CICP Provider Meeting
March 19, 2010
Handout 1

D R A F T
Hospital Provider Fee Rules

Please direct comments concerning this draft proposal to:
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by 5:00 p.m. March 24, 2010

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8.2000: HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3, authorizes the Department of Health Care Policy and Financing (Department) to assess a hospital provider fee, pursuant to rules adopted by the State Medical Services Board, to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program (CICP). In addition, the Act requires the Department to use the hospital provider fee to expand health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan *Plus* (CHP+), and for low-income adults without dependent children; to provide a Medicaid buy-in program for people with disabilities; to implement twelve month continuous eligibility for Medicaid eligible children; and to pay the Department's administrative costs of implementing and administering the Act.

Amendments to this rule shall be subject to approval by the State Medical Services Board.

8.2001: DEFINITIONS

A. "Bad Debt" means the current period charge for actual or expected doubtful accounts resulting from the extension of credit.

B. "Charity Care" results from a hospital's policy to provide health care services free of charge, or where only partial payments are expected, (not to include contractual allowances for otherwise insured patients) to individuals who meet certain financial criteria. Charity Care does not include health care services rendered under the CICP or those classified as Bad Debt.

C. "CICP" means the Colorado Indigent Care Program, as described in Section 8.900.

D. "Day" means an inpatient hospital admission for at least twenty-four hours as reported on the hospital's patient census.

E. "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 CFR 485.601-645 and certified as a critical access hospital by the Department of Public Health and Environment.

F. "Essential Access Hospital" means a General Hospital or Critical Access Hospital located in a Rural Area with 25 or fewer licensed beds.

G. "General Hospital" means a hospital licensed as a general hospital by the Department of Public Health and Environment.

H. "High Volume Medicaid and CICP Hospital" means a hospital with at least 35,000 Medicaid days per year that provides over 30% of its total days to Medicaid and CICP clients.

I. "HMO" means a health maintenance organization that provides health care insurance coverage to an individual.

J. "Hospital-Specific Disproportionate Share Hospital Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under federal regulations Section 447.299(c) based on uncompensated Medicaid and uninsured costs for inpatient and outpatient hospital services.

K. "Long Term Care Hospital" means a General Hospital that is certified as a long term care hospital by the Colorado Department of Public Health and Environment.

L. "Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

M. "Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

N. "Managed Care Day" means a Day listed as HMO or PPO Days on the hospital's patient census.

O. "Medicaid Fee-for-Service Day" means a Non-Managed Care Day for which Medicaid is the primary payer. For these Days the hospital is reimbursed directly through the Department's fiscal agent.

P. "Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.

Q. "Medicaid Nursery Day" means a Managed Care Day or Non-Managed Care Day provided to Medicaid newborns while the mother is in the hospital.

R. "Medicaid Psychiatric Day" means a Managed Care Day or Non-Managed Care Day provided to a Medicaid recipient in the hospital's sub-acute psychiatric unit.

S. "Medicaid Rehabilitation Day" means a Managed Care Day or Non-Managed Care Day provided to a Medicaid recipient in the hospital's sub-acute rehabilitation unit.

T. "Medically Indigent Costs" are calculated by multiplying CICP Write-Off Charges by the cost-to-charge ratio that is calculated from the most recently audited Medicaid cost report.

U. "Medicare Fee-for-Service Day" means a Non-Managed Care Day for which Medicare is the primary payer and the hospital is reimbursed on the basis of a Diagnostic Related Group (DRG).

V. "Medicare HMO Day" means an HMO Day for which the primary payer is Medicare.

W. "Medicare-Medicaid Dual Eligible Day" means a Day for which the primary payer is Medicare and the secondary payer is Medicaid.

X. "Non-Managed Care Day" means a Day for which the primary payer is an indemnity insurance plan or other insurance plan not servingas an HMO or PPO.

Y. "Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local government.

Z. "Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges.

AA. "Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

BB. "Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.

