Colorado Health Care Affordability Act

Annual Report

Hospital Provider Fee Oversight and Advisory Board

January 15, 2014

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 2013, the CHCAA has:

- **Provided $586 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, 2013, more than $3.4 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 $586 million in new federal funds. These net new funds reduced uncompensated costs incurred by hospitals for care provided to Medicaid and CICP clients with no increase in General Fund expenditures.

- **Provided health care coverage through Medicaid and CHP+ for nearly 83,000 Coloradans**

  In May 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. In March 2012, the Medicaid Buy-In Program for Working Adults with Disabilities to 450% FPL was implemented, and in July 2012 the Medicaid Buy-In Program for Children with Disabilities to 300% FPL was implemented. In April 2012, Medicaid coverage for Adults without Dependent Children (AwDC) up to 10% FPL with enrollment initially capped at 10,000 individuals was implemented. The AwDC enrollment cap was subsequently increased to 21,691 individuals through phased monthly increases. As of September 30, 2013, the Department had enrolled approximately 43,000 Medicaid Parents, 17,000 CHP+ children and pregnant women, 1,700 adults and children with disabilities, and 21,000 adults without dependent children in these expansion populations with no increase in General Fund expenditures.

- **Provided $174.5 million in state General Fund budget relief**

  In state fiscal years (SFYs) 2009-10 and 2010-11 more than $99.5 million of General Fund relief was provided pursuant to Senate Bill (SB) 10-169 through additional federal funds drawn due to the enhanced Federal Medicaid Assistance Percentage (FMAP) under the federal American Recovery and Reinvestment Act of 2009 (ARRA). Additionally, hospital provider fees provided $50 million in SFY 2011-12 and $25 million in SFY 2012-13 of General Fund relief pursuant to SB 11-212.

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. The legislation provides health care coverage to previously uninsured Coloradans, reduces uncompensated care costs, and benefits the state as a whole. These benefits are achieved through an increase in federal funds 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, the CHCAA allows Colorado to draw down more than $500 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 133%[1] 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 (AwDC) with incomes of up to 133% FPL[1];
- 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.

[1] Note: Senate Bill 13-200 increased the coverage for Medicaid parents and AwDC to 133% of the FPL.

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 (MSB) 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 Committees of the Colorado Senate and House of Representatives.

The OAB's meetings are held regularly from 3:00 p.m. to 5:00 p.m. on the fourth Tuesday of most months (the OAB typically does not meet in January, March, May, or September). 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 MSB Roles

The MSB, 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. Rules regarding the hospital provider fee and payments can be found at 10 CCR 2505-10, Section 8.2000.

The Department administers and provides technical and regulatory expertise to the OAB. Department staff prepares and presents proposed rule changes as recommended by the OAB to the MSB. The Department is responsible for calculating the fee and assessing the fee on a schedule established in rule by the MSB. The Department implements and calculates the hospital payments and administers the public health care expansions.

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 have provided $50 million of General Fund relief for the Department's budget for SFY 2011-12 and provided another $25 million for SFY 2012-13.

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 2012 through September 2013 basis unless otherwise noted.

In the October 2012 through September 2013 period, the Department collected $662 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 $983 million, including $142 million in new CICP funding for hospitals participating in the CICP.

2012-13 Hospital Reimbursement	
Inpatient Hospital Reimbursement	$147,058,000
Outpatient Hospital Reimbursement	$166,479,000
CICP Hospital Reimbursement	$305,236,000
Additional Hospital Payments	$363,966,000
Total Supplemental Hospital Payments	**$982,796,000**

Table 1

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 SB 11-212, and the CICP hospital reimbursement level prior to increased payments under CHCAA, the net gain to hospitals in SFY 2009-10 was $124 million, the net gain for the July to September 2010 period was $22 million, the net gain for October 2010 through September 2011 was $159 million, and the net gain for October 2011 through September 2012 was $123 million. The net gain for October

2012 through September 2013 was $158 million, for a total net gain to hospitals through September 2013 of $586 million. These net gains represent the reduction in uncompensated costs incurred by hospitals for providing care to Medicaid clients and the uninsured.

2012-13 Net New Funds to Hospitals	
Total Supplemental Hospital Payments	$982,796,000
Total Fees	($661,834,000)
Approximate CICP payments pre-CHCAA	($162,876,000)
Net New Funds to Hospitals	**$158,062,000**

Table 2

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

Increase the Number of Insured Coloradans

In May 2010, the population expansions for Medicaid Parents to 100% FPL and for CHP+ to 250% FPL were implemented. In March 2012, the Medicaid Buy-In Program for Working Adults with Disabilities to 450% FPL was implemented, and in July 2012 the Medicaid Buy-In Program for Children with Disabilities to 300% FPL was implemented. In April 2012, Medicaid coverage for AwDC up to 10% FPL with enrollment capped at 10,000 individuals was implemented. Subsequently, in April 2013, the Department increased the AwDC enrollment cap by 3,000 individuals, then by 1,250 additional individuals each month. Ultimately, the enrollment cap stood at 21,691 in September 2013. This phased monthly enrollment allowed the Department to evaluate program expenditures to ensure that cost did not exceed available provider fee funds.

As of September 30, 2013, the Department had enrolled:

- 43,247 Medicaid Parents,
- 16,949 CHP+ children and pregnant women,
- 1,692 working adults and children with disabilities, and
- 20,951 Adults without Dependent Children.

