Title of Rule: Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000
Rule Number: MSB 25-08-12-C
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 state charges and collects Healthcare Affordability and Sustainability (HAS) fees from hospitals to leverage federal matching funds. These combined funds are used to increase hospital reimbursement through monthly supplemental payments, to fund coverage for more than 400,000 Coloradans eligible through Medicaid expansion and Child Health Plan Plus (CHP+), and to cover the program's administrative costs. HAS fees are updated annually to ensure alignment with program objectives and compliance with federal regulations.

   The proposed rule revisions include updates to HAS fees for federal fiscal year (FFY) 2024–25 (October 1, 2024, through September 30, 2025). These updates establish the outpatient percentage fees (Section 8.3003.A) and the inpatient per diem fees (Section 8.3003.B), ensuring that provider fees, together with federal matching funds, meet the total funding obligation for the federal fiscal year. The revisions also incorporate clarifying amendments to the rules approved at the July 3, 2025, emergency Medical Services Board meeting. The rules approved at that meeting established maximum fee rates for the current fee methodology calculation, in accordance with the provisions of H.R. 1, the One Big Beautiful Bill Act (OBBA).

   The revisions include updates to the Disproportionate Share Hospital (DSH) supplemental payment calculation for FFY 2024-25 (Section 8.3004.D), as well as a one-year extension of the current Rural Support Program (RSP) supplemental payment calculation (Section 8.3004.G). This extension will remain in effect while the state completes the required State Plan Approval (SPA) process with the Centers for Medicare and Medicaid Services (CMS) to implement the next round of RSP supplemental payments.

   To develop the proposed changes, the state collaborated with the provider community over the past year on the calculation of FFY 2024-25 provider fees and supplemental payments. On Tuesday, September 2, 2025, the CHASE Board unanimously approved the calculations and recommends that the Medical Services Board approve the proposed rule revisions.

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:

Initial Review
Proposed Effective Date **09/12/25**
Final Adoption
Emergency Adoption **09/12/25**

**DOCUMENT #13**

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The Colorado Healthcare Affordability and Sustainability Enterprise Act [C.R.S. § 25.5-4-402.4 (2018)] directs the state to charge provider fees to hospitals and obtain federal matching funds to finance supplemental payments to hospitals, healthcare coverage for Medicaid & CHP+ expansion members, and related administrative costs. The proposed emergency rule revisions are necessary to address increased funding obligations for FFY 2024-25. Without emergency approval, there will not be sufficient time to collect the required provider fees from hospitals by the end of the federal fiscal year (September 30, 2025) to fully meet these obligations, resulting in noncompliance with state statute.

The funding obligation for Medicaid and CHP+ expansion members and related administrative costs for FFY 2024-25 has increased by $160 million compared to FFY 2023-24. Since October 2024, the HAS cash fund reserve has been used to cover the increased funding obligations. However, the reserve was not intended to sustain such a large funding obligation for an extended period. Without increased provider fees collected from hospitals, the available funds will be depleted, resulting in the inability to fully reimburse services for Medicaid and CHP+ expansion members supported through this program.

These rules were not presented to the Medical Services Board until the September 12, 2025, board meeting due to the UCHealth provider fee classification lawsuit (*UCHealth v. Colorado Department of Health Care Policy and Financing*), which concerned the classification of two UCHealth hospitals within the HAS model. Because the lawsuit could have significantly affected the model, the rules could not be presented until it was resolved. A settlement with UCHealth was reached late last month, and the necessary revisions have been incorporated. A revised model was presented to the CHASE Board on September 2, 2025, and the Board unanimously approved it, recommending that the Medical Services Board approve the proposed rule revisions.

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

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

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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.

   Hospitals will benefit from increased supplemental payments. The state will benefit from the increased provider fees collected from hospitals, which are necessary to fund the obligations for Medicaid & CHP+ expansion populations.

   At the same time, hospitals will bear the cost through increased provider fees that support supplemental payments, Medicaid and CHP+ expansion populations, and administrative costs.

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 revisions will result in a $60 million net increase in hospital reimbursement for FFY 2024–25. The proposed rules will also increase provider fees collected to fund the $160 million increase in funding obligations for Medicaid and CHP+ expansion populations and the $3 million funding obligation increase for administrative costs.

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 administrative costs exist, they are funded through provider fees and federal Medicaid matching funds. No State General Fund dollars are used.

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

   If no action is taken, the Department will be unable to collect sufficient provider fees from hospitals to fully fund supplemental payments, coverage for Medicaid and CHP+ expansion populations, and administrative costs as required by state statute. The state does not have the resources to meet these increased funding obligations without raising provider fees.

