COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

January 5, 2011

The Honorable Betty Boyd, Chair
Senate Health and Human Services Committee
State Capitol Building, Room 346
Denver, CO 80203

The Honorable Jim Riesberg, Chair
House Health and Human Services Committee
State Capitol Building, Room 271
Denver, CO 80203

Dear Senator Boyd and Representative Riesberg:

On behalf of the Hospital Provider Fee Oversight and Advisory Board (OAB) and the Department of Health Care Policy and Financing (the Department), it is our pleasure to present to you this annual report for the Colorado Health Care Affordability Act, pursuant to Section 25.5-4-402.3, C.R.S. (2010). The Act authorized the Department, with federal approval, to collect a fee from hospital providers to increase Medicaid payments to hospitals and expand coverage under public health care programs. In addition, the Act established the Board to provide recommendations to the Department and the Medical Services Board on the implementation of the Colorado Health Care Affordability Act.

On March 31, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the FY 2009-10 hospital provider fee and payments. In FY 2009-10, more than $590 million was paid to hospitals, for a net gain to hospitals of more $124 million in federal funds. On May 1, 2010, the health care expansions for Medicaid Parents to 100% of the federal poverty level and the Child Health Plan *Plus* (CHP+) children and pregnant women to 250% of the federal poverty level were implemented, with more than 27,000 covered clients as of September 30, 2010. The Department is now focused on expanding coverage to the uninsured with an Adults without Dependent Children health care program and implementing a Medicaid Buy-In Program for People with Disabilities.

Questions about this report can be addressed to Nancy Dolson, Manager, Safety Net Programs section, at 303-866-3698.

Sincerely,

Joan Henneberry
Executive Director

Ellen Robinson
Chair, Hospital Provider Fee
Oversight and Advisory Board

Cc: Members of the Senate Health and Human Services Committee
Members of the House Health and Human Services Committee
Members of the Joint Budget Committee
President of the Senate
Speaker of the House
Members of the Medical Services Board
Joan Henneberry, Executive Director
John Bartholomew, Budget Director
Sue Williamson, Deputy Director, Client and Community Relations Office
Laurel Karabatsos, Acting Medicaid Director
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Executive Summary

The Department of Health Care Policy and Financing (the Department) and the Hospital Provider Fee Oversight and Advisory Board (OAB) have prepared this annual report concerning the implementation of the Colorado Health Care Affordability Act (CHCAA). The CHCAA authorizes the Department, pursuant to federal approval, to assess a hospital provider fee to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients serviced by public health insurance programs, increase funding for hospital care for Medicaid and uninsured clients, and to reduce cost-shifting to private payers.

On March 31, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the hospital provider fee and payments to be retroactively effective July 1, 2009. In FY 2009-10, more than $590 million in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed by hospital provider fees were paid to hospitals, resulting in a net gain to hospitals of approximately $124 million in federal funds. These net new funds provided a reduction in uncompensated costs incurred by hospitals for care provided to Medicaid and Colorado Indigent Care Program (CICP) clients.

On May 1, 2010, the population expansions for Medicaid Parents to 100% federal poverty level (FPL) and the Child Health Plan *Plus* (CHP+) to 250% FPL were implemented. As of September 30, 2010, the Department had enrolled approximately 25,000 Medicaid Parents, and approximately 2,500 CHP+ children and 200 CHP+ pregnant women in these expansion populations. The Department is now focused on expanding coverage to the uninsured with an Adults without Dependent Children health care program (Early 2012) and implementing a Medicaid Buy-In Program for People with Disabilities (Summer 2011).

Colorado Health Care Affordability Act Overview

On April 21, 2009, Governor Ritter signed House Bill 09-1293, the Colorado Health Care Affordability Act (CHCAA) into law. Once fully implemented, the legislation will provide health care coverage for more than 100,000 uninsured Coloradans, reduce uncompensated care costs, and benefit the state as a whole. All this will be achieved through an increase in federal funds and with no General Fund impact. The Colorado Hospital Association (CHA), the Department of Health Care Policy and Financing (the Department), and the Governor's Office worked together for nearly one year to develop House Bill 09-1293, which passed both the House and the Senate with more than 40 co-sponsors and bipartisan support.

The CHCAA requires the Department to assess and collect a provider fee from all licensed or certified hospital providers, including providers that do not serve Medicaid clients. The provisions of the legislation prohibit shifting the fee to either clients or insurers. By partnering with hospitals, when fully implemented the CHCAA will allow Colorado to draw down approximately $600 million in federal Medicaid matching funds for the following purposes authorized under CHCAA:

- Increase hospital reimbursement payments for Medicaid inpatient and outpatient care, up to a maximum of the federal Upper Payment Limit (UPL);
- Increase hospital reimbursement rates through the Colorado Indigent Care Program (CICP), up to 100% of cost;
- Create hospital quality incentive payments for rewarding enhanced quality, health outcomes, and cost effectiveness;
- Increase coverage for parents with incomes of up to 100% of the federal poverty level (FPL) through Medicaid;
- Increase coverage in the Child Health Plan *Plus* (CHP+) up to 250% FPL;
- Reduce the number of uninsured through implementation of health care coverage for adults without dependent children with incomes of up to 100% FPL;
- Create a Medicaid buy-in program for individuals with disabilities whose family incomes are too high for Medicaid eligibility but are under 450% FPL;
- Implement continuous eligibility for Medicaid children to reduce administrative burdens on Colorado families and keep eligible kids covered on a continuing basis; and,
- Cover the Department's related administrative costs.

Hospital Provider Fee Oversight and Advisory Board

A thirteen member Hospital Provider Fee Oversight and Advisory Board (OAB) appointed by the Governor provides oversight and makes recommendations to the Department of Health Care Policy and Financing (the Department) and the Medical Services Board on the implementation of the Colorado Health Care Affordability Act (CHCAA). (See Appendix C for a list of OAB members.)

The CHCAA outlines the specific duties of the OAB, including:

- Recommend to the Department the method of calculating the provider fee, the amount of the provider fee, and changes in the provider fee that increase the number of hospitals benefitting from the fee;
- Recommend to the Department changes to Medicaid inpatient and outpatient hospital payments and quality incentive payments to increase hospital accountability, performance, and reporting;
- Recommend to the Department the approach to health coverage expansions;
- Monitor the impact of the hospital provider fee on the broader health care marketplace; and
- As requested, consult with the Health and Human Services Committees of the Colorado Senate and House of Representatives.

