approval. The STCs document developed between the Department and CMS will specify required evaluation components, due date for the evaluation design, process for ongoing reporting, and process for adjustments to the program based on the formative evaluation.

VIII. Public Comment and Stakeholder Consultation

A. Overview of Stakeholder Engagement

The CHASE Board makes recommendations to the Medical Services Board regarding the implementation of the health care affordability and sustainability fee (commonly referred to as hospital provider fee) established pursuant to the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, Section 25.5-4-402.4, Colorado Revised Statutes. These recommendations include the amount of the fee, reforms to hospital reimbursement and quality incentive payments, and the approach to expanding coverage under Health First Colorado and CHP+. The CHASE Board also directs the implementation of the delivery system reform incentive payments program and monitors the impact of the fee on the health care market.

Under the direction of the CHASE Board, the Department has conducted an extensive multi-year stakeholder process that includes monthly meetings with both its rural and urban hospital workgroups. These groups began meeting in June 2016 and will continue to meet on the third Thursday of each month throughout the demonstration. The purpose of these meetings is for the Department to share updates on the progress of the HTP, solicit feedback on proposed solutions, and to share timeline information. Subsequently, appointees of these workgroups were selected to participate in measure and specification workgroups to recommend a robust set of statewide and local measures.

In addition to these monthly calls, the Department hosts a webinar to share updates and information about the Colorado HTP with stakeholders and has convened an HTP Community Advisory Council to hear consumer feedback on all aspects of the proposed HTP.

The webpage (www.colorado.gov/pacific/hcpf/colorado-hospital-transformation-program) provides information under the following dropdown menus:

- HTP Overview & Framework
- CHNE Process
- HTP Rural Support Fund
- HTP Community Advisory Council

- HTP Application Documents
- Federal Approval Process
- Newsletters and Communications
- Tools & Resources
- Program Contact

Stakeholders can sign up for HTP Updates on the homepage of the website by clicking “Sign-up” and then entering their contact information and selecting the “Hospital Transformation Program” box.

B. Public Notice and Comment

In addition to the ongoing and extensive stakeholder engagements described above, the Department conducted a statewide public comment process consistent with 42 CFR 431.408. The public comment period is at least 30 days, as required.

Start date of public comment period: November 10, 2019 at 8:00 a.m. MST

The end date of public comment period: December 15, 2019 at 5:00 p.m. MST

C. Certification of Public Notice

Colorado certifies that it provided the required advance public notice of the public comment period on the Department on Health Care Policy & Financing website, and in the *Colorado Register*, the sole official publication for state agency notices, operated by the Secretary of State. The website and notices include all information required per 42 CFR 431.408.

The website for the Colorado HTP, which includes the detailed public notice information, the draft application for public comment, and other information on the program, is available at: www.colorado.gov/pacific/hcpf/colorado-hospital-transformation-program.

Date public notice and other information was posted on the website: November 10, 2019 at 7:59 a.m. MST

Link to public notice on state website: www.colorado.gov/pacific/hcpf/http-waiver

Date of public notice published in *Colorado Register*: November 10, 2019

Link to public notice published in *Colorado Register*:

www.sos.state.co.us/CCR/RegisterHome.do

D. Public Hearings

The dates, times, and locations of the public hearings are as follows:

	Public Hearing #1	Public Hearing #2	Public Hearing #3
Date	November 19, 2019	November 20, 2019	December 3, 2019
Time	3:00 p.m. to 5:00 p.m. MST	6:00 p.m. to 7:30 p.m. MST	2:00 p.m. to 4:00 p.m. MST
Location	Colorado Department of Health Care Policy & Financing Hibiscus Conference Room 1570 Grant Street Denver, Colorado 80203	Colorado Department of Health Care Policy & Financing 7th Floor, Room 7B 303 East 17th Avenue Denver, Colorado 80203	Webinar
Teleconference	Conference Line: 1-877-820-7831 Participant Code: 549607#	Not available	Conference Line: 1-877-820-7831; Participant Code: 549607#
Capabilities Webinar	cohcpf.adobeconnect.com/chase/	Not available	cohcpf.adobeconnect.com/chase/

Reasonable accommodations were provided upon request for persons with disabilities for all stakeholder meetings. Individuals with disabilities were able to request these by contacting the Department 504/ADA Coordinator at hcpf504ada@state.co.us.

E. Other Mechanisms Used to Notify the Public

Colorado certifies it engaged in the following additional means of notifying the public of the proposed demonstration application and opportunities to review and provide comment:

- The public notice and proposed demonstration application were shared with all Colorado hospitals, the Colorado Hospital Association (CHA), CHASE Board members, HTP Community Advisory Council members, and statewide stakeholders by email using an electronic stakeholder mailing list on November 10, 2019.
- A copy of the public notice can be viewed on the Department's website via the following link, www.colorado.gov/pacific/hcpf/http-waiver.

- Relevant webpages and additional information regarding the Medicaid demonstration can also be viewed on the CMS/Medicaid website, at www.medicaid.gov/medicaid/section-1115-demo/index.html.

F. Tribal Consultation

Colorado certifies the Department conducted the necessary tribal consultations on the demonstration application with the two federally recognized American Indian Tribes in Colorado and the one Urban Indian Health Organization in accordance with transparency regulations under 42 C.F.R 431.408(b). The Department creates a Programmatic Action Log, sent to federally recognized American Indian Tribes in Colorado and the Urban Indian Health Organization on an as-needed basis, with details about potential changes to programs impacting those communities. If the tribes request or require additional consultation, follow-up takes place via in-person meeting or teleconference call.

- Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado
 - Programmatic Action Log sent via email on Friday, November 8, 2019
- Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah
 - Programmatic Action Log sent via email on Friday, November 8, 2019
- Denver Indian Health and Family Services, Colorado's Urban Indian Health Organization
 - Programmatic Action Log sent via email on Friday, November 8, 2019

The November 8, 2019 programmatic action log sent to each of the tribes included details about the proposed Hospital Transformation Program 1115 Demonstration Waiver, including a link to the draft waiver application, public hearing information. A copy of this log is attached to this application and can be found under Attachment F.

During the tribal consultation period, the state did not receive any comments, questions or request for additional consultation from any tribe.

G. Public Comments and State Responses

During the required, public stakeholder engagement process for this 1115 Demonstration application, the Department solicited comments from all

stakeholders with an interest in this application. Stakeholders providing comment included regional hospital associations, individual hospitals, other State Agencies, public health agencies, rural health associations, community health alliance(s), managed care organizations, disability advocates, maternal and child health advocates, and provider and community subcommittees.

The Department prepared and adhered to the required section 1115 demonstration waiver public notice process outline under federal regulation 42 C.F.R. 431.408. The proposed 1115 Demonstration application was posted on the Departments' website on Sunday, November 10, 2019, and a copy can be viewed here: www.colorado.gov/pacific/hcpf/htp-waiver. By clicking on this link a copy of proposed 1115 demonstration application, a copy of the public notice, including the postal address for individuals choosing to send comments via the United States Postal Service (USPS), and a slide presentation that was used at both statewide public stakeholder meetings:

Public Hearing #1:

Date / Time: November 19, 2019; 3:00 p.m. to 5:00 p.m. MST
Location: Colorado Department of Health Care Policy and Financing, Hibiscus Conference Room, 1570 Grant Street, Denver, Colorado 80203
Teleconference Information: Conference Line: 1-877-820-7831;
Participant Code: 549607#
Webinar Information: cohcpf.adobeconnect.com/chase/

Public Hearing #2:

Date / Time: November 20, 2019; 6:00 p.m. to 7:30 p.m. MST
Location: Colorado Department of Health Care Policy and Financing, 7th Floor, Room 7B, 303 East 17th Avenue, Denver, Colorado 80203
Teleconference Information: Not Available
Webinar Information: Not Available

A public notice was published in the Colorado Register, in accordance with the Colorado's State Administrative Procedures Act, Part 24 of Article 4, Colorado Revised Statutes, on November 10, 2019 allowing for the minimally required thirty (30) day public comment period

(<https://www.sos.state.co.us/CCR/RegisterContents.do?publicationDay=11/10/2019&Volume=42&yearPublishNumber=21&Month=11&Year=2019>). The public

comment period began on November 10, 2019 at 8:00 a.m. MST and ran through December 15, 2019 at 5:00 p.m. MST. The notice, the application and the slides were available for public review on the Department's HCPF HTP website. A series of stakeholder emails were also sent out on November 10, 2019 notifying them that the proposed 1115 Demonstration was posted for review and that comments were being solicited until December 15, 2019. A copy of this email was also sent to Colorado's CMS Regional Office contact on November 12, 2019.

Updates to the status of this Section 1115 Demonstration application will be made primarily through the bimonthly CHASE Board Meetings and the federally required State Medical Assistance and Services Advisory Council (MAAC) meetings. The purposes of these updates will be to inform stakeholders on the approval process and to continually solicit input from the stakeholders on policies for this demonstration. These meetings will also be the primary venue where the post-award public input process will take place. A schedule of these meetings is published on the Department website and can be located via the following website: www.colorado.gov/hcpf/committees-boards-and-collaboration. MAAC meetings are typically scheduled once a quarter. Once an approval of this demonstration is negotiated, a post-award forum will be held. The Department anticipates the public post-award to occur in the Fall of 2020. Within 30 days of notice of approval, and at least thirty (30) days prior to the Fall MAAC meeting, the Department will publish information on the HTP webpage, to inform stakeholders on the date, time, and location of the MAAC forum where the post-award forum will be held.

