COLORADO

Department of Health Care Policy & Financing

Colorado Health Care Affordability Act Annual Report

Hospital Provider Fee Oversight and Advisory Board
January 15, 2015

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Executive Summary

The Department of Health Care Policy and Financing (the Department) and the Hospital Provider Fee Oversight and Advisory Board (OAB) have prepared this annual report concerning the implementation of the Colorado Health Care Affordability Act (CHCAA). The CHCAA authorizes the Department 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 reduce cost-shifting to private payers.

From October 2013 through September 2014, the CHCAA has:

Provided $215 million in increased reimbursement to hospital providers

During the October 2013 through September 2014 time period, hospitals received more than $913 million in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed with hospital provider fees, including $34 million in hospital quality incentive payments. This funding resulted in more than $215 million in a net reimbursement increase for care provided to Medicaid and CICP clients with no increase in General Fund expenditures.

Reduced uncompensated care costs and the need to shift uncompensated care costs to other payers

The CHCAA reduces uncompensated care for hospital providers and the need to shift those costs to private payers by increasing reimbursement to hospitals for care provided to Medicaid and CICP patients and by reducing the number of uninsured Coloradans. In calendar year 2009, prior to the implementation of the CHCAA, Medicaid reimbursement to Colorado hospitals was approximately 61% of cost. The latest data from calendar year 2013 indicates that Medicaid reimbursement to hospitals has improved to approximately 80% of cost.

Provided health care coverage through Medicaid and the Child Health Plan *Plus* (CHP+) for more than 300,000 Coloradans

Health coverage expansions in Medicaid and CHP+ funded with hospital provider fees began in 2010, when the population expansions for Medicaid parents and CHP+ children and pregnant women were implemented. In 2012, the Medicaid Buy-In Programs for Working Adults and Children with Disabilities, as well as a limited enrollment for adults without dependent children, were implemented. In 2014, pursuant to Senate Bill 13-200, Medicaid coverage for parents and adults without dependent children was increased up to federal limits and 12-month continuous eligibility for children enrolled in Medicaid were implemented.

As of September 30, 2014, the Department has enrolled approximately 73,000 Medicaid parents, 18,000 CHP+ children and pregnant women, 2,900 adults and children with disabilities, and 210,000 adults without dependent children with no increase in General Fund expenditures.

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 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 Coloradans 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 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 (or any successor 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 under Colorado.gov/hcpf/committees-boards-and-collaboration.

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. 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 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 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.

Increase Hospital Reimbursement for Care Provided to Medicaid and CICP Clients

Following the implementation of the hospital provider fee in SFY 2009-10, the OAB recommended that subsequent hospital provider fee and payment calculations be moved to an October 1 start date. Therefore, figures in this report are reported on an October 2013 through September 2014 basis unless otherwise noted.

In the October 2013 through September 2014 period, the Department collected $535 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 $913 million, including $34 million in quality incentive payments.

2013-14 Hospital Reimbursement	
Inpatient Hospital Reimbursement	$147,945,000
Outpatient Hospital Reimbursement	$138,022,000
CICP Hospital Reimbursement	$309,547,000
Hospital Quality Incentive Payments	$34,388,000
Additional Hospital Payments	$317,596,000
Total Supplemental Hospital Payments	$913,110,000

Table 1

After taking into account the hospital provider fees collected for health coverage expansions, the Department's administrative expenses, and the CICP hospital reimbursement level prior to increased payments under CHCAA, the net reimbursement increase to hospitals for care provided to Medicaid and CICP patients and quality incentive payments was more than $215 million for the 2013-14 time period.

2013-14 Net Reimbursement Increase to Hospitals	
Total Supplemental Hospital Payments	$913,110,000
Total Fees	($534,568,000)
Approximate CICP payments pre-CHCAA	($162,876,000)
Net Reimbursement Increase to Hospitals	$215,666,000

Table 2

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

Increase the Number of Insured Coloradans

In May 2010 the population expansions for Medicaid parents to 100% FPL and 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. On January 1, 2014, pursuant to Senate Bill 13-200, coverage for Medicaid parents and AwDC was increased to 133% FPL and the waitlist for AwDC clients was eliminated. On March 1, 2014, 12-month continuous eligibility for children enrolled in Medicaid was implemented.

The caseload reported as of September 30, 2014 was as follows:

72,906 Medicaid parents,

18,849 CHP+ children and pregnant women,

2,925 working adults and children with disabilities, and

210,970 adults without dependent children.

Improve the Quality of Health Care for Medicaid Clients

The CHCAA included a provision to establish Hospital Quality Incentive Payments (HQIP) funded by hospital provider fees to improve the quality of care provided in Colorado hospitals.

At the request of the OAB, a HQIP subcommittee was formed to develop a thorough proposal for quality incentive payments. Members of the HQIP subcommittee include representatives from the Department, the CHA, and hospital representatives with expertise in quality measurement and hospital payment. The subcommittee is supported in its efforts by the Department's contracted consultant, Public Consulting Group, and began meeting in January 2011.

The HQIP subcommittee seeks 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.

The HQIP measures are specific to the hospital provider fee program and are not intended to be a full hospital report card.

HQIP payments were first implemented in the October 2012 through September 2013 time period. Payments in that first year were based on the following four measures:

Central Line-Associated Blood Stream Infections (CLABSI);

Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT);

Elective Delivery between 37 and 39 Weeks Gestation; and

Structured Efforts to Improve Care Transitions and Reduce Readmissions.