After House Bill 09-1293 was signed into law in April 2009 and the Governor appointed OAB members, the OAB began meeting in June 2009. The OAB's meetings are held regularly from 3:00 to 5:00 p.m. on the third Tuesday of each month. Time for public comments is reserved at all meetings and the meetings are streamed over the Internet. All OAB meeting dates, agendas, minutes, and materials discussed at the meetings are posted on the Department's website at Colorado.gov/hcpf under Boards & Committees.

Department and Medical Services Board Roles

The Medical Services Board, in consultation with the OAB, is responsible for promulgating rules related to implementing the CHCAA, including the calculation, assessment, and timing of the Hospital Provider Fee; the reports that hospitals will be required to report to the Department; and other rules necessary to implement the CHCAA. At its April 2010 meeting, the Medical Services Board promulgated rules implementing the hospital provider fee and payments under 10 CCR 2505-10, Section 8.2000.

The Department administers and provides technical and regulatory expertise to the OAB. Department staff prepare and present proposed rule changes as recommended by the OAB to the Medical Services Board. The Department is responsible for calculating the fee and assessing the fee on a schedule established in rule by the Medical Services Board. The Department implements and calculates the hospital payments and administers the public health care expansion programs.

Colorado Health Care Affordability Act Benefits

The Hospital Provider Fee, State Plan Amendments, and Upper Payment Limit (UPL) methodologies were officially approved by the Centers for Medicare and Medicaid Services (CMS) on March 31, 2010 and retroactively effective July 1, 2009. Hospital Provider Fee collections and payments were assessed and collected in four installments for FY 2009-10. At the end of the fiscal year, all the expected payments and fee collections were properly paid and collected. With the hospitals' authorization, all providers who pay a fee use electronic funds transfers for payments and fee collection.

Increase Hospital Reimbursement for Medicaid and the CICP

In FY 2009-10, the hospital provider fees with approved federal matching funds increased payments for inpatient and outpatient hospital services, financed hospital payments for the Colorado Indigent Care Program (CICP), and funded additional, targeted supplemental hospital payments. Payments to hospitals totaled over $590 million, including $115 million additional funding for hospitals participating in the CICP.

FY 2009-10 Hospital Reimbursement	
Inpatient Hospital Reimbursement	$54,131,000
Outpatient Hospital Reimbursement	$78,031,000
CICP Hospital Reimbursement	$277,270,000
Additional Hospital Payments	$180,307,000
Total Supplemental Hospital Payments	**$590,239,000**

Source: Table 1 Hospital Reimbursement

In FY 2009-10, fees were assessed on inpatient and outpatient services at all licensed hospitals except free-standing psychiatric hospitals, long term care hospitals, and rehabilitation hospitals. The OAB recommended exempted free-standing psychiatric hospitals, long term care hospitals, and rehabilitation hospitals from fees because the goals of the Colorado Health Care Affordability Act (CHCAA) include reducing uncompensated costs and increasing access for Medicaid and uninsured clients. Free-standing psychiatric hospitals meet the definition of Institutions for Mental Diseases (IMDs) under 42 CFR §435.1010. Federal Financial Participation (FFP) is not available for Medicaid clients from age 22 through age 64 who are patients in an IMD, as noted under 42 CFR §435.1009(a)(2). Long term care and rehabilitation hospitals do not pay fees but do receive an increased Medicaid inpatient hospital payment if they choose to participate in Medicaid to assure access for Medicaid clients.

With the hospitals' authorization, fees are collected from hospitals by electronic funds transfer. Fees for FY 2009-10 were collected in four installments after CMS approval of the hospital provider fee.

For FY 2009-10, the Department of Health Care Policy and Financing (the Department) collected nearly $341 million in hospital provider fees to fund estimated expenditures. At the close of FY 2009-10, due in large part to due to a difference between actual expenditures for expansion populations and estimated expenditures, the Hospital Provider Fee Cash Fund had excess revenue at the end of FY 2009-10 of approximately $43 million.

During the course of the fiscal year, if expenditures are exceeding the fees collected and a negative Hospital Provider Fee Cash Fund balance is anticipated, action must be taken to ensure that the fund is not over-expended. As estimating expenditures during the ramp up of health care expansions is difficult, any over- or under-collection of fees will be due in large part to a difference between actual and estimated expenditures for expansion populations. To avoid the need to raise fees and/or decrease payments during the year, the OAB recommended maintaining a reserve balance in the Hospital Provider Fee Cash Fund of approximately 5% of estimated expansion expenditures for the upcoming year.

After the close of the state fiscal year, the Department refunded $38 million in fees that exceeded actual expenditures, and, with the recommendation of the Hospital Provider Fee Oversight and Advisory Board (OAB), retained approximately $5 million as a reserve in the Hospital Provider Fee Cash Fund for use in FY 2010-11. Fees were refunded to the hospitals in proportion to each hospital's fee payment.

FY 2009-10 Hospital Provider Fees	
Fees Collected	$340,870,000
Fees Refunded	($38,000,000)
Total Hospital Provider Fees	**$302,870,000**

Source: Table 2 Hospital Provider Fees

After taking into account the hospital provider fees collected for health coverage expansions, the Department's administrative expenses, General Fund relief per Senate Bill (SB) 10-169, and the CICP hospital reimbursement level prior to increased payments under CHCAA, the net gain to hospitals in FY 2009-10 was approximately $124 million, the net gain to hospitals for the July to September 2010 period was approximately $22 million, for a net gain to hospitals through September 2010 of $146 million. The net gain is estimated to increase to $159 million in 2010-11 for the year beginning October 1, 2010. These net gains represent the reduction in uncompensated costs incurred by hospitals for providing care to Medicaid clients and the uninsured.

FY 2009-10 Net Gains to Hospitals	
Total Supplemental Hospital Payments	$590,239,000
Total Hospital Provider Fees	($302,870,000)
Approximate CICP payments pre-CHCAA	($162,876,000)
Total Net Gain to Hospitals	**$124,493,000**

Source: Table 3 Net Gains to Hospitals

See Appendix B for a list of fees, payments, and net gains by hospital.

Increase the Number of Insured Coloradans

On May 1, 2010, the population expansions for Medicaid Parents to 100% of the Federal Poverty Level (FPL) and the Child Health Plan *Plus* (CHP+) to 250% FPL were implemented. As of September 30, 2010, the Department had enrolled approximately 25,000 Medicaid Parents, 2,500 CHP+ children, and 200 CHP+ pregnant women in these expansion populations. Of these enrollees, approximately 14,200 Medicaid Parents, 1,200 CHP+ children, and 160 CHP+ pregnant women were newly eligible for public assistance.

