CICP Provider Meeting
March 19, 2010

Handout 1a

D R A F T
Hospital Provider Fee Rules to Delete or Modify Current Portions of Existing Rules

Please direct comments concerning this draft proposal to:
Cindy Arcuri, Supervisor, Safety Net Financing Programs
by 5:00 p.m. March 24, 2010

phone: 303-866-3996
e-mail Cynthia.Arcuri@state.co.us

8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

1. Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a ~~Low Income~~ CICP Disproportionate Share Hospital Payment defined in 10 CCR 2505-10 section 8.~~903~~2000.

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

3. ~~The total available funds for the Low Income Shortfall payment equals the percentage of Self Pay Days plus Other Paid Days of those providers who qualify for the Low income Shortfall payment compared to all other Medicaid Inpatient Hospital providers multiplied by the General Fund appropriated by the General Assembly to Safety Net Provider Payments. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital-specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low-Income Shortfall payment for the specific provider.~~

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Contract Requirements for Qualified Health Care Providers

1. A contract 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 26-15-106 (5)(a)(I), C.R.S.

2. A contract 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 (5)(a)(II), C.R.S.

3. Contracts may be executed with general providers throughout Colorado that can meet the following minimum criteria:

   a. Licensed or certified as a general hospital, community health clinic, or maternity hospital (birth center) by the Department of Public Health and Environment.

   b. Hospital providers shall assure that emergency care is available to all clients throughout the contract year.

   c. Hospital providers shall have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

   d. If the general provider is located within the City and County of Denver, the general provider must offer discounted specialty health care services to a specific population, of which more than 50% must reside outside the City and County of Denver (does not apply to University Hospital or Denver Health).

B. Determination of Client Eligibility to Receive Discounted Health Care Services Under Available CICP Funds

1. Using the information submitted in connection with an application to receive discounted health care services under available CICP funds, the provider shall determine whether the applicant meets all requirements to receive discounted health care services under available CICP funds. If the applicant is eligible to receive discounted health care services under available CICP funds, the qualified health care provider shall determine an appropriate rating and copayment for the client, using the current federal poverty levels (referred to as the ability-to-pay scale) and copayment table, under section 8.907 in these regulations.

2. The qualified health care provider should determine if the applicant is eligible to receive discounted services under available CICP funds at the time of application, unless required documentation is not available. The qualified health care provider shall determine whether the applicant is eligible to receive discounted health care services

within 15 days from the date that the applicant submits a signed application and such other information, written or otherwise, as is necessary to process the application.

3. The qualified health care provider shall provide the applicant and/or representative a written notice of the provider's determination as to the applicant's eligibility to receive discounted services under available CICP funds. If eligibility to receive discounted health care services is granted by the qualified health care provider, the notice shall include the date when eligibility began. If eligibility to receive discounted health care services is denied, the notice shall include a brief, understandable explanation of the reason(s) for the denial. Every notice of the qualified health care provider's decision, whether an approval or a denial, shall include an explanation of the applicant's appeal rights found at Section 8.908 in these regulations.

C. Distribution of Available Funds to Providers

1. Distribution of available funds to qualified hospitals is found in 10 CCR 2505-10 section 8.2000. ~~health care providers (providers) is limited by the annual legislative appropriation and funds will be proportionately allocated to providers based on the anticipated utilization of services. Payments made under this section to state-owned and local-owned hospital providers will consist of Certification of Public Expenditure (see 8.903.C.3) and federal funds, as determined by the federal financial participation (FFP) amount. Payments made under this section to private-owned hospital providers will consist of General Fund and federal funds, as determined by the FFP amount.~~

   ~~Hospital providers who participate in the Colorado Indigent Care Program and whose percent of Medicaid-eligible inpatient days relative to total inpatient days is equal to 1% or greater, qualify to receive a Low-Income payment and a High-Volume payment. In addition, local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and those state-owned hospital providers whose percent of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association, qualify for a Bad Debt payment if funding exists.~~

   ~~To receive a Low-Income payment, hospital providers must have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.~~

2. 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. Available medically indigent charges are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 of each fiscal year. Medically indigent costs are inflated forward to the budget year using Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year. The basis for this calculation will be data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year.

~~3. Annually, state-owned and local-owned hospital providers shall submit a letter to the Department which states the cost not directly compensated by General Fund or Federal Funds for Medicaid inpatient hospital services and medically indigent services associated with the distribution of available funds. (Referred to as Certification of Public Expenditures.)~~

~~4.~~ Providers will be notified of the distribution amounts for each State fiscal year no later than thirty (30) days prior to July 1 of each State fiscal year. The Department will notify the provider, without prior notice, of any changes in the distribution amounts applicable to the provider for a current State fiscal year that occur after July 1 of that State fiscal year.

