

Title of Rule: Revision to the Medical Assistance Rule Concerning Hospital Provider Fee Collection and Disbursement, Section 8.2000, et seq

Rule Number: MSB 16-02-22-D

Division / Contact / Phone: Special Financing / Nancy Dolson / 303.866.3698

STATEMENT OF BASIS AND PURPOSE

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

Under recommendation of the Hospital Provider Fee Oversight and Advisory Board (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. (2015)] 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 also clarifies definitions and removes obsolete language identified through the Department's regulatory review process. These definitions and obsolete language concern information the Department is no longer gathering and terminology that was vendor-specific that has been revised to be applicable no matter the Department's vendor.

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:

3. Federal authority for the Rule, if any:

Initial Review

04/08/2016

Final Adoption

05/13/2016

Proposed Effective Date

06/30/2015

Emergency Adoption

DOCUMENT # 02

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42 CFR Section 433.68

42 U.S.C. Section 1396b(w).

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2015);

25.5-4-402.3, C.R.S. (2015)

Initial Review

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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 CHP+ eligibility.

In regard to the quality incentive payment, Colorado hospitals 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 the year ending September 30, 2016, hospitals will pay approximately \$668 million in fees, which will generate nearly \$2.4 billion in federal funds to Colorado. Hospitals will receive \$1.12 billion in supplemental and quality incentive payments resulting in increased reimbursement for care provided to Medicaid and CACP patients of \$290 million. Currently more than 400,000 Coloradans are enrolled in expanded Medicaid and CHP+ coverage financed with hospital provider fees.

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

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fund the hospital payments and coverage expansions under the Colorado Health Care Affordability Act in absence of the provider fees.

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

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

14 **8.2001: DEFINITIONS**

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

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

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

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

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

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

28 "CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section
29 8.900.

30 "CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

31 ~~"CICP Write-Off Charges" means those charges reported to the Department by the hospital in
32 accordance with 10 CCR 2505-10, Section 8.903.C.5.~~

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

34 ~~"Cost to Charge Ratio" means the sum of the hospital's total ancillary costs and physician costs
35 divided by the sum of the hospital's total ancillary charges and physician charges.~~

36 "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C.
37 § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public
38 Health and Environment.

1 ~~“Diagnosis Related Group” or “DRG” means a cluster of similar conditions within a classification~~
2 ~~system used for hospital reimbursement. It reflects clinically cohesive groupings of inpatient~~
3 ~~hospitalizations that utilize similar amounts of hospital resources.~~

4 “Disproportionate Share Hospital Payment” or “DSH Payment” means the payments made to
5 qualified hospitals that serve a large number of Medicaid and uninsured individuals as required
6 under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that
7 limits federal financial participation for total statewide DSH payments made to hospitals.

8 “Essential Access Hospital” means a Critical Access Hospital or General Hospital located in a
9 Rural Area with 25 or fewer licensed beds.

10 “Exclusive Provider Organization” or “EPO” means a type of managed care health plan where
11 members are not required to select a primary care provider or receive a referral to receive
12 services from a specialist. EPOs will not cover care provided out-of-network except in an
13 emergency.

14 “Fund” means the hospital provider fee cash fund described in C.R.S. § 25.5-4-402.3(4).

15 “General Hospital” means a hospital licensed as a general hospital by the Colorado Department
16 of Public Health and Environment.

17 “High Volume Medicaid and CICP Hospital” means a hospital with at least 30,000 Medicaid Days
18 per year that provides over 30% of its total days to Medicaid and CICP clients.

19 ~~“Health Maintenance Organization” or “HMO” means a health maintenance organization means a~~
20 ~~type of managed care health plan that limits coverage to providers who work for or contract with~~
21 ~~the HMO and requires selection of a primary care provider and referrals to receive services from~~
22 ~~a specialist. HMOs will not cover care provided out-of-network except in an emergency. that~~
23 ~~provides health care insurance coverage to an individual.~~

24 “Hospital-Specific Disproportionate Share Hospital Limit” means a hospital’s maximum allowable
25 Disproportionate Share Hospital payment eligible for Medicaid federal financial participation
26 allowed under 42 U.S.C. § 1396r-4.

27 “Inpatient Services Fee” means an assessment on hospitals based on inpatient Managed Care
28 Days and Non-Managed Care Days.

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

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

33 “Managed Care Day” means an inpatient hospital day for which the primary payer is a managed
34 care health plan, including a listed as HMO, or PPO, POS, and EPO. Days on the hospital’s
35 patient census.

