COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

January 17, 2012

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

The Honorable Ken Summers, Chair
House Health and Environment Committee
State Capitol Building, Room 271
Denver, CO 80203

Dear Senator Boyd and Representative Summers:

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. 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 OAB to provide recommendations to the Department and the Medical Services Board on its implementation.

Federal approval for the hospital provider fee was granted on March 31, 2010 by the Centers for Medicare and Medicaid Services (CMS). Through September 30, 2011, more than $305 million in new federal funding has been provided to hospitals in Colorado — reducing uncompensated care for Medicaid and Colorado Indigent Care Program (CICP) clients and reducing the need to shift those costs on to private payers. On May 1, 2010, the first 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 40,000 covered clients as of September 30, 2011. The Department is now focused on expanding coverage to the uninsured with an Adults without Dependent Children health care program and a Medicaid Buy-In Program for People with Disabilities, scheduled to be implemented on March 1, 2012, and providing 12-month continuous eligibility for children covered by Medicaid in the future.

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

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

Ellen Robinson
Chair, Hospital Provider Fee
Oversight and Advisory Board

Colorado Health Care Affordability Act

Annual Report

Hospital Provider Fee Oversight and Advisory Board

January 17, 2012

Colorado Health Care Affordability Act
Annual Report

Table of Contents

Appendices

Tables

Figures

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 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 Colorado Indigent Care Program (CICP) clients, and to reduce cost-shifting to private payers.

Through September 2011, the CHCAA has:

- **Provided $305 million in net new federal funds to hospital providers, reducing uncompensated care costs**

  From implementation of the hospital provider fee effective July 1, 2009 through September 30, 2011, more than $1.5 billion 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 $305 million in new federal funds. These net new funds provided a reduction in uncompensated costs incurred by hospitals for care provided to Medicaid and CICP clients.

- **Provided health care coverage through Medicaid and CHP+ for more than 40,000 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, 2011, the Department had enrolled approximately 33,000 Medicaid Parents and approximately 7,200 CHP+ children and 375 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 and a Medicaid Buy-In Program for People with Disabilities, scheduled for implementation on March 1, 2012, and providing 12-month continuous eligibility for children covered by Medicaid in the future.

- **Provided $99.5 million in state General Fund budget relief**

  Pursuant to Senate Bill (SB) 10-169, additional federal funds drawn due to the enhanced Federal Medicaid Assistance Percentage (FMAP) under the federal American Recovery and Reinvestment Act of 2009 (ARRA) provided General Fund relief in state fiscal year (SFY) 2009-10 and SFY 2010-11 of more than $99.5 million.

Colorado Health Care Affordability Act Overview

On April 21, 2009, the Governor 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 more than $600 million in federal Medicaid matching funds annually 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 and the Medical Services Board on the implementation of the 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 and Health and Environment Committees of the Colorado Senate and House of Representatives.

The OAB's meetings are held regularly from 3:00 to 5:00 p.m. on the fourth Tuesday of the 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 first 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 CHCAA benefits Colorado by providing additional federal matching funds in the state without additional General Fund expenditure. Fees assessed on hospital providers with federal matching funds allow Colorado to:

- Increase hospital reimbursement for care provided to Medicaid and CICP clients;
- Increase the number of insured Coloradans
- Improve the quality of health care for Medicaid clients; and
- Reduce the need to shift the cost of uncompensated care to other payers.

The CHCAA has also provided relief for the state's budget. Pursuant to Senate Bill (SB) 10-169, additional federal funds drawn due to the enhanced Federal Medicaid Assistance Percentage (FMAP) under the federal American Recovery and Reinvestment Act of 2009 (ARRA) provided General Fund relief in State Fiscal Year (SFY) 2009-10 and SFY 2010-11 of more than $99.5 million. Additionally, pursuant to SB 11-212, hospital fees will provide a total of $50 million and $25 million General Fund relief for the Department's budget for SFY 2011-12 and SFY 2012-13, respectively. Finally, the CHCAA reduces the impact on the General Fund related to the federal health care reform legislation, the Affordable Care Act of 2010 (ACA).

Increase Hospital Reimbursement for Care Provided to Medicaid and CICP Clients

Following the first Hospital Provider Fee Model in SFY 2009-10, the OAB recommended that subsequent Hospital Provider Fee Models be moved to an October 1 start date. Therefore, figures in this report are reported on an October 2010 through September 2011 basis unless otherwise noted.

In the October 2010 through September 2011 period, the Department collected over $474 million in hospital provider fees to fund estimated expenditures, which, with approved federal matching funds, increased payments for inpatient and outpatient hospital services, financed hospital payments for the CICP, and funded additional, targeted supplemental hospital payments. Payments to hospitals totaled over $796 million, including $131 million additional funding for hospitals participating in the CICP.

2010-11 Hospital Payments	
Inpatient Hospital Reimbursement	$106,240,000
Outpatient Hospital Reimbursement	$121,563,000
CICP Hospital Reimbursement	$293,928,000
Additional Hospital Payments	$275,047,000
Total Supplemental Hospital Payments	**$796,778,000**

Table 1 Hospital Reimbursement

After taking into account the hospital provider fees collected for health coverage expansions, the Department's administrative expenses, General Fund relief per SB 10-169, and the CICP hospital reimbursement level prior to increased payments under CHCAA, the net gain to hospitals in

SFY 2009-10 was approximately $124 million and the net gain to hospitals for the July to September 2010 period was approximately $22 million. The net gain for October 2010 through September 2011 was approximately $159 million, for a total net gain to hospitals through September 2011 of $305 million. These net gains represent the reduction in uncompensated costs incurred by hospitals for providing care to Medicaid clients and the uninsured.

2010-11 Net New Funds to Hospitals	
Total Supplemental Hospital Payments	$796,778,000
Total Fees	($474,454,000)
Approximate CICP payments pre-CHCAA	($162,876,000)
Net New Funds to Hospitals	**$159,448,000**

Table 2 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 FPL and the CHP+ to 250% FPL were implemented. As of September 30, 2011, the Department had enrolled approximately 33,000 Medicaid Parents and approximately 7,200 CHP+ children and 375 CHP+ pregnant women in these expansion populations.

