8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

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

8.3000.A~~1~~: DEFINITIONS

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

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

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

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

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

6. "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.

7. "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.

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

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

10. "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.

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

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

13. "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.

14. "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.

15. "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.

16. "Hospital Transformation Program Supplemental Medicaid Payments" or "HTP Supplemental Medicaid Payments" means the:

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

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

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

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

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

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

19. "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.

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

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

22. "Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.

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

24. "MMIS" means the Medicaid Management Information System, the Department's Medicaid claims payment system.

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

26. "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.

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

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

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

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

31. "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.

32. "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.

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

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

35. "Rehabilitation Hospital" means an inpatient rehabilitation facility.

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

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

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

39. "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.

40. "Supplemental Medicaid Payments" means the:

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

b. ~~2.~~ Inpatient Hospital Supplemental Medicaid Payment described in 8.3004.C.,

c. ~~3.~~ Essential Access Hospital Supplemental Medicaid Payment described in 8.3004.E.,

d. ~~4.~~ Hospital Quality Incentive Payment described in 8.3004.F., and

e. ~~5.~~ Rural Support Program Hospital Supplemental Medicaid Payment described in 8.3004.G.

41. "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.

42. "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%

8.3000.B~~2~~: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS

8.3000.B.1~~2.A~~. DATA REPORTING

a. ~~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.

i. ~~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.

ii. ~~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.

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

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

d. ~~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.

8.300~~2.B~~0.B.2. FEE ASSESSMENT AND COLLECTION

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

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

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

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

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

a. ~~3.~~ Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Enterprise for the collection of fees and the disbursement of payments unless the Enterprise has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Enterprise describing an alternative fee collection process and/or payment process. The Enterprise shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

i. ~~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.

ii. ~~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~~3000.C: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.300~~3.A~~0.C.1. OUTPATIENT SERVICES FEE

a. ~~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).

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

c. ~~3.~~ Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as ~~1.6365~~1.8705% of total hospital outpatient charges with the following exception.

i. ~~a.~~ High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to ~~1.6228~~1.8548% of total hospital outpatient charges.

8.300~~0.C.2~~3.B. INPATIENT SERVICES FEE

a. ~~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).

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

c. ~~3.~~ Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $~~105.53~~114.10 per day for Managed Care Days and $~~471.76~~510.05 per day for all Non-Managed Care Days with the following exceptions:

i. ~~a.~~ High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $~~55.10~~59.57 per day for Managed Care Days and $~~246.31~~266.30 per day for all Non-Managed Care Days, and.

ii. ~~b.~~ Essential Access Hospitals' Inpatient Services Fee is discounted to $~~42.21~~45.64 per day for Managed Care Days and $~~188.70~~204.02 per day for Non-Managed Care Days.

8.300~~3.C.~~0.C.3 ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

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

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

c. ~~3.~~ In order to receive a Supplemental Medicaid Payment or DSH Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.300~~3.D.~~0.C.4 REFUND OF EXCESS FEES

~~1.~~ If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Enterprise shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Enterprise shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.3002.B.

~~2.~~ After the close of each ~~State~~ federal fiscal year ~~and no later than the following August 31,~~ the Enterprise shall present a summary of fees collected, expenditures made or encumbered, and interest earned in the Fund during the ~~State~~ federal fiscal year to the Enterprise Board.

~~a.~~ If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Enterprise has not expended or encumbered those fees at the close of each ~~State~~ federal fiscal year:

~~i.~~ The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less the minimum Fund reserve recommended by the Enterprise Board.

~~ii.~~ The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the ~~State~~ federal fiscal year.

~~iii. The Enterprise shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.3002.B.~~

8.3004~~3000~~.E: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004~~.A~~0.E.1. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

a. ~~1.~~ All Supplemental Medicaid Payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Enterprise.

b. ~~2.~~ No hospital shall receive a DSH Payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.3004.D, exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction shall 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 Disproportionate Share Hospital Limit.

c. ~~3.~~ In order to receive a Supplemental Medicaid Payment or 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~~0.E.2. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

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

c. ~~3.~~ Calculation methodology for payment. For each qualified hospital, the annual payment shall equal outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. Outpatient billed costs equal outpatient billed charges multiplied by the Medicare cost-to-charge ratio. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, 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 Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004~~.C~~0.E.3. INPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

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

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

8.300~~4.D.~~0.E.4 DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

a. ~~1.~~ Qualified hospitals.

i. ~~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.

ii. ~~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.

iii. ~~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

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

c. ~~3.~~ Calculation methodology for payment.

i. ~~a.~~ Total funds for the payment shall equal $~~226,610,302~~244,068,958.

ii. ~~b.~~ A qualified hospital with CICP write-off costs greater than ~~1,000.00~~700% of the state-wide average shall receive a payment equal to 96.00% of their Hospital-Specific DSH Limit. A qualified Critical Access Hospital shall receive a payment equal to 96.00% 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~~2,400 Medicaid ~~Days~~ days shall receive a payment equal to ~~50.00~~96.00% of their Hospital-Specific DSH Limit.

iii. ~~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.

iv. ~~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.

v. ~~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%.

