

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2022-23 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 8.3000
Rule Number: MSB 22-11-22-A
Division / Contact / Phone: Special Financing / Riley De Valois / 6621

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule is being amended to reflect the changes necessary for the federal fiscal year (FFY) 2022-23 Hospital Affordability and Sustainability (HAS) provider fees and supplemental payments.

The Department submitted a state plan amendment (SPA) on 12/27/2022 to the Centers for Medicare and Medicaid Services (CMS) and expects approval in the next several months. We expect to present FFY 2022-23 HAS provider fees and supplemental payments to the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board on 02/28/2023. FFY 2022-23 provider fees and supplemental payments will be implemented only after the CHASE Board, the CMS, and the MSB approval. For FFY 2022-23, hospitals will pay \$1.23 billion in fees, which will generate \$3.86 billion in federal funds for Colorado. Hospitals will receive \$1.69 billion in supplemental and quality incentive payments. Currently, more than 668,000 Coloradans are enrolled in Medicaid and CHP+ coverage financed with hospital provider fees. As the hospital provider fee funds the Department's administrative costs, there is no impact on state General Fund.

The amendment revises the Essential Access Hospital Supplemental Payment calculation methodology, the Disproportionate Share Hospital Supplemental Payment allotment and calculation methodology, as well as removes measure group language from the Hospital Quality Incentive Payment (HQIP) indicating it can be found elsewhere. Further, language regarding a scoring review and reconsideration period has been added for HQIP to give the Department authority about score revisions in the event a hospital does not agree with the preliminary scores.

2. An emergency rule-making is imperatively necessary

- to comply with state or federal law or federal regulation and/or
 for the preservation of public health, safety and welfare.

Explain:

Not necessary

3. Federal authority for the Rule, if any:

N/A

Initial Review **04/14/23**
Proposed Effective Date **06/30/23**

Final Adoption **05/12/23**
Emergency Adoption

DOCUMENT #09

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4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S.(2022);

Sections 25.5-4-402.4(4)(b), (g), C.R.S.

Initial Review

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Colorado hospitals benefit from increased Medicaid reimbursement made possible through HAS supplemental payments and the reduced number of uninsured Coloradans from expanded Medicaid and CHP+ eligibility. Low-income persons benefit from having healthcare coverage through the expanded Medicaid and CHP+ eligibility.

Colorado hospitals bear the costs of the proposed rule due to paying the HAS fee to fund HAS supplemental payments and expanded Medicaid and CHP+ eligibility expenditures before federal matching funds.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The HAS fee, with federal matching funds, will result in approximately \$3.3 billion in annual health care expenditures for more than 668,000 Coloradans and will provide more than \$464 million new funds to Colorado hospitals.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

While there are administrative costs, such costs are funded with HAS fees and federal matching funds. No state General Fund is used.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

The benefits of the proposed rule are the funding of approximately \$3.3 billion in annual health care expenditures for more than 668,000 Coloradans and more than \$464 million in new funds to Colorado hospitals. The cost of the proposed rule is the HAS fee paid by Colorado hospitals to fund the expanded Medicaid and CHP+ eligibility and HAS supplemental payments.

If no action is taken, there will not be enough HAS fee to fund Colorado Medicaid and CHP+ expansions, affecting over 668,000 currently enrolled persons or the ability to fund the HAS supplemental payments.

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5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

No other methods are available to achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

No other alternatives to rule making are available.

1 **8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND**
2 **DISBURSEMENT**

3 8.3000.A PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid
4 Services (CMS), the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017
5 (Act), C.R.S. § 25.5-4-402.4, authorizes the Colorado Healthcare Affordability and Sustainability
6 Enterprise (CHASE) to assess a healthcare affordability and sustainability fee, pursuant to rules
7 adopted by the State Medical Services Board, to provide business services to hospitals as
8 described in C.R.S. § 25.5-4-402.4(4)(a). These business services include, but are not limited to,
9 obtaining federal financial participation to increase reimbursement to hospitals for care provided
10 under the state medical assistance program (Medicaid) and the Colorado Indigent Care Program
11 (CICP); expanding health coverage for parents of Medicaid eligible children, for children and
12 pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without
13 dependent children; providing a Medicaid buy-in program for people with disabilities;
14 implementing twelve month continuous eligibility for Medicaid eligible children; paying CHASE's
15 administrative costs of implementing and administering the Act; consulting with hospitals to help
16 them improve cost efficiency, patient safety, and clinical effectiveness; advising hospitals
17 regarding potential changes to federal and state laws and regulations governing Medicaid;
18 providing coordinating services to hospitals to help them adapt and transition to any new or
19 modified performance tracking and payment systems for the Medicaid program; and providing
20 funding for a health care delivery system reform incentive payments program.

21 **8.3000.B4: DEFINITIONS**

- 22 1. "Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, §
23 25.5-4-402.4, C.R.S.
- 24 2. "CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability
25 Enterprise described in C.R.S. § 25.5-4-402.4(3).
- 26 3. "CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section
27 8.900.
- 28 4. "CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.
- 29 5. "CMS" means the federal Centers for Medicare and Medicaid Services.
- 30 6. "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C.
31 § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public
32 Health and Environment.
- 33 7. "Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to
34 qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as
35 required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each
36 state that limits federal financial participation for total statewide DSH payments made to hospitals.
- 37 8. "Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise
38 Board described in C.R.S. § 25.5-4-402.4(7).
- 39 9. "Essential Access Hospital" means a Critical Access Hospital or General Hospital not located
40 within a Metropolitan Statistical Area (MSA) designated by the United States Office of
41 Management and Budget and having 25 or fewer licensed beds.