HQIP: 2013-14 Measures and Payments

Following the implementation of the first year's incentive payments, the subcommittee reconvened in March 2013 to discuss possible improvements to the existing HQIP program. The HQIP subcommittee recommended and the OAB approved the following measures for HQIP payments for the year beginning October 1, 2013:

Maintain the CLABSI measure;

Maintain the PPE/DVT measure and add an improvement component to the scoring methodology;

Maintain the Elective Delivery between 37 and 39 Weeks Gestation measure and add an improvement component to the scoring methodology ;

Add a 30 Day All-Cause Readmission Rate measure to replace Structured Efforts to Improve Care Transitions and Reduce Readmissions; and

Add a Cesarean Section measure for low-risk, first birth women.

The HQIP payments earned for each of the 2013-14 measures are based on points per Medicaid adjusted discharge. Medicaid adjusted discharges are calculated by dividing the total Medicaid gross charges by Medicaid inpatient service charges and multiplying the result by the total Medicaid discharges. Additionally, in 2013-14 a cap of 5 to the adjusted discharge factor was applied for hospitals that have a high outpatient volume relative to inpatient volume.

Points Eligible
The total points eligible for any hospital are the sum of points for each measure for which the hospital qualified.

Points Earned
Total points earned were normalized so hospitals were not negatively impacted by the measures for which they did not meet the minimum criteria. That is, if a hospital scored 15 points, but only qualified for three measures (30 points), the total HQIP points earned would be 25: (15/30 = 0.5 x 50 = 25). A maximum award of 10 points was possible for each of the five HQIP measures in 2013-14 for 50 total possible points.

During the 2013-14 timeframe, HQIP payments totaled more than $34 million with 82 hospitals receiving payments. HQIP payments, eligible points, and earned points by hospital are listed in the following table.

2013-14 Hospital Quality Incentive Payments

Hospital	County	Total Points Earned	Total Points Eligible	HQIP Payment
Children's Hospital Colorado	Adams	8	20	$1,648,414
HealthOne North Suburban Medical Center	Adams	23	50	$980,110
HealthOne Spalding Rehabilitation Hospital	Adams	5	10	$9,352
Kindred Hospital Aurora	Adams	5	20	$146
Platte Valley Medical Center	Adams	32	50	$691,311
University of Colorado Hospital	Adams	25	50	$1,648,953
Vibra Long Term Acute Care Hospital	Adams	15	20	$4,384
San Luis Valley Regional Medical Center	Alamosa	18	40	$408,520
Centura Health - Littleton Adventist Hospital	Arapahoe	31	50	$360,760
Craig Hospital	Arapahoe	8	20	$9,282
HealthOne Medical Center of Aurora	Arapahoe	25	50	$1,048,147
HealthOne Swedish Medical Center	Arapahoe	30	50	$867,890
Pagosa Mountain Hospital	Archuleta	10	10	$20,458
Southeast Colorado Hospital	Baca	10	10	$24,362
Boulder Community Hospital	Boulder	29	50	$420,730
Centura Health - Avista Adventist Hospital	Boulder	35	50	$677,246
Exempla Good Samaritan Medical Center	Boulder	31	50	$321,970
Longmont United Hospital	Boulder	30	50	$640,629
Heart of the Rockies Regional Medical Center	Chaffee	31	40	$153,441
Keefe Memorial Hospital	Cheyenne	10	10	$17,536
Conejos County Hospital	Conejos	3	10	$26,304
Delta County Memorial Hospital	Delta	25	50	$118,298

Hospital	County	Total Points Earned	Total Points Eligible	HQIP Payment
Centura Health - Porter Adventist Hospital	Denver	11	30	$142,574
Colorado Acute Long Term Hospital	Denver	5	20	$1,607
Denver Health Medical Center	Denver	33	50	$2,882,251
Exempla Saint Joseph Hospital	Denver	30	50	$979,688
HealthOne Presbyterian/St. Luke's Medical Center	Denver	31	50	$670,793
HealthOne Rose Medical Center	Denver	23	50	$707,240
Kindred Hospital	Denver	5	10	$2,338
National Jewish Health	Denver	5	10	$71,605
Select Specialty Hospital - Denver	Denver	10	10	$585
Centura Health - Parker Adventist Hospital	Douglas	28	50	$291,574
HealthOne Sky Ridge Medical Center	Douglas	28	50	$267,923
Vail Valley Medical Center	Eagle	28	50	$158,356
Centura Health - Penrose -St. Francis Health Services	El Paso	28	50	$1,127,705
HealthSouth Rehabilitation Hospital - Colorado Springs	El Paso	5	20	$6,654
Memorial Hospital	El Paso	35	50	$4,314,728
Select Long Term Care Hospital	El Paso	10	10	$585
Centura Health - St. Thomas More Hospital	Fremont	30	50	$308,191
Grand River Medical Center	Garfield	15	20	$73,312
Valley View Hospital	Garfield	35	50	$431,449
Middle Park Medical Center	Grand	10	10	$35,072
Gunnison Valley Hospital	Gunnison	10	20	$50,979
Spanish Peaks Regional Health Center	Huerfano	10	10	$93,524
Centura Health - Ortho Colorado	Jefferson	6	10	$0
Centura Health - Saint Anthony Central Hospital	Jefferson	5	30	$154,239
Centura Health - Saint Anthony North Hospital	Jefferson	36	50	$970,551
Exempla Lutheran Medical Center	Jefferson	30	50	$1,256,293
Weisbrod Memorial County Hospital	Kiowa	10	10	$2,923
Kit Carson County Memorial Hospital	Kit Carson	0	20	$0
Animas Surgical Hospital	La Plata	10	10	$40,917
Mercy Medical Center	La Plata	33	50	$372,402
St. Vincent General Hospital District	Lake	0	10	$0
Estes Park Medical Center	Larimer	28	30	$66,855
McKee Medical Center	Larimer	31	50	$662,688
Medical Center of the Rockies	Larimer	22	40	$149,047
Poudre Valley Hospital	Larimer	28	50	$929,235
Mount San Rafael Hospital	Las Animas	18	20	$221,620
Lincoln Community Hospital and Nursing Home	Lincoln	20	20	$23,381
Sterling Regional MedCenter	Logan	31	50	$201,984
Community Hospital	Mesa	10	30	$39,943