The Department is now focused on implementing a Medicaid Buy-In Program for People with Disabilities and Adults without Dependent Children expansions. At the Hospital Provider Fee Oversight and Advisory Board in August 2011, the Department announced that the implementation for the Adults without Dependent Children expansion is planned for March 1, 2012. Enrollment will be limited to 10,000 individuals with incomes up to 10% FPL to keep costs within available funding. The Department will maintain a waitlist and enroll individuals in AwDC as space becomes available, and if funding allows, the Department may increase the enrollment cap. The Medicaid Buy-In Program for Working Adults will also be implemented on March 1, 2012. The Medicaid Buy-In Program for Children with Disabilities will be implemented approximately 4-6 months after the Medicaid Buy-In Program for Working Adults with Disabilities implementation. The Department does not have an implementation timeframe for non-working adults with disabilities at this time.

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 the CHCAA leave Colorado well-positioned to implement the federal health care reform law, the ACA. The enhanced federal financial participation that will be available through the ACA beginning in January 2014 for expansion populations included in the CHCAA will help ensure the viability of the hospital provider fee. In addition, the ACA 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 the CHCAA. The Department continues to explore the interplay between the ACA and the CHCAA.

Improve the Quality of Health Care for Medicaid Clients

The Hospital Quality Incentive Payment (HQIP) is a mechanism under the CHCAA 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 OAB and tasked with determining and developing the measures that will be used for the HQIP as required by the CHCAA. In September 2010, a quality incentive payment model was presented to the OAB. At the time, the members of the OAB expressed concerns with the proposal, especially with regard to the healthy behaviors (smoking cessation) and emergency department utilization domains. The primary concerns centered on the need for metrics that align more closely with a series of Value-Based Purchasing (VBP) Principles recommended by the Colorado Hospital Association (CHA) Board of Trustees.

At the request of the OAB, a new HQIP ad hoc Committee was formed to continue the work to develop a thorough proposal for quality incentive payments. Members of the HQIP Committee included representatives from the Department, CHA, and hospital representatives with expertise in quality measurement and hospital payment. The committee was supported in its efforts by the Department's contracted consultant, Public Consulting Group (PCG), and met on a bi-weekly basis beginning in January 2011.

The HQIP Committee sought to:

- Identify measures and methodologies that apply to care provided to Medicaid clients;
- Adhere to the VBP principles;
- Maximize participation in the Medicaid program; and
- Minimize the number of hospitals which would not qualify for selected measures.

In May 2011, the Department and CHA jointly presented a quality incentive payment proposal to the OAB. The quality incentive payment proposal is intended to evolve over time. As performance on different measures improves, measures can be retired and new measures can be introduced. Also, as new and different data sources become available, the measures will change and grow. The proposed HQIP measures for the first payment year are:

- Central Line-Associated Blood Stream Infections (CLABSI)
- Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT)
- Elective Delivery Prior to 39 Weeks Gestation
- Structured Efforts to Improve Care Transitions and Reduce Readmissions

The HQIP Committee also proposed a payment methodology that consists of hospitals earning points based on performance on each measure. The points system would be normalized using the total number of points for which the hospital was qualified; that is, hospitals are not held responsible or are not negatively impacted by the measures for which they do not meet the minimum criteria.

The OAB approved the HQIP Committee's recommendations. The Department is currently working with CMS on a State Plan Amendment to implement the quality incentive payments and gathering baseline data. The Department expects that quality incentive payments will begin in the 2012-13 Hospital Provider Fee Model.

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

The CHCAA reduces the need for hospital providers to shift uncompensated care costs to private payers by providing higher reimbursement for patients covered by public health care programs and reducing the number of uninsured Coloradans. By raising the rates paid to hospital providers, the need to shift costs is reduced. The CHCAA increases reimbursement paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the CICP. Fewer uninsured Coloradans leads to lower uncompensated costs by creating a funding source for these clients. In the first year, the hospital provider fee increased eligibility for parents of Medicaid covered children and children and pregnant women covered by CHP+.

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.

As recommended by the Cost Shift Data Work Group, cost and payment data is reported on a per patient basis for four payer groups: Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other. The information is calculated on a calendar year basis using data from the CHA DATABANK and survey data collected by CHA. CICP is shown as a separate item and is calculated on a state fiscal year basis using the Department's CICP Annual Report. The data is calculated for CYs and SFYs 2006 through 2010. An analysis of Bad Debt and Charity care is also included as a supplemental item.

The CHCAA was implemented following federal approval in April 2010; therefore, changes to cost to payment ratios due to the CHCAA are captured with the CY 2010 data.

Cost Shift Data: Payment less Cost per Patient by Payer Group

The table and graph below display the difference between total payments and total costs on a per patient basis for Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups. Negative values indicate that costs exceed payments. This is the case for Medicare, Medicaid, and the CICP/Self Pay/Other payer groups and indicates that hospitals are undercompensated for care provided to these clients.

Positive values indicate that payments exceed costs. This is the case for the private sector insurance group, where there is overcompensation relative to costs. This is the essence of cost shift as publicly insured and uninsured care is paid under cost and private payers pay more to cover those costs.

The data show that following the implementation of the CHCAA in July 2009, overcompensation by the private sector insurance was flat in CY 2010 – increasing less than 1% over CY 2009. The average rate of growth of private sector overcompensation was more than 18% per year for the previous three years. At the same time, the undercompensation for the Medicaid and CICP/Self Pay/Other payer groups sharply decreased in CY 2010.