36 “Medicaid Day” means a Managed Care Day or Non-Managed Care Day for which the primary or
37 secondary payer is Medicaid.

38 ~~“Medicaid Fee-for-Service Day” means a Non-Managed Care Day for which Medicaid is the~~
39 ~~primary payer. For these days the hospital is reimbursed directly through the Department’s fiscal~~
40 ~~agent.~~

- 1 "Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is
2 Medicaid.
- 3 ~~"Medicaid NICU Day" means a Medicaid Fee-for-Service Day in a hospital's neo-natal intensive
4 care unit, reimbursed under APR-DRG 588, 591, 593, 602, 609, 630, or 631 up to the average
5 length of stay.~~
- 6 ~~"Medicaid Nursery Day" means a Managed Care Day or Non-Managed Care Day provided to
7 Medicaid newborns while the mother is in the hospital.~~
- 8 ~~"Medicaid Psychiatric Day" means a Managed Care Day or Non-Managed Care Day provided to
9 a Medicaid recipient in the hospital's sub-acute psychiatric unit.~~
- 10 ~~"Medicaid Rehabilitation Day" means a Managed Care Day or Non-Managed Care Day provided
11 to a Medicaid recipient in the hospital's sub-acute rehabilitation unit.~~
- 12 ~~"Medicare Fee-for-Service Day" means a Non-Managed Care Day for which Medicare is the
13 primary payer and the hospital is reimbursed on the basis of a DRG.~~
- 14 ~~"Medicare HMO Day" means a Managed Care Day for which the primary payer is Medicare.~~
- 15 ~~"Medicare-Medicaid Dual Eligible Day" means a day for which the primary payer is Medicare and
16 the secondary payer is Medicaid.~~
- 17 "Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS
18 2552-10, or any successor form created by CMS.
- 19 "MMIS" means the Medicaid Management Information System, the Department's Medicaid claims
20 payment system.
- 21 "MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by
22 total hospital days.
- 23 "Non-Managed Care Day" means an inpatient hospital day for which the primary payer is an
24 indemnity insurance plan or other insurance plan not serving as an HMO, ~~or~~ PPO, POS, or EPO.
- 25 "Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a
26 local government.
- 27 ~~"Other Payers Day" means a day where the primary payer is not Medicaid or Medicare, which is
28 not a CIGP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care
29 Day.~~
- 30 "Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital
31 charges
- 32 "Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a
33 provider for outpatient hospital services and still receive federal financial participation.
- 34 "Oversight and Advisory Board" means the hospital provider fee oversight and advisory board
35 described in C.R.S. § 25.5-4-402.3(6).
- 36 "Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric
37 populations.

- 1 “POS” or “Point of Service” means a type of managed care health plan that charges patients less
 2 to receive services from providers in the plan’s network and requires a referral from a primary
 3 care provider to receive services from a specialist.
- 4 “PPO” or means a p”Preferred Pprovider Oorganization”_ means a type of managed care health
 5 plan that contracts with providers to create a network of participating providers. Patients are
 6 charged less to receive services from providers that belong to the network and may receive
 7 services from providers outside the network at an additional cost that is a type of managed care
 8 health plan.
- 9 “Privately-Owned Hospital” means a hospital that is privately owned and operated.
- 10 “Psychiatric Hospital” means a hospital licensed as a psychiatric hospital by the Colorado
 11 Department of Public Health and Environment.
- 12 “Rehabilitation Hospital” means an inpatient rehabilitation facility.
- 13 “Rural Area” means a county outside a Metropolitan Statistical Area or an area within an outlying
 14 county of a Metropolitan Statistical Area designated by the United States Office of Management
 15 and Budget.
- 16 “State-Owned Government Hospital” means a hospital that is either owned or operated by the
 17 State.
- 18 “State University Teaching Hospital” means a High Volume Medicaid and CICIP Hospital which
 19 provides supervised teaching experiences to graduate medical school interns and residents
 20 enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its
 21 credentialed physicians are members of the faculty at a state institution of higher education.
- 22 ~~“Third-Party Medicaid Day” means a day for which third party coverage, other than Medicare, is~~
 23 ~~the primary payer and Medicaid is the secondary payer.~~
- 24 ~~“Uncompensated CICIP Costs” means CICIP Write-Off Charges multiplied by the most recent~~
 25 ~~provider specific audited Cost-to-Charge Ratio and inflated forward to the payment year.~~
- 26 ~~“Uncompensated Charity Care Costs” means Charity Care Write-Off Charges multiplied by the~~
 27 ~~most recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment~~
 28 ~~year.~~
- 29 ~~“Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report” or~~
 30 ~~“Uniform Cost Report” means the online hospital data reporting system which combines~~
 31 ~~information from hospitals’ Medicare Cost Reports, the MMIS, hospital financial statements, and~~
 32 ~~other hospital records.~~
- 33 “Uninsured Cost” means uninsured days and charges allocated to routine and ancillary cost
 34 centers and multiplied by the most recent provider-specific per diem cost and audited Ccost-to-
 35 cCharge ratio from the Medicare eCost rReport._s applicable to the Uniform Cost Report.
- 36 ~~“Uninsured/Self Pay Day” means a day for self-pay patients and patients without third party~~
 37 ~~health insurance coverage. Uninsured/Self Pay Day does not include Charity Care Days or CICIP~~
 38 ~~Days.~~
- 39 ~~“Uninsured/Self Pay Write-Off Charges” means charges for self-pay patients and those with no~~
 40 ~~third party coverage less adjustments for a hospital’s courtesy or uninsured or self-pay policy~~
 41 ~~discounts.~~