The Department plans to implement continuous 12-month eligibility for children covered by Medicaid in Spring 2014.

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.

At the request of the OAB, a HQIP ad hoc Committee was formed to develop a thorough proposal for quality incentive payments. Members of the HQIP Committee included representatives from the Department, the 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 Value-Based Purchasing (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 were:

- 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 Department and PCG subsequently gathered and analyzed baseline data and established the criteria for earning points. In June 2012, the HQIP Committee 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 on June 26, 2012. Subsequently, the HQIP rules were adopted in October 2012 by the MSB and were approved by the Centers for Medicare and Medicaid Services (CMS) in December 2012. Quality incentive payments began in 2012-13. HQIP payments totaled approximately $32 million with 63 hospitals receiving payments. HQIP payments by hospital are listed in the following table.

2012-13 Hospital Quality Incentive Payments	
Arkansas Valley Regional Medical Center	$272,511
Aspen Valley Hospital	$27,055
Boulder Community Hospital	$473,631
Centura Health - Avista Adventist Hospital	$631,703
Centura Health - Littleton Adventist Hospital	$253,280
Centura Health - Mercy Regional Medical Center	$327,477
Centura Health - Parker Adventist Hospital	$396,617
Centura Health - Penrose -St. Francis Health Services	$1,533,978
Centura Health - Porter Adventist Hospital	$225,673
Centura Health - Saint Anthony Central Hospital	$402,827
Centura Health - Saint Anthony North Hospital	$880,138
Centura Health - Saint Anthony Summit Hospital	$130,739
Centura Health - St. Mary-Corwin Medical Center	$884,574
Centura Health - St. Thomas More Hospital	$335,378
Children's Hospital Colorado	$2,690,736
Colorado Acute Long Term Hospital	$3,053
Colorado Plains Medical Center	$257,825
Community Hospital	$69,546
Craig Hospital	$15,151
Delta County Memorial Hospital	$92,688
Denver Health Medical Center	$2,851,363
East Morgan County Hospital	$27,140
Exempla Good Samaritan Medical Center	$259,953
Exempla Lutheran Medical Center	$1,139,261
Exempla Saint Joseph Hospital	$1,421,477
Grand River Medical Center	$63,823
Gunnison Valley Hospital	$44,380
HealthOne Medical Center of Aurora	$456,243
HealthOne North Suburban Medical Center	$1,391,174
HealthOne Presbyterian/St. Luke's Medical Center	$353,209
HealthOne Rose Medical Center	$669,241
HealthOne Sky Ridge Medical Center	$260,319
HealthOne Swedish Medical Center	$472,224
Heart of the Rockies Regional Medical Center	$129,272
Longmont United Hospital	$464,760
McKee Medical Center	$465,255
Medical Center of the Rockies	$88,470
Melissa Memorial Hospital	$17,531
Memorial Hospital	$2,012,288
Montrose Memorial Hospital	$133,544
Mount San Rafael Hospital	$160,780
North Colorado Medical Center	$2,019,560
Northern Colorado Long Term Acute Care Hospital	$14,380
Parkview Medical Center	$1,510,437
Pikes Peak Regional Hospital	$59,858

2012-13 Hospital Quality Incentive Payments	
Platte Valley Medical Center	$705,274
Poudre Valley Hospital	$541,717
Prowers Medical Center	$335,846
Rio Grande Hospital	$40,710
San Luis Valley Regional Medical Center	$592,742
Sedgwick County Memorial Hospital	$14,631
Southwest Memorial Hospital	$145,991
Spanish Peaks Regional Health Center	$40,710
St. Mary's Hospital and Medical Center	$420,586
St. Vincent General Hospital District	$15,902
Sterling Regional MedCenter	$212,711
The Memorial Hospital	$58,310
University of Colorado Hospital	$1,794,411
Vail Valley Medical Center	$141,553
Valley View Hospital	$402,435
Wray Community District Hospital	$31,788
Yampa Valley Medical Center	$106,383
Yuma District Hospital	$40,364
Total Hospital Quality Incentive Payments	**$32,032,584**

Table 3

Subsequently, the HQIP Committee began meeting again in March 2013 to review the current measures and propose new measures for 2013-14. The 2013-14 recommendations were approved by the OAB in August 2013 and include:

- Maintaining the Central Line-Associated Blood Stream Infections (CLABSI) measure;
- Maintaining the Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT) measure and adding an improvement component to the scoring methodology;
- Maintaining the Elective Delivery between 37 and 39 weeks measure and adding an improvement component to the scoring methodology;
- Adding a 30 Day All-Cause Readmission Rate measure to replace Structured Efforts to Improve Care Transitions and Reduce Readmissions; and
- Adding a Cesarean Section measure for low-risk first birth women.

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. Since its inception, the hospital provider fee has increased Medicaid eligibility and CHP+ to nearly 83,000 persons.

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 (CY) 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. An analysis of Bad Debt and Charity care is also included as a supplemental item.

The first report appears as part of the January 2012 OAB Annual Report. The data in that report was calculated for CYs 2006 through 2010 and SFYs 2005-06 through 2009-10. With the January 2013 report, some providers refined and improved their reporting to the CHA DATABANK. While this is good for data integrity, it did cause a break in our series, since the providers only revised their data back to 2009. This report will show the calculations for CYs 2009 through 2002 and SFYs 2008-09 through 2011-12. 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. The CY 2009 data will not include impacts from the implementation of the CHCAA.

