Title of Rule: Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement and Creation of Hospital Transformation Program
Rule Number: MSB 19-11-05-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

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).

   The rule change makes necessary revisions for the federal fiscal year (FFY) 2019-20 Healthcare Affordability and Sustainability (HAS) fee and supplemental payment amounts. Inpatient per-diem fees and Outpatient percentage fees are updated to account for changes to estimated Medicaid expansion costs, estimated administration costs, and HAS supplemental payments. Without the rule change there will not be enough HAS fee to fund Colorado Medicaid and CHP+ expansions and HAS supplemental payments.

   The Rule change includes the creation of the Inpatient supplemental payment, Essential Access supplemental payment, and the Hospital Transformation Program (HTP).

   The Inpatient Base Rate supplemental payment is now the Inpatient supplemental payment. The new Inpatient supplemental payment is calculated using a hospital's Medicaid patient days not their Medicaid Base Rate, allowing for greater fluctuation in payments based on changing Medicaid utilization. The Uncompensated Care Cost (UCC) Medicaid payment is now the Essential Access supplemental payment. The new Essential Access supplemental payment was one of two parts creating the UCC supplemental payment in prior years. The Essential Access part continues while the non-Essential access part is removed with its funding being absorbed into the Inpatient supplemental payment. The new HTP leverages supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost. Hospitals must work to achieve certain milestones established by the hospital in the first year of the program. Hospitals not achieving milestones or completing activities will have their HAS supplemental payments reduced with the reduced payments being paid to hospitals achieving the milestones or completing the activities.

   The Rule also includes revisions to the Disproportionate Share Hospital (DSH) supplemental payment for the FFY 2021 DSH allotment reduction, revisions to the Hospital Quality Incentive Payment (HQIP) supplemental payment for changes recommended by the HQIP sub-committee and approved by the Colorado Healthcare Affordability and Sustainably Enterprise (CHASE) Board, and revisions to language used throughout to increase transparency and understanding.

An Emergency rule-making is imperatively necessary

Initial Review	**03/13/2020**	Final Adoption	**04/10/2020**
Proposed Effective Date	**05/30/2020**	Emergency Adoption	

DOCUMENT #07

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

Explain:

2. Federal authority for the Rule, if any:

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

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);

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

Title of Rule: Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement and Creation of Hospital Transformation Program
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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 $2 billion in annual health care expenditures for more than 400,000 Coloradans and will provide more than $50 million new federal 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 billion in annual health care expenditures for more than 400,000 Coloradoans and more than $500 million in new federal 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 400,000 currently enrolled persons or the ability to fund the HAS supplemental payments.

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

   There are no alternative resources to fund HAS supplemental payments or health coverage for Medicaid and CHP+ expansion populations. 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.

   The CHASE Act directs the Medical Services Board to promulgate rules for the implementation of the HAS fee and supplemental payments. No other alternatives to rule making are available.

"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 Payment" or "HTP Supplemental Medicaid Payment" means the:

1. Outpatient Supplemental Medicaid Payment described in Section 8.3004.B.,
2. Inpatient Supplemental Medicaid Payment described in Section 8.3004.C., and
3. Essential Access Supplemental Medicaid Payment described in Section 8.3004.E.

The HTP Supplemental Medicaid Payment does not include the Hospital Quality Incentive Payment Supplemental Medicaid Payment described in Section 8.3004.F.

"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~~s~~ 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 Area" means a county outside a Metropolitan Statistical Area ~~or an area within an outlying county of a Metropolitan Statistical Area~~ 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 Payment" means ~~any of~~ the ~~payments~~:

1. Outpatient Supplemental Medicaid Payment described in Section 8.3004.B.,
2. Inpatient Supplemental Medicaid Payment described in Section 8.3004.C.,
3. Essential Access Supplemental Medicaid Payment described in Section 8.3004.E., and
4. Hospital Quality Incentive Payment Supplemental Medicaid Payment described in Section 8.3004.F.

