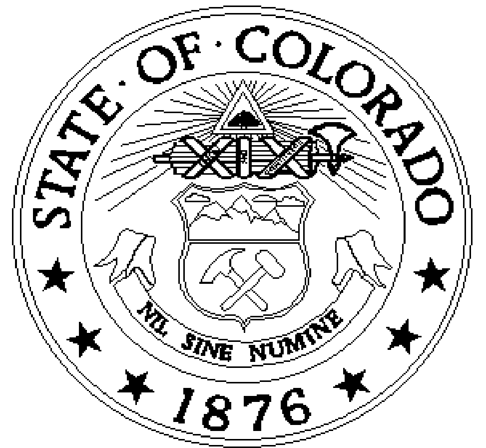

COLORADO

MEDICALLY INDIGENT AND COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2002-03 ANNUAL REPORT

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Karen Reinertson, Executive Director

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Owens
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February 1, 2004

The Honorable Steve Johnson, Chairman
Senate Health, Environment, Welfare and Institutions Committee
State Capitol
200 E. Colfax Avenue, Room 346
Denver, CO 80203

Dear Senator Johnson:

Enclosed please find the *Medically Indigent and Colorado Indigent Care Program FY 2002-03 Annual Report*. The Department of Health Care Policy and Financing prepared this annual report pursuant to Section 26-15-105, C.R.S. (2003). This annual report provides background information, statistics, patterns and an overview of medically indigent financing and utilization features.

Major outcomes identified and discussed in this report include:

- Total reimbursement to health care providers of indigent care exceeded \$120,678,000 in FY 2002-03. State General Fund accounted for 13.5%, or \$15,604,000, of this reimbursement. Over recent years, the State General Fund portion of this reimbursement has continued to decrease while the total reimbursement has increased.
- The number of individuals who received care under the Colorado Indigent Care Program grew by 3.2% to 160,989. Children represented 8.0% of the total population served, which was a 21.1% decline from the previous fiscal year.
- The average provider reimbursement on costs for providing care to the indigent population to under the Colorado Indigent Care Program was 16.46% for Outstate Disproportionate Share Hospitals and 26.93% for Outstate clinics.

Questions regarding the *Medically Indigent and Colorado Indigent Care Program FY 2002-03 Annual Report* can be addressed to Christopher Underwood, Manager, Safety Net Financing Section, by e-mail at chris.underwood@state.co.us or by phone at 303-866-5177.

Sincerely,

Karen Reinertson
Executive Director

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Governor

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February 1, 2004

The Honorable Lauri Clapp, Chairman
House Health, Environment, Welfare and Institutions Committee
State Capitol
200 E. Colfax Avenue, Room 271
Denver, CO 80203

Dear Representative Clapp:

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Sincerely,

Karen Reinertson
Executive Director

Department of Health Care Policy and Financing
Operations and Finance Office
Safety Net Financing Section

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EXECUTIVE SUMMARY

The Department of Health Care Policy and Financing (the Department) prepared this annual report concerning the medically indigent program, and related payments, to fulfill the statutory requirement found under 26-15-105, C.R.S. (2003). Total payments made to providers of indigent care exceeded $120,678,000 in FY 2002-03 and were distributed as follows:

❑ Bad Debt Payments	$4,075,312
❑ Component 1A Payments	$60,626,814
❑ Comprehensive Primary and Preventive Care Grants	$4,965,304
❑ Major Teaching Payments	$21,753,694
❑ Outstate Clinic Payments	$6,119,760
❑ Outstate Disproportionate Share Hospital Payments	$18,366,312
❑ Pre-component 1 Payments	$4,771,714

State General Fund was used for approximately 13.5% of these payments, while 4.1% was from the Tobacco Settlement Trust and the remainder was federal funds. In recent years, the General Fund portion of these payments has continued to decrease while the payments have increased overall. This is possible by using certification of public expenditures for provider costs related to Medicaid eligible and low-income individuals, which receives a federal match. The federal match rate Colorado receives on Medicaid and medically indigent hospital payments to providers stood at 50.0% in FY 2002-03.

The primary focus of this report is the Colorado Indigent Care Program (CICP), established in 1983 by the "Reform Act for the Provision of Health Care for the Medically Indigent." The number of individuals served under the CICP increased by 3.2% to 160,989 in FY 2002-03. Children, age 0-18, represented 8.0% of the population served, which was 21.1% lower than the previous fiscal year. The number of children served by the program continues to decline as enrollment in the Children's Basic Health Plan increases. The number of inpatient admissions grew by 9.5% for all participating providers, while the Outstate Disproportionate Share Hospitals increased admissions by 23.5%. In addition, Outstate Disproportionate Share Hospitals had an increase in outpatient visits of 12.0% and Outstate clinics showed an increase in visits of 5.8%. Of the $110,941,893 distributed as reimbursement under the CICP, 11.9% of the total funds consisted of General Fund, while the remaining portion was federal funds.

In FY 2002-03, Comprehensive Primary and Preventive Care (CPPC) Grant Program contracts were awarded to 14 different health care providers for a total of 18 different projects which provided medical and/or dental services to a large part of the state. Although this program is not part of the Colorado Indigent Care Program, it is closely related, as the purpose of the program is to provide grants to health care providers to expand primary and preventive health care services to Colorado's low-income residents and a majority of the grantees participate in the Colorado Indigent Care Program. CPPC Grants expanded services in Boulder, Glenwood Springs, Grand Junction, Greeley, Lafayette, Longmont, Norwood, Pueblo and the Denver metro area. Final reports from the grantees showed that almost all grantees exceeded their original goals.

DEFINITIONS

I. GENERAL

Certification of Public Expenditure – An uncompensated cost by a public (State or local government) entity incurred in association with providing a qualified medical service to an eligible Medicaid or indigent client.

Disproportionate Share Hospitals (DSH) – DSH payments are made to hospitals that have a high number of Medicaid and indigent care clients compared to other hospitals in the state. The payments help defray the cost of treating uninsured and low-income patients. DSH payments assist in securing the hospitals' financial viability, preserving access to care for the Medicaid and low-income clients, while reducing cost shifting onto private payers. There are two distinct DSH provider groups described throughout this report:

1. **Medicaid Disproportionate Share Hospitals** – Federal regulations allow that hospitals that provide services to a disproportionate share of Medicaid recipients receive an additional payment amount. The minimum criterion is having a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals receiving Medicaid payments in the state, or a low-income utilization rate that exceeds 25%. Because of the high volume of Medicaid and low-income recipients, these providers typically receive a higher reimbursement than Outstate Disproportionate Share Hospitals under the Colorado Indigent Care Program.
2. **Outstate Disproportionate Share Hospitals** – The disproportionate share payment to these providers is based on Medicaid inpatient days utilizing a minimum of one percent of the hospital services. In addition, hospitals must participate in the Colorado Indigent Care Program to receive this reimbursement adjustment.

Federal Match Rate or Federal Financial Participation (FFP) – The federal match rate is the portion of the total Medicaid or Disproportionate Share Hospital payments that consist of federal funds. For example, if the federal match rate is 50%, then for every qualified payment of $100, $50 is federal funds while the remaining $50 is State General Fund or other public dollars from the local level.

Indigent Client – A person who meets the guidelines outlined in the Colorado Indigent Care Program Client Eligibility Manual, which stipulates that the individual must have income and assets combined at or below 185% of the Federal Poverty Level (FPL). For the Comprehensive Primary and Preventive Care Grant Program, the individual must have income and assets combined at or below 200% of the Federal Poverty Level (FPL).

Legal Immigrant – An individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the Immigration and Naturalization Service as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by the Immigration and Naturalization Service pursuant to Section 26-4-103 (8.5), C. R. S.

Major Teaching Hospital – A Colorado hospital qualifies as a Major Teaching Hospital when its Medicaid days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30% of its total patient days for the prior state fiscal year, or the most recent year for which data are available. In addition, a Major Teaching Hospital must fulfill the following criteria:

1. Maintains a minimum of 110 total Intern and Resident Full Time Equivalents (FTEs).
2. Maintains a minimum ratio of .30 Intern and Resident FTEs per licensed bed.
3. Meets the Department's eligibility requirement for Medicaid Disproportionate Share Hospital payment.

Medicare Upper Payment Limit – The Medicare Upper Payment Limit is the maximum amount Medicaid can reimburse a provider and still receive the federal match rate (federal financial participation). The Medicare Upper Payment Limit is relevant to three distinct provider payments: Inpatient Hospital, Outpatient Hospital and Nursing Home payments. The three unique Medicare Upper Payment Limits are calculated by the Department such that each must be a reasonable estimate of the amount Medicare would reimburse providers for providing Medicaid services.

Residency – The residence of a person is the principal or primary home or place of abode of a person. A principal or primary home or place of abode is that home or place in which a person's habitation is fixed and to which they, whenever absent, have the present intention of returning after a departure or absence there from, regardless of the duration of such absence, pursuant to Section 1-2-102, C.R.S.

Third Party Coverage – Any payment for health services including, but not limited to, private health insurance, medical payments under any other private insurance plan, Workers' Compensation, Medicare, CHAMPUS, The Health Care Program for Children with Special Needs, and other insurance coverage responsible for payment of medical expenses incurred by individuals. Responsibility for payment may be established by contract, by statute, or by legal liability. Third party payment does not include: 1) payment from voluntary sources or 2) payment under the Colorado Crime Victim Compensation Act, Section 24-4.1-100.1, C.R.S.

II. COLORADO INDIGENT CARE PROGRAM (CICP) SPECIFIC

CICP Income and Asset Test – The income and equity in assets, combined, must be at or below 185% of the Federal Poverty Level (FPL) for client eligibility in the program.

Covered Services – All medically necessary services that a provider customarily furnishes to and can lawfully offer to patients. These covered services include medical services furnished by participating physicians. The responsible physician must deem the covered services are medically necessary. The CICP does not reimburse providers for outpatient mental health benefits as a primary diagnosis, but does cover limited inpatient mental health services for a period of 30 days within a calendar year, per client.

Denver Health Medical Center (Denver Indigent Care Program) – Under the CICP, Denver Health serves primarily eligible patients who reside in the city and county of Denver. These facilities include Denver Health and eleven neighborhood health clinics, all in Denver.

Emergency Care – Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 26-15-103, C.R.S.

General Provider – Any general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1-107 (1) (l) (I) or (1) (l) (II), C.R.S.; any health maintenance organization issued a certificate of authority pursuant to Section 10-16-402, C.R.S.; and the Health Sciences Center.

Health Sciences Center – The schools of medicine, dentistry, nursing, and pharmacy established by the regents of the University of Colorado under Section 5 of Article VIII of the Colorado Constitution, Section 26-15-103, C.R.S.

Indigent Client – A person who meets the guidelines outlined in the Colorado Indigent Care Program Client Eligibility Manual, which stipulates that the individual must have income and assets combined at or below 185% of the Federal Poverty Level (FPL).

Legal Immigrant – An individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the Immigration and Naturalization Service as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by the Immigration and Naturalization Service pursuant to Section 26-4-103 (8.5), C. R. S. As a condition of eligibility for services under the Colorado Indigent Care Program, a legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the Immigration and Naturalization Service during the interim of such legal immigrant's receipt of services under this article. Nothing in this section shall be construed to affect a legal immigrant's eligibility for services under this article based upon such legal immigrant's responsibilities under an affidavit of support entered into before July 1, 1997 pursuant to Section 26-15-104.3, C. R. S.

Non-Emergency Care – Treatment for any conditions not included in the emergency care definition and any additional medical care for those conditions the Department determines to be the most serious threat to the health of medically indigent persons.

Outstate Indigent Care Program – General providers in the Outstate Program are located throughout the state and must be located outside the City and County of Denver.

Specialty Care Program – Specialty providers must either offer unique services or serve a unique population. Additionally, at least 50% of the care rendered through the CICP must be provided to individuals who reside outside the City and County of Denver.

Subsequent Insurance Payments – If patients receive coverage under the CICP, and their insurance subsequently pays for services, or if the patient is awarded a settlement, the CICP is due reimbursement for amounts paid by the CICP to the provider for services rendered to the patient. The provider is then responsible to reimburse the CICP for payments it received for care reimbursed under the CICP.

University Hospital – Under the CICP, University Hospital serves primarily the residents of the Denver metropolitan area who are not residents of the City and County of Denver. University Hospital also serves as a referral center to provide such complex care that is not available or not contracted for in Denver and the remaining areas of the state.

MEDICAID DISPROPORTIONATE SHARE HOSPITALS

I. INTRODUCTION

FEDERAL LAW AND REGULATIONS

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

However, as states exercised this flexibility to finance the state share of Medicaid, the federal government became alarmed at the corresponding impact on the federal budget. Regulations were put into effect to limit states' discretion in using provider taxes and contributions for this purpose. In addition, these regulations placed caps on the amount of Disproportionate Share Hospital payments states can make. Since January 1991, the Colorado Medicaid Program has developed and implemented several measures, using Disproportionate Share Hospital payments, to finance Medicaid program expansions and to cover the escalating costs of ongoing Medicaid programs and costs associated with the Colorado Indigent Care Program.

FEDERAL MATCH RATES

Any payments for medical services covered under the Colorado Medicaid Program, including Disproportionate Share Hospital payments, are subject to federal match rates or Federal Financial Participation (FFP). The federal match rate is the portion of the total payments that consists of federal funds. For example, if the federal match rate is 50%, then for every qualified payment of $100, $50 is federal funds while the remaining $50 is State General Fund or other public dollars from the local level. The federal match rate is based on the state median income level relative to the national average.

The highest federal match rate any state can receive is 78.00%, while the lowest is 50.00%. Colorado's federal match rate was 51.76% in FY 1989-90, and then the match peaked at 54.59% in FY 1991-92 and then fell to 50.00% in FY 2000-01. In Federal Fiscal Year 2002-03, the federal match rate was held level as it was for ten other states also receiving the lowest federal match rate, while Mississippi had the highest federal match rate at 77.05%. Chart 1 lists the federal match rates for Colorado since 1989-90.

On May 28, 2003, President Bush enacted legislation (P.L. 108-27, subsection 401(a)), through the Jobs and Growth Tax Relief Reconciliation Act, which temporarily increased the State's federal match rate. This increase is for the State's medical assistance expenditures under the Medicaid program. The legislation allows an additional 2.95% federal match rate to be distributed to the State for the last two quarters of Federal Fiscal Year 2003 and the first three

quarters of Federal Fiscal Year 2004. This amount is not show on Chart 1, since these additional federal funds were specified to augment the State's General Fund and not directed to increase provider payments.

Chart 1 - Federal Match Rates

Federal Fiscal Year (October – September)	Match Rate	State Fiscal Year (July – June)	Calculated Match Rate for State Fiscal Year*
1989-90	52.11%	1989-90	51.76%
1990-91	53.59%	1990-91	53.34%
1991-92	54.79%	1991-92	54.59%
1992-93	54.42%	1992-93	54.48%
1993-94	54.30%	1993-94	54.32%
1994-95	53.10%	1994-95	53.30%
1995-96	52.44%	1995-96	52.55%
1996-97	52.32%	1996-97	52.34%
1997-98	51.97%	1997-98	52.03%
1998-99	50.59%	1998-99	50.82%
1999-00	50.00%	1999-00	50.10%
2000-01	50.00%	2000-01	50.00%
2001-02	50.00%	2001-02	50.00%
2002-03	50.00%	2002-03	50.00%

*Colorado weighted-average Medicaid fee-for-service federal match rates.

FEDERAL DISPROPORTIONATE SHARE PAYMENT ALLOTMENT

The federal Balanced Budget Act of 1997 (BBA97) established declining limits on the amount of federal funds available to states for Disproportionate Share Hospital (DSH) payments. These limits were established as allotments (or caps) for each state starting in Federal Fiscal Year 1997-98 based on their previous levels of payments. Under BBA97 the allotment for Colorado in Federal Fiscal Year 2000-01 was to be $74 million. However, federal legislation was enacted in December 2000 that provided temporary relief from the BBA97 allotments by maintaining the Federal Fiscal Year 1999-00 allotment of $79 million for Federal Fiscal Years 2000-01 and 2001-02, plus increases tied to the Consumer Price Index for All Urban Consumers (CPI-U) for those years.

For Federal Fiscal Year 2002-03, the Disproportionate Share Hospital Allotment reverted to the Balanced Budget Act of 1997 allotment of $74 million plus an inflationary increase for Colorado. Using an inflationary increase (based on the CPI-U) of 1.5%, the Federal Fiscal Year 2002-03 allotment for Colorado was $75,110,000. Due to the $8,780,890 decrease in the Disproportionate Share Hospital Allotment, Disproportionate Share Hospital provider payments in FY 2002-03 were substantially lower than the previous state fiscal year.

The anticipated allotment for Colorado in Federal Fiscal Year 2003-04 is $87,127,600, based on provisions in the recently passed Medicare Prescription Drug, Improvement and Modernization Act of 2003. It is possible that additional federal legislation could be implemented to change the Federal Fiscal Year 2003-04 allotment.

For Colorado the federal fund allotments were as follows:

Chart 2 - Colorado DSH Allotments

Federal Fiscal Year	Disproportionate Share Hospital Allotments (Federal Funds)
1997-98	$93,000,000
1998-99	$85,000,000
1999-00	$79,000,000
2000-01	$81,765,000
2001-02	$83,890,890
2002-03	$75,110,000

All of the federal shares of the following payment methodologies are covered under the Disproportionate Share Hospital Allotment:

- Pre-Component 1 Payments
- Component 1A Payments
- Bad Debt Payments
- Payments to Outstate Disproportionate Share Hospitals

II. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

PRE-COMPONENT 1 PAYMENTS

To fulfill the federal requirement that states make enhanced payments for those "safety net" hospitals that provide services to a disproportionate share of Medicaid and low-income patients, Colorado made Disproportionate Share Hospital payments called Pre-component 1 payments. These payments are made to any Colorado Medicaid hospital that meets the following criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or a low income utilization rate that exceeds 25%; and
2. Have at least two obstetricians with staff privileges at the hospital that agree to provide obstetric services to individuals entitled to such services under the State Plan.

Federal Medicaid regulations require that states provide additional compensation to hospitals meeting these minimum criteria. The requirements on the amount of payments a state can make are not specified by the federal regulations. These payments are funded with General Fund and federal funds, subject to the federal match rates.

Chart 3 – Pre-Component 1 Qualifying Providers and Payments

Provider	State Fiscal Year 1999-00 Payment	State Fiscal Year 2000-01 Payment	State Fiscal Year 2001-02 Payment	State Fiscal Year 2002-03 Payment
Cleo Wallace Center	$21,286	$33,636	$13,138	$12,057
Colorado Psychiatric Hospital	$2,037	$1,114	$2,397	$126,302
Conejos County Hospital	$211	-	-	-
Denver Health	$1,715,580	$1,641,097	$1,442,625	$1,122,636
Mediplex Rehabiliation (Sunrise)	-	-	$199,608	$29,061
National Jewish Medical and Research Center	$4,066	$2,844	$3,825	$3,420
Platte Valley Medical Center	$57,405	$96,131	$68,724	$61,633
Presbyterian/St.Luke's Medical Center	-	-	-	$1,435,315
Prowers Medical Center	-	-	-	$100,047
SCCI Hospital	-	-	-	$75,251
San Luis Valley Regional Medical Center	$46,609	$58,070	$52,431	$15,598
St. Vincent General Hospital	-	$17,462	$12,927	$5,427
The Children's Hospital	$1,614,576	$1,730,482	$1,825,766	$625,927
The Springs Center for Women	$189,024	$289,202	$121,849	-
University Hospital	$690,200	$730,735	$943,684	$1,082,512
Valley View Hospital	$55,876	$76,929	$84,740	$76,528
Vencor	$132,897	$40,061	-	-
Total	**$4,529,767**	**$4,717,763**	**$4,771,714**	**$4,771,714**

Historically, Pre-Component 1 has been reimbursed as a percentage add-on to the hospital's inpatient base rate. In FY 2001-02, the state share of these payments was allocated to providers as of February 22, 2002, and the adjustment was suspended until June 30, 2002. An amount of

Pre-Component 1 funds totaling $452,640 accrued by the Department in FY 2001-02 was paid to the providers on February 28, 2003. Chart 3 lists the providers who have qualified for Pre-Component 1 payment and the amount each received.

Effective July 1, 2002, for FY 2002-03, the payment for this program resumed and was distributed to facilities under a new prospective payment system, which excludes medically indigent days and is adjusted for each facility's Colorado Medicaid fee-for-service case mix. Based on this calculation, amounts are allocated based on the dollars appropriated by the General Assembly. There was no change in the previous level of General Fund or federal funds associated with this new prospective payment system.

COMPONENT 1A PAYMENTS

Component 1A payments can be made to any Colorado Medicaid hospital that meets the following criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or a low income utilization rate that exceeds 25%;
2. Have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan; and
3. Participate in the Colorado Indigent Care Program (CICP).

These payments are based on uncompensated CICP write-off costs. Payments to Denver Health and University Hospital consist entirely of federal funds, by using the certification of public expenditures for the costs of care provided to CICP clients. Payments to the other qualifying providers are financed with General Fund and federal funds. Due to the $8,780,890 decrease in the Disproportionate Share Hospital Allotment, Disproportionate Share Hospital provider payments in FY 2002-03 were substantially lower than the previous state fiscal year. Chart 4 demonstrates that Component 1A Payments stood at to $60,626,814 in FY 2002-03 after reaching $73,659,121 in the previous fiscal year.

Chart 4 - Component 1A Payments

Provider	State Fiscal Year 1999-00 Payment	State Fiscal Year 2000-01 Payment	State Fiscal Year 2001-02 Payment	State Fiscal Year 2002-03 Payment
Platte Valley Medical Center	$689,074	$1,054,289	$834,933	$932,048
Prowers Medical Center	-	-	-	$482,708
San Luis Valley Regional Medical Center	$891,219	$856,704	$1,082,078	$791,716
St. Vincent General Hospital	-	$76,997	$91,189	$139,649
The Springs Center for Women	$221,377	$277,640	$78,432	-
Valley View Hospital	$671,064	$213,611	$753,419	$360,794
National Jewish Medical and Research Center	$1,749,561	$1,509,286	$1,446,853	$1,317,900
The Children's Hospital	$2,841,477	$3,598,925	$3,543,952	$3,039,546
Denver Health	$37,142,062	$38,902,280	$42,776,228	$35,685,582
University Hospital	$18,787,541	$22,898,166	$23,052,037	$17,876,871
Total	**$62,993,375**	**$69,387,898**	**$73,659,121**	**$60,626,814**

BAD DEBT

Bad debt payments can be made to any Colorado Medicaid hospital that meets the following criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or a low income utilization rate that exceeds 25 percent;
2. Have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan;
3. Participate in the Colorado Indigent Care Program (CICP);
4. Be a State-owned entity; and
5. Providers must report bad debt to the Colorado Health and Hospital Association's Annual Report.

A payment is made only if there are funds remaining under the Federal Disproportionate Share Payment Allotment after all other payments covered under this allotment have been made and if the General Assembly approves the payments. The goal of this payment is to maximize federal dollars, while minimizing General Fund expenditures. All General Fund was removed from the payment in FY 1999-00, by using the certification of expenditures on unpaid debt from self-pay clients. A percentage of Bad Debt is reimbursed each year. All payments are made directly to Denver Health and University Hospital, which then voluntarily distribute some of the funding to private hospitals. This distribution is necessary since certification of expenditures is strictly limited to publicly-owned facilities and Denver Health and University Hospital wish to maintain equality between providers. Chart 5, Chart 6 and Chart 7 show the Bad Debt payments made in FY 2002-03, FY 2001-02 and FY 2000-01 respectively. Any payments made under Bad Debt are considered reimbursement on costs associated with providing care under the CICP, although the payment is not based on medically indigent write-off costs. Instead, payments are based on the hospital's bad debt costs.

Chart 5 – Bad Debt Payments State Fiscal Year 2002-03

Provider	Federal Fiscal Year 2002-03 Bad Debt Payment	Total State Fiscal Year 2002-03 Payment
Platte Valley Medical Center	$93,777	$93,777
Prowers Medical Center	$35,986	$35,986
San Luis Valley Regional Medical Center	$60,389	$60,389
St. Vincent General Hospital	$38,408	$38,408
Valley View Hospital	$169,004	$169,004
National Jewish Medical and Research Center	$40,183	$40,183
The Children's Hospital	$174,181	$174,181
Denver Health	$3,010,791	$3,010,791
University Hospital	$452,593	$452,593
Total	**$4,075,312**	**$4,075,312**

Chart 6 – Bad Debt Payments State Fiscal Year 2001-02

Provider	Federal Fiscal Year 2001-02 Bad Debt Payment	Total State Fiscal Year 2001-02 Payment
Platte Valley Medical Center	$96,356	$96,356
San Luis Valley Regional Medical Center	$43,424	$43,424
St. Vincent General Hospital	$54,605	$54,605
The Springs Center for Women	$0	$0
Valley View Hospital	$93,635	$93,635
National Jewish Medical and Research Center	$34,958	$34,958
The Children's Hospital	$135,022	$135,022
Denver Health	$2,238,691	$2,238,691
University Hospital	$578,641	$578,641
Total	**$3,275,332**	**$3,275,332**

Chart 7 – Bad Debt Payments State Fiscal Year 2000-01

Provider	Federal Fiscal Year 1998-99 Bad Debt Payment	Federal Fiscal Year 1999-00 Bad Debt Payment	Federal Fiscal Year 2000-01 Bad Debt Payment	Total State Fiscal Year 2000-01 Payment
Platte Valley Medical Center	$257,594	$184,435	$218,450	$660,479
San Luis Valley Regional Medical Center	$223,785	$63,703	$98,449	$385,937
St. Vincent General Hospital	$0	$0	$123,797	$123,797
The Springs Center for Women	$0	$0	$0	$0
Valley View Hospital	$221,347	$212,253	$212,283	$645,883
National Jewish Medical and Research Center	$305,475	$187,771	$79,255	$572,501
The Children's Hospital	$433,830	$291,223	$306,112	$1,031,165
Denver Health	$4,560,950	$5,845,868	$5,075,409	$15,482,227
University Hospital	57455	1098574	1311838	$2,467,867
Total	**$6,060,436**	**$7,883,827**	**$7,425,593**	**$21,369,856**

MEDICARE UPPER PAYMENT LIMIT

I. INTRODUCTION

The Medicare Upper Payment Limit is the maximum amount Medicaid can reimbursement a provider and still receive the federal match rate (federal financial participation). The Medicare Upper Payment Limit is relevant to three distinct provider payments: Inpatient Hospital, Outpatient Hospital and Nursing Home payments. The three unique Medicare Upper Payment Limits are calculated by the Department such that each must be a reasonable estimate of the amount Medicare would reimburse providers for providing Medicaid services.