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 declined in CY 2010 by 3%. In CY 2011, the overcompensation by the private sector insurance increased by 10%. In CY 2012, the overcompensation by the private sector insurance and the undercompensation for Medicaid and Medicare remained at roughly the same levels as CY 2011. Between CY 2006 and CY 2009, the average rate of growth of private sector overcompensation was more than 18% per year.

Payment Less Cost per Patient by Payer Group				
	CY 2009	**CY 2010**	**CY 2011**	**CY 2012**
Medicare	($3,039)	($3,941)	($3,821)	($3,886)
Medicaid	($3,799)	($2,529)	($2,249)	($2,465)
Insurance	$7,271	$7,045	$7,744	$7,746
CICP/Self Pay/ Other	($4,106)	($3,892)	($4,433)	($4,013)
Overall	$898	$622	$905	$903

Table 4

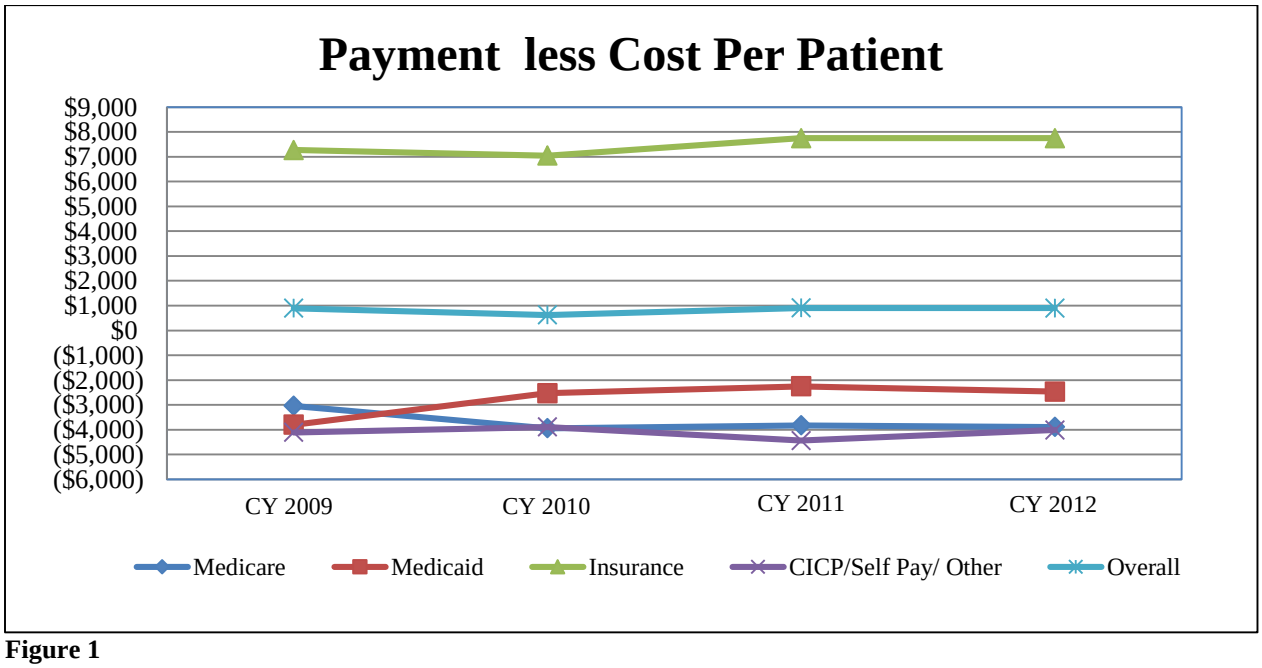

Figure 1

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.

Payment to Cost Ratio by Payer Group				
	CY 2009	**CY 2010**	**CY 2011**	**CY 2012**
Medicare	0.79	0.74	0.75	0.74
Medicaid	0.61	0.75	0.79	0.79
Insurance	1.64	1.58	1.61	1.54
CICP/Self Pay/ Other	0.55	0.62	0.63	0.67
Overall	1.08	1.05	1.07	1.07

