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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 19-0031-A

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

May 12, 2020

John Bartholomew
Finance Office Director
Colorado Department of Health Care
Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Re: Colorado 19-0031-A

Dear Mr. Bartholomew:

We have reviewed the proposed amendment to Attachment 4.19-A of your Colorado Medicaid State plan submitted under transmittal number (TN) 19-0031-A. Effective for services on or after October 1, 2019, this amendment revises the disproportionate share hospital (|DSH) methodology to address CMS' delay in national DSH reductions. In addition, this amendment implements new supplemental hospital payments; updates the payment pool amount(s) for existing supplemental and quality improvement incentive payments; and, removes obsolete language.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Colorado Medicaid State plan amendment TN 19-0031-A is approved effective October 1, 2019. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

[redacted]

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938 0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **19 – 0031 – A**

2. STATE: **COLORADO**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2019**

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS A NEW PLAN | **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.272
42 CFR 447.297

7. FEDERAL BUDGET IMPACT:

a. FFY 2020: $ 55.0 million
b. FFY 2021: $ 60.0 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A – Pages 29b, 29c, 29d, 49a, 51c, 56, 57, 57a, 57b, 57c

Attachment 4.19A – Page 29e (NEW)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19A – Pages 29d, 56, 57 (TN 14-052)
Attachment 4.19A – Pages 29b, 57a, 57b (TN 16-0014)
Attachment 4.19A – Pages 29c, 49a, 51c, 57c, 57d (TN 18-0045)

10. SUBJECT OF AMENDMENT:

Revise hospital inpatient supplemental payments.

11. GOVERNOR'S REVIEW *(Check One)*:

GOVERNOR'S OFFICE REPORTED NO COMMENT | **X OTHER, AS SPECIFIED**

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | **Governor's letter dated 11 October, 2019**

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. L: [redacted]

13. TYPED NAME:
John Bartholomew

14. TITLE:
Finance Office Director

15. DATE SUBMITTED: Initial: December 31, 2019

1st Update: April 15, 2020

16. RETURN TO:

Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Lauren Reveley

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
05/12/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
10/01/19

20. SIGNA[redacted]

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

23. REMARKS

FORM CMS 179 *(07/92)*

Instructions on Back

2. Effective October 1, 2014, qualified hospitals shall receive a disproportionate share hospital payment commonly referred to as the "Disproportionate Share Hospital Supplemental payment", which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

   To qualify for the Disproportionate Share Hospital payment a Colorado hospital shall meet one of the following criteria:

   a. Is not a licensed or certified Psychiatric Hospital, is a Colorado Indigent Care Program (CICP) provider, and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act; or

   b. Is not a licensed or certified Psychiatric Hospital, has a Medicaid Inpatient Utilization Rate equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act; or

   c. Effective October 1, 2019, is a Critical Access Hospital and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act.

   Effective October 26, 2015, CICP-participating hospitals with CICP write-off costs as published in the most recent CICP Annual Report greater than or equal to 750% of the statewide average will receive a payment equal to their estimated hospital-specific Disproportionate Share Hospital limit. CICP-participating hospitals with CICP write-off costs as published in the most recent CICP Annual Hospital Report less than 750% but greater than 200% of the statewide average will receive a payment equal to 96% of their estimated hospital-specific Disproportionate Share Hospital limit.

   All remaining qualified hospitals shall receive a payment calculated as a percent of uninsured costs multiplied by the remaining amount of the state's annual Disproportionate Share Hospital allotment. The percent of uninsured costs shall be the total of all uninsured costs for a remaining qualified hospital divided by the total uninsured costs for all remaining qualified hospitals.

   Effective October 26, 2016, all qualified hospital shall receive a payment calculated as a percent of uninsured costs multiplied by the state's annual Disproportionate Share Hospital allotment. The percent of uninsured costs shall be the total of all uninsured costs for a qualified hospital divided by the total uninsured costs for all remaining qualified hospitals.

   No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit as specified in federal regulation. A respiratory hospital's Disproportionate Share Hospital limit shall be limited to 60%. A new CICP hospital's Disproportionate Share Hospital limit shall be limited to 20%. If upon review, the Disproportionate Share Hospital Supplemental payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific Disproportionate Share Hospital limit. The reduction shall then be redistributed to the other qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital limit

based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital Limit.

Effective October 1, 2017, total funds for the Disproportionate Share Hospital (DSH) payment shall be $172,633,510.

CICP-participating hospitals with CICP write-off costs, as published in the most recent CICP Annual Report, greater than or equal to 950% of the statewide average shall receive a payment equal to 85.5% to their estimated hospital-specific DSH limit. A Respiratory Hospital shall receive a payment equal to 45% of their estimated hospital-specific DSH limit.