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

   No alternative 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 are available. These rules are necessary to comply with the Colorado Healthcare Affordability and Sustainability Enterprise Act, § 25.5-4-402.4, C.R.S.

# 8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

## 8.3001: DEFINTIONS (*Page 7*)

m. Patients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

52. "Sole Community Hospital" means a hospital that is designated as a sole community hospital by the Centers for Medicare and Medicaid Services (CMS) as the only source of inpatient hospital services reasonably available in a geographic area, due to factors like an isolated location, poor accessibility from nearby hospitals, or the inability of nearby hospitals to provide necessary services.

~~52.~~53. "Supplemental Medicaid Payments" means the:

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

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

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

d. Hospital Quality Incentive Payment described in Section 8.3004.F., and

e. Rural Support Program Hospital Supplemental Medicaid Payment described in Section 8.3004.G.

~~53.~~54. "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.

~~54.~~55. "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 uninsured inpatient days relative to total inpatient hospital days per year, rounded to the nearest percent, equals, or exceeds 65%.

~~55.~~56. "Urgent Care" means treatment needed because of an injury or serious illness that requires treatment within 48 hours.

# 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~~ and is capped at 1.8020% of total hospital outpatient charges, with the following exception:

    a. High Volume Medicaid Hospitals' Outpatient Services Fee is ~~discounted to~~ capped at 1.7869% of total hospital outpatient charges.

The Outpatient Services Fee for federal fiscal year 2024-25 (October 1, 2024, through September 30, 2025) is 1.6940% of total hospital outpatient charges, with the following exception:

a. For High Volume Medicaid Hospitals, the Outpatient Services Fee is 1.6798% 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~~ and is capped at $122.18 per day for Managed Care Days and $546.15 per day for all Non-Managed Care Days, with the following exceptions:

    a. High Volume Medicaid Hospitals' Inpatient Services Fee is ~~discounted to~~ capped at $63.79 per day for Managed Care Days and $285.14 per day for all Non-Managed Care Days, and

    b. Essential Access Hospitals' Inpatient Services Fee is ~~discounted to~~ capped at $48.87 per day for Managed Care Days and $218.46 per day for Non-Managed Care Days.

The Inpatient Services Fee for federal fiscal year 2024-25 (October 1, 2024, through September 30, 2025) is $116.64 per Managed Care Day and $521.40 per Non-Managed Care Day, with the following exceptions:

a. For High Volume Medicaid Hospitals, the Inpatient Services Fee is capped at $60.90 per Managed Care Day and $272.22 per Non-Managed Care Day.

b. For Essential Access Hospitals, the Inpatient Services Fee is capped at $46.66 per Managed Care Day and $208.56 per Non-Managed Care Day.

# 8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

## 8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals are hospitals that:

   a. 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, and

   b. Have a Qualified Charity Care Program, or

   c. Have a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals, or

   d. Are Critical Access Hospitals or Rural Hospitals designated as Sole Community Hospitals pursuant to 42 U.S.C. § 1395ww(d)5(D)(iii).

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

3. Calculation methodology for payment.

   a. Total DSH payments shall equal Colorado's total computable DSH allotment pursuant to 42 U.S.C. § 1396r–4(f)(3)

   b. No qualified hospital shall receive a payment greater than 100% of their Hospital-Specific DSH Limit.

   c. A qualified hospital with uninsured patient write-off costs greater than ~~700%~~950% of the state-wide average shall receive a payment equal to a minimum of ~~96.00%~~90.00% of their Hospital-Specific DSH Limit.

   d. A qualified State-Owned Government Teaching Hospitals shall receive a payment equal to a minimum of 96.00% of their Hospital Specific DSH Limit.

   ~~d~~e. A qualified Critical Access Hospital or Rural Hospital shall receive a payment equal to ~~a minimum of 86.00%~~100.00% of their Hospital Specific DSH Limit.

   ~~e~~f. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area ~~and having less than 2,700 Medicaid Days~~and have less than or equal to 50 licensed beds shall receive a payment equal to a minimum of ~~80.00%~~40.00% of their Hospital-Specific DSH Limit.

   ~~f~~g. 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.

   ~~g~~h. A Low MIUR hospital shall have their Hospital-Specific DSH Limit equal ~~10.00%~~20.00%.

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

~~h~~i. The payment percentage of the hospital specific DSH limit shall be published in provider bulletin.

## 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. Meets one of the below: 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~~ six 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.