

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

8 ~~“EPO” or “Exclusive Provider Organization” means a type of managed care health plan where~~
9 ~~services are only covered if provided by providers in the plan’s network except in an emergency.~~

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

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

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

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

17 ~~“HMO” or “Health Maintenance Organization” means a type of managed care~~
18 ~~health plan that limits coverage to providers who work for or contract with the HMO and will not~~
19 ~~cover care provided out-of-network except in an emergency. that provides health care insurance~~
20 ~~coverage to an individual.~~

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

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

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

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

30 ~~“Managed Care Day” means an inpatient hospital day where the patient is restricted to a specific~~
31 ~~or preferred network or providers including listed as HMO, or PPO, POS, and EPO. Days on the~~
32 ~~hospital’s patient census.~~

33 ~~“Medicaid Day” means a Managed Care Day or Non-Managed Care Day for which the primary or~~
34 ~~secondary payer is Medicaid.~~

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

38 “Medicaid Managed Care Day” means a Managed Care Day for which the primary payer is
39 Medicaid.

1 ~~“Medicaid NICU Day” means a Medicaid Fee-for-Service Day in a hospital’s neo-natal intensive~~
2 ~~care unit, reimbursed under APR DRG 588, 591, 593, 602, 609, 630, or 631 up to the average~~
3 ~~length of stay.~~

4 ~~“Medicaid Nursery Day” means a Managed Care Day or Non-Managed Care Day provided to~~
5 ~~Medicaid newborns while the mother is in the hospital.~~

6 ~~“Medicaid Psychiatric Day” means a Managed Care Day or Non-Managed Care Day provided to~~
7 ~~a Medicaid recipient in the hospital’s sub-acute psychiatric unit.~~

8 ~~“Medicaid Rehabilitation Day” means a Managed Care Day or Non-Managed Care Day provided~~
9 ~~to a Medicaid recipient in the hospital’s sub-acute rehabilitation unit.~~

10 ~~“Medicare Fee-for-Service Day” means a Non-Managed Care Day for which Medicare is the~~
11 ~~primary payer and the hospital is reimbursed on the basis of a DRG.~~

12 ~~“Medicare HMO Day” means a Managed Care Day for which the primary payer is Medicare.~~

13 ~~“Medicare-Medicaid Dual Eligible Day” means a day for which the primary payer is Medicare and~~
14 ~~the secondary payer is Medicaid.~~

15 “Medicare Cost Report” means the Medicare hospital cost report, form CMS 2552-96 or CMS
16 2552-10, or any successor form created by CMS.

17 “MMIS” means the Medicaid Management Information System, the Department’s Medicaid claims
18 payment system.

19 “MIUR” means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by
20 total hospitals days.

21 “Non-Managed Care Day” means an [inpatient hospital](#) day for which the primary payer is an
22 indemnity insurance plan or other insurance plan not serving as an HMO, ~~or~~ PPO, [POS](#), or [EPO](#).

23 “Non-State-Owned Government Hospital” means a hospital that is either owned or operated by a
24 local government.

25 ~~“Other Payers Day” means a day where the primary payer is not Medicaid or Medicare, which is~~
26 ~~not a CICP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care~~
27 ~~Day.~~

28 “Outpatient Services Fee” means an assessment on hospitals based on outpatient hospital
29 charges

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

32 “Oversight and Advisory Board” means the hospital provider fee oversight and advisory board
33 described in C.R.S. § 25.5-4-402.3(6).

34 “Pediatric Specialty Hospital” means a hospital that provides care exclusively to pediatric
35 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 “Preferred Provider Organization” 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
10 “Privately-Owned Hospital” means a hospital that is privately owned and operated.

11 “Psychiatric Hospital” means a hospital licensed as a psychiatric hospital by the Colorado
12 Department of Public Health and Environment.

13 “Rehabilitation Hospital” means an inpatient rehabilitation facility.

14 “Rural Area” means a county outside a Metropolitan Statistical Area or within an outlying county
15 of a Metropolitan Statistical Area designated by the United States Office of Management and
16 Budget.

17 “State-Owned Government Hospital” means a hospital that is either owned or operated by the
18 State.