IX. Demonstration Contact

For the Centers for Medicare and Medicaid Services (CMS), contact information for the state's point of contact for this application is:

Nancy Dolson

Special Financing Division Director

Colorado Department of Health Care Policy & Financing

Telephone: 303-866-3698

Email: COHTP@state.co.us

X. Appendix A - Waiver Application Check List

For the convenience of CMS review of this application for completeness under 42 CFR 431.412, Appendix A is a checklist using the CMS template for section 1115 waiver applications. For each content element or question in the template, the following table indicates the primary pages where the relevant content or answers may be found or when template content or questions are not applicable (“NA”) to this demonstration. The template used is found on the CMS website at:

www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/fillable-1115-demo-10-12v2.pdf

XI. Appendix B - Completed CMS Demonstration Financing Form

Regarding the proposed Hospital Transformation Program demonstration, this appendix provides Colorado's answers to standard CMS financing-related questions on proposed section 1115 waiver demonstrations.

1. Source of Non-Federal Share of Demonstration Expenditures?

Answer: The State proposes to finance the non-federal share (NFS) of expenditures under the Demonstration solely using the existing hospital provider fee. The portion of hospital provider fee revenues now used to finance the NFS of State Plan inpatient and outpatient hospital supplemental payments for uncompensated care will instead be used to finance the NFS of hospital DSRIP incentive payments.

2. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Answer: Colorado confirms providers will retain 100 percent of payments made under the demonstration. In the context of the proposed demonstration, the providers are hospitals and the payments are DSRIP incentive payments.

3. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

Answer: Yes, for providers participating the HTP DSRIP initiative under this 1115 demonstration authority.

4. Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

Answer: No, the providers do not participate in such activities as IGTs or CPE payments as a condition of participating in the HTP DSRIP initiative under this 1115 demonstration authority. Further, no portion of payments are returned to any governmental or intermediary entity.

5. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of

percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State.

Answer: Under the HTP, supplemental payments will be distributed to each hospital according to the approved State Plan. Throughout each program year, hospitals will be expected to meet specified at-risk categories with designated funds at-risk that must be earned. The Department will determine the amount of at-risk dollars earned, and conversely those not earned. Hospitals will be expected to return any at-risk funds lost as adjustments in the last quarter of the program year. Any funds not earned for reporting, activity, and milestones, will be redistributed to hospitals that meet program requirements. Any funds not earned for performance on measures will be redistributed to those hospitals that performed in the top 10%.

6. Section 1902(a)(2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Answer: Nothing in the proposed demonstration, including the financing of the non-federal share of the demonstration, will result in lowering the amount, duration, scope, or quality of care and services available to beneficiaries in Health First Colorado. The proposed demonstration is explicitly designed to improve care delivery and does not reduce aggregate funding available for providers. Therefore, consistent with section 1902(a)(2) of the Act, the demonstration will not result in lowering the amount, duration, scope, or quality of care and services available under the State Plan. The State proposes to finance the non-federal share of expenditures under the Demonstration using the existing hospital provider fee.

7. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the State share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Answer: To provide the required non-federal share for demonstration expenditures, this demonstration will only use revenues from the hospital provider fee authorized under Colorado's approved Medicaid Provider Tax waiver¹ and the CHASE Act of 2017. No intergovernmental transfers (IGTs), certified public expenditures (CPEs), voluntary donations, or other provider fees or assessments under s. 1903(w) of the Act will be used to finance the non-federal share of demonstration expenditures. The hospital provider fee revenues used to finance

¹ Approved March 2010.

the non-federal share of demonstration expenditures will be made available directly to the Colorado Department of Health Care Policy and Financing (the state Medicaid agency) through state appropriations and state processes established by the Colorado General Assembly for the purpose of managing the hospital provider fee revenues.

8. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from.

Answer: Please see the tables on historical and projected expenditures found in sections 4.2 and 4.3 of this application.

9. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

Answer: Not applicable.

10. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from.

Answer: Not applicable.

11. Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type and indicate the time period that the data is from.

Answer: The demonstration proposes to provide DSRIP program payments to hospitals. Hospitals are the only providers eligible to receive the DSRIP program payments. No other payments are made under the demonstration. At the start of the demonstration, a portion of current inpatient and outpatient supplemental hospitals for uncompensated care will end and be replaced by the DSRIP program. The table in section 4.2 above shows historical expenditures for the current hospital supplemental payment program. The table in section 4.3 of this application shows projected expenditures for DSRIP to hospitals under the proposed demonstration.

12. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Answer: The methodologies used by Colorado to estimate the respective UPL for inpatient hospital services and outpatient hospital services, by type of ownership, are consistent with CMS guidance and instructions and are described in the State's annual hospital UPL demonstrations as submitted to CMS. The UPL methodologies are not affected by this demonstration except that demonstration expenditures for DSRIP will be excluded from the annual inpatient and outpatient hospital UPL demonstrations since DSRIP program payments are not applicable or relevant to Medicare Part A and Part B hospital payment principles under 42 CFR 412 and 42 CFR 419.

13. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

Answer: No.

14. In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Answer: Not applicable.

15. If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Answer: Yes.

16. Use of other Federal Funds: Are other federal funds, from CMS or another federal agency, being used for Demonstration program?

Answer: No.

XII. Appendix C - Budget Neutrality Spreadsheet

FEDERAL BUDGET NEUTRALITY CEILING, EXPENDITURES & SAVINGS

This table summarizes the budget neutrality calculation, which calculates the Without Waiver ceiling and compares it to the With Waiver Expenditures to produce the budget neutrality savings.

Members	Demonstration Year (DY) 1	DY 2	DY 3	DY 4	DY 5
Members	1,085,517	1,107,983	1,131,136	1,154,656	1,178,737
Total Members Months	13,026,202	13,295,793	13,573,626	13,855,871	14,144,841
TOTAL PMPM CAP (excludes HTP Supplementals)	\$322	\$337	\$353	\$371	\$390

Expenditure	DY 1	DY 2	DY 3	DY 4	DY 5	Total
Total Expenditures less HTP Supps.	\$4,191,102,062	\$4,478,899,887	\$4,791,971,996	\$5,141,086,844	\$5,521,218,297	\$24,124,279,086
HTP Supplemental Payments	\$1,218,866,302	\$1,265,197,730	\$1,316,297,292	\$1,369,228,325	\$1,424,052,420	\$6,593,642,068
Total CEILING	\$5,409,968,364	\$5,744,097,616	\$6,108,269,288	\$6,510,315,169	\$6,945,270,717	\$30,717,921,155

Expenditure	DY 1	DY 2	DY 3	DY 4	DY 5	Total
Total MEGS Expenditures	\$3,902,085,534	\$4,144,346,305	\$4,406,959,236	\$4,699,413,454	\$5,016,622,162	\$22,169,426,690
non HTP Supplemental Payments	\$263,176,282	\$269,739,831	\$273,360,689	\$277,021,950	\$280,759,222	\$1,364,057,973
HTP Supplemental Payments	\$1,182,300,313	\$1,189,285,866	\$1,118,852,698	\$1,095,382,660	\$996,836,694	\$5,582,658,231
HTP Supplemental Payments at risk-non Patient Service	\$36,565,989	\$75,911,864	\$197,444,594	\$273,845,665	\$427,215,726	\$1,010,983,838

Expenditure	DY 1	DY 2	DY 3	DY 4	DY 5	Total
Rural Support Payments	\$12,000,000	\$12,000,000	\$12,000,000	\$12,000,000	\$12,000,000	\$60,000,000
Shared Savings Bonus Payments	N/A	N/A	N/A	N/A	N/A	\$-
Total Expenditures	\$5,396,128,118	\$5,691,283,865	\$6,008,617,216	\$6,357,663,729	\$6,733,433,804	\$30,187,126,731
BN Savings	\$13,840,247	\$52,813,751	\$99,652,072	\$152,651,440	\$211,836,913	\$530,794,423

Fee-For-Service (FFS) Trend Rates & Medical Inflation Rate Percentages

This table calculates the With Waiver fee for service expenditures using actual base year expenditures and With Waiver expected trend rates

SFY	Expenditure Growth	Limited Expenditure Growth	Growth Difference
FY 2013-14	\$2,022,188,287	N/A	N/A
FY 2014-15	\$3,043,632,978	N/A	N/A
FY 2015-16	\$3,200,100,120	N/A	N/A
FY 2016-17	\$3,245,455,950	N/A	N/A
FY 2017-18	\$3,570,640,291	N/A	N/A
FY 2018-19	\$3,555,491,211	N/A	N/A
FY 2019-20	\$3,719,043,807	\$3,719,043,807	\$-
FY 2020-21	\$3,890,119,822	\$3,878,083,557	\$12,036,265
FY 2021-22	\$4,072,955,453	\$4,035,338,575	\$37,616,879
FY 2022-23	\$4,268,457,315	\$4,203,212,436	\$65,244,879
FY 2023-24	\$4,486,148,638	\$4,390,844,027	\$95,304,611
FY 2024-25	\$4,719,428,367	\$4,591,467,433	\$127,960,935

