

Title of Rule: Revisions to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Section 8.2000.
Rule Number: MSB 10-08-23-A.
Division / Contact / Phone: State Programs and Federal Financing / Nancy Dolson / 303-866-3698

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers, payments to hospital providers, and clarification of some terms, as noted below.

The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2010). An additional supplemental Medicaid payment for inpatient psychiatric care in general hospitals is proposed to assure access to inpatient psychiatric services to Medicaid clients. The methodology for the calculation of the High Level Neo-Natal Intensive Care Unit Supplemental Medicaid Payment has been revised to align with the purpose of the payment, i.e., to reduce uncompensated care costs for Medicaid neonates requiring specialized care.

The proposed rule increases the fees assessed on hospital providers to fund these payments as well as funding the expansions of Medicaid and CHP+ eligibility authorized under the Act.

Finally, the proposed rule includes clarification of some defined terms and clarification of the timing of fee collection and payment distribution.

2. An emergency rule-making is imperatively necessary
 - to comply with state or federal law or federal regulation and/or
 - for the preservation of public health, safety and welfare.

Explain:

Initial Review

Proposed Effective Date

10/08/2010

Final Adoption

Emergency Adoption

10/08/2010

DOCUMENT #01

MD

Title of Rule: Revisions to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Section 8.2000.

Rule Number: MSB 10-08-23-A.

Division / Contact / Phone: State Programs and Federal Financing / Nancy Dolson / 303-866-3698

The Colorado Health Care Affordability Act [25.5-4-402.3, C.R.S. (2010)] instructs the Department to charge hospital provider fees and obtain federal Medicaid matching funds. The hospital provider fee is the source of funding for supplemental Medicaid payments to hospitals and payments associated with the Colorado Indigent Care Program (CICP). It is also the source of funding for the expansion of eligibility for Medicaid Parents from 60% to 100% of the federal poverty level (FPL) and the expansion of the Child Health Plan Plus (CHP+) from 205% to 250% FPL implemented in May 2010, and the planned expansion in 2011 of a Medicaid Buy-In Program for people with disabilities up to 450% of the federal poverty level.

The proposed rule revisions will allow the Department to collect sufficient fees from hospitals to fund the health coverage expansions and hospital payments to comply with its Medicaid State Plan agreement with the Centers for Medicare and Medicaid Services, ensuring continuing health care coverage for the Medicaid and CHP+ expansions funded by hospital provider fees and access to discounted health care services for CICP clients.

3. Federal authority for the Rule, if any:

42 CFR Section 433.68

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2009);
25.5-4-402.3, C.R.S. (2010)

Initial Review

Final Adoption

Proposed Effective Date **10/08/2010**

Emergency Adoption

10/08/2010

DOCUMENT #01

Title of Rule: Revisions to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Section 8.2000.

Rule Number: MSB 10-08-23-A.

Division / Contact / Phone: State Programs and Federal Financing / Nancy Dolson / 303-866-3698

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Colorado hospitals benefit from increased Medicaid and Colorado Indigent Care Program (CICP) reimbursements made possible through provider fee funding. Low-income persons benefit from the expanded Medicaid and Child Health Plan Plus (CHP+) eligibility.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

From October 2010 through September 2011, the provider fee will generate approximately \$292 million in federal funds to Colorado. Hospitals will have an estimated net benefit of \$159 million

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

While there are administrative costs associated with implementation of the Colorado Health Care Affordability Act, all such costs are covered by provider fees collected; no State General Fund is used.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

If no action is taken, the Department will not have the ability to fully fund Medicaid and CHP+ expansions, affected over 22,000 currently enrolled persons and up to 100,000 persons in the long run. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+ and reduce the federal revenue.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

The State does not currently have the resources to fund the hospital payments and coverage expansions under the hospital provider fee. The Department began collecting fees from hospitals in April 2010, after the rules were established and federal approval was obtained. The Department has implemented an electronic fee and payment mechanism with the

Title of Rule: Revisions to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Section 8.2000.

Rule Number: MSB 10-08-23-A.

Division / Contact / Phone: State Programs and Federal Financing / Nancy Dolson / 303-866-3698

hospitals, reducing the administrative burden on hospitals and the Department alike. For SFY 2009-10, all fees and payments were collected and disbursed efficiently and on time.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

The Department continues to meet regularly with stakeholders and the Hospital Provider Fee Oversight and Advisory Board and seeks their input and recommendations to maximize the benefit to the State from the Colorado Health Care Affordability Act. The first hospital provider fee expansions have been implemented and increased reimbursement has been made to hospitals. The proposed rules continue to fund the implementation of the Act to increase health care coverage and reduce uncompensated hospital costs for Medicaid and uninsured persons.