1) ~~i.~~ A new CICP hospital is a hospital approved as a CICP provider after October 1, ~~2021~~2022.

2) ~~ii.~~ A low MIUR hospital is a hospital with a MIUR less than or equal to ~~15.00~~22.50%.

8.300~~4.E~~0.E.5. ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

b. ~~2.~~ Calculation methodology for payment. For each qualified hospital, the annual payment shall equal ~~the percentage of beds to total beds for all qualified hospitals, multiplied by~~ the available Essential Access funds divided by the total number of qualified Essential Access hospitals.

8.300~~4.F.~~0.E.6 HOSPITAL QUALITY INCENTIVE PAYMENT

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

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

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

i. ~~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 scale for measures a hospital is not eligible to complete. ~~There are fifteen measures separated into three measure groups.~~The measures and measure groups are published annually in the Colorado Medicaid Provider Bulletin.

~~1) The measures and measure groups are:~~

~~2) Maternal Health and Perinatal Care Measure Group~~

~~3) 1. Exclusive Breast Feeding~~

~~4) 2. Cesarean Section~~

~~5) 3. Perinatal Depression and Anxiety~~

~~6) 4. Maternal Emergencies and Preparedness~~

~~7) 5. Reduction of Peripartum Racial and Ethnic Disparities~~

~~8) 6. Reproductive Life/Family Planning~~

~~9) Patient Safety Measure Group~~

~~10) 7. Zero Suicide~~

~~11) 8. Clostridium Difficile~~

~~12) 9. Sepsis~~

~~13) 10. Antibiotics Stewardship~~

~~14) 11. Adverse Event~~

~~15) 12. Culture of Safety Survey~~

~~16) 13. Handoffs and Sign-Outs~~

~~17) Patient Experience Measure Group~~

~~18) 14. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)~~

~~19) 15. Advance Care Plan~~

~~20)~~1) Adjusted Medicaid Discharges equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.

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

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

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

1) 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)

2) 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.

c) A hospital shall have the opportunity to request a reconsideration of points awarded that are provided with the preliminary scoring letter.

i. To be considered for payment, a hospital shall submit a survey through the data collection tool on or before May 31 of each year.

ii. 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.

iii. 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.

1) 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.

iv. 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.

v. 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.

1) 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.

vi. 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 score was made or if the escalation request was denied.

The escalation response is final, and points awarded may not be reconsidered further.

~~i.~~vii. No other reconsiderations of points awarded, both preliminary and final, may be accepted by the Department outside of this process.

8.300~~4.G.~~0.E.7 RURAL SUPPORT PROGRAM HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

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

ii. ~~b.~~ Is a nonprofit hospital, and

iii. ~~c.~~ Meets one of the below:

1) ~~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

2) ~~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,

a. ~~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.

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

c. ~~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.

8.300~~4.H~~0.E.8 REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENTS AND DISPROPORTIONATE SHARE HOSPITAL PAYMENT

a. ~~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.

8.300~~4.I~~0.E.9 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.

A hospital shall have the opportunity to request a reconsideration of scores for reporting compliance, milestone completion (including milestone amendments and course corrections), and performance measure data accuracy.

The scoring review and reconsideration period begins when the Department notifies hospitals of initial scores. This period consists of multiple steps that will span 45 business days.

The Department completes initial review of reports within 20 business days of report due date.

The Department notifies hospital of scores available for viewing and the scoring review and reconsideration period begins within 21 business days of report due date.

The hospital request for reconsideration is due within 10 business days of release of initial scores.

The Department issues final scores and reconsideration decisions within 14 business day of the scoring review and reconsideration period close date.

All hospitals will receive electronic notification when initial scores are released to the Department's web portal.

To submit a request for reconsideration of an initial score, a hospital must utilize the scoring review and reconsideration form available on the Department's web portal. It must identify the specific scoring elements the hospital would like reconsidered and the rationale for the reconsideration request. The form must be emailed following the proper guidelines as mentioned on the form.

Late report submissions and report revisions are not accepted through the reconsideration process.

The hospital will receive an electronic notification of the outcome of the reconsideration request.

If a hospital is not satisfied with the reconsideration response, the hospital may request the reconsideration be escalated to the Project Manager or the Special Financing Division Director. Initial escalations to the Project Manager must be made within five business days of delivery of the reconsideration response. Final escalations to the Special Financing Division Director must be made within 15 business days of delivery of the reconsideration response. Any escalations must be provided to the Department via electronic notice.

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

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

No other reconsiderations of scores, both preliminary and final, may be accepted by the Department outside of this process.