COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

November 2, 2009

Dear ,

The Colorado Health Care Affordability Act (House Bill 09-1293) allows the Department of Health Care Policy and Financing (Department) to implement a hospital provider fee to generate millions of dollars in 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). Securing this new source of revenue will also increase health insurance coverage to over 100,000 Coloradans through Medicaid and Child Health Plan *Plus* (CHP+) and other medical benefits expansions in the future.

We are pleased to provide your facility with preliminary estimates of your fees and payments at this time. Based on recommendations from Colorado's Hospital Provider Fee Oversight and Advisory Board, the Department has submitted a proposed Medicaid State Plan Amendment to the federal Centers for Medicare and Medicaid Services (CMS) seeking authority to implement its Hospital Provider Fee Model. Aspects of the model are subject to change through negotiations between the Department and CMS. While final approval of the model is not anticipated until April 2010, the Department will keep you apprised of significant changes to the proposal, fees and payments prior to implementation.

This letter serves as an introduction to the accompanying packet that:

- Provides your facility with current estimates of its FY 2009-10 fees and payments under the Act (the hospital provider fee and payment methodologies are referred to in general as the "Hospital Provider Fee Model"),
- Describes the model's fee and payment methodologies that generate this additional funding for hospitals, and
- Requests that you complete the simple "Confirmation of Hospital Survey Data" to affirm the accuracy of the data elements the Department has used to estimate your fees and payments under the proposed Hospital Provider Fee Model.

The Department will utilize the data as presented in your "Confirmation of Hospital Survey Data". If you wish to submit revisions to the data, you must appeal in writing to Nancy Dolson by December 4, 2009. Ms. Dolson can be reached at 303-866-3698 or nancy.dolson@state.co.us if you have questions about your data or any other materials in this packet.

Sincerely,

Christopher W. Underwood
Director, State Programs and Federal Financing

Hospital Provider Fee Model Overview
State Fiscal Year 2009-2010

The Colorado Health Care Affordability Act (House Bill 09-1293) allows the Department of Health Care Policy and Financing (Department) to implement a hospital provider fee to generate millions of dollars in additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient services provided through Medicaid and the Colorado Indigent Care Program (CICP), to expand eligibility under Medicaid and the Child Health Plan *Plus* (CHP+), and to offer medical benefits to low-income adults without dependent children. A 13-member Oversight and Advisory Board (Board) provides oversight and makes recommendations to the Department on the implementation of the Act, including how fees are assessed and payments are calculated. (The hospital provider fee and payment methodologies are referred to in general as the "Hospital Provider Fee Model.")

This overview summarizes the Hospital Provider Fee Model recommended by the Board and currently being discussed by the Department and the federal Centers for Medicare and Medicaid Services (CMS). Aspects of this model are subject to change through this discussion period.

Once federal approval from CMS is gained, the fee and payments will be implemented retroactively to July 1, 2009. The Department will work with the Board and hospitals regarding fee collection and payments for FY 2009-10. The Department will also provide you with a description of the final model approved by CMS prior to assessing any fees. Federal final approval of the model is anticipated by April 2010.
Fees can be collected and payments can be made only after federal approval of the model. Additionally, payments can only be made if there is available federal financial participation under the Upper Payment Limit for inpatient and outpatient hospital services after Medicaid reimbursement.

The Hospital Provider Fee Model Description

Provider Fees:

- Inpatient Hospital Fee
  - $50 per day for commercial payer days
  - $230 per day for non-commercial payer days

    Commercial days are private payer days
    Non-commercial days are all other payers

- Outpatient Hospital Fee
  - 0.375% of total outpatient charges

- Hospitals Excluded from Paying the Provider Fee
  - State Licensed Psychiatric Hospitals
  - Medicare Certified Long Term Care (LTC) Hospitals
  - State Licensed and Medicare Certified Rehabilitation Hospitals

- Discounted Fees
    - High Volume Medicaid and CICP providers' Inpatient Hospital Fee is discounted by 42%
    - High Volume Medicaid and CICP Providers' Outpatient Hospital Fee is discounted by 1.22%

      High Volume Medicaid and CICP providers are those providers with at least 35,000 Medicaid days/year and provide over 30% of their total days to Medicaid and CICP clients.

Supplemental Medicaid (Inpatient) Base Rate Payment: The intent of this payment is to increase Medicaid Inpatient Hospital Base Rate to approximately 100% of Medicare Inpatient Hospital Base Rate to reduce uncompensated Medicaid costs and increase access for Medicaid clients. The current Medicaid Hospital Base Rate is 85% of the Medicare Base Rate, as calculated prior to Medicaid add-ons. (Medicaid add-ons are Medicaid Graduate Medical Education [GME], and Nursery, and Neonatal Intensive Care Unit [NICU]).