- 1 10. "Exclusive Provider Organization" or "EPO" means a type of managed care health plan where
2 members are not required to select a primary care provider or receive a referral to receive
3 services from a specialist. EPOs will not cover care provided out-of-network except in an
4 emergency.
- 5 11. "Fund" means the healthcare affordability and sustainability fee cash fund described in C.R.S. §
6 25.5-4-402.4(5).
- 7 12. "General Hospital" means a hospital licensed as a general hospital by the Colorado Department
8 of Public Health and Environment.
- 9 13. "High Volume Medicaid and CICP Hospital" means a hospital with at least 27,500 Medicaid Days
10 per year that provides over 30% of its total days to Medicaid and CICP clients.
- 11 14. "Health Maintenance Organization" or "HMO" means a type of managed care health plan that
12 limits coverage to providers who work for or contract with the HMO and requires selection of a
13 primary care provider and referrals to receive services from a specialist. HMOs will not cover care
14 provided out-of-network except in an emergency.
- 15 15. "Hospital-Specific Disproportionate Share Hospital Limit" or "Hospital-Specific DSH Limit" means
16 a hospital's maximum allowable Disproportionate Share Hospital ~~Payment~~ payment eligible for Medicaid
17 federal financial participation allowed under 42 U.S.C. § 1396r-4.
- 18 16. "Hospital Transformation Program Supplemental Medicaid Payments" or "HTP Supplemental
19 Medicaid Payments" means the:
- 20 a. ~~1. Outpatient Hospital Supplemental Medicaid Payment described in Section~~
21 ~~8.30004.E.2B.~~,
- 22 b. ~~2. Inpatient Hospital Supplemental Medicaid Payment described in Section~~
23 ~~8.30004.E.3C.~~, and
- 24 c. ~~3. Essential Access Hospital Supplemental Medicaid Payment described in Section~~
25 ~~8.30004.E.5E.~~
- 26 ~~The HTP Supplemental Medicaid Payments do not include the Hospital Quality Incentive Payment~~
27 ~~described in Section 8.3004.F. or Rural Support Program Hospital Supplemental Medicaid Payment~~
28 ~~described in Section 8.3004.G.~~
- 29 17. "Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care
30 Days and Non-Managed Care Days.
- 31 18. "Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a
32 provider for inpatient hospital services and still receive federal financial participation.
- 33 19. "Long Term Care Hospital" means a General Hospital that is certified as a long-term care hospital
34 by the Colorado Department of Public Health and Environment.
- 35 20. "Managed Care Day" means an inpatient hospital day for which the primary payer is a managed
36 care health plan, including HMO, PPO, POS, and EPO days.
- 37 21. "Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or
38 secondary payer is Medicaid.

- 1 22. "Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is
2 Medicaid.
- 3 23. "Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS
4 2552-10, or any successor form created by CMS.
- 5 24. "MMIS" means the Medicaid Management Information System, the Department's Medicaid claims
6 payment system.
- 7 25. "MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by
8 total hospital days.
- 9 26. "Non-Managed Care Day" means an inpatient hospital day for which the primary payer is an
10 indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.
- 11 27. "Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a
12 local government.
- 13 28. "Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital
14 charges.
- 15 29. "Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a
16 provider for outpatient hospital services and still receive federal financial participation.
- 17 30. "Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric
18 populations.
- 19 31. "POS" or "Point of Service" means a type of managed care health plan that charges patients less
20 to receive services from providers in the plan's network and requires a referral from a primary
21 care provider to receive services from a specialist.
- 22 32. "PPO" or "Preferred Provider Organization" means a type of managed care health plan that
23 contracts with providers to create a network of participating providers. Patients are charged less
24 to receive services from providers that belong to the network and may receive services from
25 providers outside the network at an additional cost.
- 26 33. "Privately-Owned Hospital" means a hospital that is privately owned and operated.
- 27 34. "Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado
28 Department of Public Health and Environment.
- 29 35. "Rehabilitation Hospital" means an inpatient rehabilitation facility.
- 30 36. "Respiratory Hospital" means a hospital that primarily specializes in respiratory related diseases.
- 31 37. "Rural Hospital" means a hospital not located within a Metropolitan Statistical Area (MSA)
32 designated by the United States Office of Management and Budget.
- 33 38. "State-Owned Government Hospital" means a hospital that is either owned or operated by the
34 State.
- 35 39. "State University Teaching Hospital" means a High-Volume Medicaid and CICP Hospital which
36 provides supervised teaching experiences to graduate medical school interns and residents

1 enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its
2 credentialed physicians are members of the faculty at a state institution of higher education.

3 40. "Supplemental Medicaid Payments" means the:

- 4 a. ~~1.~~ Outpatient Hospital Supplemental Medicaid Payment described in 8.30004.E.2B.,
5 b. ~~2.~~ Inpatient Hospital Supplemental Medicaid Payment described in 8.30004.E.3C.,
6 c. ~~3.~~ Essential Access Hospital Supplemental Medicaid Payment described in
7 8.30004.E.5E.,
8 d. ~~4.~~ Hospital Quality Incentive Payment described in 8.30004.E.6F., and
9 e. ~~5.~~ Rural Support Program Hospital Supplemental Medicaid Payment described in
10 8.30004.E.7G.

