

Title of Rule: Revisions to the Medicaid Assistance Rule Concerning the Health Care Affordability and Sustainability Fee, Section 8.3000
Rule Number: MSB 23-07-05-A
Division / Contact / Phone: Special Financing Division / Nancy Dolson / 303-866-3698

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 proposed rule change will define a new Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) hospital classification for the safety net hospital that serves Pueblo and the southern Colorado region, Parkview Medical Center. This rule change will ensure continuity of Parkview's CHASE provider fee-funded payments upon its expected acquisition by UHealth, allowing continuity of health care services, including birthing services, for the Pueblo region.

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:

Parkview Medical Center is the safety net in Pueblo County and southern Colorado as the region's largest Medicaid provider and only hospital participant in the Colorado Indigent Care Program. Parkview is also the top 6th hospital in the state in number of Medicaid-covered births, with 1,124 Medicaid-covered births in 2022, which was more than 2/3rds of the 1,703 total births in Pueblo County. Moreover, besides Colorado Springs 45 minutes to the north, the only other birthing hospitals within 1 hour of Pueblo are three critical access hospitals.

Parkview Medical Center is facing significant financial challenges: for FY 2022, Parkview recorded a net operating loss of (\$34.6 million) and is projecting similar losses in FY 2023 and beyond. Parkview approached UHealth about an acquisition to ensure financial viability for this important safety net for the community. This acquisition has been approved by the Federal Trade Commission and the Colorado Attorney General's Office with stakeholder engagement. On January 24, 2023, Parkview and UHealth entered into an Integration and Affiliation Agreement, which is currently on hold while this regulatory issue is resolved. This rule change will remove this regulatory barrier to ensure continuity of Parkview's CHASE provider fee-funded payments upon its expected acquisition by UHealth.

Without this rule change, Pueblo residents' access to hospital care in the greater Pueblo region will be jeopardized because following acquisition, Parkview and UHealth would realize a (\$26 million) net impact to their CHASE reimbursement. If the rule change is not made and therefore UHealth acquisition is not finalized, Parkview Medical Center will be faced with difficult choices to reduce its losses to meet its debt obligations.

Initial Review
Proposed Effective Date

07/14/23

Final Adoption
Emergency Adoption

09/08/23
07/14/23

DOCUMENT #06

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3. Federal authority for the Rule, if any:

42 CFR § 447; 42 CFR § 433.68

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
Section 25.5-4-402.4(5)(g), C.R.S. (2023)

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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.

The residents of Pueblo and the southern Colorado region are affected and will benefit from the proposed rule. Parkview Medical Center is the safety net hospital serving Pueblo and southern Colorado. Parkview is facing significant financial challenges: for FY 2022, Parkview recorded a net operating loss of (\$34.6 million) and is projecting similar losses in FY 2023 and beyond. Parkview approached UHealth about an acquisition to ensure financial viability for this important safety net for the community.

UHealth's acquisition of Parkview Medical Center was expected to occur on July 1, 2023. The acquisition is currently on hold due to the recent discovery of an unintended consequence in the CHASE hospital provider fee-funded supplemental payments for Parkview Medical Center that would be triggered on the occasion of its acquisition by UHealth. Specifically, without the new CHASE hospital classification definition proposed by this rule, once acquired by UHealth, Parkview and UHealth would receive (\$26 million) net impact to their CHASE reimbursement.

There are no costs of the proposed rule: this rule will maintain current levels of CHASE provider fees and related for Parkview Medical Center, UHealth, and all other hospitals in the state.

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 proposed rule maintains the current level of CHASE provider fees and payments for Parkview Medical Center, UHealth, and all other hospitals in the state.

