

Hospital Provider Fee Question & Answer Document
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1. What is a Hospital Provider Fee?

The Hospital Provider Fee is authorized under the Health Care Affordability Act of 2009 (HB 09-1293). Provider fees are a bona fide, legal funding source eligible for federal matching funds when used to reimburse Medicaid covered services. Such assessments and related payments are allowable under federal regulations 42 CFR 433.68.

In many states, such assessments are called “provider taxes” since the revenue may be used for other items not related not directly related to the assessment (such as paving highways), but in Colorado the assessment is a “provider fee” since the intent of the hospital provider is to increase reimbursements to the hospitals paying the fee, not to increase revenue for general governmental purposes.

Revenue collected from health care related provider fees may serve as the state share of Medicaid expenditures to draw a federal match. In general, to be eligible for Federal Financial Participation (FFP), health care related provider fees must:

- (1) Be imposed on a permissible class of health care services, including, but not limited to, inpatient hospital services, outpatient hospital services, home health care services, and nursing facility services.
- (2) Be broad-based, such that the fee is imposed on all providers within a class.
- (3) Be imposed uniformly throughout a jurisdiction, such that all providers within a class are assessed at the same rate.
- (4) Avoid hold harmless arrangements where the reimbursement amount is positively correlated to the assessment paid by the provider, either directly or indirectly. In other words, there will be winners and losers, where some providers will receive proportionately less in reimbursement compared to their assessed amount.

The federal Medicaid oversight agency, Centers for Medicare and Medicaid Services (CMS) may grant waivers of the broad-based and uniformity provisions if the net impact of the provider fee is generally redistributive and the amount of the fee is not positively correlated to Medicaid payments, as demonstrated via statistical tests described in regulation (see “What is the B1/B2 Test?”).

Health care related fees may be based on a licensing fee on a class of health care services, on a fee per bed, on revenues or other general statistic with respect to a class of services. Per federal law and regulations, the amount assessed on providers of a class of services may not exceed 5.5% of the net patient revenue for that class of services. Congress capped health care related taxes at 6% and temporarily reduced the cap to 5.5% from January 1, 2008 through September 30, 2011.

Distribution of provider fees and resulting FFP back to providers under a provider assessment model may be made through increased Medicaid rates, supplemental Medicaid payments, Disproportionate Share Hospital (DSH) payments, a combination of methods, or other methodologies approved by CMS. All provider payments must be approved by CMS, which are submitted by the Department through a State Plan Amendment (SPA).

A survey by the National Association of State Medicaid Directors (NASMD) found that of 47 responding states, 41 had at least one provider fees. Those include 15 states with inpatient hospital fees, 7 with outpatient hospital fees, 29 with nursing home fees, and 10 with managed care fees, among others. Colorado implemented a nursing home provider fee on July 1, 2008 through HB 08-1114.

2. What is a Provider Fee Waiver?

CMS regulations require that provider fees be broad-based (such that the fee is imposed on all providers within a class) and that the fees are imposed uniformly throughout the state (all providers within a class are assessed at the same rate). CMS may grant a waiver of the broad-based and uniformity provisions if the net impact of the provider fee is generally redistributive and the amount of the fee is not positively correlated to Medicaid payments, as demonstrated via statistical tests described in regulation (see “What is the B1/B2 Test?”). Upon approval by the Hospital Provider Fee Oversight and Advisory Board, the Department will submit a Provider Fee Waiver with a retroactive effective date of July 1, 2009.

3. How is the “Provider Fee Waiver” different from other Medicaid waivers?

The Provider Fee Waiver is specific to the B1/B2 Test and has no relationship to 1915 Waivers, 1115 Waivers, HIFA Waivers or Home and Community Based Services (HCBS) Waiver Programs. The Department will need to submit the Provider Fee Waiver to CMS for approval. Once approved, there is no need to update the waiver unless the Department changes how the fee is structured. CMS has the right to audit the Department and review the Provider Fee Waiver at any time. The Department may also need to submit an 1115 Waiver to expand health care coverage to adults without a dependent child in the household, as scheduled for implementation in early 2012, but that waiver will have no connection to the Provider Fee Waiver.

Two Medicaid program waivers frequently used by states are 1915(b) Waivers and 1915(c) Waivers (referring to different sections of the Social Security Act). 1915(b) Waivers provide managed care services to Medicaid populations and 1915(c) Waivers enable states to provide HCBS to people who would otherwise be institutionalized. There are different sub-groups of these waivers, for example 1915(c) “model” waivers are intended to allow states to test new HCBS.

Programs authorized under Section 1115 of the Social Security Act allow experiments, pilot, or demonstration projects that promote the objectives of the Medicaid policy. The way 1115 “Research and Demonstration” Waivers are used varies because each is a unique project to test new ideas of policy merit. They are generally approved for 5 years and can be extended with CMS approval. 1115 Waiver authority provides flexibility for the provision of services that would not otherwise be matched by federal funding and allows eligibility for those who would otherwise not be eligible for the Medicaid program. A HIFA Waiver is a subset of 1115 waivers that uses a boiler-plate application form that encourages states to experiment with alternative

strategies in an effort to reduce the number of uninsured. HIFA Waivers simplify the waiver application process for states and allows more flexibility in how states restructure their Medicaid and SCHIP programs and expand coverage to new populations.