19 “State University Teaching Hospital” means a High Volume Medicaid and CICIP Hospital which
20 provides supervised teaching experiences to graduate medical school interns and residents
21 enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its
22 credentialed physicians 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~~
24 ~~the primary payer and Medicaid is the secondary payer.~~

25 ~~“Uncompensated CICIP Costs” means CICIP Write-Off Charges multiplied by the most recent~~
26 ~~provider 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~~
28 ~~most recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment~~
29 ~~year.~~

30 ~~“Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report” or~~
31 ~~“Uniform Cost Report” means the online hospital data reporting system which combines~~
32 ~~information from hospitals’ Medicare Cost Reports, the MMIS, hospital financial statements, and~~
33 ~~other hospital records.~~

34 “Uninsured Cost” means uninsured days and charges allocated to routine and ancillary cost
35 centers and multiplied by the most recent provider-specific per diem cost and audited Cost-to-
36 Charge ratio from the Medicare eCost rReport. s applicable to the Uniform Cost Report.

37 ~~“Uninsured/Self Pay Day” means a day for self-pay patients and patients without third party~~
38 ~~health insurance coverage. Uninsured/Self Pay Day does not include Charity Care Days or CICIP~~
39 ~~Days.~~

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

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

8 **8.2002: RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS**

9 **8.2002.A. DATA REPORTING**

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

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

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

37 4. An authorized hospital signatory shall certify that the data included in the ~~Uniform Cost~~
 38 ~~Report~~[data reporting template](#) are correct, are based on actual hospital records, and that
 39 all supporting documentation will be maintained for a minimum of ~~seven~~[six](#) years.

40 **8.2002.B. FEE ASSESSMENT AND COLLECTION**

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

~~2. Fee Collection and Payment Disbursement. In state fiscal year (SFY) 2009-10 Outpatient Services Fee and Inpatient Services Fee (collectively referred to as "fee") will be assessed on an annual basis and collected in four installments on or about, April 16, 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. Payments 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. Payments through a warrant (paper check) will be processed by the Department within two business days of receipt of the Outpatient Services Fee or 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.~~

~~54. 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.~~

8.2003: HOSPITAL PROVIDER FEE

8.2003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial

1 participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§
2 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

3 2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation
4 Hospitals are exempted from the Outpatient Services Fee.

5 3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis
6 as 4.94471.534% of total hospital outpatient charges. High Volume Medicaid and CICP
7 Hospitals' Outpatient Services Fee is discounted by 0.84%.

8 **8.2003.B. INPATIENT SERVICES FEE**

9 1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS.
10 The Department shall demonstrate to CMS, as necessary for federal financial
11 participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302
12 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

13 2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation
14 Hospitals are exempted from the Inpatient Services Fee.

15 3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per
16 inpatient day basis of \$76.1679.54 per day for Managed Care Days and \$340.39355.49
17 per day for all other Days Non-Managed Care Days as reported to the Department by
18 each hospital by April 30 with the following exceptions:

19 a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted
20 to \$39.7641.53 per day for Managed Care Days and \$177.72185.60 per day for
21 all other Days Non-Managed Care Days, and.

22 b. Essential Access Hospitals' Inpatient Services Fee is discounted to \$30.4631.82
23 per day for Managed Care Days and \$136.16142.20 per day for Non-Managed
24 Care Days all other Days.

25 **8.2003.C. ASSESSMENT OF FEE**

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

36 2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the
37 basis of the qualifications of the hospital in the year the fee is assessed as confirmed by
38 the hospital in the data confirmation report. The Department will prorate and adjust the
39 Inpatient Services Fee and Outpatient Services Fee for the expected volume of services
40 for hospitals that open, close, relocate or merge during the payment year.

41 **8.2003.D. REFUND OF EXCESS FEES**

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

25 **8.2004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL**
26 **PAYMENTS**

27 **8.2004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS**

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

1 is received as confirmed by the hospital during the data confirmation report. Payments
 2 will be prorated and adjusted for the expected volume of services for hospitals that open,
 3 close, relocate or merge during the payment year.

