

Title of Rule: Revision to the Medical Assistance Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.2000  
Rule Number: MSB 14-11-04-A  
Division / Contact / Phone: Special Financing / Matt Haynes / 303.866.6305

### 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 (OAB), the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers.

The Colorado Health Care Affordability Act [section 25.5-4-402.3, C.R.S. (2014)] 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 adults to 133% of the federal poverty level (FPL), the expansion of the Child Health Plan Plus (CHP+) to 250% FPL implemented, the implementation of a Medicaid Buy-In Program for working adults with disabilities up to 450% of FPL and children with disabilities up to 300% of the FPL, and to fund 12 months of continuous eligibility for Medicaid children.

The proposed rule updates the hospital provider fee and payment calculations in accordance with the recommendation of the OAB. The proposed rule revisions make changes to the fee and payment calculations that will allow the Department to collect sufficient fees from hospitals to fund the health coverage expansions and hospital payments to comply with state statute and the Medicaid State Plan agreement with the Centers for Medicare and Medicaid Services, and to cover the Department's administrative costs.

The proposed rule eliminates the supplemental payments at 8.2004.C through 8.2004.M. they are being replaced by supplemental payments now found at 8.2004.C through 8.2004.E. The Department is making these changes to streamline the program and make it less complex. This will make the program easier for providers and stakeholders to understand and will simplify the State Plan and rule-making processes going forward.

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

Final Adoption

02/13/2015

Proposed Effective Date 03/30/2015

Emergency Adoption

DOCUMENT # 02

MSH 2.8.15

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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. (2014);  
Section 25.5-4-402.3, C.R.S. (2014)

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## **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 bear the cost of the provider fee, but also benefit from increased reimbursements made possible through provider fee funding. Low-income persons benefit from the expanded Medicaid and Child Health Plan Plus (CHP+) eligibility.

In regard to the Hospital Quality Incentive Payment, Colorado hospitals will benefit from the receipt of supplemental provider fee payments based on performance on measures related to the quality of care provided. Medicaid clients benefit to the extent that the supplemental payments, as well as quality measurement and reporting activities, lead to improved quality of care and health outcomes.

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

For FFY 2014-15, hospitals will pay approximately \$526.9 million in fees, which will generate nearly \$1.4 billion in federal funds to Colorado. Hospitals will receive \$899 million in payments resulting in increased reimbursement for care provided to Medicaid and CACP patients of \$209 million. In addition, by September 2014, an estimated 225,000 Coloradans will have health coverage due to expansions of the Medicaid and CHP+ programs.

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 be able to collect sufficient fees from hospitals to fund the health coverage expansions and hospital payments to comply with state statute and the Medicaid State Plan agreement with the Centers for Medicare and Medicaid Services. The state does not currently have the resources to fund the hospital payments and coverage expansions under the Colorado Health Care Affordability Act in absence of the provider fees.

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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 Colorado Health Care Affordability Act. The Department began collecting fees from hospitals in April 2010, after the rules were established and federal approval was obtained.

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.

No alternatives were considered. These rules are necessary for the Department to comply with the Colorado Health Care Affordability Act under section 25.5-4-402.3, C.R.S.

1 **8.2001: DEFINITIONS**

2 "Act" means the Colorado Health Care Affordability Act, C.R.S. [§ 25.5-4-402.3](#).

3 "APR-DRG" means all patient refined-diagnosis related group.

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

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

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

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

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

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

15 "CICP Write-Off Charges" means those charges reported to the Department by the hospital in accordance  
16 with 10 CCR 2505-10, Section 8.903.C.[65](#).

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

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

20 "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. [§ 1395i-](#)  
21 [4\(c\)\(2\) 1302 Section 1320\(c\)](#) and certified as a critical access hospital by the Colorado Department of  
22 Public Health and Environment.

23 "Diagnosis Related Group" or "DRG" means a cluster of similar conditions within a classification system  
24 used for hospital reimbursement. It reflects clinically cohesive groupings of inpatient hospitalizations that  
25 utilize similar amounts of hospital resources.

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

28 "Fund" means the hospital provider cash fund described in C.R.S. [§ 25.5-4-402.3\(4\)](#).