Like 1915(c) Waiver programs, 1115 Waiver programs must be budget neutral. However, for 1115 Waiver programs this means that the program cannot cost Medicaid any more than the state would have spent in the absence of the waiver, whereas 1915(c) programs should not cost more than providing state plan services, such as nursing home care, to the same population. There is no budget neutrality requirement or population expansion required under the Provider Fee Waiver.

4. What is the B1/B2 Test?

Usually a provider fee (such as the one Colorado is implementing) must be both broad-based -- all hospitals in the state are paying -- and uniform -- all hospitals are paying at the same rate. In the case that a policy decision is made to exclude some class of hospitals from paying (for example, free standing psychiatric hospitals) or discounting the fee for some class of hospitals, a "B1/B2" test must be passed in order for CMS to approve the implementation of the fee. The name of the test is due to the fact that the test is mathematical in nature and "B" is often used as the symbol for the slope of a graphed line which is central to the definition of the test.

B1/B2 measures the ratio of the slope of two regression lines. B1 is the slope of the regression line when the provider fee is uniform and broad-based fee. B2 is the slope of the regression line when the provider fee is not uniform and board-based. CMS requires that B1/B2 is at least equal to 1. The purpose of the test is to indicate to CMS that a provider fee is "redistributive"; that is, some hospitals will lose money as a result of implementing the provider fee. The reason CMS would like to ensure this is to avoid a "hold harmless" situation where the state would collect a fee from hospitals, collect a federal match, and return the fee plus the federal match in equal proportions to hospitals, thereby directly doubling their money.

From the state's perspective the B1/B2 test is a mathematically defined test which removes any subjectivity when CMS is assessing the redistributive question. For more information on the technical implementation of B1/B2 see http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr433.68.pdf pg. 81, paragraph (2).

5. What is the Provider Fee assessment metric?

The Department has designed that the assessment metric for the inpatient hospital fee on patient days. A patient day is counted for each admitted patient in the hospital at midnight. Hospitals are required to perform a midnight census each day/night, and this is a standard definition used by the industry.

The Department has designed that the assessment metric for the outpatient hospital fee on total charges. Charges are from the hospitals charge master, which under federal law are the same for

all payers. Charges for a specified service must be the same, no matter the payer source. Charges do not include any payer discounts, such as charity care discounts, contractual adjustments, payer discounts or bad debt write-offs. Reporting charges, prior to any payer discount, is a standard definition used by the industry.

Both these metrics were chosen since the data is available and reported uniformly.

6. What is the “Provider Fee Model”?

The Provider Fee Model is a balance between the provider fee revenue collected from hospitals, the payments to Medicaid providers and the funds needed to cover expansion populations. The “model” is generated in an Excel spreadsheet.

First, the Provider Fee is generated. The Provider Fee is constructed to pass the B1/B2 test and generate a fixed amount of revenue needed for the fiscal year. The Department will need to calculate the provider fee needed to cover related costs at the beginning of each state fiscal year. The provider fee revenue must be enough to cover the increased Medicaid inpatient and outpatient hospital payments, the CICP payments, the supplemental Medicaid payments, and the expected cost related to the expansion populations.

Second, the increased payments using the provider fee revenue for Medicaid inpatient and outpatient hospital payments, the CICP payments are calculated. These are the policy directions related to hospital reimbursement as specified under HB 09-1293. These payments use payment methodologies that are already established:

- Medicaid Inpatient Rates are increased to 100% of the Medicare Base Rate. Current payments are generally at 84% of the Medicaid Base Rate. As such, the difference between the 100% and 84% can be calculated, the number of Medicaid discharges and case mix for each hospital estimate to generate the payment. $(100\% \text{ Medicaid Base Rate} - 84\% \text{ Medicaid Base Rate}) * \text{Estimated Discharges} * \text{Case Mix} = \text{Medicaid Inpatient Provider Fee Payment}$.
- Medicaid Outpatient Rates are increased to 100% of Medicaid Cost. Currently, Medicaid pays at 72% of cost. The Department can calculate the difference between historical costs to generate the payment. $100\% \text{ Medicaid Cost Payment} - 72\% \text{ Medicaid Cost Payment} = \text{Medicaid Outpatient Provider Fee Payment}$.
- CICP Payments are increased to 100% of CICP costs. The Department can estimate the amount the CICP costs and compare them to the prior year payments. $100\% \text{ of CICP Costs} - \text{Prior year CICP payments} = \text{CICP Provider Fee Payment}$.

Third, the expected cost related to the expansion populations has been calculated by the Department’s budget office using a forecast of caseload and expenditures. These costs are included in the Department’s fiscal note.

