COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

January 15, 2013

Mary Trujillo-Young, PhD
Vice President, Medical Services Board
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dear Dr. Trujillo-Young:

Enclosed please find a report to the Medical Services Board from the Department of Health Care Policy and Financing (the Department) and the Hospital Provider Fee Oversight and Advisory Board (the Board) on the Colorado Health Care Affordability Act.

Section 25.5-4-402.3 (6)(f), C.R.S. requires the Board to submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee, and the medical services board concerning the implementation of the Colorado Health Care Affordability Act by January 15 each year. This report includes a description of the hospital provider fee; the total amount of the provider fee paid and revenue received by each hospital; an itemization of the Department's costs in administering the hospital provider fee; and estimates of the differences between the cost of care provided and payment received by hospitals for patients covered by Medicaid, Medicare, and other payers.

Through September 2012, the Colorado Health Care Affordability Act has provided $428 million in net new federal funds to hospitals, reducing uncompensated care costs; has provided health coverage through Medicaid and the Child Health Plan Plus *(CHP+) for more than 65,000 Coloradoans; and has provided more than $149.5 million in General Fund budget relief.*

If you require further information or have additional questions, please contact the Department's Legislative Liaison, MaryKathryn Hurd, at MK.Hurd@state.co.us or 303-547-8494.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

Ellen Robinson
Chair, Hospital Provider Fee
Oversight and Advisory Board

SEB/nad

Enclosure

Cc: Michael Stahl, Vice President, Medical Services Board
Linda Andre, LCSW, Medical Services Board
Jeffrey J. Cain, MD, Medical Services Board
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Wendell Phillips, Medical Services Board
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Colorado Health Care Affordability Act

Annual Report

Hospital Provider Fee Oversight and Advisory Board

January 15, 2013

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Executive Summary

The Department of Health Care Policy and Financing (the Department) and the Hospital Provider Fee Oversight and Advisory Board (OAB) have prepared this annual report concerning the implementation of the Colorado Health Care Affordability Act (CHCAA). The CHCAA authorizes the Department to assess a hospital provider fee to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients serviced by public health insurance programs, increase funding for hospital care for Medicaid and Colorado Indigent Care Program (CICP) clients, and to reduce cost-shifting to private payers.

Through September 2012, the CHCAA has:

- **Provided $428 million in net new federal funds to hospital providers, reducing uncompensated care costs**

  From implementation of the hospital provider fee effective July 1, 2009 through September 30, 2012, more than $2.4 billion in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed by hospital provider fees were paid to hospitals, resulting in a net gain to hospitals of approximately $428 million in new federal funds. These net new funds reduced uncompensated costs incurred by hospitals for care provided to Medicaid and CICP clients with no increase in General Fund expenditures.

- **Provided health care coverage through Medicaid and CHP+ for more than 65,000 Coloradans**

  In May 2010, the population expansions for Medicaid Parents to 100% of the federal poverty level (FPL) and the Child Health Plan *Plus* (CHP+) to 250% FPL were implemented. In March 2012, the Medicaid Buy-In Program for Working Adults with Disabilities to 450% FPL was implemented, and in July 2012 the Medicaid Buy-In Program for Children with Disabilities to 300% FPL was implemented. In April 2012, Medicaid coverage for Adults without Dependent Children up to 10% FPL with enrollment capped at 10,000 individuals was implemented. As of September 30, 2012, the Department had enrolled approximately 39,000 Medicaid Parents, 15,000 CHP+ children and pregnant women, 540 adults and children with disabilities, and 9,800 adults without dependent children in these expansion populations with no increase in General Fund expenditures.

- **Provided $149.5 million in state General Fund budget relief**

  In state fiscal years (SFYs) 2009-10 and 2010-11 more than $99.5 million of General Fund relief was provided pursuant to Senate Bill (SB) 10-169 through additional federal funds drawn due to the enhanced Federal Medicaid Assistance Percentage (FMAP) under the federal American Recovery and Reinvestment Act of 2009 (ARRA). Additionally, in SFY 2011-12 hospital provider fees provided $50 million of General Fund relief pursuant to SB 11-212.

Colorado Health Care Affordability Act Overview

On April 21, 2009, the Governor signed House Bill 09-1293, the Colorado Health Care Affordability Act (CHCAA) into law. The legislation provides health care coverage to previously uninsured Coloradans, reduces uncompensated care costs, and benefits the state as a whole. These benefits are achieved through an increase in federal funds with no General Fund impact. The Colorado Hospital Association (CHA), the Department of Health Care Policy and Financing (the Department), and the Governor's Office worked together for nearly one year to develop House Bill 09-1293, which passed both the House and the Senate with more than 40 co-sponsors and bipartisan support.

The CHCAA requires the Department to assess and collect a provider fee from all licensed or certified hospital providers, including providers that do not serve Medicaid clients. The provisions of the legislation prohibit shifting the fee to either clients or insurers. By partnering with hospitals, the CHCAA allows Colorado to draw down more than $500 million in federal Medicaid matching funds annually for the following purposes authorized under CHCAA:

- Increase hospital reimbursement payments for Medicaid inpatient and outpatient care, up to a maximum of the federal Upper Payment Limit (UPL);
- Increase hospital reimbursement rates through the Colorado Indigent Care Program (CICP), up to 100% of cost;
- Create hospital quality incentive payments for rewarding enhanced quality, health outcomes, and cost effectiveness;
- Increase coverage for parents with incomes of up to 100% of the federal poverty level (FPL) through Medicaid;
- Increase coverage in the Child Health Plan *Plus* (CHP+) up to 250% FPL;
- Reduce the number of uninsured through implementation of health care coverage for adults without dependent children with incomes of up to 100% FPL;
- Create a Medicaid buy-in program for individuals with disabilities whose family incomes are too high for Medicaid eligibility but are under 450% FPL;
- Implement continuous eligibility for Medicaid children to reduce administrative burdens on Colorado families and keep eligible kids covered on a continuing basis; and,
- Cover the Department's related administrative costs.

Hospital Provider Fee Oversight and Advisory Board

A thirteen member Hospital Provider Fee Oversight and Advisory Board (OAB) appointed by the Governor provides oversight and makes recommendations to the Department and the Medical Services Board on the implementation of the CHCAA. See Appendix C for a list of OAB members.

The CHCAA outlines the specific duties of the OAB, including:

- Recommend to the Department the method of calculating the provider fee, the amount of the provider fee, and changes in the provider fee that increase the number of hospitals benefitting from the fee;
- Recommend to the Department changes to Medicaid inpatient and outpatient hospital payments and quality incentive payments to increase hospital accountability, performance, and reporting;
- Recommend to the Department the approach to health coverage expansions;
- Monitor the impact of the hospital provider fee on the broader health care marketplace; and
- As requested, consult with the Health and Human Services Committees of the Colorado Senate and House of Representatives.

The OAB's meetings are held regularly from 3:00 to 5:00 p.m. on the fourth Tuesday of most months (the OAB typically does not meet in January, March, May, or September). Time for public comments is reserved at all meetings and the meetings are streamed over the Internet. All OAB meeting dates, agendas, minutes, and materials discussed at the meetings are posted on the Department's website at Colorado.gov/hcpf under Boards & Committees.