Hospital	County	Total Points Earned	Total Points Eligible	HQIP Payment
Family Health West Hospital	Mesa	5	20	$731
St. Mary's Hospital and Medical Center	Mesa	15	30	$386,493
The Memorial Hosptial	Moffat	18	40	$80,375
Southwest Memorial Hospital	Montezuma	26	50	$174,403
Montrose Memorial Hospital	Montrose	29	50	$142,354
Colorado Plains Medical Center	Morgan	31	50	$293,787
East Morgan County Hospital	Morgan	10	20	$23,381
Arkansas Valley Regional Medical Center	Otero	30	50	$375,632
Melissa Memorial Hospital	Phillips	3	10	$12,082
Aspen Valley Hospital	Pitkin	21	30	$65,262
Prowers Medical Center	Prowers	23	40	$266,186
Centura Health - St. Mary-Corwin Medical Center	Pueblo	27	50	$823,030
Parkview Medical Center	Pueblo	24	50	$1,332,479
Pioneers Hospital	Rio Blanco	20	20	$35,072
Rangely District Hospital	Rio Blanco	10	10	$5,845
Rio Grande Hospital	Rio Grande	3	10	$28,057
Yampa Valley Medical Center	Routt	20	40	$97,759
Sedgwick County Memorial Hospital	Sedgwick	20	30	$16,806
Centura Health - Saint Anthony Summit Hospital	Summit	31	50	$124,145
Pikes Peak Regional Hospital	Teller	7	20	$32,087
North Colorado Medical Center	Weld	35	50	$2,165,160
Northern Colorado Long Term Acute Care Hospital	Weld	5	10	$0
Northern Colorado Rehabilitation Hospital	Weld	5	20	$5,838
Wray Community District Hospital	Yuma	15	40	$22,821
Yuma District Hospital	Yuma	15	20	$69,547
Total				**$34,388,388**

Table 3

Subsequently, the HQIP Committee began meeting again in February 2014 to review the existing measures and propose new measures for 2014-15 as well as 2015-16 with the goal of adopting measures that can be prospectively set to allow time for planning and successful implementation. HQIP 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 2014-15 recommendations were approved by the OAB in August 2014 and include:

- Maintain the PPE/DVT measure;
- Maintain the Elective Delivery between 37 and 39 Weeks measure and add an improvement component to the scoring methodology;
- Maintain the 30 Day All-Cause Readmission Rate measure to replace Structured Efforts to Improve Care Transitions and Reduce Readmissions;
- Maintain the Cesarean Section measure for low-risk first birth women;
- Move the CLABSI measure to a maintenance or legacy measure to which no points will be assigned; and
- Add a measure designed to reduce non-urgent Emergency Department visits.

To increase participation from all hospitals regardless of type, for 2015-16 the HQIP subcommittee recommended adding optional measures to the existing base and maintenance measures. Hospitals that do not qualify for all five of the base measures will be asked to report on optional measures.

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

The CHCAA reduces the need to shift uncompensated care costs to private payers by increasing reimbursement to hospitals for inpatient and outpatient care provided for Medicaid and CICP patients and by reducing the number of uninsured Coloradans. Since its inception in July 2009, the hospital provider fee has increased hospital reimbursement an average of more than $150 million per year and increased enrollment in Medicaid and CHP+ to over 300,000 persons as of September 2014.

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 Medicare, Medicaid, and private insurance.

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.

The information that follows shows calculations for CYs 2009 through 2013 and SFYs 2008-09 through 2012-13[2]. The CHCAA was implemented following federal approval in April 2010. The CY 2009 data shows cost to payment ratios prior to the implementation of the CHCAA, while changes due to the CHCAA are captured with data from CY 2010 and years that follow.

Because the information includes calculations through 2013 only, the impact of the January 2014 expansion of Medicaid coverage and implementation of the Connect for Health Colorado Marketplace pursuant to the Affordable Care Act (ACA) is not known at this time and is not reflected in this report.

[2] Cost shift data for per patient calculations for CY 2010-11 and SFY 2010-11 in this annual report have been corrected and differ from the data reflected in the previous annual report.

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

The table and graph below display the differences 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, while positive values indicate that payments exceed costs. This is the essence of cost shift as publicly funded care (Medicare and Medicaid) and uninsured care (CICP/Self Pay/Other) are paid under cost while private payers pay more to cover those costs.

The data in Table 4 show that the undercompensation for the Medicaid and CICP/Self Pay/Other payer groups has reduced sharply following the implementation of the CHCAA in July 2009. On a per patient basis, the payment below cost for hospital care has improved by more than $1,300 for Medicaid and more than $2,000 for CICP/Self Pay/Other when comparing CY 2009 to CY 2013 data.

Payment Less Cost per Patient by Payer Group

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Medicare	($3,039)	($3,941)	($3,762)	($3,886)	($5,319)[3]
Medicaid	($3,799)	($2,529)	($2,168)	($2,465)	($2,419)
Insurance	$7,271	$7,045	$7,598	$7,746	$7,717
CICP/Self Pay/ Other	($4,106)	($3,892)	($4,070)	($4,013)	($2,070)
Overall	$898	$622	$881	$903	$746

Table 4

[3] The recent decrease in the Medicare payer group reflects Medicare hospital payment reductions resulting from various federal laws including the ACA, the Budget Control Act of 2011, and the Bipartisan Budget Act of 2013.