11 41. "Uninsured Cost" means uninsured days and charges allocated to routine and ancillary cost
12 centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio
13 from the Medicare Cost Report.

14 42. "Urban Center Safety Net Specialty Hospital" means a hospital located in a Metropolitan
15 Statistical Area designated by the United States Office of Management and Budget where its
16 Medicaid Days plus CICIP Days relative to total inpatient hospital days, rounded to the nearest
17 percent, equals, or exceeds, 65%

18 **8.3000.C.2: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS**

19 **8.3000.C.12.A. DATA REPORTING**

- 20 a. ~~1.~~ For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee
21 and the distribution of supplemental payments, the Enterprise shall distribute a data
22 reporting template to all hospitals. The Enterprise shall include instructions for completing
23 the data reporting template, including definitions and descriptions of each data element to
24 be reported. Hospitals shall submit the requested data to the Enterprise within thirty (30)
25 calendar days after receiving the data reporting template or on the stated due date,
26 whichever is later. The Enterprise may estimate any data element not provided directly by
27 the hospital.
- 28 i. ~~a.~~ For hospitals that do not participate in the electronic funds process
29 utilized by the Enterprise for the collection of fees, payments to hospitals shall be
30 processed by the Enterprise within two business days of receipt of the Outpatient
31 Services Fee and Inpatient Services Fee.
- 32 ii. ~~b.~~ For hospitals that do not participate in the electronic funds process
33 utilized by the Enterprise for the disbursement of payments, payments to
34 hospitals shall be processed through a warrant (paper check) by the Enterprise
35 within two business days of receipt of the Outpatient Services Fee and Inpatient
36 Services Fee.
- 37 b. ~~2.~~ Hospitals shall submit days and charges for Medicaid Managed Care, out-of-
38 state Medicaid, and uninsured patients, Managed Care Days, and any additional
39 elements requested by the Enterprise.

- 1 c. ~~3.~~—The Enterprise shall distribute a data confirmation report to all hospitals annually.
 2 The data confirmation report shall include a listing of relevant data elements used by the
 3 Enterprise in calculating the Outpatient Services Fee, the Inpatient Services Fee and the
 4 supplemental payments. The data confirmation report shall clearly state the manner and
 5 timeline in which hospitals may request revisions to the data elements recorded by the
 6 Enterprise. Revisions to the data will not be permitted by a hospital after the dates
 7 outlined in the data confirmation report.
- 8 d. ~~4.~~—The hospital shall certify that based on best information, knowledge, and belief,
 9 the data included in the data reporting template is accurate, complete, and truthful, is
 10 based on actual hospital records, and that all supporting documentation will be
 11 maintained for a minimum of six years. The certification shall be made by the hospital's
 12 Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the
 13 Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the
 14 Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or
 15 Chief Financial Officer is ultimately responsible for the certification.

16 ~~8.3002-B0.C.2.~~ FEE ASSESSMENT AND COLLECTION

- 17 a. ~~1.~~—Establishment of Electronic Funds Process. The Enterprise shall utilize an
 18 Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee
 19 and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT)
 20 payment process to deposit supplemental payments in financial accounts authorized by
 21 hospitals. The Enterprise shall supply hospitals with all necessary information,
 22 authorization forms and instructions to implement this electronic process.
- 23 b. ~~2.~~—The Outpatient Services Fee and Inpatient Services Fee will be assessed on an
 24 annual basis and collected in twelve monthly installments. Payments to hospitals will be
 25 calculated on an annual basis and disbursed in twelve monthly installments.
- 26 i. ~~a.~~—For those hospitals that participate in the electronic funds process
 27 utilized by the Enterprise, fees will be assessed and payments will be disbursed
 28 on the second Friday of the month, except when State offices are closed during
 29 the week of the second Friday, then fees will be assessed and payment will be
 30 disbursed on the following Friday of the month. If the Enterprise must diverge
 31 from this schedule due to unforeseen circumstances, the Enterprise shall notify
 32 hospitals in writing or by electronic notice as soon as possible.
- 33 1) ~~i.~~—The Enterprise may assess fees and disburse payments for
 34 Urban Center Safety Net Specialty Hospitals on an alternate schedule
 35 determined by the Department.
- 36 ii. ~~b.~~—At no time will the Enterprise assess fees or disburse payments prior to
 37 the state fiscal year for which they apply.

- 38 ~~iii.c.~~ ~~3.~~—Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient
 39 Services Fee and Inpatient Services Fee must participate in the electronic funds process
 40 utilized by the Enterprise for the collection of fees and the disbursement of payments
 41 unless the Enterprise has approved an alternative process. A hospital requesting to not
 42 participate in the electronic fee collection process and/or payment process must submit a
 43 request in writing or by electronic notice to the Enterprise describing an alternative fee
 44 collection process and/or payment process. The Enterprise shall approve or deny the
 45 alternative process in writing or by electronic notice within 30 calendar days of receipt of
 46 the request.