The Department is now focused on expanding coverage to the uninsured with an Adults without Dependent Children health care program (Early 2012) and implementing a Medicaid Buy-In Program for People with Disabilities (Summer 2011). As the health care expansion programs are implemented and enrollment grows, the Department will closely monitor the costs of these newly eligible populations to ensure that adequate fee revenue and federal funds can be collected within federal limitations.

The provisions of CHCAA leave Colorado well-positioned to implement the federal Patient Protection and Affordable Care Act of 2010 (PPACA). The enhanced federal financial participation that will be available through PPACA beginning in January 2014 for expansion populations included in CHCAA will help ensure the viability of the hospital provider fee. In addition, PPACA has numerous provisions that are anticipated to reduce the level of uncompensated care, decrease the rate of growth in health care costs, and improve health outcomes of individuals, all of which are goals of the Department in implementing CHCAA. The Department continues to explore the interplay between PPACA and CHCAA.

Improve the Quality of Health Care for Medicaid Clients

The Hospital Quality Incentive Payment (HQIP) is a mechanism under the Act that will be used to incent hospitals serving Medicaid clients for delivering high quality care that yields positive health outcomes. A stakeholder group comprised of representatives from the Department, Colorado hospitals, and from the general community was established as an ad hoc committee of the Board and tasked with determining and developing the measures that will be used for the HQIP as required by the CHCAA.

The Department, in conjunction with the Board, will determine the amount of funding pursuant to the percentages allowable in statute to be allocated to the payment and the methodology for distributing those funds. The Department expects that these payments will begin in FY 2011-12.

Reduce the Need to Shift Costs of Uncompensated Care to Other Payers

The implementation of the hospital provider fee will reduce the need for hospital providers to shift uncompensated care costs to private payers in the following ways:

1) *Higher rates for public insurance clients*. By raising the rates paid to hospital providers, the need to shift costs is reduced. The hospital provider fee increases rates paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the CICP.

2) *Reducing the number of uninsured*. Fewer uninsured Coloradans leads to lower uncompensated costs by creating a funding source for these clients. In the first year, the hospital provider fee will increase eligibility for parents of Medicaid covered children, prenatal care, and CHP+.

3) *Measurement of cost to payment ratio by payer*.

The OAB authorized a Cost Shift Data Work Group to determine what data will be collected by hospitals to fulfill the legislative requirement to report the difference between costs and payments for each of Medicare, Medicaid, and private insurance. This work group convened in Spring 2010 and made its recommendations to the OAB in Fall 2010, including a methodology to produce estimates of the differences of the cost of care provided and the payments received by providers.

The Cost Shift Data Work Group made the following recommendations to the OAB:

1. Utilize the Colorado Hospital Association (CHA) DATABANK as the primary data source;
2. The OAB should request from CHA a survey of DATABANK reporting of Bad Debt and Charity Care on an annual basis;
3. Collect Colorado Indigent Care Program (CICP) data from the Department's CICP Annual Report;
4. Model the following payer groups:
    - Medicare
    - Medicaid
    - Private sector insurance
    - CICP/self pay/other
5. Follow their methodology to estimate costs and payments on per patient for each payer group;
6. Display CICP as a separate item;
7. Display Bad Debt and Charity Care as a supplemental item;
8. Report by State Fiscal Years, beginning with FY 2005-06; and
9. Only include hospitals that receive payments under CHCAA.

The OAB is considering these recommendations and will begin reporting in its next annual report.

Department of Health Care Policy and Financing Expenditures

In FY 2009-10, the Department of Health Care Policy and Financing (the Department) distributed approximately $300 million in fees from hospitals which, with federal matching funds, funded health coverage expansions, payments to hospitals, and the Department's administrative expenses. Additional federal funds drawn due to the enhanced Federal Medicaid Assistance Percentage (FMAP) under the federal American Recovery and Reinvestment Act of 2009 (ARRA) General Fund relief pursuant to Senate Bill (SB) 10-169. The following table outlines the Hospital Provider Fee expenditures in FY 2009-10.

FY 2009-10 Hospital Provider Fee Expenditures (Total Funds)	
Supplemental Hospital Payments	$590,239,000
Department Administration	$2,939,000
Expansion Populations	$3,242,000
SB 10-169 – ARRA enhanced FMAP	$46,329,000
Total Expenditures	**$642,749,000**

Source: Table 4 Hospital Provider Fee Expenditures

The Colorado Health Care Affordability Act (CHCAA) appropriated funding to the Department for administrative expenses on a bottom-line basis giving the Department flexibility to distribute and utilize resources as effectively as possible. At the end of FY 2009-10, the Department hired 26 positions for the administration of CHCAA. The expenditures reflected in the table below are funded entirely by hospital provider fees and federal funds. These are new expenditures and do not supplant existing Department administrative funds. Less than 0.5% of total expenditures were for the Department's administrative expenses of implementing CHCAA.

FY 2009-10 Actual Expenditures	
(1) Executive Director's Office; (A) General Administration, Personal Services	$1,408,888
(1) Executive Director's Office; (A) General Administration: Operating Expenses	$228,529
(1) Executive Director's Office; (A) General Administration: Leased Space	$31,101
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$257,716
(1) Executive Director's Office; (C) Information Technology Contracts and Projects: Information Technology Contracts	$511,488
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration	$438,518
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach	$11,703
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$11,000
Total Executive Director's Office Expenditures	**$2,898,943**
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Mgmt System (CBMS)	$39,800
Total	**$2,938,743**

Source: Table 5 Department Administrative Expenditures

Hospital Provider Fee Model – Fee and Payment Methodologies

On March 31, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the Department of Health Care Policy and Financing's (the Department's) request to waive the "uniform" and "broad-based" requirements for a provider fee under 42 CFR § 433.68(e)(2) and approved the Department's State Plan Amendments for supplemental Medicaid and Disproportionate Share Hospital (DSH) payments for hospitals for FY 2009-10.

Hospital provider fees are calculated on inpatient and outpatient hospital services. Inpatient hospital fees are assessed on patient days; outpatient hospital fees are assessed on outpatient charges. Free-standing psychiatric, long term care, and rehabilitation hospitals are exempt from paying the fees, while high-volume Medicaid and CICP hospitals and small rural hospitals pay reduced fees.