Department and Medical Services Board Roles

The Medical Services Board, in consultation with the OAB, is responsible for promulgating rules related to implementing the CHCAA, including the calculation, assessment, and timing of the Hospital Provider Fee; the reports that hospitals will be required to report to the Department; and other rules necessary to implement the CHCAA. Rules regarding the hospital provider fee and payments can be found at 10 CCR 2505-10, Section 8.2000.

The Department administers and provides technical and regulatory expertise to the OAB. Department staff prepare and present proposed rule changes as recommended by the OAB to the Medical Services Board. The Department is responsible for calculating the fee and assessing the fee on a schedule established in rule by the Medical Services Board. The Department implements and calculates the hospital payments and administers the public health care expansions.

Colorado Health Care Affordability Act Benefits

The CHCAA benefits Colorado by providing additional federal matching funds in the state without additional General Fund expenditure. Fees assessed on hospital providers with federal matching funds allow Colorado to:

- Increase hospital reimbursement for care provided to Medicaid and CICP clients;
- Increase the number of insured Coloradans;
- Improve the quality of health care for Medicaid clients; and
- Reduce the need to shift the cost of uncompensated care to other payers.

The CHCAA has also provided relief for the state's budget. Pursuant to Senate Bill (SB) 10-169, additional federal funds drawn due to the enhanced Federal Medicaid Assistance Percentage (FMAP) under the federal American Recovery and Reinvestment Act of 2009 (ARRA) provided General Fund relief in State Fiscal Year (SFY) 2009-10 and SFY 2010-11 of more than $99.5 million. Additionally, pursuant to SB 11-212, hospital fees have provided $50 million of General Fund relief for the Department's budget for SFY 2011-12 and will provide another and $25 million for SFY 2012-13.

Increase Hospital Reimbursement for Care Provided to Medicaid and CICP Clients

Following the first Hospital Provider Fee Model in SFY 2009-10, the OAB recommended that subsequent Hospital Provider Fee Models be moved to an October 1 start date. Therefore, figures in this report are reported on an October 2011 through September 2012 basis unless otherwise noted.

In the October 2011 through September 2012 period, the Department collected over $618 million in hospital provider fees to fund estimated expenditures, which, with approved federal matching funds, increased payments for inpatient and outpatient hospital services, financed hospital payments for the CICP, and funded additional, targeted supplemental hospital payments. Payments to hospitals totaled over $904 million, including $124 million additional funding for hospitals participating in the CICP.

2011-12 Hospital Payments	
Inpatient Hospital Reimbursement	$164,039,000
Outpatient Hospital Reimbursement	$127,764,000
CICP Hospital Reimbursement	$287,055,000
Additional Hospital Payments	$325,671,000
Total Supplemental Hospital Payments	**$904,529,000**

Table 1

After taking into account the hospital provider fees collected for health coverage expansions, the Department's administrative expenses, General Fund relief per SB 10-169 and SB 11-212, and the CICP hospital reimbursement level prior to increased payments under CHCAA, the net gain to hospitals in SFY 2009-10 was approximately $124 million, the net gain for the July to

September 2010 period was approximately $22 million, and the net gain for October 2010 through September 2011 was approximately $159 million. The net gain for October 2011 through September 2012 was approximately $123 million, for a total net gain to hospitals through September 2012 of $428 million. These net gains represent the reduction in uncompensated costs incurred by hospitals for providing care to Medicaid clients and the uninsured.

2011-12 Net New Funds to Hospitals	
Total Supplemental Hospital Payments	$904,529,000
Total Fees	($618,724,000)
Approximate CICP payments pre-CHCAA	($162,876,000)
Net New Funds to Hospitals	**$122,929,000**

Table 2

See Appendix B for a list of fees, payments, and net gains by hospital.

Increase the Number of Insured Coloradans

In May 2010, the population expansions for Medicaid Parents to 100% FPL and for CHP+ to 250% FPL were implemented. In March 2012, the Medicaid Buy-In Program for Working Adults with Disabilities to 450% FPL was implemented, and in July 2012 the Medicaid Buy-In Program for Children with Disabilities to 300% FPL was implemented. In April 2012, Medicaid coverage for Adults without Dependent Children up to 10% FPL with enrollment capped at 10,000 individuals was implemented. As the health care expansions are implemented and enrollment grows, the Department closely monitors the costs of these newly eligible populations to ensure that adequate fee revenue and federal funds can be collected within federal limitations.

As of September 30, 2012, the Department had enrolled:

- 39,689 Medicaid Parents,
- 15,749 CHP+ children and pregnant women,
- 539 working adults and children with disabilities, and
- 9,880 Adults without Dependent Children.

The Department maintains a waitlist and enrolls individuals in the Adults without Dependent Children expansion as space becomes available, and if funding allows, the Department may increase the enrollment cap. The Department does not have an implementation timeframe for providing continuous 12-month eligibility for children covered by Medicaid at this time.

Improve the Quality of Health Care for Medicaid Clients

The Hospital Quality Incentive Payment (HQIP) is a mechanism under the CHCAA that will be used to incent hospitals serving Medicaid clients for delivering high quality care that yields positive health outcomes.

At the request of the OAB, a HQIP ad hoc Committee was formed to develop a thorough proposal for quality incentive payments. Members of the HQIP Committee included representatives from the Department, the CHA, and hospital representatives with expertise in quality measurement and hospital payment. The committee was supported in its efforts by the Department's contracted consultant, Public Consulting Group (PCG), and met on a bi-weekly basis beginning in January 2011.

The HQIP Committee sought to:

- Identify measures and methodologies that apply to care provided to Medicaid clients;
- Adhere to Value-Based Purchasing (VBP) principles;
- Maximize participation in the Medicaid program; and
- Minimize the number of hospitals which would not qualify for selected measures.

In May 2011, the Department and CHA jointly presented a quality incentive payment proposal to the OAB. The quality incentive payment proposal is intended to evolve over time. As performance on different measures improves, measures can be retired and new measures can be introduced. Also, as new and different data sources become available, the measures will change and grow. The proposed HQIP measures for the first payment year are:

- Central Line-Associated Blood Stream Infections (CLABSI)
- Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT)
- Elective Delivery Prior to 39 Weeks Gestation
- Structured Efforts to Improve Care Transitions and Reduce Readmissions

The Department and PCG subsequently gathered and analyzed baseline data and established the criteria for earning points. In June 2012, the HQIP Committee proposed a payment methodology that consists of hospitals earning points based on performance on each measure. The points system would be normalized using the total number of points for which the hospital was qualified; that is, hospitals are not held responsible or are not negatively impacted by the measures for which they do not meet the minimum criteria.

The OAB approved the HQIP Committee's recommendations on June 26, 2012. As of September 2012, the Department is working with stakeholders to develop quality incentive payment rules for adoption by the Medical Services Board and with Centers for Medicare and Medicaid Services (CMS) on a State Plan Amendment. Quality incentive payments are expected to begin with the 2012-13 Hospital Provider Fee Model.