- 1 i. ~~a.~~ For hospitals that do not participate in the electronic funds process
 2 utilized by the Enterprise for the collection of fees, payments to hospitals shall be
 3 processed by the Enterprise within two business days of receipt of the Outpatient
 4 Services Fee and Inpatient Services Fee.
- 5 ii. ~~b.~~ For hospitals that do not participate in the electronic funds process
 6 utilized by the Enterprise for the disbursement of payments, payments to
 7 hospitals shall be processed through a warrant (paper check) by the Enterprise
 8 within two business days of receipt of the Outpatient Services Fee and Inpatient
 9 Services Fee.

10 ~~8.30033000.D:~~ **HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE**

11 ~~8.3003.A0.D.1.~~ **OUTPATIENT SERVICES FEE**

- 12 a. ~~1.~~ Federal requirements. The Outpatient Services Fee is subject to federal approval
 13 by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial
 14 participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§
 15 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).
- 16 b. ~~2.~~ Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and
 17 Rehabilitation Hospitals are exempted from the Outpatient Services Fee.
- 18 c. ~~3.~~ Calculation methodology. The Outpatient Services Fee is calculated on an
 19 annual basis as ~~4.63651.8705~~% of total hospital outpatient charges with the following
 20 exception.
- 21 i. ~~a.~~ High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is
 22 discounted to ~~4.62281.8548~~% of total hospital outpatient charges.

23 ~~8.3000.D.23.B.~~ **INPATIENT SERVICES FEE**

- 24 a. ~~1.~~ Federal requirements. The Inpatient Services Fee is subject to federal approval
 25 by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial
 26 participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§
 27 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).
- 28 b. ~~2.~~ Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and
 29 Rehabilitation Hospitals are exempted from the Inpatient Services Fee.
- 30 c. ~~3.~~ Calculation methodology. The Inpatient Services Fee is calculated on an annual
 31 per inpatient day basis of ~~\$405.53114.10~~ per day for Managed Care Days and
 32 ~~\$474.76510.05~~ per day for all Non-Managed Care Days with the following exceptions:
- 33 i. ~~a.~~ High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is
 34 discounted to ~~\$55.1059.57~~ per day for Managed Care Days and ~~\$246.34266.30~~
 35 per day for all Non-Managed Care Days, and.
- 36 ii. ~~b.~~ Essential Access Hospitals' Inpatient Services Fee is discounted to
 37 ~~\$42.2145.64~~ per day for Managed Care Days and ~~\$188.70204.02~~ per day for
 38 Non-Managed Care Days.

39 ~~8.3003.C.0.D.3~~ **ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE**

- 1 a. ~~1.~~ The Enterprise shall calculate the Inpatient Services Fee and Outpatient Services
 2 Fee under this section on an annual basis in accordance with the Act. Upon receiving a
 3 favorable recommendation by the Enterprise Board, the Inpatient Services Fee and
 4 Outpatient Services Fee shall be subject to approval by the CMS and the Medical
 5 Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing
 6 or by electronic notice, of the annual fee to be collected each year, the methodology to
 7 calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in
 8 writing or by electronic notice, at least thirty calendar days prior to any change in the
 9 dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be
 10 assessed.
- 11 b. ~~2.~~ The Inpatient Services Fee and the Outpatient Services Fee will be assessed on
 12 the basis of the qualifications of the hospital in the year the fee is assessed as confirmed
 13 by the hospital in the data confirmation report. The Enterprise will prorate and adjust the
 14 Inpatient Services Fee and Outpatient Services Fee for the expected volume of services
 15 for hospitals that open, close, relocate or merge during the payment year.
- 16 c. ~~3.~~ In order to receive a Supplemental Medicaid Payment or DSH Payment,
 17 hospitals must meet the qualifications for the payment in the year the payment is
 18 received as confirmed by the hospital during the data confirmation report. Payments will
 19 be prorated and adjusted for the expected volume of services for hospitals that open,
 20 close, relocate or merge during the payment year.

21 ~~8.3003.D.0.D.4~~ REFUND OF EXCESS FEES

22 ~~a. 1. If, at any time, fees have been collected for which the intended expenditure has~~
 23 ~~not received approval for federal Medicaid matching funds by CMS at the time of~~
 24 ~~collection, the Enterprise shall refund to each hospital its proportion of such fees paid~~
 25 ~~within five business days of receipt. The Enterprise shall notify each hospital of its refund~~
 26 ~~amount in writing or by electronic notice. The refunds shall be paid to each hospital~~
 27 ~~according to the process described in Section 8.3002.B.~~

28 ~~a. 2. After Within ninety days of the close of each State a federal fiscal year and no~~
 29 ~~later than the following August 31, the Enterprise shall present to the Enterprise Board a~~
 30 ~~summary of revenues received fees collected, and expenditures made or encumbered,~~
 31 ~~and interest earned in through the Fund during the State federal fiscal year to the~~
 32 ~~Enterprise Board. The Enterprise shall also present to the Enterprise Board the federal~~
 33 ~~fiscal year ending Fund balance and the Fund reserve limit.~~

34 ~~a. The Fund reserve limit shall equal an Enterprise Board approved percent,~~
 35 ~~multiplied the total CHASE funding obligation for the subsequent federal fiscal~~
 36 ~~year.~~

37 ~~b. a. If the federal fiscal year ending Fund balance is greater than the Fund reserve~~
 38 ~~limit the difference shall be refunded back to hospitals based on the percent of total fees~~
 39 ~~paid during the federal fiscal year. The Enterprise shall notify each hospital of its fee~~
 40 ~~refund within thirty days and the fee refund will occur within sixty days of CHASE Board~~
 41 ~~review and approval.~~