~~5~~3. Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department concerning the use of CICP funding.

~~6~~4. Providers shall deduct the full patient liability amount from total charges, which is the amount due from the client as identified in the CICP Copayment Table, as defined under Section 8.907 in these regulations. The summary information submitted to the Department concerning the use of CICP funding by the provider shall include the full patient liability amount even if the provider receives the full payment at a later date or through several smaller installments or no payment from the client.

~~7~~5. Beyond the distribution of available funds made by the CICP, allowable client copayments, and other third-party sources, a provider shall not seek payment from a client for the provider's CICP discounted health care services to the client.

~~8. High-Volume Payment. This payment is an allocation of the available Medicare Upper Payment Limit and is available only to hospital providers. As required by federal regulations, there would be three allotments of the upper payment limit: state-owned, local-owned, and private-owned hospital providers.~~

~~The amount of available funds under the Medicare Upper Payment Limit is distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for qualified hospital providers. This calculation would be separate for state-owned, local-owned, and private-owned hospital providers, since the three groups are limited to unique pools of funds.~~

~~The available funds under the Medicare Upper Payment Limit are multiplied by the hospital provider specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for qualified hospital providers to calculate the High-Volume payment for the specific hospital provider. The available funds under the Medicare Upper Payment Limit by hospital provider category are:~~

~~a. Private-Owned Hospital Providers. The General Fund and FFP available and allocated by the Department under the Medicare Inpatient Upper Payment Limit for private-owned hospital providers.~~

~~b. Local-Owned Hospital Providers. The Certification of Public Expenditure and FFP available under the Medicare Inpatient Upper Payment Limit for local-owned hospital providers.~~

~~c. State-Owned Hospital Providers. The Certification of Public Expenditure and FFP available under the Medicare Inpatient Upper Payment Limit for state-owned hospital providers.~~

~~No payment (consisting of Federal Funds and General Fund or Certification of Public Expenditure) to a Local-Owned Hospital or State-Owned Hospital Provider will exceed 100% of uncompensated Medicaid inpatient hospital costs. Any amount of the calculated High-Volume payment that exceeds the calculated uncompensated Medicaid inpatient hospital costs will be added to the Low-Income payment calculation for that hospital provider. Uncompensated Medicaid inpatient hospital costs will be the maximum of the calculation of billed charges from inpatient claims paid in the most recently available State fiscal year multiplied by the cost-to-charge ratio available as of March 1 of each fiscal year minus the Medicaid reimbursement paid amount from inpatient claims paid in the same period, or the uncompensated Medicaid inpatient hospital costs from the prior State fiscal year, as reported under 8.903(C)(3) in these regulations, such that both figures will be inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.~~

~~9. Low-Income payment. This payment is an allocation of the available Disproportionate Share Hospital Allotment imposed by the federal Centers for Medicare and Medicaid Services and is only available to hospital providers. The Disproportionate Share Hospital Allotment (or Cap) would be distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for hospital providers. This calculation is separate for public-owned (state-owned and local-owned) and private-owned hospital providers, since the two hospital provider categories have unique pools of General Fund appropriated each fiscal year.~~

~~As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment (consisting of Federal Funds and General Fund or Certification of Public Expenditure) to a hospital provider will exceed 100% of Medically Indigent costs. No hospital provider will receive a payment greater than hospital provider specific inflated medically indigent care costs or the uncompensated medically indigent costs as required under 8.903(C)(3). If the calculation generates a hospital provider specific payment beyond either of these amounts, the federal funds will remain under the Disproportionate Share Hospital Allotment.~~

~~The available Disproportionate Share Hospital Allotment is multiplied by the hospital provider specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for hospital providers to calculate the Low-Income payment for the specific hospital provider category.~~

~~a. Private-Owned Hospital Providers. The available Disproportionate Share Hospital Allotment for private-owned hospital providers equals the General Fund and FFP available and allocated by the Department under the Disproportionate Share Hospital Allotment for private-owned hospital providers.~~

~~b. Public-Owned Hospital Providers. The available federal funds Disproportionate Share Hospital Allotment for public-owned (state-owned and local-owned) hospital providers equals the Disproportionate Share Hospital Allotment minus other federal funds designated as a Disproportionate Share Hospital payment under another payment and the amount of the federal funds distributed to the private-owned hospital providers.~~

