Title of Rule: Colorado Healthcare Affordability and Sustainability Enterprise, Sections 8.300.8, 8.905, 8.2000, and 8.3000
Rule Number: MSB 17-06-29-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Senate Bill 17-267 signed into law by the governor on May 30, 2017 creates the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) at § 25.5-4-402.4, C.R.S. effective July 1, 2017 to assess a healthcare affordability and sustainability fee to obtain federal financial participation to increase hospital reimbursement for care provided under Medicaid and the Colorado Indigent Care Program (CICP) and to fund health coverage under Medicaid and the Child Health Plan Plus (CHP+). The CHASE Act also repeals the hospital provider fee at 25.5-4-402.3, C.R.S. In accordance with statute, this proposed rule repeals the hospital provider fee rules at 10 CCR 2505-10, Section 8.2000, creates rules for the healthcare affordability and sustainability fee at Section 8.3000, and makes corresponding revisions to references under Sections 8.300.8 and 8.905.

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:

   Effective July 1, 2017, the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) at § 25.5-4-402.4, C.R.S. establishes a healthcare affordability and sustainability fee to obtain federal financial participation to increase hospital reimbursement for care provided under Medicaid and the CICP. Fee revenue also serves as the state share to fund health coverage for more than 480,000 Coloradans currently enrolled in Medicaid and the CHP+. To comply with the new state law and to comply with the State Plan with the Centers for Medicare and Medicaid Services, the CHASE must establish rules on an emergency basis in order to assess fees on hospitals to ensure continuing health care coverage for these Medicaid and CHP+ members and to make required payments to hospitals. Senate Bill 17-267 also repealed the Hospital Provider Fee program effective July 1, 2017.

3. Federal authority for the Rule, if any:

   42 CFR 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);

Title of Rule: Colorado Healthcare Affordability and Sustainability Enterprise, Sections 8.300.8, 8.905, 8.2000, and 8.3000
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25.5-4-402.4(4)(g), C.R.S.

Initial Review	**07/14/17**	Final Adoption	**09/08/17**
Proposed Effective Date	**10/30/17**	Emergency Adoption	

DOCUMENT #04

Title of Rule: Colorado Healthcare Affordability and Sustainability Enterprise, Sections 8.300.8, 8.905, 8.2000, and 8.3000
Rule Number: MSB 17-06-29-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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 and CICP reimbursement made possible through the healthcare affordability and sustainability fee and matching federal funds and the reduction in the number of uninsured Coloradans from expanded Medicaid and CHP+ eligibility. Low-income persons benefit by having health care coverage through the expanded Medicaid and CHP+ eligibility.

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 healthcare affordability and sustainability fee and matching federal funds will result in more than $2 billion in annual health care expenditures for more than 480,000 Coloradans and will provide more than $200 million in net 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 associated with CHASE, such costs are funded with fees and federal matching funds and no state general funds are expected to be 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, CHASE will not be ability to fund Medicaid and CHP+ expansions, affected over 480,000 currently enrolled persons. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+, and reduce the federal revenue to hospitals.

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

The State does not have alternative resources to fund hospital payments and health coverage for the populations as provided under CHASE; therefore, 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 healthcare affordability and sustainability fee; therefore, no alternatives to rule making are available.

8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

1. Eligible ~~H~~hospitals ~~deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program~~ will receive a ~~CICP~~ Disproportionate Share Hospital Supplemental Payment according to the terms defined in 10 CCR 2505-10 section ~~8.2000~~8.3004.D.

2. ~~Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive an Uninsured Disproportionate Share Hospital Payment defined in 10 CCR 2505-10 section 8.2000.~~

8.905 DEPARTMENT RESPONSIBILITIES

A. Provider Application

1. The Department shall produce and publish a provider application annually.

   a. The application will be updated annually to incorporate any necessary changes and update any Program information.

   b. The application will include data and quality metric submission templates.

2. The Department shall determine Qualified Health Care Providers annually through the application process.

3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108 (5)(a)(I), C.R.S.

4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108 (5)(a)(II), C.R.S.

5. The Department shall produce and publish a provider directory annually.

B. Payments to Providers

1. Funding for hospitals shall be distributed in accordance with 10 CCR 2505-10 Section 8.~~2000~~ 3000 and 8.905 B.~~5~~3.

2. Clinics

a. Funding for Clinic Providers is appropriated through the Colorado General Assembly under the Children's Hospital, Clinic Based Indigent Care line item. Effective July 1, 2018, funding for clinics shall be separated into two different groups, as follows:

I. Seventy-five (75) percent of the funding will be distributed based on Clinic Providers' write off costs relative to the total write off costs for all Clinic Providers.