Medicaid fee-for-service and managed care rates reimburse providers below all three Medicare Upper Payment Limits. This provides an opportunity for the Department to gain a federal match on the difference between the Medicaid fee-for-service and managed care reimbursement and the Medicare Upper Payment Limits. State owned and government owned providers use certification of public expenditures (State or local expenditures), which generate a federal match without a General Fund expenditure for the difference.

Colorado Indigent Care Program payments to publicly owned-providers are partially funded using certification of public expenditures under the Medicare Upper Payment Limit for inpatient hospital services. For FY 01-02 and FY 02-03, a total of $2,645,000 in federal funds had been generated for these Colorado Indigent Care Program payments, which eliminated the need for General Fund to support these payments.

Since FY 1989-90, Colorado Indigent Care Program payments to Denver Health and University Hospital have been partially funded under the Medicare Upper Payment Limit for inpatient hospital services through a payment commonly known as the “Major Teaching Payment.” Starting in FY 1999-00 certification of public expenditures for inpatient hospital services eliminated the General Fund portion of the payment. Over the three fiscal years from FY 2000-01 to FY 2002-03, $64,667,000 in federal funds had been generated for these provider payments. In addition to these federal funds, another $26,766,000 in federal funds had been generated through the payments that were contributed back to the State General Fund by Denver Health and University Hospital.

II. MAJOR TEACHING HOSPITAL

Following the implementation of SB 90-204 in FY 1990-91, a portion of the General Fund appropriation to the CICP was reduced. Denver Health and University Hospital received enhanced Medicaid reimbursement to make up for the General Fund reduction in the CICP payments. The General Fund reduction was matched with federal funds to make these enhanced payments and to help offset the costs of Medicaid program expansions. Denver Health and University Hospital, by virtue of their status as teaching hospitals and the disproportionate share of care they provide to low-income patients, are eligible for these enhanced Medicaid payments. The federal funds portions of expenditures are not counted against the Disproportionate Share Hospital Allotment, but rather the Medicare Upper Payment Limit for inpatient hospital services.

A Colorado hospital qualifies as a Major Teaching Hospital when its Medicaid days combined with indigent care days (days of care provided under the CICP) equal or exceed 30% of its total patient days for the prior state fiscal year, or the most recent fiscal year for which data are available. In addition, a Major Teaching Hospital must fulfill the following criteria:

1. Maintains a minimum of 110 total Intern and Resident Full Time Equivalents (FTEs);
2. Maintains a minimum ratio of .30 Intern and Resident FTEs per licensed bed; and
3. Meets the Department's eligibility requirement for Disproportionate Share Hospital payment.

Although the calculation of the payments is not based on the CICP write-off costs, the Major Teaching Hospital Payments are a direct reimbursement of write-off costs for the CICP. In FY 1999-00 all General Fund was removed from the payment by using the certification of public expenditures of uncompensated Medicaid costs at each facility. Chart 1 displays the Major Teaching Payment split between Denver Health and University Hospital. Between FY 1995-96 and FY 1998-99, the payments to each provider remained constant.

Chart 1 – Major Teaching Payments by Provider
(Millions of Dollars)

	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03
Denver Health	$9.68	$10.31	$10.58	$11.14	$11.14
University Hospital	$10.08	$10.31	$10.58	$10.62	$10.62
Total Payments	**$19.76**	**$20.62**	**$21.16**	**$21.76**	**$21.76**

The Major Teaching Payment has grown from $6.8 million in FY 1989-90 to $21.76 million in FY 2002-03. This represents a 220% increase in total funds, while the General Fund share of the payment reached a high of $9.72 million in FY 1998-99 and starting in FY 1999-00 General Fund appropriation became zero. Chart 2 lists these payments by funding source since the introduction of this methodology in FY 1989-90.

Chart 2 – Major Teaching Payments by Fiscal Year
(Millions of Dollars)

	FY 1989-90	FY 1990-91	FY 1991-92	FY 1992-93
Total Payments	**$6.80**	**$16.30**	**$17.40**	**$17.60**
General Fund	$3.30	$7.70	$7.90	$8.00
Federal Funds	$3.50	$8.60	$9.50	$9.60
	FY 1993-94	**FY 1994-95**	**FY 1995-96**	**FY 1996-97**
Total Payments	**$20.40**	**$20.40**	**$19.76**	**$19.76**
General Fund	$9.30	$9.50	$9.38	$9.42
Federal Funds	$11.10	$10.90	$10.38	$10.34
	FY 1997-98	**FY 1998-99**	**FY 1999-00**	**FY 2000-01**
Total Payments	**$19.76**	**$19.76**	**$20.62**	**$21.16**
General Fund	$9.48	$9.72	$0	$0
Federal Funds	$10.28	$10.04	$20.62	$21.16
	FY 2001-02	**FY 2002-03**		
Total Payments	**$21.76**	**$21.76**		
General Fund	$0	$0		
Federal Funds	$21.76	$21.76		

House Bill 02-1420 and Senate Bill 03-258, supplemental appropriations to the Department, increased the federal funds for the Major Teaching Payment to $37,347,236. It was the intent of the General Assembly that the additional federal fund payments generated through the Medicare Upper Payment Limit for inpatient hospital services funding mechanism be contributed back to the State by the hospitals via intergovernmental transfers and that the funds be used to help offset the need for Medicaid program reductions due to declining state revenues. It was the General Assembly's understanding that this intergovernmental transfer would be approximately $15,593,540 in FY 2002-03. In accordance with this supplemental appropriation, an additional $9,602,023 in Major Teaching Payment was paid to Denver Health and an additional $5,991,517 in Major Teaching Payment was paid to University Hospital, both of which were contributed back to the State General Fund.

III. CHILDREN'S HOSPITAL CLINIC PAYMENT

Effective July 1, 2002 the Children's Hospital became eligible to receive a Major Teaching Hospital Payment. The payment under the Medicare Upper Payment Limit for inpatient hospital services for FY 2002-03 was $6,119,760. Since the Children's Hospital is a privately owned facility, the certification of public expenditures for uncompensated Medicaid costs at the facility is not allowed as in the Major Teaching Hospital payment to Denver Health and University Hospital. Instead, General Fund is required as the State's share of the payment to receive the federal funds match.

An agreement was reached with the Children's Hospital and the Department, such that the hospital would administer the payments to Outstate clinics and in return the Department would use a portion of the General Fund available under the Outstate clinic payment as Children's Hospital Major Teaching Hospital payment. Of the $5,595,482 General Fund available for Outstate clinic payments in FY 2001-02, $3,059,880 General Fund was paid as the Children's Hospital Major Teaching Hospital payment in FY 2002-03. Total funds were $6,119,760, since the federal funds match rate was 50% in FY 2002-03. Of the $6,119,760 paid to Children's Hospital, $6,059,760 was paid by the facility to the Outstate clinics as reimbursement for services provided under the Colorado Indigent Care Program. The remaining $60,000 was retained by the Children's Hospital to administer the payments to and contracts with the Outstate clinics.

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM

I. INTRODUCTION

The Comprehensive Primary and Preventive Care (CPPC) Grant Program was established to provide grants to health care providers in order to expand primary and preventive health care services to Colorado's low-income residents. The program is funded through the Comprehensive Primary and Preventive Care Fund established pursuant to the tobacco litigation settlement referred to as the Master Settlement Agreement. The program is authorized by the addition of Part 10 to the Medical Assistance Act, 26-4-1001 through 26-4-1007, C.R.S.

According to statute, beginning with the 2000-01 fiscal year and for each fiscal year thereafter, the General Assembly shall appropriate to the CPPC Grant Program fund six percent of the total amount of moneys received by the state pursuant to the Master Settlement Agreement, not including attorney fees and costs, during the preceding fiscal year; except that the amount so appropriated to this fund shall not exceed $6 million in any fiscal year. In addition, the Department of Health Care Policy and Financing (the Department) may retain up to one percent of the amount annually appropriated for actual costs incurred in implementing the provisions of this grant program.

Because primary and preventive care are two of the most cost effective means of keeping people healthy, the CPPC Grant Program is intended to expand these services to Colorado's uninsured or medically indigent populations. However, it is not intended to supplant or expand state Medicaid, the Children's Basic Health Plan (CBHP), or the Colorado Indigent Care Program (CICP).

The goals of the CPPC Grant Program are to efficiently use available funding to:

- Increase access to comprehensive primary care services for uninsured or medically indigent patients who are served by qualified providers;
- Create new services or augment existing services provided to uninsured or medically indigent patients;
- Establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations; or
- Maintain increased access, capacity or services previously funded by CPPC grants.

For a complete report, the Comprehensive Primary and Preventive Care Grant Program FY 2002-03 Annual Report is available on the Department's website.

II. ADMINISTRATION

The Department became responsible for the CPPC Grant Program on July 1, 2000. Prior to awarding grants, the Department needed to establish rules, appoint an Advisory Committee and issue a Request for Proposal (RFP) to distribute the awards. Rules were developed during the summer by staff and public input was sought throughout the process. Rules were heard by the Medical Services Board in October and November 2000 and became effective January 1, 2001. The Executive Director of the Department appointed an Advisory Board in conformance with statute. The Board provided additional input to the rule making process. Their primary function was to assist the Department in establishing guidelines for awarding the grants. Their input was critical to the development of the RFP required to award the grants.

During the 2001 legislative session, modifications were made to the enabling statute to expand the definition of eligible uninsured and of eligible health care providers. The Department modified the rules, and the revisions to the rules were approved and became effective January 1, 2002.

Rules were modified to reflect changes in legislation. The legislation changed the eligibility of patients to be served in the program from 185% of the federal poverty level and below to 200% of the federal poverty level and below. In addition, legislation was changed to allow qualified health care providers to practice in an area in which they can demonstrate to the State that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons. Further, new legislation required that the qualified health care providers perform an initial screening for Medicaid, the Children's Basic Health Plan (CBHP) and Colorado Indigent Care Program (CICP).

A revised Request for Proposal (RFP) was developed in the fall of 2001 based on the advice of the Advisory Council and the experience of the first year of managing the program. Some of the changes to the RFP included:

- Requiring that only one distinct project could be presented per proposal, while placing no limit on the number of proposals that may be submitted per health care provider.
- Allowing health care providers the option of requesting funding for multiple years, with a limit to three State fiscal years (July 2002 through June 2005).
- Replacing the grant distribution categories: Previously grants were accepted in two categories, 1) up to $400,000 and 2) between $400,000 and $900,000. New categories were: 1) New sites or expansions, maximum $500,000 2) Ongoing operations at existing site(s), maximum $500,000 3) Service expansions at existing sites, maximum $500,000 and 4) Patient care equipment, maximum $100,000.

The FY 2002-03 RFP was released in March 2002. A pre-bid meeting was held at the beginning of the following month to discuss the RFP and answer questions from any interested bidder. Proposals were due in late April 2002. A total of 34 proposals were received from 19 different health care providers. The total amount requested among all proposals received was $11,913,426, more than double the $5,939,047 originally appropriated to the CPPC Grant Program for FY 2002-03.

Awards were made for FY 2002-03 totaling $5,854,153, which was distributed in 18 contracts to 14 different health care providers. Of the 18 contracts, 10 were structured to provide funding over multiple years. Those who received awards for FY 2002-03 and also requested funding for multiple years were awarded funding for the additional years they had requested. After the publication of the RFP, the grant administration team decided that the funding awarded for multiple years would be distributed at decreasing intervals in order to allow for adequate funding of new grants in subsequent years. Therefore, the funding for additional years was pledged at amounts lower than what was requested.

The awards for FY 2002-03 were reduced to accommodate a 10-month contract period spanning September 1, 2002 through June 30, 2003 and most awards were decreased by a corresponding percentage. This action was necessary because approval for the grant awards was delayed based on the impending budget shortfalls of the State of Colorado. Although some health care providers did not receive the full amount requested, it is noteworthy that the decreased award amounts allowed for two additional proposals to receive grant monies for the September 2002 through June 2003 contract period.

In January 2003, the General Assembly redirected some of the resources from the tobacco settlement funds to the General Fund in an effort to partially relieve the budget deficit experienced by the State of Colorado. This resulted in a decrease in appropriations to tobacco settlement-funded programs. The FY 2002-03 CPPC Grant Program's funding was reduced by approximately 11.5% to $4,965,304. All CPPC grant awards were decreased by that same percentage to total $5,180,225. Grantees' contract deliverables were renegotiated to coincide with the lower award amount and contract amendments were issued for all grantees.

III. AWARDS

Fourteen grants were awarded for fiscal years 2000-01 and 2001-02. The total awards for the full grant period were $9,730,381. There is a broad geographic distribution in Colorado with grants being awarded across the State with grantees representing areas as diverse as Colorado Springs, Denver, Durango, Frederick, Grand Junction, Greeley, Las Animas, Pueblo and Thornton. The scopes of work are varied and represent the diverse needs of the safety net providers in serving the uninsured. The following projects were funded for FY 2000-01 and FY 2001-02:

- Colorado Coalition for the Homeless in the amount of $899,020 to fund Denver's Stout Street Clinic expansion; hiring 7.3 Full Time Equivalents (FTEs); providing expanded clinic services for 3,652 additional uninsured visits.
- Pueblo Community Health Center, Inc. in the amount of $898,600 to fund constructing an East Side Clinic in Pueblo County; hiring 12.52 FTEs; contracting patient-related services; adding needed organization-wide quality improvement projects; providing expanded clinic services for 5,400 patients.
- Clinica Campesina Family Health Services in the amount of $525,955 to fund renovating a clinic in Thornton and obtaining infrastructure items for the clinic; provide expanded clinic services to 5,000 patients.
- Plan de Salud del Valle, Inc. in the amount of $900,000 to fund building a new clinic in Frederick.
- Metro Community Provider Network, Inc. in the amount of $900,000 to fund hiring 10.2 FTEs and beginning construction of a clinic at Jeffco Action Center.
- Inner City Health Center in the amount of $282,819 to fund remodeling/opening a dental satellite clinic in Denver County; subsidizing dental care; hiring a diabetic care coordinator; subsidizing diabetic care; conducting classes/home visits on diabetic care.
- Sunrise Community Health Center, Inc. in the amount of $880,700 to fund hiring staff (Loveland, Greeley, Weld County); providing equipment; renovating the Greeley Clinic; providing expanded clinic services to 4,000 patients.
- Denver Health Medical Center in the amount of $582,175 to fund hiring 7.25 FTEs in Denver County; contracting with a program evaluator; developing a database and tools for case management; providing linking service for inmates of Denver County correctional facilities with 3 Primary Care Providers.
- Columbine Family Health Center in the amount of $358,661 to fund expansion services in Glenwood Springs through increases in staff, facility, and equipment; systematic and rigorous outreach to target population for coordination of services.
- Community Health System in the amount of $900,000 to fund subsidizing 6.4% of uncompensated care in the Pikes Peak Region (El Paso, Teller, and Park Counties); renovating/equipping 10 new exam rooms; purchasing server/software for IDX system; hiring 1 FTE.
- Valley-Wide Health Services, Inc. in the amount of $900,000 to fund opening a new clinic in Durango; hiring staff; purchasing equipment; adding primary care services at current sites.

- Catholic Health Initiatives, Mountain Region Foundation in the amount of $141,520 to fund hiring a physician and coordinator for Pueblo County; building a database for the drug subsidy program; adding 350 new patients to program.
- Marillac Clinic, Inc. in the amount of $870,000 to fund hiring 8.15 FTEs in Mesa County; providing 500 mental health visits; expanding dental clinic; providing 372 reduced-cost eyeglasses; developing a contract with B-4 Babies Program.
- Parkview Medical Center in the amount of $690,931 to construct new sites at three high schools which will provide comprehensive health care, mental health and dental services; to hire additional staff for these sites; and to provide the infrastructure support for these sites.

For FY 2002-03, 34 proposals were received from 19 different health care providers and from these, 18 contracts were awarded to 14 providers. The amount of grants awarded totaled $4,965,304 for a 10-month grant period. Services were provided in Boulder, Glenwood Springs, Grand Junction, Greeley, Lafayette, Longmont, Norwood, Pueblo and the Denver metro area. Final reports from the grantees showed that almost all grantees exceeded their original goals. It was reported that 12,607 patients received medical services and 33,094 encounters were provided for those patients. In addition, 3,000 patients received dental care and 8,369 encounters were provided for those patients. Further, diabetes education classes and dental information sessions were held, eye exams were given, eyeglasses were distributed to 265 patients and at least 2,669 pharmaceuticals were dispensed. The following projects were funded:

- Catholic Health Initiatives, St. Anthony Foundation in the amount of $340,364 to fund hiring a patient advocate, diabetic educator and prenatal nurse, and to provide health care to at least 300 uninsured patients in Denver.
- Catholic Health Initiatives, St. Mary-Corwin in the amount of $500,000 to fund the completion of renovation to a medical clinic on the St. Mary-Corwin hospital campus in Pueblo.
- Clinica Campesina in the amount of $500,000 to fund the construction and equipping of 9 new exam rooms and to provide health care to at least 50 uninsured patients in Lafayette.
- Colorado Coalition for the Homeless in the amount of $440,000 to fund 8 FTEs and add a .5 FTE patient educator and to provide health care to at least 1,000 uninsured patients in Denver.
- Columbine Family Health Center in the amount of $136,535 to provide health care to at least 1,125 uninsured patients in Glenwood Springs.
- Columbine Family Health Center in the amount of $300,000 to fund the initial phases of construction of a medical facility in Nederland.
- Inner City Health Center in the amount of $182,127 to fund hiring a dental director, completing the remodeling of the laboratory and providing dental services to at least 300 uninsured patients at the Inner City Health Center in Denver.
- Inner City Health Center in the amount of $76,892 to fund maintaining a .5 FTE diabetic care coordinator, enrolling at least 20 additional patients in diabetic program and conducting at least 7 diabetic education classes in Denver.

- Inner City Health Center in the amount of $180,243 to fund a dental director; the installation of cabinets, countertops and new handpieces; and to provide dental services for at least 800 uninsured patients at the New Hope Dental clinic in Denver.
- Marillac Clinic in the amount of $200,000 to complete construction and relocation of dental operations to the St. Mary's Hospital campus in Grand Junction.
- Marillac Clinic in the amount of $400,000 to provide health care to at least 3,000 uninsured patients in Grand Junction.
- Metro Community Provider Network in the amount of $500,000 to fund the completion of the remodeling of space into a dental clinic, the hiring of a dentist and dental hygienist and to provide dental services to at least 450 uninsured patients in Denver.
- People's Clinic in the amount of $246,925 to hire a family practice team (including at least 1 FTE family physician) and to provide health care to at least 1,000 uninsured patients in Boulder.
- Plan de Salud del Valle in the amount of $500,000 to fund the beginning phases of construction of 24 medical offices and 6 dental operatories in Longmont.
- Pueblo Community Health Center in the amount of $424,917 to provide health care services to at least 1,800 uninsured patients and to fill at least 3,000 pharmaceutical prescriptions for uninsured patients in Pueblo.
- Sunrise Community Health Center in the amount of $415,000 to fund 5 FTEs among three clinics and to provide health care to at least 3,500 uninsured patients in Greeley.
- Uncompahgre Medical Center in the amount of $175,000 to fund the beginning phases of construction that will expand the facility in Norwood.
- University of Colorado Hospital in the amount of $336,150 to provide prenatal, postpartum, newborn care, hospital-based outpatient services and delivery services for at least 900 patient visits by uninsured patients in Denver.

IV. FINANCIAL SUMMARY

The Comprehensive Primary and Preventive Care (CPPC) Grant Program was initially appropriated $4,601,962 for FY 2000-01 and $5,191,389 in FY 2001-02. Since the Tobacco Settlement Trust continues to receive money after the finalization of the Long Bill, for any given year, the initial appropriation is adjusted through the supplemental process. The final FY 2000-01 appropriation was increased by Senate Bill 01-212, Section 21(4), the 2001 Long Bill, to $4,751,488, while the final FY 2001-02 appropriation decreased to $5,156,532. The initial appropriation for FY 2002-03 was $5,939,047, which was then reduced to $5,259,917 under SB 03-190.

The Department is required to pay a proportionate share of the costs incurred by the Department of Public Health and Environment associated with the administration of the Tobacco Settlement Trust funded programs. A similar payment is required to fund the Office of the State Auditor, which is required by statute to audit all the Tobacco Settlement Trust funded programs. Therefore, in FY 2001-02, a payment of $7,805 was made to the Department of Public Health and Environment and $4,671 was paid to the Office of the State Auditor. In addition, a one-time payment of $2,040 was made to the Stroke Prevention Board, as required by statute. In FY 2002-03, $9,632 was paid to the Department of Public Health and Environment and $5,590 was paid to the Office of the State Auditor.

The Department cannot exceed a maximum of 1% of total funds appropriated for the direct administrative costs associated with the CPPC Grant Program. The total direct administrative costs for FY 2000-01 and FY 2001-02 were $15,262. For FY 2002-03, the direct administration costs grew to $40,057 as it was determined that a full-time program coordinator was needed to administer the program. As required by statute, any funds not used at the end of the fiscal year are reverted to the Tobacco Settlement Trust. For FY 2000-01, $147,861 in appropriated funds was reverted to the Tobacco Settlement Trust, while in FY 2002-03 that amount was $239,334.

Chart 1 - CPPC Financial Summary FY 2000-01 and FY 2001-02

FY 2000-01 Appropriation	$4,751,488
FY 2001-02 Appropriation	$5,156,532
Total	$9,908,020
Provider Awards	**$9,730,381**
Department Administration Costs	$15,262
Prevention Board Payment (FY 2001-02)	$2,040
Department of Public Health and Environment Payment (FY 2001-02)	$7,805
Office of the State Auditor Payment (FY 2001-02)	$4,671
Tobacco Settlement Trust Reversion	$147,861
Total Appropriations	**$9,908,020**

Chart 2 - CPPC Financial Summary FY 2002-03

Provider Awards	**$4,965,304**
Department Administration Costs	$40,057
Department of Public Health and Environment Payment	$9,632
Office of the State Auditor Payment	$5,590
Tobacco Settlement Trust Reversion	$239,334
Total Appropriation	**$5,259,917**

COLORADO INDIGENT CARE PROGRAM

I. INTRODUCTION

The Department of Health Care Policy and Financing (the Department) has prepared this report pursuant to Section 26-15-105, C.R.S. This annual report is delivered each February 1 to the Health, Environment, Welfare and Institutions Committees of the Senate and the House of Representatives concerning the status of the medically indigent program. The report is prepared following consultation with providers in the program, Department of Personnel, and other agencies, organizations, or individuals as the Executive Director deems appropriate in order to obtain comprehensive and objective information about the program.

This report addresses:

- Program definitions
- Eligibility requirements, including residency, income and assets, and the necessity of medical treatment
- A standardized ability-to-pay schedule and establishment of copayment requirements
- Methods for allocation and disbursement of funds
- Sources of funding
- Medical services provided to medically indigent clients during FY 2002-03
- Plans for future years

The Colorado General Assembly enacted the "Reform Act for the Provision of Health Care for the Medically Indigent," Section 26-15-101, C.R.S., in 1983. This law made it possible to use state funds to partially reimburse providers for services given to the State's non-Medicaid medically indigent residents. "The general assembly also recognizes that the program for the medically indigent is a partial solution to the health care needs of Colorado's medically indigent citizens. Therefore, medically indigent persons accepting medical services from this program shall be subject to the limitations and requirements imposed in this article," Section 26-15-102 (2), C.R.S. The benefits offered to clients under this program vary from clinic to clinic and from hospital to hospital. In most settings, medically indigent cards are issued and brochures are available for patients. The CICP is not an insurance program, but rather a financial vehicle for providers to recoup some of their medical costs at a "discount." The program has been known by several names: the Medically Indigent (MI) Program, the Colorado Resident Discount Program (CRDP) and the Colorado Indigent Care Program (CICP). By statute, CICP participating providers are required to prioritize care in the following order:

1. Emergency care for the full year,
2. Additional medical care for those conditions determined to be the most serious threat to the health of indigent persons, and
3. Any other medical care.

The CICP includes these requirements in its contracts with providers to assure that indigent persons have access to emergency care throughout the year.

COLORADO HEALTH CARE TASK FORCE

H.B. 99-1019 created the Colorado Health Care Task Force. This legislation abolished the Joint Review Committee on the Medically Indigent and the Medical Assistance Reform Advisory Committee and replaced them with the Colorado Health Care Task Force (26-15-107, C.R.S.). The Task Force is responsible for examining and making recommendations to the General Assembly concerning affordable health insurance coverage for the constituents of Colorado.