Payment Less Cost per Patient by Payer Group					
	CY 2006	**CY 2007**	**CY 2008**	**CY 2009**	**CY 2010**
Medicare	($2,172)	($2,691)	($2,969)	($2,872)	($3,166)
Medicaid	($2,682)	($4,239)	($3,807)	($4,468)	($2,906)
Private Sector Insurance	$4,148	$5,221	$5,749	$6,838	$6,881
CICP/Self Pay/ Other	($3,370)	($3,754)	($3,874)	($4,561)	($3,848)
Overall	$377	$182	$328	$551	$690

Table 3 Payment Less Cost per Patient by Payer Group

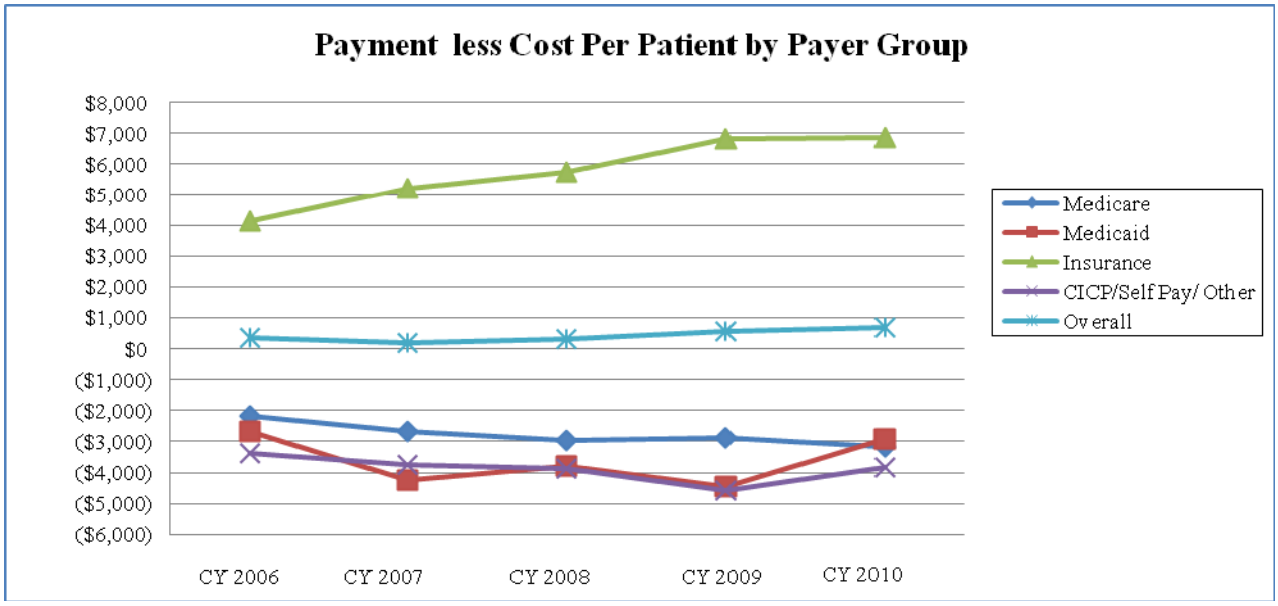

Figure 1 Payment Less Cost Per Patient by Payer Group

Cost Shift Data: Payment to Cost Ratio

The following table and graph display the impact of cost shifting through the ratio of total payments to total costs for Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups.

Ratios below 1 mean that costs exceed payments, which is the case for Medicare, Medicaid, and the CICP/Self Pay/Other payer groups as discussed before. Values greater than 1 mean that payments exceed costs, as is the case for the private sector insurance group, where there is overcompensation relative to costs.

Payment to Cost Ratio by Payer Group					
	CY 2006	**CY 2007**	**CY 2008**	**CY 2009**	**CY 2010**
Medicare	0.82	0.77	0.77	0.78	0.77
Medicaid	0.67	0.51	0.59	0.54	0.71
Insurance	1.42	1.46	1.47	1.55	1.52
CICP/Self Pay/ Other	0.55	0.56	0.59	0.52	0.63
Overall	1.04	1.02	1.03	1.05	1.06