Table 5

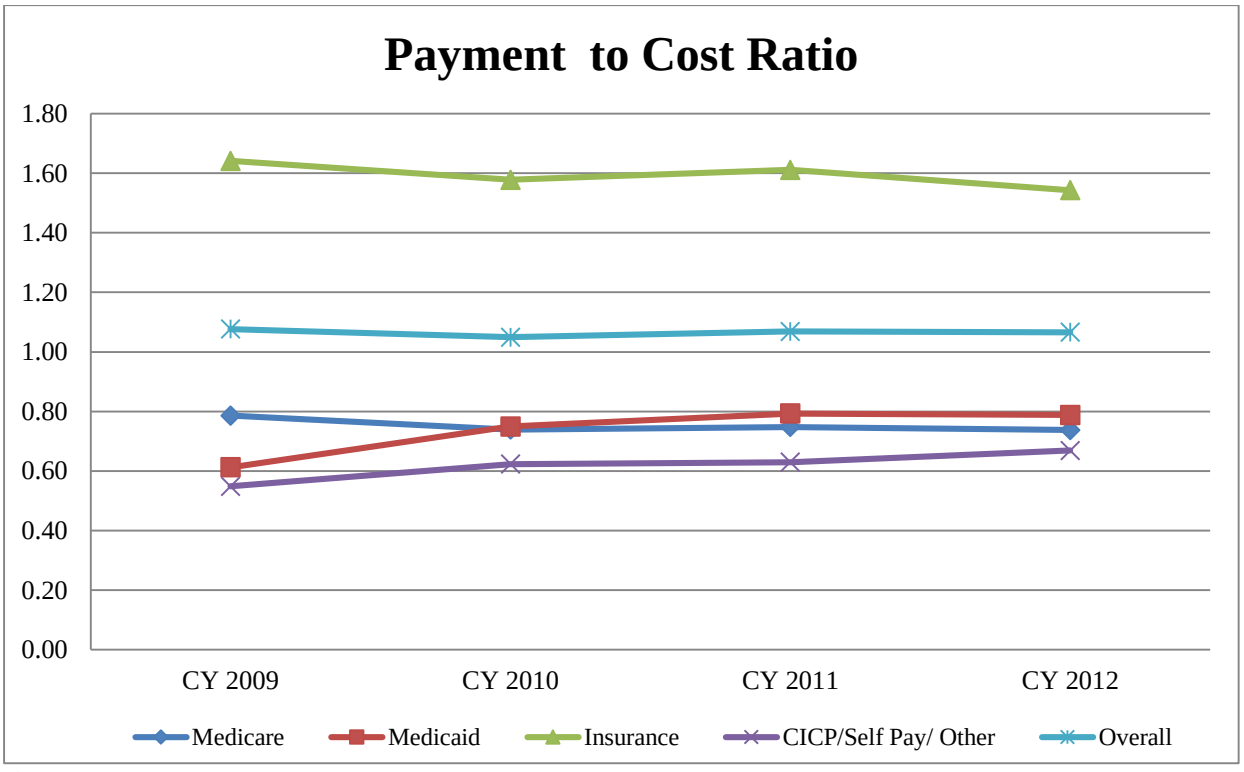

Figure 2

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 improved by 35%.

Payment Less Cost per Patient for CICP				
	SFY 2008-09	**SFY 2009-10**	**SFY 2010-11**	**SFY 2011-12**
CICP	($4,339)	($2,798)	($2,894)	($3,262)

Table 6

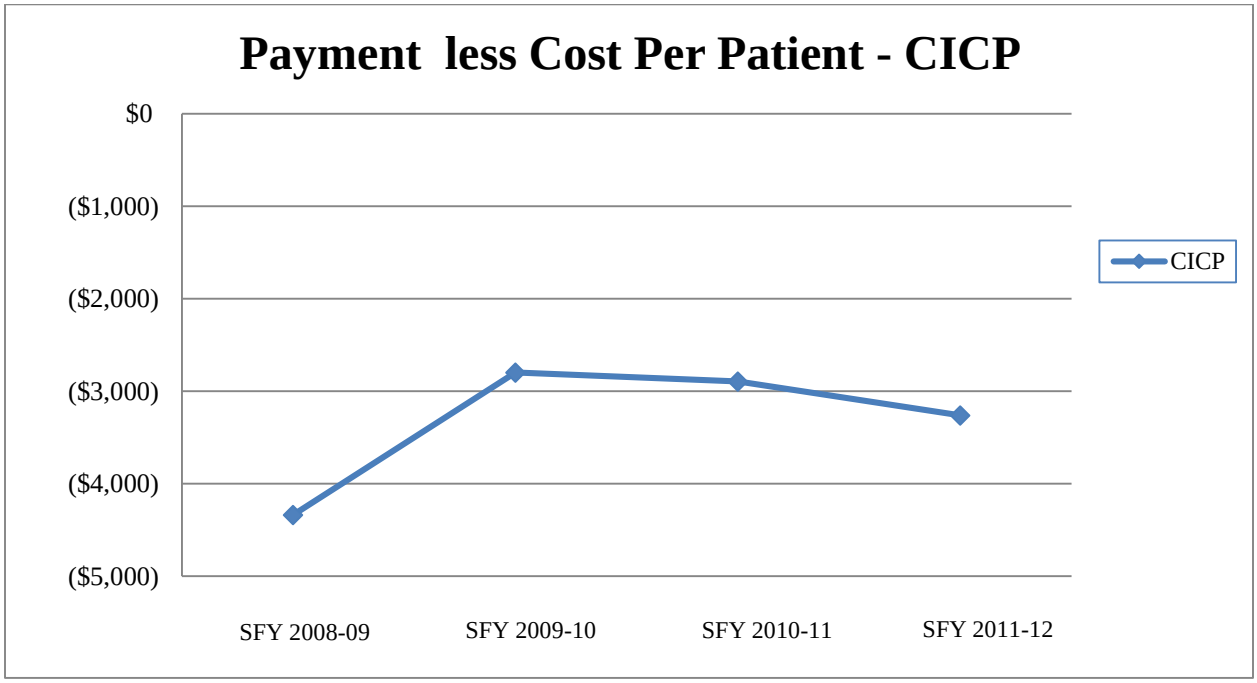

Figure 3

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 7.9% less than the CY 2009 amount and the CY 2011 Bad Debt is 0.6% lower than the CY 2010 level. Bad Debt decreased 3.6% between CY 2011 and CY 2012. The CY 2010 Charity Care amount is 1.3% greater than the CY 2009 amount and the CY 2011 Charity Care amount is 6.6% greater than the CY 2010 level. Charity Care increased 7.2% between CY 2011 and CY 2012. The calculated total Bad Debt and Charity Care for CY 2010 is lower than the total for CY 2009 and the CY 2011 total Bad Debt and Charity Care is slightly higher than the total for CY 2009. The total Bad Debt and Charity Care for CY 2012 is 3.6% higher than CY 2011. This is the result of the increase in Charity Care.

