COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

January 15, 2017

Governor John W. Hickenlooper
136 State Capitol
Denver, CO 80203-1792

Dear Governor Hickenlooper:

Enclosed please find a legislative report to the Governor from the Department of Health Care Policy and Financing on and the Hospital Provider Fee Oversight and Advisory Board on the Colorado Health Care Affordability Act.

Section 25.5-4-402.3 (6)(f), C.R.S. requires the Board to submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee, and the medical services board concerning the implementation of the Colorado Health Care Affordability Act by January 15 each year. This report includes a description of the hospital provider fee; the total amount of the provider fee paid and revenue received by each hospital; an itemization of the Department's costs in administering the hospital provider fee; and estimates of the differences between the cost of care provided and payment received by hospitals for patients covered by Medicaid, Medicare, and other payers.

During the October 2015 through September 2016 time period, the Colorado Health Care Affordability Act has provided $288 million in net new federal funds to hospitals, reduced uncompensated care costs, provided health coverage through Medicaid and the Child Health Plan *Plus* (CHP+) for more than 480,000 Coloradans, and improved quality of health care for Medicaid clients in the hospital setting.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

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

David Livingston
Chair, Hospital Provider Fee
Oversight and Advisory Board

SEB/nad
Enclosure(s): Colorado Health Care Affordability Act Annual Report

Cc: Kyle M. Brown, Senior Health Policy Advisor, Governor's Office
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Gretchen Hammer, Health Programs Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
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Jed Ziegenhagen, Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
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Zach Lynkiewicz, Legislative Liaison, HCPF

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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

January 15, 2017

The Honorable Kent Lambert, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Lambert:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on and the Hospital Provider Fee Oversight and Advisory Board on the Colorado Health Care Affordability Act.

Section 25.5-4-402.3 (6)(f), C.R.S. requires the Board to submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee, and the medical services board concerning the implementation of the Colorado Health Care Affordability Act by January 15 each year. This report includes a description of the hospital provider fee; the total amount of the provider fee paid and revenue received by each hospital; an itemization of the Department's costs in administering the hospital provider fee; and estimates of the differences between the cost of care provided and payment received by hospitals for patients covered by Medicaid, Medicare, and other payers.

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David Livingston
Chair, Hospital Provider Fee
Oversight and Advisory Board

SEB/nad
Enclosure(s): Colorado Health Care Affordability Act Annual Report

Cc: Representative Millie Hamner, Vice-chair, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

January 15, 2017

The Honorable Joann Ginal, Chair
Health, Insurance, and Environment Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Ginal:

Enclosed please find a legislative report to the House Health, Insurance, and Environment Committee from the Department of Health Care Policy and Financing on and the Hospital Provider Fee Oversight and Advisory Board on the Colorado Health Care Affordability Act.

Section 25.5-4-402.3 (6)(f), C.R.S. requires the Board to submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee, and the medical services board concerning the implementation of the Colorado Health Care Affordability Act by January 15 each year. This report includes a description of the hospital provider fee; the total amount of the provider fee paid and revenue received by each hospital; an itemization of the Department's costs in administering the hospital provider fee; and estimates of the differences between the cost of care provided and payment received by hospitals for patients covered by Medicaid, Medicare, and other payers.

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Sincerely,

Susan E. Birch, MBA, BSN, RN
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David Livingston
Chair, Hospital Provider Fee
Oversight and Advisory Board

SEB/nad
Enclosure(s): Colorado Health Care Affordability Act Annual Report

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Representative Janet Buckner, Health, Insurance and Environment Committee
Representative Phil Covarrubias, Health, Insurance and Environment Committee
Representative Steve Humphrey, Health, Insurance and Environment Committee
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Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

January 15, 2017

The Honorable Jonathan Singer, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

Enclosed please find a legislative report to the House Public Health Care and Human Services Committee from the Department of Health Care Policy and Financing on and the Hospital Provider Fee Oversight and Advisory Board on the Colorado Health Care Affordability Act.

Section 25.5-4-402.3 (6)(f), C.R.S. requires the Board to submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee, and the medical services board concerning the implementation of the Colorado Health Care Affordability Act by January 15 each year. This report includes a description of the hospital provider fee; the total amount of the provider fee paid and revenue received by each hospital; an itemization of the Department's costs in administering the hospital provider fee; and estimates of the differences between the cost of care provided and payment received by hospitals for patients covered by Medicaid, Medicare, and other payers.

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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

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

David Livingston
Chair, Hospital Provider Fee
Oversight and Advisory Board

SEB/nad
Enclosure(s): Colorado Health Care Affordability Act Annual Report

Cc: Representative Jessie Danielson, Vice-Chair, Public Health Care and Human Services Committee
Representative Don Coram, Public Health Care and Human Services Committee
Representative Justin Everett, Public Health Care and Human Services Committee
Representative Joann Ginal, Public Health Care and Human Services Committee
Representative Edie Hooton, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Kimmi Lewis, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, Public Health Care and Human Services Committee
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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

January 15, 2017

The Honorable Jim Smallwood, Chair
Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Smallwood:

Enclosed please find a legislative report to the Senate Health and Human Services Committee from the Department of Health Care Policy and Financing on and the Hospital Provider Fee Oversight and Advisory Board on the Colorado Health Care Affordability Act.