1 **8.2000: HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT**

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

13 **8.2001: DEFINITIONS**

14 "Act" means the Colorado Health Care Affordability Act, C.R.S. 25.5-4-402.3.

15 "Bad Debt" means the unpaid dollar amount for services rendered from a patient or third party payer, for
16 which the hospital expected payment, excluding Medicare bad debt.

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

21 "Charity Care Day" means a day for a recipient of the hospital's Charity Care.

22 "Charity Care Write-Off Charges" means the hospital's charges for Charity Care less payments from a
23 primary payer, less any copayment due from the client, less any other third party payments

24 "CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

25 "CICP Day" means a day for a recipient enrolled in the CICP.

26 "CICP Write-Off Charges" means those charges reported to the Department by the hospital in accordance
27 with 10 CCR 2505-10, Section 8.903.C.6.

28 "CMS" means the federal Centers for Medicare and Medicaid Services.

29 "Cost-to-Charge Ratio" means the sum of the hospital's total ancillary costs and physician costs divided
30 by the sum of the hospital's total ancillary charges and physician charges.

31 "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. 1302
32 Section 1820(c) and certified as a critical access hospital by the Colorado Department of Public Health
33 and Environment.

34 "DRG" means diagnosis related group, a cluster of similar conditions within a classification system used
35 for hospital reimbursement. It reflects clinically cohesive groupings of inpatient hospitalizations that utilize
36 similar amounts of hospital resources.

37 "DRG 801" means the DRG for neonates weighing less than 1,000 grams.

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

3 "Fund" means the hospital provider cash fund described in C.R.S. 25.5-4-402.3(4).

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

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

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

10 "Hospital-Specific Disproportionate Share Hospital Limit" means a hospital's maximum allowable
11 Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed
12 under 42 U.S.C. 1302 Section 1102.

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

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

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

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

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

22 "Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or
23 secondary payer is Medicaid.

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

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

27 "Medicaid NICU Day" means a Medicaid Fee-for-Service Day in a hospital's neo-natal intensive care unit,
28 reimbursed under DRG 801, up to the average length of stay.

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

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

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

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

1 “Medicare ~~Managed Care~~HMO Day” means an Managed Care Day for which the primary payer is
2 Medicare.

3 “Medicare-Medicaid Dual Eligible Day” means a day for which the primary payer is Medicare and the
4 secondary payer is Medicaid.

5 “Non-Managed Care Day” means a day for which the primary payer is an indemnity insurance plan or
6 other insurance plan not serving as an HMO or PPO.

7 “Non-State-Owned Government Hospital” means a hospital that is either owned or operated by a local
8 government.

9 ~~“Other Payers Day” means a day where the primary payer is not Medicaid or Medicare, which is not a~~
10 ~~CICP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care Day.~~

11 “Outpatient Services Fee” means an assessment on hospitals based on outpatient hospital charges

12 ~~“Other Payers Day” means a day where the primary payer is not Medicaid or Medicare, which is not a~~
13 ~~CICP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care Day.~~

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

16 ~~“Oversight and Advisory Board” means the hospital provider fee oversight and advisory board described~~
17 ~~in C.R.S. 25.5-4-402.3(6).~~

18 “Pediatric Specialty Hospital” means a hospital that provides care exclusively to pediatric populations.

19 “PPO” means a preferred provider organization that is a type of managed care health plan.

20 ~~“Privately-owned Hospital” means a hospital that is privately owned and operated.~~

21 ~~“Psychiatric Hospitals” means a hospital licensed as a psychiatric hospital by the Colorado Department of~~
22 ~~Public Health and Environment.~~

23 ~~“Privately-owned Hospital” means a hospital that is privately owned and operated.~~

24 “Rehabilitation Hospital” means an inpatient rehabilitation facility.

25 “Rural Area” means a county outside a Metropolitan Statistical Area designated by the United States
26 Office of Management and Budget.

27 “State-Owned Government Hospital” means a hospital that is either owned or operated by the State.

28 “State Teaching Hospital” means a High Volume Medicaid and CICP Hospital which provides supervised
29 teaching experiences to graduate medical school interns and residents enrolled in a state institution of
30 higher education, and in which more than fifty percent (50%) of its credentialed physicians are members
31 of the faculty at a state institution of higher education.