Bad Debt and Charity Care				
	CY 2009	**CY 2010**	**CY 2011**	**CY 2012**
Bad Debt	$843,859,090	$776,483,052	$772,048,150	$743,972,504
Charity Care	$1,450,212,300	$1,468,955,274	$1,565,544,819	$1,678,545,772
Total	$2,294,071,390	$2,245,438,326	$2,337,592,969	$2,422,518,276

Table 7

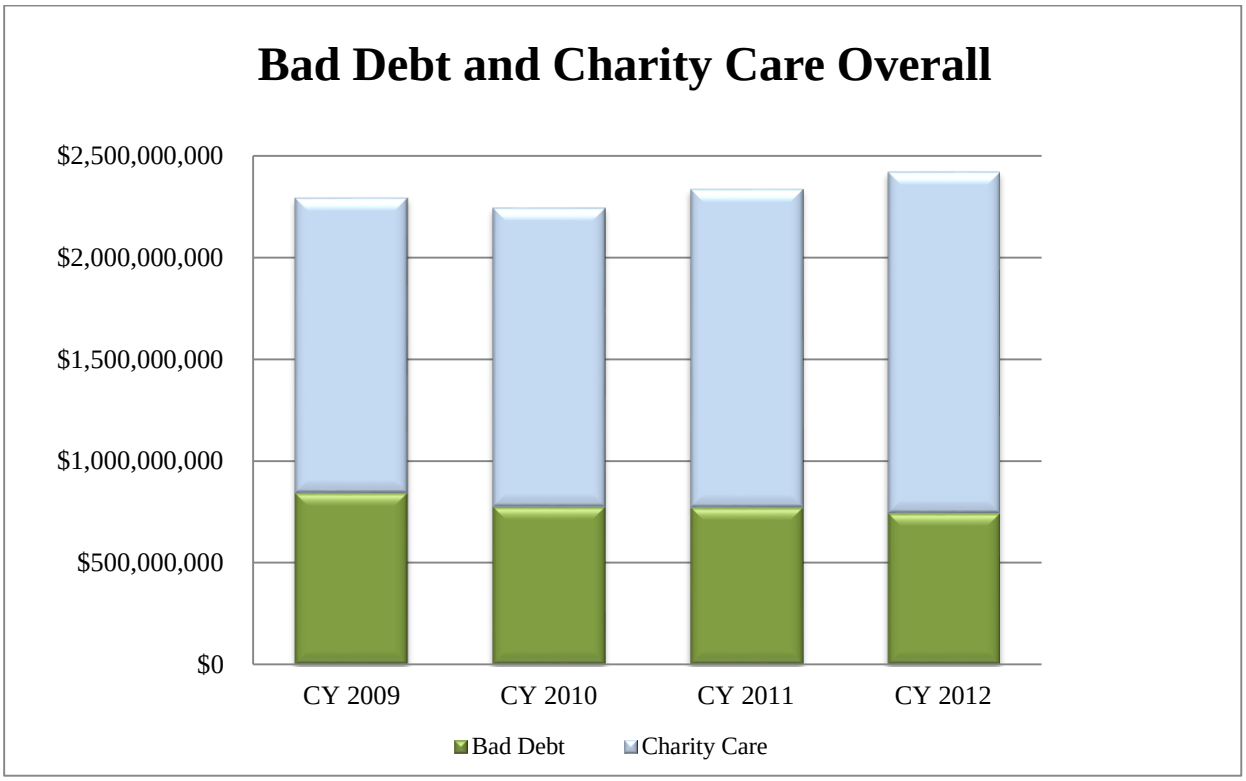

Figure 4

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 2012-13, the Department collected $651.7 million in fees from hospitals, which, with federal matching funds, funded health coverage expansions, payments to hospitals, and the Department's administrative expenses. These fees were also used to provide General Fund relief pursuant to SB 11-212. The following table outlines the Hospital Provider Fee expenditures in SFY 2012-13.

SFY 2012-13 Hospital Provider Fee Expenditures (Total Funds)*	
Supplemental Hospital Payments	$947,929,000
Department Administration	$17,626,000
Expansion Populations	$247,153,000
SB 11-212 – Provider Fee offset to General Fund	$25,000,000
25.5-4-402.3 (4)(b)(VII) – Offset revenue loss	$15,700,000
Total Expenditures	**$1,253,408,000**

Table 8

*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.

Funding in SFY 2012-13 was appropriated for CHCAA administrative expenses through the normal budget process. For SFY 2012-13, the Department had approximately 47.2 regular full-time equivalent (FTE) 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. Approximately 1.41% of total CHCAA expenditures were for the Department's administrative expenses of administering the CHCAA, while about 0.28% of total CHCAA expenditures were for the personal services costs of the FTE administering the program.