II. Twenty-five (25) percent of the funding will be distributed based on a points system granted to Clinic Providers based on their quality metric scores multiplied by the Clinic Provider's total visits from their submitted Program data.

b. The quality metric scores will be calculated based on the following four metrics. The metrics are defined by the Health Resources & Services Administration (HRSA):

I. Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up

II. Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan

III. Diabetes: Hemoglobin A1c Poor Control

IV. Controlling High Blood Pressure

c. Write off costs will be calculated as follows:

I. Distribution of available funds for indigent care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate medically indigent charges.

II. Clinic Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department.

III. Clinic Providers shall deduct the full patient liability amount from total charges, which is the amount due from the Client as

identified in the CICP Standard Client Copayment Table, as defined under Appendix A in these rules, or an alternative sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department. The summary information submitted to the Department by the provider shall include the full CICP patient liability amount even if the Clinic Provider receives the full payment at a later date or through several smaller installments or no payment from the Client.

IV. Medically indigent charges will be converted to medically indigent costs using the most recently available cost-to-charge ratio from the Clinic Provider's cost report or other financial documentation accepted by the Department.

d. The Department shall notify Clinic Providers of their expected payment no later than July 31 of each year. The notification shall include the total expected payment and a description of the methodology used to calculate the payment.

e. For the 2017-18 Program year, Clinic Provider payments will be based solely on calendar year 2016 write-off costs relative to the total write off costs for all Clinic Providers. Write off charges shall be calculated as described in part c of this section.

3. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s;

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed;

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

e. Participates in the Colorado Indigent Care Program

The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

C. Provider Appeals

1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.

2. The provider's first level appeal must be filed within five (5) business days of the receipt of the denial letter. The Department's Special Financing Division Director will respond to any first level appeals within ten (10) business days of receipt of the appeal.

3. If a provider disagrees with the Department's Special Financing Division Director's first level appeal determination, they may file a second level appeal within five (5) business days of the receipt of the first level appeal determination. The Department's Executive Director will respond to the second level appeal within ten (10) business days of the receipt of the second level appeal.

D. Advisory Council

The Department shall create a CICP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICP Stakeholder Advisory Council. Members shall include:

1. A member representing the Department;

2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;

3. A representative from a federally qualified health center as defined at 42 U.S.C. 1395x (aa)(4);

4. A representative from a rural health clinic as defined at 42 U.S.C. 1395x (aa)(2), or a representative from a clinic licensed or certified as a community health clinic by the Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;

5. A representative from either Denver Health or University Hospital;

6. A representative from an urban hospital;

7. A representative from a rural or critical access hospital;

8. A representative of an organization of Colorado community health centers, as defined in the federal "Public Health Service Act", 42 U.S.C. sec. 254b;

9. A representative from an organization of Colorado hospitals.

Members shall serve without compensation or reimbursement of expenses. The Executive Director shall at least annually select a chair for the council to serve for a maximum period of twelve months. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. Of the members initially appointed to the advisory council, the executive director shall appoint six for two-year terms and five for three-year terms. In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

The council shall

1. Advise the Department of operation and policies for the Program

2. Make recommendations to the Medical Services Board regarding rules for the Program

E. Annual Report

1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.

2. The report shall at minimum include charges for each Qualified Health Care Provider, numbers of Clients served, and total payments made to each Qualified Health Care Provider.

~~8.2000: HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT~~

~~PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3, authorizes the Department of Health Care Policy and Financing (Department) to assess a hospital provider fee, pursuant to rules adopted by the State Medical Services Board, to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program (CICP). In addition, the Act requires the Department to use the hospital provider fee to expand 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; to provide a Medicaid buy-in program for people with disabilities; to implement twelve month continuous eligibility for Medicaid eligible children; and to pay the Department's administrative costs of implementing and administering the Act.~~

~~8.2001: DEFINITIONS~~

~~"Act" means the Colorado Health Care Affordability Act, C.R.S. § 25.5-4-402.3.~~

~~"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 large number 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.~~

~~"Essential Access Hospital" means a Critical Access Hospital or General Hospital located in a Rural Area with 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 hospital provider fee cash fund described in C.R.S. § 25.5-4-402.3(4).~~

~~"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 30,000 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" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.~~

~~"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 hospitals 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.~~

~~"Oversight and Advisory Board" means the hospital provider fee oversight and advisory board described in C.R.S. § 25.5-4-402.3(6).~~

~~"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.~~

~~"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.~~

~~"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%.~~

8.2002: RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS

8.2002.A. DATA REPORTING

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Department shall distribute a data reporting template to all hospitals no later than April 30 of each year. The Department 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 Department within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Department may estimate any data element not provided directly by the hospital.