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

5 **8.2002: RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS**

6 **8.2002.A. DATA REPORTING**

7 1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the
 8 distribution of supplemental payments, the Department shall distribute a Uniform Cost
 9 Report data reporting template to all hospitals no later than April 30 of each year. The
 10 Department shall include instructions for completing the Uniform Cost Report data
 11 reporting template, including definitions and descriptions of each data element to be
 12 reported ~~in the Uniform Cost Report~~. Hospitals shall submit ~~the Uniform Cost Report,~~
 13 ~~as the requested data -requested-~~ to the Department within by May 31 of each year~~thirty~~
 14 ~~(30) calendar days after receiving the data reporting template or on the stated due date,~~
 15 whichever is later. The Department may estimate any data element not provided directly
 16 by the hospital.

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

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

34 4. An authorized hospital signatory shall certify that the data included in the Uniform Cost
 35 Report data reporting template are correct, are based on actual hospital records, and that
 36 all supporting documentation will be maintained for a minimum of seven-six years.

37 **8.2002.B. FEE ASSESSMENT AND COLLECTION**

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

44 ~~2. Fee Collection and Payment Disbursement. In state fiscal year (SFY) 2009-10 Outpatient~~
 45 ~~Services Fee and Inpatient Services Fee (collectively referred to as "fee") will be~~
 46 ~~assessed on an annual basis and collected in four installments on or about, April 16,~~
 47 ~~2010; April 30, 2010; May 14, 2010 and June 11, 2010.~~

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

32. ~~Beginning in SFY 2010-11~~ The Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve monthly installments. Payments to hospitals will be calculated on an annual basis and disbursed in twelve monthly installments.

a. For those hospitals that participate in the electronic funds process utilized by the Department, fees will be assessed and payments will be disbursed on the second Friday of the month, except when State offices are closed during the week of the second Friday, then fees will be assessed and payment will be disbursed on the following Friday of the month. If the Department must diverge from this schedule due to unforeseen circumstances, the Department shall notify hospitals in writing or by electronic notice as soon as possible.

i. The Department may assess fees and disburse payments for Urban Center Safety Net Specialty Hospitals on an alternate schedule determined by the Department.

b. At no time will the Department assess fees or disburse payments prior to the state fiscal year for which they apply.

43. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Department for the collection of fees and the disbursement of payments unless the Department has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Department describing an alternative fee collection process and/or payment process. The Department shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

a. For hospitals that do not participate in the electronic funds process utilized by the Department for the collection of fees, pPayments to hospitals shall be processed by the Department within two business days of receipt of a warrant (paper check) or wire transfer to pay the Outpatient Services Fee and Inpatient Services Fee from hospitals that do not participate in the ACH debit process utilized by the Department.

b. For hospitals that do not participate in the electronic funds process utilized by the Department for the disbursement of Ppayments, payments to hospitals shall be processed through a warrant (paper check) will be processed by the Department within two business days of receipt of the Outpatient Services Fee or and Inpatient Services Fee for those hospitals that do not participate in the EFT payment process utilized by the Department to deposit supplemental payments in financial accounts authorized by hospitals.