32 “Third-Party Medicaid Day” means a day for which third party coverage, other than Medicare, is the
33 primary payer and Medicaid is the secondary payer.

34 “Uncompensated CICP Costs” means CICP Write-Off Charges ~~f~~multiplied by the most recent provider
35 specific audited Cost-to-Charge Ratio and inflated forward to the payment year.

1 “Uncompensated Charity Care Costs” means Charity Care Write-Off Charges multiplied by the most
2 recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment year.

3 “Uninsured/Self Pay Day” means a day for self-pay patients and patients without third party health
4 insurance coverage. Uninsured/Self Pay Day does not include Charity Care Days or CICIP Days.

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

7 “Urban Center Safety Net Specialty Hospital” means a hospital located in a Metropolitan Statistical Area
8 designated by the United States Office of Management and Budget where its Medicaid Days plus CICIP
9 Days relative to total days, rounded to the nearest percent, equals or exceeds 65%.

10 **8.2002: Responsibilities of the Department and Hospitals**

11 **8.2002.A. Data Reporting**

12 1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee
13 and the distribution of supplemental payments, the Department shall distribute a
14 data survey to all hospitals by March 30 of each year. The Department shall
15 include definitions and descriptions of each data element requested in the
16 survey. Hospitals shall submit the data survey, as requested, to the Department
17 by April 30 of each year. The Department may estimate any survey data element
18 not provided directly by the hospital.

19 2. Hospitals shall submit the following data elements and any additional elements
20 requested by the Department: (a) Managed Care Days, (b) Non-Managed Care
21 Days, (c) Medicaid Fee-for-Service Days, (c) Medicaid Nursery Days, (e)
22 Medicaid Managed Care Days, (f) Medicaid Psychiatric Days, (g) Medicaid
23 Rehabilitation Days, (h) Medicare Non-Managed Care Days, (i) Medicare
24 ~~Managed Care~~HMO Days, (j) CICIP Days, (k) Charity Care Days, (l)
25 Uninsured/Self-Pay Days, (m) Other Payers Days, (n) Total days reported on the
26 patient census, (o) Charity Care Write-Off Charges, (p) Bad Debt, (q)
27 Uninsured/Self Pay Write-Off Charges, (r) Medicare-Medicaid Dual Eligible Days,
28 and (s) Third Party Medicaid Days.

29 3. The Department shall distribute a data confirmation report to all hospitals
30 annually. The data confirmation report shall include a listing of relevant data
31 elements used by the Department in calculating the Outpatient Services Fee, the
32 Inpatient Services Fee and the supplemental payments. The data confirmation
33 report shall clearly state the manner and timeline in which hospitals may request
34 revisions to the data elements recorded by the Department. Revisions to the
35 data will not be permitted by a hospital after the dates outlined in the data
36 confirmation report.

37 **8.2002.B. Fee Assessment and Collection**

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

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

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

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

17 3. Beginning in SFY 2010-11 the Outpatient Services Fee and Inpatient Services
18 Fee will be assessed on an annual basis and collected in twelve monthly
19 installments ~~on the second Friday of each month~~. Payments to hospitals will be
20 calculated on an annual basis and disbursed in twelve monthly installments.
21 ~~Fees will be assessed and payments will be disbursed on the second Friday of~~
22 ~~the month, except when State offices are closed during the week of the second~~
23 ~~Friday, then fees will be assessed and payment will be disbursed on the following~~
24 ~~Friday of the month -on the second Friday of each month.~~ If the Department
25 must diverge from this schedule due to ~~State holidays, bank holidays, or~~
26 unforeseen circumstances, the Department will shall notify hospitals in writing or
27 by electronic notice as soon as possible.

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

37 35. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient
38 Services Fee and Inpatient Services Fee must participate in the electronic funds
39 process utilized by the Department for the collection of ~~the Outpatient Services~~
40 ~~Fee and Inpatient Services Fee fees~~ and the disbursement of payment of
41 supplemental payments unless the Department has approved an alternative
42 process. A hospital requesting to not participate in the ~~ACH debit process, EFT~~
43 ~~payment process~~ electronic, fee collection process and/or payment process must
44 submit a request in writing or by electronic notice to the Department describing
45 an alternative fee collection process and/or payment process. The Department
46 shall approve or deny the alternative process in writing or by electronic notice
47 within 30 calendar days of receipt of the request.