Reduce the Need to Shift Costs of Uncompensated Care to Other Payers

The CHCAA reduces the need for hospital providers to shift uncompensated care costs to private payers by providing higher reimbursement for patients covered by public health care programs and reducing the number of uninsured Coloradans. By raising the rates paid to hospital providers, the need to shift costs is reduced. The CHCAA increases reimbursement paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the CICP. Fewer uninsured Coloradans leads to lower uncompensated costs by creating a funding source for these clients. Since its inception, the hospital provider fee has expanded health care coverage to more than 65,000 Coloradoans through expansions of the Medicaid and CHP+ programs.

The OAB authorized a Cost Shift Data Work Group to determine what data will be collected by hospitals to fulfill the legislative requirement to report the difference between costs and payments for each of Medicare, Medicaid, and private insurance. This work group convened in Spring 2010 and made its recommendations to the OAB in Fall 2010, including a methodology to produce estimates of the differences of the cost of care provided and the payments received by providers.

As recommended by the Cost Shift Data Work Group, cost and payment data is reported on a per patient basis for four payer groups: Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other. The information is calculated on a calendar year basis using data from the CHA DATABANK and survey data collected by CHA. CICP is shown as a separate item and is calculated on a state fiscal year basis using the Department's CICP Annual Report. An analysis of Bad Debt and Charity care is also included as a supplemental item.

Cost shift data was reported in the previous annual report and included data from 2006 through 2010. Since the last report, some providers have refined and improved their reporting to the CHA DATABANK. These data revisions were made back to 2009, so this report illustrates the cost and payment calculations for the 2009 to 2011 time period. The CHCAA was implemented following federal approval in March 2010; therefore, changes to cost to payment ratios due to the CHCAA are captured with the 2010 data.

Cost Shift Data: Payment less Cost per Patient by Payer Group

The table and graph on the following page display the difference between total payments and total costs on a per patient basis for Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups. Note that negative values indicate that costs exceed payments. This is the case for Medicare, Medicaid, and the CICP/Self Pay/Other payer groups and indicates that hospitals are undercompensated for care provided to these clients. Positive values indicate that payments exceed costs. This is the case for the Insurance group, where there is overcompensation relative to costs. This is the essence of cost shift as publicly insured and uninsured care is paid under cost and private payers, represented by the Insurance group in the table below, pay more to cover those costs.

The data show that following the implementation of the CHCAA in July 2009, the undercompensation for the Medicaid group has sharply decreased, while overcompensation by the Insurance group declined in CY 2010 by 3%. The CY 2011 overcompensation by the Insurance Group is 7% higher than it was in CY 2009. However, as shown in last year's report, the average rate of growth of Insurance overcompensation was more than 18% per year for three years prior to the implementation of the CHCAA.

While the increased reimbursement by Medicaid may not completely eliminate the need to shift costs or always result in declining overcompensation from the Insurance group, the early data is promising in that the rate of growth seen in the Insurance group has declined significantly. It is important to note that changes in Payment Less Cost per Patient are influenced by changes in case-mix and utilization as well as changes in costs and reimbursement.

Payment Less Cost per Patient by Payer Group			
	CY 2009	**CY 2010**	**CY 2011**
Medicare	($3,039)	($3,941)	($3,821)
Medicaid	($3,799)	($2,529)	($2,249)
Insurance	$7,271	$7,045	$7,744
CICP/Self Pay/ Other	($4,106)	($3,892)	($4,433)
Overall	$898	$622	$905

Table 3

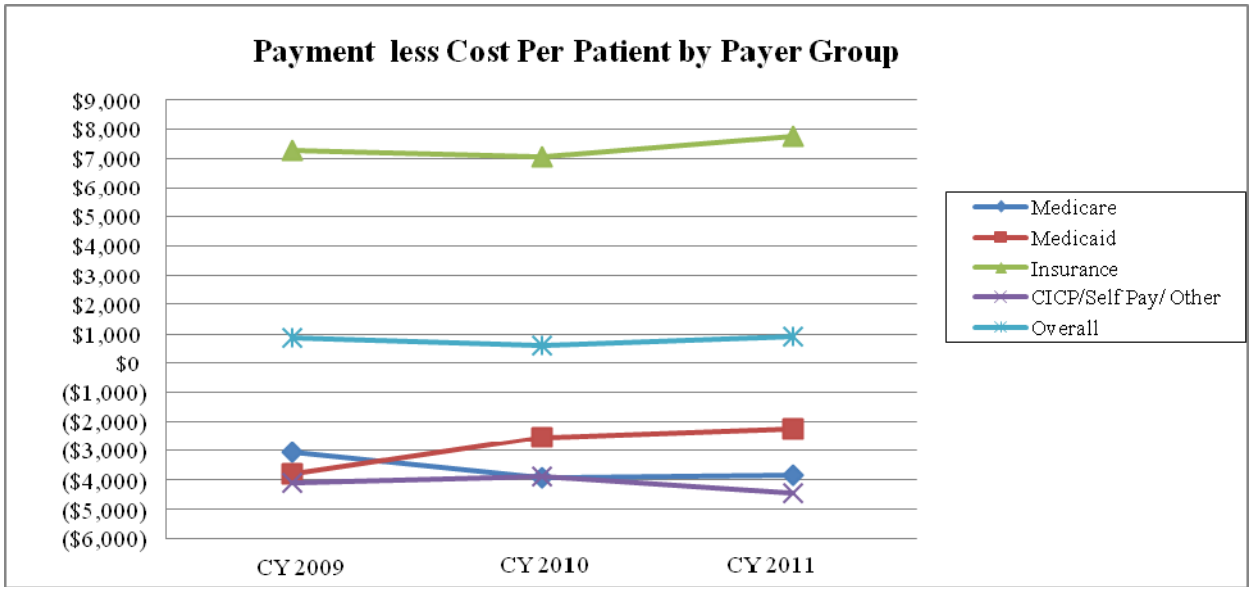

Figure 1

Cost Shift Data: Payment to Cost Ratio

The following table and graph display the impact of cost shifting through the ratio of total payments to total costs for Medicare, Medicaid, Insurance, and CICP/Self Pay/Other payer groups. Ratios below 1 mean that costs exceed payments, which is the case for Medicare, Medicaid, and the CICP/Self Pay/Other payer groups as discussed before. Values greater than 1 mean that payments exceed costs, as is the case for the Insurance group.

The Payment to Cost Ratio is a strict comparison of cost and reimbursement that is not dependent on caseload. The amount that costs exceeded payments declined significantly for the Medicaid group from CY 2009 to CY 2010 with the implementation of the CHCAA. For CY 2011 payments increased relative to cost again for the Medicaid group. While payments increased relative to costs for the Insurance group from CY 2010 to CY 2011, the Payment to Cost Ratio for Insurance in CY 2011 is still lower than the ratio for CY 2009.