42 ~~c. If the federal fiscal year ending Fund balance is less than the Fund reserve limit the~~
 43 ~~difference shall be reduced from the funds available for supplemental payments in the~~
 44 ~~subsequent federal fiscal year.~~

45 ~~1) If fees have been collected for which the intended expenditure has~~
 46 ~~received approval for federal Medicaid matching funds by CMS, but the~~

~~Enterprise has not expended or encumbered those fees at the close of each State fiscal year. i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less the minimum Fund reserve recommended by the Enterprise Board.~~

~~2) ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the federal fiscal year.~~

~~3) iii. The Enterprise shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.3002-B.~~

8.3004.3000.E: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.A0.E.1. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

- a. ~~1.~~ All Supplemental Medicaid Payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Enterprise.
- b. ~~2.~~ No hospital shall receive a DSH Payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.3004.D, exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific Disproportionate Share Hospital Limit.
- c. ~~3.~~ In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.3004.B0.E.2. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

- a. ~~1.~~ Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients are qualified to receive this payment except as provided below.
- b. ~~2.~~ Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.
- c. ~~3.~~ Calculation methodology for payment. For each qualified hospital, the annual payment shall equal outpatient billed costs, adjusted for utilization and inflation, multiplied

1 by a percentage adjustment factor. Outpatient billed costs equal outpatient billed charges
 2 multiplied by the Medicare cost-to-charge ratio. The percentage adjustment factor may
 3 vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals,
 4 Privately-Owned Hospitals, ~~for urban hospitals, and Rural HH~~ hospitals, ~~for State~~
 5 University Teaching Hospitals, ~~for~~ Pediatric Specialty Hospitals, ~~for~~ Urban Center Safety
 6 Net Specialty Hospitals, or ~~for~~ other hospital classifications. Total payments to qualified
 7 hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage
 8 adjustment factor for each qualified hospital shall be published annually in the Colorado
 9 Medicaid Provider Bulletin.

10 ~~8.3004.C0.E.3.~~ INPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

- 11 a. ~~1.~~ Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid
 12 clients are qualified to receive this payment, except as provided below.
- 13 b. ~~2.~~ Excluded hospitals. Psychiatric Hospitals are not qualified to receive this
 14 payment.
- 15 c. ~~3.~~ Calculation methodology for payment. For each qualified hospital, the annual
 16 payment shall equal Medicaid Days multiplied by an adjustment factor. The adjustment
 17 factor may vary for State-Owned Government Hospitals, Non-State-owned Government
 18 Hospitals, Privately-Owned Hospitals, ~~for urban hospitals, and Rural HH~~ hospitals, ~~for~~
 19 State University Teaching Hospitals, ~~for~~ Pediatric Specialty Hospitals, ~~for~~ Urban Center
 20 Safety Net Specialty Hospitals, or ~~for~~ other hospital classifications. Total payments to
 21 qualified hospitals shall not exceed the Inpatient Upper Payment Limit. The adjustment
 22 factor for each qualified hospital shall be published annually in the Colorado Medicaid
 23 Provider Bulletin.

24 ~~8.3004.D-0.E.4~~ DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

- 25 a. ~~1.~~ Qualified hospitals.
- 26 i. ~~a.~~ Hospitals that are Colorado Indigent Care Program providers and have
 27 at least two obstetricians who have staff privileges at the hospital and who have
 28 agreed to provide obstetric care for Medicaid clients or are exempt from the
 29 obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to
 30 receive this payment.
- 31 ii. ~~b.~~ Hospitals with a MIUR equal to or greater than the mean plus one
 32 standard deviation of all MIURs for Colorado hospitals and have at least two
 33 obstetricians who have staff privileges at the hospital and who have agreed to
 34 provide obstetric care for Medicaid clients or are exempt from the obstetrician
 35 requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this
 36 payment.
- 37 iii. ~~c.~~ Critical Access Hospitals with at least two obstetricians who have staff
 38 privileges at the hospital and who have agreed to provide obstetric care for
 39 Medicaid clients or are exempt from the obstetrician requirement pursuant to 42
 40 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment
- 41 b. ~~2.~~ Excluded hospitals. Psychiatric Hospitals are not qualified to receive this
 42 payment.
- 43 c. ~~3.~~ Calculation methodology for payment.