Medical Inflation Rate
4.60%
4.28%
3.73%
3.20%
2.87%
2.35%

Caseload Member Months (Forecast and Actuals² FY 2018-19 to FY 2024-25)

State Fiscal Year	Children and Family	Disabled Clients	Total	Rate of Change of Members Per Month	PMPM (Medical Inflation Growth Only)	Total Expenditures (PMPM times growth rate of MM)	Total Trend Rate
FY 2013-14	8,239,953	629,590	8,869,543	N/A	N/A	N/A	N/A
FY 2014-15	11,405,281	656,463	12,061,744	N/A	N/A	N/A	N/A
FY 2015-16	12,791,722	689,429	13,481,151	N/A	N/A	N/A	N/A
FY 2016-17	13,283,206	685,564	13,968,770	N/A	N/A	N/A	N/A
FY 2017-18	12,845,821	699,983	13,545,804	N/A	N/A	N/A	N/A
FY 2018-19	12,220,431	725,646	12,946,077	N/A	274.639	3,555,491,211	N/A
FY 2019-20	12,016,596	737,940	12,754,536	-1.48%	287.272	3,664,019,464	3.05%
FY 2020-21	12,264,415	761,787	13,026,202	2.13%	299.557	3,902,085,534	6.50%
FY 2021-22	12,510,070	785,723	13,295,793	2.07%	311.704	4,144,346,305	6.21%
FY 2022-23	12,762,645	810,981	13,573,626	2.09%	324.671	4,406,959,236	6.34%
FY 2023-24	13,022,387	833,484	13,855,871	2.08%	339.164	4,699,413,454	6.64%
FY 2024-25	13,291,023	853,818	14,144,841	2.09%	354.661	5,016,622,162	6.75%

Colorado HTP 1115 Demonstration, Base Year Data and Trend Rates (10/1/2020 - 9/30/2025)

This table includes base year member months and actual expenditures and trended base year plus 1 member months and expenditures.

Budget Neutrality Ceiling	Base Year	Base Year + 1
Members	1,078,840	1,062,878
Member Months	12,946,077	12,754,536
Per Member Per Month (PMPM) CAP (excluding HTP)	\$294	\$308
Total Exp less HTP Supps	\$3,807,020,760	\$3,923,226,733
HTP Supplemental Payments	\$1,018,376,171	\$1,150,054,777
Total Ceiling	\$4,825,396,931	\$ 5,073,281,509

² Source of Enrollment data is Medicaid Management Information Systems (MMIS)

Budget Expenditures

Expenditure	Base Year	Base Year Plus 1
Total MEGS Expenditures	\$3,555,491,211	\$3,664,019,464
Non HTP Supplemental Payments	\$251,529,549	\$251,170,368
HTP Supplemental Payments	\$1,018,376,171	\$1,150,054,777
Total Expenditures	\$4,825,396,932	\$5,065,244,609

Summary of Various Trend Rates Used in the CO HTP Budget Neutrality Calculations.

Budget Neutrality Ceiling Without Waiver (All Expenditures Except HTP Supplemental Payments)

Federal Fiscal Year	Demonstration Year	Trend Rates
FFY 2020	Base Year Plus 1	104.600%
FFY 2021	Waiver year 1	104.600%
FFY 2022	Waiver year 2	104.700%
FFY 2023	Waiver year 3	104.800%
FFY 2024	Waiver year 4	105.100%
FFY 2025	Waiver year 5	105.200%

Source: Federal Budget Trend Rates from MACPAC (Medicaid and CHIP Payment and Access Commission)

Budget Neutrality Ceiling - Applies to all HTP Supplemental Payments Only

Federal Fiscal Year	Demonstration Year	Trend Rates
FFY 2020	Base Year Plus 1	112.93%
FFY 2021	Waiver year 1	105.98%
FFY 2022	Waiver year 2	103.80%
FFY 2023	Waiver year 3	104.04%
FFY 2024	Waiver year 4	104.02%
FFY 2025	Waiver year 5	104.00%

Source: State of Colorado Financial/ Budget Unit Calculation

Budget Neutrality Ceiling - With Waiver Expenditures

Federal Fiscal Year	Demonstration Year	Trend Rates
FFY 2020	Base Year Plus 1	103.05%
FFY 2021	Waiver year 1	106.50%
FFY 2022	Waiver year 2	106.21%

Federal Fiscal Year	Demonstration Year	Trend Rates
FFY 2023	Waiver year 3	106.34%
FFY 2024	Waiver year 4	106.64%
FFY 2025	Waiver year 5	106.75%

Source: State of Colorado Finance Office Budget Division Calculation

Budget Neutrality Ceiling - Applies to all HTP Supplemental Payments Only

Federal Fiscal Year	Demonstration Year	Trend Rates
FFY 2020	Base Year Plus 1	112.93%
FFY 2021	Waiver year 1	105.98%
FFY 2022	Waiver year 2	103.80%
FFY 2023	Waiver year 3	104.04%
FFY 2024	Waiver year 4	104.02%
FFY 2025	Waiver year 5	104.00%

Source: State of Colorado Finance Office Budget Division Calculation

Fee-For-Service Expenditures, SFY 2018-2019

This table includes the base year fee for service expenditures included in the waiver

CLM_TYP	PROV_CNTRC_TYPE_CD	PD_AMT
Inpatient	IPHSP	\$702,253,068.38
Inpatient	IPHSP MISSING	\$462,044.62
Pharmacy	PHARM	\$951,589,902.62
Outpatient	OUTPT	\$763,977,164.08
Outpatient	OUTPT MISSING	\$94,906.16
Professional	EMTRP	\$22,242,090
Professional	CLINC	\$707,646,484
Professional	PRACT	\$114,134,555
Professional	INLAB	\$130,879,336
Professional	RDLGY	\$9,546,778
Professional	MISSING	\$272,430
Professional	SUPLY	\$150,700,282
Professional	PERCA	\$1,692,170
		\$3,555,491,210.86

Supplemental Payments for Acute Care Services³

Actuals

Payment Type	SFY 2014-15	SFY 2015-16	SFY 2016-17	SFY 2017-18	SFY 2018-19
Inpatient Payment (HTP)	\$677,631,688	\$609,774,826	\$556,025,018	\$563,792,965	\$576,982,657
Outpatient Payment (HTP)	\$190,303,954	\$251,062,723	\$306,240,955	\$403,307,956	\$441,393,514
Combined HTP Payments	\$867,935,642	\$860,837,549	\$862,265,973	\$967,100,921	\$1,018,376,171
Hospital Quality Incentive Payment	\$54,683,752	\$78,944,620	\$88,446,261	\$95,582,701	\$92,222,929
Clinic Based Indigent Care Payment	\$6,119,760	\$6,119,760	\$6,119,760	\$6,119,760	\$6,062,032
High Volume Inpatient Payment	\$438,881	N/A	\$5,728,190	\$5,279,596	\$4,718,201
University of CO School of Medicine Payment	N/A	N/A	\$62,007,786	\$68,295,619	\$77,998,160
Public Emergency Medical Services Payment	N/A	N/A	N/A	\$14,451,167	\$29,624,892
Denver Health Ambulance Payment	\$3,155,360	\$3,561,179	\$3,979,841	\$3,995,663	\$4,095,555
Family Medicine Residency Payment	\$2,371,077	\$4,565,753	\$4,565,753	\$5,030,889	\$5,030,889
Rural Family Medicine Residency Payment	\$3,030,766	\$3,030,766	\$3,030,766	\$3,030,766	\$3,000,000
State University Teach Hospital Payment	\$3,438,028	\$3,141,643	\$3,141,643	\$4,136,697	\$4,286,698
Pediatric Major Teaching Hospital Payment	\$13,455,012	\$13,455,012	\$13,455,012	\$19,574,722	\$19,545,908
Physician Supplemental Payment	\$2,663,839	\$5,107,739	\$5,071,770	\$4,823,693	\$4,944,286

³ Assumptions

- 1 % growth on caseload, IP/OP Medicaid FFS payments
- 2% growth on IP/OP Medicaid cost
- Expansion and administration costs stay constant after SFY 2022
- Limited by UPL in each projected year
- DSH payments are unreduced
- 50% FMAP for all IP/OP/HQIP supplemental payments
- HQIP is set as 7% of the prior year Medicaid FFS payment
- IP and OP UPL utilization percentages are set to 97% for projected years