Fourth, the net benefit to each provider is calculated. The amount of the Medicaid Inpatient Provider Fee Payment, Medicaid Outpatient Provider Fee Payment, CICP Provider Fee Payment,

and the expected cost related to the expansion populations are subtracted from the Provider Fee Paid.

Fifth, Department then examines which providers are paying a significant amount of Provider Fee relative to the payments received. For those which have a substantial net loss (paying more fee than receiving payment), additional Medicaid and DSH payments are created to bring the model into a balance where approximately 10% of providers may have a net loss and those losses are minimized so the providers are still able to participate in the provider fee payment. There is no established rule on the number of providers that may have a net loss, but the Department cannot create a hold harmless situation where all providers have a net gain under the model. Further, these supplemental payments need to be based on Medicaid utilization to gain a federal match.

7. What are the mechanics of accessing the federal matching funds through provider payments?

The State receives its Medicaid grant in quarterly installments. Just before the beginning of each quarter, the federal government loads the quarterly installment amounts for Medicaid program and administrative expenditures into the Payment Management System. As the State makes Medicaid program and administrative expenditures during the quarter, it records these expenditures in the Payment Management System and this creates the federal draw. The day after the State creates this federal draw the federal funds are transferred from the federal government to the State Treasury.

8. What is the difference between Medicaid payments and Supplemental Medicaid payments?

Medicaid payments are based on claims. Providers submit a claim and receive a pre-determined rate or reimbursement. Providers are only reimbursed once they submit a claim.

Supplemental payments are based on historical utilization or other known or given factors prior to calculating the payment. Unlike Medicaid payments based on claims, providers are guaranteed fixed payment no matter the volume of clients served in the future. These payments are traditionally lump-sum payments made on a monthly, quarterly, or annual basis. Supplemental payments simplify the provider fee and rate calculation since all provider payments, and the provider fee needed to generate them will be known and fixed at the beginning of the State Fiscal Year. Supplemental payments increase the cash flow and certainty of payments to providers.

9. How is the Upper Payment Limit defined?

The Upper Payment Limit (UPL) is the maximum amount Medicaid can reimburse a provider and still receive the federal match rate (or federal financial participation). The three unique

UPLs are calculated by the Department such that each must be a *reasonable estimate of the amount Medicare would reimburse providers for providing Medicaid services*. CMS will also accept a UPL demonstration based on Medicaid cost. Though all Medicaid payments must be economic and efficient, this special UPL is relevant to three distinct provider payments: Inpatient Hospital, Outpatient Hospital, and Nursing Facilities.

Medicaid fee-for-service rates reimburse providers below all three UPLs. This provides an opportunity for the Department to gain a federal match on the difference between the current Medicaid fee-for-service payment and the UPL. The UPL is an aggregate calculation for providers in three categories:

- State-owned hospital is any Hospital Provider that is either owned or operated by the State.
- Local-owned hospital is any Hospital Provider that is either owned or operated by a government entity other than the State.
- Private-owned hospital is any Hospital Provider that is privately owned and operated.

Please note, the Department's definition of a public-owned hospital (state-owned and local-owned) does not follow the tax code. Section 1903(w)(7)(G) of the Social Security Act identifies the four types of local entities that, in addition to the State itself, are considered a unit of government: a city, a county, a special purpose district, or other governmental units in the State. Currently, the interpretation of a "public-owned provider" is broad and not defined through rule. The Department considers a provider to be public-owned if the provider has a financial relationship with the governmental unit that may include one of the following: the provider receives operating revenues from the governmental unit, the governmental unit provided tax revenues to support bonds to construct the facility, the governmental unit has some financial obligation even if its daily operations of the facility have been assigned to private-owned company (for example, some providers operated by Banner Health), or the liabilities and assets of the provider revert to a governmental unit upon bankruptcy. Currently, the Department considers 31 providers to be public-owned and 3 providers to be state-owned.

Unlike the Disproportionate Share Hospital Allotment, which is specified directly by CMS, the UPL is calculated by the Department. CMS approves the calculation, but there are several approaches to calculating the UPL that have been adopted by the States over the years. For Inpatient Hospital services, the Department's calculation is complex and uses various elements from each provider's Medicare Cost report to estimate a Medicare payment per discharge and compares that figures to the Medicaid payment per discharge. For Outpatient Hospital services, the UPL is calculated based on Medicaid cost, so aggregate payments cannot exceed Medicaid cost.

For FY 2009-10 the Department is not attempting to modify the UPL calculations significantly, but the Department may want to look at other UPL calculations for future fiscal years. The Department current calculation has been approved by CMS; however, CMS has the authority to review and ask for modifications to the UPL calculation. The modification to the UPL calculations that the Department will seek is to add a portion of the Provider Fee into the UPL calculation. For examples:

- The Inpatient UPL is calculation is based on the reasonable estimate of the amount Medicare would reimburse providers for providing Medicaid services. This calculation includes Medicare costs. Since the Inpatient Provider Fee is a fee on all patient days at the facilities, the inpatient fee charged for Medicare clients can be added to the Inpatient UPL.
- The Outpatient UPL is calculated based on Medicaid costs. Since the Outpatient Provider Fee is a fee on all patient charges at the facilities, the outpatient fee charged for Medicaid clients can be added to the Outpatient UPL.