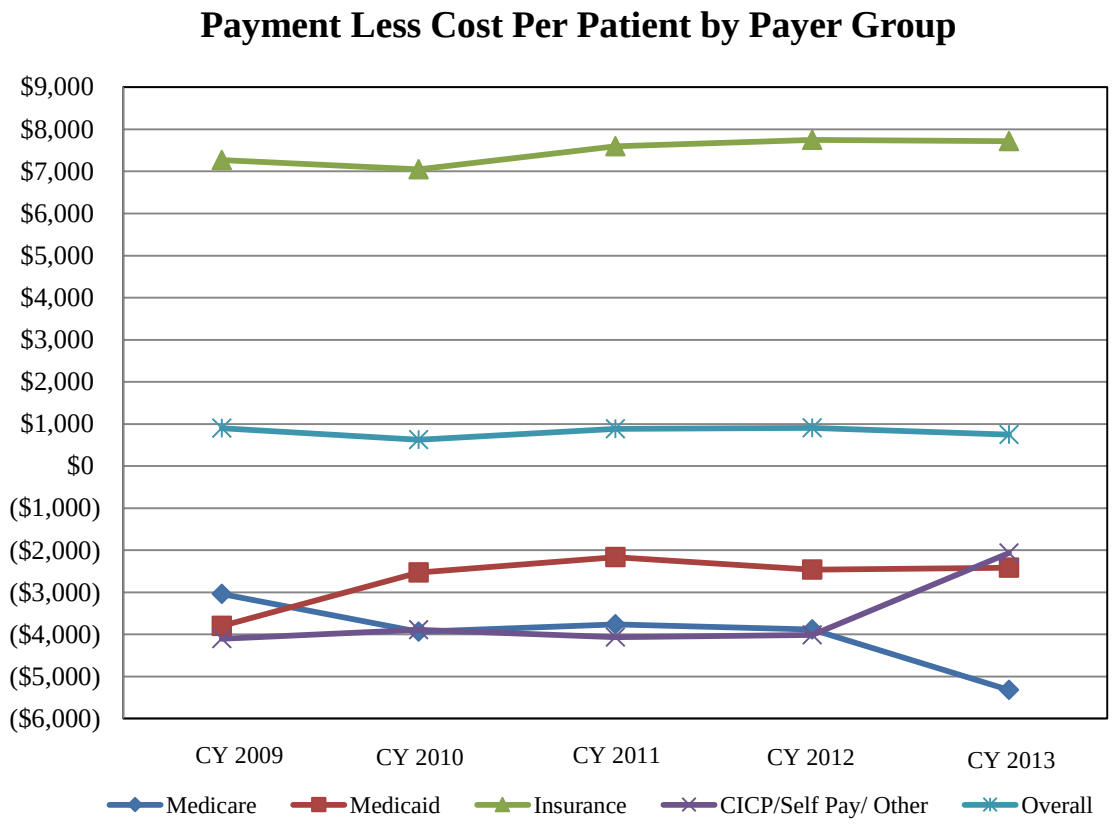

Figure 1

Cost Shift Data: Payment to Cost Ratio

Another way to view the impact of cost shifting is 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. Values greater than 1 mean that payments exceed costs, as is the case for the private sector insurance group.

As shown below, in CY 2009, prior to the implementation of the CHCAA, Medicaid reimbursement to Colorado hospitals was approximately 61% of costs. The latest data from CY 2013 indicates that Medicaid reimbursement to hospitals has improved to approximately 80% of cost.

Payment to Cost Ratio by Payer Group

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Medicare	0.79	0.74	0.75	0.74	0.66[3]
Medicaid	0.61	0.75	0.79	0.79	0.80
Insurance	1.64	1.58	1.61	1.54	1.52
CICP/Self Pay/ Other	0.55	0.62	0.63	0.67	0.84
Overall	1.08	1.05	1.07	1.07	1.05

Table 5

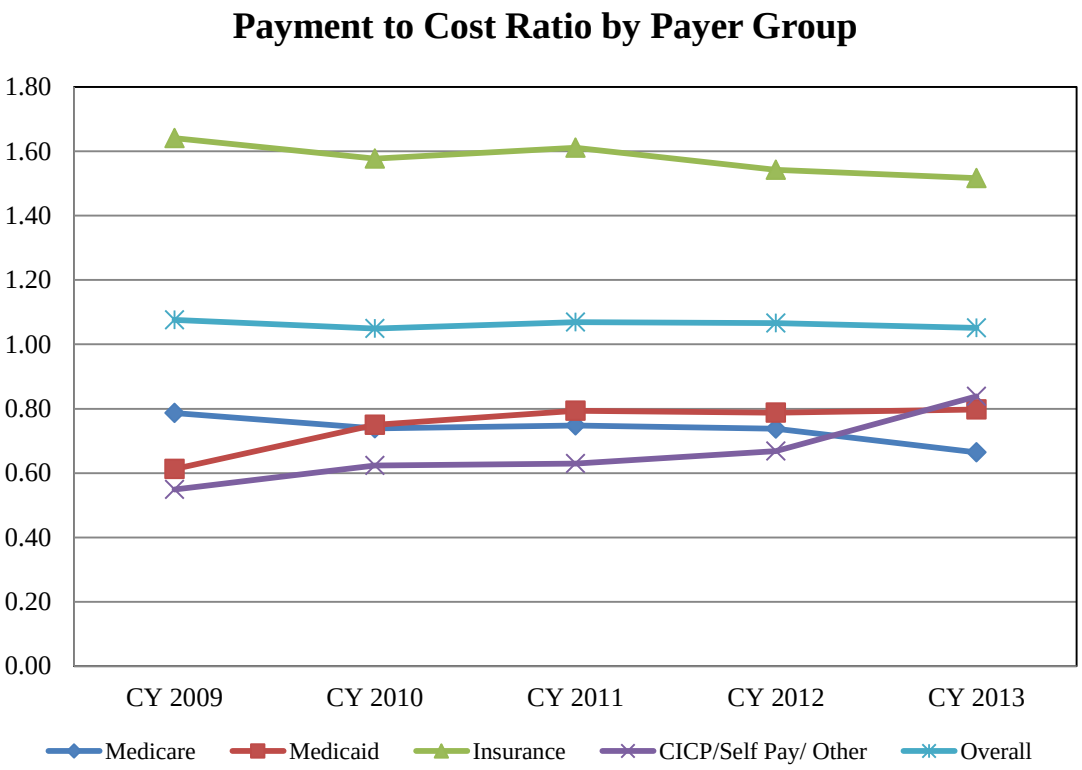
Payment to Cost Ratio by Payer Group
1.80
1.60
1.40
1.20
1.00
0.80
0.60
0.40
0.20
0.00
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
Medicare
Medicaid
Insurance
CICP/Self Pay/ Other
Overall