CC. "PPO" means a preferred provider organization that is a type of managed care organization that provides health care insurance coverage.

DD. "Psychiatric Hospitals" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

EE. "Privately-owned Hospital" means a hospital that is privately owned and operated.

FF. "Rehabilitation Hospital" means an inpatient rehabilitation facility.

GG. "Rural Area" means a county outside a federally designated Metropolitan Statistical Area.

HH. "State-Owned Government Hospital" means a hospital that is either owned or operated by the State.

II. "State Teaching Hospital" means a High Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents

enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

JJ. "Third-Party Medicaid Day" means a Day for which third party coverage, other than Medicare, is the primary payer and Medicaid is the secondary payer.

KK. "Uninsured/Self Pay Day" means Day for self-pay patients and patients without third party health insurance coverage. Uninsured/Self Pay Day does not include Charity Care Days or CICP Days.

LL. "Uninsured/Self Pay Write Off Charges" means charges for self-pay patients and those with no third party coverage less adjustments for a hospital's courtesy or uninsured or self-pay policy discounts.

MM. "Urban Center Safety Net Specialty Hospital" means a hospital with Medicaid Days plus CICP Days relative to total Days, rounded to the nearest percent, equals or exceeds 67%.

NN. "Write-Off Charges" equals the hospital's charges, less payments from a primary payer, less any copayment due from the client, less any other third party payments.

8.2002: Responsibilities of the Department and Hospitals

A. Data Reporting

For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and 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. The Department shall include definitions and descriptions of each data element requested in the survey. Hospitals shall submit the data survey, as requested, to the Department by April 30 of each year. The Department may estimate any survey data element not provided directly by a hospital.

Hospitals shall submit the following data elements and any additional elements requested by the Department: (a) Managed Care Days, (b) Non-managed Care Days, (c) Medicaid Fee-for-Service Days, (c) Medicaid Nursery Days, (e) Medicaid Managed Care Days, (f) Medicaid Psychiatric Days, (g) Medicaid Rehabilitation Days, (h) Medicare Fee-for-Service Days, (i) Medicare HMO Days, (j) CICP Days, (k) Charity Care Days, (l) Uninsured/Self-Pay Days, (m) Other Payers Days (those Days not included in letters a through l), (n) Total Days reported on the patient census, (o) Charity Care Write-Off Charges, (p) Bad Debt excluding Medicare , (q) Uninsured/Self Pay Write-Off Charges, (r) Medicare-Medicaid Dual Eligible Days, and (s) Third Party Medicaid Days.

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 data confirmation survey shall clearly state the

manner and timeline in which hospitals may request revisions to the data elements recorded by the Department. Revisions to the data will not be permitted by a hospital after the Department has completed the data confirmation survey.

B. Fee Assessment and Collection

1. Establishment of Electronic Funds Process. The Department shall utilize an Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental payments in financial accounts authorized by hospitals. The Department shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

2. Fee Collection and Payment Disbursement. In state fiscal year (SFY) 2009-10 Outpatient Services Fee and Inpatient Services Fee (collectively referred to as "fee") will be assessed on an annual basis and collected in four installments on or about, April 16, 2010; April 30, 2010; May 14, 2010 and June 11, 2010.

   For those hospitals that participate in the electronic funds process utilized by the Department, payments will be calculated on an annual basis and disbursed in four installments on the same date the fee is assessed.

   Payments to hospitals will be processed by the Department within two business days of receipt of a warrant (paper check) or wire transfer to pay the Outpatient Services Fee and Inpatient Services Fee from hospitals that do not participate in the ACH debit process utilized by the Department. Payments through a warrant (paper check) will be processed by the Department within two business days of receipt of the Outpatient Services Fee or Inpatient Services Fee for those hospitals that do not participate in the EFT payment process utilized by the Department to deposit supplemental payments in financial accounts authorized by hospitals.