10. What is the Disproportionate Share Hospital Allotment?

In 1987 Congress amended Title XIX (the Medicaid Program) to require states to make enhanced payments for those “safety net” hospitals which provide services to a disproportionate share of Medicaid and low-income patients. Disproportionate Share Hospital (DSH) payments are intended to offset the uncompensated costs of providing services to uninsured and underinsured patients. The payments assist in securing the hospitals’ financial viability and preserving access to care for the Medicaid and low-income clients, while reducing a shift in costs to private payers. In subsequent legislation, Congress gave states a great deal of flexibility in the design and implementation of their DSH plans.

The federal Balanced Budget Act of 1997 (BBA97) established declining limits on the amount of federal funds available to states for DSH payments. These limits were established as allotments (or caps) for each state starting in Federal Fiscal Year 1997-98. The DSH Allotment for FFY 2008-09 is \$92.8 Million and \$95.2 Million for FFY 2009-10. These amounts include a 2.5% increase from the American Recovery and Reinvestment Act of 2009 (ARRA). This amount is entirely federal funds. To draw the federal funds, the Department must have an equal state share (the FMAP on DSH for Colorado is 50%). As such, payments to offset the uncompensated costs of providing services to uninsured and underinsured patients cannot exceed \$185.7 Million in FFY 2008-09 and \$190.4 Million in FFY 2009-10.

11. What is the hospital specific Disproportionate Share Hospital Limit?

Section 1923 of Title XIX of the Social Security Act requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve a disproportionately large number of low-income patients. The Omnibus Budget Reconciliation Act of 1993 limits these payments to the annual costs incurred to provide services (inpatient and outpatient) to Medicaid and uninsured patients less payments received for those patients. This limit is known as the hospital-specific DSH limit.

CMS has issued Medicaid DSH reporting and auditing regulations on December 19, 2008. These regulations further define how the hospital-specific DSH limit is calculated. The Department is working to comply with these regulations and the Departments proposed implementation plan to CMS is available upon request (June 24, 2009 letter to Richard Allen). The Department estimates the hospital-specific DSH limit for each provider to verify that

Medicaid and DSH payments do not exceed those limits. Generally, the Department does not publish hospital specific data. The data will be made public until after the reporting and auditing regulations have been fulfilled and submitted to CMS.

12. Who are the current Disproportionate Share Hospitals?

Disproportionate Share Hospital (DSH) payments are made to hospitals that have a high number of Medicaid and indigent care clients compared to other hospitals in the state. The payments help defray the cost of treating uninsured and low-income patients. DSH payments assist in securing the hospitals' financial viability, preserving access to care for the Medicaid and low-income clients, while reducing cost shifting onto private payers. All hospitals participating in the CICIP receive a DSH payment under the State's regulations. Federal law specifies, at a minimum, that any hospital provider whose Medicaid eligible days exceeded or equaled one standard deviation of the mean for all Colorado Medicaid hospital providers must receive a payment from the State's DSH Allotment on an annual basis.

Under the Provider Fee Model, the Department will expand DSH payments to providers who do not participate in the CICIP. The Department has made the assumption this is necessary for the following reasons:

- To bring the model into a balance where approximately 10% of providers may have a net loss and those losses are minimized so the providers are still able to participate in the provider fee payment.
- Eventually the Department will need to seek an 1115 Waiver to expand health care coverage to Adults without dependent children in the household. To accomplish this, the Waiver must be federal funds budget neutral (see "How is the Provider Fee Waiver different from other waivers?"). In order for this population to seek services outside of the current CICIP providers, without a dramatic shift in federal funds away from the current CICIP providers it is best to have some DSH money allocated to all providers prior to submitting the waiver. Since the Department does not know how the 1115 Waiver will be structured, this method is a more of a place holder while reimbursing non-CICIP providers for uncompensated care.

13. What is the relationship of "Charity Care" and "Bad Debt" to uncompensated costs?

To help address this question, most of the text below was taken from CMS' final rule on Disproportionate Share Hospital Payments. Charity care is a term used by hospitals to describe an individual hospital's program of providing free or reduced charge care to those that qualify for the particular hospital's charity care program. Depending on the parameters of the individual charity care programs, hospital costs associated with the uninsured may be a subset of charity care in the hospital or may entirely encompass a hospital's charity care program. Regardless of a hospital's definition/parameter on what constitutes charity care, hospitals must comply with Federal Medicaid DSH law and policy guidance in determining what portion of their specific charity care program costs qualify under the hospital-specific DSH cost limits.