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 at least $115 million annually, the amount of undercompensation of CICP costs decreased by approximately 35%. CICP funding has remained at the new levels following the implementation of the CHCAA.

Payment Less Cost Per Patient - CICP

	SFY 2008-09	SFY 2009-10	SFY 2010-11	SFY 2011-12	SFY 2012-13
CICP	($4,339)	($2,798)	($3,077)	($3,262)	($3,078)

Table 6

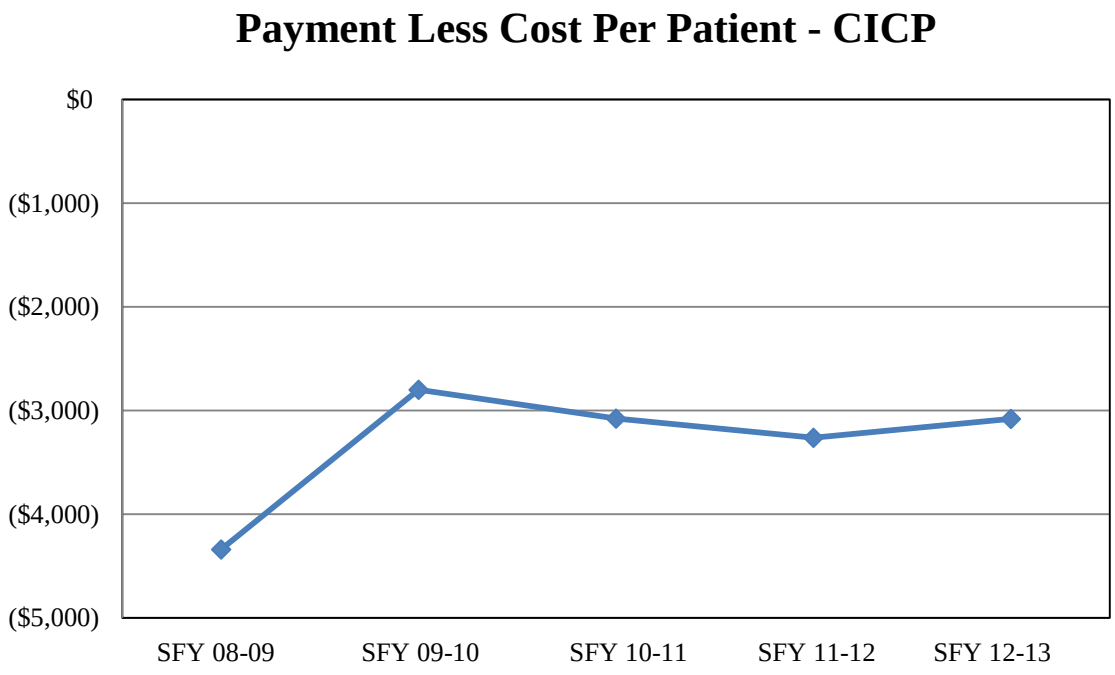

Figure 3

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.

Bad Debt was lower in each year than it was in CY 2009 until the latest data in CY 2013, where it rose by 28% compared to the prior year. More data information is needed before the Department can determine if this is the beginning of a trend for increasing Bad Debt or if this is an anomaly. Charity Care has increased an average of 3.5% each year, and the combined Bad Debt and Charity Care figure is nearly 14% higher in CY 2013 compared to CY 2009.

Bad Debt and Charity Care

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Bad Debt	$843,859,090	$776,483,052	$772,048,150	$743,972,504	$951,605,019
Charity Care	$1,450,212,300	$1,468,955,274	$1,565,544,819	$1,678,545,772	$1,657,809,286
Total	$2,294,071,390	$2,245,438,326	$2,337,592,969	$2,422,518,276	$2,609,414,305

