Provider Fee Rules Outline for Medical Services Board

Friday, February 19, 2010

The following document is made available for comment only. Text presented in this document is draft and does not represent the actual regulations that will be presented to the Medicaid Services Board. Please forward comments to Chris.Underwood@state.co.us.

Tentative Timeline

Outline presented to MSB:	Friday, February 19
Hospital Provider Fee OAB Meeting	Tuesday, February 23
Draft Rules to MSB to Read in Advance	Friday, March 12
CMS Approves Hospital Provider Fee	Thursday, April 1
Hospital Provider Fee OAB Meeting	Tuesday, March 23
Emergency Rules to MSB	Friday, April 9
First Fees Collected/Payments Made	Friday, April 16
Public Rule Review Meeting	Monday, April 19
Final Emergency Rules to MSB	Friday, May 14

Rule #1: Delete or modify portions of current rule that specify the use of Inpatient Upper Payment Limit (UPL) and Disproportionate Share Hospital (DSH) payments. These federal funding sources will be relocated under section 8.2000 Hospital Provider Fee Collection and Disbursement.

- Medicaid Inpatient Hospital Rules related to DSH payments.
- CICP Rules - 8.903 Provisions Applicable to Qualified Health Care Providers.
    - Certified Public Expenditures (CPE) Process.
    - Low-Income Payment (DSH Payment).
    - High-Volume Payment (UPL Payment).
    - Bad Debt Payment (DSH Payment).
    - Pediatric Major Teaching Hospital Payment (UPL Payment).

Rule #2: We propose to create a New Section in Volume 8.

8.2000: HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT

OVERVIEW: Subject to federal approval by the Centers for Medicare and Medicaid Services, 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 allows 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

- Medicare Upper Payment Limit.
- Major Pediatric Teaching Hospital.
- Hospital-Specific Disproportionate Share Hospital Limit.
- Medically Indigent Costs.
- High Volume Medicaid and CICP Hospital: A hospital with at least 35,000 Medicaid days/year that provides over 30% of its total days to Medicaid and CICP clients.
- Critical Access Hospital.
- Rural Area: A county outside a federally designated Metropolitan Statistical Area.
- State-Owned Government Hospital.
- Non-State-Owned Government Hospital.
- Pediatric Specialty Hospitals.
- Urban Center Safety Net Specialty Hospital.
- Essential Access Hospital: General Hospital or Critical Access Hospital located in a Rural Area with 25 or fewer licensed beds.
- General Hospital.
- Psychiatric Hospitals.
- Outpatient Services Fee.
- Inpatient Services Fee.
- Long Term Care Hospital.
- Rehabilitation Hospital.
- Managed Care Day: Primary payer is a Medicaid health maintenance organization (HMO), a Medicare HMO, or commercial managed care program, such as an HMO or a preferred provider organizations (PPOs).
- Non-Managed Care Day: Primary payer is not a Medicaid HMO, Medicare HMO, or a commercial managed care program.
- Medicaid Nursery Day: Days of care provided to Medicaid newborns while the mother is in the hospital.

8.2002: Responsibilities of the Department and Hospitals

A. Data Reporting:

For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and calculating the distribution of Supplemental Payments, the Department shall distribute a data survey to all hospitals subject to the Outpatient Services Fee or the Inpatient Services Fee by March 30 of each year. Hospitals shall report the survey data, as requested, to the Department by April 30.

The Department shall distribute a data confirmation survey to all hospitals subject to the Outpatient Services Fee or the Inpatient Services Fee annually. The data confirmation survey 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 annual data confirmation survey shall clearly state the manner and timeline in which hospitals may revise or appeal the data elements recorded by the Department.

B. Fee Assessment and Collection:

1. Establishment of Electronic Funds Transfer: 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) process to deposit Supplemental Payments. The Department shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

2. Fee Collection and Payment Timeline: In fiscal year 2009-10 Outpatient Services Fees, Inpatient Services Fees, and payments will occur on April 16, 2010; April 30, 2010; May 14, 2010 and June 11, 2010.

   Beginning in fiscal year 2010-11 Outpatient Services Fees, Inpatient Services Fees, and payments will occur monthly on the XX Friday of each month.