- 1 i. ~~a.~~ Total funds for the payment shall equal \$~~226,610,302~~244,068,958.
- 2 ii. ~~b.~~ A qualified hospital with CICP write-off costs greater than ~~1,000.00~~700%
3 of the state-wide average shall receive a payment equal to 96.00% of their
4 Hospital-Specific DSH Limit. A qualified Critical Access Hospital shall receive a
5 payment equal to ~~96.00~~96.00% of their Hospital Specific DSH Limit. A qualified
6 hospital not owned/operated by a healthcare system network within a
7 Metropolitan Statistical Area and having less than ~~2,000~~2,400 Medicaid **Days**
8 shall receive a payment equal to ~~50.00~~96.00% of their Hospital-Specific DSH
9 Limit.
- 10 iii. ~~c.~~ All remaining qualified hospitals shall receive a payment calculated as
11 the percentage of uninsured costs to total uninsured costs for all remaining
12 qualified hospitals, multiplied by the remaining funds.
- 13 iv. ~~d.~~ No remaining qualified hospital shall receive a payment exceeding
14 96.00% of their Hospital-Specific DSH Limit as specified in federal regulation. If a
15 qualified hospital's payment exceeds 96.00% of their Hospital-Specific DSH
16 Limit, the payment shall be reduced to 96.00% of the Hospital-Specific DSH
17 Limit. The amount of the reduction shall then be redistributed to other qualified
18 hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit based on
19 the percentage of uninsured costs to total uninsured costs for all qualified
20 hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit.
- 21 v. ~~e.~~ A new CICP hospital shall have their Hospital-Specific DSH Limit equal
22 to 10.00%. A Low MIUR hospital shall have their Hospital-Specific DSH Limit
23 equal 10.00%.
- 24 1) ~~i.~~ A new CICP hospital is a hospital approved as a CICP provider
25 after October 1, ~~2021~~2022.
- 26 2) ~~ii.~~ A low MIUR hospital is a hospital with a MIUR less than or equal
27 to ~~45.00~~22.50%.

28 ~~8.3004.E.0.E.5~~ **ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT**

- 29 a. ~~1.~~ Qualified hospitals. Essential Access Hospitals are qualified receive this
30 payment.
- 31 b. ~~2.~~ Calculation methodology for payment. For each qualified hospital, the annual
32 payment shall equal ~~the percentage of beds to total beds for all qualified hospitals,~~
33 ~~multiplied by the available Essential Access funds~~ divided by the total number of qualified
34 Essential Access Hospitals.

35 ~~8.3004.F.0.E.6~~ **HOSPITAL QUALITY INCENTIVE PAYMENT**

- 36 a. ~~1.~~ Qualified hospitals. Hospitals providing hospital services to Medicaid clients are
37 qualified to receive this payment except as provided below.
- 38 b. ~~2.~~ Excluded hospitals. Psychiatric Hospitals are not qualified to receive this
39 payment.

- 1 c. ~~3.~~ Calculation methodology for payment. For each qualified hospital, the annual
 2 payment shall equal adjusted discharge points multiplied by dollars per-adjusted
 3 discharge point.
- 4 i. ~~a.~~ Adjusted discharge points equal normalized points awarded multiplied by
 5 adjusted Medicaid discharges. Normalized points awarded equals the sum of
 6 points awarded, normalized to a 100-point scale for measures a hospital is not
 7 eligible to complete. ~~There are fifteen measures separated into three measure~~
 8 ~~groups. The measures and measure groups are published annually in the~~
 9 ~~Colorado Medicaid Provider Bulletin.~~
- 10 ~~1) The measures and measure groups are:~~
- 11 ~~2) Maternal Health and Perinatal Care Measure Group~~
- 12 ~~3) 1. Exclusive Breast Feeding~~
- 13 ~~4) 2. Cesarean Section~~
- 14 ~~5) 3. Perinatal Depression and Anxiety~~
- 15 ~~6) 4. Maternal Emergencies and Preparedness~~
- 16 ~~7) 5. Reduction of Peripartum Racial and Ethnic Disparities~~
- 17 ~~8) 6. Reproductive Life/Family Planning~~
- 18 ~~9) Patient Safety Measure Group~~
- 19 ~~10) 7. Zero Suicide~~
- 20 ~~11) 8. Clostridium Difficile~~
- 21 ~~12) 9. Sepsis~~
- 22 ~~13) 10. Antibiotics Stewardship~~
- 23 ~~14) 11. Adverse Event~~
- 24 ~~15) 12. Culture of Safety Survey~~
- 25 ~~16) 13. Handoffs and Sign-Outs~~
- 26 ~~17) Patient Experience Measure Group~~
- 27 ~~18) 14. Hospital Consumer Assessment of Healthcare Providers and Systems~~
 28 ~~(HCAHPS)~~
- 29 ~~19) 15. Advance Care Plan~~
- 30 ~~20) 1) Adjusted Medicaid Discharges equal inpatient Medicaid discharges~~
 31 ~~multiplied by a discharge adjustment factor.~~

a) ~~i.~~ The discharge adjustment factor equals total Medicaid charges divided by inpatient Medicaid charges. The discharge adjustment factor is limited to 5.

b) ~~ii.~~ For qualified hospitals with less than 200 inpatient Medicaid discharges, inpatient Medicaid discharges shall be multiplied by 125%.

ii. ~~b.~~ Dollars per-adjusted discharge point are determined using a qualified hospital's normalized points awarded. Dollars per-adjusted discharge point are tiered so that qualified hospitals with more normalized points awarded receive more dollars per-adjusted discharge point. There are five tiers delineating the dollars per-adjusted discharge point with each tier assigned a certain normalized points awarded range. For each tier the dollars per-adjusted discharge point increase by a multiplier.