SFY 2012-13 Administrative Expenditures	
(1) Executive Director's Office; (A) General Administration, Personal Services	$3,561,545
(1) Executive Director's Office; (A) General Administration, Legal Services	$165,729
(1) Executive Director's Office; (A) General Administration, Administrative Law Judge Services	$86,699
(1) Executive Director's Office; (A) General Administration: Operating Expenses	$72,406
(1) Executive Director's Office; (A) General Administration: COFRS Modernization	$112,524
(1) Executive Director's Office; (A) General Administration: Leased Space	$199,251
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$479,413
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$3,592,795
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$4,695,409

SFY 2012-13 Administrative Expenditures	
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards	$8,355
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations	$1,645,851
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration	$2,029,164
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach	$173,722
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$383,853
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Audit Contracts	$399,480
Total Executive Director's Office Expenditures	**$17,606,195**
(4) Indigent Care Program; Children's Basic Health Plan Administration	$19,533
Total	**$17,625,728**

Table 9

Hospital Provider Fee Model – Fee and Payment Methodologies

On March 31, 2010, the CMS first approved 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 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.

As in the previous year, in the October 2012 through September 2013 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, 2013 as there had been for the previous two (2) years. At its August 2013 meeting, the OAB unanimously recommended that any excess revenue in the cash fund be used to reduce the fees needed to be raised in 2013-14.

Hospital payments are increased for Medicaid and CICP hospital services through several 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 2012-13 fee and payment amounts by type are outlined in the table below. Please see Appendix A for more information about fee and payment methodologies.

2012-13 Hospital Provider Fees and Payments	
Inpatient Fee	$410,118,000
Outpatient fee	$251,713,000
Total Hospital Provider Fees	**$661,831,000**
Inpatient Base Rate Payment	$147,058,000
Outpatient Payment	$166,479,000
CICP DSH Payment	$152,868,000
CICP UPL Payment	$152,368,000
Uninsured DSH Payment	$41,324,000
High Level Neonatal Intensive Care Unit (NICU) Payment	$12,935,000
HQIP	$32,000,000
Large Rural Payment	$25,615,000
Denver Metro Payment	$178,622,000
Metropolitan Statistical Area Payment	$70,317,000
Pediatric Specialty Hospital Payment	$1,000,000
Acute Care Psychiatric Payment	$2,183,000
Total Supplemental Hospital Payments	**$982,769,000**

Table 10

APPENDIX A: 2012-13 Hospital Provider Fee Model Overview

This overview describes the fee assessment and payment methodologies for October 2012 through September 2013 under the CHCAA. While no hospital is eligible for all payments, all methodologies are described.

Provider Fees

Inpatient Hospital Fee and Outpatient Fee

- Total Fees collected were $661,831,000. 62% were inpatient fees and 38% were outpatient fees.
- Inpatient fee is charged on a facility's Managed Care Days and non-Managed Care Days. Fee charged on Managed Care days are discounted by 77.63% compared to the rate assessed on 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 fee is assessed as a percentage 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 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%.
  - 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%.

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 a percentage adjustment factor. Percentage adjustment factors may vary by hospital. The percentage adjustment factor for each hospital will be published annually in the Colorado Medicaid Provider Bulletin.
- State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not 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 54% for most hospitals (for High Volume Medicaid and CICP Hospitals this percentage equals 53%; for rural and Critical Access Hospitals this percentage equals 70%).
- 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.
- New in the 2012-13 provider fee model is a modification to the CICP payment calculation to provide enhanced payments to facilities with high relative Medicaid and CICP utilization. Hospitals are separated into rural and urban categories for determining eligibility for enhanced payments. The first enhancement increases the inflated CICP cost of a facility by 2% if a facility's ratio of CICP costs to Total costs are greater than one standard deviation over the mean of its peer group. The second bonus provide a cumulative, 5% increase to inflated CICP costs if a facility's ratio of Medicaid and CICP days to Total days is great than two standard deviations over the mean of the facility's peer group.
- 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 38.49%.
- 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 45% for most urban hospitals and 75% for most rural hospitals (for Pediatric Specialty Hospitals the percentage is 16%; for Urban Center Safety Net Specialty Hospitals the percentage is 15%; for Rehabilitation and Long Term Acute Care Hospitals the Percentage is 10%).
- 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 lbs. and 3.27 oz.) and capped at the average length of stay for the DRG, multiplied by $2,500.
- 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. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Large Rural Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals total Medicaid Days multiplied by $750.
- 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 $800.
- For qualified hospitals located in Jefferson, Douglas, Broomfield or Boulder County this payment equals total Medicaid Days multiplied by $1,075.
- For qualified hospitals located in Denver County, this payment equals total Medicaid Days multiplied by $865.
- Facilities that meet the qualifications for a Denver Metro Supplemental Medicaid Payment with a ratio of Medicaid and CICP days to Total days above the third quartile of all CICP providers receive an addition $100 per Medicaid day.
- Hospitals located in Adams, Arapahoe, Boulder, 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 $650.
- 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 $1 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 $200.
- State Licensed Psychiatric Hospitals, LTC Hospitals, and Rehabilitation Hospitals are not qualified for this payment.