Issues the Task Force examines include:

- Emerging trends in Colorado health care and their impacts on consumers, including, but not limited to:
  - Changes in relationships among health care providers, patients, and payers;
  - Restrictions on health care options available to consumers;
  - Professional liability issues arising from such restrictions;
  - Medical and patient record confidentiality; and
  - Health care work force requirements.
- Home health care in the continuum of care;
- The effect of recent shifts in the way health care is delivered and paid for;
- The ability of consumers to obtain and keep adequate, affordable health insurance coverage, including coverage for catastrophic illnesses;
- The effect of managed care on the ability of consumers to obtain timely access to quality care;
- The operation of the Program for the Medically Indigent in order to give guidance and direction to the Department of Health Care Policy and Financing in the development and operation of the program;
- The future trends for health care coverage rates for employees and employers;
- The role of public health programs and services;
- Social and financial costs and benefits of mandated health care coverage; and
- Costs and benefits of providing preventive care and early treatment for people with chronic illnesses who may eventually need long-term care.

The CICP administration appeared before the Task Force in August 2003 concerning the indigent care program and the financing methodologies that fund the provider payments.

CICP PROVIDER MEETINGS

The CICP administration convenes provider meetings to obtain provider input on various topics related to the program. All CICP providers and interested parties were invited to attend the CICP provider meetings. The Department held one meeting during FY 2002-03 with CICP providers. Among the issues discussed were:

- ❒ Changes to the CICP manual and provider reimbursement for FY 2003-04. This included changes to the rate setting methodology for providers, and combining all safety net appropriations into a single line within the Long Bill starting in FY 2003-04. All providers were encouraged to provide comments and suggestions for the new reimbursement method.
- ❒ Provider flexibility in administering the CICP for their facilities. Each provider was encouraged to establish policies and procedures for their facility, as long as they did not conflict with the CICP regulations. This became effective July 1, 2003.
- ❒ Change in all of the CICP provider contracts, in which the contracts have no set expiration date. This was implemented to reduce the administrative burden of renewable contracts to the providers and the CICP administration. These contracts were issued in March 2003 and became effective for most providers by July 1, 2003.
- ❒ The Colorado Benefits Management System (CBMS) Project that will include the eligibility rules for the CICP, all of the Medicaid services and the other statewide assistance programs.

Other topics included annual review of budgetary issues, legislative bills and additional matters influencing the services delivered to the medically indigent population.

II. CLIENTS

ELIGIBILITY REQUIREMENTS AND ABILITY TO PAY

Hospitals and clinics administer enrollment into the Colorado Indigent Care Program (CICP). Eligibility technicians at the CICP provider location complete the applications. Providers determine eligibility for the program using the criteria developed by the CICP administration. To be eligible for services under the CICP, an individual must meet both residency and income and asset requirements. A resident is anyone who is 1) a Colorado resident and a U.S. citizen or legal alien or 2) a migrant farm worker and a U.S. citizen or legal alien.

To qualify, a person must have income and assets combined at or below 185% of the Federal Poverty Level (FPL). In addition, a person cannot be eligible for Medicaid or, effective July 1, 2002, the Children's Basic Health Plan. There are no age limitations for CICP eligibility. Clients can have third party insurance, but these funds must be exhausted prior to the CICP reimbursing providers.

Providers assign a "rate" to the applicant clients based on their total income and assets (see Chart 1.) The rating process takes a "snapshot" of the applicants' financial resources as of the date the rating takes place. Ratings usually occur on the initial date of service. Ratings are retroactive for services received up to 90 days prior to application. Therefore, when an applicant who has received services applies for the CICP, the applicant is applying for a discount on already incurred medical charges. Based on the clients' income and assets, a rate is assigned based on their ability to pay (see Chart 2). The fee schedule has eight levels up to a maximum of 185% of the FPL based on income and family size. The income scale is based on the federal poverty guidelines, as published in the Federal Register by the U.S. Department of Health and Human Services each February and is updated each year. Client eligibility ratings are valid for one year. However, initial ratings may change. A re-rating may occur when:

a. Family income has changed significantly;
b. Number of dependents has changed; or
c. Information provided was not accurate.

For all client ratings, except the N-rating (0-40% of the FPL), annual copayments for CICP clients cannot exceed 10% of the family's "Total CICP Income and Equity in Assets." Annual copayments for clients with N-ratings cannot exceed $120.

Starting in FY 2002-03, homeless clients who are at or below 40% of the Federal Poverty Level (formerly qualifying as an N rating) will receive a "Z" rating. These clients are exempt from co-payments, income verification requirements, verification of denied Medicaid benefits and providing proof of residency when completing the CICP application.

Chart 1 - Annual Income Ranges for Each Ability-To-Pay Rate
Effective April 1, 2002 - March 31, 2003

Family Size	N	A	B	C
1	$0 - $3,544	$3,545 - $5,493	$5,494 - $7,177	$7,178 - $8,860
2	$0 - $4,776	$4,777 - $7,403	$7,404 - $9,671	$9,672 - $11,940
3	$0 - $6,008	$6,009 - $9,312	$9,313 - $12,166	$12,167 - $15,020
4	$0 - $7,240	$7,241 - $11,222	$11,223 - $14,661	$14,662 - $18,100
5	$0 - $8,472	$8,473 - $13,132	$13,133 - $17,156	$17,157 - $21,180
6	$0 - $9,704	$9,705 - $15,041	$15,042 - $19,651	$19,652 - $24,260
7	$0 - $10,936	$10,937 - $16,951	$16,952 - $22,145	$22,146 - $27,340
8	$0 - $12,168	$12,169 - $18,860	$18,861 - $24,640	$24,641 - $30,420
Poverty Level *	40%	62%	81%	100%

Family Size	D	E	F	G
1	$8,861 - $10,366	$10,367 - $11,784	$11,785 - $14,087	$14,088 - $16,391
2	$11,941 - $13,970	$13,971 - $15,880	$15,881 - $18,985	$18,986 - $22,089
3	$15,021 - $17,573	$17,574 - $19,977	$19,978 - $23,882	$23,883 - $27,787
4	$18,101 - $21,177	$21,178 - $24,073	$24,074 - $28,779	$28,780 - $33,485
5	$21,181 - $24,781	$24,782 - $28,169	$28,170 - $33,676	$33,677 - $39,183
6	$24,261 - $28,384	$28,385 - $32,266	$32,267 - $38,573	$38,574 - $44,881
7	$27,341 - $31,988	$31,989 - $36,362	$36,363 - $43,471	$43,472 - $50,579
8	$30,421 - $35,591	$35,592 - $40,459	$40,460 - $48,368	$48,369 - $56,277
Poverty Level *	117%	133%	159%	185%

* Percent of federal poverty level which corresponds to the upper limit of income in each rating level.

Chart 2 - Colorado Indigent Care Program Client Copayment Table

CICP RATING	PERCENT OF FEDERAL POVERTY LEVEL	INPATIENT FACILITY COPAYMENT	INPATIENT PHYSICIAN COPAYMENT (3)	OUTPATIENT COPAYMENT (4)	PRESCRIPTION COPAYMENT
N (1)	40%	$15	$0	$5	$3
A	62%	$64	$27	$10	$5
B	81%	$103	$44	$10	$5
C	100%	$154	$66	$10	$5
D	117%	$220	$94	$10	$10
E	133%	$297	$127	$15	$15
F	159%	$389	$167	$20	$20
G	185%	$535	$230	$25	$25
P (2)	All	N/A	N/A	$50	$5

Notes:

(1) The annual copayment cap amount for “N” rated clients is $120 per year. This rating includes “Z” rated clients who are exempt from co-payments.

(2) “P” rated clients are pregnant women receiving outpatient prenatal care. The $50 copayment covers various outpatient care as determined by the provider.

(3) Most CICP inpatient facilities do not have physician participation. In these cases, clients must use physicians who do not participate in CICP. This means that CICP clients are responsible for 100% of billed inpatient physician charges.

(4) The provider has the option of charging outpatient surgery patients rated “A” through “G” in one of two ways:

1. As an outpatient service for the outpatient copayment as listed in the above schedule; or
2. As an inpatient service for which the facility collects the copayment associated with an inpatient stay for the patient’s rating.

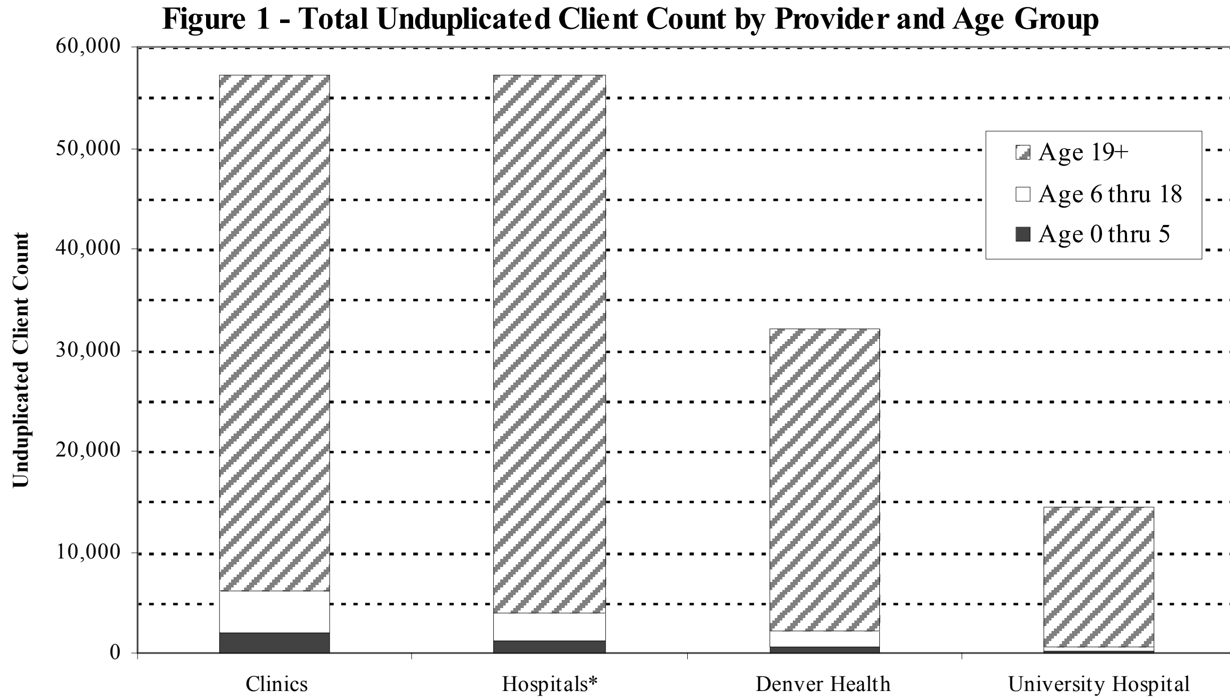
The patient is additionally responsible for the participating physician copayment. In the event that the listed inpatient charges are greater than actual patient charges for the outpatient surgery, the facility shall charge the lesser of the amounts in determining the patient’s liability.

The patient must pay the lower of the copayment listed or actual charges. Clients are notified at or before the time of services rendered of their copayment responsibility. The annual CICP provider application indicates the type of copayment system used by the provider.

CLIENTS SERVED

During FY 2002-03, 160,989 unique individuals received services through the Colorado Indigent Care Program (CICP). This figure is 3.2% higher than the FY 2001-02 reported value of 155,928 unique individuals. For the program, 12,269 unique individuals received inpatient care, while 153,171 received outpatient services in FY 2002-03[1].

Figure 1 - Total Unduplicated Client Count by Provider and Age Group



Source: Table 9B. *Hospitals include Outstate DSH and Medicaid DSH providers.

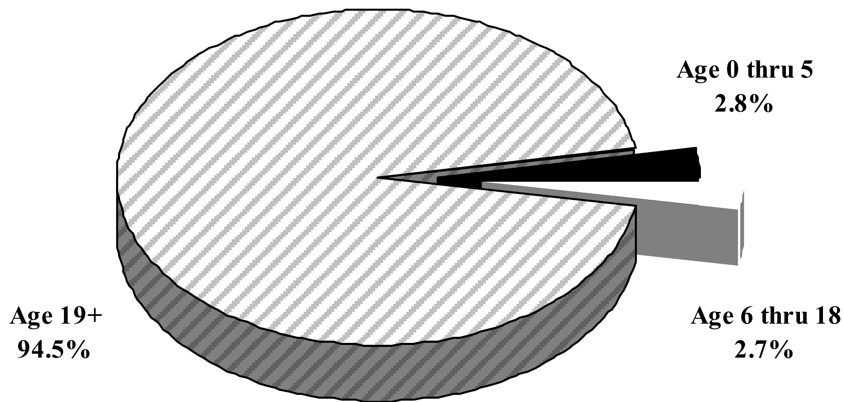
Tables 9A and 9B provide a detailed overview by provider of the total number of unique individuals served by site. The provider groups serving the greatest number of unique individuals were the Outstate clinics (35.5%), Outstate DSH (30.1%) and Denver Health (20.0%). Overall, children (age 0-18) represented 8.0% of the total unique population receiving services, which were down from 10.5% in the previous fiscal year and 15.1% in FY 2000-01. Unique adults (age 19 and over) accounted for 89.5% of the unique population served in FY 2001-02 and grew to 92.0% in FY 2002-03. The decline in unique children receiving care under the CICP is primarily due to increased enrollment in the Children's Basic Health Plan. Since FY 1998-99 the number of children receiving services under the CICP has fallen by 55.0%.

[1] See Section VIII. DATA MANAGEMENT TECHNIQUES for data collection measures and limitation.

Inpatient Admissions

Providers reported that 12,269 unique individuals received inpatient care through the CICP in FY 2002-03. This represented a 4.5% increase from the previous fiscal year figure of 11,743. Outstate DSH provided 54.7% of total unique client admissions statewide, which increased from 49.6% in the previous fiscal year. Denver Health provided 28.7% of total unique client admissions, with only 3.4% of the admissions for children (age 0-18). Dropping slightly from 6.2% in FY 2001-02, unique children receiving inpatient services through the CICP represented only 5.5% of the admissions to the Outstate DSH.

Figure 2 - Outstate Disproportionate Share Hospitals
Percent of Inpatient Unduplicated Count by Age Group



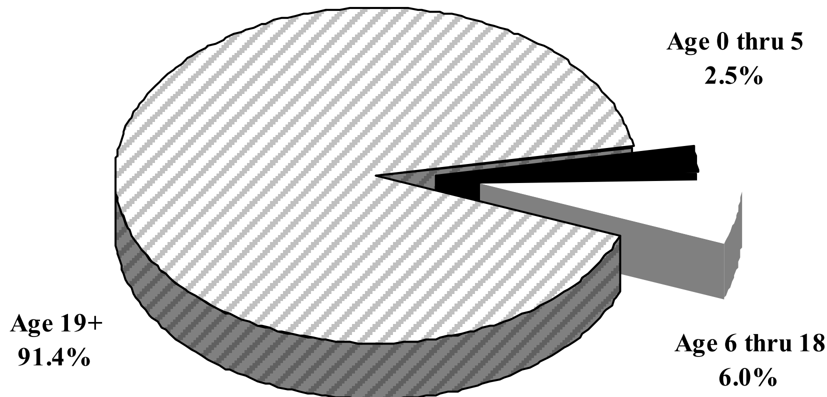
Source: Table 9A.

Outpatient Visits

Providers reported that 153,171 unique individuals received outpatient care through the CICP in FY 2002-03. This represented a 2.1% increase from the previous fiscal year figure of 149,957. The Outstate providers (clinics and hospitals) saw almost two-thirds (65.7%) of the unique outpatient visits compared to the Medicaid DSH[2] providers, Denver Health and University Hospital at 34.3%. Outstate DSH provided 28.4 % of unique client visits, while Outstate clinics provided 37.3%. Denver Health provided 20.5% of unique client visits. Outstate clinics provided 10.6% of unique outpatient visits to children (age 0-18) compared to the Outstate DSH at 5.8%. Both these figures are significant decreases from the previous year, when Outstate clinics provided 13.9% of unique outpatient visits to children compared to the Outstate DSH at 7.4%.

[2] See Chart 10 for a list of Medicaid Disproportionate Share Hospital providers.

Figure 3 - Outstate Providers
Percent of Outpatient Unduplicated Count by Age Group



Source: Table 9A.

CLIENT UTILIZATION

Inpatient Admissions

Of the 12,269 clients who received inpatient services in FY 2002-03, there were 16,538 reported admissions to CICP hospital providers.

- ❒ The number of inpatient admissions grew by 9.5% in FY 2002-03 from 15,103 in FY 2001-02.
- ❒ Total inpatient days increased to 74,974 in FY 2002-03, which was a 7.9% change from the FY 2001-02 figure of 69,505.
- ❒ During FY 2002-03, 15,899 or 96.1% of all inpatient services were provided to persons aged 18 or older.
- ❒ Inpatient services were distributed in the following manner:
  - Outstate Disproportionate Share Hospitals – 56.2%
  - Medicaid Disproportionate Share Hospitals – 4.3%
  - Denver Health – 27.7%
  - University Hospital – 11.8%

Chart 3 demonstrates that the number of inpatient admissions rose by 21.7% in FY 2001-02 after falling 6.1% in the previous fiscal year. Overall, inpatient admissions rose by 9.5% in FY 2002-03. Large increases by Outstate DSH (23.5%) and Medicaid DSH (32.0%) were offset by a decrease in admissions at Denver Health (-13.5%). University Hospital increased admissions by 11.8%, after posting no significant change in the previous year and a 19.0 decline in the FY 2000-01. Since FY 2000-01, the number of inpatient admissions for Outstate DSH have increased by 55.7%.

Chart 3 - Comparison of Inpatient Admissions

CICP Provider	FY 2000-01 Inpatient Admissions	Percent Change	FY 2001-02 Inpatient Admissions	Percent Change	FY 2002-03 Inpatient Admissions	Percent Change
Outstate DSH	5,971	11.8%	7,525	26.0%	9,296	23.5%
Medicaid DSH*	617	-7.8%	537	-13.0%	709	32.0%
Denver Health	4,074	-19.3%	5,288	29.8%	4,574	-13.5%
University Hospital	1,752	-19.0%	1,753	0.1%	1,959	11.8%
TOTAL	**12,414**	**-6.1%**	**15,103**	**21.7%**	**16,538**	**9.5%**

Source: CICP Analysis of Table 8 FY 2000-01 and FY 2001-02 Annual Reports.
*For a list of Medicaid DSH providers see Chart 10.

As shown in Chart 4, the number of inpatient days increased in FY 2002-03. The total number of days grew by 7.9% after showing a 27.8% increase in the previous fiscal year. Medicaid DSH providers posted the largest proportion of increase, growing by 32.8% in FY 2002-03. This followed a decline of 19.2% in the previous fiscal year. University Hospital had a 22.3% gain in inpatient days in FY 2002-03, while Outstate DSH providers posted an 11.9% increase. Denver Health posted a 25.3% increase in inpatient days in FY 2001-02, which was reversed in FY 2002-03 with a 3.7% decrease.

Chart 4 - Comparison of Inpatient Days

CICP Provider	FY 2000-01 Inpatient Days	Percent Change	FY 2001-02 Inpatient Days	Percent Change	FY 2002-03 Inpatient Days	Percent Change
Outstate DSH	24,059	18.2%	33,893	40.9%	37,922	11.9%
Medicaid DSH*	2,327	7.9%	1,881	-19.2%	2,498	32.8%
Denver Health	20,534	-12.5%	25,738	25.3%	24,781	-3.7%
University Hospital	7,478	-18.9%	7,993	6.9%	9,773	22.3%
TOTAL	**54,398**	**-1.5%**	**69,505**	**27.8%**	**74,974**	**7.9%**

Source: CICP Analysis of Table 8 FY 2000-01 and FY 2001-02 Annual Reports.
*For a list of Medicaid DSH providers see Chart 10.

Denver Health and University Hospital reported the primary diagnosis codes for FY 2002-03 client data. The top diagnosis at Denver Health for an inpatient admission was Other Psychoses, which includes the diagnosis of schizophrenic disorders, manic-depressive disorder, bipolar affective disorder, paranoid states and depression. Since Denver Health is one of few hospital providers that accept patients with acute mental disorders, a significant number of patients with mental health disorders qualify for CICP and select Denver Health for their care. Typically, these patients present initially with complex physical health problems and the mental health disorder is noted at the time of the physical health visit. The mental health disorder is often the cause of lack of physical health maintenance. The top ten diagnoses at Denver Health accounted for 44.9% of all the inpatient admissions at the facility.

Chart 5 - Top 10 Inpatient Diagnoses At Denver Health

	Diagnosis Description	Claim Count
1	**Other Psychoses** (Includes: Schizophrenic Disorders, Manic Depressive, Bipolar Affective Disorder, Paranoid States, Depression)	450
2	**Other Diseases of Digestive System** (Includes: Chronic Liver Disease, Acute Gallbladder Disorders, Diseases of the Pancreas, Gastrointestinal Hemorrhage)	292
3	**Symptoms** (Includes: Symptoms in Alteration of Consciousness, Nervous System, Skin, Metabolism, Head and Neck, Cardiovascular System, Respiratory System, Digestive System, Urinary System)	258
4	**Infections of Skin and Subcutaneous Tissue** (Includes: Carbuncle and Furuncle, Cellulitis and Abcess, Impetigo, Local Infections of the Skin)	205
5	**Other Forms of Heart Disease** (Acute Pericarditis, Acute Myocarditis, Heart Failure)	194
6	**Diseases of Other Endocrine Glands** (Includes: Diabetes Mellitus, Disorders of Parathyroid Gland, Disorders of Pituitary Gland, Disorders of Thymus	158
7	**Persons Encountering Health Services in Circumstances Related to Reproduction and Development** (Includes: Pregnancy, Postpartum Care, Procreative Management, Observation of Newborns)	132
8	**Complications of Surgical and Medical Care, Not Elsewhere Classified** (Includes: Mechanical Complication of Cardiac Device, Genitourinary Device or Orthopedic Device; Infection Due to Internal Prosthetic Device; Complication of Transplanted Organ)	125
9	**Organic Psychotic Conditions** (Including: Senile and Presenile Organic Psychotic Conditions, Dementia, Alcoholic and Drug Psychoses)	121
10	**Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Mental Disorders** (Includes: Hysteria, Anxiety States, Phobic Disorders, Schizoid Personality Disorder, Alcohol and Drug Dependence, Eating Disorders)	120
	Top Ten Total Claim Count	**2,055**
	Percent Of All Inpatient Claims	**44.9%**

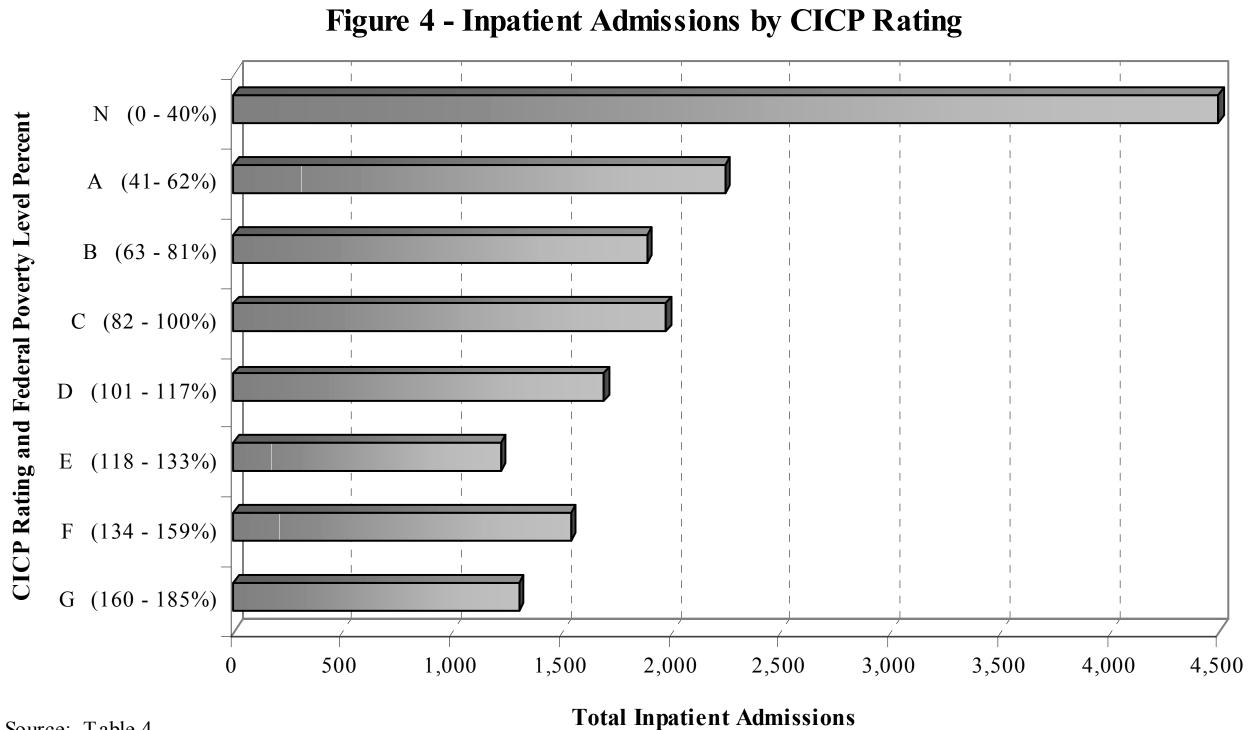
The top most common diagnosis description for an inpatient admission at University Hospital was categorized under Symptoms, which includes symptoms in alteration of consciousness, nervous system, skin, metabolism, head and neck, cardiovascular system, respiratory system, digestive system and urinary system. Comparing Denver Health and University Hospital, University Hospital had more diagnosis codes relating to heart disease, while Denver Health treated more cases of mental disorders.