3. Waive Electronic Funds Transfer: Any hospital with annual estimated or actual assessed fees greater than $X,XXX,XXX must participate in the electronic funds process utilized by the Department for the collection of Outpatient Services Fees and Inpatient Services Fees and the payment of Supplemental Payments unless the Department has approved a waiver of such requirements. Upon request, the Department will supply any hospital with instructions for applying for said waiver. Waivers will not be approved for hospitals that do not supply sufficient information to excuse themselves from the electronic funds process or for hospitals that do not propose an acceptable alternative hospital provider fee collection and payment deposit process.

8.2003: Hospital Provider Fees

A. Outpatient Services Fee:

1. Federal limits, B1/B2 Waiver, Federal Approval.

2. Exempted providers: Free-Standing Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals.

3. Calculation methodology.
   a. The Outpatient Services Fee are calculated as a percentage of total hospital outpatient charges from each hospital's most recent CMS 2552-96 cost report as available on May 1 from CMS in published Healthcare Cost Report Information System (HCRIS) data. Total hospital outpatient charges equal the sum of cost centers 37 through 62 from Worksheet C, Column 7 in the CMS 2552-96.
   b. High Volume Medicaid and CICP Hospitals' Outpatient Services Fees are calculated as .XXXX% of total outpatient hospital charges.

c. All other hospitals Outpatient Services Fees' are calculated as .XXXX% of total outpatient hospital charges.

B. Inpatient Services Fee:

1. Federal limits, B1/B2 Waiver, Federal Approval.

2. Exempted providers: Free-Standing Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals.

3. Calculation methodology.
   a. The Inpatient Services Fee are calculated on a per inpatient day basis for Managed Care Days and Non-Managed Care Days as reported to the Department by each hospital by April 30.
   b. High Volume Medicaid and CICP Hospitals' Inpatient Services Fees are calculated as $XXX.XX for each Managed Care Day and $XXX.XX for each Non-Managed Care Day.
   c. Essential Access Hospitals' Inpatient Services Fees are calculated as $XXX.XX for each Managed Care Day and $XXX.XX for each Non-Managed Care Day.
   d. All other hospitals' Inpatient Services Fees are calculated as $XXX.XX for each Managed Care Day and $XXX.XX for each Non-Managed Care Day.

C. Collection of Fees:

The Department shall calculate fees in accordance with Colorado Revised Statutes and federal regulations. Upon approval by the Centers for Medicare and Medicaid Services, the Hospital Provider Fee Oversight and Advisory Board and the Medical Services Board, the Department shall notify hospitals, in writing, of the annual fees to be collected each year, the methodology to calculate such fees, and the fee assessment schedule. Hospitals shall be notified, in writing, at least ten business days prior to any change in the dollar amount or timing of fees to be assessed.

8.2004: Supplemental Medicaid and Disproportionate Share Hospital Payments

A. Conditions applicable to all Supplemental Payments:

All Supplemental Payments are prospective payments subject to the Medicare 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 will be made retroactively.

B. Outpatient Hospital Supplemental Medicaid Payment:

Qualifications for payment: General Hospitals, Rehabilitation Hospitals or Critical Access Hospitals.

Excluded Hospitals: Psychiatric Hospitals, Long Term Care Hospitals.

Calculation methodology for payment: For each qualified hospital, the Supplemental Medicaid Outpatient Hospital Payment equals inflated hospital specific outpatient billed costs, as reported from the MMIS and inflated forward to the payment year, multiplied by XX.X%. If the hospital qualifies as a Major Pediatric Teaching Hospital this payment equals inflated hospital specific outpatient billed costs multiplied by XX.X%.

C. Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment:

Qualifications for payment: General Hospital or Critical Access Hospital located in a Rural Area, with 20 or fewer licensed beds, where at least 80% of its total Medicaid payments are for outpatient hospital services.

Excluded Hospitals: Psychiatric Hospitals, Long Term Care Hospitals.

Calculation methodology for payment: XX% of the Supplemental Medicaid Outpatient Hospital Payment.

D. CICP Disproportionate Share Hospital Payment:

Qualifications for payment: General Hospital or Critical Access Hospital, participates in the Colorado Indigent Care Program.

Excluded Hospitals: Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals.

Calculation methodology for payment: State-Owned Government Hospitals shall receive XX% of the State's Annual Disproportionate Share Hospital Allotment, Non-State-Owned Government Hospitals shall receive XX% and Private-Owned Hospitals shall receive XX%, subject to the hospital-specific Disproportionate Share Hospital limit specified in federal regulations. Payments may be reduced retroactively if upon review, it is determined that this limit has been exceeded.