For purposes hospital-specific DSH limits, uninsured individuals are those individuals without a source of third-party coverage (except coverage from State or local programs based on indigency). Self-pay, in terms of the hospital-specific DSH limits, are those individuals who are responsible to pay for the hospital services provided them because they have no source of third party coverage, (for example, the uninsured). Bad debt arises when there is non-payment on behalf of an individual who has third party coverage.

In order to meet new federal reporting requirement, hospitals will need follow standardized reporting requirements. To the extent that hospitals do not currently separately identify uncompensated care related to services provided to individuals with no source of third party coverage from other uncompensated care costs, hospitals will need to modify their accounting systems to do so. Once these reporting requirements are in place, the Department will use this data to calculated reimbursements for the uninsured and to measure hospital-specific DSH limits more accurately.

Total annual amount of uncompensated outpatient and inpatient care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive. The uncompensated care costs of providing physician services to the uninsured cannot be included in this amount. The uninsured uncompensated amount also cannot include amounts associated with unpaid co-pays or deductibles for individuals with third party coverage for the inpatient and/or outpatient hospital services they receive or any other unreimbursed costs associated with inpatient and/or outpatient hospital services provided to individuals with those services in their third party coverage benefit package. Nor does uncompensated care costs include bad debt or payer discounts related to services furnished to individuals who have health insurance or other third party payer

14. For the data collected from hospitals, what definitions were used?

In collecting data to build the Provider Fee Model, the Department requested that hospital providers use the following definitions:

- Commercial Managed Care – commercial managed care programs such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Does not include Medicare, Medicaid, or CHAMPUS managed care.
- Other Commercial – indemnity insurance plans and other plans for which no discount arrangement exists.
- CHAMPUS/TriCare – a federal program for patients insured by the Civilian Health and Medical Program for the Uniformed Services.
- Colorado Indigent Care Program (CICP) – for CICP patient days report where CICP is primary payer and where CICP is secondary payer separately.
- Section 1011 – federal reimbursement of emergency services furnished to undocumented aliens under Section 1011 of the Medicare Modernization Act of 2003 (MMA).

- Self Pay / Uninsured / Charity Care – patients with no third party coverage or in hospital's charity care program (does not include CICP).
- Medicaid fee-for-service – Medicaid FFS is primary payer, does not include Medicaid HMO or dual eligibles.
- Medicaid nursery – days of care provided to Medicaid newborns while the mother is in the hospital.
- Medicaid HMO – Medicaid HMO is primary payer.
- Medicaid dual eligible – patients with Medicare and Medicaid coverage.
- Medicaid & other payer – patients with third party and Medicaid coverage (not Medicare/Medicaid).
- Medicare fee-for-service – Medicare is primary payer; does not include Medicare HMO.
- Medicare HMO – Medicare HMO is primary payer.
- Medicare & other payer – Medicare and third party coverage (not Medicaid/Medicare).
- Inpatient Days – enter patient days by primary payer as indicated. Check that the total sum equals total per census report.

For patient days, do not use days related to swing beds, sub-acute/long-term care beds, residential treatment center beds, home health, nursing facilities, the treatment of patients on a leave of absence from the facility, patients being observed for the need of admission, or patients who receive services during the day but are not housed at the facility at midnight.

A patient day is counted for each admitted patient in the hospital at midnight.

A Medicaid nursery patient day is counted for days of care provided to newborns, while the mother is in the hospital. If the newborn stays after the mother's discharge, those days need to be included under the applicable payer category.

- Charges – charges should be calculated in same manner as when compiling the Medicare/Medicaid Cost Report (CMS 2552-96).
- Operating Revenue – net operating revenue equals gross charges less bad debts, charity care, and payer discounts. Do not include any non-hospital or physician revenues.
- Costs – calculate costs in same manner as when compiling the Medicare/Medicaid Cost Report (CMS 2552-96).

The Colorado Health Care Affordability Act allocated administration funding to allow the Department to verify make that hospitals are reimbursed equitably and accurately. Therefore, the Department proposes to build supplementary cost reports using the Medicare/Medicaid Cost Report (CMS 2552-96) format to verify the costs and payments for uninsured populations and for individuals covered under the hospital's charity care program. In addition, the Department will verify that hospitals are using standard definitions and the accuracy of data used in Provider Fee Model. The Department has already begun the procurement process and expects to have supplementary cost reports available in late 2010.

15. Provider Fee Relation to CICP

The Provider Fee Bill Addresses the Colorado Indigent Care Program (CICP) in two primary areas:

- Increases hospital reimbursements under CICP up to 100% of costs of providing care.
- CICP hospital reimbursement change. This section amends Colorado Revised Statute (C.R.S.) 25.5-3-108, which is the statute covering the CICP. This section specifies that the CICP rates, not Medicaid rates, will be increased to cost. Medicaid rates are covered in under C.R.S. 25.5-4-402 and are not paid based on cost.

a. What is the CICP?

The CICP distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding deliver discounted health care services to Colorado residents, migrant workers, and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Health Plan *Plus* (CHP+).