Section 25.5-4-402.3 (6)(f), C.R.S. requires the Board to submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee, and the medical services board concerning the implementation of the Colorado Health Care Affordability Act by January 15 each year. This report includes a description of the hospital provider fee; the total amount of the provider fee paid and revenue received by each hospital; an itemization of the Department's costs in administering the hospital provider fee; and estimates of the differences between the cost of care provided and payment received by hospitals for patients covered by Medicaid, Medicare, and other payers.

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Sincerely,

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

David Livingston
Chair, Hospital Provider Fee
Oversight and Advisory Board

SEB/nad
Enclosure(s): Colorado Health Care Affordability Act Annual Report

Cc: Senator Beth Martinez Humenik, Vice-Chair, Health and Human Services Committee
Senator Irene Aguilar, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
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COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

January 15, 2017

Christy Blakely
President, Medical Services Board
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Blakely:

Enclosed please find a legislative report to the Medical Services Board from the Department of Health Care Policy and Financing on and the Hospital Provider Fee Oversight and Advisory Board on the Colorado Health Care Affordability Act.

Section 25.5-4-402.3 (6)(f), C.R.S. requires the Board to submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee, and the medical services board concerning the implementation of the Colorado Health Care Affordability Act by January 15 each year. This report includes a description of the hospital provider fee; the total amount of the provider fee paid and revenue received by each hospital; an itemization of the Department's costs in administering the hospital provider fee; and estimates of the differences between the cost of care provided and payment received by hospitals for patients covered by Medicaid, Medicare, and other payers.

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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

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

David Livingston
Chair, Hospital Provider Fee
Oversight and Advisory Board

SEB/nad
Enclosure(s): Colorado Health Care Affordability Act Annual Report

Cc: Amanda Moorer, Vice President, Medical Services Board
Christy Blakely, Medical Services Board
Patricia Givens, Medical Services Board
Bregitta Hughes, Medical Services Board
Jessica Kuhns, Medical Services Board
Charolette Lippolis, Medical Services Board
Paul Melinkovich, MD, Medical Services Board
An Nguyen, Medical Services Board
David Potts, Medical Services Board
Donna Roberts, RN, BSN, DTR, BA, Medical Services Board
Michael Stahl, Medical Services Board
Judi Carey, Medical Services Board Coordinator
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Colorado Health Care Affordability Act Annual Report

Hospital Provider Fee Oversight and Advisory Board

January 15, 2017

COLORADO
Department of Health Care Policy & Financing

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Appendices

Tables

I. 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 2015 through September 2016, the CHCAA has:

Provided $288 million in increased reimbursement to hospital providers

During the October 2015 through September 2016 time period, hospitals received more than $1.12 billion in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed with hospital provider fees, including $84.8 million in hospital quality incentive payments. This funding increased hospital reimbursement by nearly $288 million 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 and by reducing the number of uninsured Coloradans. From 2009 to 2015, the payment for care provided to Medicaid clients has improved overall from 54% to 75% of costs. In 2015, the amount of bad debt and charity care decreased by more than 58% compared to 2013. This sharp reduction in hospitals' uncompensated care follows the increased reimbursement to hospitals under CHCAA and the reduction in the number of uninsured Coloradans due to the CHCAA and the federal Affordable Care Act (ACA).

Provided health care coverage through Medicaid and the Child Health Plan Plus (CHP+) for more than 480,000 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, 2016, the Department has enrolled approximately 98,000 Medicaid parents, 20,000 CHP+ children and pregnant women, 5,600 adults and children with disabilities, and 356,000 adults without dependent children with no increase in General Fund expenditures.

II. 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 in federal Medicaid matching funds for the following purposes:

- 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.

III. 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 even numbered months, with the exception of December, when the OAB meets on the second Tuesday. 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/hospital-provider-fee-oversight-and-advisory-board.

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.

IV. 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.

Figures in this report are reported on an October 2015 through September 2016 basis unless otherwise noted.

Increase Hospital Reimbursement for Care Provided to Medicaid and CICP Clients

In the October 2015 through September 2016 period, payments to hospitals financed with hospital provider fees totaled more than $1.12 billion, including $84.8 million in quality incentive payments as reflected in the table below. Note: CICP participating hospitals are eligible to receive Disproportionate Share Hospital (DSH) payments while all hospitals are eligible for an uncompensated care payment.

2015-16 Hospital Reimbursement

Inpatient Hospital Reimbursement	$456,819,000
Outpatient Hospital Reimbursement	$265,535,000
Uncompensated Care Payment	$115,480,000
Disproportionate Share Hospital Payment	$198,201,000
Hospital Quality Incentive Payment	$84,777,000
Total Supplemental Hospital Payments	**$1,120,812,000**

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 uninsured patients and quality incentive payments was more than $288 million for the 2015-16 time period.

2015-16 Net Reimbursement Increase to Hospitals

Total Supplemental Hospital Payments	$1,120,812,000
Total Fees	($669,501,000)
Approximate CICP payments pre-CHCAA	($162,876,000)
Net Reimbursement Increase to Hospitals	**$288,435,000**

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, 2016 was as follows:

98,140 Medicaid parents,

20,422 CHP+ children and pregnant women,

5,598 working adults and children with disabilities[2], and

356,125 adults without dependent children.

[2] In last year's report, the caseload for working adults and children with disabilities (Buy-In) was reported as 10,175 in September 2015. The Department identified a data error for July 2015 through December 2015 that incorrectly assigned children to eligibility categories for individuals with disabilities, based on their parents' disability status. This error incorrectly moved clients from Eligible Children and Children's Basic Health Plan (CHP) to Individuals to 59 with Disabilities and Children with Disabilities – Buy-In. Due to the small caseload level for this population, Children with Disabilities – Buy-In was disproportionately affected by this data issue, which was reflected in the September 2015 figure reported last year. Note: the error has been corrected and the Buy-In caseload at the end of FY 2015-16 was 5,265.