Pueblo area residents will continue to receive access to health care services at the region's largest Medicaid provider and only hospital participant in the Colorado Indigent Care Program. Parkview provides some services that otherwise would be nearly non-existent in Pueblo County, such as obstetrics and comprehensive women's health care. Parkview is the top 6th hospital in the state in number of Medicaid-covered births, with 1,124 Medicaid-covered births in 2022, which was more than 2/3rds of the 1,703 total births in Pueblo County. Moreover, besides Colorado Springs 45 minutes to the north, the only other birthing hospitals within 1 hour of Pueblo are three, small critical access hospitals.

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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.

There are no costs to the Department or other agencies with this proposed rule. This rule maintains the current CHASE fees and payments for Parkview Medical Center and there are no additional administrative costs associated with this rule.

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

The benefits of this proposed rule are maintenance of access to hospital services at the largest Medicaid provider, Colorado Indigent Care Program participant, and only hospital providing birthing services in Pueblo. There are no costs with this proposed rule as there are no changes in CHASE provider fees or payments with this proposed rule for any hospital. There are also no associated changes in administrative costs for the Department or other agencies. There are no benefits to inaction and the costs of inaction are substantial: without the proposed rule, access to hospital services including obstetrics and comprehensive women's care in the Pueblo region will be jeopardized.

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

There are no less costly or intrusive methods to achieve the purpose of this proposed rule as it maintains current reimbursement levels for Parkview Medical Center and all other hospitals in the state with no increase in administrative costs.

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.

The Department cannot maintain the same CHASE provider fee-funded reimbursement for Parkview Medical Center, the safety net hospital that serves Pueblo and the southern Colorado region, without defining a new hospital classification in rule.

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

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

20 **8.3001: DEFINITIONS**

21 "Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-
22 402.4, C.R.S.

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

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

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

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

28 "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-
29 4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and
30 Environment.

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

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

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

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

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

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

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

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

14 “Heart Institute Hospital” means a hospital recognized as a HeartCARE Center by the American College
15 of Cardiology (ACC) with at least 25,000 Medicaid Non-Managed Care Days per year.

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

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

- 21 1. Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.B.,
- 22 2. Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.C., and
- 23 3. Essential Access Hospital Supplemental Medicaid Payment described in Section
24 8.3004.E.

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

28 “Independent Metropolitan Hospital” means an independently owned and operated hospital located within
29 a Metropolitan Statistical Area designated by the United States Office of Management and Budget with at
30 least 1,500 Medicaid Days per year.

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

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

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

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

1 “Safety Net Metropolitan Hospital” means a hospital that provides services within the Pueblo, Colorado
 2 Metropolitan Statistical Area designated by the United States Office of Management and Budget (Pueblo
 3 MSA) with no less than 15,000 Days per year reported on its Medicare Cost Report, Worksheet S-3, Part
 4 1, Column 7 (Title XIX), lines 1-18, and 28 (adult, pediatrics, intensive care, and subunits).

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

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

10 “Supplemental Medicaid Payments” means the:

- 11 1. Outpatient Hospital Supplemental Medicaid Payment described in 8.3004.B.,
- 12 2. Inpatient Hospital Supplemental Medicaid Payment described in 8.3004.C.,
- 13 3. Essential Access Hospital Supplemental Medicaid Payment described in 8.3004.E.,
- 14 4. Hospital Quality Incentive Payment described in 8.3004.F., and
- 15 5. Rural Support Program Hospital Supplemental Medicaid Payment described in 8.3004.G.

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

19 “Urban Center Safety Net Specialty Hospital” means a hospital located in a Metropolitan Statistical Area
 20 designated by the United States Office of Management and Budget where its Medicaid Days plus CICP
 21 Days relative to total inpatient hospital days per year, rounded to the nearest percent, equals, or exceeds,
 22 65%