APPENDIX B: October 2012 - September 2013 Hospital Provider Fees and Payments by Hospital

Fee-Exempt Hospitals – Free-Standing Psychiatric, Long Term Care, and Rehabilitation Hospitals					
Hospital Name	**County**	**Fees**	**Payments**	**Appx CICP Payments pre-CHCAA**	**Net New Funds**
Haven Behavioral Health at North Denver	Adams	$0	$0	$0	$0
HealthOne Spalding Rehabilitation Hospital	Adams	$0	$62,513	$0	$62,513
Vibra Long Term Acute Care Hospital	Adams	$0	$17,228	$0	$17,228
Craig Hospital	Arapahoe	$0	$1,277,669	$0	$1,277,669
Triumph Hospital	Arapahoe	$0	$2,488	$0	$2,488
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0
Colorado Acute Long Term Hospital	Denver	$0	$20,310	$0	$20,310
Colorado Mental Health Institute-Ft Logan	Denver	$0	$0	$0	$0
Eating Recovery Center	Denver	$0	$0	$0	$0
Kindred Hospital	Denver	$0	$17,155	$0	$17,155
Select Specialty Hospital - Denver	Denver	$0	$623	$0	$623
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	$286,994	$0	$286,994
Peak View Behavioral Health	El Paso	$0	$0	$0	$0
Select Long Term Care Hospital	El Paso	$0	$2,488	$0	$2,488
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 Long Term Acute Care Hospital	Weld	$0	$2,488	$0	$2,488
Northern Colorado Rehabilitation Hospital	Weld	$0	$174,510	$0	$174,510
Total		**$0**	**$1,864,466**	**$0**	**$1,864,466**

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**Fees**	**Payments**	**Appx CICP Payments pre-CHCAA**	**Net New Funds**
Centura Health - Saint Anthony North Hospital	Adams	$10,612,653	$14,560,009	$0	$3,947,356
Children's Hospital Colorado	Adams	$20,075,416	$41,151,398	$2,854,794	$18,221,188
HealthOne North Suburban Medical Center	Adams	$11,516,420	$16,578,535	$0	$5,062,115
Platte Valley Medical Center	Adams	$5,057,119	$11,236,723	$1,499,298	$4,680,306
University of Colorado Hospital	Adams	$39,630,787	$81,000,344	$36,264,181	$5,105,376
San Luis Valley Regional Medical Center	Alamosa	$3,803,129	$9,225,286	$962,324	$4,459,833
Centura Health - Littleton Adventist Hospital	Arapahoe	$15,508,477	$10,452,841	$0	($5,055,636)
HealthOne Medical Center of Aurora	Arapahoe	$28,071,473	$27,512,236	$0	($559,238)
HealthOne Swedish Medical Center	Arapahoe	$31,247,323	$26,063,844	$0	($5,183,479)
Pagosa Mountain Hospital	Archuleta	$195,952	$680,759	$0	$484,807
Southeast Colorado Hospital	Baca	$227,534	$823,969	$34,179	$562,256
Boulder Community Hospital	Boulder	$17,742,970	$16,891,492	$1,063,630	($1,915,109)
Centura Health - Avista Adventist Hospital	Boulder	$6,783,814	$12,071,855	$0	$5,288,041
Exempla Good Samaritan Medical Center	Boulder	$12,958,539	$8,490,337	$0	($4,468,202)
Longmont United Hospital	Boulder	$12,714,808	$18,969,883	$1,633,746	$4,621,329
Heart of the Rockies Regional Medical Center	Chaffee	$1,171,420	$2,480,596	$247,500	$1,061,676
Keefe Memorial Hospital	Cheyenne	$119,928	$175,980	$0	$56,052
Conejos County Hospital	Conejos	$205,863	$2,599,240	$99,884	$2,293,493
Delta County Memorial Hospital	Delta	$3,562,689	$4,189,292	$912,623	($286,021)
Centura Health - Porter Adventist Hospital	Denver	$16,710,596	$13,488,329	$0	($3,222,266)
Denver Health Medical Center	Denver	$22,207,914	$105,192,090	$64,455,024	$18,529,151
Exempla Saint Joseph Hospital	Denver	$23,288,723	$29,962,573	$0	$6,673,850
HealthOne Presbyterian/St. Luke's Medical Center	Denver	$22,133,776	$37,316,167	$0	$15,182,391
HealthOne Rose Medical Center	Denver	$20,638,925	$22,485,819	$0	$1,846,894
National Jewish Health	Denver	$2,070,575	$9,452,910	$1,682,780	$5,699,555
Centura Health - Parker Adventist Hospital	Douglas	$10,121,193	$8,433,478	$0	($1,687,715)
HealthOne Sky Ridge Medical Center	Douglas	$16,993,030	$9,099,873	$0	($7,893,157)