Payment to Cost Ratio by Payer Group			
	CY 2009	**CY 2010**	**CY 2011**
Medicare	0.79	0.74	0.75
Medicaid	0.61	0.75	0.79
Insurance	1.64	1.58	1.61
CICP/Self Pay/ Other	0.55	0.62	0.63
Overall	1.08	1.05	1.07

Table 4

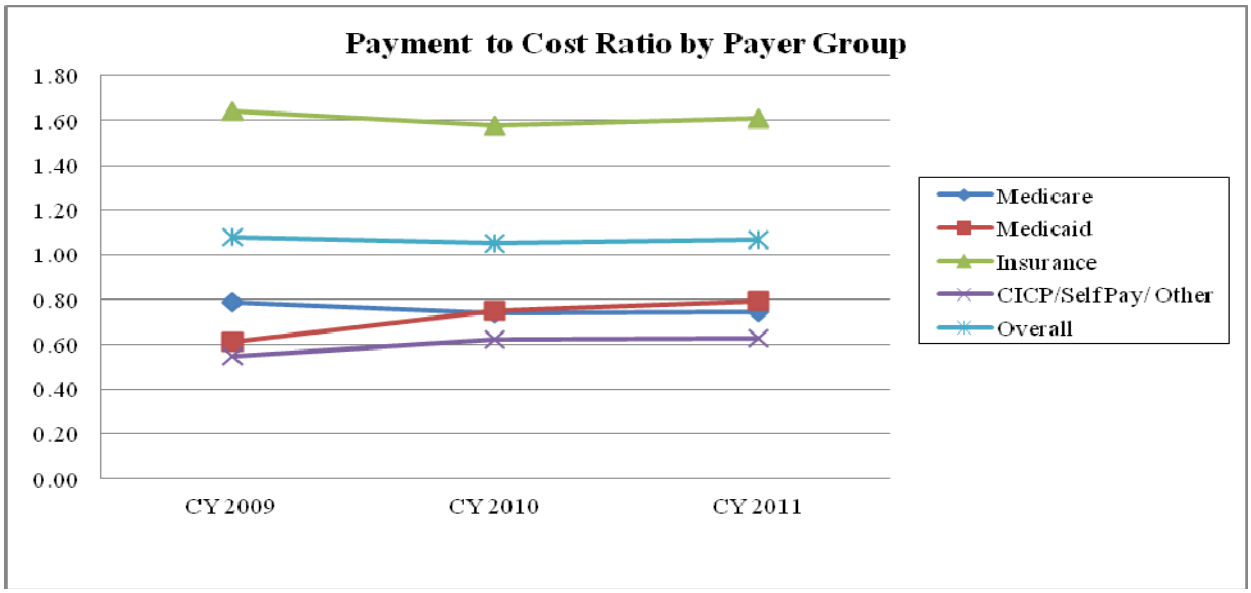

Figure 2

Cost Shift Data: Payment less Cost per Patient for CICP

The table and graph below display the difference between total payments and total costs on a per patient basis for CICP separately. The source of data for CICP is the Department's CICP Annual Report, which reports CICP costs and payments on a state fiscal year basis. As indicated before, negative values indicate that costs exceed payments, which is the case for CICP where hospitals are undercompensated for care provided to these clients.

The data show that following the implementation of the CHCAA in 2009, when CICP reimbursement rates for hospitals increased by at least $115 million annually, the amount of undercompensation of CICP costs decreased by approximately 35%. CICP funding has remained at the new levels following the implementation of the CHCAA.

Payment Less Cost per Patient for CICP			
	SFY 2008-09	**SFY 2009-10**	**SFY 2010-11**
CICP	($4,339)	($2,798)	($2,894)

Table 5

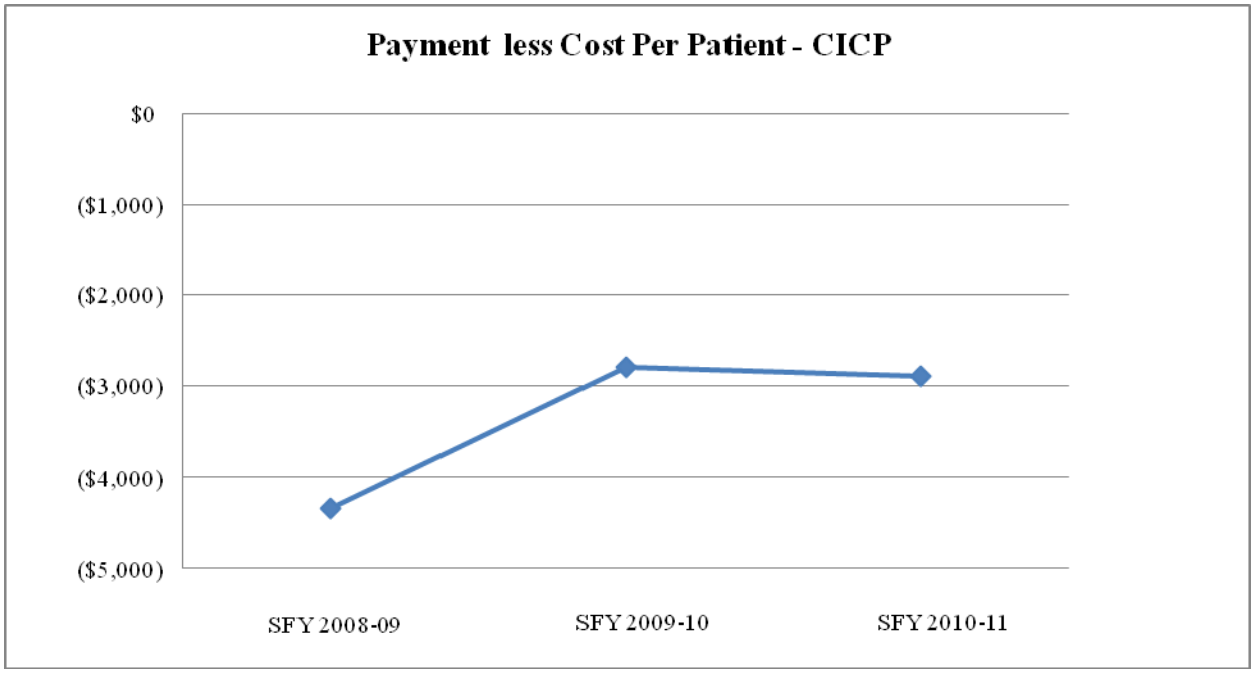

Figure 3

Cost Shift Data: Bad Debt and Charity Care

Total Bad Debt and Charity Care is collected in aggregate from the CHA DATABANK. Bad Debt and Charity Care distributions are calculated using weighted percentages as reported by providers on a survey conducted by the CHA. As shown below, Bad Debt has decreased each year, while Charity Care has increased slightly each year.