Table 7

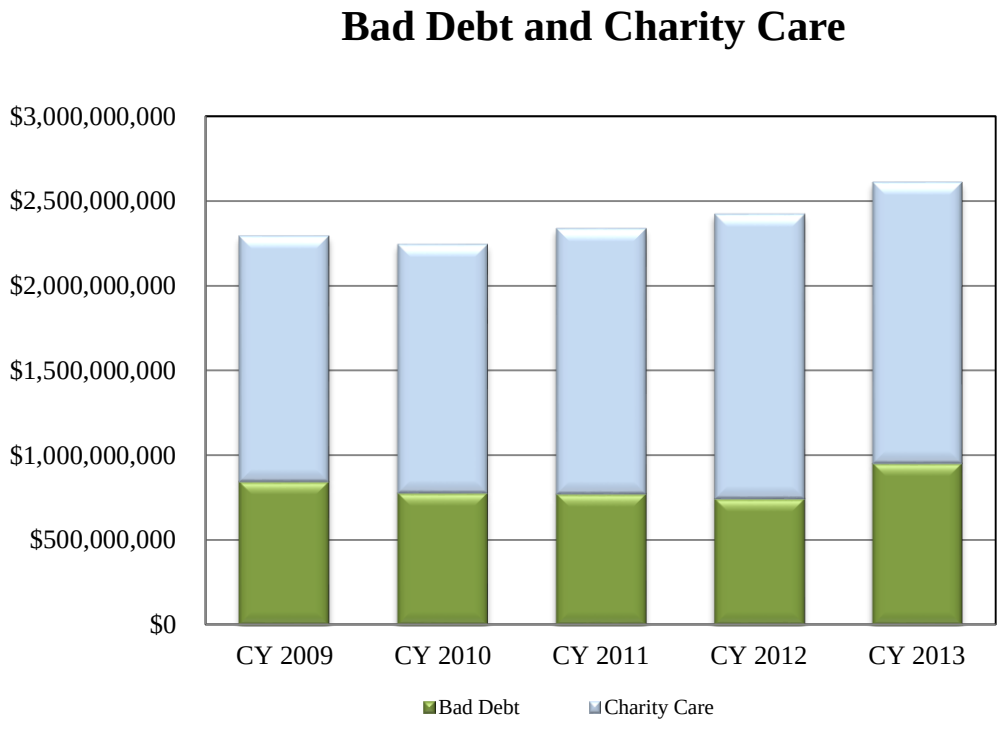

Figure 4

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 2013-14, the Department collected $566 million in fees from hospitals, which, with federal matching funds, funded health coverage expansions, payments to hospitals, and the Department's administrative expenses. The following table outlines the Hospital Provider Fee expenditures in SFY 2013-14.

SFY 2013-14 Hospital Provider Fee Expenditures (Total Funds)[4]	
Supplemental Hospital Payments	$927,590,000
Department Administration	$25,364,000
Expansion Populations	$640,648,000
25.5-4-402.3 (4)(b)(VII) – Offset revenue loss	$15,700,000
Total Expenditures	**$1,609,294,000**

Table 8

Funding in SFY 2013-14 was appropriated for CHCAA administrative expenses through the normal budget process. For SFY 2013-14, the Department had approximately 51 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 1.58% of total CHCAA expenditures were for the Department's administrative expenses of administering the CHCAA, while about 0.32% of total CHCAA expenditures were for the personal services costs of the FTE administering the program.

SFY 2013-14 Administrative Expenditures	
(1) Executive Director's Office; (A) General Administration, Personal Services	$5,126,575
(1) Executive Director's Office; (A) General Administration, Legal Services	$194,715
(1) Executive Director's Office; (A) General Administration, Administrative Law Judge Services	$98,134
(1) Executive Director's Office; (A) General Administration: Operating Expenses	$228,061
(1) Executive Director's Office; (A) General Administration: COFRS Modernization	$199,432
(1) Executive Director's Office; (A) General Administration: Leased Space	$277,748
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$603,874
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$4,433,113
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$5,633,993

[4] 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.

SFY 2013-14 Administrative Expenditures	
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards	$19,864
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations	$3,517,691
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration	$3,504,657
(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	$187,532
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$383,581
(1) Executive Director's Office; (H) Indirect Cost Recoveries, Indirect Cost Assessment	$194,926
Total Executive Director's Office Expenditures	**$24,777,618**
(4) Indigent Care Program; Children's Basic Health Plan Administration	$8,020
(7) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology, Colorado Benefits Management System, HCPF Only	$578,146
Total	**$25,363,846**

Table 9

Hospital Provider Fee – 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 fee and payment calculations are 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.

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.

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 2013-14 fee and payment amounts by type are outlined in the following table. See Appendix A for more information about fee and payment methodologies.

2013-14 Hospital Provider Fees and Payments	
Inpatient Fee	$305,000,000
Outpatient fee	$229,568,000
Total Hospital Provider Fees	**$534,568,000**

Inpatient Base Rate Payment	$147,945,000
Outpatient Payment	$138,022,000
CICP DSH Payment	$194,067,000
CICP UPL Payment	$115,480,000
Uninsured DSH Payment	$3,230,000
High Level NICU Payment	$27,355,000
State Teaching Hospital Payment	$0
Large Rural Payment	$19,218,000
Denver Metro Payment	$167,261,000
Metropolitan Statistical Area Payment	$64,217,000
Pediatric Specialty Hospital Payment	$1,000,000
Acute Care Psychiatric Payment	$927,000
Hospital Quality Incentive Payment	$34,388,000
Total Supplemental Hospital Payments	**$913,110,000**

Table 10

APPENDIX A: 2013-14 Hospital Provider Fee Overview

This overview describes the fee assessment and payment methodologies for October 2013 through September 2014 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 $534,568,000. Inpatient fees comprised 57% of total fees, while outpatient fees comprised 42%.

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 is 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 52.45% for most hospitals (for rural and Critical Access Hospitals this percentage equals 77.45%).

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.

Enhanced payments are made 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 uninsured costs multiplied by 15.18%.

Uncompensated uninsured costs equal uninsured charges as reported by the hospital, multiplied by the most hospital's cost-to-charge ratio from its CMS 2552-10 cost report.

Hospitals that do not participate in the CICP and that have a Medicaid Inpatient Utilization Rate (MIUR) equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals 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 38% for most urban hospitals and 73% for most rural hospitals (for Pediatric Specialty Hospitals the percentage is 9.5%; for Urban Center Safety Net Specialty Hospitals the percentage is 36%; 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 under APR -DRG 588 (Neonate, w/ ECMO), 591 (Neonate, Birthwt 500-749G w/o Major Procedure), 593 (Neonate, Birthwt 750-999G w/o Major Procedure), 602 (Neonate, Birthwt 1000-1249G w/ Resp Dist Synd/Oth Maj Resp Or Maj Anom), and 609 (Neonate, BWT 1500-2499G W Major Procedure) multiplied by $2400 per Medicaid NICU day. Medicaid NICU days are limited by the Average Length of Stay (ALOS) for each APR-DRG. 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 $525. Facilities that have a ratio of CICP plus Medicaid days to total days that is in the third quartile of hospitals receive for an additional $50 per Medicaid day.

