Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2021-22 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 3.8000
Rule Number: MSB 21-10-19-A
Division / Contact / Phone: Special Financing / Riley DeValois / 303-866-6621

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) 2021-22 Hospital Affordability and Sustainability (HAS) provider fees and supplemental payments. Inpatient per-diem fees and outpatient percentage fees have been updated to account for changes to estimated Medicaid expansion costs, estimated administration costs, and HAS supplemental payments. The rule also includes revisions to the disproportionate share hospital (DSH) supplemental payment for the FFY 2022 DSH allotment increase from the Centers for Medicare and Medicaid Services (CMS) and revisions to the hospital quality incentive payment (HQIP) supplemental payment for changes recommended by the HQIP subcommittee and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board. Lastly, there are some minor revisions to further clarify the scope of the CHASE and how it operates.

   The Department submitted a state plan amendment (SPA) on 12/8/2021 to the CMS and expects approval in the next several months. In addition, the Department presented FFY 2021-22 HAS provider fees and supplemental payments to the CHASE Board on 12/14/2021, which approved the fees and payments. FFY 2021-22 provider fees and supplemental payments will be implemented only after the CMS and the MSB approval.

   For FFY 2021-22, hospitals will pay $1.14 billion in fees, which will generate $3.54 billion in federal funds for Colorado. Hospitals will receive $1.59 billion in supplemental and quality incentive payments. Currently, more than 610,000 Coloradans are enrolled in Medicaid and CHP+ coverage financed with hospital provider fees. As the HAS provider fee funds the Department's administrative costs, there is no impact on state General Fund.

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:

3. Federal authority for the Rule, if any:

Initial Review	**01/14/22**	Final Adoption	**02/14/22**
Proposed Effective Date	**04/14/22**	Emergency Adoption	

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2021-22 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 3.8000
Rule Number: MSB 21-10-19-A
Division / Contact / Phone: Special Financing / Riley DeValois / 303-866-6621

42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
Sections 25.5-4-402.4(4)(b), (g), C.R.S.

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2021-22 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 3.8000
Rule Number: MSB 21-10-19-A
Division / Contact / Phone: Special Financing / Riley DeValois / 303-866-6621

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 $2.97 billion in annual health care expenditures for more than 610,000 Coloradans and will provide more than $456 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 $2.97 billion in annual health care expenditures for more than 610,000 Coloradoans and more than $456 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 610,000 currently enrolled persons or the ability to fund the HAS supplemental payments.

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2021-22 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 3.8000
Rule Number: MSB 21-10-19-A
Division / Contact / Phone: Special Financing / Riley DeValois / 303-866-6621

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.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

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

8.3001: DEFINITIONS

"Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.

"CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).

"CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

"CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

"CMS" means the federal Centers for Medicare and Medicaid Services.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.

"Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).

"Essential Access Hospital" means a Critical Access Hospital or General Hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget and having 25 or fewer licensed beds.

"Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.

“Fund” means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).

“General Hospital” means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

“High Volume Medicaid and CICP Hospital” means a hospital with at least 27,500 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.

“Health Maintenance Organization” or “HMO” means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.

“Hospital-Specific Disproportionate Share Hospital Limit” or “Hospital-Specific DSH Limit” means a hospital’s maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

“Hospital Transformation Program Supplemental Medicaid Payments” or “HTP Supplemental Medicaid Payments” means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.B.,

2. Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.C., and

3. Essential Access Hospital Supplemental Medicaid Payment described in Section 8.3004.E.

The HTP Supplemental Medicaid Payments ~~does~~ do not include the Hospital Quality Incentive Payment described in Section 8.3004.F. or Rural Support Program Hospital Supplemental Medicaid Payment described in Section 8.3004.G.

“Inpatient Services Fee” means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

“Inpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

“Long Term Care Hospital” means a General Hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment.

“Managed Care Day” means an inpatient hospital day for which the primary payer is a managed care health plan, including ~~a~~ HMO, PPO, POS, and EPO days.

“Medicaid Day” means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

“Medicaid Managed Care Day” means a Managed Care Day for which the primary payer is Medicaid.

“Medicare Cost Report” means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

“MMIS” means the Medicaid Management Information System, the Department’s Medicaid claims payment system.

"MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospital days.

"Non-Managed Care Day" means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.

"Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local government.

"Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges.

"Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

"Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.

"POS" or "Point of Service" means a type of managed care health plan that charges patients less to receive services from providers in the plan's network and requires a referral from a primary care provider to receive services from a specialist.

"PPO" or "Preferred Provider Organization" means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.

"Privately-Owned Hospital" means a hospital that is privately owned and operated.

"Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

"Rehabilitation Hospital" means an inpatient rehabilitation facility.