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.

The HQIP subcommittee seeks to:

Adopt measures that can be prospectively set to allow time for planning and successful implementation;

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.

Over time, the HQIP subcommittee has recommended some HQIP measures be moved to maintenance measures and recommended the addition of new measures. Maintenance measures are those where hospitals have shown improvement or reached attainment of an established goal. Data for maintenance measures is gathered, but HQIP payments are no longer tied to them. In this way, the HQIP program evolves to incorporate measures where performance improvement is desired.

Table 3 shows historical results for three measures that have been moved to maintenance measures: Central Line Associated Blood Stream Infection (CLABSI), Postoperative Pulmonary Embolism/Deep Vein Thrombosis (PPE/DVT), and Early Elective Deliveries.

HQIP Maintenance Measures

	2012	2013	2014	2015	2016
CLABSI	1.0%	1.0%	0.9%	0.9%	0.9%
PPE/DVT[3]	441	552	478	480	432
Early Elective Deliveries[4]	6.81%	1.52%	2.24%	2.39%	1.67%

Table 3

[3] Number per 100,000 Patients

[4] Patients with elective vaginal deliveries or elective cesarean sections at >=37 and < 39 weeks of gestation completed

HQIP: 2015-16 Measures and Payments

For the year beginning October 1, 2015, the HQIP subcommittee recommended and the OAB approved the base and optional measures for HQIP payments. If a base measure does not apply to a hospital, the hospital may substitute an optional measure. Optional measures must be selected in the order listed. Both base and optional measures are scored out of ten possible points.

Base Measures:

1. Emergency department process measure,
2. Rate of elective deliveries between 37 and 39 weeks gestation,
3. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,
4. Rate of thirty-day all-cause hospital readmissions, and
5. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.

Optional Measures:

1. Culture of safety,
2. Active participation in a Regional Care Collaborative Organization (RCCO),
3. Advance care planning, and
4. Screening for tobacco use.

The HQIP payments earned for each of the 2015-16 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.

Points Eligible

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

Points Earned

Each hospital is scored on five measures (base and optional measures, if applicable). Each measure has a maximum award of 10 points for 50 total possible points.

Payment Calculation

Each hospital's HQIP payment is calculated as:

Quality points awarded multiplied by Medicaid adjusted discharges multiplied by dollars per adjusted discharge point equals each hospital's HQIP payment.

Dollars per-adjusted discharge point are tiered so that hospitals with more quality points awarded receive a greater per-adjusted discharge point reimbursement. The dollars per-adjusted discharge point for the five tiers are shown in the table below:

Tier	Quality Points Awarded	Dollars Per-Adjusted Discharge Point
1	1-10	$ 13.18
2	11-20	$ 14.50
3	21-30	$ 15.82
4	31-40	$ 17.13
5	41-50	$ 18.45

During the 2015-16 timeframe, HQIP payments totaled more than $84.8 million with 77 hospitals receiving payments. HQIP payments, Medicaid adjusted discharges, and quality points awarded by hospital are listed in the following table.

2015-16 Hospital Quality Incentive Payments[5]

Hospital Name	County	Quality Points Awarded	Medicaid Adjusted Discharges	HQIP Payment
Children's Hospital Colorado	Adams	40	12,722	$8,717,125
HealthOne North Suburban Medical Center	Adams	30	6,008	$2,851,249
HealthOne Spalding Rehabilitation Hospital	Adams	9	100	$11,865
Kindred Hospital Aurora	Adams	5	29	$1,895
Platte Valley Medical Center	Adams	37	2,433	$1,542,369
University of Colorado Hospital	Adams	23	11,763	$4,279,912
San Luis Valley Regional Medical Center	Alamosa	32	2,269	$1,243,607
Centura Health - Littleton Adventist Hospital	Arapahoe	30	1,568	$744,097
Craig Hospital	Arapahoe	40	70	$48,070
HealthOne Medical Center of Aurora	Arapahoe	22	5,898	$2,052,907
HealthOne Swedish Medical Center	Arapahoe	20	5,181	$1,502,611
HealthSouth Rehabilitation Hospital - Denver	Arapahoe	10	195	$25,701
Southeast Colorado Hospital	Baca	45	216	$179,638
Boulder Community Hospital	Boulder	26	1,830	$752,892
Centura Health - Avista Adventist Hospital	Boulder	37	2,020	$1,280,204
Good Samaritan Medical Center	Boulder	27	2,344	$1,001,084
Longmont United Hospital	Boulder	34	2,583	$1,504,157
Heart of the Rockies Regional Medical Center	Chaffee	26	725	$298,259