- Payment Calculation
    - Supplemental Medicaid Base Rate Payment equals Expected Discharges multiplied by Average Medicaid Case Mix multiplied by the difference between the Medicare Base Rate and the Medicaid Base Rate.
    - For Pediatric Specialty Hospitals, the Supplemental Base Rate Payment equals Expected Discharges multiplied by the Average Medicaid Case Mix multiplied by 11.67% of the Medicaid Base Rate.

- Hospitals Not Qualified for Payment
    - State Licensed Psychiatric Hospitals.

Supplemental Medicaid Outpatient Hospital Payment: The purpose of this payment is to reimburse approximately 100% of Medicaid costs for outpatient hospital services to reduce uncompensated Medicaid costs and increase access for Medicaid clients. Currently, hospitals are reimbursed approximately 71% of outpatient Medicaid costs.

In addition, a Rural Medicaid Outpatient Hospital Payment Adjustment to support providers of outpatient services for Medicaid clients at small rural hospitals will be included within this payment. This adjustment will be approximately 60% increase in Supplemental Medicaid Outpatient Hospital Payments for those rural providers whose outpatient Medicaid payments make up 80% or more of their total Medicaid payments and have 15 or fewer licensed beds will be made.

- Payment Calculation
    - Outpatient billed charges are converted to outpatient billed costs using the most recently audited cost-to-charge ratio. Outpatient billed costs are then inflated to the payment year and divided by 71% to determine 100% of Medicaid outpatient costs. This payment is calculated as the difference between 100% of Medicaid outpatient costs and the calculated outpatient billed costs.

- Hospitals Not Qualified for Payment
    - State Licensed Psychiatric Hospitals
    - Medicare Certified Long Term Care (LTC) Hospitals

Colorado Indigent Care Program (CICP) Disproportionate Share Hospital Payment/CICP Supplemental Medicaid Payment: The purpose of these payments is to increase reimbursement for CICP providers to 80% - 90% of their uncompensated CICP write-off costs and increase access to health care for CICP patients.

- Payment Calculation
    - CICP write-off charges are converted to CICP write-off costs using the cost-to-charge ratio from most recently filed Medicare Cost Report (CMS 2552-96). CICP write-off costs are then inflated forward to the payment year. Inflated CICP write-off costs are then adjusted by the following factors:
        - High Volume Medicaid and CICP Hospitals 80%
        - Rural and Critical Access Hospitals 100%
        - All other qualified CICP Hospitals 90%
    - The proportion of CICP write-off costs reimbursed by hospital type as listed above are paid through a combination of the CICP Supplemental Medicaid Payment and the CICP Disproportionate Share Hospital Payment.
    - CICP participating hospitals qualified to receive 90% of their CICP write-off costs will receive the greater of 90% of their CICP write-off costs or 40% of uncompensated costs for all uninsured patients.

- Hospitals Qualified for Payment
    - Hospitals that participate in the Colorado Indigent Care Program (CICP).

Uninsured Disproportionate Share Hospital Payment: The purpose of this payment is to reimburse approximately 40% of uncompensated uninsured costs for acute care hospital providers that do not participate in the CICP to reduce uncompensated uninsured costs and increase access for uninsured patients.

- Payment Calculation
  - Total uninsured charges as reported on the hospital survey are converted to costs using the most recently audited cost-to-charge ratio. This payment equals 40% of calculated uncompensated uninsured costs for non-CICP hospitals.

- Hospitals Qualified for Payment
  - Hospitals that do not participate in the Colorado Indigent Care Program (CICP).
  - High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, Medicare Certified Long Term Care (LTC) Hospitals, and State Licensed and Medicare Certified Rehabilitation Hospitals do not qualify for this payment.

Rural and Critical Access Hospital Supplemental Medicaid Payment: The purpose of this payment is to reduce uncompensated uninsured costs and increase access for Medicaid clients at rural and critical access hospital providers. The payment is structured to account for and encourage efficiency in providing services to a greater number of Medicaid clients.

- Payment Calculation
  - For the first 150 Medicaid days, a provider will receive $1,100 per Medicaid day.
  - For the next 225 Medicaid days, a provider will receive $575 per Medicaid day.
  - For the next 1,125 Medicaid days, a provider will receive $400 per Medicaid day.
  - For days over 1,500 Medicaid days, a provider will receive $100 per Medicaid day.

