THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003 and 8.2004
Rule Number:	MSB 11-08-19-A
Division / Contact / Phone:	Financial and Administrative Services Office / Nancy Dolson / 3698

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-08-19-A, Revision to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003 and 8.2004
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.2003 and 8.2004, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.2003.A.3; §8.2003.B.3; §8.2003.B.3.a; §8.2003.B.3.b; and, §8.2004.B.3; and, §8.2004.D.3; and §8.2004.E.3; and §8.2004.F.a.i, ii and iii; and, §8.2004.G.3.a, b, (add) c & d revise c (now e.); and 8.2004.I.2; and §8.2004.J.1 and 3; and §8.2004.K.2; and §8.2004.L.3.b (add) and c (revise); and §8.2004.M.3; and §8.2004.N.2. with new text provided. All unchanged text is provided for purposes of clarity only. This change is effective December 30, 2011.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers.

The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2010).

The proposed rule increases the fees assessed on hospital providers to fund these payments, to fund expansions of Medicaid and CHP+ eligibility authorized under the Act, and to fund General Fund relief for Medicaid expenditures pursuant to Senate Bill 11-212.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR Section 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-4-402.3, C.R.S. (2010)

Initial Review — Final Adoption **11/18/ 2011**

Proposed Effective Date **12/30/2011** — Emergency Adoption

DOCUMENT #06

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Colorado hospitals benefit from increased Medicaid and Colorado Indigent Care Program (CICP) reimbursements made possible through provider fee funding. Low-income persons benefit from the expanded Medicaid and Child Health Plan Plus (CHP+) eligibility.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   From October 2011 through September 2012, the provider fee will generate approximately $645 million in federal funds to Colorado. Hospitals will have an estimated net benefit of $122 million.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   While there are administrative costs associated with implementation of the Colorado Health Care Affordability Act, all such costs are covered by provider fees collected; no state General Fund is used.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   If no action is taken, the Department will not have the ability to fully fund Medicaid and CHP+ expansions, affected over 30,000 currently enrolled persons and up to 100,000 persons in the long run. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+ and reduce the federal revenue. Inaction would also mean that $50 million in General Fund relief for the Medicaid program in FY 2011-12 would not be realized, which could result in greater provider rate cuts or other budget actions.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

The state does not currently have the resources to fund the hospital payments and coverage expansions under the hospital provider fee. The Department began collecting fees from hospitals in April 2010, after the rules were established and federal approval was obtained.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department continues to meet regularly with stakeholders and the Hospital Provider Fee Oversight and Advisory Board and seeks their input and recommendations to maximize the benefit to the state from the Colorado Health Care Affordability Act. The first hospital provider fee expansions have been implemented and increased reimbursement has been made to hospitals. The proposed rules continue to fund the implementation of the Act to increase health care coverage and reduce uncompensated hospital costs for Medicaid and uninsured persons.

8.2003: Hospital Provider Fee

8.2003.A. Outpatient Services Fee

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as ~~0.484~~0.535% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.2003.B. Inpatient Services Fee

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $~~83.46~~116.07 per day for Managed Care Days and $~~374.85~~515.69 per day for all other Days as reported to the Department by each hospital by April 30 with the following exceptions:

    a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $~~43.57~~60.60 per day for Managed Care Days and $~~195.71~~269.24 per day for all other Days.

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~33.38~~46.43 per day for Managed Care Days and $~~149.94~~206.27 per day for all other Days.

8.2004: Supplemental Medicaid and Disproportionate Share Hospital Payments

8.2004.A. Conditions applicable to all supplemental payments

1. All supplemental payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Department.

2. No hospital shall receive a payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the CICP Disproportionate Share Hospital payment or the Uninsured Disproportionate Share Hospital payment exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, that hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction for the CICP Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated CICP Costs, relative to the aggregate of Uncompensated CICP Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit. The amount of the retroactive reduction for the Uninsured Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated Charity Care Costs relative to the aggregate of Uncompensated Charity Care Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit.

3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2004.B. Outpatient Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals and Critical Access Hospitals shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals and Long Term Care Hospitals shall not receive this payment.

3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado Medicaid Management Information System (MMIS) are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient Hospital Payment Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for ~~managed care enrollment,~~ utilization and inflation, multiplied by ~~30.7~~31.50%. If the hospital qualifies as a Pediatric Specialty Hospital this payment equals hospital-specific outpatient billed costs, adjusted for ~~managed care enrollment,~~ utilization and inflation, multiplied by ~~30.7~~27.45%. ~~If the hospital qualifies as an~~For ~~Urban Center Safety Net Specialty Hospital~~State Teaching Hospitals, this payment equals hospital-specific outpatient billed costs, adjusted for ~~managed care enrollment,~~ utilization and inflation, multiplied by 25%.