Hospital payments are increased for Medicaid and Colorado Indigent Care Program (CICP) hospital services through a total of twelve (12) supplemental payments that are paid directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, CICP hospital and DSH payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients. The FY 2009-10 fee and payment amounts by type are outlined in the table below:

FY 2009-10 Hospital Provider Fees and Payments	
Inpatient Fee	$306,783,000
Outpatient fee	$34,087,000
Fees Refunded	($38,000,000)
Total Hospital Provider Fees	**$302,870,000**
Inpatient Base Rate Payment	$54,131,000
Outpatient Payment	$78,032,000
CICP DSH Payment	$152,516,000
CICP UPL Payment	$125,254,000
non CICP DSH Payment	$37,986,000
High Volume, Small Rural Outpatient Payment	$2,287,000
High Level NICU Payment	$3,677,000
State Teaching Hospital Payment	$7,110,000
Large Rural Payment	$8,497,000
Denver Metro Payment	$82,987,000
Metropolitan Statistical Area Payment	$32,762,000
Pediatric Specialty Hospital Payment	$5,000,000
Total Supplemental Hospital Payments	**$590,239,000**

Source: Table 6 Hospital Provider Fee and Payments by Type

The Hospital Provider Fee Oversight and Advisory Board (OAB) recommended that subsequent Hospital Provider Fee Models be moved to an October 1 start date to allow time for federal approval of any necessary State Plan Amendment changes and for the Medical Services Board to approve rule changes prior to implementation. This allows the Department to notify hospitals of their fees and payments in advance and reduces the need for retroactive adjustments. Consequently, the FY 2009-10 hospital provider fee methodology continued through the July to September 2010 quarter.

The Hospital Provider Fee Model is dynamic where fee and payment methodologies will be calculated, reviewed, and approved on an annual basis. Data to calculate fees and payments will be compiled annually. Changes to fee or payment methodologies may be needed to respond to changing Medicaid and uninsured client utilization patterns, Medicaid caseload, strategic goals of the Department, the health care market, or other factors. Due to federal regulations requiring that provider fees avoid hold-harmless arrangements, the proportion of payments a hospital receives is not based on the amount of fees it pays. The proportion of payments a hospital receives is based on the volume of Medicaid and uninsured clients it serves, such that higher-volume Medicaid providers receive proportionately higher payments.

Please see Appendix A for a detailed description of the fee and payment methodologies by type.

APPENDIX A: FY 2009-10 Hospital Provider Fee Model Overview

This overview describes the fee assessment and payment methodologies for FY 2009-10 under the Colorado Health Care Affordability Act (CHCAA). While no hospital is eligible for all payments, all methodologies are described.

Provider Fees

Inpatient Hospital Fee

- $60.47 per day for Managed Care Days
- $270.26 per day for non-Managed Care Days

  Managed Care Days are Medicaid HMO, Medicare HMO, and any Commercial PPO/HMO days. Non-Managed Care Days are all other days (i.e., fee for service, normal DRG or indemnity plan days).

Outpatient Hospital Fee

- 0.35% of total outpatient charges

Hospitals Exempt from Inpatient and Outpatient Hospital Fees

- State Licensed Psychiatric Hospitals
- Medicare Certified Long Term Care (LTC) Hospitals
- State Licensed and Medicare Certified Rehabilitation Hospitals

Hospitals Assessed Discounted Fees

- High Volume Medicaid and Colorado Indigent Care Program (CICP) providers are those providers with at least 35,000 Medicaid days per year that provide over 30% of their total days to Medicaid and CICP clients.
  - The inpatient fee calculation for High Volume Medicaid and CICP providers is discounted by 47.79%, or $31.57 per day for Managed Care Days and $141.10 per day for Non-Managed Care Days.
  - The outpatient fee for High Volume Medicaid and CICP providers is discounted by 0.84%.
- Essential Access providers are those providers are Critical Access Hospitals and other rural hospitals with 25 or fewer beds.
  - The inpatient fee calculation for Essential Access providers is discounted by 60%, or $24.19 per day for Managed Care Days and $108.10 per day for Non-Managed Care Days.

Supplemental Hospital Payments

Outpatient Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid outpatient billed costs, adjusted for managed care enrollment, utilization, and inflation, multiplied by 29.4% for most hospitals (for Pediatric Specialty Hospitals this percentage is 16.8%).
- Medicaid outpatient billed costs equal outpatient billed charges from the Medicaid Management Information System (MMIS), multiplied by the most recent outpatient cost-to-charge ratio as reported by CMS.
- State Licensed Psychiatric Hospitals, Long Term Care (LTC) Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid outpatient billed costs, adjusted for managed care enrollment, utilization, and inflation, multiplied by 46%.
- Medicaid outpatient billed costs are calculated in the same manner as described above for the Supplemental Outpatient Medicaid Hospital Payment.
- Acute care hospitals located in a rural area whose outpatient Medicaid payments equal 80% or more of their total Medicaid payments with have 20 or fewer beds are qualified for this payment.

Colorado Indigent Care Program (CICP) Disproportionate Share Hospital (DSH) Payment *and* CICP Supplemental Medicaid Payment

- For qualified hospitals, the sum of these payments will equal CICP write-off costs multiplied by 90% for most hospitals (for High Volume Medicaid and CICP Hospitals this percentage equals 75%; for rural and Critical Access Hospitals this percentage equals 100%).
- CICP write-off costs equal CICP write-off charges as published in the most recent CICP Annual Report, multiplied by the cost-to-charge ratio calculated from the most recently filed CMS 2552-96 Cost Report, adjusted for inflation.
- General acute care and Critical Access Hospitals that participate in the CICP are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Uninsured DSH Payment

- For qualified hospitals, this payment will equal its uncompensated charity care costs multiplied by 42.7%.
- Uncompensated charity care costs equal charity care charges as reported on the hospital survey, multiplied by the most recently audited cost-to-charge ratio.

- Hospitals that do not participate in the CICP are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Inpatient Hospital Base Rate Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid estimated discharges, multiplied by average Medicaid case mix, multiplied by the Medicaid base rate, multiplied by 18.1% for most hospitals (for Pediatric Specialty Hospitals the percentage is 13.76%; for Urban Center Safety Net Specialty Hospitals the percentage is 5.8%.)
- State Licensed Psychiatric Hospitals are not qualified for this payment.