Projected

Payment Type	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Inpatient Payment (HTP)	\$609,473,172	\$630,019,272	\$653,983,031	\$681,924,346	\$710,880,134	\$740,884,717
Outpatient Payment (HTP)	\$540,581,604	\$588,847,031	\$611,214,699	\$634,372,946	\$658,348,191	\$683,167,703
Combined HTP Payments	\$1,150,054,777	\$1,218,866,302	\$1,265,197,730	\$1,316,297,292	\$1,369,228,325	\$1,424,052,420
Hospital Quality Incentive Payment	\$90,704,209	\$101,328,604	\$106,421,860	\$108,560,940	\$110,743,015	\$112,968,950
Clinic Based Indigent Care Payment	\$6,039,386	\$6,039,386	\$6,039,386	\$6,039,386	\$6,039,386	\$6,039,386
High Volume Inpatient Payment	\$4,846,772	\$4,997,022	\$5,156,927	\$5,318,081	\$5,478,953	\$5,643,321
University of CO School of Medicine Payment	\$77,998,160	\$77,998,160	\$77,998,160	\$77,998,160	\$77,998,160	\$77,998,160
Public Emergency Medical Services Payment	\$30,432,170	\$31,375,567	\$32,379,585	\$33,391,447	\$34,401,539	\$35,433,585
Denver Health Ambulance Payment	\$4,207,159	\$4,337,581	\$4,476,383	\$4,616,270	\$4,755,912	\$4,898,590
Family Medicine Residency Payment	\$5,030,889	\$5,030,889	\$5,030,889	\$5,030,889	\$5,030,889	\$5,030,889
Rural Family Medicine Residency Payment	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000
State University Teach Hospital Payment	\$4,286,698	\$4,286,698	\$4,286,698	\$4,286,698	\$4,286,698	\$4,286,698
Pediatric Major Teaching Hospital Payment	\$19,545,908	\$19,545,908	\$19,545,908	\$19,545,908	\$19,545,908	\$19,545,908
Physician Supplemental Payment	\$5,079,017	\$5,236,467	\$5,404,034	\$5,572,910	\$5,741,491	\$5,913,735

Supplemental Payments for Acute Care Services - Trend Rates

Actuals

Payment Type	SFY 2014-15	SFY 2015-16	SFY 2016-17	SFY 2017-18	SFY 2018-19
Inpatient Payment (HTP)	N/A	-10.01%	-8.81%	1.40%	2.34%
Outpatient Payment (HTP)	N/A	31.93%	21.98%	31.70%	9.44%
Combined HTP Payments	N/A	-0.82%	0.17%	12.16%	5.30%
Hospital Quality Incentive Payment	N/A	44.37%	12.04%	8.07%	-3.52%
Clinic Based Indigent Care Payment	N/A	0.00%	0.00%	0.00%	-0.94%
High Volume Inpatient Payment	N/A	-100.00%	0.00%	-7.83%	-10.63%
University of CO School of Medicine Payment	N/A	0.00%	0.00%	10.14%	14.21%
Public Emergency Medical Services Payment	N/A	0.00%	0.00%	0.00%	105.00%
Denver Health Ambulance Payment	N/A	12.86%	11.76%	0.40%	2.50%
Family Medicine Residency Payment	N/A	-9.25%	0.00%	0.00%	0.00%
Rural Family Medicine Residency Payment	N/A	0.00%	0.00%	0.00%	-1.02%
State University Teach Hospital Payment	N/A	-8.62%	0.00%	31.67%	3.63%
Pediatric Major Teaching Hospital Payment	N/A	0.00%	0.00%	45.48%	-0.15%
Physician Supplemental Payment	N/A	91.74%	-0.70%	-4.89%	2.50%

Projected

Payment Type	SFY 2019-20	SFY 2020-21	SFY 2021-22	SFY 2022-23	SFY 2023-24	SFY 2024-25
Inpatient Payment (HTP)	5.63%	3.37%	3.80%	4.27%	4.25%	4.22%
Outpatient Payment (HTP)	22.47%	8.93%	3.80%	3.79%	3.78%	3.77%
Combined HTP Payments	12.93%	5.98%	3.80%	4.04%	4.02%	4.00%
Hospital Quality Incentive Payment	-1.65%	11.71%	5.03%	2.01%	2.01%	2.01%
Clinic Based Indigent Care Payment	-0.37%	0.00%	0.00%	0.00%	0.00%	0.00%
High Volume Inpatient Payment	2.73%	3.10%	3.20%	3.13%	3.03%	3.00%
University of CO School of Medicine Payment	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Public Emergency Medical Services Payment	2.73%	3.10%	3.20%	3.13%	3.03%	3.00%
Denver Health Ambulance Payment	2.73%	3.10%	3.20%	3.13%	3.03%	3.00%
Family Medicine Residency Payment	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Rural Family Medicine Residency Payment	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
State University Teach Hospital Payment	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Pediatric Major Teaching Hospital Payment	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

XIII. Appendix D - Copy of Public Notice

Notice of Public Comment Process

Medicaid Section 1115 Demonstration Application for Colorado Hospital

Transformation Program: Delivery System Incentive Payment Demonstration

Public Comment Period Begins: November 10, 2019 at 8:00 a.m. MST

Public Comment Period Ends: December 15, 2019 at 5:00 p.m. MST

Public Notice is hereby given that the State of Colorado's Department of Health Care Policy & Financing is seeking public comment on a Medicaid Section 1115 Delivery System Incentive Payment Demonstration application to support the implementation and operation of the Colorado Hospital Transformation Program (HTP).

Proposed Demonstration Summary

The Colorado Department of Health Care Policy & Financing ("Department") is submitting a Medicaid Section 1115 Demonstration proposal to operate the HTP. The HTP will use delivery system reform incentive payments (DSRIP) to support hospital-led projects to:

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

For the incentive payments, Colorado will leverage hospital supplemental payment funding generated through the existing hospital provider fee for which the State has submitted a State Plan Amendment. The proposed demonstration makes no other changes to provider reimbursement and makes no changes to Medicaid or Children's Health Insurance Program enrollment, eligibility, covered benefits, cost sharing, or beneficiary freedom of choice in providers for Colorado's Medicaid ("Health First Colorado") members. Medicaid Section 1115 Demonstration allow states to test new approaches to administering Medicaid programs beyond what is required by federal statute. In response to the national opioid epidemic, the

federal Centers for Medicare & Medicaid Services (CMS) has provided an opportunity for states to use the Section 1115 waiver authority to use Medicaid matching funds to expand the availability of Substance Use Disorder (SUD) treatment services. The program will operate as a five-year demonstration and requires a federal Medicaid waiver(s) under section 1115 of the Social Security Act.

Program Background

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board makes recommendations to the Medical Services Board regarding the implementation of the health care affordability and sustainability fee established pursuant to the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, Section 25.5-4-402.4, Colorado Revised Statutes. These recommendations include the amount of the fee, reforms to hospital reimbursement and quality incentive payments, and the approach to expanding coverage under Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+). The CHASE Board also directs the implementation of the delivery system reform incentive payments program and monitors the impact of the fee on the health care market.

Under the direction of the CHASE Board, The Colorado Department of Health Care Policy & Financing ("The Department") has conducted an extensive multi-year stakeholder process that includes monthly meetings with both its rural and urban hospital groups.

Demonstration Objectives and Goals

The Colorado Hospital Transformation Program is designed to achieve four strategic, statewide objectives for hospital delivery reform:

- Improve patient outcomes through care redesign and integration of care across care settings.
- Lower Health First Colorado costs through reductions in avoidable care and increased effectiveness and efficiency in care delivery.
- Accelerate hospitals' organizational, operational, and systems readiness for value-based payment.
- Increase collaboration between hospitals and other providers, particularly Accountable Care Collaborative participants, in data sharing and analytics and evidenced-based care coordination and care transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health and disparities reduction efforts.

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

- Care coordination and care transitions.
- Complex care management for targeted populations.
- Behavioral health and substance use disorder coordination.
- Perinatal care and improved birth outcomes.
- Recognizing and addressing social needs.
- Reduce total cost of care.

Eligibility

There will be no changes to the Medicaid eligibility criteria as a result of this demonstration application. The demonstration will be open to all interested general and critical access hospitals in the State.

Services

This demonstration application is not service-based and therefore, there are no changes to any services already included in the Colorado State Plan.

Cost Sharing

This demonstration application is not service based, and therefore there is no cost shared associated with this application.

Delivery System

This demonstration application pertains to all interested hospitals operating in the State of Colorado.

Demonstration Hypotheses and Measures

Colorado will partner with an independent evaluator to develop a comprehensive monitoring and evaluation plan to assess the implementation and impact of this demonstration. The evaluation will be supported by standardized metrics measuring the impact of the demonstration, incentivizing delivery system transformation. The evaluation plan will use standardized metrics, including performance measures, quality improvement, access to care, value-based payments, population health outcomes and informatics infrastructure including the health information exchange.

Based on the demonstration's core objectives and the focus of transformation project activities, Colorado proposes the following hypotheses for testing the effectiveness and overall impact of the demonstration:

- Hypothesis 1: Demonstration will improve patient outcomes through care redesign and integration of care across care settings.
- Hypothesis 2: Demonstration will improve the patient experience in the care delivery system and increase appropriate care in appropriate settings.
- Hypothesis 3: Demonstration will lower Health First Colorado costs through reductions in avoidable care and increased effectiveness and efficiency in care delivery.
- Hypothesis 4: Demonstration will accelerate hospitals' organizational, operational, and systems readiness for value-based payment.
- Hypothesis 5: Demonstration will increase coordination and collaboration between hospitals and other providers, including Accountable Care Collaborative (ACC) participants, in care coordination and transitions, data sharing, integrated physical and behavioral health care, population health, and chronic care management.

Proposed Federal Demonstration Authorities

Health First Colorado, the Colorado Medicaid program, currently operates under the State Plan and waivers under sections 1115 and 1915 of the Social Security Act. Under section 1115(a) of the Social Security Act, Colorado requests the federal waiver and expenditure authorities necessary for this proposed demonstration. These include:

- Waiver of hospital inpatient and outpatient-related rate setting, payment methods, and payment limitation requirements per sections 1902(a)(13) and 1902(a)(30) of the Social Security Act and 42 CFR Part 447.
- Expenditure authority under section 1115(a)(2) of the Social Security Act to regard delivery system reform incentive payments made by Colorado to hospitals under this demonstration, which are not otherwise included as expenditures under section 1903 of the Act, as permissible benefit expenditures under state's Title XIX State Plan.
- Such other waiver and expenditure authorities the Centers for Medicare and Medicaid Services determines are necessary for the demonstration.