- Hospitals Qualified for Payment
  - Hospitals located in a rural area outside a federally-designated Metropolitan Statistical Area and Licensed Critical Access Hospitals.
  - High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, Medicare Certified Long Term Care (LTC) Hospitals, and State Licensed and Medicare Certified Rehabilitation Hospitals do not qualify for this payment.

Denver Metro Supplemental Payment: The intent of this payment is to increase access for Medicaid clients in the Denver Metro Area.

- Payment Calculation
  - Hospitals located in Adams, Arapahoe and Weld counties will receive a supplemental payment of $150 per Medicaid day.
  - Hospitals located in Denver, Jefferson, Douglas, Boulder and Broomfield counties will receive a supplemental payment of $465 per Medicaid day.

- Hospitals Qualified for Payment
  - Hospitals located in the federally-designated Denver-Aurora-Boulder Combined Statistical Area.
  - State Licensed Psychiatric Hospitals, Medicare Certified Long Term Care (LTC) Hospitals, and State Licensed and Medicare Certified Rehabilitation Hospitals do not qualify for this payment.

Metropolitan Statistical Area Payment: The intent of this payment is to increase access for Medicaid clients in a Metropolitan Area other than the Denver-Boulder-Aurora Combined Statistical Area.

- Payment Calculation
  - Hospitals located in El Paso, Larimer, Pueblo and Mesa counties will receive a supplemental payment of $250 per Medicaid day.

- Hospitals Qualified for Payment
  - Hospitals located in a federally-designated Metropolitan Statistical Area outside the Denver-Aurora-Boulder Combined Statistical Area
  - High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, Medicare Certified Long Term Care (LTC) Hospitals, and State Licensed and Medicare Certified Rehabilitation Hospitals do not qualify for this payment.

Neonatal Intensive Care Unit Supplemental Payment: The intent of this payment is to support those providers with Level IIIb or IIIc Neo-natal Intensive Care Units (NICUs).

- Payment Calculation
  - Supplemental payment will be $300 per Medicaid nursery day.
- Hospitals Qualified for Payment
  - Hospital providers with Level IIIb or IIIc NICUs.
  - High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, Medicare Certified Long Term Care (LTC) Hospitals, and State Licensed and Medicare Certified Rehabilitation Hospitals do not qualify for this payment.

Estimated Hospital Provider Fee Model Fees and Payments as of October 30, 2009

Provider Name Here

Hospital Fee/Payment	Amount
Provider Fees for State Fiscal Year 2009-10	
Inpatient Hospital Fee	$1,400,000
Outpatient Hospital Fee	$85,000
Total Hospital Provider Fees	**$1,485,000**
Supplemental Payments for State Fiscal Year 2009-10	
Supplemental Medicaid Base Rate Payment	$410,000
Supplemental Medicaid Outpatient Hospital Payment	$930,000
Colorado Indigent Care Program (CICP) Disproportionate Share Hospital Payment/CICP Supplemental Medicaid Payment	$3,000,000
Uninsured Disproportionate Share Hospital Payment	Not Qualified
Rural and Critical Access Hospital Supplemental Medicaid Payment	$700,000
Denver Metro Supplemental Payment[1]	Not Qualified
Metropolitan Statistical Area Payment[2]	Not Qualified
Neonatal Intensive Care Unit Supplemental Payment	Not Qualified
Total Supplemental Payments	**$5,040,000**

[1] Hospitals located in the following counties receive the Denver Metro Supplemental Payment: Denver, Jefferson, Douglas, Boulder, Broomfield, Adams, Arapahoe and Weld

[2] Hospitals in the following counties receive the Metropolitan Statistical Area Payment: El Paso, Larimer, Pueblo and Mesa.

Your facility's estimated fees and payments under the proposed Hospital Provider Fee Model are summarized in the table above. Changes to these payments may be necessary due to legislative action, agreements reached through discussion with the Centers for Medicare and Medicaid Services (CMS), or changes in calculations or data entry by Department staff. The Department expects CMS to approve the Hospital Provider Fee Model by April 1, 2010. Upon approval, The Department will notify you, in writing, of final fees and payments for State Fiscal Year 2009-10. Fees will then be assessed and payments made in May and June of 2010. The fees and payments will be retroactive to the beginning of the state fiscal year, July 1, 2009. From a budgeting standpoint, your facility may chose to treat these payments as an accounts receivable.

For a detailed description and calculation of each fee and payment that applies to your hospital, please refer to each specific payment description and methodology sheet included in this packet. The "Provider Fee Model Overview" provides a general narrative of the entire model; the specific payment description and methodology sheets provide information about each fee and payment using data applicable to your hospital.

