



COLORADO

Department of Health Care
Policy & Financing

**HB09-1293 Oversight and Advisory Board
Hospital Provider Fee
October 28, 2014
Meeting Minutes**

Present

John Gardner
Chris Underwood
Peg Burnette
Bill Heller
George O'Brien - Phone
Jim Shmerling
Jeremiah Bartley
Ann King - Phone
Dan Enderson - Phone
Tom Rennell
David Livingston - Chair
Kathryn Ashenfelter
Nancy Dolson – HCPF

Absent

Mirna Castro

Guests

Matt Haynes - HCPF
Jeff Wittreich - HCPF
Mekayla Cortez - PCG
Dan Pace - HCPF
Janet Stephens – CHA
Cynthia Miley - HCPF

Agenda

- 1. Welcome**
- 2. Approval of Minutes**
- 3. 2014-15 Proposed Fees and Payments**
- 4. Open Forum Public Comment**
- 5. Additional Discussion if Needed**
- 6. Adjournment**

Next Meeting is scheduled for:
December 16, 2014; 3:00 to 5:00 p.m.
225 E 16th Ave, Denver, CO 80203
Conference Room 6 A/B

David Livingston called the meeting to order at 3:10 p.m.

Jim Shmerling moved that the minutes from the July 29, 2014 meeting be approved as written, **Peg Burnette** seconded the motion. Motion passed.

Presentations:

Nancy Dolson presented the 2014-15 Proposed Fees and Payments

- Medicaid and CHP+ expansion caseloads are now over 300,000 individuals
- Medicaid population is now over 1.1 million people
- Hospital Provider Fee cash fund balance at the end of last quarter was \$7 million
 - o This has been spent down
 - o A year ago we had \$38 million in the cash fund
- Hospital Provider Fee payments for FY 14-15 will be effective October 1st
 - o Will retroactively adjust fees and payments
- Looking to focus on the purpose of the Hospital Provider Fee which is to reduce under and uncompensated care for Medicaid and uninsured individuals
 - o Want to make this simpler and more transparent
- There is a federal limit on how much we can charge in fees to use as the state share, Net patient revenue limit
 - o Calculated using information from hospital cost reports
 - o Information is usually a couple of years old and then we trend it forward
 - o The federal limit is currently 6% of net patient revenues for all the fee payers
 - o We currently charge a fee on inpatient services and outpatient services
- Hospital Provider Fee is used to fund
 - o Expansion populations
 - o Department's administrative costs
 - o Supplemental payments to hospitals which are made under an upper payment limit and under disproportionate share hospital (DSH) allotment
- The upper payment limit calculation does need to be approved by CMS
- For the DSH dollars there is an allotment that Colorado receives, this year the state's share is \$200 million
- Want to make sure we do not exceed hospital specific DSH limits
- All DSH payments are audited about 3 years after it happens
 - o If we have exceeded hospital specific DSH limits the hospitals would need to pay back those funds and can then be redistributed to hospitals that were under their DSH limits
- DSH limit is calculation of total Medicaid inpatient and outpatient costs, total uninsured hospital costs less all the payments hospitals have received through Medicaid and DSH
- Everything that is paid to hospitals must fit within the upper payment limit that includes base payments, claims payments through MMIS and supplemental payments that are financed with provide fee.
- Total payments to public hospitals for inpatient hospital services cannot exceed the inpatient upper payment limit

- The upper payment limit calculation is an estimate of Medicaid cost.
 - o Past cost information from hospitals is used and then is trended forward using an inflation index and an adjustment based on expected utilization
- DSH allotment is a specific amount, FY 14-15 is \$200.4 million
 - o DSH reductions coming in FY 15-16
- Instead of 11 different payment methodologies we have 5
 - o Medicaid inpatient hospital services
 - o Outpatient hospital services
 - o Uncompensated care payment for all hospitals
 - o Disproportionate share hospital payment
 - o Quality incentive payments
- Still some state share associated with Medicaid adults without dependent children and parent populations, negotiations with CMS around methodology still ongoing
- Total payments proposing to increase by \$270 million to hospitals, total fees will go up \$154 million
 - o Net reimbursement increase will be \$115 million
- The upper payment limit is 74% higher than it was in the previous year
 - o Driven by the Medicaid caseload growth
- Last year Board agreed to be at 97% of upper payment limit
 - o Now the fee limit is the constraining factor
 - o Fee limit is the amount of revenue we can bring in from the hospitals
- Have an approved waiver with the Centers of Medicare and Medicaid Services (CMS) because not all hospitals pay a fee and not all hospitals pay the same fee
- Have a fee methodology that does not charge some hospital types
 - o Long term acute care hospitals
 - o Psychiatric hospitals
 - o Rehab hospitals
- Also have several fee discounts
 - o Managed care days are discounted by 78% on the inpatient per day fee
 - o Essential access hospitals inpatient fee is reduced 60%
 - o High volume Medicaid and CICP hospitals also receive a fee discount
- Outpatient fee is charged on total charges from the hospitals' cost reports
 - o High volume Medicaid and CICP hospitals receive a slight discount
- Total funding proposed for inpatient Medicaid base rate payment is \$614 million
 - o 158% for most hospitals
 - o 17% for Pediatric Specialty Hospital
 - o 99% High Volume Medicaid and CICP hospitals
 - o 5% rehab and long term acute care hospitals
 - o Percentages do get adjusted as needed to remain within the upper payment limit
- Hospital provide fee is also intended to increase the outpatient Medicaid payments for hospitals
 - o Hospitals are reimburse 71% of Medicaid outpatient costs
 - o Cost settle those payments
 - o Looking at in increase to the base rate to be within the upper payment limit
 - o Total funding is \$190 million