High Level Neonatal Intensive Care Unit (NICU) Supplemental Medicaid Payment

- For qualified hospitals, this payment will equal total Medicaid Nursery Days multiplied by $450.
- Hospitals with certified level IIIb or IIIc NICUs according to American Academy of Pediatrics guidelines by the Colorado Perinatal Care Council are qualified for this payment. High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

State Teaching Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment will equal total Medicaid Days multiplied by $75.
- High Volume Medicaid and CICP Hospitals which provide supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of their credentialed physicians are members of the faculty at a state institution of higher education, are qualified for this payment.

Large Rural Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals total Medicaid Days multiplied by $315.
- Hospitals located in a rural area outside a federally-designated Metropolitan Statistical Area with more than 25 licensed beds are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Denver Metro Supplemental Medicaid Payment

- For qualified hospitals located in Adams or Arapahoe county, this payment equals total Medicaid Days multiplied by $400.
- For qualified hospitals located in Denver, Jefferson, Douglas, Boulder, or Broomfield county, this payment equals total Medicaid Days multiplied by $510.

- Hospitals located in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, or Jefferson county are qualified for this payment. High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Metropolitan Statistical Area Supplemental Medicaid Payment

- For qualified hospitals located in El Paso, Larimer, Pueblo, Weld, or Mesa county this payment equals total Medicaid Days multiplied by $310.
- Hospitals located in El Paso, Larimer, Mesa, Pueblo, or Weld county are qualified for this payment. High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Pediatric Specialty Hospital Provider Fee Payment

- For qualified hospitals, this payment will equal $5 million.
- Hospitals which provide care exclusively to pediatric populations are qualified for this payment.

APPENDIX B: FY 2009-10 Hospital Provider Fees and Payments by Hospital

Fee-Exempt Hospitals – Free-Standing Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals							
Hospital Name	**County**	**FY 2009-10 Fees**	**FY 2009-10 Fee Refunds**	**FY 2009-10 Net Fees**	**FY 2009-10 Payments**	**Appx CICP Payments pre-CHCAA**	**FY 2009-10 Net New Funds**
Haven Behavioral Health at North Denver	Adams	$0	$0	$0	$0	$0	$0
HealthOne Spalding Rehabilitation Hospital	Adams	$0	$0	$0	$114,561	$0	$114,561
Vibra Long Term Acute Care Hospital	Adams	$0	$0	$0	$42,532	$0	$42,532
Craig Hospital	Arapahoe	$0	$0	$0	$448,505	$0	$448,505
Triumph Hospital	Arapahoe	$0	$0	$0	$6,829	$0	$6,829
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0	$0	$0
Colorado Acute Long Term Hospital	Denver	$0	$0	$0	$3,374	$0	$3,374
Colorado Mental Health Institute-Ft Logan	Denver	$0	$0	$0	$0	$0	$0
Eating Recovery Center	Denver	$0	$0	$0	$0	$0	$0
Kindred Hospital	Denver	$0	$0	$0	$24,188	$0	$24,188
Select Specialty Hospital - Denver	Denver	$0	$0	$0	$0	$0	$0
Select Specialty Hospital - Denver South Campus	Denver	$0	$0	$0	$0	$0	$0
Highlands Behavioral Health System	Douglas	$0	$0	$0	$0	$0	$0
Cedar Springs Behavior Health System	El Paso	$0	$0	$0	$0	$0	$0
HealthSouth Rehabilitation Hospital	El Paso	$0	$0	$0	$75,268	$0	$75,268
Peak View Behavioral Health	El Paso	$0	$0	$0	$0	$0	$0
Select Long Term Care Hospital	El Paso	$0	$0	$0	$0	$0	$0
West slope Mental Health Stabilization Center	Mesa	$0	$0	$0	$0	$0	$0
Colorado Mental Health Institute-Pueblo	Pueblo	$0	$0	$0	$0	$0	$0
Haven Behavioral Senior Care at St. Mary-Corwin	Pueblo	$0	$0	$0	$0	$0	$0
Northern Colorado Rehabilitation Hospital	Weld	$0	$0	$0	$40,456	$0	$40,456
Totals		$0	$0	$0	$755,713	$0	$755,713

Fee-Paying Hospitals – General, Acute Care Hospitals							
Hospital Name	**County**	**FY 2009-10 Fees**	**FY 2009-10 Fee Refunds**	**FY 2009-10 Net Fees**	**FY 2009-10 Payments**	**Appx CICP Payments pre-CHCAA**	**FY 2009-10 Net New Funds**
Centura Health - Saint Anthony North Hospital	Adams	$5,586,109	($622,736)	$4,963,373	$6,573,256	$0	$1,609,883
HealthOne North Suburban Medical Center	Adams	$5,456,388	($608,275)	$4,848,113	$7,366,080	$0	$2,517,967
Platte Valley Medical Center	Adams	$2,753,555	($306,965)	$2,446,590	$6,271,904	$1,499,298	$2,326,016
The Children's Hospital	Adams	$7,125,393	($794,335)	$6,331,058	$21,326,078	$2,854,794	$12,140,226
University of Colorado Hospital	Adams	$14,565,033	($1,623,702)	$12,941,331	$53,077,792	$36,264,181	$3,872,280
San Luis Valley Regional Medical Center	Alamosa	$2,378,987	($265,208)	$2,113,779	$4,679,240	$962,324	$1,603,137
Centura Health - Littleton Adventist Hospital	Arapahoe	$7,037,084	($784,490)	$6,252,594	$3,825,389	$0	($2,427,205)
HealthOne Medical Center of Aurora	Arapahoe	$16,036,869	($1,787,782)	$14,249,087	$17,150,895	$0	$2,901,808
HealthOne Swedish Medical Center	Arapahoe	$15,872,357	($1,769,442)	$14,102,915	$13,153,949	$0	($948,966)
Pagosa Mountain Hospital	Archuleta	$61,853	($6,895)	$54,958	$383,371	$0	$328,413
Southeast Colorado Hospital	Baca	$127,577	($14,222)	$113,355	$339,331	$34,179	$191,797
Boulder Community Hospital	Boulder	$8,943,356	($997,001)	$7,946,355	$9,673,144	$1,063,630	$663,159
Centura Health - Avista Adventist Hospital	Boulder	$3,709,738	($413,560)	$3,296,178	$5,350,260	$0	$2,054,082
Exempla Good Samaritan Medical Center	Boulder	$4,585,375	($511,175)	$4,074,200	$3,415,893	$0	($658,307)
Longmont United Hospital	Boulder	$8,086,057	($901,429)	$7,184,628	$13,675,111	$1,633,746	$4,856,737
Heart of the Rockies Regional Medical Center	Chaffee	$353,262	($39,381)	$313,881	$1,055,608	$247,500	$494,227
Keefe Memorial Hospital	Cheyenne	$83,174	($9,272)	$73,902	$124,776	$0	$50,874
Conejos County Hospital	Conejos	$159,814	($17,816)	$141,998	$1,133,814	$99,884	$891,932
Delta County Memorial Hospital	Delta	$2,455,610	($273,750)	$2,181,860	$3,369,117	$912,623	$274,634
Centura Health - Porter Adventist Hospital	Denver	$9,823,318	($1,095,098)	$8,728,220	$6,233,153	$0	($2,495,067)
Centura Health - Saint Anthony Central Hospital	Denver	$12,756,869	($1,422,129)	$11,334,740	$17,464,993	$0	$6,130,253
Denver Health Medical Center	Denver	$12,295,698	($1,370,718)	$10,924,980	$93,245,850	$64,455,024	$17,865,846
Exempla Saint Joseph Hospital	Denver	$11,017,893	($1,228,269)	$9,789,624	$13,852,842	$0	$4,063,218
HealthOne Presbyterian/St. Luke's Medical Center	Denver	$13,126,170	($1,463,298)	$11,662,872	$19,043,026	$0	$7,380,154
HealthOne Rose Medical Center	Denver	$11,386,337	($1,269,343)	$10,116,994	$13,527,288	$0	$3,410,294
National Jewish Health	Denver	$302,907	($33,768)	$269,139	$3,567,459	$1,682,780	$1,615,540
Centura Health - Parker Adventist Hospital	Douglas	$3,472,774	($387,143)	$3,085,631	$2,375,845	$0	($709,786)