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 $770.

For qualified hospitals located in Jefferson, Douglas, Broomfield or Boulder County this payment equals total Medicaid Days multiplied by $770.

For qualified hospitals located in Denver County, this payment equals total Medicaid Days multiplied by $755.

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 additional $50 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 $550.

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 by hospitals multiplied by $100.

State Licensed Psychiatric Hospitals, LTC Hospitals, and Rehabilitation Hospitals are not qualified for this payment.

APPENDIX B: October 2013 - September 2014 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 Reimbursement Increase
Haven Behavioral Health at North Denver	Adams	$0	$0	$0	$0
HealthOne Spalding Rehabilitation Hospital	Adams	$0	$117,629	$0	$117,629
Kindred Hospital Aurora	Adams	$0	$3,739	$0	$3,739
Vibra Long Term Acute Care Hospital	Adams	$0	$23,912	$0	$23,912
Craig Hospital	Arapahoe	$0	$654,862	$0	$654,862
HealthSouth Rehabilitation Hospital - Denver	Arapahoe	$0	$218,455	$0	$218,455
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0
Colorado Acute Long Term Hospital	Denver	$0	$31,035	$0	$31,035
Colorado Mental Health Institute-Ft Logan	Denver	$0	$0	$0	$0
Eating Recovery Center	Denver	$0	$0	$0	$0
Kindred Hospital	Denver	$0	$17,401	$0	$17,401
Select Specialty Hospital - Denver	Denver	$0	$3,919	$0	$3,919
Highlands Behavioral Health System	Douglas	$0	$0	$0	$0
Cedar Springs Behavior Health System	El Paso	$0	$0	$0	$0
HealthSouth Rehabilitation Hospital - Colorado	El Paso	$0	$113,813	$0	$113,813
Peak View Behavioral Health	El Paso	$0	$0	$0	$0
Select Long Term Care Hospital	El Paso	$0	$3,919	$0	$3,919
Colorado West Psychiatric Hospital Inc	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	$3,335	$0	$3,335
Northern Colorado Rehabilitation Hospital	Weld	$0	$105,755	$0	$105,755
Total		**$0**	**$1,297,775**	**$0**	**$1,297,775**

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Hospital Name	County	Fees	Payments	Appx CICP Payments pre-CHCAA	Net Reimbursement Increase
Children's Hospital Colorado	Adams	$19,897,252	$49,862,684	$2,854,794	$27,110,638
HealthOne North Suburban Medical Center	Adams	$10,578,690	$19,658,639	$0	$9,079,950
Platte Valley Medical Center	Adams	$4,321,852	$10,543,586	$1,499,298	$4,722,436
University of Colorado Hospital	Adams	$34,476,559	$79,007,277	$36,264,181	$8,266,537
San Luis Valley Regional Medical Center	Alamosa	$2,791,080	$8,882,391	$962,324	$5,128,987
Centura Health - Littleton Adventist Hospital	Arapahoe	$13,512,129	$8,412,796	$0	-$5,099,333
HealthOne Medical Center of Aurora	Arapahoe	$22,609,948	$23,516,296	$0	$906,348
HealthOne Swedish Medical Center	Arapahoe	$27,324,503	$22,391,791	$0	-$4,932,712
Pagosa Mountain Hospital	Archuleta	$221,255	$648,083	$0	$426,828
Southeast Colorado Hospital	Baca	$185,919	$864,071	$34,179	$643,972
Boulder Community Hospital	Boulder	$12,514,599	$12,763,180	$1,063,630	-$815,049
Centura Health - Avista Adventist Hospital	Boulder	$5,078,005	$7,527,037	$0	$2,449,032
Exempla Good Samaritan Medical Center	Boulder	$12,210,671	$7,926,521	$0	-$4,284,150
Longmont United Hospital	Boulder	$9,781,987	$18,123,563	$1,633,746	$6,707,831
Heart of the Rockies Regional Medical Center	Chaffee	$1,007,709	$2,464,539	$247,500	$1,209,330
Keefe Memorial Hospital	Cheyenne	$104,105	$242,542	$0	$138,436
Conejos County Hospital	Conejos	$159,952	$2,644,817	$99,884	$2,384,981
Delta County Memorial Hospital	Delta	$3,145,028	$4,274,882	$912,623	$217,231
Centura Health - Porter Adventist Hospital	Denver	$10,570,753	$9,602,494	$0	-$968,258
Denver Health Medical Center	Denver	$18,086,660	$115,854,956	$64,455,024	$33,313,271
Exempla Saint Joseph Hospital	Denver	$19,370,900	$22,546,974	$0	$3,176,073
HealthOne Presbyterian/St. Luke's Medical Center	Denver	$21,728,558	$33,687,057	$0	$11,958,499
HealthOne Rose Medical Center	Denver	$18,419,175	$21,253,113	$0	$2,833,938
National Jewish Health	Denver	$2,050,634	$10,728,548	$1,682,780	$6,995,134
Centura Health - Parker Adventist Hospital	Douglas	$9,122,834	$6,315,103	$0	-$2,807,731
HealthOne Sky Ridge Medical Center	Douglas	$15,042,018	$5,435,134	$0	-$9,606,884
Vail Valley Medical Center	Eagle	$3,530,717	$4,135,722	$0	$605,004
Centura Health - Penrose -St. Francis Health Services	El Paso	$26,262,361	$28,090,029	$2,195,836	-$368,168