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

Hospital Name	County	Quality Points Awarded	Medicaid Adjusted Discharges	HQIP Payment
Keefe Memorial Hospital	Cheyenne	29	65	$29,725
Conejos County Hospital	Conejos	8	513	$54,095
Delta County Memorial Hospital	Delta	19	795	$219,127
Centura Health - Porter Adventist Hospital	Denver	30	1,666	$790,863
Denver Health Medical Center	Denver	30	12,343	$5,857,931
HealthOne Presbyterian/St. Luke's Medical Center	Denver	30	3,562	$1,690,364
HealthOne Rose Medical Center	Denver	20	3,755	$1,088,843
Saint Joseph Hospital	Denver	22	4,702	$1,636,541
Castle Rock Adventist Hospital	Douglas	25	775	$306,537
Centura Health - Parker Adventist Hospital	Douglas	30	1,692	$803,081
HealthOne Sky Ridge Medical Center	Douglas	27	1,576	$673,305
Vail Valley Medical Center	Eagle	26	589	$242,118
Centura Health - Penrose -St. Francis Health	El Paso	37	7,635	$4,839,262
HealthSouth Rehabilitation Hospital-Colo Springs	El Paso	12	232	$40,366
Memorial Hospital	El Paso	37	13,603	$8,621,775
Centura Health - St. Thomas More Hospital	Fremont	19	1,268	$349,257
Grand River Medical Center	Garfield	21	652	$216,748
Valley View Hospital	Garfield	26	1,531	$629,567
Kremmling Memorial Hospital	Grand	41	298	$225,291
Gunnison Valley Hospital	Gunnison	23	529	$192,552
Spanish Peaks Regional Health Center	Huerfano	38	336	$218,597
Centura Health - Saint Anthony Central Hospital	Jefferson	44	2,603	$2,113,326
Centura Health - Saint Anthony North Hospital	Jefferson	33	3,763	$2,127,071
Lutheran Medical Center	Jefferson	22	6,052	$2,106,206
Kit Carson County Memorial Hospital	Kit Carson	3	361	$14,269
Animas Surgical Hospital	La Plata	46	278	$235,545
Mercy Medical Center	La Plata	37	1,660	$1,051,921
St. Vincent General Hospital District	Lake	8	214	$22,556
Estes Park Medical Center	Larimer	46	336	$285,142
McKee Medical Center	Larimer	19	2,776	$764,742
Medical Center of the Rockies	Larimer	37	2,757	$1,747,252
Poudre Valley Hospital	Larimer	27	5,387	$2,300,816
Mount San Rafael Hospital	Las Animas	16	1,151	$266,958
Lincoln Community Hospital and Nursing Home	Lincoln	10	154	$20,324
Sterling Regional Medical Center	Logan	14	932	$189,112
Community Hospital	Mesa	38	688	$448,125
Family Health West Hospital	Mesa	31	147	$78,132
St. Mary's Hospital and Medical Center	Mesa	38	2,880	$1,874,499
The Memorial Hospital	Moffat	28	549	$243,012
Southwest Memorial Hospital	Montezuma	36	1,076	$663,249

Hospital Name	County	Quality Points Awarded	Medicaid Adjusted Discharges	HQIP Payment
Montrose Memorial Hospital	Montrose	18	1,030	$268,942
Colorado Plains Medical Center	Morgan	37	1,194	$757,062
East Morgan County Hospital	Morgan	44	427	$346,839
Arkansas Valley Regional Medical Center	Otero	37	1,182	$749,034
Haxtun Hospital	Phillips	8	62	$6,493
Melissa Memorial Hospital	Phillips	45	124	$102,606
Aspen Valley Hospital	Pitkin	35	372	$222,764
Prowers Medical Center	Prowers	44	969	$786,415
Centura Health - St. Mary-Corwin Medical Center	Pueblo	19	4,464	$1,229,892
Parkview Medical Center	Pueblo	26	8,233	$3,386,209
Pioneers Hospital	Rio Blanco	11	134	$21,295
Rio Grande Hospital	Rio Grande	19	505	$139,030
Yampa Valley Medical Center	Routt	35	520	$312,019
Sedgwick County Memorial Hospital	Sedgwick	8	150	$15,862
Centura Health - Saint Anthony Summit Hospital	Summit	41	579	$438,141
Pikes Peak Regional Hospital	Teller	34	598	$348,398
North Colorado Medical Center	Weld	19	6,549	$1,804,240
Wray Community District Hospital	Yuma	48	264	$233,570
Yuma District Hospital	Yuma	46	344	$291,881
Total				**$84,776,536**

Table 4

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 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, the hospital provider fee has increased hospital reimbursement an average of more than $200 million per year and increased enrollment in Medicaid and CHP+ to over 480,000 persons as of September 2016.

This section reports the difference between costs and payments for Medicare, Medicaid, and private insurance reported on a calendar year (CY) basis. The information is calculated on a calendar year basis using data from the CHA DATABANK and survey data collected by CHA. Cost and payment data are reported on a per patient basis for four payer groups: Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other. The payment to cost ratio is also reported. To provide an even more comprehensive view, an analysis of bad debt and charity care is also included.

The 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 2010 and years that follow. The 2014 data is the first year of data that includes the expansion of Medicaid under the federal Affordable Care Act (ACA).

From 2009 to 2015, data show that the payment for care provided to Medicaid clients has improved overall from approximately 54% to 75% of costs. The most dramatic change is the reduction of bad debt and charity care, which is care hospitals write-off as uncompensated costs. In 2015, total bad debt and charity care was less than half the amount in 2013. The data also show that the payment for care provided to commercially insured clients rose from 155% in 2009 to 158% of costs in 2015, and the payment for care for all clients overall rose from 105% in 2009 to 108% in 2015.

The full impact of increased hospital reimbursement and health coverage expansions under the CHCAA and the federal ACA on these results is not known at this time. However, the Colorado Health Access Survey (CHAS)[6], published in September 2015, highlights some of the impacts of expanding Medicaid coverage under the ACA. The report indicates that the uninsured rate in Colorado has declined by more than half: from a high of 15.8% in 2011 to 6.7% in 2015, and the number of uninsured persons in Colorado declining by 57%. This means that approximately 476,000 more people are insured now than in 2011. Medicaid enrollment has increased significantly; now covering 19% of Coloradans, compared to 9% of Coloradans in 2009.