Fee-Paying Hospitals – General, Acute Care Hospitals							
Hospital Name	**County**	**FY 2009-10 Fees**	**FY 2009-10 Fee Refunds**	**FY 2009-10 Net Fees**	**FY 2009-10 Payments**	**Appx CICP Payments pre-CHCAA**	**FY 2009-10 Net New Funds**
HealthOne Sky Ridge Medical Center	Douglas	$6,432,882	($717,134)	$5,715,748	$2,880,360	$0	($2,835,388)
Vail Valley Medical Center	Eagle	$1,991,213	($221,979)	$1,769,234	$1,930,956	$0	$161,722
Centura Health - Penrose -St. Francis Health Services	El Paso	$19,746,490	($2,201,328)	$17,545,162	$18,249,850	$2,195,836	($1,491,148)
Memorial Hospital	El Paso	$18,078,636	($2,015,397)	$16,063,239	$39,567,505	$16,142,511	$7,361,755
Centura Health - St. Thomas More Hospital	Fremont	$2,419,000	($269,669)	$2,149,331	$4,739,796	$779,972	$1,810,493
Grand River Medical Center	Garfield	$286,448	($31,933)	$254,515	$1,179,532	$190,609	$734,408
Valley View Hospital	Garfield	$3,013,044	($335,893)	$2,677,151	$4,682,704	$444,750	$1,560,803
Kremmling Memorial Hospital	Grand	$228,253	($25,446)	$202,807	$141,381	$117,393	($178,819)
Gunnison Valley Hospital	Gunnison	$163,198	($18,193)	$145,005	$291,603	$42,048	$104,550
Spanish Peaks Regional Health Center	Huerfano	$165,041	($18,399)	$146,642	$791,961	$135,879	$509,440
Exempla Lutheran Medical Center	Jefferson	$16,057,627	($1,790,096)	$14,267,531	$15,728,252	$0	$1,460,721
Weisbrod Memorial County Hospital	Kiowa	$11,921	($1,329)	$10,592	$116,170	$0	$105,578
Kit Carson County Memorial Hospital	Kit Carson	$136,326	($15,198)	$121,128	$252,602	$0	$131,474
Animas Surgical Hospital	La Plata	$156,689	($17,468)	$139,221	$685,584	$0	$546,363
Mercy Medical Center	La Plata	$3,492,377	($389,328)	$3,103,049	$4,616,952	$534,968	$978,935
St. Vincent General Hospital District	Lake	$95,532	($10,650)	$84,882	$310,801	$118,153	$107,766
Estes Park Medical Center	Larimer	$193,177	($21,535)	$171,642	$1,082,262	$435,234	$475,386
McKee Medical Center	Larimer	$4,346,927	($484,593)	$3,862,334	$10,066,950	$2,131,572	$4,073,044
Medical Center of the Rockies	Larimer	$3,630,269	($404,700)	$3,225,569	$5,628,256	$1,584,786	$817,901
Poudre Valley Hospital	Larimer	$13,245,947	($1,476,651)	$11,769,296	$20,645,103	$5,935,254	$2,940,553
Mount San Rafael Hospital	Las Animas	$569,704	($63,510)	$506,194	$1,069,916	$134,622	$429,100
Lincoln Community Hospital and Nursing Home	Lincoln	$93,896	($10,467)	$83,429	$462,402	$0	$378,973
Sterling Regional MedCenter	Logan	$1,630,086	($181,721)	$1,448,365	$3,760,379	$794,952	$1,517,062
Community Hospital	Mesa	$1,882,978	($209,913)	$1,673,065	$1,739,465	$170,542	($104,142)
Family Health West Hospital	Mesa	$24,730	($2,757)	$21,973	$8,786	$0	($13,187)
St. Mary's Hospital and Medical Center	Mesa	$13,601,667	($1,516,307)	$12,085,360	$15,929,084	$1,747,192	$2,096,532
The Memorial Hosptial	Moffat	$292,080	($32,561)	$259,519	$526,025	$167,785	$98,721