This is *not* a health insurance program. Services are restricted to participating hospitals and clinics throughout the state. In addition, medical services vary by participating health care provider. The responsible physician or health care provider determines what services will be covered. These services must include emergency care, and may include, but are not limited to, inpatient care, outpatient care and prescription drugs.

Local hospitals and clinics enroll families into the CICP. A client's eligibility is not determined by the Colorado Benefits Management System (CBMS), and eligibility records are not retained by the Department. To be eligible for discounted services under the program, applicants must meet residency, citizenship, and income requirements. To qualify, applicants must have income and resources (assets outside primary residence and vehicle are included) combined at or below 250% of the Federal Poverty Level (FPL), and cannot be eligible for Medicaid or CHP+. There are no age limitations for CICP eligibility. For more information on the CICP, please see the CICP Annual Report on the Department's website: [Home → Providers → Colorado Indigent Care Program \(CICP\) → Annual Reports and Presentations](#)

b. How are the CICP providers funded?

The CICP is generally a grant program to participating providers. Available funds (State Funds and Federal Funds) are identified at the beginning of each state fiscal year. The Department determines each provider's payment based on historical data which includes the provider's uncompensated cost for providing care to those covered under the CICP. Since current funding is limited, provider payments are weighted higher for those who see more Medicaid and CICP clients.

Providers receive a letter at the beginning of each fiscal year stating the payment amount to their facility. Payments are on a fixed schedule by quarter. The provider must determine what services will be covered based on the amount they will receive. The CICP does not reconcile to actual costs for providing services.

In FY 2007-08 the CICP Hospitals were reimbursed on an average of 40.3% of indigent care costs. When examining all CICP Hospital providers, public-owned hospitals (24 providers) received an average 58.8% reimbursement relative to indigent care costs, while private-owned hospitals (22 providers) received 33.4%.

c. How can we access Medicaid matching funds for CICP?

Funding for the Colorado Indigent Care Program is through two unique funding sources. These funding sources are the Disproportionate Share Hospital Allotment and the Upper Payment Limit for inpatient hospital services (Inpatient UPL), which are financed with General Fund, federal funds, and certification of public expenditures. Any provider who participates in the program is qualified to receive funding from both funding sources and to use those funds as partial compensation for providing medical care to those individuals who qualify to receive discounted services.

- The federal government specifies that payments under the Disproportionate Share Hospital Allotment must be made to hospitals, but does not limit the State's ability to use the funds for a specific purpose. As such, Colorado has historically chosen to use the federal funds, about \$87 million, to finance the CICP.
- The Inpatient UPL is the maximum amount Medicaid can reimburse a hospital provider for inpatient services and still receive the federal match rate (or federal financial participation). Historically, Medicaid fee-for-service rates are below the Inpatient UPL. This provides an opportunity for the Department to gain a federal match on the difference between the Medicaid fee-for-service reimbursement and the Inpatient UPL. The Department specifies that in order to receive these increased or Supplemental Medicaid payments the provider must participate in the CICP.
- Payments made under either the Disproportionate Share Hospital Allotment or Inpatient UPL to public-owned hospital providers (those facilities which are owned or operated by the State or local government) consist entirely of federal funds. This is accomplished by utilizing certification of public expenditures. Certification of public expenditures documents the uncompensated cost of a public-owned hospital provider incurred in association with providing a qualified medical service to an eligible Medicaid or indigent client. These public expenditures are eligible for a federal match. Private-owned hospitals are not eligible to certify public expenditures, and payment to these provider must be 50% General Fund. Public-owned hospitals, therefore receive higher reimbursement due to the availability of federal funds match from certification of public expenditures, and private-owned hospitals receive lower reimbursement because of limited General Fund.

d. How is “cost” defined for CICIP?

Providers submit charges related to clients served under the CICIP. The charges are from the hospital’s “charge master” and are the same charges that would be submitted to any other payer (Medicaid, Medicaid, or insurance payer). Those charges are converted to costs by a cost-to-charge ratio. The cost-to-charge ratio (CCR) represents the relationship between charges associated with providing health care services and the costs involved with those services. Total provider costs divided by total provider charges equals a provider's CCR. This ratio is used to calculate CICIP reimbursement to each provider.

The Department contracts with Parrish, Moody and Fikes, P.C. (the Medicaid Cost Report Auditor) to obtain the cost-to-charge ratio which is based on total allowable Medicare costs and charges taken from the Medicare cost report. The cost centers included represent the majority of services provided to the medically indigent (inpatient, outpatient, ancillary services, emergency etc.). Hospital based costs for physicians, interns, and residents are also included in the cost-to-charge ratio for medically indigent care services. The cost-to-charge ratio is mathematically calculated by dividing total charges by total costs on a hospital specific basis.

In order to establish the CICIP payment each year, the available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio. Those costs are adjusted for inflation to estimate the expected costs for providing care in the upcoming state fiscal year.

e. What audits are performed?