[6] http://www.coloradohealthinstitute.org/key-issues/detail/health-coverage-and-the-uninsured/colorado-health-access-survey-1

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

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

The data in Table 5 show that the undercompensation for the Medicaid and CICP/Self Pay/Other payer groups reduced sharply following the implementation of the CHCAA. From 2009 to 2015, the payment below cost for hospital care improved by more than $1,200 per patient for Medicaid patients. For uninsured patients (i.e., CICP/Self Pay/Other), the payment below cost improved by more than $5,800 per patient. Conversely, from 2009 to 2015 the overcompensation for the insurance group has increased by $1,879 per patient and overall figure by $701 per patient.

Payment Less Cost per Patient by Payer Group

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
Medicare	($2,853)	($3,361)	($3,097)	($3,886)	($5,318)	($4,706)	($4,648)
Medicaid	($4,480)	($2,586)	($2,488)	($2,465)	($2,418)	($3,665)	($3,252)
Insurance	$6,820	$6,518	$7,358	$7,746	$7,717	$8,838	$8,699
CICP/Self Pay/ Other	($4,563)	($2,897)	($3,920)	($4,013)	($2,070)	($860)	$1,286[7]
Overall	$542	$701	$918	$903	$747	$1,039	$1,243

Table 5

The data in Table 6 show the relative case mix by payer. Over the seven-year time frame, the patient case mix for Medicare and Insurance are relatively constant, while the case mix figures for Medicaid and CICP/Self Pay/Other increase and decrease, respectively, beginning in CY 2014 when the Medicaid expansion occurred.

Patient Case Mix by Payer Group

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
Medicare	28%	29%	29%	29%	29%	29%	28%
Medicaid	14%	15%	15%	16%	17%	22%	25%
Insurance	40%	39%	39%	39%	39%	37%	37%
CICP/Self Pay/ Other	17%	17%	16%	16%	15%	11%	10%
Total	100%	100%	100%	100%	100%	100%	100%

Table 6

[7] The payment less cost per patient for the CICP/Self Pay/Other payer group may show a positive result in CY 2015 due to hospitals reporting revenue incorrectly as CICP revenue, rather than Medicaid revenue, or because of a decline in the allocation of bad debt and charity care to this payer group. More analysis is needed to understand the change in payment less cost per patient for the CICP/Self Pay/Other payer group.

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 2009, prior to the implementation of the CHCAA, Medicaid reimbursement to Colorado hospitals was approximately 54% of costs, while in 2015, the payment to cost ratio for Medicaid is 75% of costs. Again, a dramatic change is reflected in the uninsured population where the ratio for CICP/Self Pay/Other increased significantly to 111%. The data also show that the payment for care provided to commercially insured clients rose from 155% in 2009 to 158% of costs in 2015, and the payment for care for all clients overall rose from 105% in 2009 to 108% in 2015. Because the overcompensation for the insurance group and all payers overall has increased while the undercompensation for Medicaid and uninsured clients has improved, additional analysis and hospital data may be needed to better understand the financial performance of Colorado hospitals and cost shift drivers.

Payment to Cost Ratio by Payer Group

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
Medicare	0.78	0.76	0.77	0.74	0.66	0.71	0.72
Medicaid	0.54	0.74	0.76	0.79	0.80	0.72	0.75
Insurance	1.55	1.49	1.54	1.54	1.52	1.59	1.58
CICP/Self Pay/ Other	0.52	0.72	0.65	0.67	0.84	0.93	1.11[8]
Overall	1.05	1.06	1.07	1.07	1.05	1.07	1.08

Table 7

[8] See previous footnote.

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 are costs that hospitals typically write-off as uncompensated care. Total bad debt and charity care have decreased dramatically from 2013 to 2014, the year when health coverage expansion under the CHCAA and ACA were fully implemented, and continuing through 2015. As shown below, total bad debt and charity care are more than $1.5 billion lower in 2015 compared to 2013, which is a reduction of 59%.

Bad Debt and Charity Care

	Bad Debt	Charity Care	Total
CY 2009	$843,859,090	$1,450,212,300	$2,294,071,390
CY 2010	$776,483,052	$1,468,955,274	$2,245,438,326
CY 2011	$682,111,289	$1,655,798,414	$2,337,909,703
CY 2012	$743,972,504	$1,678,545,772	$2,422,518,276
CY 2013	$951,605,019	$1,657,809,286	$2,609,414,305
CY 2014	$570,925,681	$679,903,960	$1,250,829,641
CY 2015	$591,859,069	$482,607,359	$1,074,466,428

Table 8

V. 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 2015-16 the Department collected $804 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 2015-16.

SFY 2015-16 Hospital Provider Fee Expenditures (Total Funds)[9]

Supplemental Hospital Payments	$1,394,729,000
Department Administration	$46,375,000
Expansion Populations	$1,886,210,000
25.5-4-402.3 (4)(b)(VII) – Offset revenue loss	$15,700,000
Total Expenditures	**$3,343,014,000**

Table 9

Funding in SFY 2015-16 was appropriated for CHCAA administrative expenses through the normal budget process. For SFY 2015-16, the Department had approximately 68.2 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 1.39% of total CHCAA expenditures were for the Department's administrative expenses of administering the CHCAA, while about 0.17% of total CHCAA expenditures were for the personal services costs of the FTE administering the program.