Chart 6 - Top 10 Inpatient Diagnoses At University Hospital

	Diagnosis Description	Claim Count
1	**Symptoms** (Includes: Symptoms in Alteration of Consciousness, Nervous System, Skin, Metabolism, Head and Neck, Cardiovascular System, Respiratory System, Digestive System, Urinary System)	156
2	**Other Forms of Heart Disease** (Acute Pericarditis, Acute Myocarditis, Heart Failure)	138
3	**Other Psychoses** (Includes: Schizophrenic Disorders, Manic Depressive, Bipolar Affective Disorder, Paranoid States, Depression)	121
4	**Ischemic Heart Disease** (Includes: Acute Myocardial Infarction, Angina Pectoris, Coronary Atherosclerosis)	112
5	**Other Diseases of Digestive System** (Includes: Chronic Liver Disease, Acute Gallbladder Disorders, Diseases of the Pancreas, Gastrointestinal Hemorrhage)	106
6	**Complications of Surgical and Medical Care, Not Elsewhere Classified** (Includes: Mechanical Complication of Cardiac Device, Genitourinary Device or Orthopedic Device; Infection Due to Internal Prosthetic Device; Complication of Transplanted Organ)	101
7	**Diseases of Other Endocrine Glands** (Includes: Diabetes Mellitus, Disorders of Parathyroid Gland, Disorders of Pituitary Gland, Disorders of Thymus Gland, Ovarian Dysfunction)	68
8	**Chronic Obstructive Pulmonary Disease and Allied Conditions** (Includes: Bronchitis, Emphysema, Asthma)	58
9	**Pneumonia and Influenza** (Includes: Viral and Bacterial Pneumonia)	52
10	**Liveborn Infants According to Type of Birth** (Includes: Single, Twin and Other Multple Liveborns and Stillborns)	49
	Top Ten Total Claim Count	**961**
	Percent of All Inpatient Claims	**49.1%**

Figure 4 shows that inpatient services were rendered most frequently to individuals receiving the CICP N rating (4,493), which also consists of the new CICP Z rating for the homeless, followed by the CICP A rating (2,240) and the CICP C rating (1,973). Persons rated below 100% of the Federal Poverty Level (CICP N, A, B, or C ratings) accounted for 64.0% of inpatient admissions. The following graph shows the total inpatient admissions by CICP rating and Federal Poverty Level percentage for FY 2002-03.

Figure 4 - Inpatient Admissions by CICP Rating



Source: Table 4.

Outpatient Visits

Of the 153,171 clients who received outpatient services in FY 2002-03, there were 499,580 visits to a CICP provider.

- Total outpatient activity grew to 499,580 in FY 2002-03, which was a 4.8% increase from the FY 2001-02 figure of 476,837.
- For FY 2002-03, 96.8% of the total services rendered were for outpatient care, while outpatient visits accounted for 42.4% of charges submitted.
- 481,055 or 96.3% of all outpatient visits were provided to persons age 18 or older.
- Outpatient services were distributed in the following manner:
  - Outstate Clinics – 37.2%
  - Outstate Disproportionate Share Hospitals – 22.4%
  - Medicaid Disproportionate Share Hospitals – 3.1%
  - Denver Health – 29.4%
  - University Hospital – 7.9%

Chart 7 demonstrates that the number of outpatient visits fell by 4.7% in FY 2001-02 after rising 1.7% in the previous fiscal year. The 4.8% increase in FY 2002-03 was due significant increase in Medicaid DSH hospitals (20.5%) and moderate increases at Outstate DSH (12.0%) and Outstate clinics (5.8%). Denver Health showed a marginal decline (-0.6%). University Hospital posted a 2.7% decline, following a 7.2% decrease in the previous fiscal year and an 18.9% decline in FY 2000-01. Since FY 2000-01, visits at Outstate DSH have increased by 37.1%, while visits at University Hospital and Denver Health have decreased by 9.7% and 8.4% respectively.

Chart 7 - Comparison of Outpatient Visits

CICP Provider	FY 2000-01 Outpatient Visits	Percent Change	FY 2001-02 Outpatient Visits	Percent Change	FY 2002-03 Outpatient Visits	Percent Change
Outstate Clinics	201,268	-5.2%	175,504	-12.8%	185,619	5.8%
Outstate DSH	81,604	28.1%	99,897	22.4%	111,910	12.0%
Total Outstate	**282,872**	**2.5%**	**275,401**	**-2.6%**	**297,529**	**8.0%**
Medicaid DSH*	13,197	-5.6%	12,712	-3.7%	15,322	20.5%
Denver Health	160,576	8.5%	147,930	-7.9%	147,048	-0.6%
University Hospital	43,964	-18.9%	40,794	-7.2%	39,681	-2.7%
TOTALS	**500,609**	**1.7%**	**476,837**	**-4.7%**	**499,580**	**4.8%**

Source: CICP Analysis of Table 8 FY 2000-01 and FY 2001-02 Annual Report.
*For a list of Medicaid DSH providers see Chart 10.

The top most common diagnosis description at Denver Health and University Hospital for an outpatient visit was categorized under Symptoms, which includes symptoms in alteration of consciousness, nervous system, skin, metabolism, head and neck, cardiovascular system, respiratory system, digestive system, and urinary system. The top ten outpatient diagnoses at Denver Health accounted for 48.3% of all outpatient visits at the facility.

Chart 8 - Top 10 Outpatient Diagnoses At Denver Health

	Diagnosis Description	Claim Count
1	**Symptoms** (Includes: Symptoms in Alteration of Consciousness, Nervous System, Skin, Metabolism, Head and Neck, Cardiovascular System, Respiratory System, Digestive System, Urinary System)	11,864
2	**Persons Without Reported Diagnosis Encountered During Examination** (Includes: General Medical Examination, Screenings for Infectious Diseases, Screening for Mental Disorders)	9,872
3	**Diseases of Oral Cavity, Salivary Glands, and Jaws** (Includes: Disorder of Tooth Development, Gingival Disease, Dentofacial Anomalies, Diseases of the Salivary Glands)	9,816
4	**Diseases of Other Endocrine Glands** (Includes: Diabetes Mellitus, Disorders of Parathyroid Gland, Disorders of Pituitary Gland, Disorders of Thymus Gland, Ovarian Dysfunction)	7,646
5	**Persons Encountering Health Services in Circumstances Related to Reproduction and Development** (Includes: Pregnancy, Postpartum Care, Procreative Management, Observation of Newborns)	6,785
6	**Hypertensive Disease** (Includes: Hypertensive Heart and Renal Disease, Myocardial Infarction, Chronic Heart Disease)	5,836
7	**Arthropathies and Related Disorders** (Includes: Diseases of Connective Tissue, Rheumatoid Arthritis, Osteoarthrosis)	5,125
8	**Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Mental Disorders** (Includes: Hysteria, Anxiety States, Phobic Disorders, Schizoid Personality Disorder, Alcohol and Drug Dependence, Eating Disorders)	5,040
9	**Disorders of the Eye and Adnexa** (Includes: Retinol Disorders, Choroids Disorders, Glaucoma, Cataract)	4,603
10	**Dorsopathies** (Spondylitis, Intervertebral Disc Disorders, Other Disorders of Cervical Region)	4,434
	Top Ten Total Claim Count	**71,021**
	Percent of All Outpatient Claims	**48.3%**

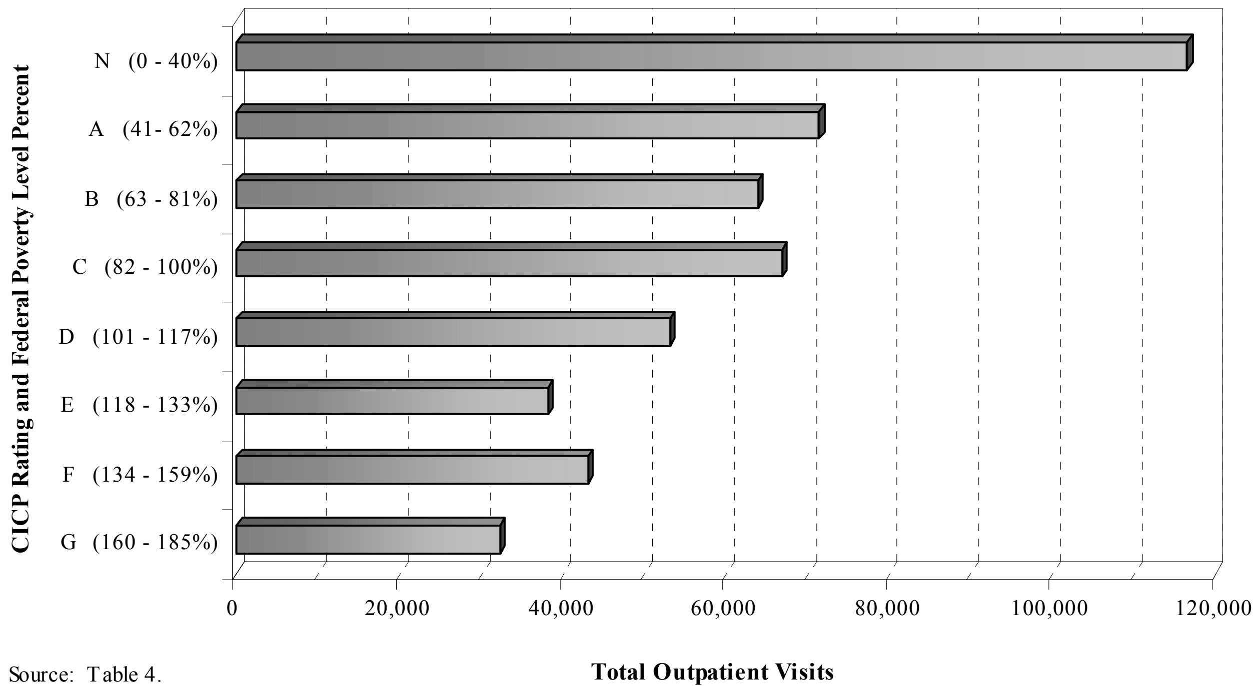
At Denver Health and University Hospital, Diseases of Other Endocrine Glands (which includes diabetes mellitus, disorders of parathyroid gland, disorders of pituitary gland, disorders of thymus gland, ovarian dysfunction), Hypertensive Disease (which includes hypertensive heart and renal disease, myocardial infarction, and chronic heart disease) were within the top ten diagnosis codes. As well, Dorsopathies (which include spondylitis, intervertebral disc disorders, and other disorders of the cervical region) showed on both lists of commonly used diagnosis codes. In contrast, University Hospital treated more cases involving heart disease than Denver. Chart 9 lists the top ten diagnosis codes at University Hospital, which accounted for 38.7% of all outpatient visits.

Chart 9 - Top 10 Outpatient Diagnoses At University Hospital

	Diagnosis Description	Claim Count
1	**Symptoms** (Includes: Symptoms in Alteration of Consciousness, Nervous System, Skin, Metabolism, Head and Neck, Cardiovascular System, Respiratory System, Digestive System, Urinary System)	4,769
2	**Arthropathies and Related Disorders** (Includes: Diseases of Connective Tissue, Rheumatoid Arthritis, Osteoarthrosis)	1,706
3	**Other Forms of Heart Disease** (Includes: Acute Pericarditis, Acute Myocarditis, Heart Failure)	1,382
4	**Dorsopathies** (Includes: Spondylitis, Intervertebral Disc Disorders, Other Disorders of Cervical Region)	1,330
5	**Human Immunodeficiency Virus (HIV) Infection** (Includes: Acquired Immune Deficiency Syndrome and Related Complex)	1,302
6	**Disorders of the Eye and Adnexa** (Includes: Retinal Disorders, Choroids Disorders, Glaucoma, Cataract)	1,298
7	**Diseases of Other Endocrine Glands** (Includes: Diabetes Mellitus, Disorders of Parathyroid Gland, Disorders of Pituitary Gland, Disorders of Thymus Gland, Ovarian Dysfunction)	960
8	**Acute Respiratory Infections** (Includes: Common Cold, Sinusitis, Bronchiolotis)	876
9	**Hypertensive Disease** (Includes: Hypertensive Heart and Renal Disease, Myocardial Infarction, Chronic Heart Disease)	872
10	**Persons With Need for Isolation, Other Potential Health Hazards and Prophylactic Measures** (Includes: Desensitization to Allergens, Aspymptomatic Human Immunodeficiency Virus, Infections with Drug-Resistant Microorganisms)	864
	Top Ten Total Claim Count	**15,359**
	Percent of All Outpatient Claims	**38.7%**

Persons with income and assets at 0 to 40% of the Federal Poverty Level (CICP N rating), which include clients who qualify under the CICP Z rating, were the most frequent users of outpatient care and individuals with an CICP A rating were the second most frequent users during FY 2002-03. Clients with a CICP N rating accounted for 22.0% of outpatient visits. Persons rated below 100% of the Federal Poverty Level (CICP N, A, B, or C ratings) accounted for 60.1% of outpatient visits. The following graph shows outpatient utilization by CICP rating for FY 2002-03.

Figure 5 - Outpatient Visits by CICP Rating



Source: Table 4.

III. PROVIDERS

BACKGROUND

The CICP contracts with any interested provider that meets all of the following criteria:

1. Is licensed as a general hospital, community clinic, or maternity hospital by the Department of Public Health and Environment;
2. Provides a minimum of 3% charity care; and
3. Has at least one on-site physician with staff privileges to perform non-emergency obstetric procedures (applies to hospitals only).

For the purposes of this FY 2002-03 Annual Report, the CICP providers are identified in the following categories by funding appropriation:

1. <u>Outstate Providers</u>
   - Outstate Clinics – clinics outside the geographic area of the City and County of Denver (except for Stout Street Clinic, which is a Specialty Clinic operating within the City and County of Denver.) For the purpose of this report, Stout Street Clinic is identified as an Outstate clinic.
   - Outstate Disproportionate Share Hospitals – hospitals located throughout the state, outside the City and County of Denver.
2. <u>Medicaid Disproportionate Share Hospital (DSH) Providers</u>
   - Medicaid Disproportionate Share Hospitals – this includes Platte Valley Medical Center, Prowers Medical Center, San Luis Valley Regional Medical Center, St. Vincent General Hospital and Valley View Hospital.
   - Medicaid Disproportionate Share Specialty Hospitals – this includes The Children's Hospital and National Jewish Medical and Research Center (in addition to qualifying for the specialty designation, these providers also qualify for Medicaid DSH payments).
   - Denver Health Medical Center – Denver Health, including 10 neighborhood outpatient clinics.
   - University Hospital – University Hospital.

Providers qualify to become Medicaid Disproportionate Share Hospitals (DSH) on a state fiscal year basis. Participation is determined by the Medicaid inpatient utilization rate. Chart 10 details the hospitals that have qualified as Medicaid DSH providers over the past eight fiscal years, excluding Denver Health and University Hospital which have qualified as Medicaid DSH providers in every year.

Chart 10 – Medicaid Disproportionate Share Hospital Providers

FY 1995-96 National Jewish Medical and Research Center Parkview Medical Center Platte Valley Medical Center San Luis Valley Regional Medical Center The Children's Hospital	**FY 1996-97** Platte Valley Medical Center The Children's Hospital
FY 1997-98 National Jewish Medical and Research Center Platte Valley Medical Center San Luis Valley Regional Medical Center The Children's Hospital	**FY 1998-99** National Jewish Medical and Research Center Platte Valley Medical Center San Luis Valley Regional Medical Center The Children's Hospital Valley View Hospital
FY 1999-00 National Jewish Medical and Research Center Platte Valley Medical Center San Luis Valley Regional Medical Center The Children's Hospital The Springs Center for Women Valley View Hospital	**FY 2000-01** National Jewish Medical and Research Center Platte Valley Medical Center San Luis Valley Regional Medical Center St. Vincent General Hospital The Children's Hospital The Springs Center for Women Valley View Hospital
FY 2001-02 National Jewish Medical and Research Center Platte Valley Medical Center San Luis Valley Regional Medical Center St. Vincent General Hospital The Children's Hospital The Springs Center for Women Valley View Hospital	**FY 2002-03** National Jewish Medical and Research Center Platte Valley Medical Center Prowers Medical Center San Luis Valley Regional Medical Center St. Vincent General Hospital The Children's Hospital Valley View Hospital

FY 2002-03 PROVIDER PARTICIPATION

A total of 62 contract providers participated in the CICP. This included 48 hospitals and 14 clinics. Most of the contracted clinic providers and several of the contracted hospital providers have multiple sites. Any site other than the main contracted facility is considered a satellite facility. There were 86 satellite CICP facilities throughout the state, including one hospital facility classified as a satellite facility.

Chart 11 - FY 2002-03 CICP Clinics and Hospitals by County

County	Clinics	Hospitals	Totals	County	Clinics	Hospitals	Totals
Adams	4	1	5	La Plata	2	1	3
Alamosa	4	1	5	Lake	0	1	1
Arapahoe	6	1	7	Larimer	5	3	8
Archuleta	0	0	0	Las Animas	0	1	1
Baca	0	1	1	Lincoln	0	0	0
Bent	1	0	1	Logan	2	1	3
Boulder	3	3	6	Mesa	1	1	2
Chaffee	2	1	3	Mineral	0	0	0
Cheyenne	0	0	0	Moffat	0	1	1
Clear Creek	1	0	1	Montezuma	1	1	2
Conejos	1	1	2	Montrose	2	1	3
Costilla	0	0	0	Morgan	1	2	3
Crowley	0	0	0	Otero	2	1	3
Custer	0	0	0	Ouray	0	0	0
Delta	0	1	1	Park	0	0	0
Denver	12	4	16	Phillips	1	1	2
Dolores	1	0	1	Pitkin	1	1	2
Douglas	0	0	0	Prowers	2	1	3
Eagle	3	0	3	Pueblo	6	2	8
El Paso	7	2	9	Rio Blanco	0	0	0
Elbert	0	0	0	Rio Grande	2	1	3
Fremont	2	1	3	Routt	0	1	1
Garfield	2	2	4	Saguache	2	0	2
Gilpin	1	0	1	San Juan	0	0	0
Grand	0	0	0	San Miguel	1	0	1
Gunnison	0	1	1	Sedgwick	1	1	2
Hinsdale	0	0	0	Summit	0	0	0
Huerfano	1	1	2	Teller	2	0	2
Jackson	0	0	0	Washington	1	0	1
Jefferson	6	1	7	Weld	5	1	6
Kiowa	0	0	0	Yuma	1	2	3
Kit Carson	2	1	3	**Totals**	**100**	**48**	**148**

Chart 12 lists CICP providers by the city in which the main contracting provider is located. A list of all current CICP providers, including satellite facilities, and the services they offer can be found on the Department of Health Care Policy and Financing's website.

Chart 12 - FY 2002-03 CICP Clinics and Hospitals by City

Provider Name	City	Provider Name	City
Outstate Clinics		**Outstate Disproportionate Share Hospitals (cont.)**	
Clinica Campesina	Lafayette	Memorial Hospital	Colorado Springs
Colorado Coalition for the Homeless	Denver	Mercy Medical Center	Durango
Columbine Family Health Center	Nederland	Montrose Memorial Hospital	Montrose
Community Health Center, Inc.	Colorado Springs	Mount San Rafael Hospital	Trinidad
Community Health Clinic	Dove Creek	North Colorado Medical Center	Greeley
High Plains Community Health Center	Lamar	Parkview Medical Center	Pueblo
La Clinica, Inc.	Gardner	Penrose-St. Francis HealthCare Systems	Colorado Springs
Metropolitan Denver Provider Network (MCPN)	Aurora	Poudre Valley Hospital	Fort Collins
People's Clinic	Boulder	Rio Grande Hospital	Del Norte
Pueblo Community Health Center	Pueblo	Sedgwick County Health Center	Julesburg
Salud Family Health Centers	Fort Lupton	Southeast Colorado Hospital	Springfield
Sunrise Community Health Center	Greeley	Southwest Memorial Hospital	Cortez
Uncompahgre Combined Clinics	Norwood	Spanish Peaks Regional Health Center	Walsenburg
Valley-Wide Health Services	Alamosa	St. Mary-Corwin Hospital	Pueblo
Outstate Disproportionate Share Hospitals		St. Mary's Hospital and Medical Center, Inc.	Grand Junction
Arkansas Valley Regional Medical Center	La Junta	St. Thomas More Hospital	Canon City
Aspen Valley Hospital	Aspen	Sterling Regional Medical Center	Sterling
Avista Hospital	Louisville	The Memorial Hospital	Craig
Boulder Community Hospital	Boulder	Wray Community District Hospital	Wray
Clagett Memorial Hospital	Rifle	Yampa Valley Medical Center	Steamboat Springs
Colorado Plains Medical Center	Fort Morgan	Yuma District Hospital	Yuma
Conejos County Hospital	La Jara	**Medicaid Disproportionate Share Hospitals**	
Delta County Memorial Hospital	Delta	Platte Valley Medical Center	Brighton
East Morgan County Hospital	Brush	Prowers Medical Center	Lamar
Estes Park Medical Center	Estes Park	San Luis Valley Regional Medical Center	Alamosa
Exempla Lutheran Medical Center	Wheat Ridge	St. Vincent General Hospital	Leadville
Gunnison Valley Hospital	Gunnison	Valley View Hospital	Glenwood Springs
HealthOne Medical Center of Aurora	Aurora	Denver Health and Hospital	Denver
Heart of the Rockies Regional Medical Center	Salida	University Hospital	Denver
Kit Carson County Memorial Hospital	Burlington	**Medicaid Disproportionate Share Specialty Hospitals**	
Longmont United Hospital	Longmont	National Jewish Medical and Research Center	Denver
McKee Medical Center	Loveland	The Children's Hospital	Denver
Melissa Memorial	Holyoke		

IV. REIMBURSEMENT

REIMBURSEMENT METHODOLOGY FOR OUTSTATE CLINICS AND HOSPITALS

Annually, the Colorado General Assembly appropriates an amount of money for Colorado Indigent Care Program (CICP) Outstate providers. In the FY 2002-03 Long Bill, these appropriations included the following line items:

Department of Health Care Policy and Financing
(4) Indigent Care Program

- Out-state Indigent Care Program
- The Children's Hospital, Clinic Based Indigent Care

Before FY 2001-02, at the beginning of each fiscal year, providers submitted estimated total annual charges for providing care to eligible CICP patients. Throughout the fiscal year, providers submitted actual utilization data to the CICP administration. Estimated payments were then reconciled to actual utilization, and provider payments were adjusted to reflect actual utilization at the end of the year. This methodology guaranteed that each provider was reimbursed the same percentage based on costs for the actual utilization in that given fiscal year. Unfortunately, the methodology also generated uncertainty for the providers, who may have been required to refund a portion of estimated payments once actual utilization was finalized. In addition, the reconciliation of estimated payments to the actual utilization data was not completed until at least six months after the close of the state fiscal year, causing accounting difficulties for the Department and providers.

Beginning July 1, 2001, payments to Outstate providers were based on historic costs. Reimbursement to general providers is limited by the annual legislative appropriation and funds were proportionately allocated to providers based on the anticipated utilization of services. The basis for the FY 2002-03 reimbursement calculation was the write-off cost data published in the CICP FY 2000-01 Annual Report. The write-off cost data was inflated forward using the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), Medical Care for Denver, through June 30 of the fiscal year payment period, which was 5.3%. The available appropriation divided by the sum of all providers' estimated write-off costs determined the CICP reimbursement percentage. This percentage was applied to each provider's costs to determine the annual reimbursement. The CICP calculated payments to providers based on 1/12 of this amount each month, distributed on a bimonthly basis. This methodology eliminated the financial uncertainty for providers, since they received a fixed reimbursement throughout the year. Increases in utilization are compensated through future reimbursements.

To generate Write-Off Costs, the following procedure was followed: Providers submitted Total Charges, Third Party Liability amounts and Patient Liability amounts to the Department. Total Charges reduced by Third Party Liability and Patient Liability determined Write-Off Charges. Write-off Charges were converted to Write-Off Costs by applying each provider's cost-to-charge ratio to Write-Off Charges. The provider's cost-to-charge ratios for this report were provided by the Colorado Medicaid Audit Contractor and were calculated from the most recently audited Medicare Cost Report for each provider.

REIMBURSEMENT FOR OUTSTATE CLINICS AND HOSPITALS

Prior to FY 1994-95, all reimbursement to Outstate CICP providers was completely General Fund. Beginning in FY 1994-95, Outstate hospitals qualified to receive a Disproportionate Share Hospital (DSH) payment allowing the providers to receive federal matching funds. For FY 2002-03 the federal matching funds rate was at 50.00% of total funds spent reimbursing providers for indigent care. In FY 2001-02, continuing in FY 2002-03, publicly-owned Outstate DSH became eligible to receive an additional Medicare Upper Payment Limit payment, which allowed their CICP reimbursement to consist entirely of federal funds. Privately-owned Outstate DSH were not eligible for this payment. Therefore, the CICP reimbursement to privately-owned Outstate DSH was completely a DSH payment, eligible for a federal match. Outstate clinics continued to be reimbursed using 100% General Fund until FY 2002-03.