48 **8.2003: Hospital Provider Fee**

1 **8.2003.A. Outpatient Services Fee**

- 2 1. Federal requirements. The Outpatient Services Fee is subject to federal
3 approval by CMS. The Department shall demonstrate to CMS, as necessary for
4 federal financial participation, that the Outpatient Services Fee is in compliance
5 with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).~~+~~
- 6 2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and
7 Rehabilitation Hospitals are exempted from the Outpatient Services Fee.
- 8 3. Calculation methodology. The Outpatient Services Fee is calculated on an
9 annual basis as 0.~~35484~~% of total hospital outpatient charges.~~-~~ High Volume
10 Medicaid and CICIP Hospitals' Outpatient Services Fee is discounted by 0.84%.

11 **8.2003.B. Inpatient Services Fee**

- 12 1. Federal requirements. The Inpatient Services Fee is subject to federal approval
13 by CMS. The Department shall demonstrate to CMS, as necessary for federal
14 financial participation, that the Inpatient Services Fee is in compliance with 42
15 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).~~-~~
- 16 2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and
17 Rehabilitation Hospitals are exempted from the Inpatient Services Fee.
- 18 3. Calculation methodology. The Inpatient Services Fee is calculated on an annual
19 per inpatient day basis of \$~~60.4783.46~~ per day for Managed Care Days and
20 \$~~270.26374.85~~ per day for all other Days as reported to the Department by each
21 hospital by April 30 with the following exceptions:
- 22 a. High Volume Medicaid and CICIP Hospitals' Inpatient Services Fee is
23 discounted to \$~~34.5743.57~~ per day for Managed Care Days and
24 \$~~144.10195.71~~ per day for all other Days.
- 25 b. Essential Access Hospitals' Inpatient Services Fee is discounted to
26 \$~~24.1933.38~~ per day for Managed Care Days and \$~~108.10149.94~~ per
27 day for all other Days.

28 **8.2003.C. Assessment of Fee**

- 29 1. The Department shall calculate the Inpatient Services Fee and Outpatient
30 Services Fee under this section on an annual basis in accordance with the
31 ~~Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3Act.~~
32 Upon receiving a favorable recommendation by the ~~Hospital Provider Fee~~
33 Oversight and Advisory Board ~~described in C.R.S. 25.5-4-402.3(6)~~, the Inpatient
34 Services Fee and Outpatient Services Fee shall be subject to approval by the
35 CMS and the Medical Services Board. Following these approvals, the
36 Department shall notify hospitals, in writing or by electronic notice, of the annual
37 fee to be collected each year, the methodology to calculate such fee, and the fee
38 assessment schedule. Hospitals shall be notified, in writing or by electronic
39 notice, at least thirty calendar days prior to any change in the dollar amount of
40 the Inpatient Services Fee and the Outpatient Services Fee to be assessed.
- 41 2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on
42 the basis of the qualifications of the hospital in the year the fee is assessed as
43 confirmed by the hospital in the data confirmation report. The Department will

1 prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for
2 the expected volume of services for hospitals that open, close, relocate or merge
3 during the payment year.

4 **8.2003.D. Refund of Excess Fees**

5 1. If, at any time, fees have been collected for which the intended expenditure has
6 not received approval for federal Medicaid matching funds by CMS at the time of
7 collection, the Department shall refund to each hospital its proportion of such
8 fees paid within five business days of receipt. The Department shall notify each
9 hospital of its refund amount in writing or by electronic notice. The refunds shall
10 be paid to each hospital according to the process described in Section 8.2002.B.

11 2. After the close of each State fiscal year and no later than the following August
12 31, the Department shall present a summary of fees collected, expenditures
13 made or encumbered, and interest earned in the Fund during the State fiscal
14 year to the Oversight and Advisory Board.

15 a. If fees have been collected for which the intended expenditure has
16 received approval for federal Medicaid matching funds by CMS, but the
17 Department has not expended or encumbered those fees at the close of
18 each State fiscal year:

19 i. The total dollar amount to be refunded shall equal the total fees
20 collected, less expenditures made or encumbered, plus any
21 interest earned in the Fund, less four percent of the estimated
22 expenditures for health coverage expansions authorized by the
23 Act for the subsequent State fiscal year as most recently
24 published by the Department.

25 ii. The refund amount for each hospital shall be calculated in
26 proportion to that hospital's portion of all fees paid during the
27 State fiscal year.

28 iii. The Department shall notify each hospital of its refund in writing
29 or by electronic notice by September 15 each year. The refunds
30 shall be paid to each hospital by September 30 of each year
31 according to the process described in Section 8.2002.B.