23 **8.3002: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS**

24 **8.3002.A. DATA REPORTING**

- 25 1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the
 26 distribution of supplemental payments, the Enterprise shall distribute a data reporting template to
 27 all hospitals. The Enterprise shall include instructions for completing the data reporting template,
 28 including definitions and descriptions of each data element to be reported. Hospitals shall submit
 29 the requested data to the Enterprise within thirty (30) calendar days after receiving the data
 30 reporting template or on the stated due date, whichever is later. The Enterprise may estimate any
 31 data element not provided directly by the hospital.
 - 32 a. For hospitals that do not participate in the electronic funds process utilized by the
 33 Enterprise for the collection of fees, payments to hospitals shall be processed by the
 34 Enterprise within two business days of receipt of the Outpatient Services Fee and
 35 Inpatient Services Fee.
 - 36 b. For hospitals that do not participate in the electronic funds process utilized by the
 37 Enterprise for the disbursement of payments, payments to hospitals shall be processed

1 through a warrant (paper check) by the Enterprise within two business days of receipt of
2 the Outpatient Services Fee and Inpatient Services Fee.

3 2. Hospitals shall submit days and charges for Medicaid Managed Care, out-of-state Medicaid, and
4 uninsured patients, Managed Care Days, and any additional elements requested by the
5 Enterprise.

6 3. The Enterprise shall distribute a data confirmation report to all hospitals annually. The data
7 confirmation report shall include a listing of relevant data elements used by the Enterprise in
8 calculating the Outpatient Services Fee, the Inpatient Services Fee and the supplemental
9 payments. The data confirmation report shall clearly state the manner and timeline in which
10 hospitals may request revisions to the data elements recorded by the Enterprise. Revisions to the
11 data will not be permitted by a hospital after the dates outlined in the data confirmation report.

12 4. The hospital shall certify that based on best information, knowledge, and belief, the data included
13 in the data reporting template is accurate, complete, and truthful, is based on actual hospital
14 records, and that all supporting documentation will be maintained for a minimum of six years. The
15 certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an
16 individual who reports directly to the Chief Executive Officer or Chief Financial Officer with
17 delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the
18 Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

19 **8.3002.B. FEE ASSESSMENT AND COLLECTION**

20 1. Establishment of Electronic Funds Process. The Enterprise shall utilize an Automated Clearing
21 House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee
22 from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental
23 payments in financial accounts authorized by hospitals. The Enterprise shall supply hospitals with
24 all necessary information, authorization forms and instructions to implement this electronic
25 process.

26 2. The Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and
27 collected in twelve monthly installments. Payments to hospitals will be calculated on an annual
28 basis and disbursed in twelve monthly installments.

29 a. For those hospitals that participate in the electronic funds process utilized by the
30 Enterprise, fees will be assessed and payments will be disbursed on the second Friday of
31 the month, except when State offices are closed during the week of the second Friday,
32 then fees will be assessed and payment will be disbursed on the following Friday of the
33 month. If the Enterprise must diverge from this schedule due to unforeseen
34 circumstances, the Enterprise shall notify hospitals in writing or by electronic notice as
35 soon as possible.

36 i. The Enterprise may assess fees and disburse payments for Urban Center Safety
37 Net Specialty Hospitals on an alternate schedule determined by the Department.

38 b. At no time will the Enterprise assess fees or disburse payments prior to the state fiscal
39 year for which they apply.

40 3. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and
41 Inpatient Services Fee must participate in the electronic funds process utilized by the Enterprise
42 for the collection of fees and the disbursement of payments unless the Enterprise has approved
43 an alternative process. A hospital requesting to not participate in the electronic fee collection
44 process and/or payment process must submit a request in writing or by electronic notice to the

1 Enterprise describing an alternative fee collection process and/or payment process. The
 2 Enterprise shall approve or deny the alternative process in writing or by electronic notice within 30
 3 calendar days of receipt of the request.

4 a. For hospitals that do not participate in the electronic funds process utilized by the
 5 Enterprise for the collection of fees, payments to hospitals shall be processed by the
 6 Enterprise within two business days of receipt of the Outpatient Services Fee and
 7 Inpatient Services Fee.

8 b. For hospitals that do not participate in the electronic funds process utilized by the
 9 Enterprise for the disbursement of payments, payments to hospitals shall be processed
 10 through a warrant (paper check) by the Enterprise within two business days of receipt of
 11 the Outpatient Services Fee and Inpatient Services Fee.