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

31 "High Volume Medicaid and CICP Hospital" means a hospital with at least [3530,000](#) Medicaid Days per  
32 year that provides over 30% of its total days to Medicaid and CICP clients.

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

- 1 "Hospital-Specific Disproportionate Share Hospital Limit" means a hospital's maximum allowable  
2 Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed  
3 under 42 U.S.C. [§1392 Section 1102.1396r-4](#).
- 4 "Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care Days and  
5 Non-Managed Care Days.
- 6 "Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for  
7 inpatient hospital services and still receive federal financial participation.
- 8 "Long Term Care Hospital" means a General Hospital that is certified as a long term care hospital by the  
9 Colorado Department of Public Health and Environment.
- 10 "Managed Care Day" means a day listed as HMO or PPO Days on the hospital's patient census.
- 11 "Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or  
12 secondary payer is Medicaid.
- 13 "Medicaid Fee-for-Service Day" means a Non-Managed Care Day for which Medicaid is the primary  
14 payer. For these days the hospital is reimbursed directly through the Department's fiscal agent.
- 15 "Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.
- 16 "Medicaid NICU Day" means a Medicaid Fee-for-Service Day in a hospital's neo-natal intensive care unit,  
17 reimbursed under APR-DRG 588, 591, 593, 602, 609, 630, or 631 up to the average length of stay.
- 18 "Medicaid Nursery Day" means a Managed Care Day or Non-Managed Care Day provided to Medicaid  
19 newborns while the mother is in the hospital.
- 20 "Medicaid Psychiatric Day" means a Managed Care Day or Non-Managed Care Day provided to a  
21 Medicaid recipient in the hospital's sub-acute psychiatric unit.
- 22 "Medicaid Rehabilitation Day" means a Managed Care Day or Non-Managed Care Day provided to a  
23 Medicaid recipient in the hospital's sub-acute rehabilitation unit.
- 24 "Medicare Fee-for-Service Day" means a Non-Managed Care Day for which Medicare is the primary  
25 payer and the hospital is reimbursed on the basis of a DRG.
- 26 "Medicare HMO Day" means a Managed Care Day for which the primary payer is Medicare.
- 27 "Medicare-Medicaid Dual Eligible Day" means a day for which the primary payer is Medicare and the  
28 secondary payer is Medicaid.
- 29 "Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or  
30 any successor form created by CMS.
- 31 "MMIS" means the Medicaid Management Information System, the Department's Medicaid claims  
32 payment system.
- 33 "MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total  
34 hospitals days.
- 35 "Non-Managed Care Day" means a day for which the primary payer is an indemnity insurance plan or  
36 other insurance plan not serving as an HMO or PPO.

- 1 "Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local  
2 government.
- 3 "Other Payers Day" means a day where the primary payer is not Medicaid or Medicare, which is not a  
4 CICP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care Day.
- 5 "Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges
- 6 "Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider  
7 for outpatient hospital services and still receive federal financial participation.
- 8 "Oversight and Advisory Board" means the hospital provider fee oversight and advisory board described  
9 in C.R.S. [§ 25.5-4-402.3\(6\)](#).
- 10 "Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.
- 11 "PPO" means a preferred provider organization that is a type of managed care health plan.
- 12 "Privately-Owned Hospital" means a hospital that is privately owned and operated.
- 13 "Psychiatric Hospitals" means a hospital licensed as a psychiatric hospital by the Colorado Department of  
14 Public Health and Environment.
- 15 "Rehabilitation Hospital" means an inpatient rehabilitation facility.
- 16 "Rural Area" means a county outside a Metropolitan Statistical Area designated by the United States  
17 Office of Management and Budget.
- 18 "State-Owned Government Hospital" means a hospital that is either owned or operated by the State.
- 19 "State University Teaching Hospital" means a High Volume Medicaid and CICP Hospital which provides  
20 supervised teaching experiences to graduate medical school interns and residents enrolled in a state  
21 institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians  
22 are members of the faculty at a state institution of higher education.
- 23 "Third-Party Medicaid Day" means a day for which third party coverage, other than Medicare, is the  
24 primary payer and Medicaid is the secondary payer.
- 25 "Uncompensated CICP Costs" means CICP Write-Off Charges multiplied by the most recent provider-  
26 specific audited Cost-to-Charge Ratio and inflated forward to the payment year.
- 27 "Uncompensated Charity Care Costs" means Charity Care Write-Off Charges multiplied by the most  
28 recent provider-specific audited Cost-to-Charge Ratio and inflated forward to the payment year.
- 29 "Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report" or "Uniform  
30 Cost Report" means the online hospital data reporting system which combines information from hospitals'  
31 Medicare Cost Reports, the MMIS, hospital financial statements, and other hospital records.
- 32 ["Uninsured Cost" means uninsured charges multiplied by the most recent provider-specific audited Cost-  
33 to-Charge ratio from the cost reports applicable to the Uniform Cost Report.](#)
- 34 "Uninsured/Self Pay Day" means a day for self-pay patients and patients without third party health  
35 insurance coverage. Uninsured/Self Pay Day does not include Charity Care Days or CICP Days.