Bad Debt and Charity Care			
	CY 2009	**CY 2010**	**CY 2011**
Bad Debt	$843,859,090	$776,483,052	$772,048,150
Charity Care	$1,450,212,300	$1,468,955,274	$1,565,544,819
Total	$2,294,071,390	$2,245,438,326	$2,337,592,969

Table 6

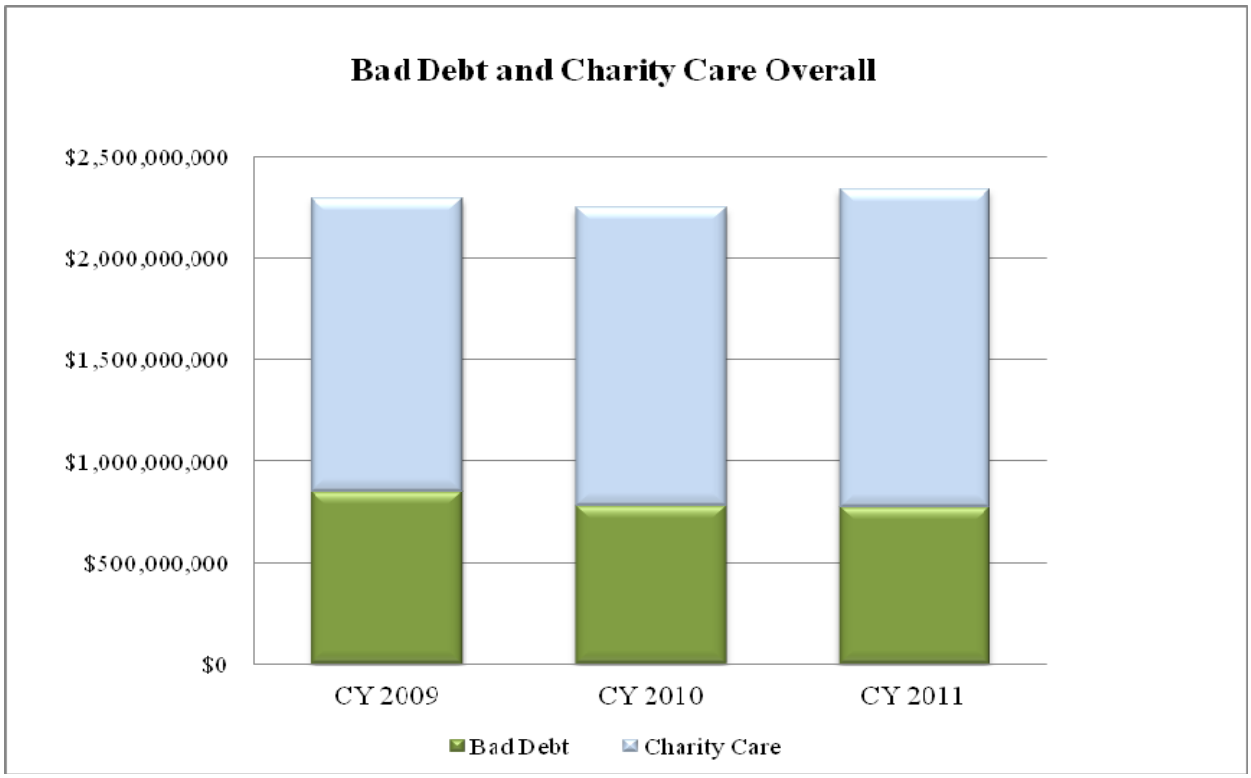

Figure 4

Department of Health Care Policy and Financing Expenditures

As funding is appropriated on a state fiscal year basis, expenditures in this section are reported on a state fiscal year basis. In SFY 2011-12, the Department collected approximately $585.7 million in fees from hospitals, which, with federal matching funds, funded health coverage expansions, payments to hospitals, and the Department's administrative expenses. These fees were also used to provide General Fund relief pursuant to SB 11-212. The following table outlines the Hospital Provider Fee expenditures in SFY 2011-12.

SFY 2011-12 Hospital Provider Fee Expenditures (Total Funds)*	
Supplemental Hospital Payments	$896,654,000
Department Administration	$15,825,000
Expansion Populations	$134,339,000
SB 11-212 – Provider Fee offset to General Fund	$50,000,000
25.5-4-402.3 (4)(b)(VII) – Offset revenue loss	$15,700,000
Total Expenditures	**$1,112,518,000**

Table 7 Hospital Provider Fee Expenditures

*Figures in this table are reported on a state fiscal year basis (July 1 through June 30) and will not match other figures in this report, which are reported on an October 1 through September 30 basis.

Funding in SFY 2011-12 was appropriated for CHCAA administrative expenses through the normal budget process. As of the last quarter of SFY 2011-12, the Department had approximately 47.2 regular full-time equivalent (FTE) positions for the administration of the CHCAA. The expenditures reflected in the following table are funded entirely by hospital provider fees and federal funds. These are new expenditures and do not supplant existing Department administrative funds. Approximately 1.42% of total CHCAA expenditures were for the Department's administrative expenses of administering the CHCAA, while about 0.3% of total CHCAA expenditures were for the personal services costs of the FTE administering the program.

SFY 2011-12 Administrative Expenditures	
(1) Executive Director's Office; (A) General Administration, Personal Services	$3,255,324
(1) Executive Director's Office; (A) General Administration, Legal Services	$111,477
(1) Executive Director's Office; (A) General Administration, Administrative Law Judge Services	$49,396
(1) Executive Director's Office; (A) General Administration: Operating Expenses	$136,686
(1) Executive Director's Office; (A) General Administration: Leased Space	$232,448
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$382,641
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$3,784,697

SFY 2011-12 Administrative Expenditures	
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$2,556,603
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards	$8,264
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations	$1,312,235
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration	$1,939,544
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach	$202,724
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$167,786
Total Executive Director's Office Expenditures	**$14,139,823**
(4) Indigent Care Program; Children's Basic Health Plan Administration	$21,971
(6) Department of Human Services Medicaid Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$1,065,504
(6) Department of Human Services Medicaid Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System - HCPF Only	$597,480
Total	**$15,824,778**

Table 8 Department Administrative Expenditures

Hospital Provider Fee Model – Fee and Payment Methodologies

On March 31, 2010, the CMS first approved the Department of Health Care Policy and Financing's (the Department's) request to waive the "uniform" and "broad-based" requirements for a provider fee under 42 CFR § 433.68(e)(2) and approved the Department's State Plan Amendments for supplemental Medicaid and DSH payments. The Hospital Provider Fee, State Plan Amendments, and UPL methodologies were first approved by the CMS on March 31, 2010 and retroactively effective July 1, 2009.

The Hospital Provider Fee Model is dynamic where fee and payment methodologies are calculated, reviewed, and approved on an annual basis. Data to calculate fees and payments are compiled annually. Changes to fee or payment methodologies may be needed to respond to changing Medicaid and uninsured client utilization patterns, Medicaid caseload, strategic goals of the Department, the health care market, or other factors.

As in the previous year, in the October 2011 through September 2012 period, hospital provider fees are calculated on inpatient and outpatient hospital services. Inpatient hospital fees are assessed on patient days; outpatient hospital fees are assessed on outpatient charges. Free-standing psychiatric, long term care, and rehabilitation hospitals are exempt from paying the fees, while high-volume Medicaid and CICP hospitals and small rural hospitals pay reduced fees. The OAB continued its recommendation to exempt free-standing psychiatric hospitals, long term care hospitals, and rehabilitation hospitals from fees because the goals of the CHCAA include reducing uncompensated costs and increasing access for Medicaid and uninsured clients. Free-standing psychiatric hospitals meet the definition of Institutions for Mental Diseases (IMDs) under 42 CFR §435.1010. 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). Long term care and rehabilitation hospitals do not pay fees but do receive an increased Medicaid inpatient hospital payment if they choose to participate in Medicaid to assure access for Medicaid clients.