EXAMPLE

All Estimates are Subject to Change

Inpatient Hospital Fee

Your Facility will be assessed an Inpatient Fee for Fiscal Year 2009-10 in the amount of:

$2,018,388

The Inpatient Fee is a per day charge assessed on commercial and non-commercial days.
Commercial days are assessed at $50 dollars per day.
Non-commercial days are assessed at $230 dollars per day.

Total Days: 11,045
Commercial Days: 2,914
Non-commercial Days: 8,131

Commercial Day Fee: $146,056
Non-commercial Day Fee: $1,872,332

2,914 * $50 = $146,056
8,131 * $230 = $1,872,332
$146,056 + $1,872,332 = **$2,018,388**

Outpatient Fee

Your Facility will be assessed an Inpatient Fee for Fiscal Year 2009-10 in the amount of:

$112,622

The Outpatient Fee is assessed as a percentage of a provider's charges for outpatient services. The percentage for Fiscal Year 2009-10 is 0.375% of outpatient charges.

Outpatient Charges (2007 HCRIS cost report): $30,030,643

$30,030,643 * 0.375% = **$112,622**

Calculations are not precise as a result of rounding

All Estimates are Subject to Change

Supplemental Medicaid Base Rate Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Supplemental Medicaid Base Rate Payment is:

$19,126

For each qualified hospital, this payment shall be calculated by using the difference between the Medicare Base Rate and the Medicaid Base Rate, multiplied by the hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix.

Estimated Number of Medicaid Discharges: 30
Current Medicaid Base Rate per Discharge: $4,738
Medicare Rate per Discharge: $5,577
Medicaid Case Mix: .76

($5,577 – $4,738) * 30 * .76 = **$19,126**

Supplemental Medicaid Outpatient Hospital Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Supplemental Medicaid Outpatient Hospital Payment is:

$505,914

Outpatient billed costs are inflated to the payment year and multiplied by 29.1%. The result is the difference between the inflated billed costs and the amount currently reimbursed by Medicaid (70.9%).

There is also a Rural Medicaid Outpatient Hospital Payment Adjustment that is approximately a 60% increase in Medicaid payments for those rural providers whose outpatient Medicaid payments make up 80% or more of their total Medicaid payments and have 15 or fewer licensed beds.

Inflated Billed Costs: $706,189
Estimated Payment at current Medicaid Reimbursement: $500,688
Rural/CAH: Yes
Your facility Does have fewer than 15 Licensed Beds
Your ratio of Outpatient Medicaid to Total Medicaid: 89.27%

Your facility Qualifies for the Rural Medicaid Outpatient Hospital Payment Adjustment
Adjustment Amount: $300,413

$706,189 – $500,688 + $300,413 = **$505,914**

Calculations are not precise as a result of rounding

Or
$706,189 * 29.1% + $300,413 = **$505,914**

Where adjustment equals
$500,688 * 60% = $300,413

Colorado Indigent Care Program (CICP) Disproportionate Share Hospital Payment/CICP Supplemental Medicaid Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the CICP Disproportionate Share Hospital Payment and the CICP Supplemental Medicaid Payment is:

$2,157,619

Rural and Critical Access Hospitals receive 100% of their CICP Write-off Costs.

High Volume Medicaid and CICP Providers receive 80% of their CICP Write-off Costs or approximately 42% of their Uncompensated Uninsured Costs.

All other qualified CICP Hospitals receive 90% of their CICP Write-off Costs or approximately 42% of their Uncompensated Uninsured Costs.

Estimated CICP costs: $2,157,619
Uncompensated Uninsured Costs: $1,707,247
Your Facility will receive: 100% of CICP Costs

100% of CICP Costs = $2,157,619

Uninsured Disproportionate Share Hospital Payment

All Estimates are Subject to Change

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Uninsured Disproportionate Share Hospital Payment is:

$684,967

For Fiscal Year 2009-10 the percentage of inflated uninsured costs is approximately 41.74%.

Estimated uninsured costs: $1,638,227

$1,638,227 * 41.74% = **$684,967**

Rural and Critical Access Hospital Supplemental Medicaid Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Rural and Critical Access Hospital Supplemental Medicaid Payment is:

$735,575

For each qualified hospital, this payment is calculated on a per Medicaid day basis as follows:

a. For the first 150 Medicaid days the hospital will receive $1,100 per day;
b. For Medicaid days 151 through 375 the hospital will receive $575 per day;
c. For Medicaid days 376 through 1,500 the hospital will receive $400 per day; and
d. For Medicaid days over 1,500 the hospital will receive $100 per day.