Waiver of hospital-related rate setting, payment methods, and payment limitation requirements per sections 1902(a)(13) and 1902(a)(30) of the Social Security Act and 42 CFR Part 447 are necessary to make delivery system reform incentive payments to hospitals and exclude DSRIP expenditures from the inpatient and outpatient hospital upper payment limits during the demonstration.

Estimated Impact of the Demonstration

The table below estimates the projected annual expenditures for (with and without the waiver) for each Demonstration Year (DY) of the waiver demonstration.

Estimated Projections of Annual Expenditures

	DY1	DY2	DY3
Total w/out Waiver	\$5,409,968,364	\$5,744,097,616	\$6,108,269,288
Total w/ Waiver	\$5,396,128,118	\$5,691,283,865	\$6,008,617,216

	DY4	DY5	5 Year Total
Total w/out Waiver	\$6,510,315,169	\$6,945,270,717	\$30,717,921,155
Total w/ Waiver	\$6,357,663,729	\$6,733,433,804	\$30,187,126,731

Opportunity for Public Comment

The proposed Section 1115 Demonstration application is available for public review and comment at:

www.colorado.gov/pacific/hcpf/htp-waiver

To request a copy of the demonstration, please contact the Department by:

- Sending an email request to COHTP@state.co.us.
- Send a request by fax to 303-866-4411. Attn: HTP DSRIP 1115 Demonstration Application, or
- Obtaining in person at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203.

During the public comment period, comments may be sent to COHTP@state.co.us. Comments may also be submitted via the United States Postal Service using the following address:

Special Financing Division Director
 Colorado Department of Health Care Policy and Financing,
 1570 Grant Street
 Denver, Colorado 80203
 ATTN: Public Comment - HTP_DSRIP

A copy of the public notice can be viewed on the Department's website via the following link www.colorado.gov/pacific/hcpf/htp-waiver.

Public Hearings

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

	Public Hearing #1	Public Hearing #2
Date	November 19, 2019	November 20, 2019
Time	3:00 p.m. to 5:00 p.m. MST	6:00 p.m. to 7:30 p.m. MST
Location	Colorado Department of Health Care Policy and Financing Hibiscus Conference Room 1570 Grant Street Denver, Colorado 80203	Colorado Department of Health Care Policy and Financing 7 th Floor, Room 7B 303 East 17 th Avenue Denver, Colorado 80203
Teleconference Capabilities	Conference Line: 1-877-820-7831 Participant Code: 549607#	Not available
Webinar	cohcpf.adobeconnect.com/chase/	Not available

Reasonable accommodations are available upon request for persons with disabilities for all stakeholder meetings. Individuals with disabilities may request these by contacting the Department 504/ADA Coordinator at hcpf504ada@state.co.us or Nancy Dolson at COHTP@state.co.us at least one week before the public hearing to make arrangements.

In addition, the Department is also hosting a webinar affording the opportunity for the public to learn about and comment on the application:

Hospital Transformation Program 1115 Demonstration Waiver Webinar

December 3, 2019

2:00 p.m. to 4:00 p.m. MST

Webinar: cohcpf.adobeconnect.com/chase/

Teleconference Capabilities: Conference Line: 1-877-820-7831; Participant Code: 549607#

CMS/Medicaid 1115 Demonstration Website

Relevant webpages and additional information regarding the Medicaid demonstration can also be viewed on the CMS/Medicaid website, at www.medicaid.gov/medicaid/section-1115-demo/index.html.

This notice is submitted pursuant to Title 42 Code of Federal Regulations, Part 431.408, Subpart G, which outlines public notice processes and transparency requirements for Section 1115 Demonstrations.

XIV. Appendix E - Summary of Public Comments and State Responses on Draft Application

The Department received 21 comments on the proposed 1115 demonstration during the public comment period that took place from November 10, 2019 through December 15, 2019. Many of the comments received focused on the implementation and operation of the program; and the Department did not make any modifications to the proposed demonstration application based on those comments. After excluding those comments, most of the remaining comments fell into one of the three following areas: 1.) Measures and Metrics; 2.) Continued Communications and Engagement; and 3.) General Clarification. A summary of the comments, and how the Department revised the final application is noted below.

**Summary of Written Comments: Colorado Hospital Transformation Program (HTP): Delivery System Reform
Incentive Payment Section 1115 Demonstration Waiver**

Focus Area of Comment	Summary of Comment	Suggested Edit
<p>General Clarification</p> <p>Measures / Metrics</p> <p>Operations</p>	<ul style="list-style-type: none"> • Are the measure calculations, and awards based on Medicaid patients only? • Suggest modifying “financial difficulties” to say, “difficulty meeting these basic needs.” • Clarify the dates of the project years. • Clarify the definition of “inpatient” (especially relating to OB/GYN and observation) <p>Sustainability plan in Year 5: How does this work? If you do it on time and complete you get 8% and if not, you get 0%? Or is there an opportunity for something in between like the performance measures?</p> <ul style="list-style-type: none"> • Reporting periods and deadlines for submissions: Do you have specific dates, even if it’s just a draft, that we can see for when the reporting periods are and the date that the submission is due? • Medicaid vs. All Patients: Could you confirm for me if we will be reporting on all patients or Medicaid only? • Change in the # of Licensed Beds: If a hospital changes its number of licensed beds during one of the performance years and that changes it from a large to a medium or vice versa, what does that mean for HTP? • CORHIO: Would ideally like to use CORHIO to send referrals to the RAE for each of our measures that require RAE notification. 	<p>The Department appreciates the thoughtful comments and will make clarifying changes to the 1115 Demonstration application.</p> <ul style="list-style-type: none"> • Clarification will be made to project years / program years / demonstration years. • Medicaid versus all: Detailed specifications for each of the measures will be outlined and included in a measures workbook and shared with the participating hospitals. • Change in number of licensed beds: Additional guidance will be forthcoming. • Discussions continue the appropriate use of the Colorado Regional Health Information Organization (CORHIO) and its capabilities under the HTP.
<p>Engagement Communication</p>	<ul style="list-style-type: none"> • Could you please advise us on how to keep the hospitals engaged in the community process throughout the next phases? • We believe that there is need for continued community stakeholder engagement beyond the needs identified to how those needs are best addressed...in community. • Concerned that once the initial evaluation was completed, that business returned as usual utilizing singular agency response that promotes duplication and a fragmented system. It begs the question of whether community or agency needs are being addressed. 	<p>The Department agrees with the desire for continued hospital engagement through all phases of this demonstration and plans to continue its robust stakeholder input process. A description of the stakeholder process to date will be included in the 1115 demonstration application.</p> <p>In addition to the Department’s commitment to keeping hospitals engaged, the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board will continue its community engagement activities and transparent process of providing an opportunity for hospital engagement into the implementation of the delivery system reform incentive payment program.</p>

Focus Area of Comment	Summary of Comment	Suggested Edit
<p>General Clarification</p> <p>Measures/ Metrics</p> <p>IT</p> <p>Operational Concerns</p>	<ul style="list-style-type: none"> • How will screening for social determinates of health be conducted? Measured? • Is there a glossary for the measures? • Can you clarify the actual dates for a program year? • How will the CMS propose supplemental rule affect HTP? • Is the IT community involved with HTP? • What calendars years are PY1-5? • When does the application period begin? • When will the hospitals know if they get into the program? • Is this all self-reported? • Is the extra data being given to CIVIC? • How is the RAE to succeed and our plan to put everything in alignment to work with these groups? • What about access to specialty care in the draft/quality measures? • How do we use the HTP to drive eHealth equity? Thinking of the African American community 	<p>The Department thanks the PIAC for its thoughtful comments on the 1115 demonstration and will amend the application by:</p> <ul style="list-style-type: none"> • Clarifying the program year, and the application period, • Considering a local measure on access to specialty care • Will consider disaggregating (by race) when doing evaluation of program. • Measure specifications will be detailed in a “Measure Specs Workbook” which will be released in the future. • The Department is continuing to have discussions on how to effectively drive eHealth equity.
<p>IT / Operations</p>	<ul style="list-style-type: none"> • Has HCPF had conversations with CORHIO about the possibility of them being the vehicle to transmit this information from the hospitals to the RAEs? 	<p>The Department appreciates the comments pertaining to eHealth and is continuing to work with the Office of eHealth Innovation and is exploring opportunities explore the best way to incorporate eHealth in the HTP.</p>
<p>Measures / Metrics</p>	<ul style="list-style-type: none"> • We are aiming for equitable and consistent reproductive health outcomes across the state—and have come up with suggested adjustments to the HTP metrics to get us there: • As an example, we could take an important evidence-based step across the entire state by adding “One Key Question” as a required metric under: Focus Area - Population Health/Total Cost of Care. • Not sure if we’d need to swap out a required Population Health/Total Cost of Care metric in order to add one, but if so, we are happy to discuss options. 	<p>The Department appreciates the comments on the proposed reproductive health measure.</p> <p>In addition, there is a complimentary program (Hospital Quality Incentive Program, HQIP) which will drive the focus on maternal health and HTP will align with HQIP where appropriate.</p> <p>The Department removed the measure related to reproductive health (long acting reversible contraceptives, LARC). HQIP asks the One Key Question and will serve to focus more in-depth on maternal health.</p> <p><i>More information about HQIP is noted below in response to comments from maternal and child health advocates.</i></p>