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

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

1 **8.2003: HOSPITAL PROVIDER FEE**

2 **8.2003.A. OUTPATIENT SERVICES FEE**

- 3 1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The  
 4 Department shall demonstrate to CMS, as necessary for federal financial participation, that the  
 5 Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and  
 6 1396b(w)(4) ~~1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).~~
- 7 2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation  
 8 Hospitals are exempted from the Outpatient Services Fee.
- 9 3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as  
 10 4.59392.0119% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals'  
 11 Outpatient Services Fee is discounted by 0.84%.

12 **8.2003.B. INPATIENT SERVICES FEE**

- 13 1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The  
 14 Department shall demonstrate to CMS, as necessary for federal financial participation, that the  
 15 Inpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E),  
 16 and 1903(w)(4).
- 17 2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation  
 18 Hospitals are exempted from the Inpatient Services Fee.
- 19 3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day  
 20 basis of \$71.3476.16 per day for Managed Care Days and \$318.83-340.39 per day for all other  
 21 Days as reported to the Department by each hospital by April 30 with the following exceptions:
- 22 a. a.—High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted  
 23 to \$37.2439.76 per day for Managed Care Days and \$166.46177.72 per day for all other  
 24 Days, and
- 25 b. b.—Essential Access Hospitals' Inpatient Services Fee is discounted to \$28.5330.46  
 26 per day for Managed Care Days and \$127.53136.16 per day for all other Days.

27 **8.2003.C. ASSESSMENT OF FEE**

- 28 1. The Department shall calculate the Inpatient Services Fee and Outpatient Services Fee under  
 29 this section on an annual basis in accordance with the Act. Upon receiving a favorable  
 30 recommendation by the Oversight and Advisory Board, the Inpatient Services Fee and Outpatient  
 31 Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following  
 32 these approvals, the Department shall notify hospitals, in writing or by electronic notice, of the  
 33 annual fee to be collected each year, the methodology to calculate such fee, and the fee  
 34 assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty  
 35 calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the  
 36 Outpatient Services Fee to be assessed.
- 37 2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the  
 38 qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the  
 39 data confirmation report. The Department will prorate and adjust the Inpatient Services Fee and

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

### 3 **8.2003.D. REFUND OF EXCESS FEES**

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

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

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

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

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

23 iii. The Department shall notify each hospital of its refund in writing or by electronic  
24 notice by September 15 each year. The refunds shall be paid to each hospital by  
25 September 30 of each year according to the process described in Section  
26 8.2002.B.

27 ~~iv. For State fiscal year ending June 30, 2011 only, the Department shall not refund~~  
28 ~~unencumbered and unexpended fees for which the intended expenditure had~~  
29 ~~received approval for federal Medicaid matching funds by CMS. Unencumbered~~  
30 ~~and unexpended fees in the Fund shall remain in the Fund to be used for~~  
31 ~~allowable expenditures in State fiscal year 2011-12.~~

32 ~~v. For State fiscal year ending June 30, 2012 only, the Department shall not refund~~  
33 ~~unencumbered and unexpended fees for which the intended expenditure had~~  
34 ~~received approval for federal Medicaid matching funds by CMS. Unencumbered~~  
35 ~~and unexpended fees in the Fund shall remain in the Fund to be used for~~  
36 ~~allowable expenditures in State fiscal year 2012-13.~~