12 **8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE**

13 **8.3003.A. OUTPATIENT SERVICES FEE**

14 1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The
 15 Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the
 16 Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and
 17 1396b(w)(4).

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

20 3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as
 21 1.8705% of total hospital outpatient charges with the following exception.

22 a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to
 23 1.8548% of total hospital outpatient charges.

24 **8.3003.B. INPATIENT SERVICES FEE**

25 1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The
 26 Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the
 27 Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and
 28 1396b(w)(4).

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

31 3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day
 32 basis of \$114.10 per day for Managed Care Days and \$510.05 per day for all Non-Managed Care
 33 Days with the following exceptions:

34 a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to
 35 \$59.57 per day for Managed Care Days and \$266.30 per day for all Non-Managed Care
 36 Days, and.

37 b. Essential Access Hospitals' Inpatient Services Fee is discounted to \$45.64 per day for
 38 Managed Care Days and \$204.02 per day for Non-Managed Care Days.

1 **8.3003.C. ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE**

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

20 **8.3003.D. REFUND OF EXCESS FEES**

- 21 1. If, at any time, fees have been collected for which the intended expenditure has not received
 22 approval for federal Medicaid matching funds by CMS at the time of collection, the Enterprise
 23 shall refund to each hospital its proportion of such fees paid within five business days of receipt.
 24 The Enterprise shall notify each hospital of its refund amount in writing or by electronic notice.
 25 The refunds shall be paid to each hospital according to the process described in Section
 26 8.3002.B.
- 27 2. After the close of each federal fiscal year the Enterprise shall present a summary of fees
 28 collected, expenditures made or encumbered, and interest earned in the Fund during the federal
 29 fiscal year to the Enterprise Board.
- 30 a. If fees have been collected for which the intended expenditure has received approval for
 31 federal Medicaid matching funds by CMS, but the Enterprise has not expended or
 32 encumbered those fees at the close of each federal fiscal year:
- 33 i. The total dollar amount to be refunded shall equal the total fees collected, less
 34 expenditures made or encumbered, plus any interest earned in the Fund, less
 35 the minimum Fund reserve recommended by the Enterprise Board.
- 36 ii. The refund amount for each hospital shall be calculated in proportion to that
 37 hospital's portion of all fees paid during the federal fiscal year.
- 38 iii. The Enterprise shall notify each hospital of its refund in writing or by electronic
 39 notice 30 days before payment is made. The refunds shall be paid to each
 40 hospital by September 30 of each year according to the process described in
 41 Section 8.3002.B.

42 **8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS**

1 **8.3004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS**

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

21 **8.3004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT**

- 22 1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients are
23 qualified to receive this payment except as provided below.
- 24 2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.
- 25 3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal
26 outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment
27 factor. Outpatient billed costs equal outpatient billed charges multiplied by the Medicare cost-to-
28 charge ratio. The percentage adjustment factor may vary for State-Owned Government Hospitals,
29 Non-State-owned Government Hospitals, Privately-Owned Hospitals, for urban and rural
30 hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban
31 Center Safety Net Specialty Hospitals, or for other hospital classifications, except that the
32 adjustment factor for a Safety Net Metropolitan Hospital shall be equal to the adjustment factor for
33 a Privately-Owned Independent Metropolitan Hospital. Total payments to qualified hospitals shall
34 not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each
35 qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

36 **8.3004.C. INPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT**

- 37 1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients are qualified
38 to receive this payment, except as provided below.
- 39 2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.
- 40 3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal
41 Medicaid Non-Managed Care Days multiplied by an adjustment factor. The adjustment factor may
42 vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, Privately-

1 Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for
 2 Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other
 3 hospital classifications, except that the adjustment factor for a Safety Net Metropolitan Hospital
 4 shall be at least equal to the adjustment factor for a Privately-Owned Independent Metropolitan
 5 Hospital. Total payments to qualified hospitals shall not exceed the Inpatient Upper Payment
 6 Limit. The adjustment factor for each qualified hospital shall be published annually in the
 7 Colorado Medicaid Provider Bulletin.