~~5. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Department for the collection of fees and the disbursement of payments unless the Department has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Department describing an alternative fee collection process and/or payment process. The Department shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.~~

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
 4 CMS. The Department shall demonstrate to CMS, as necessary for federal financial
 5 participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§
 6 1396b(w), 1396b(w)(3)(E), and 1396b(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
 10 as ~~1.94471.534~~% of total hospital outpatient charges. High Volume Medicaid and CICP
 11 Hospitals' 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.
 14 The Department shall demonstrate to CMS, as necessary for federal financial
 15 participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302
 16 Sections 1903(w), 1903(w)(3)(E), 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
 20 inpatient day basis of ~~\$76.1679.54~~ per day for Managed Care Days and ~~\$340.39355.49~~
 21 per day for all ~~other Days~~Non-Managed Care Days as reported to the Department by
 22 ~~each hospital by April 30~~ with the following exceptions:
- 23 a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted
 24 to ~~\$39.7641.53~~ per day for Managed Care Days and ~~\$177.72185.60~~ per day for
 25 all ~~other Days~~Non-Managed Care Days, and.
- 26 b. Essential Access Hospitals' Inpatient Services Fee is discounted to ~~\$30.4631.82~~
 27 per day for Managed Care Days and ~~\$136.46142.20~~ per day for Non-Managed
 28 Care Days~~all other Days~~.

29 **8.2003.C. ASSESSMENT OF FEE**

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

1 Inpatient Services Fee and Outpatient Services Fee for the expected volume of services
2 for hospitals that open, close, 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
5 received approval for federal Medicaid matching funds by CMS at the time of collection,
6 the Department shall refund to each hospital its proportion of such fees paid within five
7 business days of receipt. The Department shall notify each hospital of its refund amount
8 in writing or by electronic notice. The refunds shall be paid to each hospital according to
9 the process described in Section 8.2002.B.
- 10 2. After the close of each State fiscal year and no later than the following August 31, the
11 Department shall present a summary of fees collected, expenditures made or
12 encumbered, and interest earned in the Fund during the State fiscal year to the Oversight
13 and Advisory Board.
 - 14 a. If fees have been collected for which the intended expenditure has received
15 approval for federal Medicaid matching funds by CMS, but the Department has
16 not expended or encumbered those fees at the close of each State fiscal year:
 - 17 i. The total dollar amount to be refunded shall equal the total fees
18 collected, less expenditures made or encumbered, plus any interest
19 earned in the Fund, less four percent of the estimated expenditures for
20 health coverage expansions authorized by the Act for the subsequent
21 State fiscal year as most recently published by the Department.
 - 22 ii. The refund amount for each hospital shall be calculated in proportion to
23 that hospital's portion of all fees paid during the State fiscal year.
 - 24 iii. The Department shall notify each hospital of its refund in writing or by
25 electronic notice by September 15 each year. The refunds shall be paid
26 to each hospital by September 30 of each year according to the process
27 described in Section 8.2002.B.

28 **8.2004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL** 29 **PAYMENTS**

30 **8.2004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS**

- 31 1. All supplemental payments are prospective payments subject to the Inpatient Upper
32 Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with
33 no reconciliation to actual data for the payment period. In the event that data entry or
34 reporting errors, or other unforeseen payment calculation errors are realized after a
35 supplemental payment has been made, reconciliations and adjustments to impacted
36 hospital payments may be made retroactively, as determined by the Department.
- 37 2. No hospital shall receive a DSH payment exceeding its Hospital-Specific
38 Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share
39 Hospital Payment, described in 10 CCR 2505-10, Section 8.2004.D, exceeds the
40 Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the
41 hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share
42 Hospital Limit retroactively. The amount of the retroactive reduction shall be retroactively
43 distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs
44 compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-
45 Specific Disproportionate Share Hospital Limit.

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

6 **8.2004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT**

- 7 1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients
 8 shall receive this payment.
- 9 2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.
- 10 3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the
 11 Colorado MMIS are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at
 12 hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient
 13 Hospital Supplemental Medicaid Payment equals hospital-specific outpatient billed costs,
 14 adjusted for utilization and inflation, multiplied by a percentage adjustment factor. The
 15 percentage adjustment factor may vary for State-Owned Government Hospitals, Non-
 16 State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural
 17 hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals,
 18 for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total
 19 payments to hospitals shall not exceed the Outpatient Upper Payment Limit. The
 20 percentage adjustment factor for each qualified hospital will be published annually in the
 21 Colorado Medicaid Provider Bulletin.