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**Fees**	**Payments**	**Appx CICP Payments pre-CHCAA**	**Net New Funds**
Vail Valley Medical Center	Eagle	$4,465,710	$4,566,426	$0	$100,716
Centura Health - Penrose -St. Francis Health Services	El Paso	$34,751,999	$28,420,693	$2,195,836	($8,527,141)
Memorial Hospital	El Paso	$36,228,664	$58,912,616	$16,142,511	$6,541,441
Centura Health - St. Thomas More Hospital	Fremont	$3,971,143	$8,455,216	$779,972	$3,704,101
Grand River Medical Center	Garfield	$752,230	$1,584,437	$190,609	$641,598
Valley View Hospital	Garfield	$5,749,838	$13,187,667	$444,750	$6,993,078
Kremmling Memorial Hospital	Grand	$185,257	$333,342	$117,393	$30,692
Gunnison Valley Hospital	Gunnison	$556,592	$1,519,229	$42,048	$920,590
Spanish Peaks Regional Health Center	Huerfano	$467,042	$1,474,586	$135,879	$871,664
Centura Health - Ortho Colorado	Jefferson	$1,761,524	$0	$0	($1,761,524)
Centura Health - Saint Anthony Central Hospital	Jefferson	$22,295,247	$31,846,224	$0	$9,550,978
Exempla Lutheran Medical Center	Jefferson	$30,589,446	$32,639,831	$0	$2,050,384
Weisbrod Memorial County Hospital	Kiowa	$68,697	$344,284	$0	$275,587
Kit Carson County Memorial Hospital	Kit Carson	$371,731	$794,099	$0	$422,368
Animas Surgical Hospital	La Plata	$610,516	$1,435,609	$0	$825,093
Centura Health - Mercy Regional Medical Center	La Plata	$5,392,439	$7,212,642	$534,968	$1,285,234
St. Vincent General Hospital District	Lake	$235,501	$528,501	$118,153	$174,847
Estes Park Medical Center	Larimer	$676,987	$1,198,884	$435,234	$86,663
McKee Medical Center	Larimer	$8,204,563	$14,808,818	$2,131,572	$4,472,683
Medical Center of the Rockies	Larimer	$9,437,115	$10,748,428	$1,584,786	($273,473)
Poudre Valley Hospital	Larimer	$22,617,897	$30,078,604	$5,935,254	$1,525,453
Mount San Rafael Hospital	Las Animas	$802,156	$2,612,879	$134,622	$1,676,101
Lincoln Community Hospital and Nursing Home	Lincoln	$262,470	$903,526	$0	$641,056
Sterling Regional MedCenter	Logan	$1,718,746	$4,466,590	$794,952	$1,952,892
Community Hospital	Mesa	$3,408,914	$2,738,081	$170,542	($841,375)
Family Health West Hospital	Mesa	$278,724	$551,252	$0	$272,528
St. Mary's Hospital and Medical Center	Mesa	$20,037,787	$23,297,550	$1,747,192	$1,512,572

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**Fees**	**Payments**	**Appx CICP Payments pre-CHCAA**	**Net New Funds**
The Memorial Hospital	Moffat	$768,257	$2,261,128	$167,785	$1,325,086
Southwest Memorial Hospital	Montezuma	$1,420,251	$2,820,136	$383,352	$1,016,532
Montrose Memorial Hospital	Montrose	$5,040,273	$7,855,382	$1,054,452	$1,760,657
Colorado Plains Medical Center	Morgan	$3,388,115	$4,997,535	$162,836	$1,446,584
East Morgan County Hospital	Morgan	$606,172	$1,718,002	$175,025	$936,805
Arkansas Valley Regional Medical Center	Otero	$3,136,654	$6,453,568	$1,374,965	$1,941,949
Haxtun Hospital	Phillips	$134,097	$151,299	$0	$17,202
Melissa Memorial Hospital	Phillips	$190,302	$1,195,690	$40,279	$965,109
Aspen Valley Hospital	Pitkin	$1,219,936	$1,829,725	$490,839	$118,950
Prowers Medical Center	Prowers	$836,169	$2,608,652	$407,322	$1,365,162
Centura Health - St. Mary-Corwin Medical Center	Pueblo	$16,229,659	$27,200,984	$2,978,448	$7,992,877
Parkview Medical Center	Pueblo	$28,158,939	$40,771,330	$3,603,807	$9,008,584
Pioneers Hospital	Rio Blanco	$130,584	$513,161	$0	$382,576
Rangely District Hospital	Rio Blanco	$111,328	$189,974	$0	$78,647
Rio Grande Hospital	Rio Grande	$373,519	$3,134,737	$51,020	$2,710,198
Yampa Valley Medical Center	Routt	$2,141,406	$4,540,006	$168,950	$2,229,650
Sedgwick County Memorial Hospital	Sedgwick	$181,049	$423,181	$27,239	$214,893
Centura Health - Saint Anthony Summit Hospital	Summit	$2,024,908	$2,830,856	$0	$805,948
Pikes Peak Regional Hospital	Teller	$650,083	$2,431,358	$55,614	$1,725,660
North Colorado Medical Center	Weld	$23,049,954	$39,355,104	$6,182,516	$10,122,633
Wray Community District Hospital	Yuma	$318,734	$818,461	$107,405	$392,322
Yuma District Hospital	Yuma	$450,342	$1,558,457	$98,017	$1,010,097
Total		**$661,830,713**	**$980,904,595**	**$162,876,107**	**$156,197,775**

Total All Hospitals*		**$661,830,713**	**$982,769,061**	**$162,876,107**	**$158,062,240**

*Figures may not sum to totals due to rounding.

APPENDIX C: Hospital Provider Fee Oversight and Advisory Board Members

As required in the 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 members.

Current Board Members by Term Expiration Date

For terms expiring May 15, 2015:

John Gardner of Yuma, representing a rural hospital
William Heller of Denver, representing the Department
Ann King of Denver, representing a statewide hospital organization
Thomas Rennell of Castle Rock, representing a health insurance organization

For terms expiring May 15, 2016:

Peg Burnette of Denver, representing a hospital
Dan Enderson of Castle Rock, representing a hospital
George O'Brien of Pueblo, representing persons with disabilities

For terms expiring May 15, 2017:

Dr. Jeremiah A. Bartley of Brighton, representing the health care industry
David Livingston of Denver, representing a business, to serve as Chair
Mirna Ramirez-Castro of Thornton, representing a consumer of health care
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 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.

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.