37 ~~vi. For State fiscal year ending June 30, 2013 only, the Department shall not refund~~  
38 ~~unencumbered and unexpended fees for which the intended expenditure had~~  
39 ~~received approval for federal Medicaid matching funds by CMS. Unencumbered~~  
40 ~~and unexpended fees in the Fund shall remain in the Fund to be used for~~  
41 ~~allowable expenditures in State fiscal year 2013-14.~~

### 42 **8.2004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS**

## 8.2004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

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

~~2. No hospital shall receive a payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the CICP Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.2004.D, or the Uninsured Disproportionate Share Hospital payment exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, that the hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction for the CICP Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific Disproportionate Share Hospital Limit. in the category based on the qualified hospital's proportion of Uncompensated CICP Costs, relative to the aggregate of Uncompensated CICP Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hosp~~

~~2. ital Limit. The amount of the retroactive reduction for the Uninsured Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated Charity Care Costs relative to the aggregate of Uncompensated Charity Care Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit.~~

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

## 8.2004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

~~1. Qualified hospitals. Hospitals or certified as a General Hospital by the Colorado Department of Public Health and Environment and provides providing outpatient hospital services to Medicaid clients shall receive this payment.~~

~~1.2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.~~

~~2.3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado Medicaid Management Information System (MMIS) are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient Hospital Supplemental Medicaid Payment Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. The percentage adjustment factor may vary for sState-Owned Government Hospitals, Non-sState-owned Government Hospitals owned, and pPrivately-Owned hHospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.~~

## 8.2004.C. CICP DISPROPORTIONATE SHARE HOSPITAL PAYMENT

1. ~~Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP 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. There will be three categories for qualified hospitals: State-Owned Government Hospitals, Non-State-Owned Government Hospitals, and Private-Owned Hospitals. State-Owned Government Hospitals shall receive 19.67% of the State's annual Disproportionate Share Hospital Allotment, Non-State-Owned Government Hospitals shall receive 49.18% and Private-Owned Hospitals shall receive 29.51%.~~

~~A qualified hospital's annual payment shall equal its share of the percent of Uncompensated CICP Costs of all qualified hospitals in the category divided by the State's annual Disproportionate Share Hospital allotment allocated to the category, except that no hospital shall receive a payment which exceeds its estimated Hospital-Specific Disproportionate Share Hospital Limit.~~

**8.2004.D. UNINSURED DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

1. ~~Qualified hospitals. General Hospitals and Critical Access Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and that report charges for services provided to low-income uninsured persons to the Department in a manner as prescribed by the Department shall receive this payment.~~
2. ~~Excluded hospitals. Hospitals that participate in the CICP, Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.~~
3. ~~Calculation methodology for payment. Three million two hundred thirty thousand three hundred ninety five dollars (\$3,230,395) of the State's annual Disproportionate Share Hospital allotment shall be allocated to the Uninsured Disproportionate Share Hospital Payment. A qualified hospital's annual payment shall equal its share of the percent of Uncompensated Charity Care Costs of all qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital Payment, except that no hospital shall receive a payment which exceeds its estimated Hospital-Specific Disproportionate Share Hospital Limit.~~

**8.2004.E. CICP SUPPLEMENTAL MEDICAID PAYMENT**

1. ~~Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.~~
2. ~~Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals and hospitals that do not participate in the CICP shall not receive this payment.~~
3. ~~Calculation methodology for payment.~~
  - a. ~~Qualified hospitals shall receive an annual payment, such that, when combined with the CICP Disproportionate Share Hospital Payment, shall total to a percentage of Weighted Uncompensated CICP Costs. The percentage applied to Weighted Uncompensated CICP Costs shall be:~~
    - i. ~~Fifty two point forty five percent (52.45%) for High Volume Medicaid and CICP Hospitals,~~

1           ii. ~~Seventy-seven point forty five percent (77.45%) for Rural Hospitals, or~~

2           iii. ~~Fifty two point forty five percent (52.45%) for all other qualified hospitals.~~