32 **8.2004: Supplemental Medicaid and Disproportionate Share Hospital Payments**

33 **8.2004.A. Conditions applicable to all supplemental payments**

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

41 2. No hospital shall receive a payment exceeding its Hospital-Specific
42 Disproportionate Share Hospital Limit. If upon review, the CICP Disproportionate
43 Share Hospital payment or the Uninsured Disproportionate Share Hospital
44 payment exceeds the Hospital-Specific Disproportionate Share Hospital Limit for

1 any qualified hospital, that hospital's payment shall be reduced to the Hospital-
2 Specific Disproportionate Share Hospital Limit retroactively. The amount of the
3 retroactive reduction for the CICIP Disproportionate Share Hospital payment shall
4 be retroactively distributed to the other qualified hospitals in the category based
5 on the qualified hospital's proportion of Uncompensated CICIP Costs, relative to
6 the aggregate of Uncompensated CICIP Costs of all qualified providers in the
7 category which do not exceed their Hospital-Specific Disproportionate Share
8 Hospital Limit. The amount of the retroactive reduction for the Uninsured
9 Disproportionate Share Hospital payment shall be retroactively distributed to the
10 other qualified hospitals in the category based on the qualified hospital's
11 proportion of Uncompensated Charity Care Costs relative to the aggregate of
12 Uncompensated Charity Care Costs of all qualified providers in the category
13 which do not exceed their Hospital-Specific Disproportionate Share Hospital
14 Limit.

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

21 **8.2004.B. Outpatient Hospital Supplemental Medicaid Payment**

- 22 1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals and Critical
23 Access Hospitals shall receive this payment.
- 24 2. Excluded hospitals. Psychiatric Hospitals and Long Term Care Hospitals shall
25 not receive this payment.
- 26 3. Calculation methodology for payment. Hospital-specific outpatient billed charges
27 from the Colorado Medicaid Management Information System (MMIS) are
28 multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-
29 specific outpatient billed costs. For each qualified hospital, the annual Outpatient
30 Hospital Payment Supplemental Medicaid Payment equals hospital-specific
31 outpatient billed costs, adjusted for managed care enrollment, utilization and
32 inflation, ~~multiplied, multiplied~~ by 29.430.7%. If the hospital qualifies as a
33 Pediatric Specialty Hospital this payment equals hospital-specific outpatient billed
34 costs adjusted for managed care enrollment, utilization and inflation, multiplied by
35 46.830.7%. If the hospital qualifies as an Urban Center Safety Net Specialty
36 Hospital, this payment equals hospital-specific outpatient billed costs adjusted for
37 managed care enrollment, utilization and inflation, multiplied by 25%.

38 **8.2004. C. Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment**

- 39 1. Qualified hospitals. General Hospitals and Critical Access Hospitals located in a
40 Rural Area, with 20 or fewer licensed beds, where at least 80% of total Medicaid
41 payments are for outpatient hospital services shall receive this payment.
- 42 2. Excluded hospitals. Psychiatric Hospitals and Long Term Care Hospitals shall
43 not receive this payment.
- 44 3. Calculation methodology for payment. This payment shall equal 4650% of
45 inflated annual hospital-specific Medicaid outpatient billed costs.

1 **8.2004.D. CICP Disproportionate Share Hospital Payment**

- 2 1. Qualified hospitals. General Hospitals and Critical Access Hospitals that
3 participate in the CICP shall receive this payment.
- 4 2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals and
5 Rehabilitation Hospitals shall not receive this payment.
- 6 3. Calculation methodology for payment. There will be three categories for qualified
7 hospitals: State-Owned Government Hospitals, Non-State-Owned Government
8 Hospitals, and Private-Owned Hospitals. State-Owned Government Hospitals
9 shall receive ~~5.069.86%~~ of the State's annual Disproportionate Share Hospital
10 Allotment, Non-State-Owned Government Hospitals shall receive ~~4045.00%~~ and
11 Private-Owned Hospitals shall receive ~~3522.00%~~.

12 A qualified hospital's annual payment shall equal its share of the percent of
13 Uncompensated CICP Costs of all qualified hospitals in the category divided by
14 the State's annual Disproportionate Share Hospital allotment allocated to the
15 category.