"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%.

8.3002: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS

8.3002.A. DATA REPORTING

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Enterprise shall distribute a data reporting template to all hospitals. The Enterprise shall include instructions for completing the data reporting template, including definitions and descriptions of each data element to be reported. Hospitals shall submit the requested data to the Enterprise within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Enterprise may estimate any data element not provided directly by the hospital.

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

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

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.~~81~~19~~3~~3704% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

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 $~~93.07~~98.41 per day for Managed Care Days and $~~416.07~~439.94 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 $~~48.59~~51.38 per day for Managed Care Days and $~~217.23~~229.69 per day for all Non-Managed Care Days, and.

b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~37.23~~39.36 per day for Managed Care Days and $~~166.43~~175.98 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 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 ~~Disproportionate Share Hospital~~ Limit.

3. In order to receive a Supplemental Medicaid Payment or DSH ~~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.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 ~~Hospital-specific o~~outpatient billed charges ~~from the Colorado MMIS are~~ multiplied by ~~the hospital's~~ the Medicare cost-to-charge ratio ~~to arrive at hospital-specific outpatient billed costs~~. ~~For each qualified hospital, the annual Outpatient Hospital Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor.~~ 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 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 ~~will~~ shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.C. INPATIENT HOSPITAL ~~BASE RATE~~ 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~~s the hospital's~~ Medicaid Days ~~expected Medicaid discharges, multiplied by the hospital's~~

~~average Medicaid case mix, multiplied by the hospital's Medicaid base rate before add-ons,~~ multiplied by an ~~percentage~~ adjustment factor. ~~The percentage adjustment factor may vary by hospital such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit.~~ 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 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 ~~percentage~~ adjustment factor for each qualified hospital ~~will~~ 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)~~(ii)~~ 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)~~(ii)~~ 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 ~~Disproportionate Share Hospital payment~~ payment shall ~~be~~ equal ~~to the~~ $160,565,496~~Disproportionate Share Hospital allotment as published by CMS annually~~.

   b. All qualified hospitals with CICP write-off costs greater than 175.00% of the state-wide average shall receive a payment equal to 92.00% of their Hospital-~~-~~Specific DSH Limit.~~A Pediatric Hospital shall receive a payment equal to 45.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A Respiratory Hospital shall receive a payment equal to 75.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A new CICP hospital shall receive a payment equal to 10.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A low MIUR hospital shall receive a payment equal to 10.00% of its estimated hospital-specific Disproportionate Share Hospital limit.~~

      ~~i. A new CICP hospital is a hospital approved as a CICP provider between July 1, 2017 and June 30, 2018.~~

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

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

d. No qualified hospital shall receive a payment exceeding 92.00% of theirits ~~estimated hH~~ospital-~~specific~~ Specific DSH ~~Disproportionate Share Hospital l~~Limit as specified in federal regulation. If ~~upon review, the~~ a qualified hospital's ~~Disproportionate Share Hospital Supplemental~~ payment exceeds 92.00% of their ~~estimated hH~~ospital-~~specific~~ Specific DSH ~~Disproportionate Share Hospital l~~Limit ~~for any qualified hospital~~, ~~that hospital's~~the payment ~~payment~~ shall be reduced to 92.00% of the ~~their~~the ~~estimated hH~~ospital-~~specific~~ Specific DSH ~~Disproportionate Share Hospital l~~Limit. The amount of the reduction shall then be redistributed to ~~the~~ other qualified hospitals not exceeding 92.00% of their ~~estimated hH~~ospital-~~S~~specific DSH ~~Disproportionate Share Hospital l~~Limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding 92.00% of their ~~estimated HH~~ospital-~~s~~Specific DSH ~~Disproportionate Share Hospital~~ 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 L~~l~~imit equal 10.00%.

i. A new CICP hospital is a hospital approved as a CICP provider after October 1, 2018.