1) The multiplier and normalized points awarded for each tier are:

Tier	Normalized Points Awarded	Dollars Per-Adjusted Discharge Point
1	1-19	0(x)
2	20-39	1(x)
3	40-59	2(x)
4	60-79	3(x)
5	80-100	4(x)

2) The dollars per discharge point shall equal an amount such that the total quality incentive payments made to all qualified hospitals shall equal seven percent (7.00%) of total hospital payments in the previous state fiscal year.

d) A hospital shall have the opportunity to request a reconsideration of points awarded that are provided with the preliminary scoring letter.

i. To be considered for payment, a hospital shall submit a survey through the data collection tool on or before May 31 of each year.

ii. A preliminary scoring letter containing the scores and scoring rationale shall be provided to a hospital that submits a survey within ninety calendar days of May 31. The preliminary scoring letter will be delivered to each hospital that submitted a survey via the data collection tool.

iii. A hospital that believes a measure in the preliminary scoring letter was inaccurately scored may submit a reconsideration request within ten business days of delivery of the preliminary scoring letter. The request must be made by electronic notice.

1) The reconsideration request must be provided following the process established through the HQIP scoring review and reconsideration period user guide. Reconsideration requests may not be accepted if they are not provided through this process.

1 iv. A response to the reconsideration request shall be provided within ten business
 2 days upon receipt of the reconsideration request via electronic notice. The
 3 response shall provide whether a change to a measure score was made or if the
 4 reconsideration request was denied.

5 v. If a hospital is not satisfied with the reconsideration response, the hospital may
 6 request the reconsideration be escalated to the Special Financing Division
 7 Director within five business days of delivery of the reconsideration response.
 8 Any escalations must be provided to the Department via electronic notice.

9 1) The escalation request must be provided following the process established
 10 through the HQIP scoring review and reconsideration period user guide.
 11 Escalation requests may not be accepted if they are not provided through
 12 this process.

13 vi. A response to the escalation request shall be provided to the hospital within ten
 14 business days via electronic notice. The response shall provide whether a
 15 change to a measure score was made or if the escalation request was denied.
 16 The escalation response is final, and points awarded may not be reconsidered
 17 further.

18 vii. No other reconsiderations of points awarded, both preliminary and final, may be
 19 accepted by the Department outside of this process. The Department's decision
 20 is not an adverse action subject to administrative or judicial review under the
 21 Colorado Administrative Procedure Act (ACA).

22 8.3004-G-0.E.7 RURAL SUPPORT PROGRAM HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

23 a. 1. Qualified hospitals. Hospitals that meet all the following criteria:

24 i. a. Is state licensed as a Critical Access Hospital or is a Rural Hospital,
 25 participating in Colorado Medicaid,

26 ii. b. Is a nonprofit hospital, and

27 iii. c. Meets one of the below:

28 1) i. Their average net patient revenue for the three-year 2016, 2017, and
 29 2018 cost report period is in the bottom ten percent (10%) for all Critical
 30 Access Hospitals and Rural Hospitals, or

31 2) ii. Their funds balance for the 2019 cost report period is in the bottom two
 32 and one-half percent (2.5%) for all Critical Access Hospitals and Rural
 33 Hospitals not in the bottom 10% of the three-year average net patient
 34 revenue for all Critical Access Hospitals and Rural Hospitals,

35 b. 2. Calculation methodology for payment. For a qualified hospital, the annual
 36 payment shall equal twelve million dollars (\$12,000,000) divided by the number of
 37 qualified hospitals.

38 c. 3. The payment shall be calculated once and reimbursed in monthly installments
 39 over the subsequent five federal fiscal years.

- 1 d. ~~4.~~—A qualified hospital must submit an attestation form every year to receive the
 2 available funds. If a qualified hospital does not submit the required attestation form their
 3 funds for the year shall be redistributed to other requalified hospitals.

4 8.3004.H0.E.8 REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENTS AND
 5 DISPROPORTIONATE SHARE HOSPITAL PAYMENT

- 6 a. ~~4.~~—The Enterprise shall calculate the Supplemental Medicaid Payments and DSH
 7 Payment under this section on an annual basis in accordance with the Act. Upon
 8 receiving a favorable recommendation by the Enterprise Board, the Supplemental
 9 Medicaid Payments and DSH Payment shall be subject to approval by the CMS and the
 10 Medical Services Board. Following these approvals, the Enterprise shall notify hospitals,
 11 in writing or by electronic notice, of the annual payment made each year, the
 12 methodology to calculate such payment, and the payment reimbursement schedule.
 13 Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days
 14 prior to any change in the dollar amount of the Supplemental Medicaid Payments or the
 15 DSH Payment to be reimbursed.

16 8.3004.H0.E.9 HOSPITAL TRANSFORMATION PROGRAM

- 17 a. Qualified hospitals shall participate in the Hospital Transformation Program (HTP). The
 18 HTP leverages supplemental payments as incentives designed to improve patient
 19 outcomes and lower Medicaid cost. Qualified hospitals are required to complete certain
 20 reporting activities. Qualified hospitals not completing a reporting activity shall have their
 21 supplemental Medicaid payments reduced. The reduced supplemental Medicaid
 22 payments shall be paid to qualified hospitals completing the reporting activity. The HTP is
 23 a multi-year program with a program year (PY) being on a federal fiscal year (October 1
 24 through September 30) basis.
- 25 i. ~~1.~~—Qualified hospitals. Hospitals providing hospital services to Medicaid
 26 clients shall participate in the HTP except as provided below.
- 27 ii. ~~2.~~—Excluded hospitals. Psychiatric Hospitals, Rehabilitation Hospitals, or
 28 Long-Term Care Hospitals shall not participate in the HTP.
- 29 iii. ~~3.~~—Calculation methodology for payment.
- 30 1) ~~a.~~—Each program year includes reporting activities that a qualified hospital is
 31 required to complete. A qualified hospital not completing a reporting activity
 32 shall have their HTP Supplemental Medicaid Payments reduced by a
 33 designated percent.
- 34 2) ~~b.~~—The dollars not paid to those qualified hospitals shall be redistributed to
 35 qualified hospitals completing the reporting activity. A qualified hospital's
 36 distribution shall equal their percent of HTP Supplemental Medicaid
 37 Payments to the total HTP Supplemental Medicaid Payments for all qualified
 38 hospitals completing the reporting activity, multiplied by the total reduced
 39 dollars for qualified hospitals not completing the reporting activity.
- 40 3) ~~c.~~—The reduction and redistribution shall be calculated using the HTP
 41 Supplemental Medicaid Payments effective during the reporting activity
 42 period. The reduction and redistribution for reporting activities shall occur at
 43 the same time during the last quarter of the subsequent program year.