Focus Area of Comment	Summary of Comment	Suggested Edit
Operational	<ul style="list-style-type: none"> Clarify which hospitals are considered resort hospitals and which hospitals are non-resort. 	<p>The Department appreciates the comment and the need for a clarification. The application will be amended to reflect this clarification.</p>
Measures / Metrics Rural Hospitals	<ul style="list-style-type: none"> CRHC believes that rural hospitals should not be put in the position to take on risk because currently 22 are operating in the red and any loss of payment could result in closure of the facility and therefore decreased community access to local healthcare. Due to the nature of low volume and unique payer mix (high percentage of Medicare and Medicaid), critical access hospitals (CAH) should not be forced to take on monetary risk. The following are suggestions for the HTP 1115 waiver in the event rural hospitals are included moving forward. <ol style="list-style-type: none"> Utilize equitable data and submission requirements <ol style="list-style-type: none"> In instances where patient outcomes are dependent upon successful collaboration with a hospital's designated RAE, and collaboration is unsuccessful due to documented RAE negligence, the hospital cannot be penalized for these poor outcomes. CAHs should be benchmarked with other CAHs versus at the state-wide level which includes urban hospitals. Further, CAHs located in a frontier county should only be benchmarked against those in a frontier county Low patient volumes should be addressed by reducing the risk that CAHs take on. For example, if CAHs are required to collect six measures then that should count for 60 points and the other 40 points should be automatically provided to them. Further, frontier hospitals should only be measured on three measures that count for 30 points and the other 70 points being automatically provided to them. Change the point system and current algorithm to be agreeable for CAHs. Exact definition of inclusion and exclusion criteria that Medicare uses should be the standard for HTP measures (for example, Readmissions and Closing the Referral Loop) For the readmission measure, instead of combing all the chronic diseases together into one measure these should be broken out to allow CAHs a greater number of measures to choose from dependent on their individual patient needs. 	<p>The Department appreciates the thoughtful comments it received from the Colorado Rural Health Center. The Department is agreeable to reducing the points for Critical Access Hospitals (CAHs) to 60; ten points for each of the six measures. The Department agrees to prioritize the Rural Support fund to CAH that are financially distressed and is amenable to allowing the funding to be used to support activities laid out in CRHC's comments and other administrative activities associated with the Hospital Transformation Program.</p> <p>The Department convened a rural hospital workgroup three years ago as a forum to listen and address concerns from the rural hospital group. We believe this group has been successful in negotiating mutually successful solutions to various issues. The Department would like to use this venue to continue working through the comments noted here.</p>

Focus Area of Comment	Summary of Comment	Suggested Edit
	<ul style="list-style-type: none"> f. How does HTP plan to align metrics with community input? In many cases the input the community provided as a need is not address through HTP priorities? 2. Recognize deficiencies in workforce, time and resources through disbursement of the Rural Resort Fund. a. Support hospitals’ time and expense for the following activities (which theoretically will make transformational impact): <ul style="list-style-type: none"> i. Billing and coding audits ii. Leadership training, development and coaching iii. Financial consulting iv. Planning and creation of new service lines v. Facilitation and/or convening of community and partner meetings with key stakeholders in community vi. Travel stipends for hospital staff to attend meetings outside of their community (mainly at HCPF or CRHC offices) to help offset the barrier of getting to important meetings where their voices can be heard b. Support CRHC as the state office of rural health and rural health association for the state to provide outreach in the form of communication and marketing for the above-mentioned activities as well as facilitate/coordinate them for the hospitals c. Prioritization Methodology to receive rural support funding <ul style="list-style-type: none"> i. Rural hospitals that are both: <ul style="list-style-type: none"> 1) Designated as a CAH 2) Financially distressed according to latest iVantage Report ii. Rural hospitals in financial distress according to latest iVantage Report iii. Designated as a CAH 	
Measures / Metrics	<ul style="list-style-type: none"> • Please use 2018-2019 data for the baseline of the program • To help the state set baseline data, we would recommend the program applications do not include intervention details (duplicating the implementation plans), but the applications should instead request baseline data from the hospitals when the data won’t be available from the state. 	<p>The Department appreciates the comments on the measures and is working through the suggestions within the HTP measure workgroup.</p> <p>At this time the Department will:</p> <ul style="list-style-type: none"> • Identify type of improvement (relative) • Rename social determinants of health (SDOH)

Focus Area of Comment	Summary of Comment	Suggested Edit
	<ul style="list-style-type: none"> • Before the applications are submitted, please identify how the state intends to set benchmarks for each individual metric, e.g., will readmission rates be set with an 80% threshold, 5% improvement, or mean of top 75% of hospitals • Please consider delaying the due date for implementation plans until at least 2 months after baseline and benchmarks are set for the metrics, again so we can create the most meaningful intervention plans. • We have submitted a number of comments to HCPF in metric definitions, and those comments are attached here as well. In addition to the initial grid we provided, we add these comments: <ul style="list-style-type: none"> ○ SW-BH1- We recommend limiting collaborative discharge planning to patients with a primary diagnosis, and including only inpatient discharges- we would like to make meaningful interventions for highest risk patients and we would rather do something well and meaningful, rather than doing something less meaningful that touches more patients than we can meaningfully manage- we will need to walk before we run. ○ We don't know how the LOS benchmark will be set, but we would like the state to account for the fact that smaller hospitals will transfer their higher acuity patients to larger facilities, so their LOSs, even risk-adjusted may not be comparable. ○ All the improvements, e.g., 5% improvement, should indicate whether the improvement is a relative or an absolute rate improvement, e.g., 80%-85% is an absolute 5% improvement, whereas 80%-84% is a relative 5% improvement. ○ Can we rename the SDOH measure to "social needs screening and notification"? There is a lot of literature coming out distinguishing SDOH from social needs. I think HTP moves our state toward addressing SDOH, but the AHC tool with the five domains is a "Social Needs Screener". 	

Focus Area of Comment	Summary of Comment	Suggested Edit
Measures / Metrics	<p>Submitted questions concerning the ALTO Measure.</p> <ul style="list-style-type: none"> Do you know how the ALTO meds are to be reported? Which specific ALTO meds to report The ICD-10 CM Codes for reporting 	<p>The Department appreciates the comments on the alternatives to opioids (ALTO) measure. We have reviewed the comments and determined these are operational questions and clarification will be provided, but not in the 1115 Demonstration application.</p>
General Clarification	<ul style="list-style-type: none"> Specific to this draft 1115 waiver application, the Association requests the following: <ul style="list-style-type: none"> <i>Demonstration, program and performance year definitions should be clearly defined and aligned.</i> Three terms are used when referring to HTP timelines: demonstration year, program year and performance year and it appears that these terms may have different timeframes. For example, demonstration year zero is from Oct. 1, 2019 thru Sept. 30, 2020 (p.9), while program year zero is referred to as both the pre-program period encompassing work hospitals did prior to Sept. 30, 2019 (p.11) as well as data collected after Oct. 1, 2019 (p.12). Performance year may be a misprint, as it is only mentioned once when referring to timeframes for savings calculations (p.13). Clarification and consistency are needed on these terms. <i>More information should be provided about the independent assessment contractor and corresponding protocols for application review, project assessment, budgets and payments.</i> Section 2.7 outlines that HCPF will retain an independent assessment contractor to review and assess hospital applications and projects. More detail is needed on how the independent assessment contractor will be chosen and more detail is needed to understand how disputes will be addressed, including how hospitals can initiate dispute resolution processes and components of the HTP that are subject to dispute resolution processes. <i>HCPF should provide more detail about the Hospital Application and Project Toolkit.</i> Section 2.6 details an application and project toolkit that will specify the application process and instructions, forms, project 	<p>The Department appreciates the thoughtful comments on the 1115 Demonstration.</p> <ul style="list-style-type: none"> <i>Demonstration, program and performance year definitions should be clearly defined and aligned.</i> The Department will clarify. <i>More information should be provided about the independent assessment contractor and corresponding protocols for application review, project assessment, budgets and payments.</i> The Department is reviewing and will make clarifying edits. <i>HCPF should provide more detail about the Hospital Application and Project Toolkit.</i> The Department is reviewing and will make clarifying edits. <i>Alignment of other value-based purchasing and delivery reform initiatives should include additional guidance and technical support from HCPF.</i> The Department is in the process of drafting such guidance and technical assistance. <i>“Non-resort rural hospital” should be defined to allow for further discussion and evaluation.</i> The Department will refine and edit for clarity.