8.2004.C. Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals located in a Rural Area, with 20 or fewer licensed beds, where at least 80% of total Medicaid payments are for outpatient hospital services shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals and Long Term Care Hospitals shall not receive this payment.

3. Calculation methodology for payment. This payment shall equal ~~50~~70% of inflated annual hospital-specific Medicaid outpatient billed costs.

8.2004.D. CICP Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. There will be three categories for qualified hospitals: State-Owned Government Hospitals, Non-State-Owned Government Hospitals, and Private-Owned Hospitals. State-Owned Government Hospitals shall receive ~~7.25~~15.00% of the State's annual Disproportionate Share Hospital Allotment, Non-State-Owned Government Hospitals shall receive ~~45.00~~42.50% and Private-Owned Hospitals shall receive ~~25.00~~22.50%.

   A qualified hospital's annual payment shall equal its share of the percent of Uncompensated CICP Costs of all qualified hospitals in the category divided by the State's annual Disproportionate Share Hospital allotment allocated to the category.

8.2004.E. Uninsured Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that report charges for services provided to low-income uninsured persons to the Department in a manner as prescribed by the Department shall receive this payment.

2. Excluded hospitals. Hospitals that participate in the CICP, Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. ~~Beginning in FY 2009-10, 22.75~~Twenty percent (20.00%) of the State's annual Disproportionate Share Hospital allotment shall be allocated to the Uninsured Disproportionate Share Hospital Payment. A qualified hospital's annual payment shall equal its share of the percent of Uncompensated Charity Care Costs of all qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital Payment.

8.2004.F. CICP Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals and hospitals that do not participate in the CICP shall not receive this payment.

3. Calculation methodology for payment.

a. Qualified hospitals shall receive an annual payment, such that, when combined with the CICP Disproportionate Share Hospital Payment, shall total to a percentage of Uncompensated CICP Costs. The percentage applied to Uncompensated CICP Costs shall be:

i. ~~Sixty-four~~Fifty-two and five-tenths percent (~~64~~52.5%) for High Volume Medicaid and CICP Hospitals,

ii. ~~One hundred~~Seventy-five percent (~~100~~75%) for Rural Hospitals, or

iii. ~~Seventy-five~~Sixty percent (~~75~~60%) for all other qualified hospitals.

8.2004.G. Inpatient Hospital Base Rate Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Long Term Care Hospitals and Critical Access Hospitals with an established Medicaid inpatient base rate shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this annual payment equals the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate with increases as follows:

a. Pediatric Specialty Hospitals shall have a ~~16.8~~20.0% increase.

b. State Teaching Hospitals shall have a ~~16.0~~31.3% increase.

c. Long Term Care Hospitals and Rehabilitation Hospitals shall have a 25.0% increase.

d. Hospitals located in Rural Areas and Critical Access Hospitals shall have a 60.0% increase.

~~c~~e. Other General Hospitals~~, Long Term Care Hospitals, Rehabilitation Hospitals,~~ and Critical Access Hospitals shall have an ~~35.0~~51.3% increase.

8.2004.H. High Level Neo-natal Intensive Care Unit (NICU) Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals certified level IIIb or IIIc neo-natal intensive care unit (NICU) shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $2,~~1~~500 per Medicaid NICU Day.

8.2004.I. State Teaching Hospital Supplemental Medicaid Payment

1. Qualified hospitals. State Teaching Hospitals shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $~~125~~ 100 per Medicaid Day.

8.2004.J. Acute Care Psychiatric Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals with licensed distinct-part psychiatric units shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $~~150~~ 200 per Medicaid Psychiatric Day.

8.2004.K. Large Rural Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in a Rural Area with 26 or more licensed beds shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $~~600~~ 750 per Medicaid Day.

8.2004.L. Denver Metro Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County or Douglas County shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment.

    a. For each qualified hospital located in Adams County or Arapahoe County, this payment is calculated on an annual basis at $~~675~~ 800 per Medicaid Day.

    b. For each qualified hospital located in Denver County, this payment is calculated as $900 per Medicaid Day.

    ~~b~~c. For each qualified hospital located in Boulder County, Broomfield County, ~~Denver County~~ or Jefferson County, this payment is calculated as $~~700~~ 1100 per Medicaid Day.

8.2004.M. Metropolitan Statistical Area Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in El Paso County, Larimer County, Mesa County, Pueblo County or Weld County shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital this payment is calculated on an annual basis at $~~600~~ 650 per Medicaid Day.

8.2004.N. Pediatric Specialty Hospital Provider Fee Payment

1. Qualified hospitals. Hospitals qualified to receive the Pediatric Major Teaching Hospital Payment in 10 CCR 2505-10 Section 8.903.C.6 shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis and shall equal $~~3~~ 2 million.