In addition to the federally mandated audits hospitals must perform, the Department requires that participating providers submit a provider audit compliance statement (provider audit). The purpose of the CICIP provider audit is to furnish the Department with a report that attests to provider compliance with specified provisions covered by the CICIP contract, regulations, and CICIP provider manual. The CICIP provider audit covers client eligibility processing, provider billing, and a number other compliance issues related to the program. Detailed CICIP provider audit instructions are available on the Department’s website and are included as part of the CICIP Manual issued annually to each provider.

Those providers that receive \$1,000,000 or more in reimbursement from the CICIP must submit an audit performed by an independent auditor. Those that receive under \$1,000,000 in reimbursement from the CICIP may perform an internal audit rather than an external audit. An internal audit should be conducted by the facility’s auditor. If the facility does not have an auditor on staff, then personnel who do not directly determine client CICIP eligibility or handle CICIP billing records should be chosen. The providers submit compliance audit statements to the CICIP administration within 90 days of the completion of their annual financial audit or within 90 days of the close of the state fiscal year (June 30).

Providers who receive CICIP funding must also create a Disproportionate Share Hospital cost report in order to comply with recently issued federal regulations. This cost report will be similar to that created for the Medicaid and Medicaid programs, but specific to the provider's costs to providing care to the uninsured. The Department is required to audit those reports and report the findings to CMS. This process will create additional audit controls over the costs reported to the CICIP. As such, the Department will utilize a portion of the provider fee revenues to increase the auditing of provider costs related to the uninsured and CICIP.

16. Implementation Schedule for Eligibility Expansions

- At this point in the process, the primary focus of the Hospital Provider Fee has been on securing the financing for eligibility expansions through negotiations with the Colorado Hospital Association on the necessary statute changes. As we move forward in developing the policy and implementation concerning the eligibility expansions, the Department will need the input of stakeholders and advocates.
- Implementing a Section 1115 Demonstration (or HIFA) Waiver for one or more of the policy goals to expand health care coverage will take a considerable time to develop. Such federal waivers must be budget neutral relative to federal funds. As such, the Department will need to develop programs that guarantee benefits, while balancing the impact on federal funding sources such as the Disproportionate Share Hospital Allotment that is used to fund the current indigent care program.
 - To help achieve that balance the Department will seek the input of other states who have created similar programs, stakeholders, and advocates who understand the health care benefits needed for this population, and national consultants who have experience in calculating the budget neutrality demonstration.
 - The Department believes that it will take 1½ to 2 years to develop a benefit package, a budget neutrality demonstration and receive approval from CMS.
- Additionally, each eligibility expansion will require system changes to CBMS (eligibility system) and MMIS (claims payment system). For some eligibility expansions, the system changes will be relatively simple, while others will take significant time to develop.
- **Childless Adults.** The policy goal to increase health care coverage to Childless Adults (or adults without dependent children in the household) is not a Medicaid State Plan Optional Benefit population. As such, the Department must apply for the Section 1115 Demonstration waiver and meet the federal budget neutrality requirement.
 - The Department will need to measure the impact the program will have on the Colorado Indigent Care Program and will seek input for the providers who are currently serving that population.
 - The CBMS and MMIS system changes for this population could be extensive, as it is a new population with a benefit package that may differ from the Medicaid population in general.

- The Department expects to begin the development of the program in FY 2009-10 and begin the implementation (enrollment of clients) in early 2012. Please see the Department's web site for more details on the schedule of public meetings.
- **Disabled Medicaid Buy-in Program.** The policy goal in to create a Disabled Medicaid Buy-in Program has several target populations. These include the Disabled Children, Working Disabled Adults, and Non-Working Disabled Adults.
 - Each one of these populations has a separate opportunity to receive a federal match.
 - Disabled Children can receive a Medicaid benefit under the Family Opportunity Act (FOA) allows families with a disabled child(ren) who are over the SSI limit to have income up to 300% of the FPL for family size.
 - The Working Disabled Adult Buy-in was established under Ticket to Work and Work Incentives Act of 1999. There is not an income or asset maximum and the states can opt to not impose income or asset limits.
 - Many of the Non-Working Disabled Adults can be covered under a State Plan optional group. This allows the aged and disabled to be Medicaid eligible up to 100% of FPL. Above that threshold, the Department may need to seek an 1115 Demonstration waiver and meet the federal budget neutrality requirement.
 - Since each of these populations have different federal options, the Department may need to take a phased approach and implement the Medicaid Buy-in Program for the Disabled Children, Working Disabled Adults, and Non-Working Disabled Adults at different times. Further, the CBMS and MMIS system changes for this population could be extensive, as the Department may need to develop a system to collect but premiums or "buy-in" from the clients.
 - As such the Department will need input from stakeholders and advocates who understand the health care benefits needed for this population. The current language under the Hospital Provider Fee Bill is general in nature, so future statutory changes may be necessary as the Department learns more about the options for a Disabled Medicaid Buy-in Program.
 - The Department expects to begin the development of the program in FY 2009-10 and begin the implementation (enrollment of clients) in Summer 2011. Please see the Department's web site for more details on the schedule of public meetings.
- **CHP+ Eligibility Expansion to 250%.** The policy goal to increase eligibility for children and expecting mothers from 205% to 250% of the FPL will not require any complicated federal waivers or system changes. Therefore, The Department staff can modify the State Plan and amend the current prenatal waiver during FY 2009-10 and expects to have this expansion completed shortly after the Hospital Provider Fee is approved by CMS in Spring 2010.
- **Medicaid Parents to 100% FPL.** The policy goal to increase eligibility for parents of Medicaid eligible children from 60% to 100% of the FPL will not require any complicated federal waivers or system changes. Therefore, The Department staff can