SFY 2015-16 Administrative Expenditures

(1) Executive Director's Office; (A) General Administration, Personal Services	$5,648,522
(1) Executive Director's Office; (A) General Administration, Legal Services	$29,819
(1) Executive Director's Office; (A) General Administration, Administrative Law Judge Services	$126,686
(1) Executive Director's Office; (A) General Administration: Payments to OIT	$22,720
(1) Executive Director's Office; (A) General Administration: CORE Operations	$328,762
(1) Executive Director's Office; (A) General Administration: Leased Space	$143,503
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$929,706
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, MMIS System	$16,418,967
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$2,275,016

[9] 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 2015-16 Administrative Expenditures

(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards	$58,569
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations	$5,518,416
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration	$9,890,892
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach	$673,240
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Assistance Sites	$368,694
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$685,478
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$283,801
(1) Executive Director's Office; (H) Indirect Cost Recoveries, Indirect Cost Assessment	$303,426
Total Executive Director's Office Expenditures	**$43,706,217**
(4) Indigent Care Program; Children's Basic Health Plan Administration	$78,008
(7) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology, Colorado Benefits Management System, HCPF Only	$2,591,166
Total	**$46,375,391**

Table 10

VI. 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 financed with provider fees are made for services provided to Medicaid and CICP patients through 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, uncompensated care and DSH payments, and quality incentive payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to incentivize quality care.

Fees are collected and payments are made on a monthly basis, and nearly all hospitals have authorized electronic fee and payment processing. The 2015-16 fee and payment amounts by type are outlined in the following table. See Appendix A for more information about fee and payment methodologies.

2015-16 Hospital Provider Fees and Payments

Inpatient Fee	$387,113,000
Outpatient fee	$282,388,000
Total Hospital Provider Fees	**$669,501,000**
Inpatient Hospital Reimbursement	$456,819,000
Outpatient Hospital Reimbursement	$265,535,000
Uncompensated Care Payment	$115,480,000
Disproportionate Share Hospital Payment	$198,201,000
Hospital Quality Incentive Payment	$84,777,000
Total Supplemental Hospital Payments	**$1,120,812,000**

Table 11

APPENDIX A: 2015-16 Hospital Provider Fee Overview

This overview describes the fee assessment and payment methodologies for October 2015 through September 2016 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 $669,501,000. Inpatient fees comprised 58% 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 or 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 30,000 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

Inpatient Hospital Payment

For qualified hospitals, this payment equals Medicaid estimated discharges, multiplied by average Medicaid case mix, multiplied by the Medicaid base rate, multiplied by 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 are not qualified for this payment.

Outpatient Hospital 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 are not qualified for this payment.

Uncompensated Care Payment

The Uncompensated Care Payment for qualified hospitals with 25 or fewer beds equals the hospital's percent of beds compared to total beds for all qualified hospitals with 25 or fewer beds multiplied by $23,500,000. The Uncompensated Care Payment for qualified hospitals with greater than 25 beds is the hospitals' percent of uninsured costs compared to total uninsured costs for all qualified hospitals with greater than 25 beds multiplied by $91,980,170.

Psychiatric hospitals, LTC hospitals, and rehabilitation hospitals do not qualify for this payment.

Disproportionate Share Hospital Payment

The DSH payment in total equals $198,201,052. To qualify for the DSH Payment a Colorado hospital shall meet either of the following criteria:

- Is a Colorado Indigent Care Program (CICP) provider, and has at least two obstetricians or is obstetrician exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act; or
- Has a Medicaid Inpatient Utilization Rate equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and has at least two obstetricians or is obstetrician exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act.

No hospital receives a DSH Payment greater than its estimated DSH limit. Each qualified hospital's DSH payment is computed as follows:

The DSH Supplemental Payment equals 100% of the hospital-specific estimated DSH limit for qualified hospitals with CICP write-off cost more than 750% of the average hospital CICP write-off cost and 96% of the hospital-specific estimated DSH limit for other qualified hospitals with CICP write-off cost less than 750% but more than 200% of the average CICP write-off cost. The DSH Supplemental Payment for all remaining qualified hospitals equals each hospital's

Uninsured Costs as a percentage of total Uninsured Cost for all remaining qualified hospitals, multiplied by the remaining DSH Allotment in Total.

Any qualified hospital with CICP write-off cost less than 200% of the average CICP write-off cost with a DSH supplemental payment greater than or equal to 96% of their estimated DSH limit will have their DSH supplemental payment reduced to 96% of their estimated DSH limit. The reduction will be redistributed to other qualified hospitals with CICP write-off cost less than 200% of the average CICP write-off cost not exceeding 96% of their estimated DSH limit based on their percentage of uninsured cost to total uninsured cost for all qualified hospitals with CICP write-off cost less than 200% of the average CICP write-off cost not exceeding 96% of their estimated DSH limit.

Psychiatric hospitals, LTC hospitals, and rehabilitation hospitals do not qualify for this payment.