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

8.3004.E. ~~UNCOMPENSATED CARE~~ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. ~~General Hospitals and Critical~~Essential Access Hospitals ~~shall~~ are qualified receive this payment.

~~2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.~~

~~3~~2. Calculation methodology for payment. ~~A~~ For each qualified ~~Essential Access H~~hospital, the annual payment shall equal ~~shall receive a payment based on its~~ the percentage of beds to ~~percentage of beds to~~ total beds for all qualified ~~Essential Access Hospitals~~hospitals, multiplied by the available Essential Access funds. ~~**A qualified non-Essential Access Hospital shall receive a payment based on its percentage of Uninsured Costs to total Uninsured Costs for all qualified non-Essential Access hospitals.**~~

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. ~~General Hospitals and Critical Access Hospitals 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 100 points for measures a hospital is not eligible to complete. There are fifteen measures separated into six measure groups. The measures and measure groups are:

      ~~Measures. Quality incentive payment measures include nine measures. Qualified hospitals must report for the first and second measures. A hospital then reports for the remaining measures in which they are eligible~~

      ~~a. The measurefor the quality incentive payment are:~~

      ~~i. Active participation in the Regional Care Collaborative Organizations (RCCO) or Regional Accountable Entities (RAE),~~

      ~~ii. Culture of Safety/Patient Safety,~~

      ~~iii. Discharge Planning (Advance Care Planning (ACP)/Transition Activities),~~

      ~~iv. Rate of Cesarean Section,~~

      ~~v. Breastfeeding Practices,~~

      ~~vi. Tobacco and Substance Use Screening and Follow Up,~~

      ~~vii. Emergency Department Process,~~

      ~~viii. Percentage of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and~~

      ~~ix. 30-Day All-Cause Readmission.~~

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

~~5. Calculation methodology for payment.~~

~~a. Determine total points earned.~~

~~i. *Total points earned are the sum of the points earned for the first and second measures and the next three sequential measures for which the hospital is eligible.*~~*Maternal Health and Perinatal Care Measure Group*

1. Exclusive Breast Feeding
2. Cesarean Section
3. Perinatal Depression and Anxiety
4. Maternal Emergencies
5. Reproductive Life/Family Planning

Patient Safety Measure Group

6. Clostridium Difficile
7. Adverse Event
8. Falls with Injury
9. Culture of Safety Survey

Patient Experience Measure Group

10. Hospital Consumer Assessment of Healthcare Providers and Systems
11. Advance Care Plan

Regional Accountable Entity (RAE) Engagement Measure Group

12. RAE engagement on Physical and Behavioral Health

Substance Abuse Measure Group

13. Substance Use Disorder Composite
14. Alternatives to Opioids

Addressing Cost of Care Measure Group

15. Hospital Index

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 is 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 point.

The tiering of normalized points awarded is:

~~b. Normalize the total points for hospitals that are exempted from reporting requirements or have limited data available for certain measures.~~

~~c. Calculate adjusted Medicaid discharges.~~

~~i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by a discharge adjustment factor.~~

ii. The discharge adjustment factor is calculated as gross Medicaid billed charges divided by gross inpatient Medicaid billed charges. The Discharge Adjustment Factor is limited to 5.

iii. For hospitals with fewer than 200 annual Medicaid discharges, the total number of discharges is multiplied by 125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare prospective payment system calculation.

d. Calculate total adjusted discharge points.

i. Adjusted discharge points are calculated as the total points earned for all measures multiplied by the adjusted Medicaid discharges.

e. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality points earned receive more dollars per discharge point than hospitals with lower quality points earned. There are five tiers delineating the dollar value of a discharge point with each tier assigned at certain quality point increments. For each tier increase, the dollars per discharge point increase by a multiplier.

ii. The multiplier for the five tiers of quality points are shown in the table below:

Tier	Normalized Points Awarded~~Hospital Quality Points Earned~~	Dollars Per-Adjusted Discharge Point~~Multiplier~~
1	1-19	$ 0.00
2	20-39~~20-35~~	$ 2.04~~3.13~~
3	40-59~~36-50~~	$ 4.08~~6.26~~
4	60-79~~51-65~~	$ 6.12~~9.39~~
5	80-100~~66-80~~	$ 8.16~~12.52~~

g. Calculate payment by hospital by multiplying the adjusted discharge points by the dollars per discharge point.