16 **8.2004.E. Uninsured Disproportionate Share Hospital Payment**

- 17 1. Qualified hospitals. General Hospitals and Critical Access Hospitals that report
18 charges for services provided to low-income uninsured persons to the
19 Department in a manner as prescribed by the Department shall receive this
20 payment.
- 21 2. Excluded hospitals. Hospitals that participate in the CICP, Psychiatric Hospitals,
22 Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this
23 payment.
- 24 3. Calculation methodology for payment. Beginning in FY 2009-10, ~~49.9423.14%~~ of
25 the State's annual Disproportionate Share Hospital allotment shall be allocated to
26 the Uninsured Disproportionate Share Hospital Payment. A qualified hospital's
27 annual payment shall equal its share of the percent of Uncompensated Charity
28 Care Costs of all qualified providers divided by the State's annual
29 Disproportionate Share Hospital allotment allocated to the Uninsured
30 Disproportionate Share Hospital Payment.

31 **8.2004.F. CICP Supplemental Medicaid Payment**

- 32 1. Qualified hospitals. General Hospitals and Critical Access Hospitals that
33 participate in the CICP shall receive this payment.
- 34 2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals,
35 Rehabilitation Hospitals and hospitals that do not participate in the CICP shall not
36 receive this payment.
- 37 3. Calculation methodology for payment.
- 38 a. Qualified hospitals shall receive an annual payment, such that, when
39 combined with the CICP Disproportionate Share Hospital Payment, shall
40 total to a percentage of Uncompensated CICP Costs. The percentage
41 applied to Uncompensated CICP Costs shall be:

- i. ~~Seventy-five~~Sixty-four percent (~~75~~64%) for High Volume Medicaid and CACP Hospitals,
- ii. One hundred percent (100%) for Rural Hospitals, or
- iii. ~~Ninety percent~~Seventy-five percent (~~90~~75%) for all other qualified hospitals.

8.2004.G. Inpatient Hospital Base Rate Supplemental Medicaid Payment

- 1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Long Term Care Hospitals and Critical Access Hospitals with an established Medicaid inpatient base rate shall receive this payment.
- 2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.
- 3. 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:
 - a. Pediatric Specialty Hospitals shall have a ~~13.76~~16.8% increase.
 - b. ~~Urban Center Safety Net Specialty~~State Teaching Hospitals shall have a ~~5.8~~16.0% increase.
 - c. Other General Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and Critical Access Hospitals shall have an ~~18.135~~0.0% increase.

8.2004.H. High Level Neo-natal Intensive Care Unit (NICU) Supplemental Medicaid Payment

- 1. Qualified hospitals. General Hospitals and Critical Access Hospitals certified level IIIb or IIIc neo-natal intensive care unit (NICU) shall receive this payment.
- 2. ~~Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and High Volume Medicaid and CACP Hospitals shall not receive this payment.~~
- 3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at ~~\$450~~2,100 per Medicaid ~~NICU Day~~Nursery Day
- ~~3. High Volume Medicaid and CACP Hospitals shall not receive this payment.~~

8.2004.I. State Teaching Hospital Supplemental Medicaid Payment

- 1. Qualified hospitals. State Teaching Hospitals shall receive this payment.
- 2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at ~~\$75~~125 per Medicaid Day.

8.2004.J. Acute Care Psychiatric Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals shall receive this payment.
2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.
3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at \$150 per Medicaid Psychiatric Day.

8.2004.JK. Large Rural Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in a Rural Area with 26 or more licensed beds shall receive this payment.
2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at ~~\$345~~-600 per Medicaid Day.

8.2004.KL. Denver Metro Supplemental Medicaid Payment

1. 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.
2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, ~~or~~-and High Volume Medicaid and CICP Hospitals shall not receive this payment.
3. Calculation methodology for payment.
 - a. For each qualified hospital located in Adams County or Arapahoe County, this payment is calculated on an annual basis at ~~\$400~~-675 per Medicaid Day.
 - b. For each qualified hospital located in Boulder County, Broomfield County, Denver County or Jefferson County, this payment is calculated as ~~\$510~~-700 per Medicaid Day.

8.2004.LM. Metropolitan Statistical Area Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in El Paso County, Larimer County, Mesa County, Pueblo County or Weld County shall receive this payment.
2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, ~~or~~-and High Volume Medicaid and CICP Hospitals shall not receive this payment.
3. Calculation methodology for payment. For each qualified hospital this payment is calculated on an annual basis at ~~\$340~~-600 per Medicaid Day.

8.2004.MN. Pediatric Specialty Hospital Provider Fee Payment

1. Qualified hospitals. Hospitals qualified to receive the Pediatric Major Teaching Hospital Payment in 10 CCR 2505-10 Section 8.903.C.6 shall receive this payment.

1
2 |

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis and shall equal \$~~5~~3 million.