In FY 2002-03, the Colorado General Assembly appropriated $23,812,224 in total funds (General Fund $6,658,608, Federal Funds $11,906,112 and Cash Funds Exempt $5,247,504) to reimburse Outstate DSH providers. A total amount of $386,457 (General Fund $5,179.95, Federal Funds $193,229.05 and Cash Funds Exempt $188,048.00) was reverted, due to amounts that were to be awarded to two Outstate DSH providers, one of which terminated their relationship with the program, and the other which converted to qualify as a Medicaid DSH Hospital provider. The FY 2002-03 appropriation for Outstate clinics was $6,119,760 in total funds (General Fund $3,059,880, and Federal Funds $3,059,880).

The inflated write-off costs based on the CICP FY 2000-01 Annual Report was $73,926,736 for Outstate DSH. The actual write-off costs were $111,549,560 (see Table 1). Since the FY 2002-03 reimbursement to Outstate DSH providers was calculated at 30% of the inflated write-off costs and the actual write-off costs were $37.6 million higher, Outstate DSH providers were not actually reimbursed the expected 30% on FY 2002-03 costs. Instead, the average reimbursement was 16.5%. The low reimbursement rate is due to economic factors that have caused Outstate DSH costs to unexpectedly and dramatically increase over recent years. As shown in Chart 16, costs increased by 100% since FY 2000-01, growing by 39.4% and 43.6% in the previous two fiscal years. Because the reimbursement methodology is based on historic write-off costs, the large increase in write-off costs in FY 2001-02 was incorporated into the reimbursement rate for FY 2003-04.

The inflated write-off costs based on the CICP FY 2000-01 Annual Report was $20,199,181 for Outstate clinics. The actual write-off costs were $22,502,544 (see Table 1). The FY 2002-03 reimbursement to Outstate clinic providers was calculated at 30% of the inflated write-off costs. The actual average reimbursement was 26.9%.

On average, Outstate providers were reimbursed 18.22% of actual FY 2002-03 write-off costs. This follows a 20.12% reimbursement rate for write-off costs in FY 2001-02 and 26.96% of write-off costs in FY 2000-01. In FY 1999-00, the reimbursement rate was 24.04%, while in FY 1998-99 and FY 1997-98 the reimbursement level was 30% of write-off costs. See Chart 15 for historical reimbursement rates.

REIMBURSEMENT CHRONOLOGY FOR OUTSTATE CLINICS AND HOSPITALS

FY 1994-95 Funding – The Department received approval from the Health Care Financing Administration (HCFA) to refinance Outstate hospital payments. This allowed the State to receive federal matching funds for all Outstate hospital payments.

FY 1995-96 Funding – The General Assembly increased the FY 1995-96 Outstate appropriation by 54%. This increase was estimated to cover 30% of Outstate providers' write-off costs.

FY 1996-97 Funding – During the first quarter of the fiscal year, three hospitals were determined to no longer meet DSH requirements (Parkview Episcopal Medical Center, National Jewish Medical and Research Center and San Luis Valley Regional Medical Center). These hospitals were reimbursed from the Specialty and Outstate DSH line. A supplemental request from the Department for FY 1996-97 to maintain the existing funding level of 30% for Outstate programs was approved.

FY 1997-98 Funding – The Indigent Care Program for FY 1997-98 was appropriated $20,064,310. This included the additional appropriation of $414,648 as authorized in SB-171 to address legal immigrants that were no longer eligible for Medicaid following the federal welfare reform law and the federal immigration act. This reflected a 12.22% increase in funds.

FY 1998-99 Funding – The original Indigent Care Program appropriation of $20,109,577 was reduced by $2,749,729 to $17,359,848 (General Fund $10,851,656 and Federal Funds $6,508,192) by supplemental appropriation in January 1999. This reduction was directly related to the actual payments reported during FY 1997-98, which showed a decrease in the overall utilization compared to the estimated costs submitted early that year to the Joint Budget Committee. The reduction maintained the assumed reimbursement level at 30% of write-off costs.

FY 1999-2000 Funding – The Indigent Care Program appropriation for the year was $16,294,325 (General Fund $9,681,862 and Federal Funds $6,612,463). The lower appropriation compared to the previous year was due to savings from the estimated number of children that would move from the Medically Indigent Program to the Child Health Plan Plus program. Based on the available General Fund appropriation, providers were reimbursed at 24.045% of write-off costs.

FY 2000-01 Funding – The original appropriation of $16,294,325 was increased by a supplemental appropriation to $19,237,054 (General Fund $12,423,912 and Federal Funds $6,813,142) based on projections from FY 1999-00 estimated write-off costs to achieve a reimbursement rate of 26.966%. In addition, the General Assembly appropriated $1,467,517 (General Fund $761,802 and Federal Funds $705,715) as supplemental funds to reimburse the unreported FY 1998-99 claims identified during FY 2000-01 at 30% of write-off costs.

FY 2001-02 Funding – The General Assembly originally appropriated $18,718,067 in total funds (General Fund $5,088,378, Federal Funds $9,359,033 and Cash Funds Exempt $4,270,656) to reimburse Outstate DSH providers. This was modified by a supplemental appropriation to $18,162,000 (General Fund $4,991,246, Federal Funds $9,081,000 and Cash Funds Exempt $4,089,754). The FY 2001-02 appropriation for Outstate clinics was separated from the Outstate DSH appropriation and was set at $5,595,482 General Fund. The large increase in the Outstate

DSH appropriation was due to a change in reimbursement methodology using certification of public expenditures as the state match on Disproportionate Share Hospital and Medicare Upper Payment Limit for inpatient hospital services to receive federal funds for public hospitals. The average reimbursement for all Outstate providers was 20.13%, with Outstate DSH averaging 18.12% and Outstate clinics averaging 28.16%.

FY 2002-03 Funding – The General Assembly appropriated $23,812,224 in total funds (General Fund $6,658,608, Federal Funds $11,906,112 and Cash Funds Exempt $5,247,504) to reimburse Outstate DSH providers. The FY 2002-03 appropriation for Outstate clinics was $6,119,760 ($3,059,880 General Fund and $3,059,880 Federal Funds). The Outstate clinic reimbursement was refinanced as a Major Teaching Hospital Payment to the Children's Hospital, which was eligible for a federal match[3]. In addition, the average reimbursement for all Outstate providers was 18.22%, with Outstate DSH averaging 16.46% and Outstate clinics averaging 26.93%. Due to the decrease in Disproportionate Share Hospital Allotment, Disproportionate Share Hospital payments in SFY 2002-03 were substantially lower than the previous year.

FY 2003-04 Funding – Within the Department's FY 2003-04 budget request and approved by the General Assembly, the Department proposed changes in the distribution of the Colorado Indigent Care Program funds. The Department decided to continue basing reimbursement on indigent care costs reported by the provider, but allowed the volume of Medicaid and indigent care patients served by the provider to determine what percentage of indigent care costs would be reimbursed.

This new reimbursement method replaces the FY 2002-03 methodology for rate setting for the Outstate Indigent Care Program. The new reimbursement method maximizes federal funds and minimize the General Fund expenditure, while providing a more equitable and efficient method of distributing funds to providers. The concept of limiting Outstate Disproportionate Share Hospital payments to 30% of costs associated with servicing the medically indigent population is terminated under the new reimbursement method. The new reimbursement method raises the reimbursement rate beyond 30% of costs for some providers, with no extra General Fund expenditure.

The new reimbursement method does not effect reimbursement to CICP Outstate clinic providers nor does it request any change in the line item appropriation for this group.

[3] For more detail, please see the section titled "Medicare Upper Payment Limit".

REIMBURSEMENT FOR DISPROPORTIONATE SHARE HOSPITAL PROVIDERS

All CICP hospital are considered "safety net" hospitals because they provide services to a disproportionate share of Medicaid and low-income patients. Every year, the Medicaid program determines which hospitals are Medicaid Disproportionate Share Hospital (DSH) providers. Federal regulations allow that hospitals that provide services to a disproportionate share of Medicaid recipients shall receive an additional payment amount. The minimum criterion is having a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals receiving Medicaid payments in the state, or a low-income utilization rate that exceeds 25%. The disproportionate share payment to the Outstate DSH is based on the Medicaid inpatient days utilizing a minimum of one percent of the hospital services. These hospitals must have at least two obstetricians with staff privileges. The hospitals must participate in the CICP program to receive this reimbursement adjustment.

Medicaid DSH providers receive payments to help offset the uncompensated costs of providing services to uninsured or underinsured patients. The funding for these payments comes from State General Funds and certification of funds, which are then matched with federal funds. CICP data are used to calculate the amount of local hospital contributions, provider payment amounts and each hospital's share of uncompensated care to low income persons. Therefore, the amount paid to each facility relates directly to CICP utilization. Due to the decrease in Disproportionate Share Hospital Allotment, Disproportionate Share Hospital payments in FY 2002-03 were substantially lower than the previous year.

A more detailed description of Medicaid DSH reimbursement is described in the section titled, "Medicaid Disproportionate Share Hospitals".

REIMBURSEMENT TRENDS FOR CICP PROVIDERS

Chart 13 - FY 2002-03 CICP Reimbursement

	General Fund	Cash Funds Exempt	Federal Funds	Total Funds	Payments to Providers (7)
Outstate Clinics (1)	**$3,059,880**	**$0**	**$3,059,880**	**$6,119,760**	**$6,119,760**
Outstate Hospitals (2)	**$6,653,430**	**$5,059,456**	**$11,712,882**	**$23,425,768**	**$18,366,312**
DSH Payment	$6,653,430	$3,547,517	$10,200,943	$20,401,890	$16,854,373
UPL Payment	$0	$1,511,939	$1,511,939	$3,023,878	$1,511,939
Total Outstate Providers	**$9,713,310**	**$5,059,456**	**$14,772,762**	**$29,545,528**	**$24,486,072**
Medicaid DSH*	**$3,532,181**	**$611,928**	**$4,144,108**	**$8,288,217**	**$7,676,289**
DSH Payment	$3,532,181	$0	$3,532,180	$7,064,361	$7,064,361
Bad Debt Payment	$0	$611,928	$611,928	$1,223,856	$611,928
Denver Health	**$0**	**$49,833,221**	**$49,833,221**	**$99,666,442**	**$49,833,221**
DSH Payment	$0	$35,685,582	$35,685,582	$71,371,164	$35,685,582
Bad Debt Payment	$0	$3,010,791	$3,010,791	$6,021,582	$3,010,791
Major Teaching Payment (3)	$0	$11,136,848	$11,136,848	$22,273,696	$11,136,848
University Hospital	**$0**	**$28,946,310**	**$28,946,310**	**$57,892,620**	**$28,946,310**
DSH Payment	$0	$17,876,871	$17,876,871	$35,753,742	$17,876,871
Bad Debt Payment	$0	$452,593	$452,593	$905,186	$452,593
Major Teaching Payment (4)	$0	$10,616,846	$10,616,846	$21,233,692	$10,616,846
Total CICP Reimbursement	**$13,245,491**	**$84,450,915**	**$97,696,401**	**$195,392,807**	**$110,941,892**
Clinic Payment (5)	$3,059,880	$0	$3,059,880	$6,119,760	$6,119,760
DSH Payment (6)	$10,185,611	$57,109,970	$67,295,576	$134,591,157	$77,481,187
UPL Payment (5)	$0	$1,511,939	$1,511,939	$3,023,878	$1,511,939
Bad Debt Payment (6)	$0	$4,075,312	$4,075,312	$8,150,624	$4,075,312
Major Teaching Payment (5)	$0	$21,753,694	$21,753,694	$43,507,388	$21,753,694

Source: Table 1.

*For a list of Medicaid DSH providers see Chart 10.

(1) $6,119,760 was paid to the Children's Hospital, which administers the Outstate Clinics payment. $60,000 of total funds were retained by the Children's Hopsital for the administration of this payment.

(2) Accounts payable were created in the amount of $386,457 ($5,180 GF, $193,230 FF, $188,047 CFE) during SFY 02-03 for the Outstate Hospitals payment.

(3) An additional $9,602,023 in federal funds under a Major Teaching Payment was paid to Denver Health, which was contributed back to the State.

(4) An additional $5,991,517 in federal funds under a Major Teaching Payment was paid to University Hospital, which was contributed back to the State.

(5) Payments classified under Outstate Clinics, UPL Payment and Major Teaching Payment are accounted for under the Upper Payment Limit.

(6) Payments classified under DSH Payment and Bad Debt Payment are accounted for under the Disproportionate Share Hospital Allotment.

(7) Payments to Providers is actual cash payment and is the sum of General Fund and federal funds.

Chart 13 shows the total reimbursement to the CICP providers in FY 2002-03 by State General Fund, Cash Funds Exempt and federal funds splits. The Cash Funds Exempt section of the table is an accounting record to document the certification of public expenditures on Medicaid and indigent populations that have not previously been compensated at publicly-owned hospitals, which are eligible for a federal match.

Chart 14 calculates the reimbursement rate relative to write-off costs for all CICP provider groups. The Outstate providers were reimbursed at 18.22% of write-off costs. Denver Health received a 57.81% and University Hospital stood at 48.85%. The Medicaid DSH group received the largest reimbursement rate, 72.53%.

Chart 14 - FY 2002-03 CICP Reimbursement Rates

	Reimbursement	Write-Off Costs	Reimbursement Rate
Outstate Clinics	$6,059,760	$22,502,544	26.93%
Outstate DSH	$18,366,312	$111,549,560	16.46%
Total Outstate Providers	**$24,426,072**	**$134,052,104**	**18.22%**
Medicaid DSH*	$7,676,289	$10,584,219	72.53%
Denver Health	$49,833,221	$86,205,611	57.81%
University Hospital	$28,946,310	$59,256,585	48.85%
Total CICP Providers	**$110,881,892**	**$290,098,519**	**38.22%**

Source: Table 1.
*For a list of Medicaid DSH providers see Chart 10.

The reimbursement percentage to all CICP providers on actual costs fell to 38.22% in FY 2002-03 as shown in Chart 15. In FY 2001-02, the rate decreased from 62.68% to 47.18%, between the previous year. Medicaid DSH providers began receiving higher reimbursement rates in FY 1997-98, when bad debt was implemented. The reimbursement to University Hospital increased from 66.76% in FY 1999-00 to 83.32% in FY 2000-01, but then fell to 48.85% in FY 2002-03.

Chart 15 - Historical CICP Reimbursement Rates

	Reimbursement Rate On CICP Write-Off Costs					
	FY 1997-98	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03
Outstate Clinics	30.00%	30.00%	24.04%	26.97%	28.16%	26.93%
Outstate Hospitals	30.00%	30.00%	24.04%	26.97%	18.12%	16.46%
Total Outstate Providers	**30.00%**	**30.00%**	**24.04%**	**26.97%**	**20.13%**	**18.22%**
Medicaid DSH*	85.74%	145.69%	95.23%	135.59%	111.17%	72.53%
Denver Health	61.16%	74.47%	59.34%	76.29%	60.39%	57.81%
University Hospital	82.33%	65.48%	66.76%	83.32%	64.54%	48.85%
Average CICP Providers	**56.61%**	**61.58%**	**51.22%**	**62.68%**	**47.18%**	**38.22%**

Source: Analysis of CICP Annual Reports.
*For a list of Medicaid DSH providers see Chart 10.

As shown in Chart 16, Outstate DSH write-off costs have increased by 100% since FY 2000-01, growing by 39.4% and 43.6% in FY 2001-02 and FY 2002-03, respectively. The reimbursement to these same providers has increased by 22.3% over the FY 2000-01 level. Outstate clinic providers, write-off costs have increased 23.5% over the previous two fiscal years, and their reimbursement has grown by 23.4%. Write-off costs at Denver Health have increased by 1.2% compared to 37.3% at University hospital since FY 2000-01. The reimbursement to these facilities has decreased by 23.3% and 19.5%, respectively, over the same period. Due to the decrease in Disproportionate Share Hospital Allotment, Disproportionate Share Hospital payments in FY 2002-03 were substantially lower than the previous year.

Chart 16 - Historical CICP Charges, Costs and Reimbursements

	Charges			Write-Off Costs			Net Reimbursement		
	FY 2000-01	FY 2001-02	FY 2002-03	FY 2000-01	FY 2001-02	FY 2002-03	FY 2000-01	FY 2001-02	FY 2002-03
Outstate Clinics	$21,318,773	$22,650,884	$26,259,085	$18,217,007	$19,443,758	$22,502,544	$4,912,464	$5,475,170	$6,059,760
Percent Change	2.4%	6.2%	15.9%	-1.5%	6.7%	15.7%	10.5%	11.5%	10.7%
Outstate Hospitals	$136,990,893	$195,351,197	$274,312,222	$55,709,729	$77,671,355	$111,549,560	$15,022,896	$14,072,240	$18,366,312
Percent Change	32.5%	42.6%	40.4%	31.7%	39.4%	43.6%	47.7%	-6.3%	30.5%
Total Outstate Providers	**$158,309,666**	**$218,002,081**	**$300,571,307**	**$73,926,736**	**$97,115,113**	**$134,052,104**	**$19,935,360**	**$19,547,410**	**$24,426,072**
Percent Change	27.4%	37.7%	37.9%	21.6%	31.4%	38.0%	36.4%	-1.9%	25.0%
Medicaid DSH*	$15,053,914	$14,675,946	$21,350,006	$8,117,838	$7,456,097	$10,584,219	$11,007,214	$8,288,856	$7,676,289
Percent Change	11.4%	-2.5%	45.5%	9.4%	-8.2%	42.0%	55.8%	-24.7%	-7.4%
Denver Health	$130,875,256	$147,780,952	$165,558,750	$85,152,277	$92,989,560	$86,205,611	$64,962,873	$56,151,768	$49,833,221
Percent Change	9.3%	12.9%	12.0%	6.5%	9.2%	-7.3%	36.9%	-13.6%	-11.3%
University Hospital	$79,361,923	$96,313,575	$119,036,083	$43,147,496	$53,066,076	$59,256,585	$35,948,849	$34,247,524	$28,946,310
Percent Change	-0.4%	21.4%	23.6%	-1.0%	23.0%	11.7%	23.5%	-4.7%	-15.5%
Total Medicaid DSH	**$225,291,093**	**$258,770,473**	**$305,944,839**	**$136,417,611**	**$153,511,733**	**$156,046,415**	**$111,918,936**	**$98,688,148**	**$86,455,820**
Percent Change	5.8%	14.9%	18.2%	4.2%	12.5%	1.7%	33.9%	-11.8%	-12.4%
Total CICP Providers	**$383,600,759**	**$476,772,554**	**$606,516,146**	**$210,344,347**	**$250,626,846**	**$290,098,519**	**$131,854,296**	**$118,235,558**	**$110,881,892**
Percent Change	**13.8%**	**24.3%**	**27.2%**	**9.7%**	**19.2%**	**15.7%**	**34.2%**	**-10.3%**	**-6.2%**

Source: CICP Analysis of Table 1 FY 2000-01, FY 2001-02 and FY 2002-03 Annual Reports. Includes updated information.

*For a list of Medicaid DSH providers see Chart 10.

REIMBURSEMENT PER INPATIENT DAY

Chart 17 reports the reimbursement per inpatient day by provider group for FY 2002-03. The reimbursement per inpatient day at Outstate DSH was $302.63, compared to Denver Health at $1,211.78 and University Hospital at $1,463.74.

Chart 17 - FY 2002-03 Reimbursement per Inpatient Day

CICP Provider	Inpatient Days	Total Net CICP Inpatient Reimbursment	Net CICP Reimbursement Per Inpatient Day*
Outstate Providers			
Clinics	N/A	N/A	N/A
Hospitals	37,922	$11,476,356	$302.63
Total Outstate	**37,922**	**$11,476,356**	**$302.63**
Medicaid DSH**	2,498	$3,595,404	$1,439.31
Denver Health	24,781	$30,029,018	$1,211.78
University Hospital	9,773	$14,305,151	$1,463.74

Source: Analysis of Tables 1, 2 and 8.
*Percentage of inpatient charges times estimated inpatient net reimbursement divided by the number of inpatient days.
**For a list of Medicaid DSH providers see Chart 10.

From FY 2000-01 to FY 2002-03 the number of inpatient days for Outstate DSH grew 57.6%, while net CICP reimbursement per inpatient day fell 26.8% to $302.63. In FY 2002-03, reimbursement per inpatient day fell by 71.8% to $1,463.74, while the number of days decreased by 30.7% over the past two fiscal years. Overall, CICP hospital providers have reported an increase in the ailment level of the clients served under the program, which increased the number of average number of days and the average cost per inpatient day. Historical reimbursement per inpatient day is show on Chart 18.

Chart 18 - Historical Reimbursement per Inpatient Day

CICP Provider	FY 2000-01 Net CICP Reimbursement Per Inpatient Day*	FY 2001-02 Net CICP Reimbursement Per Inpatient Day*	FY 2002-03 Net CICP Reimbursement Per Inpatient Day*
Outstate Providers			
Clinics	N/A	N/A	N/A
Hospitals	$383.77	$256.92	$302.63
Total Outstate	**$383.77**	**$256.92**	**$302.63**
Medicaid DSH**	$2,544.94	$2,055.54	$1,439.31
Denver Health	$1,495.06	$1,252.06	$1,211.78
University Hospital	$2,514.54	$2,021.05	$1,463.74

Source: Analysis of CICP Annual Reports.
*Percentage of inpatient charges times estimated inpatient net reimbursement divided by the number of inpatient days.
**For a list of Medicaid DSH providers see Chart 10.

REIMBURSEMENT PER OUTPATIENT VISIT

Chart 19 reports outpatient visits and reimbursement payments by CICP provider group during FY 2002-03. The reimbursement per outpatient visit at Outstate clinics was $32.65, compared to the Outstate DSH, which provided more outpatient emergency care at $61.57.

Chart 19 - FY 2002-03 Reimbursement per Outpatient Visit

CICP Provider	Outpatient Visits	Total CICP Outpatient Reimbursement	CICP Reimbursement Pre Outpatient Visit*
Outstate			
Clinics	185,619	$6,059,760	$32.65
Outstate DSH	111,910	$6,889,956	$61.57
Total Outstate	**297,529**	**$12,949,716**	**$43.52**
Medicaid DSH**	15,322	$3,461,730	$225.93
Denver Health	147,048	$19,804,204	$134.68
University Hospital	39,681	$11,544,283	$290.93

Source: Analysis of Tables 1, 2 and 8.
*Percentage of outpatient charges times estimated outpatient net reimbursement divided by the number of outpatient visits.
**For a list of Medicaid DSH providers see Chart 10.

From FY 2000-01 the number of outpatient visits at Outstate clinics declined by 7.8%, while the reimbursement per visit grew by 55.9%, as demonstrated in Chart 20. Over the same two fiscal year period, Outstate DSH visits increased by 37.1% and the reimbursement by visit rose by 3.4%. The numbers of outpatient visits at University Hospital have decreased 9.7%, while the average reimbursement per visit has increased 26.6% since FY 2000-01.

Chart 20 - Historical Reimbursement per Outpatient Visit

CICP Provider	FY 2000-01 CICP Reimbursement Pre Outpatient Visit*	FY 2001-02 CICP Reimbursement Pre Outpatient Visit*	FY 2002-03 CICP Reimbursement Pre Outpatient Visit*
Outstate Providers			
Clinics	$20.94	$31.20	$32.65
Outstate DSH	$59.53	$53.70	$61.57
Total Outstate	**$29.84**	**$39.36**	**$43.52**
Medicaid DSH**	$264.01	$291.32	$225.93
Denver Health	$164.05	$161.74	$134.68
University Hospital	$229.89	$329.09	$290.93

Source: Analysis of CICP Annual Reports.
*Percentage of outpatient charges times estimated outpatient net reimbursement divided by the number of outpatient visits.
**For a list of Medicaid DSH providers see Chart 10.

V. PROGRAM ADMINISTRATION

REPORTING REQUIREMENTS AND PREVENTION OF FRAUD BY PROVIDERS

The Colorado Indigent Care Program (CICP) Provider Audit Guidelines for FY 2002-03 require providers to submit an annual audit compliance statement. The purpose of the audit requirement is to furnish the Department of Health Care Policy and Financing (the Department) with a separate audit report that attests to provider compliance with specified provisions of the CICP's contract and related manuals.

The audit must be conducted in one of two ways depending on the amount of total reimbursement received under the CICP:

External Audit: If a provider received over $500,000 in reimbursement from CICP an independent auditor must perform an annual audit and submit a formal audit statement of compliance to the CICP administration.

Internal Audit: If a provider received under $500,000 in reimbursement from CICP the provider may elect to conduct the annual compliance audit internally, rather than an external audit. If the provider elects to perform an internal audit, the provider administrator must submit an internal audit statement following the same Provider Compliance Audit guidelines as the External Audit. An internal audit should be conducted by the facility's auditor. If the facility does not have an auditor on staff, then personnel who do not directly determine client CICP eligibility or handle CICP billing records should be chosen.

The provider contract contains remedies to be taken by the State in the event the scope of work is not fulfilled. Providers are required to retain patient records validating income and assets claimed by the patient in determining eligibility for CICP.

PREVENTION OF FRAUD BY RECIPIENTS

At the time of application, each CICP applicant is required to sign a statement that the information given to the provider is accurate and that false statements could result in a prosecution by local authorities. The individual is notified of his/her client rights at the time of application.

The application also includes a penalty clause, confirmation statement and authorization for release of information. Part of the statement reads, "I authorize the Department of Health Care Policy and Financing to use any information contained in the application to verify my eligibility for this program, and to obtain records pertaining to eligibility from a financial institution as defined in Section 15-15-201(4), C.R.S., or from any insurance company." The client is required to sign this statement.