A Respiratory Hospital is defined as a hospital primarily specializing in respiratory related diseases.

All remaining qualified hospitals shall receive a payment calculated as their percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. A hospital's uninsured costs shall be for their Cost Report Year End 2015 period.

Effective July 1, 2018, an additional DSH payment shall be made such that Colorado will fully expend its final DSH allotment for federal fiscal year 2017-18.

The additional DSH payment shall be made only to qualified hospitals below 96% of their estimated hospital-specific DSH limit allocated such that hospitals with CICP write-off costs greater than 900% of the statewide average shall receive 92% of their estimated hospital-specific DSH limit, hospitals with CICP write-off costs greater than 400% of the statewide average and a Medicaid Inpatient Utilization Rate (MIUR) greater than 35% shall receive 92% of their estimated hospital-specific DSH limit, Pediatric Specialty Hospitals and hospitals with CICP write-off costs between 105% and 400% of the statewide average shall receive 30% of their estimated hospital-specific DSH limit, Critical Access Hospitals shall receive 96% of their estimated hospital-specific DSH limit, and Respiratory Hospitals shall receive 49.5% of their estimated hospital-specific DSH limit. Any remaining available DSH funds shall be allocated to qualified hospitals proportionate to their uninsured costs to total uninsured costs for all remaining qualified hospitals.

Effective October 11, 2018, total funds for the DSH payment shall be $212,928,574.

A Respiratory Hospital shall receive a payment equal to 75% of their estimated hospital-specific DSH limit. A Pediatric Specialty Hospital shall receive a payment equal to 45% of their estimated hospital-specific DSH limit. A hospital with a MIUR less than or equal to 15% shall receive a payment equal to 10% of their estimated hospital-specific DSH limit. New CICP-participating hospitals shall receive a payment equal to 10% of their estimated hospital-specific DSH limit.

All remaining qualified hospitals shall receive a payment calculated as their percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. A hospital's uninsured costs shall be for their Cost Report Year End 2016 period.

Effective October 1, 2019, total funds for the DSH payment shall equal an amount such that federal DSH funds shall not exceed the allowable FFY 2019-20 Colorado DSH allotment.

Qualified hospitals with CICP write-off costs greater than or equal to 1,000% of the statewide average and qualified Critical Access Hospitals shall receive a payment equal to at least 90%of their estimated hospital-specific DSH limit but not exceeding 100% of their estimated hospital-specific DSH limit.

Remaining qualified hospitals shall receive a payment equal to their percent of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. No remaining qualified hospital shall receive a payment exceeding 96% of their hospital-specific DSH limit as specified in federal regulation. If a remaining qualified hospital's DSH Supplemental payment exceeds 96.00% of their hospital-specific DSH limit, the payment shall be reduced to 96.00% of their hospital-specific DSH limit. The reduction shall then be redistributed to other remaining 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 remaining qualified hospitals not 96.00% of exceeding their hospital-specific DSH limit.

Notwithstanding the above, a qualified hospital with a MIUR less than or equal to 15% shall have their hospital-specific DSH limit equal to 10%. A qualified new CICP-participating hospital shall have their hospital-specific DSH limit equal to 10%.

The state shall not exceed the total of all the hospital-specific DSH limits even if the total reimbursement is below the state's annual DSH allotment.

Uninsured Disproportionate Share Hospital Payment

Fiscal Year	Percent of the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital payment
State Fiscal Year 2009-10	19.94%
State Fiscal Year 2010-11 July 1 - September 30, 2010	19.94%
Federal Fiscal Year 2010-11	23.14%
Federal Fiscal Year 2011-12	20.00%
Federal Fiscal Year 2012-13	21.28%
Federal Fiscal Year 2013-14	1.64%

No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit (as specified in federal regulations). If upon review or audit, the Uninsured Disproportionate Share Hospital payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific DSH limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to the other qualified hospitals based on the qualified hospital proportion of uninsured cost relative to aggregate of uninsured costs of all qualified providers who do not exceed their hospital-specific Disproportionate Share Hospital limit.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after an Uninsured Disproportionate Share Hospital payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

2. Effective October 1, 2014, the Disproportionate Share Hospital adjustment commonly referred to as "Uninsured Disproportionate Share Hospital payment" is suspended.

Effective October 1, 2014 for each qualified hospital, the percentage adjustment factor shall vary for state-owned, non-state government owned, and private hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Safety Net Specialty Hospitals, or for other hospital classifications such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit.

The percentage adjustment factor for each qualified hospital effective October 11, 2018 shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at www.colorado.gov/hcpf/bulletins.