E. Uninsured Disproportionate Share Hospital Payment:

Qualifications for payment: General Hospital or Critical Access Hospital. Reports to the Department charges for services provided to low-income uninsured persons. Does not participate in the CICP Program.

Excluded Hospitals: Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals.

Calculation methodology for payment: Share of the percent of uncompensated uninsured costs of all qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital Payment. Beginning in FY 2009-10, XX% of the State's annual Disproportionate Share Hospital allotment shall be allocated to this Payment.

F. CICP Supplemental Medicaid Payment:

Qualifications for payment: General Hospital or Critical Access Hospital, participates in the Colorado Indigent Care Program.

Excluded Hospitals: Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals or does not participate in the CICP.

Calculation methodology for payment:

1. Uncompensated CICP costs are calculated as available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) multiplied by the most recent provider specific audited cost-to-charge ratio (as calculated from the audited CMS 2552-96 cost report available as of May 1 each fiscal year) and inflated forward to the payment year.

2. Qualified hospitals shall receive a payment equal to uncompensated CICP costs multiplied by the percent of inflated medically indigent costs less the payment received under the CICP Disproportionate Share Hospital Payment The percent of inflated medically indigent costs shall be:
   a. High Volume Medicaid and CICP Hospitals will be reimbursed at 75% of uncompensated CICP costs.
   b. Rural Hospitals will be reimbursed at 100% of uncompensated CICP costs.
   c. All other qualified hospitals will be reimbursed at 90% of uncompensated CICP costs.

G. Inpatient Hospital Base Rate Supplemental Medicaid Payment:

Qualifications for payment: General Hospital, Rehabilitation Hospital, Long Term Care Hospital or Critical Access Hospital with an established Medicaid inpatient base rate.

Excluded Hospitals: Psychiatric Hospitals.

Calculation methodology for payment: For each qualified hospital, this payment is calculated as the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate and increased as follows:

1. Pediatric Specialty Hospitals shall have a XX.X% increase.

2. Urban Center Safety Net Specialty Hospitals shall have a XX.X% increase.

3. Rehabilitation, Specialty Acute, Rural and Urban Hospitals shall have a XX.X% increase.

H. High Level Neo-natal Intensive Care Unit (NICU) Supplemental Medicaid Payment:

Qualifications for payment:

1. Certified Level IIIb or IIIc Neo-Natal Intensive Care Unit (NICU) according to American Academy of Pediatrics guidelines by the Colorado Perinatal Care Council.

2. General Hospital or Critical Access Hospital.

Calculation methodology for payment: For each qualified hospital, this payment is calculated as $XXX.XX per Medicaid Nursery Day.

I. State Teaching Hospital Supplemental Medicaid Payment:

Qualifications for payment: General Hospital, State University Teach Hospital, is a High Volume Medicaid and CICP Hospital.

Calculation methodology for payment:
For each qualified hospital, this payment is calculated as $XXX.XX per Medicaid day.

J. Large Rural Hospital Supplemental Medicaid Payment:

Qualifications for payment: General Hospital, located in a Rural Area, with 26 or more licensed beds.

Calculation methodology for payment: For each qualified hospital, this payment is calculated as $XXX.XX per Medicaid day.

K. Denver Metro Supplemental Payment:

Qualifications for payment: General Hospital located in Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County or Douglas County.

Excluded Hospitals: Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, High Volume Medicaid and CICP Hospitals.

Calculation methodology for payment:

1. For each qualified hospital located in Adams County or Arapahoe County, this payment is calculated as $XXX.XX per Medicaid day.

2. For each qualified hospital located in Boulder County, Broomfield County, Denver County or Jefferson County, this payment is calculated as $XXX.XX per Medicaid day.

L. Metropolitan Statistical Area Payment:

Qualifications for payment: General Hospital located in El Paso, Larimer, Pueblo or Weld county.

Excluded Hospitals: Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, High Volume Medicaid and CICP Hospitals.

Calculation methodology for payment: For each qualified hospital this payment is calculated as $XXX.XX per Medicaid day.

M. Quality Incentive Payments:

Under development through the Hospital Quality Incentive Payment (HQIP) committee.