Title of Rule: FFY 20-21 HAS Fees & Payments Amendment, Creation of HTP & RSP
Rule Number: MSB 21-01-28-B
Division / Contact / Phone: Special Financing / Jeff Wittreich / 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) 2020-21 Healthcare Affordability & Sustainability (HAS) fees and supplemental payments. 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 fees to fund Colorado Medicaid and CHP+ expansions and HAS supplemental payments. The rule change includes revisions to the Disproportionate Share Hospital (DSH) supplemental payment for the FFY 2022 DSH allotment and 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.

   The rule change also includes the creation of the Hospital Transformation Program (HTP) and Rural Support Program (RSP). The HTP will leverage 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 going to hospitals achieving the milestones or completing the activities. The RSP will provide complementary funding to the HTP to prepare critical access and rural hospitals for future value-based environments.

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:

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

4. State Authority for the Rule:

Initial Review	**05/14/21**	Final Adoption	**06/11/21**
Proposed Effective Date	**08/10/21**	Emergency Adoption	

DOCUMENT #09

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

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

Initial Review	**05/14/21**	Final Adoption	**06/11/21**
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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.

   HAS Fees/Payments - 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. The state benefits with HAS fee revenue used to offset General Fund expenditures for the medical assistance program due to the budget shortfall created by the COVID-19 pandemic.

   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.

   Creation of HTP/RSP – For HTP, Colorado hospitals will be affected by the proposed rule as their HAS supplemental payments will now be at-risk if they don't complete required HTP reporting deliverables. Hospitals completing the deliverables will experience an increase in Medicaid reimbursement. Colorado hospitals not completing the deliverables will experience a decrease in Medicaid reimbursement. For RSP, Critical Access hospitals and rural hospitals will experience an increase in Medicaid reimbursement through a new Medicaid supplemental payment.

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

   HAS Fees/Payments - The HAS fee, with federal matching funds, will result in approximately $2.8 billion in annual health care expenditures for more than 400,000 Coloradans and will provide more than $500 million new federal funds to Colorado hospitals. $63 million in HAS fees will be used to offset General Fund expenditures for the medical assistance program.

   Creation of HTP/RSP - The impact of HTP will be hospitals implementing quality-based initiatives, demonstrating meaningful community engagement, and improving health outcomes by incorporating value-based purchasing strategies into existing hospital quality and payment improvement initiatives. Rural hospital will now receive necessary resources to assist in the transition to a more value-based environment.

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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.

   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.

   HAS Fees/Payments - The benefits of the proposed rule are the funding of approximately $2.8 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. HAS fee revenue cannot be allocated to offset General Fund expenditures pursuant to H.B. 20-1386.

   HTP/RSP - If no action is taken, HAS supplemental payments will not be at-risk and there will be less incentive to improve health outcomes and to lower Medicaid costs. Rural hospitals will not receive additional funding to support their transition to a more value-based environment.

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

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 ~~located in a Rural Area~~ and ~~with~~ 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 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~~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~~Hospital” means a hospital not located within a ~~county outside 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 ~~any of the payments~~the: ~~described in 10 CCR 2505-10,~~

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., ~~and~~
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.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 ~~1.8664~~1.7592% of total hospital outpatient charges with the following exception.

    a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to ~~1.8507~~1.7444% 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 $~~91.39~~96.42 per day for Managed Care Days and $~~408.56~~431.01 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 $~~47.71~~50.34 per day for Managed Care Days and $~~213.31~~225.03 per day for all Non-Managed Care Days, and.

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~36.56~~38.56 per day for Managed Care Days and $~~163.42~~172.41 per day for Non-Managed Care Days.

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 $~~216,338,548~~219,367,288.

   b. ~~All~~ A qualified hospital~~s~~ with CICP write-off costs greater than 1,000.00% of the state-wide average shall receive a payment equal to ~~96~~88.00% 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 88.00% 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, ~~2018~~2019.

      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~~s~~ scale for measures a hospital is not eligible to complete. There are ~~fifteen~~ eleven measures separated into ~~six~~ 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
5. Reproductive Life/Family Planning
6. Incidence of Episiotomy

Patient Safety Measure Group

7~~6~~. Clostridium Difficile
8~~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 (HCAHPS)
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~~ 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 ~~(x)~~ 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.

8.3004.G. RURAL SUPPORT PROGRAM HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

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

   b. Is a nonprofit hospital, and

   c. Meets one of the below:

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

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

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

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

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

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

1. The Enterprise shall calculate the Supplemental Medicaid Payments and DSH 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 Payments and DSH 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 Payments or the DSH Payment to be reimbursed.

8.3004.I 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 are required to complete certain reporting activities. Qualified hospitals not completing a reporting activity shall have their supplemental Medicaid payments reduced. The reduced supplemental Medicaid payments shall be paid to qualified hospitals completing the reporting activity. The HTP is a multi-year program with a program year (PY) 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 Payments reduced by a designated percent.

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

    c. The reduction and redistribution shall be calculated using the HTP Supplemental Medicaid Payments effective during the reporting activity period. The reduction and redistribution for reporting activities shall occur at the same time during the last quarter of the subsequent program year.

    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.

        i. Application (1.5% at-risk total) – Qualified hospitals must provide interventions and measures focusing on improving processes of care and health outcomes and reducing avoidable utilization and cost. The percent at-risk shall be scored on timely and satisfactory submission.

        ii. Implementation Plan (1.5% at-risk total) – Qualified hospitals must submit a plan to implement interventions with clear milestones that shall impact their measures. The percent at-risk shall be scored on timely and satisfactory submission.

        iii. Quarterly Reporting (0.5% at-risk per report) – Qualified hospitals must report quarterly on the different activities that occurred in that quarter. For any given quarter, this includes interim activity reporting, milestone reporting, self-reported data associated with the measures, and Community and Health Neighborhood Engagement (CHNE) reporting. The percent at-risk shall be scored on timely and satisfactory submission.

        iv. Milestone Report (2.0% at-risk per report in PY 2, 4.0% at-risk per report in PY 3) – Qualified hospitals must report on achieved/missed milestones over the

previous two quarters. The percent at-risk shall be scored on timely and satisfactory submission and for achievement of milestones. Qualified hospitals that miss a milestone can have the reduction for the milestone reduced by 50% if they submit a course correction plan with the subsequent Milestone Report. A course correction reduction for a missed milestone can only be done once per intervention.

v. Sustainability Plan (8.0% at-risk total) – Qualified hospitals must submit a plan demonstrating how the transformation efforts will be maintained after the HTP is over. The percent at-risk shall be scored on timely and satisfactory submission.

f. A qualified hospital not participating in the HTP may have the entirety of their HTP Supplemental Medicaid Payments withheld.