Focus Area of Comment	Summary of Comment	Suggested Edit
	<p>description and justification forms, budget and implementation plans, and the types of delivery reform projects that may be supported by the demonstration. It is unclear if this application process is different from HCPF’s currently outlined application process for hospital participation in the HTP. Additionally, it is unclear when this toolkit would be available. CHA requests that due dates, to be specified in the waiver standard terms and conditions, allow sufficient time for robust completion of the toolkit.</p> <ul style="list-style-type: none"> • <i>Alignment of other value-based purchasing and delivery reform initiatives should include additional guidance and technical support from HCPF.</i> CHA supports HCPF’s objective of increasing collaboration between hospitals and other providers. While the Association appreciates HCPF’s understanding that such increased collaboration should allow for regional and local flexibility, moving forward the Association asks for additional guidance regarding expected points of accountability and additional technical assistance in connecting and aligning data analytics, such as the ACC Data Analytics Portal and the Business Intelligence and Data Management system (mentioned in Sections 2.6 and 6.3). • <i>“Non-resort rural hospital” should be defined to allow for further discussion and evaluation.</i> The Association supports the rural hospital support program outlined in Section 2.3. While the term “non-resort rural” has been initially discussed in a few forums outside of the HTP, the term is not defined in this document, nor is it defined in the State Plan, rules or billing guidance. This term needs further definition before comment can be provided. 	
Measures / Metrics	<ul style="list-style-type: none"> • CCHN does have some reservations about the measures selected for the program: 	The Department appreciates the thoughtful comments on the 1115 draft application.

Focus Area of Comment	Summary of Comment	Suggested Edit
	<p>Ensure that the HTP measures align with the objectives and goals of the program.</p> <p>The application notes in section 2.1 (p. 11), that two workgroups were formed to review the preliminary measures for HTP, and that these workgroups were charged with measure feasibility and specification. In addition to ensuring that each measure can be measured, CCHN encourages HCPF to continue to engage stakeholders to ensure that the measures are not only feasible but will also result in the intended outcomes of the HTP. In addition, the overarching intended outcome of the program is improved care delivery across the health care systems in Colorado. CCHN encourages further exploration of metrics that would indicate movement toward that outcome.</p> <p>Ensure that measures do not put undue burden on other providers that will not receive payments directly through the HTP.</p> <p>In the measure discussion in section 2.3, CCHN is supportive of the intention but has concerns about the implementation of the measure of reducing avoidable hospital utilization. While reducing avoidable hospital utilization is a shared goal with CHCs, and is an effective method to reduce costs in the overall health system, success in both the regional and local measures proposed will require hospitals to enter into new and thoughtful agreements with primary care providers (especially with CHCs) and the Regional Accountable Entity. However, only hospitals will receive the HTP payment.</p> <ul style="list-style-type: none"> • Safeguards should be put in place to ensure that other providers, community partners, and CHCs are not asked by hospitals to fulfill an aspect of the hospital’s measure without proper reimbursement. For example, the local measure which requires a connection to a PCMP prior to discharge, having an initial appointment made, and notification to the RAE (p. 19), will require a specific and thoughtful process and workflow determined by the RAE, PCMP, and hospitals for each Health First Colorado patient. Most of the actions needed for the hospital to receive credit for this measure are actually those completed by the PCMP and RAE (e.g. making the appointment for the newly discharged patient). Therefore, hospitals should be encouraged to enter into specific agreements with the other entities to ensure these workflows are mutually beneficial. In addition, HCPF should consider incentives for achieving these metrics through partnerships 	<p>The Department convened a workgroup to develop the measures and has recalled that group to review the comments associated with the measures and metrics proposed under the HTP 1115 demonstration application. The measures for this initiative were designed with considerations for the hospitals in mind. the measures are ones that the Department believes are attainable by the participating hospitals and were chosen by the hospitals because they believe they will be able to meet and exceed these metrics.</p>

Focus Area of Comment	Summary of Comment	Suggested Edit
	with existing primary care providers rather than by building duplicative and competitive primary care infrastructure.	
<p>Communications</p> <p>General Clarification</p> <p>Operations</p>	<ul style="list-style-type: none"> The single goal within the transformation plan related to the disability community appears to be to have discharge planners provide an intrusive, often meaningless assessment and make a referral. This is in no way addresses the needs and concerns of the disability community. It is important to focus on this community because we are a major cost driver in the Medicaid system. Our hospitalizations are often more complex. Failure to provide inpatient and outpatient services appropriately almost always leads to tragic and expensive outcomes. This program offers a great opportunity to make real and meaningful change in how hospitals interact with our community. <i>The disability community requires a true transformation of how hospitals both perceive and address our needs.</i> We need to be treated as equal partners in our individual treatment plans and as we look to transformation on a systemic and policy level. Treatment protocols and hospital policies need to be easily amended to meet our unique needs. Personnel need to understand the difference between long-term care needs and acute care needs. For example, mobility devices and personal care attendants to address daily long-term care needs are very different than those used to address acute care needs. Hospital personnel need to respect and partner with them in making all care treatment decisions. Individuals with long-term care needs and the care partners are the experts in addressing those needs. Discharge planning should include referrals to agencies that have the expertise to assess for community-based care and the ability to put those supports in place quickly. A true comprehensive cultural competency project with the disability community with a clear goal of movement towards disability competent care would be the most useful for our community. This would include <ul style="list-style-type: none"> a) Time measured specific process with resources to undergo a review and modification of policies that get in the way of competent care, b) Training on cultural competence & ADA compliance 	<p>The Department appreciates the thoughtful comments submitted by the Colorado Cross-Disability Coalition. CCDC has been an engaged and thoughtful partner throughout the HTP waiver process. We look forward to continuing this collaborative working relationship with the CCDC and the other members of the Colorado disability community as we implement and evaluate HTP.</p>
Measures / Metrics	<ul style="list-style-type: none"> A measure of maternal physical health outcomes should be included as a required statewide measure for all birthing hospitals. 	<p>The Department appreciates the comments on the proposed 1115 demonstration measures.</p>

Focus Area of Comment	Summary of Comment	Suggested Edit
	<ul style="list-style-type: none"> • The measures on screening and referral for perinatal depression and anxiety should be a required statewide measure at all birthing hospitals and aligned with NCQA measures to the extent possible. • The section on “Vulnerable Populations” should be renamed “Core Populations.” • The percent of postpartum patients who are asked whether they would like to become pregnant in the next year should be added as a required statewide measure for all birthing hospitals and should replace the current measures focused on provision of long-acting reversible contraception. • Measures should include an increased focus on patient experience. 	<p>Colorado has a complimentary pay for performance effort known as the Hospital Quality Incentive Payment (HQIP) program, with most hospitals in Colorado participating in the program. The development and evolution of the HQIP program is being done in parallel with the HTP to serve as a compliment to the HTP. The HQIP program allows the Department to focus on important areas of acute care in a robust way and drives hospitals to significant enhancements in the delivery of care and in improving outcomes. Maternal measures account for 35% of the 2020 HQIP program total points and include measures for: exclusive breast feeding, cesarean section rates, perinatal depression and anxiety, maternal emergencies, reproductive life/family planning, incidence of episiotomy, and reduction of peripartum racial and ethnic disparities. These measures will potentially account for more than \$30 million per year in HQIP payments based on prior year performance statistics. Maintaining the inclusion of maternal measures in HQIP allows HTP to focus efforts on the improvement in neonatal complications which also reflect improvements in obstetric care.</p> <p>Vulnerable populations will be changed in the draft application to “core populations.”</p>
Funding (Community Based Organizations, CBOs)	<ul style="list-style-type: none"> • Based on the examples of CO’s Accountable Health Communities (AHC) and the lessons learned from the AHC, DRCOG requests the State of Colorado consider a similar approach and allocate funding to CBOs. This action would improve the capacity of community-based organizations to meet the demand for services that this 1115 waiver will require. 	<p>The Department appreciates the comments on the proposed 1115 demonstration. Operational considerations regarding provider collaboration were taken into consideration in the HTP design.</p> <p>Under the statutory authority for this initiative funding is only permitted to be directed toward hospitals.</p>
Measures / Metrics	<ul style="list-style-type: none"> • Suggest a minor modification to SW-VP1 (SDOH measure). Current language from specification document: <ul style="list-style-type: none"> ○ Number of notifications to appropriate entity <u>or</u> Regional Accountable Entities (RAE) of positive social determinates of health (SDoH) screens. Rather than making notification to local agencies <u>OR</u> the RAE, consider making this an AND statement. It 	<p>The Department has made this change and renamed to include ‘and’ statement.</p>

Focus Area of Comment	Summary of Comment	Suggested Edit
	<p>will be helpful for the RAEs to have SDOH information in order to more effectively risk stratify in determining appropriate interventions. For the individual currently at the hospital who has an SDOH concern, it may be most helpful to get referral information by the hospital social worker, prior to discharge. The RAEs can always follow up on this but how the metric is currently written, notification/referral would not need to occur to the community organization that may be able to help at time of discharge. HTP is an opportunity to cement-in good practice.</p> <ul style="list-style-type: none"> o Since the metric numerator has to do with “appropriate referral,” this appears to cover the hospital if the individual screened at zero or had a low score, not requiring referral. 	
<p>IT / Technology</p>	<p>Regarding the current measures proposed by HTP, Office of eHealth Innovation (OeHI) and the eHealth Commission had the measures reviewed by HealthTech Solutions, Health Data Colorado, and other key stakeholders. To best prioritize measures OeHI, in collaboration with the team, developed a methodology in alignment with Colorado’s Health Roadmap.</p> <p>With the Roadmap in mind the team established that measures of priority needs to fall into one of four categories that it identifies; reducing reporting burden, improving data quality to ensure actionable data for quality improvements, better care delivery, and reduced costs. The analysis that follows reflects that and is an effort to capture the best path forward for the state of Colorado.</p> <p>In alignment with the Governor and Lt. Governor priorities, it is recommended HTP focus on measures for suicide prevention and readmission rate reduction as these measures can be reported electronically via the EHR and HIEs.</p>	<p>The Department appreciates the thoughtful and comprehensive comments for the Colorado Office of eHealth Innovations. We look forward to continuing the conversation and collaborative efforts to ensure access and innovation through technology for all Coloradans.</p>
<p>Measures / Metrics</p>	<p>CCLP joined the comment letter drafted by the Colorado Children’s Campaign. We agree that maternal and perinatal health should be a priority of HTP. CCLP submits this supplemental comment letter to urge HCPF to ensure data on HTP performance metrics is disaggregated by race.</p>	<p>The Department appreciates the comments on the maternal and perinatal health measures.</p> <p><i>See the above comment on the HQIP.</i></p>

