

Title of Rule: Revision to the Medical Assistance Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.2000
Rule Number: MSB 15-04-03-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 Department brought emergency rule changes to the MSB in January 2015 to 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. Subsequent to the adoption of those rules, significant data errors were discovered that required revisions to the provider fee and supplemental payment calculations, and revisions to the State Plan submission. The Hospital Provider Fee Oversight and Advisory Board (OAB) approved the revisions unanimously at its March 17, 2015 meeting. The proposed rule revisions are necessary to reflect the approved revisions to the calculations and to comply with the proposed State Plan amendment in order to ensure continuing health care coverage for the Medicaid and CHP+ expansions funded by hospital provider fees and access to discounted health care services for CICP clients.

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

06/12/2015

Proposed Effective Date **07/30/2015**

Emergency Adoption

DOCUMENT #04

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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. (2013);
Section 25.5-4-402.3, C.R.S. (2014)

Initial Review

Proposed Effective Date **07/30/2015**

Final Adoption

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DOCUMENT #04

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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 \$688.5 million in fees, which will generate nearly \$1.4 billion in federal funds to Colorado. Hospitals will receive approximately \$1.2 billion in payments resulting in increased reimbursement for care provided to Medicaid and CICP patients of approximately \$200 million.

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

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

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

If no action is taken, the Department will not be in compliance with the recommendation of the OAB from its March 17, 2015 meeting and will not be in compliance with the proposed Medicaid State Plan agreement with the Centers for Medicare and Medicaid Services.

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

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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 **8.2003: 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 ~~2.0119%~~1.9447% of total hospital outpatient charges. High Volume Medicaid and
11 CICIP Hospitals' Outpatient Services Fee is discounted by 0.84%.
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8.2004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

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 three million five hundred thousand dollars ~~(\$30,000,000)~~(\$33,500,000). 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 one million four nine hundred eighty thousand one hundred seventy six dollars ~~(\$85,480,176)~~(\$81,980,176).