Table 4 Payment to Cost Ratio by Payer Group

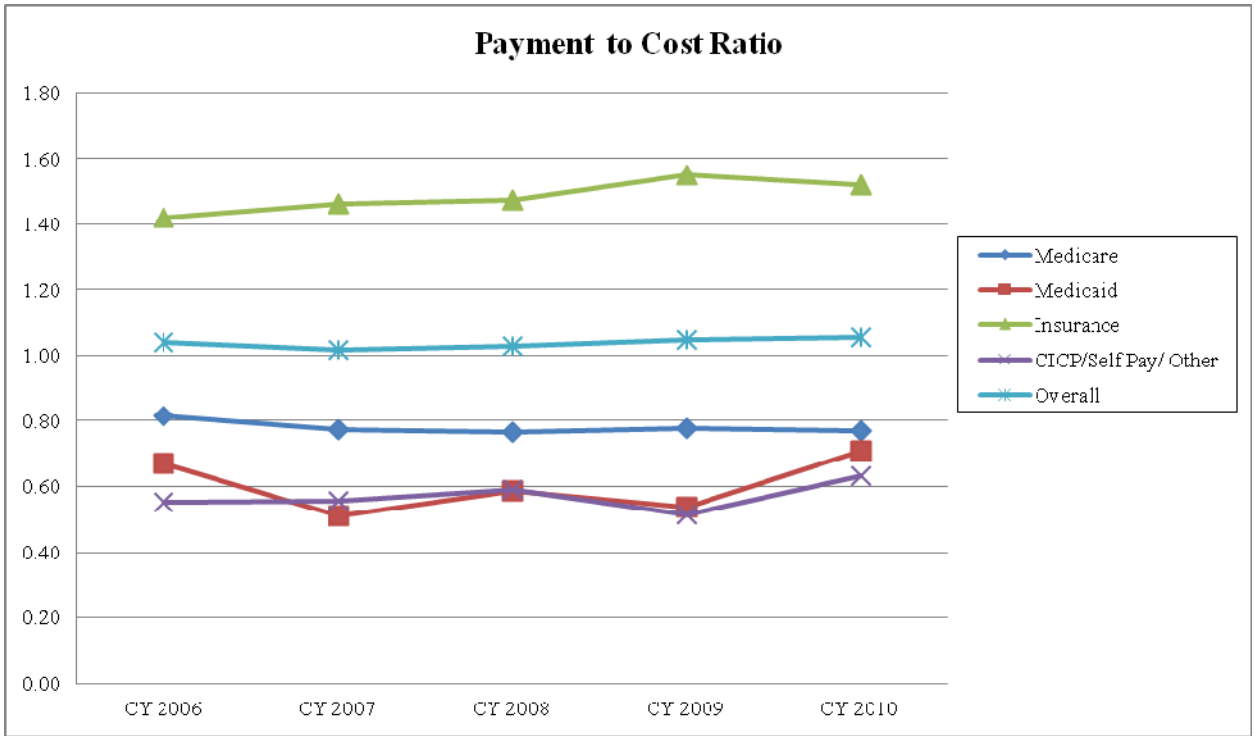

Figure 2 Payment to Cost Ratio Patient by Payer Group

Cost Shift Data: Payment less Cost per Patient for CICP

The table and graph below display the difference between total payments and total costs on a per patient basis for CICP separately. The source of data for CICP is the Department's CICP Annual Report, which reports CICP costs and payments on a state fiscal year basis. As indicated before, negative values indicate that costs exceed payments, which is the case for CICP where hospitals are undercompensated for care provided to these clients.

The data show that following the implementation of the CHCAA in 2009, when CICP reimbursement rates for hospitals increased by $115 million annually, the amount of undercompensation of CICP costs decreased by 32%.

Payment Less Cost per Patient for CICP					
	SFY 2005-06	**SFY 2006-07**	**SFY 2007-08**	**SFY 2008-09**	**SFY 2009-10**
CICP	($3,270)	($2,959)	($3,449)	($4,000)	($2,712)

Table 5 Payment Less Cost per Patient for CICP

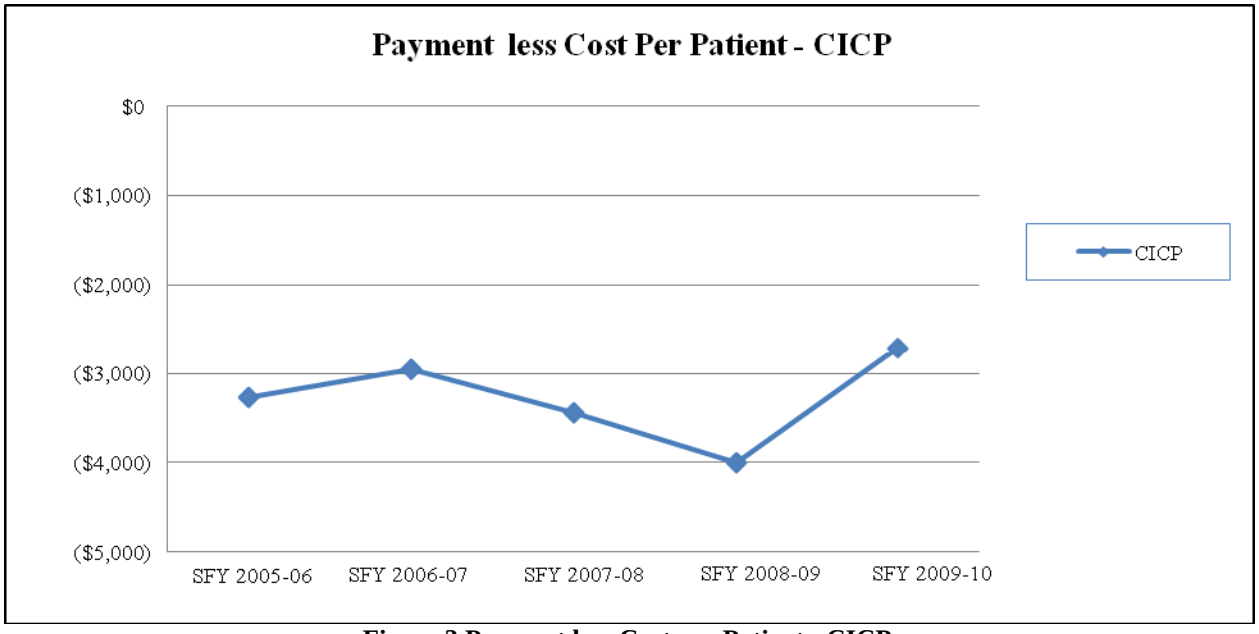

Figure 3 Payment less Cost per Patient - CICP

Cost Shift Data: Bad Debt and Charity Care

Total Bad Debt and Charity Care is collected in aggregate from the CHA DATABANK. Bad Debt and Charity Care distributions are calculated using weighted percentages as reported by providers on a survey conducted by the CHA. The CY 2010 Bad Debt is 7.98% less than the CY 2009 amount and is 0.77% lower than the CY 2006 amount. The CY 2010 Charity Care amount is 3.47% greater than the CY 2009 amount and 70.32% greater than the CY 2006 amount. The calculated total Bad Debt and Charity Care for CY 2010 is the only year in which the amount was less than the previous calendar year.