Fee-Paying Hospitals – General, Acute Care Hospitals							
Hospital Name	**County**	**FY 2009-10 Fees**	**FY 2009-10 Fee Refunds**	**FY 2009-10 Net Fees**	**FY 2009-10 Payments**	**Appx CICP Payments pre-CHCAA**	**FY 2009-10 Net New Funds**
Southwest Memorial Hospital	Montezuma	$688,391	($76,741)	$611,650	$1,493,231	$383,352	$498,229
Montrose Memorial Hospital	Montrose	$2,801,552	($312,316)	$2,489,236	$4,012,677	$1,054,452	$468,989
Colorado Plains Medical Center	Morgan	$1,290,385	($143,851)	$1,146,534	$1,803,122	$162,836	$493,752
East Morgan County Hospital	Morgan	$145,414	($16,211)	$129,203	$1,013,075	$175,025	$708,847
Arkansas Valley Regional Medical Center	Otero	$2,166,872	($241,562)	$1,925,310	$3,956,769	$1,374,965	$656,494
Haxtun Hospital	Phillips	$33,523	($3,737)	$29,786	$128,810	$0	$99,024
Melissa Memorial Hospital	Phillips	$171,206	($19,086)	$152,120	$396,808	$40,279	$204,409
Aspen Valley Hospital	Pitkin	$423,212	($47,179)	$376,033	$936,232	$490,839	$69,360
Prowers Medical Center	Prowers	$563,884	($62,862)	$501,022	$2,193,442	$407,322	$1,285,098
Centura Health - St. Mary-Corwin Medical Center	Pueblo	$8,346,728	($930,489)	$7,416,239	$18,039,908	$2,978,448	$7,645,221
Parkview Medical Center	Pueblo	$15,615,788	($1,740,840)	$13,874,948	$26,458,152	$3,603,807	$8,979,397
Pioneers Hospital	Rio Blanco	$61,032	($6,804)	$54,228	$174,068	$0	$119,840
Rangely District Hospital	Rio Blanco	$45,108	($5,029)	$40,079	$103,261	$0	$63,182
Rio Grande Hospital	Rio Grande	$224,460	($25,023)	$199,437	$983,931	$51,020	$733,474
Yampa Valley Medical Center	Routt	$1,211,022	($135,004)	$1,076,018	$1,575,943	$168,950	$330,975
Sedgwick County Memorial Hospital	Sedgwick	$76,099	($8,483)	$67,616	$158,959	$27,239	$64,104
Centura Health - Saint Anthony Summit Hospital	Summit	$448,492	($49,998)	$398,494	$854,257	$0	$455,763
Pikes Peak Regional Hospital	Teller	$52,944	($5,902)	$47,042	$881,788	$55,614	$779,132
North Colorado Medical Center	Weld	$14,630,729	($1,631,026)	$12,999,703	$24,696,419	$6,182,516	$5,514,200
Wray Community District Hospital	Yuma	$146,773	($16,362)	$130,411	$598,657	$107,405	$360,841
Yuma District Hospital	Yuma	$180,649	($20,139)	$160,510	$683,385	$98,017	$424,858
Total		$340,869,958	($38,000,000)	$302,869,958	$589,482,995	$162,876,107	$123,736,930

Total All Hospitals		**$340,869,958**	**($38,000,000)**	**$302,869,958**	**$590,238,708**	**$162,876,107**	**$124,492,643**

*Figures may not sum to totals due to rounding.

APPENDIX C: Hospital Provider Fee Oversight and Advisory Board (OAB) Members

As required in the Colorado Health Care Affordability Act (CHCAA), the OAB is comprised of the following:

- Five hospital members including at least one rural hospital representative and one safety-net hospital representative;
- One statewide hospital organization member;
- One health insurance organization or carrier member;
- One health care industry member who does not represent a hospital or health insurance carrier;
- One health care consumer who does not represent employees of a hospital, health insurance carrier, or other health care industry entity;
- One representative of persons with disabilities who does not represent employees of a hospital, health insurance carrier, or other health care industry entity;
- One business representative who purchases health insurance for employees; and
- Two Department of Health Care Policy and Financing (Department) members.

Board Members by Term Expiration Date

For terms expiring May 15, 2011:

Philip B. Kalin of Denver, representing the Department
Thomas N. Henton of Monte Vista, representing a rural hospital
Ann King of Denver, representing a statewide hospital organization
Janet E. Pogar of Monument, representing a health insurance organization

For terms expiring May 15, 2012:

Karl Gills of Steamboat Springs, representing a rural hospital
Randolph W. Safady of Parker, representing a hospital
Menda K. Warne of Gilcrest, representing persons with disabilities

For terms expiring May 15, 2013:

Ellen Robinson of Denver, representing a business, to serve as chair
Dr. Jeremiah A. Bartley of Brighton, representing the health care industry
Flora Rodriguez Russel of Lakewood, representing a health care consumer
Madeleine L. Roberson of Greenwood Village, representing a hospital, to serve as vice-chair
James E. Shmerling of Denver, representing a safety-net hospital
Christopher W. Underwood of Evergreen, representing the Department

APPENDIX D: Federal Requirements Overview

Provider fees are a funding source eligible for federal matching funds when used to reimburse Medicaid covered services as allowed under 42 CFR 433.68(d). Through this regulation, revenue collected from provider fees may serve as state share of Medicaid expenditures to draw a federal match. In general, to be eligible for federal financial participation (FFP), provider fees must:

(1) Be imposed on a permissible class of health care services, including, but not limited to, inpatient hospital services and outpatient hospital services.

(2) Be broad-based, such that the fee is imposed on all providers within a class.

(3) Be imposed uniformly throughout a jurisdiction, such that all providers within a class are assessed at the same rate.

(4) Avoid hold harmless arrangements where the non-Medicaid payments reimbursement amount is positively correlated to the assessment paid by the provider, either directly or indirectly, or where the Medicaid payments vary based only on the tax amount. In other words, there will be winners and losers, where some providers will receive proportionately less in reimbursement compared to their assessed amount.

The Centers for Medicare and Medicaid Services (CMS) may grant waivers of the broad-based and uniformity provisions if the net impact of the fee is generally redistributive, as demonstrated via statistical tests described in regulation.

Health care related fees may be based on a licensing fee on a class of health care services, on a fee per bed, on revenues or other general statistic with respect to a class of services. Per federal law and regulations, the amount assessed on providers of a class of services may not exceed 5.5% of the net patient revenue for that class of services. Congress capped health care related taxes at 6% and temporarily reduced the cap to 5.5% from January 1, 2008 through September 30, 2011.

Fees can be collected and payments can be made only after approval of the Hospital Provider Fee Model is obtained from CMS and only to the extent FFP is available under the Upper Payment Limit (UPL) for inpatient and outpatient hospital services after Medicaid reimbursement. Distribution of funds under a provider fee model may be made through supplemental Disproportionate Share Hospital (DSH) payments, increased Medicaid rates, supplemental Medicaid payments, a combination of methods, or other methodologies approved by CMS.