APPENDIX B: October 2015 - September 2016 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
Kindred Hospital Aurora	Adams	$0	$17,907	$0	$17,907
HealthOne Spalding Rehabilitation Hospital	Adams	$0	$127,411	$0	$127,411
Vibra Long Term Acute Care Hospital	Adams	$0	$50,296	$0	$50,296
Craig Hospital	Arapahoe	$0	$476,786	$0	$476,786
HealthSouth Rehabilitation Hospital - Denver	Arapahoe	$0	$154,608	$0	$154,608
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0
Colorado Mental Health Institute-Ft Logan	Denver	$0	$0	$0	$0
Eating Recovery Center	Denver	$0	$0	$0	$0
Kindred Hospital	Denver	$0	$17,278	$0	$17,278
Colorado Acute Long Term Hospital	Denver	$0	$52,389	$0	$52,389
Select Specialty Hospital - Denver	Denver	$0	$73,507	$0	$73,507
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
Peak View Behavioral Health	El Paso	$0	$0	$0	$0
HealthSouth Rehabilitation Hospital-Colorado Springs	El Paso	$0	$217,313	$0	$217,313
Select Long Term Care Hospital	El Paso	$0	$2,932	$0	$2,932
Northern Colorado Long Term Acute Care Hospital	Larimer	$0	$1,035	$0	$1,035
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 Rehabilitation Hospital	Weld	$0	$91,053	$0	$91,053
Total		**$0**	**$1,282,515**	**$0**	**$1,282,515**

Fee-Paying Hospitals – General, Acute Care Hospitals

Hospital Name	County	Fees	Payments	Appx CICP Payments pre-CHCAA	Net Reimbursement Increase
Children's Hospital Colorado	Adams	$21,197,990	$52,063,388	$2,854,794	$28,010,604
HealthOne North Suburban Medical Center	Adams	$13,434,780	$16,789,646	$0	$3,354,866
Platte Valley Medical Center	Adams	$4,654,520	$8,962,385	$1,499,298	$2,808,567
University of Colorado Hospital	Adams	$43,763,183	$70,087,234	$36,264,181	-$9,940,130
San Luis Valley Regional Medical Center	Alamosa	$2,830,695	$10,939,409	$962,324	$7,146,390
Centura Health - Littleton Adventist Hospital	Arapahoe	$15,963,149	$18,280,738	$0	$2,317,589
HealthOne Medical Center of Aurora	Arapahoe	$34,194,917	$20,899,051	$0	-$13,295,866
HealthOne Swedish Medical Center	Arapahoe	$34,109,123	$44,329,948	$0	$10,220,825
Pagosa Mountain Hospital	Archuleta	$333,802	$1,435,221	$0	$1,101,419
Southeast Colorado Hospital	Baca	$180,694	$1,439,622	$34,179	$1,224,749
Boulder Community Hospital	Boulder	$17,138,675	$17,154,628	$1,063,630	-$1,047,677
Centura Health - Avista Adventist Hospital	Boulder	$6,215,014	$13,845,257	$0	$7,630,243
Good Samaritan Medical Center	Boulder	$13,509,270	$8,003,308	$0	-$5,505,962
Longmont United Hospital	Boulder	$10,674,535	$18,415,077	$1,633,746	$6,106,796
Heart of the Rockies Regional Medical Center	Chaffee	$1,167,467	$4,011,450	$247,500	$2,596,483
Keefe Memorial Hospital	Cheyenne	$71,740	$1,044,165	$0	$972,425
Conejos County Hospital	Conejos	$171,461	$2,037,857	$99,884	$1,766,512
Delta County Memorial Hospital	Delta	$2,957,094	$4,692,114	$912,623	$822,397
Centura Health - Porter Adventist Hospital	Denver	$17,780,723	$10,780,867	$0	-$6,999,856
Denver Health Medical Center	Denver	$22,885,153	$119,172,683	$64,455,024	$31,832,506
HealthOne Presbyterian/St. Luke's Medical Center	Denver	$25,184,056	$49,095,481	$0	$23,911,425
HealthOne Rose Medical Center	Denver	$20,328,555	$27,805,388	$0	$7,476,833
National Jewish Health	Denver	$2,228,218	$8,734,964	$1,682,780	$4,823,966
Saint Joseph Hospital	Denver	$23,545,657	$46,344,842	$0	$22,799,185
Castle Rock Adventist Hospital	Douglas	$4,549,041	$4,720,913	$0	$171,872
Centura Health - Parker Adventist Hospital	Douglas	$11,075,820	$7,173,622	$0	-$3,902,198
HealthOne Sky Ridge Medical Center	Douglas	$17,764,452	$5,700,963	$0	-$12,063,489