There were no provider fee refunds following the close of the state fiscal year on June 30, 2011 as there had been for the previous year. At its July 2012 meeting, the OAB unanimously recommended that any excess revenue in the cash fund be used to reduce the fees needed to be raised in the 2012-13 Hospital Provider Fee Model to partially meet the SB 11-212 obligation, which requires the Department to collect $25 million in fees from hospital providers to offset General Fund dollars in the Department's Medicaid budget in SFY 2012-13.

Hospital payments are increased for Medicaid and CICP hospital services through several supplemental payments that are paid directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, CICP hospital and DSH payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients.

Fees are collected and payments are made on a monthly basis, and nearly all hospitals have authorized electronic fee and payment processing. The 2011-12 fee and payment amounts by

type are outlined in the table below. Please see Appendix A for more information about fee and payment methodologies.

2011-12 Hospital Provider Fees and Payments	
Inpatient Fee	$556,852,000
Outpatient fee	$61,872,000
Total Hospital Provider Fees	**$618,724,000**
Inpatient Base Rate Payment	$164,039,000
Outpatient Payment	$127,764,000
CICP DSH Payment	$152,416,000
CICP UPL Payment	$134,639,000
Uninsured DSH Payment	$37,039,000
High Level NICU Payment	$5,815,000
State Teaching Hospital Payment	$10,100,000
Large Rural Payment	$22,589,000
Denver Metro Payment	$177,196,000
Metropolitan Statistical Area Payment	$69,148,000
Pediatric Specialty Hospital Payment	$2,000,000
Acute Care Psychiatric Payment	$1,784,000
Total Supplemental Hospital Payments	**$904,529,000**

Table 9 Hospital Provider Fee and Payments by Type

APPENDIX A: 2011-12 Hospital Provider Fee Model Overview

This overview describes the fee assessment and payment methodologies for October 2011 through September 2012 under the CHCAA. While no hospital is eligible for all payments, all methodologies are described.

Provider Fees

Inpatient Hospital Fee and Outpatient Fee

- Total Fees collected were $618,724,000. 90% were inpatient fees and 10% were outpatient fees.
- Inpatient fee is charged on a facility's Managed Care Days and non-Managed Care Days. Fee charged on Managed Care days are discounted by 77.73% compared to the rate assessed on non-Managed Care days. Managed Care Days are Medicaid HMO, Medicare HMO, and any Commercial. PPO/HMO days. Non-Managed Care Days are all other days (i.e., fee for service, normal DRG or indemnity plan days).
- Outpatient fee is assessed as a percentage of total outpatient charges.

Hospitals Exempt from Inpatient and Outpatient Hospital Fees

- State Licensed Psychiatric Hospitals
- Medicare Certified Long Term Care (LTC) Hospitals
- State Licensed and Medicare Certified Rehabilitation Hospitals

Hospitals Assessed Discounted Fees

- High Volume Medicaid and CICP providers are those providers with at least 35,000 Medicaid days per year that provide over 30% of their total days to Medicaid and CICP clients.
  - The inpatient fee calculation for High Volume Medicaid and CICP providers is discounted by 47.79%.
  - The outpatient fee for High Volume Medicaid and CICP providers is discounted by 0.84%.
- Essential Access providers are those providers that are Critical Access Hospitals and other rural hospitals with 25 or fewer beds.

The inpatient fee calculation for Essential Access providers is discounted by 60%.

Supplemental Hospital Payments

Outpatient Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid outpatient billed costs, adjusted for utilization, and inflation, multiplied by a percentage adjustment factor. Percentage adjustment factors may vary by hospital. The percentage adjustment factor for each hospital will be published annually in the Colorado Medicaid Provider Bulletin.
- State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Colorado Indigent Care Program (CICP) Disproportionate Share Hospital (DSH) Payment *and* CICP Supplemental Medicaid Payment

- For qualified hospitals, the sum of these payments will equal CICP write-off costs multiplied by 60% for most hospitals (for High Volume Medicaid and CICP Hospitals this percentage equals 52.5%; for rural and Critical Access Hospitals this percentage equals 75%).
- CICP write-off costs equal CICP write-off charges as published in the most recent CICP Annual Report, multiplied by the cost-to-charge ratio calculated from the most recently filed CMS 2552-96 Cost Report, adjusted for inflation.
- General acute care and Critical Access Hospitals that participate in the CICP are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Uninsured DSH Payment

- For qualified hospitals, this payment will equal its uncompensated charity care costs multiplied by 40.5%.
- Uncompensated charity care costs equal charity care charges as reported on the hospital survey, multiplied by the most recently audited cost-to-charge ratio.
- Hospitals that do not participate in the CICP are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Inpatient Hospital Base Rate Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid estimated discharges, multiplied by average Medicaid case mix, multiplied by the Medicaid base rate, multiplied by 51.3% for most urban hospitals and 60.0% for most rural hospitals (for Pediatric Specialty Hospitals the percentage is 20.0%; for Urban Center Safety Net Specialty Hospitals the percentage is 31.3%; for Rehabilitation and Long Term Acute Care Hospitals the Percentage is 25.0%).
- State Licensed Psychiatric Hospitals are not qualified for this payment.

High Level Neonatal Intensive Care Unit (NICU) Supplemental Medicaid Payment

- For qualified hospitals, this payment will equal Medicaid NICU days paid during the prior year under DRG 801 (neonates < 1,000 grams; 2 lb and 3.27 oz) and capped at the average length of stay for the DRG, multiplied by $2,500.
- Hospitals with certified level IIIb or IIIc NICUs according to American Academy of Pediatrics guidelines by the Colorado Perinatal Care Council are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

State Teaching Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment will equal total Medicaid Days multiplied by $100.
- High Volume Medicaid and CICP Hospitals which provide supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of their credentialed physicians are members of the faculty at a state institution of higher education, are qualified for this payment.

Large Rural Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals total Medicaid Days multiplied by $750.
- Hospitals located in a rural area outside a federally-designated Metropolitan Statistical Area with more than 25 licensed beds are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Denver Metro Supplemental Medicaid Payment

- For qualified hospitals located in Adams or Arapahoe county, this payment equals total Medicaid Days multiplied by $800.
- For qualified hospitals located in Jefferson, Douglas, Broomfield or Boulder county this payment equals total Medicaid Days multiplied by $1,100.
- For qualified hospitals located in Denver county, this payment equals total Medicaid Days multiplied by $900.
- Hospitals located in Adams, Arapahoe, Boulder, Denver, Douglas, or Jefferson county are qualified for this payment. High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Metropolitan Statistical Area Supplemental Medicaid Payment

- For qualified hospitals located in El Paso, Larimer, Pueblo, Weld, or Mesa county this payment equals total Medicaid Days multiplied by $650.
- Hospitals located in El Paso, Larimer, Mesa, Pueblo, or Weld county are qualified for this payment. High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Pediatric Specialty Hospital Provider Fee Payment

- For qualified hospitals, this payment will equal $2 million.
- Hospitals which provide care exclusively to pediatric populations are qualified for this payment.