Focus Area of Comment	Summary of Comment	Suggested Edit
Measures / Metrics	<ul style="list-style-type: none"> Strengthen Accountability to Communities and Existing: Concern is that the HTP will create inefficiencies and slow progress is the program does not take additional steps to hold hospitals accountable for approaching their work in a collaborative and transparent manner. Call for further integration in the following larger Accountable Care Collaborative (ACC) efforts: Metric Selection and Improvement Plans - recommend HTP strengthen the responsive and accountability that hospitals have to the community by requiring that HTP applications and hospital improvement plans demonstrate how they have incorporated feedback from the RAEs and other partners. Data & Analytics: The Department could consider requiring participating hospitals to articulate their data strategies and partnerships in their HTP applications and hospital improvement plans. (Stronger data connection = collaboration, alignment and program transparency.) Recommend that the hospital improvement plans be made public. Drive Alternative Payment Model (APM) Adoption through Public-Private Partnerships The Department could benefit from “lessons learned” from the knowledge and experience of RAEs and value-based arrangements. Encourage the Department to partner with RMHP and other RAEs to evaluate hospital performance throughout the HTP. HTP could benefit from the tools, specifically agreements that RAEs can implement with hospitals and other providers to improve and address challenges with Health First Colorado’s members’ access to services. 	<p>The Department appreciates the comments on the draft 1115 demonstration and is continuing to have discussion on the areas raised by Rocky Mountain Health Plans.</p> <p>The Department will make the hospital improvement plans public.</p> <p>The Department is working with the Office of eHealth Innovation on collaborative efforts around strong data and analytics partnerships.</p>
Funding Measures / Metrics	<ul style="list-style-type: none"> The Department of Health Care Policy & Financing (“the Department”) should work with CMS to minimize at-risk funding. The Department should seek additional payment programs and entitlement amounts (beyond the HTP) to maximize funding for providers. The Department should finalize data requirements and measure specifications before requiring providers to select their final measures for the HTP. The HTP should allow providers to amend their selected quality measures. 	<p>The Department appreciates the comments on the 1115 demonstration draft application.</p> <p>The Department always seeks to minimize at-risk funding for the State. The Department will continue working with the HTP hospital workgroups to address operational questions.</p>

Focus Area of Comment	Summary of Comment	Suggested Edit
	<ul style="list-style-type: none"> The HTP should not penalize high-performing providers who have reached and maintained a performance ceiling. Clarifying the achievement structure for statewide priorities. The HTP should minimize reporting burdens on providers. 	
Measures / Metrics	<p>Some concerns expressed by the State for a couple of the inpatient measures related to re-admissions because the sample size for NJH could be low enough that one or two cases could produce a significant swing in the results.</p> <p>Measures to be confirmed with NJH Human Resources and Pediatric service:</p> <ol style="list-style-type: none"> PH5 (cultural competence) VP2 (admissions with bronchiolitis meeting best practice) 	The Department appreciates National Jewish Health’s comment regarding the measures and will address the issues as part of normal business operations.
General Clarification Communications	<p>Section-Specific Recommendations and Comments:</p> <p><i>Section 1.2 Rationale for Proposed Demonstration Program:</i> Clarify where the program design will be measuring or collecting feedback on the “patient” and/ “provider” experience related to changes made as a part of the HTP plan.</p> <p><i>Section 1.4 Statewide Operation and Affected Medicaid Stakeholders</i></p> <ul style="list-style-type: none"> Consider establishing a strategy for directly engaging physicians. Refer to this in the Waiver. <p><i>Section 2.1 Scope of Delivery Reform and Incentive Payments</i></p> <ul style="list-style-type: none"> Consider alternatives for mitigating unforeseen situations which may arise as a result of less than ideal levels of true community engagement in the CHNE process; include reference to having a plan in place in the application. Address in the application how there will be an opportunity for the respective communities to provide feedback on the nature and quality of the engagement experience. Consider including a statement in the application referencing any role which the community may have in the determination of additional awards or creation of corrective action plans. <p><i>Section 2.5 Expected Impact on Outcomes, Quality, Access and Cost Efficiency</i></p> <ul style="list-style-type: none"> Include an example or a list of what is meant by a vulnerable population Review last paragraph on pg. 23 for clarity between bullet points and the broader categorization in lead statement. 	<p>The Department appreciates the thoughtful comments on the 1115 Application for the ACC & PIAC Provider & Community Experience Subcommittee. The 1115 Demonstration application will be clarified to include the following:</p> <p>Section 1.2: Review and clarify the rationale of the program</p> <p>Section 1.4: Clarify that the Department will continue encouraging stakeholder input through ongoing communication opportunities both between provider groups and hospitals and between hospitals and the Department. A reference to future operational guidance to address the other concerns will be added to the draft.</p> <p>Section 2.5: Rename vulnerable populations to core populations</p> <p>Section 2.6: The grammatical mistake will be corrected.</p>

Focus Area of Comment	Summary of Comment	Suggested Edit
	<ul style="list-style-type: none"> • Section 2.6 Hospital Participation and Toolkit for Application and Projects • Pg. 24 correct “countries” to “counties” • Consider footnoting anticipated list of “other stakeholders” that will be included in the hospital application and toolkit development • Pursue direct interface with medical providers in providing dissemination information about the program and gather questions 	
<p>General clarification</p> <p>Measures / Metrics</p>	<p>The Community Advisory Council provided feedback across each measure focus area and overall programmatic components. These primarily included specific measure questions surrounding clarity and purpose as well as proposed measures for inclusion.</p>	<p>The Department thanks the HTP Community Advisory Council for its thoughtful comments and will amend the application by:</p> <ul style="list-style-type: none"> • Renaming ‘vulnerable populations’ to ‘core populations’ • Adding a local measure on access to specialty care • Removing measures on long acting reversible contraception (LARC) • Revising the measure on discharge planning to include a collaboratively developed process ‘AND’ notification to the RAE in lieu of ‘or’ • Revising the measure on cultural competency to leadership diversity to better focus the metric and drive impact <p>In addition, the committee provided suggestions to simplify the language of metrics, clarify processes and mechanics of measures, and ensure measures will drive the desired outcome. We have reviewed the comments and determined these are operational questions and clarifications will be made, but not in the 1115 Demonstration application.</p> <p>A memo detailing the Department’s responses to the HTP Community Advisory Council’s feedback is available online at https://www.colorado.gov/pacific/hcpf/HTP-Community-Advisory-Council under the December 19, 2019 meeting: Department Responses to Feedback on HTP Quality Measures.</p>

XV. Appendix F: Tribal Notice: Programmatic Log (November 8, 2019)

Log #	Log Date	Major Program (Medicaid, CHP+, etc)	Action Type (SPA, waiver, other)	Category (Eligibility, benefits, rates, etc)	Programmatic Action Title	Brief Description	Important Dates and Timelines	Clearly Foreseeable Tribal Implications	Actionable or Non-Actionable Item - Why
333	11/8/2019	Medicaid	Waiver	Reimbursement through creation of Hospital Delivery System Reform Incentive Payments	Hospital Transformation Program	<p>The Department of Health Care Policy and Financing (Department) intends to submit a Medicaid Section 1115 Demonstration Application for the Colorado Hospital Transformation Program (HTP). The HTP will use delivery reform incentive payments to support hospital-led projects designed to make significant, evidence-based improvements to Health First Colorado health care delivery in population health and total cost of care in critical priority areas:</p> <ul style="list-style-type: none"> • Care coordination and care transitions. • Complex care management for targeted populations. • Behavioral health and substance use disorder coordination. • Perinatal care and improved birth outcomes. • Recognizing and addressing social determinants. • Reduce total cost of care. <p>The proposed Section 1115 Demonstration application and Information about public hearings are available at: www.colorado.gov/pacific/hcpf/htp-waiver</p> <p>Comments are requested by December 15, 2019 at 5 p.m. MST and may be sent to COHTP@state.co.us</p>	<p>Estimated Effective Date: October 1, 2020 Estimated Submission Date: December 31, 2019</p>	<p>The Department does not foresee any negative tribal implications as a result of this waiver. The Hospital Transformation Program will have positive impacts on clients as it is intended to improve patient outcomes, increase effectiveness of hospital care, and increase collaboration between hospitals and other partners.</p>	<p>Actionable. The Department was directed to implement hospital delivery system reform incentive payments with the passage of Senate Bill 17-267. Comments, feedback, and questions about the Hospital Transformation Program and proposed waiver are welcome.</p>