Bad Debt and Charity Care					
	CY 2006	**CY 2007**	**CY 2008**	**CY 2009**	**CY 2010**
Bad Debt	$782,478,390	$860,206,456	$956,660,231	$843,859,090	$776,483,052
Charity Care	$880,978,718	$902,921,944	$1,142,997,234	$1,450,212,300	$1,500,488,001
Total	$1,663,457,108	$1,763,128,400	$2,099,657,465	$2,294,071,390	$2,276,971,053

Table 6 Bad Debt and Charity Care

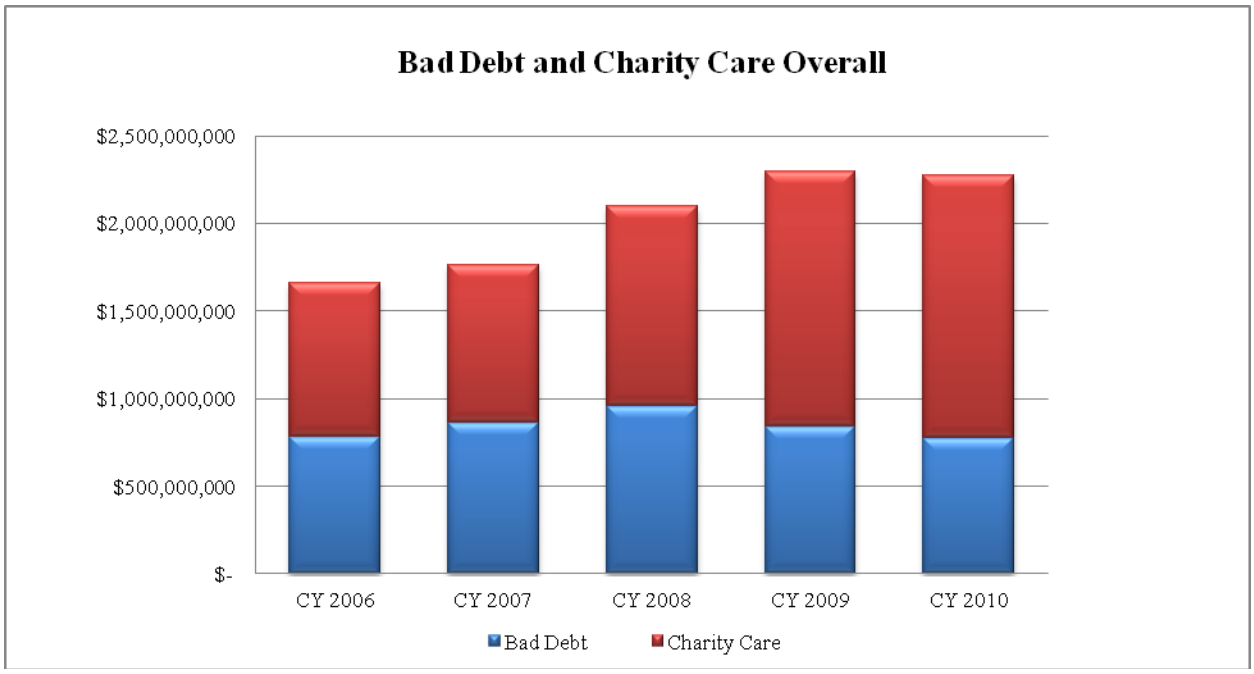

Figure 4 Bad Debt and Charity Care

Department of Health Care Policy and Financing Expenditures

As funding is appropriated on a state fiscal year basis, expenditures in this section are reported on a state fiscal year basis. In SFY 2010-11, the Department collected approximately $441 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 FMAP under ARRA also provided General Fund relief pursuant to SB 10-169. The following table outlines the Hospital Provider Fee expenditures in SFY 2010-11.

SFY 2010-11 Hospital Provider Fee Expenditures (Total Funds)*	
Supplemental Hospital Payments	$745,237,000
Department Administration	$5,744,000
Expansion Populations	$90,099,000
SB 10-169 – ARRA enhanced FMAP	$53,494,000
25.5-4-402.3 (4)(b)(VII) – Offset revenue loss	$7,850,000
Total Expenditures	**$902,424,000**

Table 7 Hospital Provider Fee Expenditures

*Figures in this table are reported on a state fiscal year basis (July 1 through June 30) and will not match other figures in this report, which are reported on an October 1 through September 30 basis.

Unlike SFY 2009-10, funding in SFY 2010-11 was appropriated for CHCAA administrative expenses through the normal budget process. By the end of SFY 2010-11, the Department had hired 49 positions for the administration of the CHCAA. The expenditures reflected in the following table are funded entirely by hospital provider fees and federal funds. These are new expenditures and do not supplant existing Department administrative funds. Less than 0.65% of total expenditures were for the Department's administrative expenses of implementing the CHCAA.

SFY 2010-11 Administrative Expenditures	
(1) Executive Director's Office; (A) General Administration, Personal Services	$2,292,633
(1) Executive Director's Office; (A) General Administration, Legal Services and Third Party Recovery Legal Services	$55,996
(1) Executive Director's Office; (A) General Administration, Administrative Law Judge Services	$28,610
(1) Executive Director's Office; (A) General Administration: Operating Expenses	$80,843
(1) Executive Director's Office; (A) General Administration: Leased Space	$213,287
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$239,844
(1) Executive Director's Office; (C) Information Technology Contracts and Projects: Information Technology Contracts	$909,661
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration	$1,760,501

SFY 2010-11 Administrative Expenditures	
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach	$80,504
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$62,096
Total Executive Director's Office Expenditures	**$5,723,975**
(4) Indigent Care Program; Children's Basic Health Plan Administration	$19,926
Total	**$5,743,901**

Table 8 Department Administrative Expenditures

Hospital Provider Fee Model – Fee and Payment Methodologies

On March 31, 2010, the Centers for Medicare and Medicaid Services (CMS) first 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 DSH payments. The Hospital Provider Fee, State Plan Amendments, and UPL methodologies were first approved by the Centers for Medicare and Medicaid Services (CMS) on March 31, 2010 and retroactively effective July 1, 2009.

The Hospital Provider Fee Model is dynamic where fee and payment methodologies are calculated, reviewed, and approved on an annual basis. Data to calculate fees and payments are 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.

Following the first Hospital Provider Fee Model in SFY 2009-10, the 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. Consequently, the SFY 2009-10 hospital provider fee methodology continued through the July to September 2010 quarter. State Plan Amendments to implement changes for the 2010-11 Hospital Provider Fee Model were approved by CMS on December 23, 2010 and retroactively effective October 1, 2010.

As in the SFY 2009-10 Hospital Provider Fee Model, in the October 2010 through September 2011 period, 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. The OAB continued its recommendation to exempt free-standing psychiatric hospitals, long term care hospitals, and rehabilitation hospitals from fees because the goals of the 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.