   Beginning in SFY 2010-11 the Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve installments on the second Friday of each month. Payments to hospitals will be calculated on an annual basis and disbursed in twelve installments on the second Friday of each month. If the Department must diverge from this schedule due to State holidays, bank holidays, or unforeseen circumstances, the Department will notify hospitals in writing as soon as possible.

3. Electronic Funds Process Waiver. Hospitals must participate in the electronic funds process utilized by the Department for the collection of the Outpatient Services Fee and Inpatient Services Fee and the payment of supplemental payments unless the Department has approved an alternative process. A hospital requesting to not participate in the ACH debit process, EFT payment process, fee collection process and/or payment process must submit a written request to the Department describing an alternative collection process and/or payment process. The Department shall approve or deny the alterative process within 30 calendar days of receipt of the request.

8.2003: Hospital Provider Fee

A. Outpatient Services Fee

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with federal regulations at 42 CFR 433.68.

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 0.35% 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 cost report. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted 0.84%.

B. Inpatient Services Fee

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with federal regulations at 42 CFR 433.68.

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $60 per day for Managed Care Days and $270 per day for all other Days as reported to the Department by each hospital by April 30 with the following exceptions:

   a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $32 per day for Managed Care Days and $141 per day for all other Days.

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to $24 per day for Managed Care Days and $108 per day for all other Days.

C. Assessment of Fee

The Department shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3 and federal regulations. Upon receiving a favorable recommendation by the Hospital Provider Fee Oversight and Advisory Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these

approvals, the Department shall notify hospitals, in writing, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing, at least thirty calendar days prior to any change in the dollar amount of Inpatient Services Fee and Outpatient Services Fee to be assessed.

The Inpatient Services Fee and Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital during the data confirmation survey. The Inpatient Services Fee and Outpatient Services Fee will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2004: Supplemental Medicaid and Disproportionate Share Hospital Payments

A. Conditions applicable to all supplemental payments

All supplemental payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Department.

No hospital shall receive a payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the CICP Disproportionate Share Hospital payment or the Uninsured Disproportionate Share Hospital payment exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, that hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction for the CICP Disproportionate Share Hospital payment shall be then retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of uncompensated CICP cost, relative to the aggregate of uncompensated CICP costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit. The amount of the retroactive reduction for the Uninsured Disproportionate Share Hospital payment shall be then retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of uncompensated uninsured cost relative to the aggregate of uncompensated uninsured costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit.

In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation survey. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

B. Outpatient Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals or Critical Access Hospitals shall receive this payment.

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

3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado Medicaid Management Information System (MMIS) are multiplied by the cost-to-charge ratio calculated from the most recent audited CMS 2552-96 cost report for each hospital available as of May 1 of each year to arrive at hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient Hospital Payment Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for managed care enrollment, changes and utilization and inflation, where inflation is measured 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, multiplied by 29.4%. If the hospital qualifies as a Pediatric Specialty Hospital this payment equals hospital-specific outpatient billed costs adjusted for managed care enrollment, changes in utilization and inflation, multiplied by 16.8%.

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

Qualified hospitals. General Hospitals or Critical Access Hospitals located in a Rural Area, with 20 or fewer licensed beds, where at least 80% of total Medicaid payments are for outpatient hospital services shall receive this payment.

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

Calculation methodology for payment. This payment shall equal 46% of inflated annual hospital-specific Medicaid outpatient billed costs.

D. CICP Disproportionate Share Hospital Payment

Qualified hospitals. General Hospitals or Critical Access Hospitals that participate in the CICP shall receive this payment.

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

Calculation methodology for payment. State-Owned Government Hospitals shall receive 5.06% of the State's annual Disproportionate Share Hospital Allotment, Non-State-Owned Government Hospitals shall receive 40% and Private-Owned Hospitals shall receive 35%.

E. Uninsured Disproportionate Share Hospital Payment

Qualified hospitals. General Hospitals or Critical Access Hospitals that report charges for services provided to low-income uninsured persons to the Department in a manner as prescribed by the Department shall receive this payment.