Hospital Name	County	Fees	Payments	Appx CICP Payments pre-CHCAA	Net Reimbursement Increase
Vail Valley Medical Center	Eagle	$3,451,166	$6,913,137	$0	$3,461,971
Centura Health - Penrose -St. Francis Health Services	El Paso	$32,826,577	$39,161,244	$2,195,836	$4,138,831
Memorial Hospital	El Paso	$33,803,398	$65,672,365	$16,142,511	$15,726,456
Centura Health - St. Thomas More Hospital	Fremont	$1,865,045	$9,341,615	$779,972	$6,696,598
Grand River Medical Center	Garfield	$840,618	$4,382,169	$190,609	$3,350,942
Valley View Hospital	Garfield	$4,838,321	$17,540,848	$444,750	$12,257,777
Kremmling Memorial Hospital	Grand	$328,828	$2,053,810	$117,393	$1,607,589
Gunnison Valley Hospital	Gunnison	$615,730	$2,427,683	$42,048	$1,769,905
Spanish Peaks Regional Health Center	Huerfano	$314,968	$2,113,262	$135,879	$1,662,415
Centura Health - Ortho Colorado	Jefferson	$1,196,768	$0	$0	-$1,196,768
Centura Health - Saint Anthony Central Hospital	Jefferson	$20,784,253	$19,709,244	$0	-$1,075,009
Centura Health - Saint Anthony North Hospital	Jefferson	$10,168,970	$15,092,234	$0	$4,923,264
Lutheran Medical Center	Jefferson	$28,027,537	$22,383,833	$0	-$5,643,704
Weisbrod Memorial County Hospital	Kiowa	$39,958	$962,779	$0	$922,821
Kit Carson County Memorial Hospital	Kit Carson	$316,177	$1,979,910	$0	$1,663,733
Animas Surgical Hospital	La Plata	$677,782	$1,727,785	$0	$1,050,003
Mercy Medical Center	La Plata	$6,105,346	$13,335,389	$534,968	$6,695,075
St. Vincent General Hospital District	Lake	$176,523	$1,578,961	$118,153	$1,284,285
Banner Health Fort Collins	Larimer	$2,379,269	$5,887,842	$0	$3,508,573
Estes Park Medical Center	Larimer	$717,211	$1,639,758	$435,234	$487,313
McKee Medical Center	Larimer	$6,530,951	$13,674,667	$2,131,572	$5,012,144
Medical Center of the Rockies	Larimer	$13,966,594	$21,086,935	$1,584,786	$5,535,555
Poudre Valley Hospital	Larimer	$22,067,829	$34,727,901	$5,935,254	$6,724,818
Mount San Rafael Hospital	Las Animas	$848,929	$3,754,213	$134,622	$2,770,662
Lincoln Community Hospital and Nursing Home	Lincoln	$203,341	$962,097	$0	$758,756
Sterling Regional Medical Center	Logan	$1,307,392	$5,280,854	$794,952	$3,178,510
Community Hospital	Mesa	$3,209,256	$4,069,819	$170,542	$690,021
Family Health West Hospital	Mesa	$500,024	$1,867,123	$0	$1,367,099

Hospital Name	County	Fees	Payments	Appx CICP Payments pre-CHCAA	Net Reimbursement Increase
St. Mary's Hospital and Medical Center	Mesa	$21,327,587	$31,297,846	$1,747,192	$8,223,067
The Memorial Hospital	Moffat	$743,460	$4,211,368	$167,785	$3,300,123
Southwest Memorial Hospital	Montezuma	$1,223,019	$6,500,518	$383,352	$4,894,147
Montrose Memorial Hospital	Montrose	$4,413,931	$7,917,501	$1,054,452	$2,449,118
Colorado Plains Medical Center	Morgan	$3,128,894	$6,863,218	$162,836	$3,571,488
East Morgan County Hospital	Morgan	$552,476	$2,784,148	$175,025	$2,056,647
Arkansas Valley Regional Medical Center	Otero	$2,310,068	$6,542,856	$1,374,965	$2,857,823
Haxtun Hospital	Phillips	$72,414	$1,153,103	$0	$1,080,689
Melissa Memorial Hospital	Phillips	$171,698	$978,237	$40,279	$766,260
Aspen Valley Hospital	Pitkin	$1,078,688	$3,623,895	$490,839	$2,054,368
Prowers Medical Center	Prowers	$647,624	$5,122,519	$407,322	$4,067,573
Centura Health - St. Mary-Corwin Medical Center	Pueblo	$12,795,386	$26,574,881	$2,978,448	$10,801,047
Parkview Medical Center	Pueblo	$29,737,107	$49,707,923	$3,603,807	$16,367,009
Pioneers Hospital	Rio Blanco	$155,912	$754,797	$0	$598,885
Rangely District Hospital	Rio Blanco	$85,504	$1,229,625	$0	$1,144,121
Rio Grande Hospital	Rio Grande	$344,783	$1,735,386	$51,020	$1,339,583
Yampa Valley Medical Center	Routt	$1,969,313	$6,077,957	$168,950	$3,939,694
Sedgwick County Memorial Hospital	Sedgwick	$160,428	$964,276	$27,239	$776,609
Centura Health - Saint Anthony Summit Hospital	Summit	$1,758,659	$3,897,274	$0	$2,138,615
Pikes Peak Regional Hospital	Teller	$574,528	$2,242,704	$55,614	$1,612,562
North Colorado Medical Center	Weld	$19,546,573	$31,978,212	$6,182,516	$6,249,123
Wray Community District Hospital	Yuma	$279,244	$2,030,429	$107,405	$1,643,780
Yuma District Hospital	Yuma	$405,818	$2,052,182	$98,017	$1,548,347
Total		**$669,501,659**	**$1,119,528,553**	**$162,876,107**	**$287,150,787**
Total All Hospitals[10]		**$669,501,659**	**$1,120,811,068**	**$162,876,107**	**$288,433,302**

[10]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, 2017:

Kathryn Ashenfelter of Denver, representing a hospital
Dr. Jeremiah Bartley of Brighton, representing the health care industry
Ann King White of Denver, representing a statewide hospital organization
David Livingston of Denver, representing a business, to serve as Chair
Shepard Nevel of Denver, representing a consumer of health care
Dan Rieber of Castle Rock, representing a safety-net hospital
Christopher Underwood of Evergreen, representing the Department

For terms expiring May 15, 2019:

Kimberly Monjesky of Woodland Park, representing a rural hospital
William Heller of Denver, representing the Department
Thomas Rennell of Castle Rock, representing a health insurance organization
Peg Burnette of Denver, representing a hospital

For terms expiring May 15, 2020:

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

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.