3   4. ~~Calculation methodology for weighting CICP uncompensated costs~~

4   a. ~~Hospitals can qualify for up to two increases to weight their inflated CICP costs. Weighted CICP~~  
5   ~~costs are calculated separately for hospitals within a Rural Area and hospitals not within a Rural~~  
6   ~~Area. Qualifying for, and weighting inflated CICP costs are determined and calculated as follows:~~

7   i. ~~CICP Cost as a percentage of total cost~~

8   a. ~~Hospitals not within a Rural Area whose CICP costs as a percentage of total costs is greater than~~  
9   ~~the mean plus one standard deviation percentage for all hospitals not within a Rural Area will~~  
10 ~~have their inflated CICP costs increased by 2% for the purposes of calculating the CICP~~  
11 ~~Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.~~

12           b. ~~Hospitals within a Rural Area whose CICP costs as a percentage of total~~  
13 ~~costs is greater than the mean plus one standard deviation percentage~~  
14 ~~for all hospitals within a Rural Area will have their inflated CICP costs~~  
15 ~~increased by 2% for the purposes of calculating the CICP Supplemental~~  
16 ~~Medicaid Payment and CICP Disproportionate Share Hospital Payment.~~

17   ii. ~~Medicaid and CICP Days as a percentage of total days~~

18           a. ~~Hospitals not within a Rural Area whose combined Medicaid and CICP~~  
19 ~~Days as a percentage of Total Days is greater than the mean plus one~~  
20 ~~standard deviation percentage for all hospitals not within a Rural Area~~  
21 ~~will have their inflated CICP costs increased by 5% for the purposes of~~  
22 ~~calculating the CICP Supplemental Medicaid Payment and CICP~~  
23 ~~Disproportionate Share Hospital Payment.~~

24           b. ~~Hospitals within a Rural Area whose combined Medicaid and CICP Days~~  
25 ~~as a percentage of Total Days is greater than the mean plus one~~  
26 ~~standard deviation percentage for all hospitals within a Rural Area will~~  
27 ~~have their inflated CICP costs increased by 5% for the purposes of~~  
28 ~~calculating the CICP Supplemental Medicaid Payment and CICP~~  
29 ~~Disproportionate Share Hospital Payment.~~

30           c. ~~For those facilities that qualify for both CICP Inflated Cost weightings, the~~  
31 ~~inflated CICP cost will be increased by 2% first, and the resulting~~  
32 ~~weighted CICP costs will then be increased by 5%.~~

33 **8.2004.FC.    INPATIENT HOSPITAL BASE RATE SUPPLEMENTAL MEDICAID PAYMENT**

34    1. Qualified hospitals. Hospitals [providing inpatient hospital services to Medicaid clients shall](#)  
35    [receive this payment.](#)

36    2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

37    3. Calculation methodology for payment. For each qualified hospital, [this-the](#) annual payment equals  
38    [the difference between](#) the hospital's expected Medicaid discharges, multiplied by the hospital's  
39    [average Medicaid case mix, multiplied by the hospital's Medicaid base rate and the hospital's](#)  
40    [expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied](#)

by the hospital's Medicaid base rate increased by a percentage adjustment factor. The percentage adjustment factor may vary by hospital such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

#### 8.2004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

##### 1. Qualified hospitals.

a. Hospitals that are Colorado Indigent Care Program providers and have at least two Obstetricians or is Obstetrician-exempt pursuant to 42 U.S.C. § 1396r-4(d) shall receive this payment; or

b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two Obstetricians or is Obstetrician-exempt pursuant to 42 U.S.C. § 1396r-4(d) shall receive this payment.

##### 2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment equals the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals multiplied by the State's total annual Disproportionate Share Hospital allotment in total computable published by the Center for Medicare and Medicaid Services in the Federal Register. No hospital shall receive a payment exceeding its Estimated Hospital-Specific Disproportionate Share Hospital Limit.

#### 8.2004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals that are not Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.

Calculation methodology for payment. For each qualified hospital with twenty-five or fewer beds, the annual payment equals the hospital's percentage of beds compared to total beds for all qualified hospitals with twenty-five beds or fewer multiplied by thirty million dollars (\$30,000,000). For each qualified hospital with greater than twenty-five beds, the annual payment equals the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals with greater than twenty-five beds multiplied by eighty five million four hundred eighty thousand one hundred seventy six dollars (\$85,480,176).