Excluded hospitals. Hospitals that participate in the CICP, Psychiatric Hospitals, Long Term Care Hospitals or Rehabilitation Hospitals shall not receive this payment.

Calculation methodology for payment. Beginning in FY 2009-10, 19.94% of the State's annual Disproportionate Share Hospital allotment shall be allocated to the Uninsured Disproportionate Share Hospital Payment. A qualified hospital's annual payment shall equal its 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.

F. CICP Supplemental Medicaid Payment

Qualified hospitals. General Hospitals or Critical Access Hospitals that participate in the CICP shall receive this payment.

Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals or hospitals that do not participate in the CICP shall not receive this payment.

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 an annual payment equal to a percentage of uncompensated CICP costs less the payment received under the CICP Disproportionate Share Hospital Payment. The percentage applied to uncompensated CICP costs shall be:

   a. Seventy-five percent for High Volume Medicaid and CICP Hospitals,

   b. One hundred percent for Rural Hospitals, or

   c. Ninety percent for all other qualified hospitals.

G. Inpatient Hospital Base Rate Supplemental Medicaid Payment

Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Long Term Care Hospitals or Critical Access Hospitals with an established Medicaid inpatient base rate shall receive this payment.

Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

Calculation methodology for payment. For each qualified hospital, this annual payment equals the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate with increases as follows:

1. Pediatric Specialty Hospitals shall have a 13.76% increase.

2. Urban Center Safety Net Specialty Hospitals shall have a 5.8% increase.

3. Rehabilitation, Specialty Acute, Rural and Urban Hospitals shall have an 18.1% increase.

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

Qualified hospitals. General Hospitals or Critical Access Hospitals certified level IIIb or IIIc neo-natal intensive care unit (NICU) according to American Academy of Pediatrics guidelines by the Colorado Perinatal Care Council shall receive this payment.

Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $450 per Medicaid Nursery Day.

I. State Teaching Hospital Supplemental Medicaid Payment.

Qualified hospitals. State Teaching Hospitals shall receive this payment.

Calculation methodology for payment.
For each qualified hospital, this payment is calculated on an annual basis at $75 per Medicaid day.

J. Large Rural Hospital Supplemental Medicaid Payment

Qualified hospitals. General Hospitals located in a Rural Area with 26 or more licensed beds shall receive this payment.

Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $315 per Medicaid day.

K. Denver Metro Supplemental Medicaid Payment

Qualified hospitals. General Hospitals located in Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County or Douglas County shall receive this payment.

Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, or High Volume Medicaid and CICP Hospitals shall not receive this payment.

Calculation methodology for payment.

1. For each qualified hospital located in Adams County or Arapahoe County, this payment is calculated on an annual basis at $400 per Medicaid day.

2. For each qualified hospital located in Boulder County, Broomfield County, Denver County or Jefferson County, this payment is calculated as $510 per Medicaid day.

L. Metropolitan Statistical Area Supplemental Medicaid Payment

Qualified hospitals. General Hospitals located in El Paso County, Larimer County, Pueblo County or Weld County shall receive this payment.

Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, or High Volume Medicaid and CICP Hospitals shall not receive this payment.

Calculation methodology for payment. For each qualified hospital this payment is calculated on an annual basis at $310 per Medicaid day.

M. Pediatric Specialty Hospital Provider Fee Payment

Qualified hospitals. Hospitals qualified to receive the Pediatric Major Teaching Hospital Payment in Section 8.903.C.2 shall receive this payment.

Calculation methodology for payment. For each qualified hospital, this payment shall equal $5 million.

8.2005: Effective Date

This rule is effective April 9, 2010 upon approval of the Medical Services Board, or upon CMS approval of the corresponding hospital provider fee waivers and State Plan Amendments, whichever date is later. If CMS approval of the Outpatient Services portions of this rule does not occur simultaneously with CMS approval of the Inpatient Services portions of this rule, the Department is neither precluded from implementing approved portions, nor bound to implement approved portions upon the approval date of said portion.