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- 4) ~~e.~~—There are five HTP reporting activities. The reporting activities are listed below, along with the total percent at-risk associated with each reporting activity.
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- a) ~~i.~~—Application (1.5% at-risk total) – Qualified hospitals must provide interventions and measures focusing on improving processes of care and health outcomes and reducing avoidable utilization and cost. The percent at-risk shall be scored on timely and satisfactory submission.
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- b) ~~ii.~~—Implementation Plan (1.5% at-risk total) – Qualified hospitals must submit a plan to implement interventions with clear milestones that shall impact their measures. The percent at-risk shall be scored on timely and satisfactory submission.
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- c) ~~iii.~~—Quarterly Reporting (0.5% at-risk per report) – Qualified hospitals must report quarterly on the different activities that occurred in that quarter. For any given quarter, this includes interim activity reporting, milestone reporting, self-reported data associated with the measures, and Community and Health Neighborhood Engagement (CHNE) reporting. The percent at-risk shall be scored on timely and satisfactory submission.
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- d) ~~iv.~~—Milestone Report (2.0% at-risk per report in PY 2, 4.0% at-risk per report in PY 3) – Qualified hospitals must report on achieved/missed milestones over the previous two quarters. The percent at-risk shall be scored on timely and satisfactory submission and for achievement of milestones. Qualified hospitals that miss a milestone can have the reduction for the milestone reduced by 50% if they submit a course correction plan with the subsequent Milestone Report. A course correction reduction for a missed milestone can only be done once per intervention.
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- e) ~~v.~~—Sustainability Plan (8.0% at-risk total) – Qualified hospitals must submit a plan demonstrating how the transformation efforts will be maintained after the HTP is over. The percent at-risk shall be scored on timely and satisfactory submission.
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- 5) ~~f.~~—A qualified hospital not participating in the HTP may have the entirety of their HTP Supplemental Medicaid Payments withheld.

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iv. A hospital shall have the opportunity to request a reconsideration of scores for reporting compliance, milestone completion (including milestone amendments and course corrections), and performance measure data accuracy.

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1) The scoring review and reconsideration period begins when the Department notifies hospitals of initial scores. This period consists of multiple steps that will span 45 business days.

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a) The Department completes initial review of reports within 20 business days of report due date.

1 b) The Department notifies hospital of scores available for viewing and
2 the scoring review and reconsideration period begins within 21
3 business days of report due date.

4 c) The hospital request for reconsideration is due within 10 business
5 days of release of initial scores.

6 d) The Department issues final scores and reconsideration decisions
7 within 14 business day of the scoring review and reconsideration
8 period close date.

9 2) All hospitals will receive electronic notification when initial scores are
10 released to the Department's web portal.

11 3) To submit a request for reconsideration of an initial score, a hospital
12 must utilize the scoring review and reconsideration form available on the
13 Department's web portal. It must identify the specific scoring elements
14 the hospital would like reconsidered and the rationale for the
15 reconsideration request. The form must be emailed following the proper
16 guidelines as mentioned on the form.

17 4) Late report submissions and report revisions are not accepted through
18 the reconsideration process.

19 a) The hospital will receive an electronic notification of the outcome of
20 the reconsideration request.

21 5) If a hospital is not satisfied with the reconsideration response, the
22 hospital may request the reconsideration be escalated to the Project
23 Manager or the Special Financing Division Director. Initial escalations to
24 the Project Manager must be made within five business days of delivery
25 of the reconsideration response. Final escalations to the Special
26 Financing Division Director must be made within 15 business days of
27 delivery of the reconsideration response. Any escalations must be
28 provided to the Department via electronic notice.

29 a) The escalation request must be provided following the process
30 established through the HTP scoring review and reconsideration
31 period user guide. Escalation requests may not be accepted if they
32 are not provided through this process.

33 6) A response to the initial escalation request shall be provided to the
34 hospital within ten business days via electronic notice. A response to the
35 final escalation request shall be provided to the hospital within 20
36 business days via electronic notice. Any response shall provide whether
37 a change to a measure score was made or if the escalation request was
38 denied. The escalation response is final, and points awarded may not be
39 reconsidered further.

40 2)7) No other reconsiderations of scores, both preliminary and final, may be
41 accepted by the Department outside of this process. The Department's
42 decision is not an adverse action subject to administrative or judicial
43 review under the Colorado Administrative Procedure Act (ACA).