8 **8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT**

9 1. Qualified hospitals.

- 10 a. Hospitals that are Colorado Indigent Care Program providers and have at least two
 11 obstetricians who have staff privileges at the hospital and who have agreed to provide
 12 obstetric care for Medicaid clients or are exempt from the obstetrician requirement
 13 pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.
- 14 b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of
 15 all MIURs for Colorado hospitals and have at least two obstetricians who have staff
 16 privileges at the hospital and who have agreed to provide obstetric care for Medicaid
 17 clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-
 18 4(d)(2)(A) are qualified to receive this payment.
- 19 c. Critical Access Hospitals with at least two obstetricians who have staff privileges at the
 20 hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt
 21 from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified
 22 to receive this payment

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

24 3. Calculation methodology for payment.

- 25 a. Total funds for the payment shall equal \$244,068,958.
- 26 b. A qualified hospital with CICIP write-off costs greater than 700% of the state-wide average
 27 shall receive a payment equal to 96.00% of their Hospital-Specific DSH Limit. A qualified
 28 Critical Access Hospital shall receive a payment equal to 96.00% of their Hospital
 29 Specific DSH Limit. A qualified hospital not owned/operated by a healthcare system
 30 network within a Metropolitan Statistical Area and having less than 2,400 Medicaid days
 31 shall receive a payment equal to 96.00% of their Hospital-Specific DSH Limit.
- 32 c. All remaining qualified hospitals shall receive a payment calculated as the percentage of
 33 uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by
 34 the remaining funds.
- 35 d. No remaining qualified hospital shall receive a payment exceeding 96.00% of their
 36 Hospital-Specific DSH Limit as specified in federal regulation. If a qualified hospital's
 37 payment exceeds 96.00% of their Hospital-Specific DSH Limit, the payment shall be
 38 reduced to 96.00% of the Hospital-Specific DSH Limit. The amount of the reduction shall
 39 then be redistributed to other qualified hospitals not exceeding 96.00% of their Hospital-
 40 Specific DSH Limit based on the percentage of uninsured costs to total uninsured costs
 41 for all qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit.

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

3 i. A new CICP hospital is a hospital approved as a CICP provider after October 1,
4 2022.

5 ii. A low MIUR hospital is a hospital with a MIUR less than or equal to 22.50%.

6 **8.3004.E. ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT**

7 1. Qualified hospitals. Essential Access Hospitals are qualified receive this payment.

8 2. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal
9 the available Essential Access funds divided by the total number of qualified Essential Access
10 Hospitals.

11 **8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT**

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

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

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

17 a. Adjusted discharge points equal normalized points awarded multiplied by adjusted
18 Medicaid discharges. Normalized points awarded equals the sum of points awarded,
19 normalized to a 100-point scale for measures a hospital is not eligible to complete. The
20 measures and measure groups are published annually in the Colorado Medicaid Provider
21 Bulletin.

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

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

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

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

34 The multiplier and normalized points awarded for each tier are:

35

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.

4. A hospital shall have the opportunity to request a reconsideration of points awarded that are provided with the preliminary scoring letter.
- a. To be considered for payment, a hospital shall submit a survey through the data collection tool on or before May 31 of each year.
 - b. 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.
 - c. 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.
 - i. 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.
 - d. A response to the reconsideration request shall be provided within ten business days upon receipt of the reconsideration request via electronic notice. The response shall provide whether a change to a measure score was made or if the reconsideration request was denied.
 - e. If a hospital is not satisfied with the reconsideration response, the hospital may request the reconsideration be escalated to the Special Financing Division Director within five business days of delivery of the reconsideration response. Any escalations must be provided to the Department via electronic notice.
 - i. The escalation request must be provided following the process established through the HQIP scoring review and reconsideration period user guide. Escalation requests may not be accepted if they are not provided through this process.
 - f. A response to the escalation request shall be provided to the hospital within ten business days via electronic notice. The response shall provide whether a change to a measure

1 score was made or if the escalation request was denied. The escalation response is final,
2 and points awarded may not be reconsidered further.