Total Medicaid Days: 1,478

a. Total Amount at $1,100/day = $165,000
b. Total Amount at $575/day = $129,375
c. Total Amount at $400/day = $441,200
d. Total Amount at $100/day = $ 0

$165,000 + $129,375 + $441,200 + $ 0 = **$735,575**

Denver Metro Supplemental Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Denver Metro Supplemental Payment is:

Calculations are not precise as a result of rounding

All Estimates are Subject to Change

$3,739,200

For each hospital, this payment is calculated on a per Medicaid day basis as follows:

a. Hospitals located in Adams, Arapahoe and Weld counties will receive a supplemental payment of $150 per Medicaid day.
b. Hospitals located in Denver, Jefferson, Douglas, Boulder and Broomfield counties will receive a supplemental payment of $465 per Medicaid day.

County:
Your facility Does receive the
Boulder/Broomfield/Douglas/Jefferson county add-on
Your facility Does Not receive the Denver county add-on.
Medicaid Days: 6,080

6,080 * (150 + $465) = **$3,739,200**

Metropolitan Statistical Area Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Metropolitan Statistical Area Payment is:

$2,856,750

For each hospital, this payment is calculated on a per Medicaid day basis at $270 per Medicaid day.

County:
Medicaid Days: 11,427

11,427 * $270 = **$2,856,750**

Neonatal Intensive Care Unit Supplemental Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement to for the Neonatal Intensive Care Unit Supplemental Payment is:

$617,100

Calculations are not precise as a result of rounding

All Estimates are Subject to Change

Providers with level IIIb or IIIc Neo-natal Intensive Care Units will receive a payment of $300 per Medicaid Nursery day.

Your Facility Does have level IIIb or IIIc Neo-natal Intensive Care
Medicaid Nursery Days: 2,057

2,057 * $300 = **$617,100**

Calculations are not precise as a result of rounding

Confirmation of Hospital Survey Data
Provider Name Here

The following table outlines data elements that the Department has used in calculations for the Hospital Provider Fee Model. At this time, we would like you to confirm the survey data submitted to us in February 2009 for modeling purposes by placing an "X" in the Check to Confirm column and mailing it to the address noted on page 2. If you wish to submit revisions to the data, you must appeal in writing to Nancy Dolson at the address on page 2 by December 4, 2009. For your convenience, we have included a copy of the February 2009 Hospital Survey *we* received from your facility. This survey requested data from Calendar Year 2007.

Please note that if you did not return a survey or only submitted a partial year's data, the Department estimated your figures from similar facilities or from the partial data.

The Hospital Provider Fee Model uses data elements from a variety of sources. You do not need to confirm the accuracy of data that was drawn from sources other than your facility's February 2009 Hospital Survey. We have included other data elements and their source only as a reference and courtesy. Note that the "Check to Confirm" column has been blackened out for these data elements.

Data Element	Source	Figure	Check to Confirm	Hospital Comments
Inpatient Days	Hospital Survey – Feb 2009			
Commercial Managed Care Days/Other Commercial (sum)		2,132		
Medicaid – fee for service		200		
Medicaid – nursery		47		
Medicaid HMO		6		
Total Inpatient Days		5,027		
Medicaid dual eligible (Medicaid & Medicare)		62		
Medicaid & other payer (not Medicare)		13		
Charges – Inpatient				
Section 1011 / Self Pay / Uninsured / Charity Care (sum)		$3,450,621		

EXAMPLE

Confirmation of Hospital Survey Data
Provider Name Here

Data Element	Source	Figure	Check to Confirm	Hospital Comments
Cost-to-Charge Ratio	Most Recently Filed Medicare Cost Report (CMS 2552-96)	57.32%		
CICP Write-Off Charges	FY 2007-08 CICP Annual Report	$1,586,230		
Total Outpatient Charges	Provider's FY 2007 Medicare Cost Report (CMS 2552-96)	$385,957		

Hospital Contact Information:

Contact Name: _____
Title: _____
Email: _____
Phone: _____

The Department will utilize this data to determine your FY 2009-10 fees and payments under the Hospital Provider Fee Model. **If you wish to submit revisions to the data, you must appeal in writing to Nancy Dolson at the address below by December 4, 2009.** Ms. Dolson can be reached at 303-866-3698 or nancy.dolson@state.co.us if you have questions about your data or any materials in this packet.

Return by December 4, 2009 to:

Safety Net Programs Section
Dept of Health Care Policy and Financing
1570 Grant St.
Denver, CO 80203

For questions, contact Nancy Dolson at:
nancy.dolson@state.co.us or 303-866-3698

EXAMPLE