modify the State Plan during FY 2009-10 and expects to have this expansion completed shortly after the Hospital Provider Fee is approved by CMS in Spring 2010.

- **Continuous Eligibility for Medicaid Children.** The Department would like to guarantee eligibility for Medicaid Children for 12 months of continuous enrollment. This is very similar to the guarantee that children enrolled in CHP+ currently receive.
 - Children would have a 12-month guarantee until they move out of the state or age out of Medicaid coverage.
 - This is State Plan option, so federal approval is simple. The system changes are complicated to implement. One complicating factor is by the potential to impact eligibility spans on other programs in CBMS. For instance, if the state chooses this option, if a child can not be moved to CHP+ during that 12 month guarantee as they are guaranteed the Medicaid benefit, which also impacts the Department ability to draw federal funds at a higher match rate. Therefore, there are several policy and budget impacts that the Department must examine prior to making this change. Further, a guarantee of Medicaid eligibly may have a significant impact on how eligibility spans are built for programs administered by the Department of Human Services, since eligibility for these programs are also determined by CBMS. As such, the Department will need input from CBMS systems staff, CMS, and stakeholders on how to prioritize this policy goal relative to other expansion populations. The current expected implementation date is Spring 2012.
- The timeline on eligibility expansions is primarily based on the ability of the Department to modify CBMS and MMIS to handle the increased populations and the time necessary to receive CMS approval of the expansions. As noted above, CHP+ Eligibility Expansion to 250% and Medicaid Parents to 100% FPL are simpler system changes and easier to get CMS approval, relative to Continuous Eligibility for Medicaid Children, Disabled Medicaid Buy-in Program and Childless Adults. Remember for Childless Adults, the Department must apply for the Section 1115 Waiver and meet the federal budget neutrality requirement, which could take up to 2 years negotiate with CMS.

17. What is the Federal Match Rate or Federal Financial Participation (FFP) used in the Model?

The federal match rate or FFP is the portion of the total Medicaid or Disproportionate Share Hospital payments that consist of federal funds. For example, if the federal match rate is 50%, then for every qualified payment of \$100, \$50 is federal funds while the remaining \$50 is State General Fund or other public dollars from the local level. The federal match rate is based on the state median income level relative to the national average. Theoretically, states with a larger proportion of their population at low-income levels will get a higher federal match than states with a smaller proportion of low-income individuals. The federal matching rate varies from state to state, but is never less than 50% and not more than 78%.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), the State's FFP for Medicaid payments (not Disproportionate Share Hospital payments) was increased above the standard 50% level until January 2011. Currently the FFP is around 61% federal funds for every

dollar spent on Medicaid costs. The increased FFP is based on the State's unemployment rate. The increased federal match is also available for provider fees used for provider payments, but the current Provider Fee Models uses a FFP of 50% since the ARRA funds are temporary.

18. What are Institutions for Mental Diseases (IMDs)?

Institutions for Mental Diseases (IMDs) are defined in federal regulations under 42 CFR 435.1010 as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." State mental hospitals and private stand alone psychiatric facilities meet the IMD definition. Federal financial participation (FFP) is not available for Medicaid clients from age 22 through age 64 who are patients in an IMD, as noted under 42 CFR 435.1009(a)(2).

19. What is a Behavioral Health Organization (BHO)?

The Colorado Medicaid Community Mental Health Services Program (Mental Health Program) is a managed care mental health program where contracted Behavioral Health Organizations (BHO) arrange for and coordinate mental health services for Medicaid clients. The State is divided into five (5) geographic service areas, with each BHO responsible for one of these service areas. All Medicaid clients eligible for full Medicaid benefits are automatically enrolled in the BHO covering their county.

Since 1995, the State has had an approved waiver under Section 1915 (b) of Title XIX of the Social Security Act to have a managed care mental health program. The waiver is approved by CMS and must be renewed every two (2) years. The waiver allows the Department to offer a variety of alternative mental health services to Medicaid clients that are not normally considered Medicaid billable services, such as intensive case management, vocational services, recovery services, clubhouses, and drop-in centers.

The goals of the Mental Health Program are in part to assure access to necessary mental health services for Medicaid clients, provide all necessary services through a cost-effective system, achieve a coordinated system of delivering mental health services to Medicaid clients, and maximize community resources in an effort to maintain the least restrictive level of care for Medicaid clients.