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

7 **8.3004.G. RURAL SUPPORT PROGRAM HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT**

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

9 a. Is state licensed as a Critical Access Hospital or is a Rural Hospital, participating in
10 Colorado Medicaid,

11 b. Is a nonprofit hospital, and

12 c. Meets one of the below:

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

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

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

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

24 4. A qualified hospital must submit an attestation form every year to receive the available funds. If a
25 qualified hospital does not submit the required attestation form their funds for the year shall be
26 redistributed to other requalified hospitals.

27 **8.3004.H REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENTS AND**
28 **DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

29 1. The Enterprise shall calculate the Supplemental Medicaid Payments and DSH Payment under
30 this section on an annual basis in accordance with the Act. Upon receiving a favorable
31 recommendation by the Enterprise Board, the Supplemental Medicaid Payments and DSH
32 Payment shall be subject to approval by the CMS and the Medical Services Board. Following
33 these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the
34 annual payment made each year, the methodology to calculate such payment, and the payment
35 reimbursement schedule. Hospitals shall be notified, in writing or by electronic notice, at least
36 thirty calendar days prior to any change in the dollar amount of the Supplemental Medicaid
37 Payments or the DSH Payment to be reimbursed.

38 **8.3004.I HOSPITAL TRANSFORMATION PROGRAM**

- 1 Qualified hospitals shall participate in the Hospital Transformation Program (HTP). The HTP leverages
2 supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost.
3 Qualified hospitals are required to complete certain reporting activities. Qualified hospitals not completing
4 a reporting activity shall have their supplemental Medicaid payments reduced. The reduced supplemental
5 Medicaid payments shall be paid to qualified hospitals completing the reporting activity. The HTP is a
6 multi-year program with a program year (PY) being on a federal fiscal year (October 1 through September
7 30) basis.
- 8 1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients shall participate in
9 the HTP except as provided below.
- 10 2. Excluded hospitals. Psychiatric Hospitals, Rehabilitation Hospitals, or Long-Term Care Hospitals
11 shall not participate in the HTP.
- 12 3. Calculation methodology for payment.
- 13 a. Each program year includes reporting activities that a qualified hospital is required to
14 complete. A qualified hospital not completing a reporting activity shall have their HTP
15 Supplemental Medicaid Payments reduced by a designated percent.
- 16 b. The dollars not paid to those qualified hospitals shall be redistributed to qualified
17 hospitals completing the reporting activity. A qualified hospital's distribution shall equal
18 their percent of HTP Supplemental Medicaid Payments to the total HTP Supplemental
19 Medicaid Payments for all qualified hospitals completing the reporting activity, multiplied
20 by the total reduced dollars for qualified hospitals not completing the reporting activity.
- 21 c. The reduction and redistribution shall be calculated using the HTP Supplemental
22 Medicaid Payments effective during the reporting activity period. The reduction and
23 redistribution for reporting activities shall occur at the same time during the last quarter of
24 the subsequent program year.
- 25 e. There are five HTP reporting activities. The reporting activities are listed below, along
26 with the total percent at-risk associated with each reporting activity.
- 27 i. Application (1.5% at-risk total) – Qualified hospitals must provide interventions
28 and measures focusing on improving processes of care and health outcomes
29 and reducing avoidable utilization and cost. The percent at-risk shall be scored
30 on timely and satisfactory submission.
- 31 ii. Implementation Plan (1.5% at-risk total) – Qualified hospitals must submit a plan
32 to implement interventions with clear milestones that shall impact their measures.
33 The percent at-risk shall be scored on timely and satisfactory submission.
- 34 iii. Quarterly Reporting (0.5% at-risk per report) – Qualified hospitals must report
35 quarterly on the different activities that occurred in that quarter. For any given
36 quarter, this includes interim activity reporting, milestone reporting, self-reported
37 data associated with the measures, and Community and Health Neighborhood
38 Engagement (CHNE) reporting. The percent at-risk shall be scored on timely and
39 satisfactory submission.
- 40 iv. Milestone Report (2.0% at-risk per report in PY 2, 4.0% at-risk per report in PY 3)
41 – Qualified hospitals must report on achieved/missed milestones over the
42 previous two quarters. The percent at-risk shall be scored on timely and