Any client reporting false information on a CICP application should be reported to the local county District Attorney's office or the local police by the provider. In accordance with 26-15-122, C.R.S., any person who represents that any medical service is reimbursable or subject to payment under this article when he knows that it is not and any person who represents that he is eligible for assistance under this article when he knows that he is not commits a class 2 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S.

In addition, if the false information is to defraud the provider or the State, it is a Class 5 Felony, as defined by the following:

> C.R.S 18-5-102 - Forgery.
>
> (1) A person commits forgery, if, with intent to defraud, such person falsely makes, completes, alters, or utters a written instrument which is or purports to be, or which is calculated to become or to represent if completed:
>
> (e) A written instrument officially issued or created by a public office, public servant, or government agency; or
>
> C.R.S. 18-5-114 - Offering a false instrument for recording.
>
> (1) A person commits offering a false instrument for recording in the first degree if, knowing that a written instrument relating to or affecting real or personal property or directly affecting contractual relationships contains a material false statement or material false information, and with intent to defraud, he presents or offers it to a public office or a public employee, with the knowledge or belief that it will be registered, filed, or recorded or become a part of the records of that public office or public employee.
>
> (2) Offering a false instrument for recording in the first degree is a class 5 felony.
>
> (3) A person commits offering a false instrument for recording in the second degree if, knowing that a written instrument relating to or affecting real or personal property or directly affecting contractual relationships contains a material false statement or material false information, he presents or offers it to a public office or a public employee, with the knowledge or belief that it will be registered, filed, or recorded or become a part of the records of that public office or public employee.
>
> (4) Offering a false instrument for recording in the second degree is a class 1 misdemeanor.

PRIORITIES AMONG MEDICAL SERVICES RENDERED

The legislation authorizing CICP, Section 26-15-106, (9)(a) - (9)(b)(III), C.R.S., requires that every provider awarded a contract must prioritize, for each fiscal year, the medical services which it will be able to render, within the limits of its funds. Each contract must specify the extent of the contractor's physical, staff, and financial capabilities. The statute prioritizes the following services:

- ❒ Emergency care for the full year;
- ❒ Any additional medical care for those conditions the state department determines to be the most serious threat to the health of medically indigent persons; and
- ❒ Any other medical care.

The indigent care population, for the majority of the time, utilizes hospital care for catastrophic injuries or events. Clinics, on the other hand, have the opportunity to focus on preventive care to control and avoid hospitalization. Several of the clinics provide evening and Saturday clinic hours and in several counties are the only available CICP providers.

COLLECTION OF THIRD PARTY PAYMENTS

The CICP guidelines for FY 2002-03 require providers to collect all available payments from third party resources. A patient with third party insurance coverage must provide verification that:

1. Payment was sought from the third party insurer for the patient billing, and
2. Any third party liability was taken into account along with any contractual adjustments and applied against the total write-off charges.

Providers are required to seek third party reimbursement before the account is charged to the CICP. This requirement is described in the CICP Manual and regulations, as follows:

- If patients receive coverage under the CICP, and their insurance subsequently pays for services, or if the patient is awarded a settlement, the CICP is due reimbursement for amounts paid by CICP to the provider for services rendered to the patient. The provider is then responsible to reimburse CICP for payments it received for care so reimbursed.
- Providers shall identify and shall collect payments from third-party payment sources before billing the CICP program.

In addition, the contract between the Department and the CICP provider states that the provider shall make all reasonable efforts to collect amounts due from third party coverage and applicable copayment amounts, and shall maintain auditable evidence of such efforts.

INCENTIVES FOR UTILIZATION CONTROL

Incentives for efficient utilization of resources are built into the CICP by the very nature of the reimbursement level and providers are contracted to prioritize their services to emergency and urgent care to CICP patients. Most Outstate DSH providers have limited services to provide only emergency and urgent care.

VI. FUTURE DIRECTION

COORDINATION WITH OTHER MEDICAL PROGRAMS

A major Department effort has been to inform families about the Child Health Plan Plus (CHP+), a health insurance plan available to families with incomes under 185% of the Federal Poverty Level. Many of the Colorado Indigent Care Program (CICP) providers also participate as an enrollment site for the CHP+ program. Providers are encouraged to educate families on the benefits of the CHP+ program. It is anticipated that the CICP program will serve fewer children each year as more children gradually enroll into the CHP+ program (actual number of children transferring from CICP to CHP+ is not available at this time). Effective July 1, 2002 children eligible for CHP+ were no longer eligible for the CICP.

The 1997 Balanced Budget Act provided states with the opportunity to receive federal funding to provide subsidized health insurance to low-income children. The federal authorization falls under Title XXI of the Social Security Act (P.L. 105-100), known as the Children's Health Insurance Program (CHIP). Legislation was passed in Colorado in 1997 and 1998 (26-19-101 et seq. C.R.S.*)* that provided authority to implement Colorado's program, the Children's Basic Health Plan (CBHP), marketed as the Child Health Plan Plus (CHP+). Colorado submitted its Title XXI State Plan to the federal Health Care Financing Administration on October 13, 1997 (the first state in the country to submit a non-Medicaid Expansion State Plan) and obtained approval on February 18, 1998. The CHP+ provides subsidized comprehensive health insurance for Colorado children at or below 185% of the Federal Poverty Level. The comprehensive health benefits package covers inpatient and outpatient services, including preventative care, prescription drugs, limited vision and hearing services, and limited mental health and substance abuse services. Effective February 1, 2002 a dental benefit was added to the CHP+ benefit package and then on October 8, 2002, the program expanded prenatal care to eligible pregnant women.

CENTRAL REGISTRY OF PERSONS RECEIVING ASSISTANCE

The goal of the Colorado Benefits Management System (CBMS) is to provide system-wide electronic eligibility rules for a spectrum of medical/public assistance programs. The CICP has been included in the design of this system and was included in the RFP released in March of 1999. The Department, along with the Department of Human Services, has contracted with Electronic Data Systems (EDS) to design and implement CBMS. This system will provide a benefit to the CICP since it will automatically verify that a client is not eligible for Medicaid and CBHP before enrollment into CICP.

PROPOSED REIMBURSEMENT METHODOLOGY

In the Department's FY 2003-04 budget request to the General Assembly, the Department requested a change to the reimbursement methodology for Disproportionate Share Hospitals and CICP providers. This request combines the methodologies for rate setting for the Major Teaching Hospitals, Out-state Indigent Care Program, Disproportionate Share Payments to Hospitals, Pre-Component 1 Disproportionate Share Payments to Hospitals and Bad Debt. The primary goal in combining the methodologies was to create a more simplified system that can be generally understood by Department staff and the providers. Another goal was to make the calculation dependent on information available for the November 1 budget submission to reduce the number of Supplemental and Budget Request Amendments associated with these payments. Further, the rate setting process was changed to maximize the federal funds and minimize the General Fund available to the system, while equitably distributing the pool of money to providers who served a disproportionate number of Medicaid and low-income clients.

In addition, this methodology utilizes the Medicare Upper Payment Limit for privately-owned facilities. This allows the Department to shift payments from the Disproportionate Share Hospital Limit to the Medicare Upper Payment Limit and increase the reimbursement to publicly owned providers. Since certification of public expenditures is available to match federal funds for publicly-owned providers, their reimbursement will increase and no increase in General Fund is required. The new reimbursement methodology for Outstate DSH providers increases reimbursements beyond the 30% of costs that was regarded as a cap, with no extra General Fund expenditure.

The initial calculations under the proposed reimbursement methodology demonstrate a more equitable distribution of funds. A privately owned hospital, which provides 14.5% of total days to Medicaid and 5.1% of total days to indigent care, receives approximately 48.2% reimbursement on indigent care costs. A publicly owned hospital, which provides 14.4% of total days to Medicaid and 2.8% of total days to indigent care, receives a slightly lower reimbursement (approximately 47.8%) on indigent care costs, since they provide fewer total days to the medically indigent population. Under the current methodology, both these providers would have received the same reimbursement percentage on indigent care costs. The proposed methodology allows Denver Health and University Hospital to receive the highest reimbursement on indigent care costs (approximately 60.4%), since they provide the largest percentage of Medicaid and indigent care days. These figures are only estimates based on the data used to set the FY 2002-03 provider reimbursement. The percentage of indigent care costs reimbursed for each provider will change for FY 2003-04.

VII. DATA MANAGEMENT TECHNIQUES

Data Collection at University of Colorado Health Sciences Center (UCHSC): The Colorado Indigent Care Program (CICP) providers, prior to FY 1997-98, submitted on a monthly basis, patient demographic and financial information to UCHSC. These claims were entered manually or downloaded by tape or disk. Claims were accepted at UCHSC without the Social Security Number. Sources believe that prior years' unduplicated client count was understated and was reported as "estimated" due to the probability of a reporting error. Unduplicated claims were verified using statistical models that matched the claim by the Social Security Number, Name, and/or Provider Name.

Electronic Claims submission to Blue Cross Blue Shield (BCBS) and to Consultec, Inc.: For the first four months of FY 1998-99 (July 1, 1998 – November 20, 1998) the claims processing system was with BCBS for acceptance of the CICP electronic claims. From November 1998 through April 1999, providers were unable to submit claims electronically, due to the transition to Consultec, Inc. In April 1999, Consultec began accepting claims. Providers were allowed to submit claims electronically using the Automated Medical Payment (AMP) DOS-based software or through an electronic claims vendor service. Claims were submitted on a daily basis and accepted/ rejected reports were available online within less than two hours. These reports were retrieved electronically. All claims were required to include a Social Security Number, date of birth, CICP rating, county of residence and other features. Mandatory fields with missing information were rejected. In a few cases, claims without a Social Security Number were submitted with a patient account number.

Problems that occurred during the Start-Up Process and Steps taken to Correct the Data: During the transition period from BCBS to Consultec, several electronic errors occurred that resulted in unreported claims and omissions of critical data elements from the claims (third party payments and patient liability information). Within one fiscal year, providers were required to work with two fiscal agents. However, as with the transition from BCBS and to Consultec, Inc. the Department acknowledges that not all claims were received for the entire fiscal year. Many providers chose not to submit any of their FY 1998-99 claims to BCBS and decided to wait until Consultec was accepting them. A level of frustration occurred when providers learned that they only had six months or less to submit an entire year of claims. Similar to FY 1997-98, providers were allowed an additional 30 days to submit FY 1998-99 claims (through October 29). In the event FY 1998-99 claims were not billed, providers were allowed to submit them to the fiscal agent during FY 1999-00. The lists of reasons for errors and slow start-ups range from incompatibility of equipment and software specifications, to limited qualified electronic information staff, especially in rural Colorado. The Department received a number of FY 1998-99 claims during the FY 1999-00. These FY 1998-99 claim data were not part of the CICP annual report.

Electronic Claims submission to Consultec, Inc.: During FY 1999-00 providers electronically submitted claims to Consultec. The CICP administration received notice from almost every provider that not all claims had been transmitted correctly by Consultec. Providers were allowed to self-declare any missing charges and claims directly to the CICP administration, since providers were frustrated with the Consultec system. These self-reported figures were included in the FY 1999-00 Annual Report and the final reimbursement to providers.

Consultec, Inc. Proposed Phase II for the Colorado Indigent Care Program: The FY 1998-99 Colorado Indigent Care Annual Report stated that beginning in late Spring of FY 1999-00 the CICP claim process would be fully integrated into the Medicaid Management Information System (MMIS). Due to the increase in administrative costs associated with processing CICP claims, the Department reversed this decision on February 1, 2001.

CICP Data Collection System: Effective July 1, 2001 the CICP administration began receiving summary information from each provider that allowed the Department to publish the annual report and reimburse providers. Providers no longer electronically submit claims. The summary information is reported on a quarterly basis and providers submitted the FY 2000-01 claim information in this format. The goal of the CICP Data Collection System is to reduce the program's administration costs for the Department and providers. Data collection under this format was used to write this annual report and reimburse providers. Overall, the CICP administration and providers are pleased with this system.

CICP Data: Inpatient admissions and outpatient visits are normally counted on a claim basis. Providers are allowed to span bill on outpatient claims, so a claim with several visits in a month would count as only one visit in this report. Several providers have reported actual visits, not using a claim count.

Unduplicated client count is a count of unique social security numbers by provider. Providers are requested to report a unique count for inpatient, outpatient and total clients served. Several providers could not produce a separate count for total clients, so inpatient and outpatient totals were added to create total clients. Since this count is done at the provider level, a client who receives care at multiple CICP providers is counted multiple times in this figure. These conditions create an unduplicated count that overstates the number of actual clients receiving care under the CICP.

VIII. FINANCIAL TABLES

Table 1 - Total Financial Activity and CICP Reimbursement

Providers	Charges	Third Party Liability	Patient Liability	Write-Off Charges	Write-Off Costs	Reimbursement
Outstate Clinic Providers						
Clinica Campesina	$1,298,833	$0	$200,445	$1,098,388	$1,098,388	$261,992
Colorado Coalition for the Homeless (2)	$2,712,317	$32,285	$0	$2,680,032	$2,680,032	$639,872
Columbine Family Health Center	$626,291	$0	$74,918	$551,373	$551,373	$110,330
Community Health Center, Inc. (2)	$5,577,995	$267,767	$772,848	$4,537,380	$4,537,380	$1,564,478
Community Health Clinic (2)	$71,666	$1,125	$13,715	$56,826	$56,826	$7,414
High Plains Community Health Center (2)	$604,666	$15,805	$51,245	$537,616	$537,616	$106,156
La Clinica	$15,633	$0	$3,132	$12,501	$12,501	$3,568
Metropolitan Denver Provider Network (2)	$2,799,877	$0	$440,992	$2,358,885	$2,358,885	$500,916
People's Clinic	$1,227,944	$0	$121,235	$1,106,709	$1,106,709	$240,635
Pueblo Community Health Center (2)	$3,091,221	$1,236	$503,168	$2,586,817	$2,586,817	$745,931
Salud Family Health Centers	$4,162,884	$0	$758,329	$3,404,555	$3,404,555	$817,054
Sunrise Community Health Center	$1,789,850	$0	$155,070	$1,634,780	$1,634,780	$614,547
Uncompahgre Combined Clinics	$52,217	$2,416	$6,108	$43,693	$43,693	$13,288
Valley-Wide Health Systems	$2,227,691	$0	$334,702	$1,892,989	$1,892,989	$433,579
Total Outstate Clinics	**$26,259,085**	**$320,634**	**$3,435,907**	**$22,502,544**	**$22,502,544**	**$6,059,760**
Outstate Disproportionate Share Hospital Providers						
Arkansas Valley Regional Medical Center	$4,234,740	$529,345	$62,943	$3,642,452	$2,012,455	$403,764
Aspen Valley Hospital	$1,041,353	$53,719	$20,161	$967,473	$656,915	$94,044
Avista Adventist Hospital	$2,380,072	$65,431	$44,803	$2,269,838	$1,141,728	$211,044
Boulder Community Hospital (1)	$7,282,922	$299,244	$90,928	$6,892,750	$3,773,091	$434,016
Clagett Memorial Hospital	$578,425	$31,486	$11,739	$535,200	$400,116	$35,292
Colorado Plains Medical Center	$1,801,592	$237,883	$27,344	$1,536,365	$736,380	$178,572
Conejos County Hospital	$374,048	$7,370	$15,576	$351,102	$202,691	$57,000
Delta County Memorial Hospital	$1,101,486	$24,816	$31,907	$1,044,763	$627,276	$126,660
East Morgan County Hospital	$261,300	$95,939	$7,507	$157,854	$142,401	$24,084
Estes Park Medical Center	$1,668,249	$43,762	$63,070	$1,561,417	$1,184,647	$70,584
Exempla Lutheran Medical Center	$10,628,116	$1,184,490	$123,769	$9,319,857	$3,685,071	$445,932
Gunnison Valley Hospital	$77,438	$1,875	$835	$74,728	$49,156	$8,760
HealthOne Medical Center of Aurora	$8,934,237	$48,062	$46,910	$8,839,265	$2,783,485	$379,092
Heart of the Rockies Regional Medical Center	$1,296,765	$270,808	$27,023	$998,934	$594,166	$100,200
Kit Carson County Memorial Hospital	$228,561	$19,577	$9,204	$199,780	$136,669	$33,264

Table 1 - Total Financial Activity and CICP Reimbursement

Providers	Charges	Third Party Liability	Patient Liability	Write-Off Charges	Write-Off Costs	Reimbursement
Longmont United Hospital	$4,696,860	$51,061	$61,745	$4,584,054	$2,535,898	$343,980
McKee Medical Center	$10,199,578	$4,110,512	$321,958	$5,767,108	$3,110,778	$491,220
Melissa Memorial	$168,340	$35,208	$9,772	$123,360	$95,185	$27,516
Memorial Hospital (1)	$58,337,585	$4,091,929	$717,886	$53,527,770	$20,720,600	$3,619,956
Mercy Medical Center	$4,727,564	$308,573	$116,071	$4,302,920	$2,405,332	$417,444
Montrose Memorial Hospital	$2,127,965	$415,506	$82,991	$1,629,468	$862,477	$520,416
Mount San Rafael Hospital	$1,273,845	$152,338	$22,768	$1,098,739	$517,396	$105,120
North Colorado Medical Center	$19,916,442	$6,723,857	$974,502	$12,218,083	$6,827,465	$1,444,548
Parkview Medical Center (1)	$31,656,089	$2,651,706	$265,899	$28,738,484	$12,009,812	$1,765,116
Penrose-St. Francis Health Services (1)	$25,332,181	$1,391,259	$181,449	$23,759,473	$9,950,467	$1,174,800
Poudre Valley Hospital (1)	$13,125,454	$568,445	$256,192	$12,300,817	$7,528,100	$1,080,132
Rio Grande Hospital	$340,755	$22,399	$12,020	$306,336	$232,478	$45,984
Sedgwick County Health Center	$47,490	$5,066	$3,291	$39,133	$31,029	$17,760
Southeast Colorado Hospital and LTC	$161,953	$36,994	$5,185	$119,774	$119,774	$21,324
Southwest Memorial Hospital (1)	$2,868,078	$875,179	$55,807	$1,937,092	$1,242,063	$129,900
Spanish Peaks Regional Health Center	$1,116,061	$254,775	$20,999	$840,287	$574,756	$79,524
St. Mary-Corwin Hospital (1)	$34,694,877	$1,744,031	$382,659	$32,568,187	$14,417,937	$2,344,080
St. Mary's Hospital and Medical Center, Inc. (1)(2)	$12,755,224	$160,192	$342,465	$12,252,567	$5,687,641	$1,205,736
St. Thomas More Hospital (1)	$3,309,145	$174,677	$47,836	$3,086,632	$1,590,541	$298,116
Sterling Regional Medical Center	$2,556,125	$811,514	$73,499	$1,671,112	$1,019,044	$216,276
The Memorial Hospital (1)	$630,069	$36,244	$20,572	$573,253	$435,157	$162,588
Wray Community District Hospital	$248,234	$13,100	$8,436	$226,698	$167,530	$23,736
Yampa Valley Medical Center (1)	$1,383,532	$49,518	$40,564	$1,293,450	$946,676	$167,904
Yuma District Hospital	$749,472	$138,015	$37,321	$574,136	$395,177	$60,828
Total Outstate Disproportionate Share Hospital Providers	**$274,312,222**	**$27,735,905**	**$4,645,606**	**$241,930,711**	**$111,549,560**	**$18,366,312**
Total Outstate Providers	**$300,571,307**	**$28,056,539**	**$8,081,513**	**$264,433,255**	**$134,052,104**	**$24,426,072**

Table 1 - Total Financial Activity and CICP Reimbursement

Providers	Charges	Third Party Liability	Patient Liability	Write-Off Charges	Write-Off Costs	Reimbursement
Medicaid Disproportionate Share Hospitals						
Platte Valley Medical Center (5)	$4,129,071	$531,093	$50,548	$3,547,430	$1,666,228	$1,025,825
Prowers Medical Center (5)	$2,377,125	$429,967	$59,122	$1,888,036	$992,163	$518,694
San Luis Valley Regional Medical Center (5)	$4,172,845	$796,657	$105,087	$3,271,101	$1,812,844	$852,105
St. Vincent General Hospital (5)	$153,928	$8,453	$13,255	$132,220	$94,219	$178,057
Valley View Hospital (5)	$1,127,675	$89,143	$16,551	$1,021,981	$705,371	$529,798
Medicaid Disproportionate Share Specialty Hospitals						
National Jewish Medical and Research Center (2)(5)	$2,445,047	$348,996	$60,057	$2,035,994	$1,905,283	$1,358,083
The Children's Hospital (1)(2)(3)(5)	**$6,944,315**	**$299,986**	**$99,080**	**$6,545,249**	**$3,408,111**	**$3,213,727**
The Children's Hospital	$5,719,014	$259,403	$87,413	$5,372,198	$2,797,303	$2,594,572
University Physicians, Inc.	$1,225,301	$40,583	$11,667	$1,173,051	$610,808	$619,155
Sub-Total Medicaid Disproportionate Share Hospital Providers	**$21,350,006**	**$2,504,295**	**$403,700**	**$18,442,011**	**$10,584,219**	**$7,676,289**
Denver Health Medical Center (1)(2)(4)(5)(6)	**$165,558,750**	**$11,262,556**	**$4,059,855**	**$150,236,339**	**$86,205,611**	**$49,833,221**
University Hospital (1)(2)(3)(5)(6)	**$119,036,083**	**$12,198,229**	**$1,436,600**	**$105,401,254**	**$59,256,585**	**$28,946,310**
University Hospital	$102,679,463	$11,327,495	$1,351,980	$89,999,988	$50,597,993	$25,849,434
University Physicians, Inc.	$16,356,620	$870,734	$84,620	$15,401,266	$8,658,592	$3,096,876
Total Medicaid Disproportionate Share Hospital Providers	**$305,944,839**	**$25,965,080**	**$5,900,155**	**$274,079,604**	**$156,046,415**	**$86,455,820**
Total All CICP Providers	**$606,516,146**	**$54,021,619**	**$13,981,668**	**$538,512,859**	**$290,098,519**	**$110,881,892**

Notes:
(1) Includes physician charges, third party payments and patient liabilities.
(2) Includes outpatient pharmacy charges, third party payments and patient liabilities.
(3) Includes University Physicians, Inc. charges, third party payments and patient liabilities.
(4) Includes ambulance charges, third party payments and patient liabilities.
(5) Total Reimbursement Includes Component 1A payment and Bad Debt payment.
(6) Total Reimbursement Includes Major Teaching Hopsital payment.

Table 1A - Bad Debt, Medicaid Disproportionate Share Hospitals and Major Teaching Reimbursement Detail

	FFY 2002-03 Bad Debt	Component 1A	Major Teaching Hospital	CICP Reimbursement
Platte Valley Medical Center	$93,777	$932,048	$0	$1,025,825
Prowers Medical Center	$35,986	$482,708	$0	$518,694
San Luis Valley Regional Medical Center	$60,389	$791,716	$0	$852,105
St. Vincent General Hospital	$38,408	$139,649	$0	$178,057
Valley View Hospital	$169,004	$360,794	$0	$529,798
National Jewish Medical and Research Center	$40,183	$1,317,900	$0	$1,358,083
The Children's Hospital	$174,181	$2,420,391	$0	$2,594,572
University Physicians, Inc.	$0	$619,155	$0	$619,155
Denver Health and Hospital (1)	$3,010,791	$35,685,582	$11,136,848	$49,833,221
University Hospital (2)	$452,593	$14,779,995	$10,616,846	$25,849,434
University Physicians, Inc.	$0	$3,096,876	$0	$3,096,876
Total	**$4,075,312**	**$60,626,814**	**$21,753,694**	**$86,455,820**

Notes:
(1) An additional $9,602,023 in Major Teaching was paid to Denver Health, which was contributed back to the State.
(2) An additional $5,991,517 in Major Teaching was paid to University Hospital, which was contributed back to the State.

Table 1B - Physician Detail

	Charges	Third Party Liability	Patient Liability	Write-Off Charges
Boulder Community Hospital	$108,951	$0	$0	$108,951
Memorial Hospital	$6,628,054	$254,570	$159,930	$6,213,554
Parkview Medical Center	$1,799,714	$0	$0	$1,799,714
Penrose-St. Francis HealthCare Systems	$3,628,496	$0	$0	$3,628,496
Poudre Valley Hospital	$46,626	$6,676	$1,925	$38,025
Southwest Memorial Hospital	$51,109	$0	$3,249	$47,860
St. Mary-Corwin Hospital	$3,621,026	$0	$0	$3,621,026
St. Mary's Hospital and Medical Center, Inc.	$1,569,772	$157,743	$124,405	$1,287,624
St. Thomas More Hospital	$1,114,835	$53,579	$0	$1,061,256
The Memorial Hospital	$75,969	$816	$1,140	$74,013
University Physicians Inc.	**$17,581,921**	**$911,317**	**$96,287**	**$16,574,317**
The Children's Hospital	$1,225,301	$40,583	$11,667	$1,173,051
University Hospital	$16,356,620	$870,734	$84,620	$15,401,266
Yampa Valley Medical Center	$37,811	$0	$0	$37,811
Total	**$36,264,284**	**$1,384,701**	**$386,936**	**$34,492,647**

Table 1C - Outpatient Pharmacy Detail

	Charges	Third Party Liability	Patient Liability	Write-Off Charges
Colorado Coalition for the Homeless	$503,389	$0	$0	$503,389
Community Health Center, Inc.	$1,214,158	$0	$495,842	$718,316
Community Health Clinic	$4,538	$0	$2,640	$1,898
High Plains Community Health Center	$77,817	$0	$8,095	$69,722
Metropolitan Denver Provider Network	$943,978	$0	$273,611	$670,367
Pueblo Community Health Center	$1,268,150	$0	$312,598	$955,552
St. Mary's Hospital and Medical Center, Inc.	$70,137	$0	$6,517	$63,620
National Jewish Medical and Research Center	$136,755	$376	$15,724	$120,655
The Children's Hospital	$231,270	$0	$15,625	$215,645
University Hospital	$4,017,863	$1,682,462	$412,660	$1,922,741
Total	**$8,468,055**	**$1,682,838**	**$1,543,312**	**$5,241,905**

Table 1D - Denver Health Detail

	Charges	Third Party Liability	Patient Liability	Write-Off Charges
Inpatient and Outpatient Charges	$142,065,462	$11,077,094	$2,477,523	$128,510,845
Physician Services (1)	$16,084,854	$735,415	$0	$15,349,439
Ambulance Services	$2,003,662	$45,103	$25,270	$1,933,289
Stout Street Lab Services	$924,315	$0	$0	$924,315
Outpatient Pharmacy	$4,480,457	$0	$962,006	$3,518,451
Total	**$165,558,750**	**$11,857,612**	**$3,464,799**	**$150,236,339**

Notes:
(1) Starting in FY 2003 Denver Health began reporting Outpatient Physician Services, which were not reported in the previous years' Annual Reports.