~~10. Weighted Costs, High-Volume Payment and Low-Income Payment.~~

~~The hospital provider specific medically indigent costs are increased by the percent of Medicaid-eligible inpatient (fee-for-service and managed care) days relative to total inpatient days and percent of medically indigent days relative to total inpatient days to measure the relative Medicaid and low-income care to total care provided. For state-~~

~~owned hospital providers, these percentages are not allowed to exceed one standard deviation above the mean for each weight.~~

~~The hospital provider specific medically indigent costs are further increased by the Disproportionate Share Hospital Factor, if the hospital provider qualifies, to account for disproportionately high volumes of Medicaid. To qualify for the Disproportionate Share Hospital Factor, the hospital provider's percent of Medicaid-eligible inpatient days relative to total inpatient days must equal or exceed one standard deviation above the mean. If the hospital provider does qualify, then the Disproportionate Share Hospital Factor would equal the hospital provider's specific percent of Medicaid-eligible inpatient days relative to total inpatient days. For local-owned hospital providers with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and private-owned hospital providers, the Disproportionate Share Hospital Factor is doubled. For local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the mean. If the hospital provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.~~

~~The hospital provider specific medically indigent costs are further increased by the Medically Indigent Factor, if they qualify, to account for disproportionately high volumes of low-income care provided. To qualify for the Medically Indigent Factor, the hospital provider's percent of medically indigent days relative to total inpatient days must exceed the mean. If the hospital provider does qualify, then the Medically Indigent Factor equals the hospital provider specific percent of medically indigent days relative to total inpatient days. For local-owned hospital providers with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and private-owned hospital providers, this factor is doubled. For local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers, the Medically Indigent Factor is not allowed to exceed one standard deviation above the mean. If the hospital provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.~~

~~11. Bad Debt Payment. A Bad Debt payment is made only if federal funds remain available under the Disproportionate Share Hospital Allotment (or Cap) following the distribution of the Low-Income payment and the Low-Income Shortfall payment. This payment is available to local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers whose percent of Medicaid-eligible inpatient days relative to total inpatient days equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association if funding exists.~~

~~The amount of available federal funds remaining under the Disproportionate Share Hospital Allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt costs for all hospital providers that qualified to receive the Bad Debt payment. Available Bad Debt charges are converted to Bad Debt costs using the most recent hospital provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.~~

~~Available funds under the Disproportionate Share Hospital Allotment are multiplied by the hospital provider specific Bad Debt costs divided by the sum of all Bad Debt costs for all hospital providers that qualified to receive the Bad Debt payment to calculate the Bad Debt payment for the specific hospital provider.~~

6~~12~~. 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: [Eff. 7/1/2007]

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s; [Eff. 7/1/2007]

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed; [Eff. 7/1/2007]

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations. [Eff. 7/1/2007]

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 [Eff. 7/1/2007]

e. Participates in the Colorado Indigent Care Program [Eff. 7/1/2007]

~~The payment will be made prior to the High-Volume payment and will equal the Major Teaching Hospital Rate multiplied by the available Medicare Upper Payment Limit for the hospital providers that qualified to receive the Pediatric Major Teaching Payment.~~ The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly. [Eff. 7/1/2007]

~~13. To calculate the distribution of available funds to hospital providers, hospital providers shall annually submit data relating to the number of Medicaid-eligible inpatient days and total inpatient days in a form specified by the Department by April 30 of each year. [Eff. 7/1/2007]~~

7~~14~~. Colorado Health Care Services Payment. This payment is repealed effective September 1, 2009.

8~~15~~. Rural Hospital Payment. This payment is repealed effective September 1, 2009.

9~~16~~. Public Hospital Payment. This payment is repealed effective September 1, 2009.

D. Audit Requirements [Eff. 7/1/2007]

The qualified health care provider shall provide the Department with an annual audit compliance statement as specified in the CICP Manual. The purpose of the audit requirement is to furnish the Department with a separate audit report, which attests to the qualified health care provider's compliance with the use of CICP funding and other requirements for participation. In addition, the audit report will furnish verification that the qualified health care provider accurately reported to the Department Medicaid-eligible inpatient days and total inpatient days used to calculate the distribution of available funds to providers defined under 8.903(C). [Eff. 7/1/2007]

E. HIPAA [Eff. 7/1/2007]

The Department has determined that the Colorado Indigent Care Program (CICP) is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the Colorado Indigent Care Program (CICP)

is not a part of Medicaid, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a qualified health care provider or client. [Eff. 7/1/2007]