There were no provider fee refunds following the close of the state fiscal year on June 30, 2011 as there had been for the previous year. At its June 2011 meeting, the OAB unanimously recommended that any excess revenue in the cash fund be used to reduce the fees needed to be raised in the 2011-12 Hospital Provider Fee Model to partially meet the SB 11-212 obligation, which requires the Department to collect $50 million in fees from hospital providers to offset General Fund dollars in the Department's Medicaid budget in SFY 2011-12 and $25 million in fees for SFY 2012-13.

Hospital payments are increased for Medicaid and Colorado Indigent Care Program (CICP) hospital services through a total of thirteen (13) 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.

Fees are collected and payments are made on a monthly basis, and nearly all hospitals have authorized electronic fee and payment processing. The 2010-11 fee and payment amounts by type are outlined in the table below. Please see Appendix A for a detailed description of the fee and payment methodologies by type.

2010-11 Hospital Provider Fees and Payments	
Inpatient Fee	$427,009,000
Outpatient fee	$47,445,000
Total Hospital Provider Fees	**$474,454,000**
Inpatient Base Rate Payment	$106,240,000
Outpatient Payment	$121,563,000
CICP DSH Payment	$143,008,000
CICP UPL Payment	$150,920,000
Uninsured DSH Payment	$42,189,000
High Volume, Small Rural Outpatient Payment	$3,029,000
High Level NICU Payment	$6,004,000
State Teaching Hospital Payment	$12,377,000
Large Rural Payment	$19,336,000
Denver Metro Payment	$127,245,000
Metropolitan Statistical Area Payment	$61,090,000
Pediatric Specialty Hospital Payment	$3,000,000
Acute Care Psychiatric Payment	$777,000
Total Supplemental Hospital Payments	**$796,778,000**

Table 9 Hospital Provider Fee and Payments by Type

APPENDIX A: 2010-11 Hospital Provider Fee Model Overview

This overview describes the fee assessment and payment methodologies for October 2010 through September 2011 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

- $83.45 per day for Managed Care Days
- $374.79 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

- 0.484% 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 $43.57 per day for Managed Care Days and $195.67 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 that 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 $33.38 per day for Managed Care Days and $149.91 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 utilization, and inflation, multiplied by 30.70% for most hospitals (for Pediatric Specialty Hospitals this percentage is 20.45% and for Urban Safety Net Hospitals this percentage is 25.00%).
- 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 50%.
- 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 75% for most hospitals (for High Volume Medicaid and CICP Hospitals this percentage equals 64%; 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 51%.
- 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 35.0% for most hospitals (for Pediatric Specialty Hospitals the percentage is 16.8%; for Urban Center Safety Net Specialty Hospitals the percentage is 16.0%).
- 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 Medicaid NICU days paid during the prior year under DRG 801 (neonates < 1,000 grams; 2 lb and 3.27 oz) and capped at the average length of stay for the DRG, multiplied by $2,100.
- 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 $125.
- 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 $600.
- 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 $675.
- For qualified hospitals located in Denver, Jefferson, Douglas, Boulder, or Broomfield county, this payment equals total Medicaid Days multiplied by $700.

- 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 $600.
- 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 $3 million.
- Hospitals which provide care exclusively to pediatric populations are qualified for this payment.

Acute Care Psychiatric Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid Psychiatric Days as reported on the hospitals survey multiplied by $150.
- State Licensed Psychiatric Hospitals, LTC Hospitals, and Rehabilitation Hospitals are not qualified for this payment.

APPENDIX B: October 2010 - September 2011 Hospital Provider Fees and Payments by Hospital

Fee-Exempt Hospitals – Free-Standing Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals					
Hospital Name	**County**	**2010-11 Fees**	**2010-11 Payments**	**Appx CICP Payments pre-CHCAA**	**2010-11 Net New Funds**
Haven Behavioral Health at North Denver	Adams	$0	$0	$0	$0
HealthOne Spalding Rehabilitation Hospital	Adams	$0	$161,755	$0	$161,755
Vibra Long Term Acute Care Hospital	Adams	$0	$81,830	$0	$81,830
Craig Hospital	Arapahoe	$0	$1,399,137	$0	$1,399,137
Triumph Hospital	Arapahoe	$0	$8,369	$0	$8,369
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0
Colorado Acute Long Term Hospital	Denver	$0	$27,407	$0	$27,407
Colorado Mental Health Institute-Ft Logan	Denver	$0	$0	$0	$0
Eating Recovery Center	Denver	$0	$0	$0	$0
Kindred Hospital	Denver	$0	$51,643	$0	$51,643
Select Specialty Hospital - Denver	Denver	$0	$0	$0	$0
Select Specialty Hospital - Denver South Campus	Denver	$0	$0	$0	$0
Highlands Behavioral Health System	Douglas	$0	$0	$0	$0
Cedar Springs Behavior Health System	El Paso	$0	$0	$0	$0
HealthSouth Rehabilitation Hospital	El Paso	$0	$235,964	$0	$235,964
Peak View Behavioral Health	El Paso	$0	$0	$0	$0
Select Long Term Care Hospital	El Paso	$0	$0	$0	$0
West slope Mental Health Stabilization Center	Mesa	$0	$0	$0	$0
Colorado Mental Health Institute-Pueblo	Pueblo	$0	$0	$0	$0
Haven Behavioral Senior Care at St. Mary-Corwin	Pueblo	$0	$0	$0	$0
Northern Colorado Rehabilitation Hospital	Weld	$0	$166,208	$0	$166,208
Totals		**$0**	**$2,132,314**	**$0**	**$2,132,314**