- 24.39% increase for most hospitals, will limit if need be to be within the upper payment limit
 - 60% increase for rural hospitals
 - 100% specialty hospital
- Proposing uncompensated care payment
 - For all general hospitals
 - Reimbursement for hospital services provided to uninsured
 - Look at proportion of uninsured costs compared to all hospitals and then dividing the funding
 - Propose a separate pot of money for hospitals with 25 or fewer beds
 - Total funding proposed is \$115.5 million
 - \$30 million for hospitals with 25 or fewer beds, distributed by beds
 - \$85.5 million distributed to other hospitals based on proportion of uninsured costs
- Total funding for DSH payments is set by the federal government, \$200.4 million
 - 50/50 state and federal match
 - Looking at having DSH funds for hospitals that participate in the Colorado Indigent Care Program or have a Medicaid Inpatient Utilization Rate (MIUR) one standard deviation above the mean
 - There is a reduction in uninsured due to Medicaid expansions
 - The formula that the federal government set up rewards states that focus their DSH money on hospitals with a higher MIUR
 - The DSH payments are audited 3 years after the fact so there is always the audit risk
 - Hospital's proportion of uninsured costs compared to all qualified hospitals is limited to no more than 90% of the hospital's estimated specific DSH limit
- The Board approved the quality measures and payment methodology in August
 - Total funding is \$61.4 million
 - State statute has a limit for funding
 - The first 2 years of the quality incentive payments cannot be more than 5% of the base Medicaid outpatient/inpatient reimbursement
 - After the first 2 years the limit goes up to 7%, with the Medicaid expansion that is 7% of a higher number instead of 5% of a lower number
- If adopted the total supplemental payment for FY 14-15 will be \$1.2 billion
- The fee formula and the payment formulas are very different intentionally and are required to be different.
 - Fees are assessed on all payer types
 - Payments go out based on Medicaid and uninsured volume
- The outpatient upper payment limit is 91.5% for each pool
- The inpatient upper payment limit is 88.1% by pool and then HQIP is added on
- The amount that we can pay out will either be limited by the upper payment limit or by the fee limit
- In the annual report the Department would like to highlight more the reduction in the need to shift costs.

- Fee for Service base rates are around 85% of Medicare rates. For Medicaid inpatient hospital services we are not paying up to Medicare rates
- This program allows us to increase hospital reimbursement in the Medicaid program. We can go up to the upper payment limit, the upper payment limit is an estimate of Medicaid costs

Public Comment

- Chris Tholen - The Colorado Hospital Association supports the proposed 2014-15 Provider Fee Model as presented to the Oversight Advisory Board. The 2014-15 proposed model funds the Colorado Medicaid expansion that is not included in the Affordable Care Act, it funds Colorado's cost to administer the expansion programs and the model provides reimbursement to Providers for the care they provide to Medicaid recipients. The proposed revisions ensures the model adjusts as Medicaid volumes and services provided by hospitals increase. The simplified provider fee model allows for greater transparency to stakeholders and follows the principles of the provider fee as outlined in statute. Would like to thank the Department of Health Care Policy and Financing for their work and revisions on this year's model. There is much more work behind this model than what comes through today.

Action Items

- Jim Shmerling motioned to approve the 2014-15 model as presented. Dan Enderson seconded the motion. Motion passed

The meeting was adjourned at 4:35 pm.

The next meeting is scheduled for:
Tuesday, December 16, 2014; 3:00 to 5:00 PM
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