~~1. a. Pediatric Specialty Hospitals shall have a 9.5% increase.~~

~~b. State University Teaching Hospitals shall have a 20.0% increase.~~

~~c. Long Term Care Hospitals and Rehabilitation Hospitals shall have a 10.0% increase.~~

~~d. Hospitals located in Rural Areas shall have a 73.0% increase.~~

~~e. Urban Safety Net Hospitals shall have a 36.00% increase.~~

~~f. Other General Hospitals and Critical Access Hospitals shall have an 38.0% increase.~~

1 ~~8.2004.G. — HIGH LEVEL NEO-NATAL INTENSIVE CARE UNIT (NICU) SUPPLEMENTAL~~  
2 ~~MEDICAID PAYMENT~~

3 1. ~~Qualified hospitals. General Hospitals and Critical Access Hospitals certified level IIIb or IIIc neo-~~  
4 ~~natal intensive care unit (NICU) shall receive this payment.~~

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

7 3. ~~Calculation methodology for payment. For each qualified hospital, this payment is calculated on~~  
8 ~~an annual basis at \$2,400 per Medicaid NICU Day.~~

9 ~~8.2004.H. — STATE TEACHING HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT~~

10 1. ~~Qualified hospitals. State Teaching Hospitals shall receive this payment.~~

11 2. ~~Calculation methodology for payment. For each qualified hospital, this payment is calculated on~~  
12 ~~an annual basis at \$100 per Medicaid Day.~~

13 3. ~~Effective October 1, 2012 the State Teaching Hospital Supplemental Medicaid Payment is~~  
14 ~~suspended.~~

15 ~~8.2004.I. — ACUTE CARE PSYCHIATRIC SUPPLEMENTAL MEDICAID PAYMENT~~

16 1. ~~Qualified hospitals. General Hospitals with distinct part psychiatric units shall receive this~~  
17 ~~payment.~~

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

20 3. ~~Calculation methodology for payment. For each qualified hospital, this payment is calculated on~~  
21 ~~an annual basis at \$100 per Medicaid Psychiatric Day.~~

22 ~~8.2004.J. — LARGE RURAL HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT~~

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

25 2. ~~Calculation methodology for payment. For each qualified hospital, this payment is calculated on~~  
26 ~~an annual basis at \$525 per Medicaid Day, Qualified hospitals who participate in the CICP, and whose~~  
27 ~~percentage of Medicaid Days plus CICP Days to total days is in the top 25% of all providers will receive~~  
28 ~~an additional \$50 per Medicaid Day.~~

29 ~~8.2004.K. — DENVER METRO SUPPLEMENTAL MEDICAID PAYMENT~~

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

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

35 3. ~~Calculation methodology for payment.~~

1 a. ~~For each qualified hospital located in Adams County or Arapahoe County, this payment is~~  
 2 ~~calculated on an annual basis at \$770 per Medicaid Day. Qualified hospitals who participate in the CICP,~~  
 3 ~~and whose percentage of Medicaid Days plus CICP Days to total days is in the top 25% of all providers~~  
 4 ~~will receive an additional \$50 per Medicaid Day.~~

5 b. ~~For each qualified hospital located in Denver County, this payment is calculated as \$755 per~~  
 6 ~~Medicaid Day. Qualified hospitals who participate in the CICP, and whose percentage of Medicaid Days~~  
 7 ~~plus CICP Days to total days is in the top 25% of all providers will receive an additional \$50 per Medicaid~~  
 8 ~~Day.~~

9 c. ~~For each qualified hospital located in Boulder County, Broomfield County, or Jefferson County,~~  
 10 ~~this payment is calculated as \$770 per Medicaid Day. Qualified hospitals who participate in the CICP, and~~  
 11 ~~whose percentage of Medicaid Days plus CICP Days to Total Days is in the top 25% of all providers will~~  
 12 ~~receive an additional \$50 per Medicaid Day.~~