Acute Care Psychiatric Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid Psychiatric Days as reported on the hospitals survey multiplied by $200.
- State Licensed Psychiatric Hospitals, LTC Hospitals, and Rehabilitation Hospitals are not qualified for this payment.

APPENDIX B: October 2011 - September 2012 Hospital Provider Fees and Payments by Hospital

Fee-Exempt Hospitals – Free-Standing Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals					
Hospital Name	**County**	**2011-12 Fees**	**2011-12 Payments**	**Appx CICP Payments pre-CHCAA**	**2011-12 Net New Funds**
HealthOne Spalding Rehabilitation Hospital	Adams	$0	$218,738	$0	$218,738
Vibra Long Term Acute Care Hospital	Adams	$0	$476,696	$0	$476,696
Craig Hospital	Arapahoe	$0	$1,997,923	$0	$1,997,923
Triumph Hospital	Arapahoe	$0	$12,158	$0	$12,158
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0
Colorado Mental Health Institute-Ft Logan	Denver	$0	$0	$0	$0
Colorado Acute Long Term Hospital	Denver	$0	$127,699	$0	$127,699
Eating Recovery Center	Denver	$0	$0	$0	$0
Kindred Hospital	Denver	$0	$69,904	$0	$69,904
Select Specialty Hospital - Denver	Denver	$0	$0	$0	$0
Select Specialty Hospital - Denver South Campus	Denver	$0	$0	$0	$0
Highlands Behavioral Health System	Douglas	$0	$0	$0	$0
Cedar Springs Behavior Health System	El Paso	$0	$0	$0	$0
HealthSouth Rehabilitation Hospital	El Paso	$0	$369,138	$0	$369,138
Peak View Behavioral Health	El Paso	$0	$0	$0	$0
Select Long Term Care Hospital	El Paso	$0	$0	$0	$0
Northern Colorado Long Term Acute Care Hospital	Larimer	$0	$11,521	$0	$11,521
West slope Mental Health Stabilization Center	Mesa	$0	$0	$0	$0
Colorado Mental Health Institute-Pueblo	Pueblo	$0	$0	$0	$0
Haven Behavioral Senior Care at St. Mary-Corwin	Pueblo	$0	$0	$0	$0
Haven Behavioral Health at North Denver	Pueblo	$0	$0	$0	$0
Northern Colorado Rehabilitation Hospital	Weld	$0	$266,641	$0	$266,641
Total		**$0**	**$3,550,420**	**$0**	**$3,550,420**

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**2011-12 Fees**	**2011-12 Payments**	**Appx CICP Payments pre-CHCAA**	**2011-12 Net New Funds**
Centura Health - Saint Anthony North Hospital	Adams	$10,830,288	$14,734,555	$0	$3,904,267
Children's Hospital Colorado	Adams	$16,537,671	$33,888,360	$2,854,794	$14,495,895
HealthOne North Suburban Medical Center	Adams	$9,260,497	$13,563,797	$0	$4,303,300
Platte Valley Medical Center	Adams	$5,638,783	$10,751,478	$1,499,298	$3,613,397
University of Colorado Hospital	Adams	$27,513,356	$69,893,272	$36,264,181	$6,115,735
San Luis Valley Regional Medical Center	Alamosa	$4,550,959	$7,163,029	$962,324	$1,649,746
Centura Health - Littleton Adventist Hospital	Arapahoe	$13,094,104	$8,329,571	$0	($4,764,533)
HealthOne Medical Center of Aurora	Arapahoe	$25,921,695	$25,359,444	$0	($562,252)
HealthOne Swedish Medical Center	Arapahoe	$29,676,240	$23,910,639	$0	($5,765,601)
Pagosa Mountain Hospital	Archuleta	$79,996	$530,604	$0	$450,607
Southeast Colorado Hospital	Baca	$333,908	$709,538	$34,179	$341,452
Boulder Community Hospital	Boulder	$14,652,567	$13,270,238	$1,063,630	($2,445,959)
Centura Health - Avista Adventist Hospital	Boulder	$6,447,202	$11,863,133	$0	$5,415,931
Exempla Good Samaritan Medical Center	Boulder	$10,604,825	$7,852,040	$0	($2,752,785)
Longmont United Hospital	Boulder	$14,591,505	$18,282,587	$1,633,746	$2,057,336
Heart of the Rockies Regional Medical Center	Chaffee	$826,690	$1,623,053	$247,500	$548,863
Keefe Memorial Hospital	Cheyenne	$141,272	$167,243	$0	$25,971
Conejos County Hospital	Conejos	$260,702	$1,956,450	$99,884	$1,595,864
Delta County Memorial Hospital	Delta	$4,096,644	$4,476,563	$912,623	($532,703)
Centura Health - Porter Adventist Hospital	Denver	$16,302,215	$13,119,717	$0	($3,182,498)
Denver Health Medical Center	Denver	$24,095,809	$101,658,241	$64,455,024	$13,107,408
Exempla Saint Joseph Hospital	Denver	$22,108,111	$30,895,654	$0	$8,787,543
HealthOne Presbyterian/St. Luke's Medical Center	Denver	$22,772,525	$33,485,092	$0	$10,712,566
HealthOne Rose Medical Center	Denver	$20,168,682	$24,329,109	$0	$4,160,427
National Jewish Health	Denver	$608,582	$8,396,832	$1,682,780	$6,105,470
Centura Health - Parker Adventist Hospital	Douglas	$7,349,476	$6,998,875	$0	($350,601)
HealthOne Sky Ridge Medical Center	Douglas	$12,906,952	$7,276,371	$0	($5,630,580)

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**2011-12 Fees**	**2011-12 Payments**	**Appx CICP Payments pre-CHCAA**	**2011-12 Net New Funds**
Vail Valley Medical Center	Eagle	$3,281,968	$4,229,177	$0	$947,209
Centura Health - Penrose -St. Francis Health Services	El Paso	$30,544,124	$23,573,623	$2,195,836	($9,166,337)
Memorial Hospital	El Paso	$33,153,350	$54,878,968	$16,142,511	$5,583,106
Centura Health - St. Thomas More Hospital	Fremont	$3,699,114	$10,317,379	$779,972	$5,838,293
Grand River Medical Center	Garfield	$430,181	$1,007,053	$190,609	$386,263
Valley View Hospital	Garfield	$5,316,857	$10,749,424	$444,750	$4,987,817
Kremmling Memorial Hospital	Grand	$82,326	$278,268	$117,393	$78,549
Gunnison Valley Hospital	Gunnison	$359,897	$384,729	$42,048	($17,216)
Spanish Peaks Regional Health Center	Huerfano	$287,156	$1,490,638	$135,879	$1,067,602
Centura Health - Ortho Colorado	Jefferson	$1,172,262	$0	$0	($1,172,262)
Centura Health - Saint Anthony Central Hospital	Jefferson	$21,493,294	$26,885,766	$0	$5,392,471
Exempla Lutheran Medical Center	Jefferson	$30,364,806	$29,919,532	$0	($445,275)
Weisbrod Memorial County Hospital	Kiowa	$120,783	$268,360	$0	$147,576
Kit Carson County Memorial Hospital	Kit Carson	$425,701	$796,859	$0	$371,158
Animas Surgical Hospital	La Plata	$242,090	$1,052,504	$0	$810,414
Centura Health - Mercy Regional Medical Center	La Plata	$6,159,798	$8,227,201	$534,968	$1,532,435
St. Vincent General Hospital District	Lake	$165,675	$388,528	$118,153	$104,699
Estes Park Medical Center	Larimer	$529,868	$933,471	$435,234	($31,632)
McKee Medical Center	Larimer	$7,356,683	$14,927,195	$2,131,572	$5,438,940
Medical Center of the Rockies	Larimer	$8,860,235	$9,678,753	$1,584,786	($766,268)
Poudre Valley Hospital	Larimer	$23,369,670	$29,276,091	$5,935,254	($28,833)
Mount San Rafael Hospital	Las Animas	$845,676	$2,346,496	$134,622	$1,366,198
Lincoln Community Hospital and Nursing Home	Lincoln	$402,420	$734,762	$0	$332,342
Sterling Regional MedCenter	Logan	$2,592,908	$4,428,090	$794,952	$1,040,231
Community Hospital	Mesa	$3,342,473	$2,457,171	$170,542	($1,055,844)
Family Health West Hospital	Mesa	$117,042	$776,030	$0	$658,988
St. Mary's Hospital and Medical Center	Mesa	$23,298,601	$24,615,737	$1,747,192	($430,056)