Hospital Name	County	Fees	Payments	Appx CICP Payments pre-CHCAA	Net Reimbursement Increase
Memorial Hospital	El Paso	$26,494,032	$45,997,295	$16,142,511	$3,360,752
Centura Health - St. Thomas More Hospital	Fremont	$3,108,215	$7,069,056	$779,972	$3,180,869
Grand River Medical Center	Garfield	$660,652	$1,625,134	$190,609	$773,874
Valley View Hospital	Garfield	$4,487,390	$16,501,177	$444,750	$11,569,038
Kremmling Memorial Hospital	Grand	$148,094	$877,991	$117,393	$612,504
Gunnison Valley Hospital	Gunnison	$454,660	$2,297,364	$42,048	$1,800,656
Spanish Peaks Regional Health Center	Huerfano	$462,024	$1,457,033	$135,879	$859,129
Centura Health - Ortho Colorado	Jefferson	$1,443,862	$0	$0	-$1,443,862
Centura Health - Saint Anthony Central Hospital	Jefferson	$15,951,793	$15,711,833	$0	-$239,960
Centura Health - Saint Anthony North Hospital	Jefferson	$9,129,003	$12,217,275	$0	$3,088,272
Exempla Lutheran Medical Center	Jefferson	$20,226,362	$26,488,004	$0	$6,261,643
Weisbrod Memorial County Hospital	Kiowa	$53,868	$297,268	$0	$243,400
Kit Carson County Memorial Hospital	Kit Carson	$317,898	$953,214	$0	$635,316
Animas Surgical Hospital	La Plata	$496,107	$1,306,966	$0	$810,859
Mercy Medical Center	La Plata	$5,496,957	$7,189,409	$534,968	$1,157,484
St. Vincent General Hospital District	Lake	$205,756	$1,250,946	$118,153	$927,037
Estes Park Medical Center	Larimer	$634,675	$2,136,383	$435,234	$1,066,474
McKee Medical Center	Larimer	$6,848,045	$11,376,366	$2,131,572	$2,396,749
Medical Center of the Rockies	Larimer	$9,207,490	$12,862,615	$1,584,786	$2,070,340
Poudre Valley Hospital	Larimer	$16,335,415	$27,267,903	$5,935,254	$4,997,234
Mount San Rafael Hospital	Las Animas	$444,531	$2,417,902	$134,622	$1,838,749
Lincoln Community Hospital and Nursing Home	Lincoln	$210,909	$805,808	$0	$594,899
Sterling Regional MedCenter	Logan	$1,377,661	$3,762,234	$794,952	$1,589,620
Community Hospital	Mesa	$2,822,727	$2,025,224	$170,542	-$968,045
Family Health West Hospital	Mesa	$299,422	$981,466	$0	$682,045
St. Mary's Hospital and Medical Center	Mesa	$16,066,440	$22,062,411	$1,747,192	$4,248,779
The Memorial Hospital	Moffat	$528,877	$2,600,879	$167,785	$1,904,217
Southwest Memorial Hospital	Montezuma	$1,115,591	$3,055,008	$383,352	$1,556,065
Montrose Memorial Hospital	Montrose	$3,157,438	$7,685,928	$1,054,452	$3,474,038

Hospital Name	County	Fees	Payments	Appx CICP Payments pre-CHCAA	Net Reimbursement Increase
Colorado Plains Medical Center	Morgan	$1,922,398	$4,989,921	$162,836	$2,904,687
East Morgan County Hospital	Morgan	$579,866	$1,813,554	$175,025	$1,058,663
Arkansas Valley Regional Medical Center	Otero	$2,473,563	$6,463,637	$1,374,965	$2,615,109
Haxtun Hospital	Phillips	$76,606	$971,581	$0	$894,974
Melissa Memorial Hospital	Phillips	$265,156	$1,184,633	$40,279	$879,199
Aspen Valley Hospital	Pitkin	$1,023,525	$2,133,028	$490,839	$618,664
Prowers Medical Center	Prowers	$579,093	$2,793,770	$407,322	$1,807,355
Centura Health - St. Mary-Corwin Medical Center	Pueblo	$11,859,357	$22,547,287	$2,978,448	$7,709,482
Parkview Medical Center	Pueblo	$19,176,973	$37,373,538	$3,603,807	$14,592,757
Pioneers Hospital	Rio Blanco	$126,644	$523,253	$0	$396,609
Rangely District Hospital	Rio Blanco	$78,316	$492,399	$0	$414,084
Rio Grande Hospital	Rio Grande	$333,367	$3,235,114	$51,020	$2,850,727
Yampa Valley Medical Center	Routt	$1,755,501	$4,854,629	$168,950	$2,930,178
Sedgwick County Memorial Hospital	Sedgwick	$151,226	$439,898	$27,239	$261,434
Centura Health - Saint Anthony Summit Hospital	Summit	$1,777,460	$1,769,027	$0	-$8,434
Pikes Peak Regional Hospital	Teller	$602,891	$2,500,527	$55,614	$1,842,022
North Colorado Medical Center	Weld	$18,800,896	$37,772,074	$6,182,516	$12,788,662
Wray Community District Hospital	Yuma	$311,404	$916,238	$107,405	$497,429
Yuma District Hospital	Yuma	$381,594	$1,356,027	$98,017	$876,416
Total		**$534,567,583**	**$911,814,051**	**$162,876,107**	**$214,370,361**
Total All Hospitals[5]		**$534,567,583**	**$913,111,826**	**$162,876,107**	**$215,668,136**

[5] 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
Kathryn Ashenfelter of Denver, representing a hospital
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:

- Be imposed on a permissible class of health care services, including, but not limited to, inpatient hospital services and outpatient hospital services.
- Be broad-based, such that the fee is imposed on all providers within a class.
- Be imposed uniformly throughout a jurisdiction, such that all providers within a class are assessed at the same rate.
- 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 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.