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**2010-11 Fees**	**2010-11 Payments**	**Appx CICP Payments pre-CHCAA**	**2010-11 Net New Funds**
Centura Health - Saint Anthony North Hospital	Adams	$7,740,595	$12,262,748	$0	$4,522,153
HealthOne North Suburban Medical Center	Adams	$7,560,944	$10,393,359	$0	$2,832,415
Platte Valley Medical Center	Adams	$3,816,551	$10,551,135	$1,499,298	$5,235,286
Children's Hospital Colorado	Adams	$9,870,892	$30,546,096	$2,854,794	$17,820,410
University of Colorado Hospital	Adams	$20,182,998	$63,489,714	$36,264,181	$7,042,535
San Luis Valley Regional Medical Center	Alamosa	$3,298,411	$8,377,993	$962,324	$4,117,258
Centura Health - Littleton Adventist Hospital	Arapahoe	$9,746,477	$6,618,326	$0	($3,128,151)
HealthOne Medical Center of Aurora	Arapahoe	$22,226,494	$21,056,434	$0	($1,170,060)
HealthOne Swedish Medical Center	Arapahoe	$21,993,717	$20,219,349	$0	($1,774,368)
Pagosa Mountain Hospital	Archuleta	$85,659	$682,853	$0	$597,194
Southeast Colorado Hospital	Baca	$176,862	$509,950	$34,179	$298,909
Boulder Community Hospital	Boulder	$12,392,032	$12,392,172	$1,063,630	($1,063,489)
Centura Health - Avista Adventist Hospital	Boulder	$5,139,614	$8,494,692	$0	$3,355,078
Exempla Good Samaritan Medical Center	Boulder	$6,341,526	$4,449,453	$0	($1,892,074)
Longmont United Hospital	Boulder	$11,207,381	$17,268,183	$1,633,746	$4,427,056
Heart of the Rockies Regional Medical Center	Chaffee	$489,549	$1,495,388	$247,500	$758,340
Keefe Memorial Hospital	Cheyenne	$115,333	$95,197	$0	($20,136)
Conejos County Hospital	Conejos	$221,593	$1,557,895	$99,884	$1,236,418
Delta County Memorial Hospital	Delta	$3,404,422	$4,825,900	$912,623	$508,855
Centura Health - Porter Adventist Hospital	Denver	$13,611,810	$11,328,109	$0	($2,283,700)
Denver Health Medical Center	Denver	$17,045,144	$105,879,288	$64,455,024	$24,379,120
Exempla Saint Joseph Hospital	Denver	$15,246,490	$22,617,298	$0	$7,370,807
HealthOne Presbyterian/St. Luke's Medical Center	Denver	$18,187,328	$29,712,763	$0	$11,525,435
HealthOne Rose Medical Center	Denver	$15,774,682	$17,535,683	$0	$1,761,001
National Jewish Health	Denver	$419,253	$5,666,411	$1,682,780	$3,564,378
Centura Health - Parker Adventist Hospital	Douglas	$4,808,947	$4,757,558	$0	($51,389)

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**2010-11 Fees**	**2010-11 Payments**	**Appx CICP Payments pre-CHCAA**	**2010-11 Net New Funds**
HealthOne Sky Ridge Medical Center	Douglas	$8,905,862	$4,369,752	$0	($4,536,110)
Vail Valley Medical Center	Eagle	$2,758,957	$2,876,583	$0	$117,626
Centura Health - Penrose -St. Francis Health Services	El Paso	$27,366,133	$23,568,953	$2,195,836	($5,993,015)
Memorial Hospital	El Paso	$25,058,395	$50,310,384	$16,142,511	$9,109,478
Centura Health - St. Thomas More Hospital	Fremont	$3,353,430	$6,459,916	$779,972	$2,326,514
Grand River Medical Center	Garfield	$396,992	$1,271,622	$190,609	$684,020
Valley View Hospital	Garfield	$4,175,980	$9,085,311	$444,750	$4,464,581
Kremmling Memorial Hospital	Grand	$316,495	$215,333	$117,393	($218,555)
Gunnison Valley Hospital	Gunnison	$226,094	$526,738	$42,048	$258,595
Spanish Peaks Regional Health Center	Huerfano	$228,756	$1,150,774	$135,879	$786,139
Centura Health – OrthoColorado Hospital	Jefferson	$2,096,051	$0	$0	($2,096,051)
Centura Health - Saint Anthony Hospital	Jefferson	$17,680,609	$23,067,169	$0	$5,386,560
Exempla Lutheran Medical Center	Jefferson	$22,248,643	$21,316,412	$0	($932,230)
Weisbrod Memorial County Hospital	Kiowa	$16,512	$209,512	$0	$193,001
Kit Carson County Memorial Hospital	Kit Carson	$188,922	$548,978	$0	$360,056
Animas Surgical Hospital	La Plata	$217,003	$535,895	$0	$318,892
Mercy Medical Center	La Plata	$4,841,058	$6,868,204	$534,968	$1,492,178
St. Vincent General Hospital District	Lake	$132,393	$425,930	$118,153	$175,384
Estes Park Medical Center	Larimer	$267,651	$1,442,798	$435,234	$739,912
McKee Medical Center	Larimer	$6,023,800	$12,741,202	$2,131,572	$4,585,831
Medical Center of the Rockies	Larimer	$5,031,009	$7,904,297	$1,584,786	$1,288,501
Poudre Valley Hospital	Larimer	$18,357,779	$27,434,887	$5,935,254	$3,141,854
Mount San Rafael Hospital	Las Animas	$789,860	$1,816,998	$134,622	$892,517
Lincoln Community Hospital and Nursing Home	Lincoln	$130,147	$523,084	$0	$392,937
Sterling Regional MedCenter	Logan	$2,259,789	$4,380,496	$794,952	$1,325,755
Community Hospital	Mesa	$2,610,178	$2,424,558	$170,542	($356,161)
Family Health West Hospital	Mesa	$34,247	$94,325	$0	$60,078