Effective October 1, 2019 the Supplemental Medicaid Payment commonly referred to as "Inpatient Base Rate Supplemental Hospital Medicaid Payment" is suspended.

Inpatient Supplemental Medicaid Payment

Effective October 1, 2019, qualified hospitals shall receive an additional supplemental Medicaid payment commonly referred to as "Inpatient Supplemental Medicaid Payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Inpatient Supplemental Medicaid Payment is made only if there is available federal financial participation under the Inpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

The Inpatient Supplemental Medicaid Payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the Inpatient Supplemental Medicaid Payment a hospital shall meet the following criteria:

1. Is licensed as a General Hospital, Critical Access Hospital, Children's Hospital, Rehabilitation Hospital, or Long Term Care Hospital by the Colorado Department of Public Health & Environment. Psychiatric Hospitals are not qualified for this payment.

For a qualified hospital, the payment shall equal total Medicaid patient days multiplied by an adjustment factor. The adjustment factor shall vary for certain hospital classifications/groups such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit.

The adjustment factor for each qualified hospital effective October 1, 2019 shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at:
www.colorado.gov/hcpf/bulletins.

If Inpatient Supplemental Medicaid payment calculation errors are realized after the payment has been made, adjustments shall be made to a hospital's payment retroactively.

Effective October 11, 2018, qualified Essential Access hospitals shall receive a payment calculated as the percentage of beds to total beds for qualified Essential Access hospitals with twenty-five or fewer beds multiplied by $15,000,000. Qualified non-Essential Access hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for qualified non-Essential Access hospitals multiplied by $92,980,176.

Effective October 1, 2019 the Supplemental Medicaid Payment commonly referred to as "Uncompensated Care Supplemental Hospital Medicaid Payment" is suspended.

Essential Access Supplemental Medicaid Payment

Effective October 1, 2019, qualified hospitals shall receive an additional supplemental Medicaid payment commonly referred to as "Essential Access Supplemental Medicaid Payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Essential Access Supplemental Medicaid Payment is made only if there is available federal financial participation under the Inpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

The Essential Access Supplemental Medicaid Payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the Essential Access Supplemental Medicaid Payment a hospital shall meet the following criteria:

1. Is a Rural Hospital or Critical Access Hospital; and
2. Has less than or equal to 25 licensed beds.

For a qualified hospital, the payment shall equal the percent of licensed beds to total licensed beds for all qualified hospitals, multiplied by the available Essential Access funds.

The Essential Access funds effective October 1, 2019 shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at: www.colorado.gov/hcpf/bulletins.

If Essential Access Supplemental Medicaid Payment calculation errors are realized after the payment has been made, adjustments shall be made to a hospital's payment retroactively.

P. Hospital Quality Incentive Payments

Effective October 1, 2012, Colorado hospitals that provide services to improve the quality of care and health outcomes for their patients may qualify to receive an additional monthly supplemental Medicaid payment. This additional supplemental Medicaid payment shall be commonly referred to as the "Hospital Quality Incentive Payment" (HQIP) which shall be calculated on an annual Federal Fiscal Year (October I through September 30) basis and dispensed in monthly installments.

The HQIP shall be made only if there is available federal financial participation under the Inpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

The HQIP is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for HQIP a hospital shall meet the following criteria:

1. Is licensed as a General Hospital, Critical Access Hospital, Children's Hospital, Rehabilitation Hospital, or Long Term Care Hospital by the Colorado Department of Public Health & Environment.

For each qualified hospital, the payment shall equal adjusted discharge points multiplied by dollars per-adjusted discharge point.

1. Adjusted discharge points shall equal normalized points awarded multiplied by adjusted Medicaid discharges.

    a. Normalized points awarded shall equal the sum of points awarded, normalized for measures a hospital is not eligible to complete.

    b. Adjusted Medicaid discharges shall equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.

        i. The discharge adjustment factor shall equal total Medicaid charges divided by inpatient Medicaid charges. The discharge adjustment factor shall be limited to 5.

        ii. Inpatient Medicaid discharges shall be multiped by 125% for qualified hospitals with less than 200 inpatient Medicaid discharges.

2. Dollars per-adjusted discharge point shall be determined using a qualified hospital's normalized points awarded. Dollars per-adjusted discharge point are tiered so that qualified hospitals with more normalized points awarded receive more dollars per-adjusted point.

Effective October 26, 2015, HQIP measures include five (5) base measures and four (4) optional measures. Hospitals can report data on up to five (5) measures annually. Hospitals that choose to participate in HQIP 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.

The base measures for HQIP are:

1. Emergency department process measure,
2. Rate of elective deliveries between 37 and 39 weeks gestation,
3. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position, 4. Rate of thirty (30) day all-cause hospital readmissions, and 5. Percentage of patients who gave the hospital an overall rating of "9" or "l O" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.