Table 2A - Inpatient and Outpatient Charges (Details)

Providers	Urgent Outpatient Charges	Non-Urgent Outpatient Charges	Urgent Inpatient Charges	Non-Urgent Inpatient Charges	Total Charges
Outstate Clinic Providers					
Clinica Campesina	$0	$1,298,833	$0	$0	$1,298,833
Colorado Coalition for the Homeless	$0	$2,208,928	$0	$0	$2,208,928
Columbine Family Health Center	$239,653	$386,638	$0	$0	$626,291
Community Health Center, Inc.	$144,157	$4,219,680	$0	$0	$4,363,837
Community Health Clinic	$7,733	$59,395	$0	$0	$67,128
High Plains Community Health Center	$496,405	$30,444	$0	$0	$526,849
La Clinica	$1,521	$14,112	$0	$0	$15,633
Metropolitan Denver Provider Network	$0	$1,855,899	$0	$0	$1,855,899
People's Clinic	$0	$1,227,944	$0	$0	$1,227,944
Pueblo Community Health Center	$784	$1,822,287	$0	$0	$1,823,071
Salud Family Health Centers	$4,162,884	$0	$0	$0	$4,162,884
Sunrise Community Health Center	$0	$1,789,850	$0	$0	$1,789,850
Uncompahgre Combined Clinics	$44,036	$8,181	$0	$0	$52,217
Valley-Wide Health Systems	$2,227,691	$0	$0	$0	$2,227,691
Total Outstate Clinics	**$7,324,864**	**$14,922,191**	**$0**	**$0**	**$22,247,055**
Outstate Disproportionate Share Hospital Providers					
Arkansas Valley Regional Medical Center	$1,235,460	$1,442,276	$1,210,407	$346,597	$4,234,740
Aspen Valley Hospital	$119,864	$249,098	$521,653	$150,738	$1,041,353
Avista Adventist Hospital	$240,922	$732,641	$776,836	$629,673	$2,380,072
Boulder Community Hospital	$1,197,379	$1,644,852	$2,848,178	$1,483,562	$7,173,971
Clagett Memorial Hospital	$132,344	$225,926	$34,512	$185,643	$578,425
Colorado Plains Medical Center	$323,942	$157,696	$984,349	$335,605	$1,801,592
Conejos County Hospital	$116,627	$0	$257,421	$0	$374,048
Delta County Memorial Hospital	$262,318	$304,140	$307,036	$227,992	$1,101,486
East Morgan County Hospital	$52,072	$136,507	$40,152	$32,569	$261,300
Estes Park Medical Center	$342,603	$728,751	$304,508	$292,387	$1,668,249
Exempla Lutheran Medical Center	$1,745,383	$1,745,341	$5,355,275	$1,782,117	$10,628,116
Gunnison Valley Hospital	$77,438	$0	$0	$0	$77,438
HealthOne Medical Center of Aurora	$2,492,057	$137,884	$6,006,965	$297,331	$8,934,237
Heart of the Rockies Regional Medical Center	$526,626	$0	$770,139	$0	$1,296,765
Kit Carson County Memorial Hospital	$24,631	$84,742	$100,696	$18,492	$228,561

Table 2A - Inpatient and Outpatient Charges (Details)

Providers	Urgent Outpatient Charges	Non-Urgent Outpatient Charges	Urgent Inpatient Charges	Non-Urgent Inpatient Charges	Total Charges
Longmont United Hospital	$498,374	$644,551	$2,459,621	$1,094,314	$4,696,860
McKee Medical Center	$1,399,377	$2,515,405	$3,472,508	$2,812,288	$10,199,578
Melissa Memorial	$66,922	$76,868	$24,550	$0	$168,340
Memorial Hospital	$8,342,771	$8,853,830	$29,887,799	$4,625,131	$51,709,531
Mercy Medical Center	$1,007,342	$1,262,779	$1,937,648	$519,795	$4,727,564
Montrose Memorial Hospital	$347,142	$872,189	$423,613	$485,021	$2,127,965
Mount San Rafael Hospital	$459,304	$258,033	$346,916	$209,592	$1,273,845
North Colorado Medical Center	$2,526,544	$3,296,916	$7,774,566	$6,318,416	$19,916,442
Parkview Medical Center	$8,585,313	$3,531,596	$13,995,231	$3,744,235	$29,856,375
Penrose-St. Francis Health Services	$2,438,987	$2,970,175	$12,742,798	$3,551,725	$21,703,685
Poudre Valley Hospital	$1,645,093	$2,660,682	$7,726,482	$1,046,571	$13,078,828
Rio Grande Hospital	$125,989	$103,456	$111,310	$0	$340,755
Sedgwick County Health Center	$2,150	$41,021	$0	$4,319	$47,490
Southeast Colorado Hospital and LTC	$38,329	$49,563	$49,088	$24,973	$161,953
Southwest Memorial Hospital	$647,929	$812,981	$0	$1,356,059	$2,816,969
Spanish Peaks Regional Health Center	$333,331	$450,637	$332,093	$0	$1,116,061
St. Mary-Corwin Hospital	$3,211,170	$12,218,823	$10,569,255	$5,074,603	$31,073,851
St. Mary's Hospital and Medical Center, Inc.	$927,173	$2,887,698	$5,774,440	$1,526,004	$11,115,315
St. Thomas More Hospital	$263,317	$614,407	$394,976	$921,610	$2,194,310
Sterling Regional Medical Center	$0	$1,253,453	$0	$1,302,672	$2,556,125
The Memorial Hospital	$97,680	$150,907	$305,513	$0	$554,100
Wray Community District Hospital	$1,582	$129,155	$0	$117,497	$248,234
Yampa Valley Medical Center	$282,357	$0	$1,063,364	$0	$1,345,721
Yuma District Hospital	$45,673	$442,429	$241,814	$19,556	$749,472
Total Outstate Disproportionate Share Hospital Providers	**$42,183,515**	**$53,687,408**	**$119,151,712**	**$40,537,087**	**$255,559,722**
Total Outstate Providers	**$49,508,379**	**$68,609,599**	**$119,151,712**	**$40,537,087**	**$277,806,777**

Table 2A - Inpatient and Outpatient Charges (Details)

Providers	Urgent Outpatient Charges	Non-Urgent Outpatient Charges	Urgent Inpatient Charges	Non-Urgent Inpatient Charges	Total Charges
Medicaid Disproportionate Share Hospitals					
Platte Valley Medical Center	$624,852	$889,139	$1,927,739	$687,341	$4,129,071
Prowers Medical Center	$391,025	$672,644	$1,313,456	$0	$2,377,125
San Luis Valley Regional Medical Center	$1,110,655	$1,397,294	$1,664,896	$0	$4,172,845
St. Vincent General Hospital	$75,984	$0	$77,944	$0	$153,928
Valley View Hospital	$496,609	$79,754	$514,012	$37,300	$1,127,675
Medicaid Disproportionate Share Specialty Hospitals					
National Jewish Medical and Research Center	$10,537	$2,251,776	$5,593	$40,386	$2,308,292
The Children's Hospital	$672,998	$1,017,961	$3,796,785	$0	$5,487,744
Sub-Total Medicaid Disproportionate Share Hospital Providers	**$3,382,660**	**$6,308,568**	**$9,300,425**	**$765,027**	**$19,756,680**
Denver Health Medical Center	**$31,910,251**	**$24,547,937**	**$72,130,494**	**$13,476,780**	**$142,065,462**
University Hospital	**$18,362,653**	**$25,699,333**	**$44,948,302**	**$9,651,312**	**$98,661,600**
Total Medicaid Disproportionate Share Hospital Providers	**$53,655,564**	**$56,555,838**	**$126,379,221**	**$23,893,119**	**$260,483,742**
Total All CICP Providers	**$103,163,943**	**$125,165,437**	**$245,530,933**	**$64,430,206**	**$538,290,519**

Notes:

Table does not include physician, University Physicians Inc., outpatient pharmacy, or ambulance charges. Total Charges in Tables 2A and 2B will equal Charges in Table 1 by adding physician charges from Table 1B, pharmacy charged from Table 1C, and Denver Health detail charges (excluding inpatient and outpatient charges) from Table 1D.

Table 2B - Inpatient and Outpatient Charges (Totals)

Providers	Total Urgent Charges	Total Non-Urgent Charges	Total Charges	Total Outpatient Charges	Total Inpatient Charges	Total Charges
Outstate Clinic Providers						
Clinica Campesina	$0	$1,298,833	$1,298,833	$1,298,833	$0	$1,298,833
Colorado Coalition for the Homeless	$0	$2,208,928	$2,208,928	$2,208,928	$0	$2,208,928
Columbine Family Health Center	$239,653	$386,638	$626,291	$626,291	$0	$626,291
Community Health Center, Inc.	$144,157	$4,219,680	$4,363,837	$4,363,837	$0	$4,363,837
Community Health Clinic	$7,733	$59,395	$67,128	$67,128	$0	$67,128
High Plains Community Health Center	$496,405	$30,444	$526,849	$526,849	$0	$526,849
La Clinica	$1,521	$14,112	$15,633	$15,633	$0	$15,633
Metropolitan Denver Provider Network	$0	$1,855,899	$1,855,899	$1,855,899	$0	$1,855,899
People's Clinic	$0	$1,227,944	$1,227,944	$1,227,944	$0	$1,227,944
Pueblo Community Health Center	$784	$1,822,287	$1,823,071	$1,823,071	$0	$1,823,071
Salud Family Health Centers	$4,162,884	$0	$4,162,884	$4,162,884	$0	$4,162,884
Sunrise Community Health Center	$0	$1,789,850	$1,789,850	$1,789,850	$0	$1,789,850
Uncompahgre Combined Clinics	$44,036	$8,181	$52,217	$52,217	$0	$52,217
Valley-Wide Health Systems	$2,227,691	$0	$2,227,691	$2,227,691	$0	$2,227,691
Total Outstate Clinics	**$7,324,864**	**$14,922,191**	**$22,247,055**	**$22,247,055**	**$0**	**$22,247,055**
Outstate Disproportionate Share Hospital Providers						
Arkansas Valley Regional Medical Center	$2,445,867	$1,788,873	$4,234,740	$2,677,736	$1,557,004	$4,234,740
Aspen Valley Hospital	$641,517	$399,836	$1,041,353	$368,962	$672,391	$1,041,353
Avista Adventist Hospital	$1,017,758	$1,362,314	$2,380,072	$973,563	$1,406,509	$2,380,072
Boulder Community Hospital	$4,045,557	$3,128,414	$7,173,971	$2,842,231	$4,331,740	$7,173,971
Clagett Memorial Hospital	$166,856	$411,569	$578,425	$358,270	$220,155	$578,425
Colorado Plains Medical Center	$1,308,291	$493,301	$1,801,592	$481,638	$1,319,954	$1,801,592
Conejos County Hospital	$374,048	$0	$374,048	$116,627	$257,421	$374,048
Delta County Memorial Hospital	$569,354	$532,132	$1,101,486	$566,458	$535,028	$1,101,486
East Morgan County Hospital	$92,224	$169,076	$261,300	$188,579	$72,721	$261,300
Estes Park Medical Center	$647,111	$1,021,138	$1,668,249	$1,071,354	$596,895	$1,668,249
Exempla Lutheran Medical Center	$7,100,658	$3,527,458	$10,628,116	$3,490,724	$7,137,392	$10,628,116
Gunnison Valley Hospital	$77,438	$0	$77,438	$77,438	$0	$77,438
HealthOne Medical Center of Aurora	$8,499,022	$435,215	$8,934,237	$2,629,941	$6,304,296	$8,934,237
Heart of the Rockies Regional Medical Center	$1,296,765	$0	$1,296,765	$526,626	$770,139	$1,296,765
Kit Carson County Memorial Hospital	$125,327	$103,234	$228,561	$109,373	$119,188	$228,561

Table 2B - Inpatient and Outpatient Charges (Totals)

Providers	Total Urgent Charges	Total Non-Urgent Charges	Total Charges	Total Outpatient Charges	Total Inpatient Charges	Total Charges
Longmont United Hospital	$2,957,995	$1,738,865	$4,696,860	$1,142,925	$3,553,935	$4,696,860
McKee Medical Center	$4,871,885	$5,327,693	$10,199,578	$3,914,782	$6,284,796	$10,199,578
Melissa Memorial	$91,472	$76,868	$168,340	$143,790	$24,550	$168,340
Memorial Hospital	$38,230,570	$13,478,961	$51,709,531	$17,196,601	$34,512,930	$51,709,531
Mercy Medical Center	$2,944,990	$1,782,574	$4,727,564	$2,270,121	$2,457,443	$4,727,564
Montrose Memorial Hospital	$770,755	$1,357,210	$2,127,965	$1,219,331	$908,634	$2,127,965
Mount San Rafael Hospital	$806,220	$467,625	$1,273,845	$717,337	$556,508	$1,273,845
North Colorado Medical Center	$10,301,110	$9,615,332	$19,916,442	$5,823,460	$14,092,982	$19,916,442
Parkview Medical Center	$22,580,544	$7,275,831	$29,856,375	$12,116,909	$17,739,466	$29,856,375
Penrose-St. Francis Health Services	$15,181,785	$6,521,900	$21,703,685	$5,409,162	$16,294,523	$21,703,685
Poudre Valley Hospital	$9,371,575	$3,707,253	$13,078,828	$4,305,775	$8,773,053	$13,078,828
Rio Grande Hospital	$237,299	$103,456	$340,755	$229,445	$111,310	$340,755
Sedgwick County Health Center	$2,150	$45,340	$47,490	$43,171	$4,319	$47,490
Southeast Colorado Hospital and LTC	$87,417	$74,536	$161,953	$87,892	$74,061	$161,953
Southwest Memorial Hospital	$647,929	$2,169,040	$2,816,969	$1,460,910	$1,356,059	$2,816,969
Spanish Peaks Regional Health Center	$665,424	$450,637	$1,116,061	$783,968	$332,093	$1,116,061
St. Mary-Corwin Hospital	$13,780,425	$17,293,426	$31,073,851	$15,429,993	$15,643,858	$31,073,851
St. Mary's Hospital and Medical Center, Inc.	$6,701,613	$4,413,702	$11,115,315	$3,814,871	$7,300,444	$11,115,315
St. Thomas More Hospital	$658,293	$1,536,017	$2,194,310	$877,724	$1,316,586	$2,194,310
Sterling Regional Medical Center	$0	$2,556,125	$2,556,125	$1,253,453	$1,302,672	$2,556,125
The Memorial Hospital	$403,193	$150,907	$554,100	$248,587	$305,513	$554,100
Wray Community District Hospital	$1,582	$246,652	$248,234	$130,737	$117,497	$248,234
Yampa Valley Medical Center	$1,345,721	$0	$1,345,721	$282,357	$1,063,364	$1,345,721
Yuma District Hospital	$287,487	$461,985	$749,472	$488,102	$261,370	$749,472
Total Outstate Disproportionate Share Hospital Providers	**$161,335,227**	**$94,224,495**	**$255,559,722**	**$95,870,923**	**$159,688,799**	**$255,559,722**
Total Outstate Providers	**$168,660,091**	**$109,146,686**	**$277,806,777**	**$118,117,978**	**$159,688,799**	**$277,806,777**

Table 2B - Inpatient and Outpatient Charges (Totals)

Providers	Total Urgent Charges	Total Non-Urgent Charges	Total Charges	Total Outpatient Charges	Total Inpatient Charges	Total Charges
Medicaid Disproportionate Share Hospitals						
Platte Valley Medical Center	$2,552,591	$1,576,480	$4,129,071	$1,513,991	$2,615,080	$4,129,071
Prowers Medical Center	$1,704,481	$672,644	$2,377,125	$1,063,669	$1,313,456	$2,377,125
San Luis Valley Regional Medical Center	$2,775,551	$1,397,294	$4,172,845	$2,507,949	$1,664,896	$4,172,845
St. Vincent General Hospital	$153,928	$0	$153,928	$75,984	$77,944	$153,928
Valley View Hospital	$1,010,621	$117,054	$1,127,675	$576,363	$551,312	$1,127,675
Medicaid Disproportionate Share Specialty Hospitals						
National Jewish Medical and Research Center	$16,130	$2,292,162	$2,308,292	$2,262,313	$45,979	$2,308,292
The Children's Hospital	$4,469,783	$1,017,961	$5,487,744	$1,690,959	$3,796,785	$5,487,744
Sub-Total Medicaid Disproportionate Share Hospital Providers	**$12,683,085**	**$7,073,595**	**$19,756,680**	**$9,691,228**	**$10,065,452**	**$19,756,680**
Denver Health Medical Center	**$104,040,745**	**$38,024,717**	**$142,065,462**	**$56,458,188**	**$85,607,274**	**$142,065,462**
University Hospital	**$63,310,955**	**$35,350,645**	**$98,661,600**	**$44,061,986**	**$54,599,614**	**$98,661,600**
Total Medicaid Disproportionate Share Hospital Providers	**$180,034,785**	**$80,448,957**	**$260,483,742**	**$110,211,402**	**$150,272,340**	**$260,483,742**
Total All CICP Providers	**$348,694,876**	**$189,595,643**	**$538,290,519**	**$228,329,380**	**$309,961,139**	**$538,290,519**

Notes: Same as Table 2A.

IX. UTILIZATION DATA

Table 3 - Utilization by County*

County	Outstate Clinics	Outstate DSH	Medicaid DSH**	Denver Health	University Hospital	Total
Adams	20,141	403	1,930	1,513	9,377	33,364
Alamosa	9,759	163	2,094	4	51	12,071
Arapahoe	230	1,402	1,417	1,020	10,191	14,260
Archuleta	66	320	13	2	9	410
Baca	65	362	75	2	13	517
Bent	770	564	68	15	43	1,460
Boulder	17,978	4,556	182	20	765	23,501
Broomfield	954	106	20	2	355	1,437
Chaffee	9	1,011	11	2	60	1,093
Cheyenne	74	1	2	-	17	94
Clear Creek	864	86	10	3	138	1,101
Conejos	1,732	270	1,030	4	10	3,046
Costilla	2,209	72	762	5	18	3,066
Crowley	408	295	-	4	10	717
Custer	18	170	2	38	15	243
Delta	9	1,625	4	17	20	1,675
Denver	19,939	1,028	2,043	147,690	9,726	180,426
Dolores	873	414	2	-	-	1,289
Douglas	547	71	127	91	716	1,552
Eagle	45	46	17	17	40	165
Elbert	85	50	7	7	109	258
El Paso	27,728	21,437	154	10	421	49,750
Fremont	2,306	3,567	27	2	102	6,004
Garfield	1,638	646	478	-	58	2,820
Gilpin	854	61	13	-	68	996
Grand	23	45	31	-	107	206
Gunnison	5	125	13	2	27	172
Hindsdale	-	2	-	-	-	2
Huerfano	244	1,367	7	-	26	1,644
Jackson	-	28	-	1	1	30
Jefferson	4,975	2,652	511	820	6,431	15,389
Kiowa	62	33	26	1	8	130
Kit Carson	40	677	22	6	79	824
Lake	1	8	49	-	24	82
La Plata	1,435	2,817	1	-	21	4,274
Larimer	11,080	15,862	47	18	422	27,429
Las Animas	33	1,251	9	4	66	1,363
Lincoln	59	17	4	7	93	180
Logan	1,835	1,591	9	8	42	3,485
Mesa	18	4,284	15	1	63	4,381
Mineral	48	158	12	-	7	225
Moffat	16	307	1	1	6	331
Montezuma	586	2,294	-	3	41	2,924
Montrose	275	2,132	1	1	19	2,428
Morgan	2,913	1,260	11	13	69	4,266
Otero	3,188	3,924	22	2	83	7,219
Ouray	5	25	-	3	21	54
Park	86	57	34	4	111	292

Table 3 - Utilization by County*

County	Outstate Clinics	Outstate DSH	Medicaid DSH**	Denver Health	University Hospital	Total
Phillips	7	602	4	-	4	617
Pitkin	11	219	11	-	6	247
Prowers	3,032	186	1,351	2	52	4,623
Pueblo	20,228	29,216	57	6	142	49,649
Rio Blanco	-	35	1	1	3	40
Rio Grande	3,779	904	1,535	2	33	6,253
Routt	-	290	2	-	20	312
Saguache	2,236	145	785	-	3	3,169
San Juan	1	48	1	-	2	52
San Miguel	299	135	-	1	8	443
Sedgwick	-	278	8	-	8	294
Summit	23	39	23	7	70	162
Teller	2,431	372	14	-	15	2,832
Washington	68	58	7	1	17	151
Weld	14,679	5,920	437	23	750	21,809
Yuma	40	1,630	8	1	67	1,746
Unknown	2,557	1,487	474	215	341	5,074
Total	**185,619**	**121,206**	**16,031**	**151,622**	**41,640**	**516,118**

Notes:

*Total admit and visit count by reported patient residency.

**Medicaid Disproportionate Share Hospitals include: Platte Valley Medical Center, Prowers Medical Center, San Luis Valley Regional Center, St. Vincent General Hospital, Valley View Hospital, National Jewish Medical and Research Center and The Children's Hospital.

Table 4 - Outpatient Visits and Inpatient Admissions by CICP Rating

Outpatient Visits

	Outstate Clinics		Outstate DSH		Medicaid DSH*		Denver Health		University Hospital		All Providers	
CICP Rating	Visits	% of Total	Visits	% of Total	Visits	% of Total	Visits	% of Total	Visits	% of Total	Visits	% of Total
A	29,043	15.7%	14,695	13.1%	2,280	14.8%	19,904	13.5%	5,472	13.8%	71,394	14.3%
B	22,063	11.9%	12,555	11.2%	1,995	13.0%	21,829	14.9%	5,436	13.7%	63,878	12.7%
C	23,155	12.5%	12,471	11.1%	2,540	16.6%	22,199	15.1%	6,447	16.2%	66,812	13.4%
D	19,000	10.2%	11,559	10.3%	1,856	12.1%	15,575	10.6%	5,186	13.1%	53,176	10.6%
E	13,367	7.2%	8,665	7.8%	1,495	9.8%	11,453	7.8%	3,218	8.1%	38,198	7.6%
F	15,520	8.4%	10,780	9.6%	1,675	10.9%	10,880	7.4%	4,266	10.8%	43,121	8.6%
G	11,011	5.9%	8,960	8.0%	1,634	10.7%	7,446	5.1%	3,294	8.3%	32,345	6.5%
N	28,465	15.3%	19,073	17.0%	1,831	12.0%	30,213	20.5%	6,106	15.4%	85,688	17.2%
P	1,353	0.7%	9,902	8.9%	-	-	-	-	38	0.1%	11,293	2.3%
Z	21,294	11.5%	1,859	1.8%	-	-	7,549	5.1%	218	0.5%	30,920	6.2%
Unknown	1,348	0.7%	1,391	1.2%	16	0.1%	-	-	-	-	2,755	0.6%
Total	**185,619**	**100%**	**111,910**	**100%**	**15,322**	**100%**	**147,048**	**100%**	**39,681**	**100%**	**499,580**	**100%**

Inpatient Admissions

	Outstate Clinics		Outstate DSH		Medicaid DSH*		Denver Health		University Hospital		All Providers	
CICP Rating	Visits	% of Total	Admits	% of Total	Admits	% of Total	Admits	% of Total	Admits	% of Total	Admits	% of Total
A	-	-	1,315	14.1%	83	11.7%	564	12.3%	278	14.2%	2,240	13.5%
B	-	-	1,071	11.5%	68	9.6%	507	11.1%	240	12.3%	1,886	11.4%
C	-	-	1,055	11.3%	107	15.1%	552	12.1%	259	13.2%	1,973	11.8%
D	-	-	1,034	11.1%	82	11.6%	347	7.6%	226	11.5%	1,689	10.2%
E	-	-	772	8.3%	74	10.4%	241	5.3%	131	6.7%	1,218	7.4%
F	-	-	977	10.5%	104	14.6%	249	5.4%	206	10.5%	1,536	9.3%
G	-	-	849	9.1%	85	12.0%	195	4.3%	172	8.8%	1,301	7.9%
N	-	-	1,755	19.0%	104	14.7%	1,337	29.2%	339	17.3%	3,535	21.4%
P	-	-	58	0.6%	-	-	-	-	-	-	58	0.4%
Z	-	-	268	3.0%	-	-	582	12.7%	108	5.5%	958	5.8%
Unknown	-	-	142	1.5%	2	0.3%	-	-	-	-	144	0.9%
Total	-	-	**9,296**	**100%**	**709**	**100%**	**4,574**	**100%**	**1,959**	**100%**	**16,538**	**100%**

Notes:

*Medicaid Disproportionate Share Hospitals include: Platte Valley Medical Center, Prowers Medical Center, San Luis Valley Regional Center, St. Vincent General Hospital, Valley View Hospital, National Jewish Medical and Research Center and The Children's Hospital.