6. The dollars per discharge point for tier 2 will be set to an amount so that the total quality incentive payments made to all qualified hospitals will equal seven percent of the total reimbursement made to hospitals in the previous state fiscal year.

8.3004.G. REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENT AND DISPROPORTIONATE SHARE HOSPITAL PAYMENT

1. The Enterprise shall calculate the Supplemental Medicaid Payment and DSH ~~Disproportionate Share Hospital~~ Payment under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Supplemental Medicaid Payment and DSH ~~Disproportionate Share Hospital~~ Payment 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 payment made each year, the methodology to calculate such payment, and the payment reimbursement 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 Supplemental Medicaid Payment or the DSH ~~Disproportionate Share Hospital~~ Payment to be reimbursed.

8.3004.H. HOSPITAL TRANSFORMATION PROGRAM

Qualified hospitals shall participate in the Hospital Transformation Program (HTP). The HTP leverages supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost. Qualified hospitals not completing a reporting activity shall have their supplemental payment dollars reduced. The reduced payment dollars shall then be paid to qualified hospitals completing the reporting activity. The HTP is a multi-year program with a program year being on a federal fiscal year (October 1 through September 30) basis.

1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients shall participate in the HTP except as provided below.

2. Excluded hospitals. Psychiatric Hospitals, Rehabilitation Hospitals, or Long Term Care Hospitals shall not participate in the HTP.

3. Calculation methodology for payment.

    a. Each program year includes reporting activities that a qualified hospital is required to complete. A qualified hospital not completing a reporting activity shall have their HTP supplemental Medicaid payment reduced by a designated percent.

    b. The dollars not paid to those qualified hospitals shall be distributed to qualified hospitals completing the reporting activity. A qualified hospital's distribution shall equal their percent of HTP Supplemental Medicaid Payment to the total HTP Supplemental Medicaid Payment for all qualified hospitals completing the reporting activity, multiplied by the total reduced dollars for qualified hospitals not completing the reporting activity.

    d. The reduction and distribution for reporting activities shall occur at the same time during the last quarter of the subsequent program year. The reduction and distribution shall be determined using the HTP Supplemental Medicaid Payment effective during the reporting activity period.

    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, and when it is due.

        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 application shall be scored on timely and satisfactory submission. Due the third quarter of program year 1.

        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 plan shall be scored on timely and satisfactory submission. Due the fourth quarter of program year 1.

        iii. Interim Report (0.5% at-risk per report) – Qualified hospitals must report on the interventions undertaken over the previous quarter along with self-reported data associated with their measures. The report shall be scored on timely and satisfactory submission. Due one month following the end of every quarter starting with the first quarter of program year 2.

        iv. Milestone Report (2.0% at-risk per report in program year 2, 4.0% at-risk per report in program year 3) – Qualified hospitals must report on achieved/missed milestones over the previous two quarters. The report shall be scored on timely and satisfactory submission and the percent of milestones achieved to total milestones. Due within one month following the end of the second quarter and fourth quarter of program

year 2 and program year 3. 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.

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 plan shall be scored on timely and satisfactory submission. Due the third quarter following program year 5.

f. A qualified hospital not participating in the HTP may have the entirety of their HTP Supplemental Medicaid Payment withheld. This includes the option to recover any HTP Supplemental Medicaid Payment previously reimbursed to the qualified hospital during the current program year.