13 **8.2004.L. METROPOLITAN STATISTICAL AREA SUPPLEMENTAL MEDICAID PAYMENT**

14 1. ~~Qualified hospitals. General Hospitals located in El Paso County, Larimer County, Mesa County,~~  
 15 ~~Pueblo County or Weld County shall receive this payment.~~

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

18 3. ~~Calculation methodology for payment. For each qualified hospital this payment is calculated on~~  
 19 ~~an annual basis at \$550 per Medicaid Day.~~

20 **8.2004.M. PEDIATRIC SPECIALTY HOSPITAL PROVIDER FEE PAYMENT**

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

23 2. ~~Calculation methodology for payment. For each qualified hospital, this payment is calculated on~~  
 24 ~~an annual basis and shall equal \$1 million.~~

25 **8.2004.NF. HOSPITAL QUALITY INCENTIVE PAYMENT**

26 1. ~~Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Pediatric Hospitals, Long Term~~  
 27 ~~Acute Care Hospitals and Critical Access Hospitals Hospitals with an established Medicaid~~  
 28 ~~inpatient base rate, and that meet the minimum criteria for one or more of the selected measures,~~  
 29 ~~may qualify to receive this payment.~~

30 2. ~~Excluded hospitals. Psychiatric Hospitals and Out-of-State Hospitals in both bordering and non-~~  
 31 ~~bordering states.~~

32 3. ~~Measures. The measures for the Hospital Quality Incentive Payment are:~~

33 a. ~~a. Rate of Central Line Associated Blood Stream Infections (CLABSI)Rate of Non-~~  
 34 ~~Emergent Emergency Room Visits,~~

35 b. ~~Rate of elective deliveries between 37 and 39 weeks gestation,~~

36 c. ~~Rate of Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT),~~

37 d. ~~Rate of thirty (30) day all-cause hospital readmissions, and~~

1 e. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in  
2 a vertex position.

3 4. Calculation methodology for payment. Payments shall be calculated on an annual Federal Fiscal  
4 Year (October 1 through September 30) basis and dispensed in monthly installments. For each  
5 qualified hospital, this payment will be calculated as follows:

6 a. Determine Available Points by hospital, subject to a maximum of 10 points per measure.

7 i. Available Points are defined as the number of measures for which a hospital  
8 qualifies multiplied by ~~40~~the number of points designated for the measure.

9 b. Determine the total points earned per measure by hospital based on scoring criteria  
10 established by the Department.

11 c. Normalize the total points earned per measure to total possible points for all measures by  
12 hospital.

13 d. Calculate Adjusted Medicaid Discharges by hospital

14 i. Adjusted Medicaid Discharges are calculated by multiplying the number of  
15 Medicaid inpatient discharges by the Adjusted Discharge Factor.

16 For hospitals with less than 200 annual Medicaid discharges, the total number of  
17 discharges multiplied by .25 to arrive at the number of Medicaid discharges for  
18 use in this calculation, consistent with the Medicare Prospective Payment  
19 System calculation.

20 ~~i.~~ ii. The Adjusted Discharge Factor is defined as the most recently available annual  
21 total gross Medicaid billed charges divided by the inpatient gross Medicaid billed  
22 charges.

23 e. Calculate Total Discharge Points

24 i. Discharge Points are defined as the total number of points earned per-for all  
25 measures multiplied by the number of Adjusted Medicaid Discharges.

26 f. Calculate the Dollars per Discharge Point

27 i. Dollars per Discharge Point will be calculated by dividing the total HQIP funds  
28 available under the inpatient UPL by the total number of Discharge Points across  
29 qualified hospitals.

30 g. Determine HQIP payout by hospital by multiplying the total Discharge Points for that  
31 hospital by the Dollars per Discharge Point.

32 ~~5. The total funds for the Hospital Quality Incentive Payment for the Federal Fiscal Year beginning~~  
33 ~~October 1, 2012 will be \$32,000,000.~~

34 ~~The total funds for the Hospital Quality Incentive Payment for the Federal Fiscal Year beginning~~  
35 ~~October 1, 2013 will be \$34,388,388.~~

36 6.5. The total funds for the Hospital Quality Incentive Payment for the Federal Fiscal Year beginning  
37 October 1, 2014 will be \$61,448,873.

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