22 **8.2004.C. INPATIENT HOSPITAL BASE RATE SUPPLEMENTAL MEDICAID PAYMENT**

- 23 1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients
 24 shall receive this payment.
- 25 2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.
- 26 3. Calculation methodology for payment. For each qualified hospital, the annual payment
 27 equals the ~~difference between the~~ hospital's expected Medicaid discharges, multiplied by
 28 the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate
 29 ~~before add-ons, and the hospital's expected Medicaid discharges, multiplied by the~~
 30 ~~hospital's average Medicaid case mix,~~ multiplied by ~~the hospital's Medicaid base rate~~
 31 ~~increased by~~ a percentage adjustment factor. The percentage adjustment factor may vary
 32 by hospital such that total payments to hospitals do not exceed the available Inpatient
 33 Upper Payment Limit. The percentage adjustment factor may vary for State-Owned
 34 Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned
 35 Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for ~~Major~~
 36 ~~Pediatric~~ Teaching Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals,
 37 or for other hospital classifications. The percentage adjustment factor for each qualified
 38 hospital will be published annually in the Colorado Medicaid Provider Bulletin.

39 **8.2004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT**

- 40 1. Qualified hospitals.
- 41 a. Hospitals that are Colorado Indigent Care Program providers and have at least
 42 two ~~o~~ Obstetricians who have staff privileges at the hospital and who have agreed
 43 to provide obstetric care for Medicaid clients or is ~~Obstetrician-exempt from the~~
 44 obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) shall receive
 45 this payment; or.

1 b. Hospitals with a MIUR equal to or greater than the mean plus one standard
 2 deviation of all MIURs for Colorado hospitals and have at least two
 3 Obstetricians who have staff privileges at the hospital and who have agreed to
 4 provide obstetric care for Medicaid clients or is exempt from the obstetrician
 5 requirement or is Obstetrician-exempt pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii)
 6 shall receive this payment.

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

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

14 a. Qualified hospitals whose CICP write-off costs are greater than or equal to 750%
 15 of all CICP hospitals write-off costs as published in the most recent CICP annual
 16 report will receive a DSH payment equal to 100% of the estimated Hospital-
 17 Specific Disproportionate Share Hospital Limit.

18 b. Qualified hospitals whose CICP write-off costs are less than 750% and more
 19 than 200% of all CICP hospitals write-off costs as published in the most recent
 20 CICP annual report will receive a DSH payment equal to 96% of the estimated
 21 Hospital-Specific Disproportionate Share Hospital Limit.

22 c. All other qualified hospitals will receive a DSH payment calculated as the
 23 hospital's percentage of Uninsured Costs compared to total Uninsured Costs for
 24 all remaining qualified hospitals multiplied by the remainder of the state's total
 25 annual Disproportionate Share Hospital allotment to not exceed 96% of the
 26 estimated Hospital-Specific Disproportionate Share Hospital Limit.

27 **8.2004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID**
 28 **PAYMENT**

29 1. Qualified hospitals. General Hospitals and Critical Access Hospitals shall receive this
 30 payment.

31 2. Excluded hospitals. Hospitals that are not Psychiatric Hospitals, Long Term Care
 32 Hospitals, and Rehabilitation Hospitals shall not receive this payment.

33 3. Calculation methodology for payment. For each qualified hospital with twenty-five or
 34 fewer beds, the annual payment equals the hospital's percentage of beds compared to
 35 total beds for all qualified hospitals with twenty-five beds or fewer multiplied by ~~thirty~~
 36 ~~twenty~~ three million five hundred thousand dollars (~~\$32~~3,500,000). For each qualified
 37 hospital with greater than twenty-five beds, the annual payment equals the hospital's
 38 percentage of Uninsured Costs compared to total Uninsured Costs for all qualified
 39 hospitals with greater than twenty-five beds multiplied by ~~eighty-ninety~~ one million nine
 40 hundred eighty thousand one hundred seventy six dollars (~~\$89~~1,980,176).

41 **8.2004.F. HOSPITAL QUALITY INCENTIVE PAYMENT**

42 1. Qualified hospitals. Hospitals with an established Medicaid inpatient base rate₇ and that
 43 meet the minimum criteria for one or more of the selected measures₇ may qualify to
 44 receive this payment.