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**2010-11 Fees**	**2010-11 Payments**	**Appx CICP Payments pre-CHCAA**	**2010-11 Net New Funds**
St. Mary's Hospital and Medical Center	Mesa	$18,855,613	$21,589,290	$1,747,192	$986,485
The Memorial Hosptial	Moffat	$404,809	$1,718,155	$167,785	$1,145,560
Southwest Memorial Hospital	Montezuma	$954,429	$2,003,497	$383,352	$665,716
Montrose Memorial Hospital	Montrose	$3,883,773	$6,678,545	$1,054,452	$1,740,319
Colorado Plains Medical Center	Morgan	$1,788,830	$3,054,262	$162,836	$1,102,597
East Morgan County Hospital	Morgan	$201,491	$1,389,711	$175,025	$1,013,194
Arkansas Valley Regional Medical Center	Otero	$3,004,721	$5,960,353	$1,374,965	$1,580,667
Haxtun Hospital	Phillips	$46,467	$73,756	$0	$27,289
Melissa Memorial Hospital	Phillips	$237,408	$705,274	$40,279	$427,588
Aspen Valley Hospital	Pitkin	$586,177	$1,394,553	$490,839	$317,537
Prowers Medical Center	Prowers	$781,758	$3,003,482	$407,322	$1,814,402
Centura Health - St. Mary-Corwin Medical Center	Pueblo	$11,570,123	$24,281,552	$2,978,448	$9,732,981
Parkview Medical Center	Pueblo	$21,648,350	$35,442,191	$3,603,807	$10,190,035
Pioneers Hospital	Rio Blanco	$84,600	$222,550	$0	$137,950
Rangely District Hospital	Rio Blanco	$62,509	$124,937	$0	$62,429
Rio Grande Hospital	Rio Grande	$311,184	$853,850	$51,020	$491,646
Yampa Valley Medical Center	Routt	$1,677,925	$3,154,042	$168,950	$1,307,167
Sedgwick County Memorial Hospital	Sedgwick	$105,477	$237,646	$27,239	$104,930
Centura Health - Saint Anthony Summit Hospital	Summit	$621,137	$1,731,886	$0	$1,110,749
Pikes Peak Regional Hospital	Teller	$73,329	$1,035,254	$55,614	$906,311
North Colorado Medical Center	Weld	$20,282,392	$34,140,574	$6,182,516	$7,675,666
Wray Community District Hospital	Yuma	$203,408	$432,084	$107,405	$121,271
Yuma District Hospital	Yuma	$250,362	$1,063,992	$98,017	$715,613
Total		**$474,453,717**	**$794,645,494**	**$162,876,107**	**$157,315,670**

Total All Hospitals		**$474,453,717**	**$796,777,807**	**$162,876,107**	**$159,447,983**

*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, 2012:

Peg Burnette of Denver, representing a hospital
Karl Gills of Steamboat Springs, representing a rural 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

For terms expiring May 15, 2015:

Ann King of Denver, representing a statewide hospital organization
William Heller of Denver, representing the Department
Michelle Joy of Sterling, representing a rural hospital
Thomas Rennell of Castle Rock, representing a health insurance organization

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 6% of the net patient revenue for that class of services. (Congress 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

Dr. Patricia Gabow, CEO, Denver Health Medical Center, Denver:

> The provider fee has made a significant difference in Denver Health's ability to remain financially viable and continue to care for the highest number of Medicaid and uninsured patients in the State. The provider fee program is a great example of how hospital providers worked collaboratively to access additional federal funding for the State. Due to receipt of this funding, Denver Health was able to care for 3,000 more Medicaid patients in 2010 than 2009 while still caring for approximately 71,000 uninsured and self pay patients. The provider fee funding helped mitigate the Medicaid rate reductions that have occurred since 2009.
>
> One issue of concern for us is the reduction in the provider fee reimbursement that Denver Health and other providers sustained for SFY 2011-12 and we are hopeful that some or all of this funding can be restored as soon as possible. We are also hopeful that the Adults without Dependent Children (AwDC) Medicaid expansion can ultimately extend beyond the 10,000 cap currently proposed through use of efficient care models and integrated delivery systems like Denver Health.
>
> Overall, Denver Health is very appreciative of the provider fee and our uninsured and Medicaid patients have greatly benefitted from the resulting reimbursement and coverage expansions. We strongly support continuation of this program for the future.

Michelle L. Joy, FACHE, CEO, Sterling Regional MedCenter, Sterling:

> Sterling Regional MedCenter is a 25-bed rural hospital serving an area of nearly 45,000 residents. Over the past six years, our net income has declined to negative margins while bad debt and charity care has nearly doubled. The Hospital Provider Fee program has helped in easing the struggle we face in balancing our budget in the face of declining reimbursement for the services we provide. Our net gain from the Provider Fee this fiscal year is approximately $1,355,000.
>
> One intent of the Provider Fee is to decrease the cost shift to commercial and private insurers through expanded coverage of the uninsured. Because of the Provider Fee we have been able to expand coverage to more patients through CICP and Charity Care; from 2010 to 2011 that amount of coverage increased by approximately $1,200,000. We appreciate the continued support and efforts of the Department, the Governor's office, and the state legislature on this program. The Hospital Provider Fee program has enabled us to continue to provide much needed health care services and maintain access to quality care for our community.

Henry Garvin, CEO, Conejos County Hospital Corporation, La Jara:

> Conejos County is one of the poorest communities in Southern Colorado. Our margins are razor thin and we are continually trying to balance providing needed services to our community and keeping our heads above water financially. Without the Provider Fee we

would be forced to limit the amount of CICP services we provide; which would increase the number of people in our community that would go without much needed health care services. The Provider Fee not only allows us to provide services but also enables us to expand services that are critical in a rural community such as ours.

In the next fiscal year, Conejos County Hospital Corporation anticipates receiving an increased net $570,287.00, which approximately funds an additional 6,500 out-patient ancillary and clinic visits per year. In the past 5 months we have recruited 2 local physicians back to Conejos County and in the coming year we plan to increase our specialty clinics in OB-Gyn, ENT, Orthopedics, Geriatrics, General Surgery and Cardiology. We are also adding Holter and Event Cardiac Monitoring as well as increasing our Sleep Lab availability. We are focusing on providing excellent primary care and wellness to our entire community, not just the financially fortunate. Without the Provider Fee a significant portion of our population might not be able to access the care they need.