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**2011-12 Fees**	**2011-12 Payments**	**Appx CICP Payments pre-CHCAA**	**2011-12 Net New Funds**
The Memorial Hosptial	Moffat	$577,331	$1,891,635	$167,785	$1,146,519
Southwest Memorial Hospital	Montezuma	$1,254,041	$2,011,384	$383,352	$373,991
Montrose Memorial Hospital	Montrose	$4,784,260	$5,983,221	$1,054,452	$144,509
Colorado Plains Medical Center	Morgan	$3,846,851	$3,739,703	$162,836	($269,985)
East Morgan County Hospital	Morgan	$311,267	$1,586,062	$175,025	$1,099,770
Arkansas Valley Regional Medical Center	Otero	$3,756,179	$6,221,168	$1,374,965	$1,090,024
Haxtun Hospital	Phillips	$78,741	$115,423	$0	$36,682
Melissa Memorial Hospital	Phillips	$136,174	$1,017,810	$40,279	$841,356
Aspen Valley Hospital	Pitkin	$655,486	$1,585,317	$490,839	$438,992
Prowers Medical Center	Prowers	$914,029	$2,838,744	$407,322	$1,517,393
Centura Health - St. Mary-Corwin Medical Center	Pueblo	$16,003,043	$28,571,950	$2,978,448	$9,590,459
Parkview Medical Center	Pueblo	$27,992,974	$37,434,546	$3,603,807	$5,837,765
Pioneers Hospital	Rio Blanco	$92,656	$429,589	$0	$336,933
Rangely District Hospital	Rio Blanco	$87,886	$168,497	$0	$80,611
Rio Grande Hospital	Rio Grande	$219,307	$2,305,914	$51,020	$2,035,586
Yampa Valley Medical Center	Routt	$1,959,328	$3,712,913	$168,950	$1,584,634
Sedgwick County Memorial Hospital	Sedgwick	$129,072	$370,617	$27,239	$214,305
Centura Health - Saint Anthony Summit Hospital	Summit	$790,426	$1,808,327	$0	$1,017,901
Pikes Peak Regional Hospital	Teller	$516,747	$1,614,851	$55,614	$1,042,490
North Colorado Medical Center	Weld	$24,652,572	$35,870,163	$6,182,516	$5,035,075
Wray Community District Hospital	Yuma	$295,462	$1,225,170	$107,405	$822,302
Yuma District Hospital	Yuma	$284,043	$1,368,071	$98,017	$986,012
Total		**$618,724,091**	**$900,978,360**	**$162,876,107**	**$119,378,162**

Total All Hospitals		**$618,724,091**	**$904,528,780**	**$162,876,107**	**$122,928,582**

*Figures may not sum to totals due to rounding.

APPENDIX C: Hospital Provider Fee Oversight and Advisory Board Members

As required in the CHCAA, the OAB is comprised of the following:

- Five hospital members including at least one rural hospital representative and one safety-net hospital representative;
- One statewide hospital organization member;
- One health insurance organization or carrier member;
- One health care industry member who does not represent a hospital or health insurance carrier;
- One health care consumer who does not represent employees of a hospital, health insurance carrier, or other health care industry entity;
- One representative of persons with disabilities who does not represent employees of a hospital, health insurance carrier, or other health care industry entity;
- One business representative who purchases health insurance for employees; and
- Two Department of Health Care Policy and Financing members.

Board Members by Term Expiration Date

For terms expiring May 15, 2013:

Ellen Robinson of Denver, representing a business, to serve as chair
Dr. Jeremiah A. Bartley of Brighton, representing the health care industry
Madeleine L. Roberson of Greenwood Village, representing a hospital, to serve as vice-chair
Flora Rodriguez Russel of Lakewood, representing a health care consumer
James E. Shmerling of Denver, representing a safety-net hospital
Christopher W. Underwood of Evergreen, representing the Department

For terms expiring May 15, 2015:

Henry Garvin of La Jara, representing a rural hospital
William Heller of Denver, representing the Department
Ann King of Denver, representing a statewide hospital organization
George O'Brien of Pueblo, representing persons with disabilities
Thomas Rennell of Castle Rock, representing a health insurance organization

For terms expiring May 15, 2016:

Peg Burnette of Denver, representing a hospital
Dan Enderson of Englewood, representing a hospital

APPENDIX D: Federal Requirements Overview

Provider fees are a funding source eligible for federal matching funds when used to reimburse Medicaid covered services as allowed under 42 CFR 433.68(d). Through this regulation, revenue collected from provider fees may serve as state share of Medicaid expenditures to draw a federal match. In general, to be eligible for FFP, provider fees must:

(1) Be imposed on a permissible class of health care services, including, but not limited to, inpatient hospital services and outpatient hospital 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 non-Medicaid payments reimbursement amount is positively correlated to the assessment paid by the provider, either directly or indirectly, or where the Medicaid payments vary based only on the tax amount. In other words, there will be winners and losers, where some providers will receive proportionately less in reimbursement compared to their assessed amount.

CMS may grant waivers of the broad-based and uniformity provisions if the net impact of the fee is generally redistributive, as demonstrated via statistical tests described in regulation.

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 6% of the net patient revenue for that class of services. (Congress temporarily reduced the cap to 5.5% from January 1, 2008 through September 30, 2011.)

Fees can be collected and payments can be made only after approval of the Hospital Provider Fee Model is obtained from CMS and only to the extent FFP is available under the Upper Payment Limit (UPL) for inpatient and outpatient hospital services after Medicaid reimbursement. Distribution of funds under a provider fee model may be made through supplemental Disproportionate Share Hospital (DSH) payments, increased Medicaid rates, supplemental Medicaid payments, a combination of methods, or other methodologies approved by CMS.