- 1 2. Excluded hospitals. ~~Psychiatric Hospitals and Out-of-State Hospitals in both bordering~~
2 ~~and non-bordering states.~~
- 3 3. Measures. Quality incentive payment measures include five base measures and four
4 optional measures. Hospitals can report data on up to five measures annually. Qualified
5 hospitals must report all of the base measures that apply to the hospital's services. If any
6 base measure does not apply, a hospital may substitute an optional measure. Optional
7 measures must be selected in the order listed. The measures for the Hospital Quality
8 Incentive Payment are:
- 9 a. The base measures for the quality incentive payment are:
- 10 aj. Rate of Non-Emergent Emergency Room VisitsEmergency department
11 process measure, which includes communicating information about the
12 Medicaid nurse advice line, primary care providers, and Regional Care
13 Collaborative Organizations (RCCO) to Medicaid clients when they are
14 seen in the emergency department and establishing emergency
15 department policies or guidelines for prescribing opioids,
- 16 bij. Rate of elective deliveries between 37 and 39 weeks gestation,
- 17 iii. Rate of Cesarean section deliveries for nulliparous women with a term,
18 singleton baby in a vertex position,
- 19 ~~c. Rate of Postoperative Pulmonary Embolism or Deep Vein Thrombosis~~
20 ~~(PPE/DVT),~~
- 21 d. Rate of thirty (30) day all-cause hospital readmissions, and
- 22 ey. Percentage of patients who gave the hospital an overall rating of "9" or
23 "10" on the Hospital Consumer Assessment of Healthcare Providers and
24 Systems (HCAHPS) survey. Rate of Cesarean section deliveries for
25 nulliparous women with a term, singleton baby in a vertex position.
- 26 b. The optional measures for the quality incentive payment are:
- 27 i. Culture of safety,
- 28 ii. Active participation in the RCCO,
- 29 iii. Advance care planning, and
- 30 iv. Screening for tobacco use.
- 31 4. Calculation methodology for payment. ~~Payments shall be calculated on an annual~~
32 ~~Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly~~
33 ~~installments. For each qualified hospital, this payment will be calculated as follows:~~
- 34 a. Determine aAvailable Points by hospital, ~~subject~~ to a maximum of 10 points per
35 measure.
- 36 i. Available Points are defined as the number of measures for which a
37 hospital qualifies multiplied by the number of points designated for the
38 measure.

- b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department.
- c. Normalize the total points earned per measure to total possible points for all measures by hospital.
- d. Calculate aAdjusted Medicaid Ddischarges by hospital.
 - i. Adjusted Medicaid Ddischarges are calculated by multiplying the number of Medicaid inpatient discharges by the Aadjusted Ddischarge fFactor.

For hospitals with less than 200 annual Medicaid discharges, the total number of discharges is multiplied by .125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare Prospective Payment System calculation.
 - ii. The aAdjusted Ddischarge fFactor is defined as the most recently available annual total gross Medicaid billed charges divided by the inpatient gross Medicaid billed charges.

- e. Calculate Ttotal aadjusted Ddischarge pPoints
 - i. Adjusted dDischarge pPoints are defined as the total number of points earned for all measures multiplied by the number of Aadjusted Medicaid Ddischarges.
- f. ~~Calculate-Determine~~ the dDollars per dDischarge pPoint.
 - i. Dollars per discharge point are tiered such that hospitals with higher quality point scores receive higher points per discharge. The dollar amount per discharge point for five tiers of quality points between 1 and 50 are shown in the table below:

<u>Tier</u>	<u>Hospital Quality Points Earned</u>	<u>Dollars per Discharge Point</u>
<u>1</u>	<u>1-10</u>	<u>\$13.18</u>
<u>2</u>	<u>11-20</u>	<u>\$14.50</u>
<u>3</u>	<u>21-30</u>	<u>\$15.82</u>
<u>4</u>	<u>31-40</u>	<u>\$17.13</u>
<u>5</u>	<u>41-50</u>	<u>\$18.45</u>

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

- g. ~~Determine~~ Calculate HQIP payout by hospital by multiplying the adjusted-total-D discharge pPoints for that hospital by the Ddollars per Ddischarge Ppoint.

- 1 5. The total funds for the ~~Hospital Quality Incentive p~~Payment for the ~~Federal Fiscal~~
2 ~~Year~~ beginning ending September 30, 2016 October 1, 2014 will be is
3 \$61,448,87384,810,386.

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