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 Department.

3. The Department 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 Department 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 Department. Revisions to the data will not be permitted by a hospital after the dates outlined in the data confirmation report.

4. An authorized hospital signatory shall certify that the data included in the data reporting template are correct, are based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years.

8.2002.B. FEE ASSESSMENT AND COLLECTION

1. Establishment of Electronic Funds Process. The Department 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 Department shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

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.

    a. For those hospitals that participate in the electronic funds process utilized by the Department, 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 Department must diverge from this schedule due to unforeseen circumstances, the Department shall notify hospitals in writing or by electronic notice as soon as possible.

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

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

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 Department for the collection of fees and the disbursement of payments unless the Department 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 Department describing an alternative fee collection process and/or payment process. The Department shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

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

8.2003: HOSPITAL PROVIDER FEE

8.2003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department 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 1.534% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.2003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(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 $79.54 per day for Managed Care Days and $355.49 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 $41.53 per day for Managed Care Days and $185.60 per day for all Non-Managed Care Days, and.

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to $31.82 per day for Managed Care Days and $142.20 per day for Non-Managed Care Days.

8.2003.C. ASSESSMENT OF FEE

1. The Department 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 Oversight and Advisory 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 Department 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.

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 Department 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.

8.2003.D. 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 Department shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Department 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 8.2002.B.

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

a. If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Department has not expended or encumbered those fees at the close of each State 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 four percent of the estimated expenditures for health coverage expansions authorized by the Act for the subsequent State fiscal year as most recently published by the Department.

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

iii. The Department 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 8.2002.B.

8.2004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.2004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

1. All supplemental 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 Department.

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 8.2004.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.

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.

8.2004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado MMIS are multiplied by the hospital's 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 hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

8.2004.C. INPATIENT HOSPITAL BASE RATE SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment equals the hospital's 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 a 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. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.~~

~~**8.2004.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 is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) shall receive this payment; or.~~

~~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 is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) shall receive this payment.~~

~~2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.~~

~~3. Calculation methodology for payment.~~

~~a. Qualified hospitals whose CICP write-off costs are greater than or equal to 750% of all CICP hospitals write-off costs as published in the most recent CICP annual report will receive a DSH payment equal to 100% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.~~

~~b. Qualified hospitals whose CICP write-off costs are less than 750% and more than 200% of all CICP hospitals write-off costs as published in the most recent CICP annual report will receive a DSH payment equal to 96% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.~~

~~c. All other qualified hospitals will receive a DSH payment calculated as the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all remaining qualified hospitals multiplied by the remainder of the state's total annual Disproportionate Share Hospital allotment to not exceed 96% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.~~

~~**8.2004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT**~~

1. Qualified hospitals. General Hospitals and Critical Access Hospitals shall receive this payment.

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

3. Calculation methodology for payment. For each qualified hospital with twenty-five or fewer beds, the annual payment equals the hospital's percentage of beds compared to total beds for all qualified hospitals with twenty-five beds or fewer multiplied by twenty three million five hundred thousand dollars ($23,500,000). For each qualified hospital with greater than twenty-five beds, the annual payment equals the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals with greater than twenty-five beds multiplied by ninety one million nine hundred eighty thousand one hundred seventy six dollars ($91,980,176).

8.2004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals with an established Medicaid inpatient base rate and that meet the minimum criteria for one or more of the selected measures may qualify to receive this payment.

2. Excluded hospitals. Psychiatric Hospitals.

3. Measures. Quality incentive payment measures include five base measures and four optional measures. Hospitals can report data on up to five measures annually. Qualified hospitals must report all of the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed.

a. The base measures for the quality incentive payment are:

i. Emergency department process measure, which includes communicating information about the Medicaid nurse advice line, primary care providers, and Regional Care Collaborative Organizations (RCCO) to Medicaid clients when they are seen in the emergency department and establishing emergency department policies or guidelines for prescribing opioids,

ii. Rate of elective deliveries between 37 and 39 weeks gestation,

iii. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,

iv. Rate of thirty (30) day all-cause hospital readmissions, and

v. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

b. The optional measures for the quality incentive payment are:

i. Culture of safety,

ii. Active participation in the RCCO,

iii. Advance care planning, and

iv. Screening for tobacco use.