APPENDIX E: Stakeholder Remarks

Karl B. Gills, FACHE, CEO, Yampa Valley Medical Center, Steamboat Springs:

> In our next fiscal year, Yampa Valley Medical Center anticipates receiving a net gain in proceeds of $1,476,389. This will allow us to increase the payments that we make to our physicians under the CICP program from around $84,000 this year to $225,000 next year. In addition we have set aside $150,000 specifically for support of community programs for the underserved. That will be in addition to the support we provide each year as part of our routine operating budget.
>
> This year, our average rate increase is 3.85% with increases ranging from 0% to 6%, depending on specific service. Had we not had the revenue from the provider fee, the average rate increase would have been 6.26% to achieve the same financial outcome. That would mean our charges would have had to be increased by and additional $2,217,000. Since our contracts with commercial insurers are based on charges, this is a direct benefit to both those that pay out of pocket and the commercial insurers who cover our patients. Additional beneficiaries, of course, are those that now qualify for Medicaid that would not have without the funds to expand the program.

Michael T. Baxter, President/CEO, Parkview Medical Center, Pueblo:

> Last fiscal year, as a result of the great efforts of Department staff and many people in and out of state government, the Hospital Provider Fee program became a reality. The Provider Fee provided $7 million in additional reimbursement for charity to Parkview Medical Center during fiscal year ending June 30, 2010.
>
> In the spirit of the legislation which was passed to enable the Provider Fee, the Parkview Medical Center Board of Directors determined in its budgetary process to freeze all hospital charges at the current level for at least six month[s] and most likely twelve months pending the operating budget performance. One intent of the Provider Fee is to decrease the cost shift to commercial and private insurers; we intend to play our part the best we can and believe the freeze will significantly decrease this cost shift.

Russ Johnson, CEO, San Luis Valley Regional Medical Center, Alamosa:

> The San Luis Valley is larger than New Jersey with 48,000 residents in six counties. The average household income for the area is one half of the Colorado average and the uninsured percentage is twice the average. Over 40% of our discharges are either Medicaid or uninsured and we are facing increasing financial pressures due to a decline in commercial insurance and growth in high-deductible health plans resulting in significant growth in bad debt expense.
>
> The Provider Fee enables us to continue to provide services that are so badly needed by our community. It is an essential part of providing adequate primary care and specialist services, including surgery, to the low income participants in CICP and Medicaid. The Provider Fee has been instrumental in helping us continue our charitable mission in as broad a manner of possible.

APPENDIX F: Hospital Provider Fee FAQs

How is the Upper Payment Limit defined?

The Upper Payment Limit (UPL) is the maximum amount Medicaid can reimburse a provider and still receive the federal match rate (or federal financial participation). The three unique UPLs are calculated by the Department such that each must be a reasonable estimate of the amount Medicare would reimburse providers for providing Medicaid services. The Centers for Medicare and Medicaid Services (CMS) will also accept a UPL demonstration based on Medicaid cost.

What is the Disproportionate Share Hospital Allotment?

In 1987 Congress amended Title XIX (the Medicaid Program) to require states to make enhanced payments for those "safety net" hospitals which provide services to a disproportionate share of Medicaid and low-income patients. Disproportionate Share Hospital (DSH) payments are intended to offset the uncompensated costs of providing services to uninsured and underinsured patients. The payments assist in securing the hospitals' financial viability and preserving access to care for the Medicaid and low-income clients, while reducing a shift in costs to private payers. In subsequent legislation, Congress gave states a great deal of flexibility in the design and implementation of their DSH plans.

The federal Balanced Budget Act of 1997 (BBA97) established declining limits on the amount of federal funds available to states for DSH payments. These limits were established as allotments (or caps) for each state starting in Federal Fiscal Year (FFY) 1997-98. The DSH Allotment for FFY 2008-09 is $92.8 Million and $95.2 Million for FFY 2009-10. These amounts include a 2.5% increase from the American Recovery and Reinvestment Act of 2009 (ARRA). This amount is entirely federal funds. To draw the federal funds, the Department must have an equal state share (the FMAP on DSH for Colorado is 50%). As such, payments to offset the uncompensated costs of providing services to uninsured and underinsured patients cannot exceed $185.7 Million in FFY 2008-09 and $190.4 Million in FFY 2009-10.

What is the CICP?

The Colorado Indigent Care Program (CICP) distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding deliver discounted health care services to Colorado residents, migrant workers, and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Health Plan *Plus* (CHP+).

This is *not* a health insurance program. Services are restricted to participating hospitals and clinics throughout the state. In addition, medical services vary by participating health care provider. The responsible physician or health care provider determines what services will be covered. These services must include emergency care, and may include, but are not limited to, inpatient care, outpatient care and prescription drugs.

What are the Patient Days used in the Hospital Provider Fee Model?

- **Commercial Managed Care**: Commercial managed care programs such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Does not include Medicare, Medicaid, or CHAMPUS managed care.
- **Other Commercial**: Indemnity insurance plans and other plans for which no discount arrangement exists.
- **CHAMPUS/TriCare**: A federal program for patients insured by the Civilian Health and Medical Program for the Uniformed Services.
- **Colorado Indigent Care Program (CICP)**: For CICP patient days report where CICP is primary payer and where CICP is secondary payer separately.
- **Section 1011**: Federal reimbursement of emergency services furnished to undocumented aliens under Section 1011 of the Medicare Modernization Act of 2003 (MMA).
- **Self Pay / Uninsured / Charity Care**: Patients with no third party coverage or in hospital's charity care program (does not include CICP).
- **Medicaid fee-for-service (FFS)**: Medicaid FFS is primary payer, does not include Medicaid HMO or dual eligibles.
- **Medicaid nursery days**: Days of care provided to Medicaid newborns while the mother is in the hospital.
- **Medicaid HMO**: Medicaid HMO is primary payer.
- **Medicaid dual eligible**: Patients with Medicare and Medicaid coverage.
- **Medicaid and other payer**: Patients with third party and Medicaid coverage (not Medicare/Medicaid).
- **Medicare fee-for-service:** Medicare is primary payer; does not include Medicare HMO.
- **Medicare HMO:** Medicare HMO is primary payer.
- **Medicare and other payer**: Medicare and third party coverage (not Medicaid/Medicare).