Table 5 - Inpatient Days by CICP Rating

CICP Rating	Outstate DSH	Medicaid DSH**	Denver Health	University Hospital	Total
A	5,352	285	2,659	1,318	9,614
B	4,269	197	2,791	1,382	8,639
C	4,274	419	2,931	1,278	8,902
D	4,272	253	1,987	1,280	7,792
E	3,105	237	1,125	563	5,030
F	3,764	365	1,074	880	6,083
G	2,938	305	859	788	4,890
N	8,043	428	7,597	1,634	17,702
P	255	-	-	-	255
Z	1,165	-	3,758	650	5,573
Unknown	485	9	-	-	494
Total	**37,922**	**2,498**	**24,781**	**9,773**	**74,974**

Note:

*Medicaid Disproportionate Share Hospitals include: Platte Valley Medical Center, Prowers Medical Center, San Luis Valley Regional Center, St. Vincent General Hospital, Valley View Hospital, National Jewish Medical and Research Center and The Children's Hospital.

Table 6 - Inpatient Admissions by Age and Sex

Outstate Disproportionate Share Hospitals

	Female		Male		Total Inpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	89	$219,245	128	$486,693	217	2.3%	$705,938
06-17	65	$786,581	61	$742,436	126	1.4%	$1,529,017
18-24	516	$5,264,983	481	$7,832,658	997	10.7%	$13,097,641
25-54	2,739	$40,623,454	3,041	$55,942,901	5,780	62.2%	$96,566,355
55-64	772	$16,375,199	763	$17,056,308	1,535	16.5%	$33,431,507
65+	327	$7,801,096	314	$6,557,245	641	6.9%	$14,358,341
TOTAL	**4,508**	**$71,070,558**	**4,788**	**$88,618,241**	**9,296**	**100%**	**$159,688,799**

Medicaid Disproportionate Share Hospitals*

	Female		Male		Total Inpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	30	$764,274	27	$615,697	57	8.0%	$1,379,971
06-17	41	$812,339	33	$589,980	74	10.4%	$1,402,319
18-24	52	$720,818	45	$483,840	97	13.7%	$1,204,658
25-54	167	$1,662,726	158	$2,592,488	325	45.9%	$4,255,214
55-64	48	$534,056	50	$592,423	98	13.8%	$1,126,479
65+	30	$373,572	28	$323,239	58	8.2%	$696,811
TOTAL	**368**	**$4,867,785**	**341**	**$5,197,667**	**709**	**100%**	**$10,065,452**

Denver Health

	Female		Male		Total Inpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	31	$176,632	33	$84,875	64	1.4%	$261,507
06-17	24	$158,194	22	$200,729	46	1.0%	$358,923
18-24	167	$1,931,243	184	$3,844,622	351	7.7%	$5,775,865
25-54	1,072	$17,119,834	1,944	$38,212,665	3,016	65.9%	$55,332,499
55-64	306	$5,641,500	417	$8,874,943	723	15.8%	$14,516,443
65+	193	$4,172,706	181	$5,189,331	374	8.2%	$9,362,037
TOTAL	**1,793**	**$29,200,109**	**2,781**	**$56,407,165**	**4,574**	**100%**	**$85,607,274**

Table 6 - Inpatient Admissions by Age and Sex

University Hospital

	Female		Male		Total Inpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	23	$199,227	26	$155,416	49	2.5%	$354,643
06-17	5	$79,607	1	$16,514	6	0.3%	$96,121
18-24	54	$1,220,976	59	$920,074	113	5.8%	$2,141,050
25-54	566	$13,568,999	706	$20,192,688	1,272	64.9%	$33,761,687
55-64	153	$5,172,175	193	$7,505,305	346	17.7%	$12,677,480
65+	97	$2,295,534	76	$3,273,099	173	8.8%	$5,568,633
TOTAL	**898**	**$22,536,518**	**1,061**	**$32,063,096**	**1,959**	**100%**	**$54,599,614**

All CICP Providers

	Female		Male		Total Inpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	173	$1,359,378	214	$1,342,681	387	2.3%	$2,702,059
06-17	135	$1,836,721	117	$1,549,659	252	1.5%	$3,386,380
18-24	789	$9,138,020	769	$13,081,194	1,558	9.4%	$22,219,214
25-54	4,544	$72,975,013	5,849	$116,940,742	10,393	62.9%	$189,915,755
55-64	1,279	$27,722,930	1,423	$34,028,979	2,702	16.3%	$61,751,909
65+	647	$14,642,908	599	$15,342,914	1,246	7.6%	$29,985,822
TOTAL	**7,567**	**$127,674,970**	**8,971**	**$182,286,169**	**16,538**	**100%**	**$309,961,139**

Notes:

*Medicaid Disproportionate Share Hospitals include: Platte Valley Medical Center, Prowers Medical Center, San Luis Valley Regional Center, St. Vincent General Hospital, Valley View Hospital, National Jewish Medical and Research Center and The Children's Hospital.

Charges reported in this table are from Table 2B.

Table 7 - Outpatient Activity by Age and Sex

Outstate Clinics

	Female		Male		Total Outpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	1,715	$190,271	1,806	$197,203	3,521	1.8%	$387,474
06-17	3,020	$331,374	2,544	$268,820	5,564	3.0%	$600,194
18-24	14,291	$1,617,426	5,316	$736,122	19,607	10.6%	$2,353,548
25-54	77,000	$9,111,307	45,868	$5,774,447	122,868	66.2%	$14,885,754
55-64	17,907	$2,046,333	10,271	$1,331,211	28,178	15.2%	$3,377,544
65+	3,555	$371,162	2,326	$271,379	5,881	3.2%	$642,541
TOTAL	**117,488**	**$13,667,873**	**68,131**	**$8,579,182**	**185,619**	**100%**	**$22,247,055**

Outstate Disproportionate Share Hospitals

	Female		Male		Total Outpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	438	$179,234	541	$263,906	979	0.9%	$443,140
06-17	1,221	$719,581	1,123	$877,087	2,344	2.1%	$1,596,668
18-24	8,443	$6,449,123	4,736	$4,672,101	13,179	11.8%	$11,121,224
25-54	42,805	$33,628,627	29,541	$26,511,686	72,346	64.5%	$60,140,313
55-64	11,457	$9,153,549	6,736	$7,215,413	18,193	16.3%	$16,368,962
65+	2,878	$3,075,594	1,991	$3,125,022	4,869	4.4%	$6,200,616
TOTAL	**67,242**	**$53,205,708**	**44,668**	**$42,665,215**	**111,910**	**100%**	**$95,870,923**

Medicaid Disproportionate Share Hospitals*

	Female		Male		Total Outpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	372	$239,012	555	$321,126	927	6.1%	$560,138
06-17	665	$361,051	826	$583,846	1,491	9.7%	$944,897
18-24	978	$538,402	538	$611,073	1,516	9.9%	$1,149,475
25-54	5,127	$3,241,939	2,981	$2,035,400	8,108	52.9%	$5,277,339
55-64	1,673	$863,530	641	$389,024	2,314	15.1%	$1,252,554
65+	624	$320,955	342	$185,870	966	6.3%	$506,825
TOTAL	**9,439**	**$5,564,889**	**5,883**	**$4,126,339**	**15,322**	**100%**	**$9,691,228**

Table 7 - Outpatient Activity by Age and Sex

Denver Health

	Female		Male		Total Outpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	404	$82,331	539	$101,963	943	0.7%	$184,294
06-17	1,239	$286,254	937	$233,176	2,176	1.5%	$519,430
18-24	7,996	$2,664,805	3,086	$1,508,176	11,082	7.5%	$4,172,981
25-54	51,292	$18,391,503	41,485	$18,507,637	92,777	63.0%	$36,899,140
55-64	14,810	$5,209,690	10,785	$4,427,774	25,595	17.4%	$9,637,464
65+	8,691	$2,888,926	5,784	$2,155,953	14,475	9.9%	$5,044,879
TOTAL	**84,432**	**$29,523,509**	**62,616**	**$26,934,679**	**147,048**	**100%**	**$56,458,188**

University Hospital

	Female		Male		Total Outpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	85	$53,464	85	$57,822	170	0.4%	$111,286
06-17	238	$194,018	172	$193,964	410	1.0%	$387,982
18-24	2,050	$2,535,725	1453	$1,640,370	3,503	8.8%	$4,176,095
25-54	11,945	$13,042,664	12089	$14,480,837	24,034	60.7%	$27,523,501
55-64	4,037	$4,151,162	3159	$3,735,807	7,196	18.1%	$7,886,969
65+	2,660	$2,497,665	1708	$1,478,488	4,368	11.0%	$3,976,153
TOTAL	**21,015**	**$22,474,698**	**18,666**	**$21,587,288**	**39,681**	**100%**	**$44,061,986**

All CICP Providers

	Female		Male		Total Outpatient		
Age Group	Count	Charges	Count	Charges	Count	Percent of Total	Charges
0-5	3,014	$744,312	3,526	$942,020	6,540	1.3%	$1,686,332
06-17	6,383	$1,892,278	5,602	$2,156,893	11,985	2.4%	$4,049,171
18-24	33,758	$13,805,481	15,129	$9,167,842	48,887	9.8%	$22,973,323
25-54	188,169	$77,416,040	131,964	$67,310,007	320,133	64.1%	$144,726,047
55-64	49,884	$21,424,264	31,592	$17,099,229	81,476	16.3%	$38,523,493
65+	18,408	$9,154,302	12,151	$7,216,712	30,559	6.1%	$16,371,014
TOTAL	**299,616**	**$124,436,677**	**199,964**	**$103,892,703**	**499,580**	**100%**	**$228,329,380**

Notes: Same as Table 6.

Table 8 - Utilization by Provider

Provider Name	Visits	Admissions	Days	LOS*
Outstate Clinic Providers				
Clinica Campesina	10,349	-	-	-
Colorado Coalition for the Homeless	17,902	-	-	-
Columbine Family Health Center	4,621	-	-	-
Community Health Center, Inc.	30,506	-	-	-
Community Health Clinic	1,076	-	-	-
High Plains Community Health Center	3,469	-	-	-
La Clinica	228	-	-	-
Metropolitan Denver Provider Network	13,660	-	-	-
People's Clinic	11,774	-	-	-
Pueblo Community Health Center	20,142	-	-	-
Salud Family Health Centers	33,973	-	-	-
Sunrise Community Health Center	14,554	-	-	-
Uncompahgre Combined Clinics	509	-	-	-
Valley-Wide Health Systems	22,856	-	-	-
Total Outstate Clinics	**185,619**	-	-	-
Outstate Disproportionate Share Hospital Providers				
Arkansas Valley Regional Medical Center	3,905	189	743	3.93
Aspen Valley Hospital	320	48	157	3.27
Avista Adventist Hospital	997	117	355	3.03
Boulder Community Hospital	2,921	203	932	4.59
Clagett Memorial Hospital	427	23	50	2.17
Colorado Plains Medical Center	517	97	251	2.59
Conejos County Hospital	265	37	122	3.30
Delta County Memorial Hospital	1,004	82	223	2.72
East Morgan County Hospital	245	12	34	2.83
Estes Park Medical Center	2,604	69	179	2.59
Exempla Lutheran Medical Center	2,824	376	1,490	3.96
Gunnison Valley Hospital	66	-	-	-
HealthOne Medical Center of Aurora	1,575	235	1,112	4.73
Heart of the Rockies Regional Medical Center	986	71	260	3.66
Kit Carson County Memorial Hospital	598	25	61	2.44
Longmont United Hospital	1,410	284	982	3.46
McKee Medical Center	5,028	387	1,481	3.83
Melissa Memorial	624	7	12	1.71
Memorial Hospital	15,511	1,648	7,775	4.72
Mercy Medical Center	3,443	148	620	4.19
Montrose Memorial Hospital	2,189	89	412	4.63
Mount San Rafael Hospital	864	53	178	3.36
North Colorado Medical Center	5,072	852	3,741	4.39
Parkview Medical Center	6,873	827	3,730	4.51
Penrose-St. Francis Health Services	4,281	824	3,593	4.36
Poudre Valley Hospital	7,641	647	2,693	4.16
Rio Grande Hospital	1,049	23	54	2.35
Sedgwick County Health Center	241	3	5	1.67
Southeast Colorado Hospital and LTC	278	25	29	1.16
Southwest Memorial Hospital	2,391	140	441	3.15
Spanish Peaks Regional Health Center	1,117	32	115	3.59

Table 8 - Utilization by Provider

Provider Name	Visits	Admissions	Days	LOS*
St. Mary-Corwin Hospital	24,060	613	2,637	4.30
St. Mary's Hospital and Medical Center, Inc.	4,813	524	1,618	3.09
St. Thomas More Hospital	2,216	269	834	3.10
Sterling Regional Medical Center	1,577	112	368	3.29
The Memorial Hospital	260	25	103	4.12
Wray Community District Hospital	415	10	42	4.20
Yampa Valley Medical Center	203	120	376	3.13
Yuma District Hospital	1,100	50	114	2.28
Total Outstate Disproportionate Share Hospital Providers	**111,910**	**9,296**	**37,922**	**4.08**
Total Outstate Providers	**297,529**	**9,296**	**37,922**	**4.08**
Medicaid Disproportionate Share Hospitals				
Platte Valley Medical Center	1,197	120	452	3.77
Prowers Medical Center	1,366	145	456	3.14
San Luis Valley Regional Medical Center	6,017	243	663	2.73
St. Vincent General Hospital	48	10	23	2.30
Valley View Hospital	489	47	154	3.28
Medicaid Disproportionate Share Specialty Hospitals				
National Jewish Medical and Research Center	3,763	5	23	4.60
The Children's Hospital	2,442	139	727	5.23
Sub-Total Medicaid Disproportionate Share Hospital Providers	**15,322**	**709**	**2,498**	**3.52**
Denver Health Medical Center	**147,048**	**4,574**	**24,781**	**5.42**
University Hospital	**39,681**	**1,959**	**9,773**	**4.99**
Total Medicaid Disproportionate Share Hospital Providers	**202,051**	**7,242**	**37,052**	**5.12**
Total All CICP Providers	**499,580**	**16,538**	**74,974**	**4.53**

Notes:

*Calculated average length of stay. Number of days divided by total admissions.

Table 9A - Unduplicated Inpatient and Outpatient Count by Age Group

Provider Name	Inpatient				Outpatient			
	Age 0 thru 5	Age 6 thru 18	Age 19+	Total	Age 0 thru 5	Age 6 thru 18	Age 19+	Total
Outstate Clinic Providers								
Clinica Campesina	-	-	-	-	187	279	2,463	2,929
Colorado Coalition for the Homeless	-	-	-	-	79	112	3,868	4,059
Columbine Family Health Center	-	-	-	-	18	68	1,316	1,402
Community Health Center, Inc.	-	-	-	-	499	743	8,468	9,710
Community Health Clinic	-	-	-	-	13	47	392	452
High Plains Community Health Center	-	-	-	-	21	60	1,054	1,135
La Clinica	-	-	-	-	1	3	86	90
Metropolitan Denver Provider Network	-	-	-	-	63	186	3,694	3,943
People's Clinic	-	-	-	-	67	110	2,925	3,102
Pueblo Community Health Center	-	-	-	-	61	219	5,031	5,311
Salud Family Health Centers	-	-	-	-	674	1,619	10,732	13,025
Sunrise Community Health Center	-	-	-	-	230	439	4,549	5,218
Uncompahgre Combined Clinics	-	-	-	-	1	1	130	132
Valley-Wide Health Systems	-	-	-	-	62	215	6,347	6,624
Total Outstate Clinics	**-**	**-**	**-**	**-**	**1,976**	**4,101**	**51,055**	**57,132**
Outstate Disproportionate Share Hospital Providers								
Arkansas Valley Regional Medical Center	5	3	73	81	22	76	1,313	1,411
Aspen Valley Hospital	5	2	35	42	10	5	99	114
Avista Adventist Hospital	15	3	81	99	8	17	436	461
Boulder Community Hospital	2	1	72	75	7	26	990	1,023
Clagett Memorial Hospital	1	-	17	18	5	7	136	148
Colorado Plains Medical Center	-	2	89	91	4	20	343	367
Conejos County Hospital	-	1	24	25	-	3	142	145
Delta County Memorial Hospital	2	2	64	68	11	18	404	433
East Morgan County Hospital	1	-	8	9	5	7	89	101
Estes Park Medical Center	-	-	14	14	1	14	448	463
Exempla Lutheran Medical Center	9	18	335	362	16	41	1,793	1,850
Gunnison Valley Hospital	-	-	-	-	-	2	50	52
HealthOne Medical Center of Aurora	-	3	167	170	15	49	918	982
Heart of the Rockies Regional Medical Center	1	2	50	53	7	14	304	325
Kit Carson County Memorial Hospital	1	-	24	25	9	11	123	143

Table 9A - Unduplicated Inpatient and Outpatient Count by Age Group

Provider Name	Inpatient				Outpatient			
	Age 0 thru 5	Age 6 thru 18	Age 19+	Total	Age 0 thru 5	Age 6 thru 18	Age 19+	Total
Longmont United Hospital	9	1	205	215	16	29	527	572
McKee Medical Center	17	11	249	277	29	97	1,622	1,748
Melissa Memorial	-	-	4	4	6	24	130	160
Memorial Hospital	29	25	1,216	1,270	92	242	5,489	5,823
Mercy Medical Center	2	1	119	122	13	45	991	1,049
Montrose Memorial Hospital	2	2	78	82	9	54	820	883
Mount San Rafael Hospital	-	1	27	28	-	11	154	165
North Colorado Medical Center	33	23	576	632	70	158	1,844	2,072
Parkview Medical Center	6	19	677	702	48	211	3,198	3,457
Penrose-St. Francis Health Services	8	16	575	599	19	68	1,397	1,484
Poudre Valley Hospital	8	10	387	405	22	67	2,226	2,315
Rio Grande Hospital	-	-	20	20	11	14	320	345
Sedgwick County Health Center	-	-	3	3	4	4	69	77
Southeast Colorado Hospital and LTC	1	-	11	12	2	6	87	95
Southwest Memorial Hospital	1	2	46	49	13	92	786	891
Spanish Peaks Regional Health Center	-	2	22	24	9	27	581	617
St. Mary-Corwin Hospital	6	7	246	259	51	271	7,156	7,478
St. Mary's Hospital and Medical Center, Inc.	8	9	507	524	15	65	3,497	3,577
St. Thomas More Hospital	1	6	79	86	4	41	1,168	1,213
Sterling Regional Medical Center	9	4	85	98	15	53	508	576
The Memorial Hospital	2	-	22	24	2	4	166	172
Wray Community District Hospital	1	-	7	8	1	9	159	169
Yampa Valley Medical Center	-	5	97	102	-	4	139	143
Yuma District Hospital	6	-	29	35	15	32	291	338
Total Outstate Disproportionate Share Hospital Providers	**191**	**181**	**6,340**	**6,712**	**586**	**1,938**	**40,913**	**43,437**
Total Outstate Providers	**191**	**181**	**6,340**	**6,712**	**2,562**	**6,039**	**91,968**	**100,569**

Table 9A - Unduplicated Inpatient and Outpatient Count by Age Group

Provider Name	Inpatient				Outpatient			
	Age 0 thru 5	Age 6 thru 18	Age 19+	Total	Age 0 thru 5	Age 6 thru 18	Age 19+	Total
Medicaid Disproportionate Share Hospitals								
Platte Valley Medical Center	2	1	71	74	15	43	644	702
Prowers Medical Center	3	2	101	106	7	24	506	537
San Luis Valley Regional Medical Center	11	2	217	230	58	120	5,082	5,260
St. Vincent General Hospital	-	1	6	7	-	1	20	21
Valley View Hospital	1	-	18	19	4	9	191	204
Medicaid Disproportionate Share Specialty Hospitals								
National Jewish Medical and Research Center	1	2	1	4	6	16	654	676
The Children's Hospital	38	52	17	107	278	507	110	895
Sub-Total Medicaid Disproportionate Share Hospital Providers	**56**	**60**	**431**	**547**	**368**	**720**	**7,207**	**8,295**
Denver Health Medical Center	**63**	**58**	**3,396**	**3,517**	**546**	**1,530**	**29,317**	**31,393**
University Hospital	**49**	**8**	**1,436**	**1,493**	**148**	**449**	**12,317**	**12,914**
Total Medicaid Disproportionate Share Hospital Providers	**168**	**126**	**5,263**	**5,557**	**1,062**	**2,699**	**48,841**	**52,602**
Total All CICP Providers	**359**	**307**	**11,603**	**12,269**	**3,624**	**8,738**	**140,809**	**153,171**

Table 9B - Unduplicated Total Count by Age Group

Provider Name	Total			
	Age 0 thru 5	Age 6 thru 18	Age 19+	Total
Outstate Clinic Providers				
Clinica Campesina	187	279	2,463	2,929
Colorado Coalition for the Homeless	79	112	3,868	4,059
Columbine Family Health Center	18	68	1,316	1,402
Community Health Center, Inc.	499	743	8,468	9,710
Community Health Clinic	13	47	392	452
High Plains Community Health Center	21	60	1,054	1,135
La Clinica	1	3	86	90
Metropolitan Denver Provider Network	63	186	3,694	3,943
People's Clinic	67	110	2,925	3,102
Pueblo Community Health Center	61	219	5,031	5,311
Salud Family Health Centers	674	1,619	10,732	13,025
Sunrise Community Health Center	230	439	4,549	5,218
Uncompahgre Combined Clinics	1	1	130	132
Valley-Wide Health Systems	62	215	6,347	6,624
Total Outstate Clinics	**1,976**	**4,101**	**51,055**	**57,132**
Outstate Disproportionate Share Hospital Providers				
Arkansas Valley Regional Medical Center	27	79	1,386	1,492
Aspen Valley Hospital	9	7	113	129
Avista Adventist Hospital	23	20	517	560
Boulder Community Hospital	9	32	996	1,037
Clagett Memorial Hospital	6	7	140	153
Colorado Plains Medical Center	4	22	432	458
Conejos County Hospital	-	4	166	170
Delta County Memorial Hospital	11	19	415	445
East Morgan County Hospital	6	7	97	110
Estes Park Medical Center	1	14	462	477
Exempla Lutheran Medical Center	25	59	2,128	2,212
Gunnison Valley Hospital	-	2	50	52
HealthOne Medical Center of Aurora	15	52	1,085	1,152
Heart of the Rockies Regional Medical Center	8	16	354	378
Kit Carson County Memorial Hospital	10	11	147	168

Table 9B - Unduplicated Total Count by Age Group

Provider Name	Total			
	Age 0 thru 5	Age 6 thru 18	Age 19+	Total
Longmont United Hospital	26	30	600	656
McKee Medical Center	46	108	1,871	2,025
Melissa Memorial	6	24	134	164
Memorial Hospital	113	251	5,905	6,269
Mercy Medical Center	15	45	1,022	1,082
Montrose Memorial Hospital	11	55	840	906
Mount San Rafael Hospital	-	12	181	193
North Colorado Medical Center	103	181	2,420	2,704
Parkview Medical Center	50	221	3,477	3,748
Penrose-St. Francis Health Services	27	84	1,972	2,083
Poudre Valley Hospital	30	77	2,613	2,720
Rio Grande Hospital	11	14	340	365
Sedgwick County Health Center	4	4	72	80
Southeast Colorado Hospital and LTC	2	7	98	107
Southwest Memorial Hospital	14	94	832	940
Spanish Peaks Regional Health Center	9	29	603	641
St. Mary-Corwin Hospital	57	278	7,402	7,737
St. Mary's Hospital and Medical Center, Inc.	23	74	4,004	4,101
St. Thomas More Hospital	4	47	1,247	1,298
Sterling Regional Medical Center	24	57	593	674
The Memorial Hospital	4	4	182	190
Wray Community District Hospital	2	9	166	177
Yampa Valley Medical Center	-	9	228	237
Yuma District Hospital	21	32	320	373
Total Outstate Disproportionate Share Hospital Providers	**756**	**2,097**	**45,610**	**48,463**
Total Outstate Providers	**2,732**	**6,198**	**96,665**	**105,595**

Table 9B - Unduplicated Total Count by Age Group

Provider Name	Total			
	Age 0 thru 5	Age 6 thru 18	Age 19+	Total
Medicaid Disproportionate Share Hospitals				
Platte Valley Medical Center	17	44	715	776
Prowers Medical Center	10	26	607	643
San Luis Valley Regional Medical Center	69	122	5,299	5,490
St. Vincent General Hospital	-	2	26	28
Valley View Hospital	5	9	209	223
Medicaid Disproportionate Share Specialty Hospitals				
National Jewish Medical and Research Center	7	18	655	680
The Children's Hospital	298	559	145	1,002
Sub-Total Medicaid Disproportionate Share Hospital Providers	**406**	**780**	**7,656**	**8,842**
Denver Health Medical Center	**591**	**1,559**	**29,995**	**32,145**
University Hospital	**197**	**457**	**13,753**	**14,407**
Total Medicaid Disproportionate Share Hospital Providers	**1,194**	**2,796**	**51,404**	**55,394**
Total All CICP Providers	**3,926**	**8,994**	**148,069**	**160,989**