"Respiratory Hospital" means a hospital that primarily specializes in respiratory related diseases.

"Rural Hospital" means a hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget.

"State-Owned Government Hospital" means a hospital that is either owned or operated by the State.

"State University Teaching Hospital" means a High-Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

"Supplemental Medicaid Payments" means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in ~~Sections~~ 8.3004.B.,
2. Inpatient Hospital Supplemental Medicaid Payment described in 8.3004.C.,
3. Essential Access Hospital Supplemental Medicaid Payment described in 8.3004.E.,
4. Hospital Quality Incentive Payment described in 8.3004.F., and
5. Rural Support Program Hospital Supplemental Medicaid Payment described in 8.3004.G.

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

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

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.~~7592~~6365% of total hospital outpatient charges with the following exception.

    a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to 1.~~7444~~6228% of total hospital outpatient charges.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $105.53~~96.42~~ per day for Managed Care Days and $471.76~~31.01~~ per day for all Non-Managed Care Days with the following exceptions:

    a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $55.10~~9.34~~ per day for Managed Care Days and $246.31~~25.03~~ per day for all Non-Managed Care Days, and.

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to $42.21~~38.56~~ per day for Managed Care Days and $188.70~~172.41~~ per day for Non-Managed Care Days.

8.3003.C. ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

1. The Enterprise shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed. ~~and the fee assessment 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 DSH Limit.~~

2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Enterprise will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

3. In order to receive a Supplemental Medicaid Payment or DSH 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: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. Outpatient billed costs equal outpatient billed charges multiplied by the Medicare cost-to-charge ratio. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, ~~and~~ Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for ~~Major~~ Pediatric ~~Teaching~~ Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to qualified hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.C. INPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients are qualified to receive this payment, except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal Medicaid Days multiplied by an adjustment factor. The adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, ~~and~~ Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to qualified hospitals shall not exceed the Inpatient Upper Payment Limit. The adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

    a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

    b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

    c. Critical Access Hospitals with at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt

from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

   a. Total funds for the payment shall equal $~~219,367,288~~226,610,302.

   b. A qualified hospital with CICP write-off costs greater than 1,000.00% of the state-wide average shall receive a payment equal to ~~88~~96.00% of their Hospital-Specific DSH Limit. A qualified Critical Access Hospital shall receive a payment equal to 96% of their Hospital Specific DSH Limit. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than 2,000 Medicaid Days shall receive a payment equal to ~~88~~50.00% of their Hospital-Specific DSH Limit.

   c. All remaining qualified hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining funds.

   d. No remaining qualified hospital shall receive a payment exceeding 96.00% of their Hospital-Specific DSH Limit as specified in federal regulation. If a qualified hospital's payment exceeds 96.00% of their Hospital-Specific DSH Limit, the payment shall be reduced to 96.00% of the Hospital-Specific DSH Limit. The amount of the reduction shall then be redistributed to other qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit.

   e. A new CICP hospital shall have their Hospital-Specific DSH Limit equal to 10.00%. A Low MIUR hospital shall have their Hospital-Specific DSH Limit equal 10.00%.

      i. A new CICP hospital is a hospital approved as a CICP provider after October 1, ~~2019~~2021.

      ii. A low MIUR hospital is a hospital with a MIUR less than or equal to 15.00%.

8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal adjusted discharge points multiplied by dollars per-adjusted discharge point.

   a. Adjusted discharge points equal normalized points awarded multiplied by adjusted Medicaid discharges. Normalized points awarded equals the sum of points awarded, normalized to a ~~100-point~~100-point scale for measures a hospital is not eligible to complete. There are ~~eleven~~ fifteen measures separated into three measure groups.

   ~~b. Due to the COVID-19 pandemic, not all measures were implemented resulting in only 65 available awarded points. Every qualified hospital's points awarded shall be normalized to the 100-point scale.~~

The measures and measure groups are:

Maternal Health and Perinatal Care Measure Group

1. Exclusive Breast Feeding
2. Cesarean Section
3. Perinatal Depression and Anxiety
4. Maternal Emergencies and Preparedness
5. ~~Reproductive Life/Family Planning~~Reduction of Peripartum Racial and Ethnic Disparities
6. ~~Incidence of Episiotomy~~Reproductive Life/Family Planning

Patient Safety Measure Group

7. ~~Clostridium Difficile~~Zero Suicide
8. Clostridium Difficile~~Adverse Event~~
9. Sepsis~~Culture of Safety Survey~~
10. Antibiotics Stewardship
11. Adverse Event
12. Culture of Safety Survey
13. Handoffs and Sign-Outs

Patient Experience Measure Group

14~~0~~. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

15~~1~~. Advance Care Plan

Adjusted Medicaid Discharges equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.

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

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

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.

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)

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.