- 1 satisfactory submission and for achievement of milestones. Qualified hospitals
 2 that miss a milestone can have the reduction for the milestone reduced by 50% if
 3 they submit a course correction plan with the subsequent Milestone Report. A
 4 course correction reduction for a missed milestone can only be done once per
 5 intervention.
- 6 v. Sustainability Plan (8.0% at-risk total) – Qualified hospitals must submit a plan
 7 demonstrating how the transformation efforts will be maintained after the HTP is
 8 over. The percent at-risk shall be scored on timely and satisfactory submission.
- 9 f. A qualified hospital not participating in the HTP may have the entirety of their HTP
 10 Supplemental Medicaid Payments withheld.
- 11 4. A hospital shall have the opportunity to request a reconsideration of scores for reporting
 12 compliance, milestone completion (including milestone amendments and course corrections), and
 13 performance measure data accuracy.
- 14 a. The scoring review and reconsideration period begins when the Department notifies
 15 hospitals of initial scores. This period consists of multiple steps that will span 45 business
 16 days.
- 17 i. The Department completes initial review of reports within 20 business days of
 18 report due date.
- 19 ii. The Department notifies hospital of scores available for viewing and the scoring
 20 review and reconsideration period begins within 21 business days of report due
 21 date.
- 22 iii. The hospital request for reconsideration is due within 10 business days of
 23 release of initial scores.
- 24 iv. The Department issues final scores and reconsideration decisions within 14
 25 business day of the scoring review and reconsideration period close date.
- 26 b. All hospitals will receive electronic notification when initial scores are released to the
 27 Department's web portal.
- 28 c. To submit a request for reconsideration of an initial score, a hospital must utilize the
 29 scoring review and reconsideration form available on the Department's web portal. It
 30 must identify the specific scoring elements the hospital would like reconsidered and the
 31 rationale for the reconsideration request. The form must be emailed following the proper
 32 guidelines as mentioned on the form.
- 33 i. Late report submissions and report revisions are not accepted through the
 34 reconsideration process.
- 35 ii. The hospital will receive an electronic notification of the outcome of the
 36 reconsideration request.
- 37 d. If a hospital is not satisfied with the reconsideration response, the hospital may request
 38 the reconsideration be escalated to the Project Manager or the Special Financing
 39 Division Director. Initial escalations to the Project Manager must be made within five
 40 business days of delivery of the reconsideration response. Final escalations to the

1 Special Financing Division Director must be made within 15 business days of delivery of
2 the reconsideration response. Any escalations must be provided to the Department via
3 electronic notice.

4 i. The escalation request must be provided following the process established
5 through the HTP scoring review and reconsideration period user guide.
6 Escalation requests may not be accepted if they are not provided through this
7 process.

8 e. A response to the initial escalation request shall be provided to the hospital within ten
9 business days via electronic notice. A response to the final escalation request shall be
10 provided to the hospital within 20 business days via electronic notice. Any response shall
11 provide whether a change to a measure score was made or if the escalation request was
12 denied. The escalation response is final, and points awarded may not be reconsidered
13 further.

14 f. No other reconsiderations of scores, both preliminary and final, may be accepted by the
15 Department outside of this process. The Department's decision is not an adverse action
16 subject to administrative or judicial review under the Colorado Administrative Procedure
17 Act (ACA).

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