4 **8.2004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT**

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

19 **8.2004.C. INPATIENT HOSPITAL BASE RATE SUPPLEMENTAL MEDICAID PAYMENT**

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

36 **8.2004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT**

- 37 1. Qualified hospitals.
 - 38 a. Hospitals that are Colorado Indigent Care Program providers and have at least
 39 two ~~o~~Obstetricians ~~who have staff privileges at the hospital and who have agreed~~
 40 ~~to provide obstetric care for Medicaid clients~~ or is ~~Obstetrician-exempt from the~~
 41 ~~obstetrician requirement~~ pursuant to 42 U.S.C. § 1396r-4(d) shall receive this
 42 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) shall
 6 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 (~~\$323,500,000~~). 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 (~~\$891,980,176~~).

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

- 1 1. Qualified hospitals. Hospitals with an established Medicaid inpatient base rate, and that
 2 meet the minimum criteria for one or more of the selected measures, may qualify to
 3 receive this payment.

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

- 6 3. Measures. Quality incentive payment measures include five base measures and four
 7 optional measures. Hospitals can report data on up to five measures annually. Qualified
 8 hospitals must report all of the base measures that apply to the hospital's services. If any
 9 base measure does not apply, a hospital may substitute an optional measure. Optional
 10 measures must be selected in the order listed. The measures for the Hospital Quality
 11 Incentive Payment are:
 - 12 a. The base measures for the quality incentive payment are:
 - 13 aj. Rate of Non-Emergent Emergency Room Visits~~Emergency department~~
 14 process measure,
 - 15 bij. Rate of elective deliveries between 37 and 39 weeks gestation,
 - 16 iii. Rate of Cesarean section deliveries for nulliparous women with a term,
 17 singleton baby in a vertex position,
 - 18 e. Rate of Postoperative Pulmonary Embolism or Deep Vein Thrombosis
 19 (PPE/DVT),
 - 20 div. Rate of thirty (30) day all-cause hospital readmissions, and
 - 21 ev. Percentage of patients who gave the hospital an overall rating of "9" or
 22 "10" on the Hospital Consumer Assessment of Healthcare Providers and
 23 Systems (HCAHPS) survey. Rate of Cesarean section deliveries for
 24 nulliparous women with a term, singleton baby in a vertex position.
 - 25 b. The optional measures for the quality incentive payment are:
 - 26 i. Culture of safety,
 - 27 ii. Active participation in the Regional Care Collaborative Organization
 28 (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.

- 1 i. Available Points are defined as the number of measures for which a
2 hospital qualifies multiplied by the number of points designated for the
3 measure.

- 4 b. Determine the total points earned per measure by hospital based on scoring
5 criteria established by the Department.

- 6 c. Normalize the total points earned per measure to total possible points for all
7 measures by hospital.

- 8 d. Calculate aAdjusted Medicaid Discharges by hospital.
 - 9 i. Adjusted Medicaid Discharges are calculated by multiplying the number
10 of Medicaid inpatient discharges by the Aadjusted Discharge fFactor.

 - 11 For hospitals with less than 200 annual Medicaid discharges, the total
12 number of discharges is multiplied by -125% to arrive at the number of
13 Medicaid discharges for use in this calculation, consistent with the
14 Medicare Prospective Payment System calculation.

 - 15 ii. The aAdjusted Discharge fFactor is defined as the most recently
16 available annual total gross Medicaid billed charges divided by the
17 inpatient gross Medicaid billed charges.

- 18 e. Calculate Total aadjusted Discharge points
 - 19 i. Adjusted discharge points are defined as the total number of points
20 earned for all measures multiplied by the number of Aadjusted Medicaid
21 Discharges.

- 22 f. Calculate-Determine the dollars per discharge point.
 - 23 i. Dollars per discharge point are tiered such that hospitals with higher
24 quality point scores receive higher points per discharge. The dollar
25 amount per discharge point for five tiers of quality points between 1 and
26 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.

- 1 g. Determine/Calculate HQIP payout/payment by hospital by multiplying the
2 adjusted total D discharge pPoints for that hospital by the Ddollars per
3 Ddischarge Ppoint.
- 4 5. The total funds for the Hospital Quality Incentive pPayment for the Federal Fiscal
5 Year/year beginning ending September 30, 2016 October 1, 2014 will be s
6 \$61,448,87384,810,386.

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