4. Calculation methodology for payment.

a. Determine available points by hospital to a maximum of 10 points per measure.

i. Available points are defined as the number of measures for which a hospital qualifies multiplied by the number of points designated for the measure.

b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department.

c. Normalize the total points earned per measure to total possible points for all measures by hospital.

d. Calculate adjusted Medicaid discharges by hospital.

i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by the adjusted discharge factor.

For hospitals with less 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.

ii. The adjusted discharge factor is defined as the most recently available annual total gross Medicaid billed charges divided by the inpatient gross Medicaid billed charges.

e. Calculate total adjusted discharge points

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

f. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality point scores receive higher points per discharge. The dollar amount per discharge point for five tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	$13.18
2	11-20	$14.50
3	21-30	$15.82
4	31-40	$17.13
5	41-50	$18.45

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

5. The total funds for the quality incentive payment for the year ending September 30, 2016 is $84,810,386.

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 a 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.

8.3001: 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 located in a Rural Area with 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 30,000 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.

"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 hospitals 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 described in 10 CCR 2505-10, Sections 8.3004.B., 8.3004.C., 8.3004.E., and 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 no later than April 30 of each year. 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.

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.

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.

4. ~~An authorized~~The hospital ~~signatory~~ shall certify that based on best information, knowledge, and belief, the data included in the data reporting template ~~are~~ is accurate, complete, and truthful~~correct~~, is~~are~~ 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.,

8.3002.B. FEE ASSESSMENT AND COLLECTION

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.

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.

   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.

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

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

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.

   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 1.8208% 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 $86.22 per day for Managed Care Days and $385.35 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 $45.02 per day for Managed Care Days and $201.19 per day for all Non-Managed Care Days, and.

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to $34.49 per day for Managed Care Days and $154.14 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 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.

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.

8.3003.D. 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 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 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 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 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: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

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.

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.

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. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

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

3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado MMIS are multiplied by the hospital's 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 hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital will 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 ~~shall~~are qualified to receive this payment, except as provided below.

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

3. Calculation methodology for payment. For each qualified hospital, the annual payment equals the hospital's 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 a 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. The percentage adjustment factor for each qualified hospital will 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 is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) ~~shall~~ are qualified to receive this payment.~~; or~~

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 is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) ~~shall~~are qualified to receive this payment.

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

3. Calculation methodology for payment.

a. Qualified hospitals will receive a DSH Payment calculated as the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all remaining qualified hospitals multiplied by the state's total annual Disproportionate Share Hospital allotment to not exceed the estimated Hospital-Specific Disproportionate Share Hospital Limit.

b. DSH Payments to a Respiratory Hospital shall be limited to 60% of its estimated Hospital-Specific Disproportionate Share Hospital Limit. DSH Payments to a hospital that opened within the last two state fiscal years shall be limited to 20% of its estimated Hospital-Specific Disproportionate Share Hospital Limit.

8.3004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. General Hospitals and Critical Access Hospitals ~~shall~~are qualified to receive this payment except as provided below.

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

3. Measures. Quality incentive payment measures include five base measures and three optional measures. Hospitals can report data on up to five measures annually. Qualified hospitals must report all the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed.

   a. The base measures for the quality incentive payment are:

      i. Emergency department process measure, which includes communicating information about the Medicaid nurse advice line, primary care providers, and Regional Care Collaborative Organizations (RCCO) to Medicaid clients when they are seen in the emergency department and establishing emergency department policies or guidelines for prescribing opioids,

      ii. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,

      iii. Rate of thirty (30) day all-cause hospital readmissions,

      iv. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and

      v. Culture of safety.

   b. The optional measures for the quality incentive payment are:

      i. Active participation in the RCCO,

      ii. Advance care planning, and

      iii. Screening and intervention for tobacco use.

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 available points by hospital to a maximum of 10 points per measure.

i. Available points are defined as the number of measures for which a hospital qualifies multiplied by the number of points designated for the measure.

b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department.

c. Normalize the total points awarded by dividing total points earned by total points eligible, multiplied by 50.

d. Calculate adjusted Medicaid discharges by hospital.

i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by gross Medicaid billed charges divided by gross inpatient Medicaid billed charges.

ii. 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.

e. Calculate total adjusted discharge points

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

f. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality point scores receive higher points per discharge. The dollar amount per discharge point for five tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	$5.95
2	11-20	$8.93
3	21-30	$11.90
4	31-40	$14.88
5	41-50	$17.85

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

5. The total funds for the quality incentive payment for the year ending September 30, 2017 is eighty-nine million six hundred ~~sixty nine~~sixty-nine thousand five hundred two dollars ($89,669,502).