The optional measures for HQIP are:

1. Culture of safety,
2. Active participation in the Regional Care Collaborative Organization (RCCO),
3. Advance care planning, and
4. Screening for tobacco use.

The dollars per discharge point will be tiered such that hospitals with higher quality point scores will receive higher points per discharges. The dollar amount per discharge point for five (5) 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

Effective October 26, 2016, HQIP measures include five (5) base measures and three (3) optional measures. Hospitals can report data on up to five (5) measures annually. Hospitals that choose to participate in HQIP 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.

The base measures for HQIP are:

1. Emergency department process measure,2. Rate of Cesarean section deliveries
3. Rate of thirty (30) day all-cause hospital readmissions,4. Percentage of patients who gave the hospital an overall rating of "9" or "1 O" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey,
5. Culture of safety.

The optional measures for HQIP are:

I. Active participation in the Regional Care Collaborative Organization (RCCO),
2. Advance care planning, and
3. Screening for tobacco use.

The dollar amount per discharge point for five (5) 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	$5.67
2	11-20	$8.51
3	21-30	$11.34
4	31-40	$14.18
5	41-50	$17.01

Effective October l, 2017, HQIP includes seven (7) measures. Hospitals can report data on up to four (4) measures. Hospitals that choose to participate in HQIP are required to report for the first and second measures. A hospital must report data for the remaining measures in sequence. If a hospital is not eligible for a measure, then the next measure is reported. A hospital's score is normalized to a SO-point scale by dividing the hospital's earned points by 40 and multiplying by 50. Effective October 1, 2017, the measures for HQIP are:

1. Culture of safety,
2. Active participation in the Regional Care Collaborative Organization (RCCO), 3. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,
4. Percentage of patients who gave the hospital an overall rating of "9" or "1 0" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey,
5. Emergency department process,
6. Advance care planning, and
7. Screening and intervention for tobacco use.

The dollar per discharge point for five (5) 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	$5.69
2	11-20	$8.54
3	21-30	$11.38
4	31-40	$14.23
5	41-50	$17.07

Effective October 11, 2018, HQIP includes nine (9) measures. Hospitals can report data on up to five (5) measures. Hospitals that choose to participate in HQIP are required to report for the first and second measures. A hospital must report data for the remaining measures in sequence. If a hospital is not eligible for a measure, then the next measure is reported. The measures for HQIP are:

1. Active participation in the Regional Accountable Entity and Behavioral Health Organization (BHO) activities,
2. Culture of safety/patient safety,
3. Discharge Planning (Advance Care Planning (ACP)/Transition Activities),
4. Rate of Cesarean section,
5. Breastfeeding Practices,
6. Tobacco and substance use screening and follow-up,
7. Emergency Department Process,
8. Percentage of patients who gave the hospital an overa11 rating of"9" or "1 0" on the HCAHPS Survey, and
9. 30-day all-cause readmissions.

The dollar amount per discharge point for five (5) tiers of quality points between 0 and 80 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	0-19	$0.00
2	20-35	$3.13
3	36-50	$6.26
4	51-65	$9.39
5	66-80	$12.52

Effective October 1, 2019, HQIP includes fifteen (15) measures separated into six (6) measure groups. A hospital is requested to complete all measures but is not required to complete a measure if they are not eligible. The HQIP measure groups and measures are:

Maternal Health and Perinatal Care Measure Group

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

Patient Safety Measure Group

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

Patient Experience Measure Group

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

Regional Accountable Entity (RAE) Engagement Measure Group

12. RAE engagement on Physical and Behavioral Health

Substance Abuse Measure Group

13. Substance Use Disorder Composite
14. Alternatives to Opioids

Addressing Cost of Care Measure Group

15. Hospital Index

The dollar amount per-adjusted discharge point for five (5) tiers of normalized points awarded between 0 and 100 are shown in the table below:

Tier	Normalized Points Awarded	Dollars Per-Adjusted Discharge Point
1	0-19	$0.00
2	20-39	$2.04
3	40-59	$4.08
4	60-79	$6.12
5	80-100	$8.16

Total Funds for this payment equal:

FFY 2012-13	$32,000,000	FFY 2015-16	$84,810,386	FFY 2018-19	$90,496,734
FFY 2013-14	$34,388,388	FFY 2016-17	$89,775,895	FFY 2019-20	$90,778,024
FFY 2014-15	$61,488,873	FFY 2017-18	$97,553,767		

In the event that HQIP payment calculation errors are realized after HQIP payments have been made, reconciliations and adjustments to impacted hospitals will be made retroactively.