COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

January 15, 2010

The Honorable Betty Boyd, Chairman
Senate Health and Human Services Committee
State Capitol Building, Room 346
Denver, CO 80203

The Honorable Jim Riesberg, Chair
House Health and Human Services Committee
State Capitol Building, Room 271
Denver, CO 80203

Dear Senator Boyd and Representative Riesberg:

On behalf of the Hospital Provider Fee Oversight and Advisory Board (the Board) and the Department of Health Care Policy and Financing (the Department), it is our pleasure to present to you the first annual report for the Colorado Health Care Affordability Act, pursuant to Section 25.5-4-402.3, C.R.S. (2009). The Act authorizes the Department pursuant to federal approval to collect a fee from hospital providers to increase Medicaid payments to hospitals and expand coverage under public health care programs. In addition, the Act established the Board to provide recommendations to the Department and the Medical Services Board on the implementation of the Colorado Health Care Affordability Act.

Following the enactment of the legislation in April 2009, the Board was formed and met every two weeks over the summer. The Board established a work plan, agreed on guiding principles, and reviewed several fee and payment options. On September 15, 2009, the Board approved the submission of the hospital provider fee and resulting payment methodologies to the federal Centers for Medicare and Medicaid Services (CMS) for their review and approval. The Department expects approval of the hospital provider fee and resulting payment methodologies in April 2010.

Questions about this report can be addressed to Nancy Dolson, Manager, Safety Net Programs section, at 303-866-3698.

Sincerely,

Joan Henneberry
Executive Director

Bruce Alexander
Chair, Hospital Provider Fee
Oversight and Advisory Board

Cc: Senator Lois Tochtrop, Vice-Chair, Senate Health and Human Services Committee
Senator Morgan Carroll, Senate Health and Human Services Committee
Senator Shawn Mitchell, Senate Health and Human Services Committee
Senator Kevin Lungberg, Senate Health and Human Services Committee
Senator David Schultheis, Senate Health and Human Services Committee
Senator Linda Newell, Senate Health and Human Services Committee
Senator John Morse, Senate Health and Human Services Committee
Representative Sara Gagliardi, Vice-Chairman, House Health and Human Services Committee
Representative Cindy Acree, House Health and Human Services Committee
Representative Dennis Apuan, House Health and Human Services Committee
Representative John Kefalas, House Health and Human Services Committee
Representative Jim Kerr, House Health and Human Services Committee
Representative Cheri Gerou, House Health and Human Services Committee
Representative Max Tyler, House Health and Human Services Committee
Representative Dianne Primavera, House Health and Human Services Committee
Representative Ellen Roberts, House Health and Human Services Committee
Representative Spencer Swalm, House Health and Human Services
Representative Jack Pommer, Chair, Joint Budget Committee
Senator Moe Keller, Vice-Chairman, Joint Budget Committee
Senator Abel Tapia, Joint Budget Committee
Senator Al White, Joint Budget Committee
Representative Mark Ferrandino, Joint Budget Committee
Representative Kent Lambert, Joint Budget Committee
Senator Brandon Shaffer, President of the Senate
Senator Josh Penry, Senate Minority Leader
Representative Terrance Carroll, Speaker of the House
Representative Paul Weissmann, House Majority Leader
Representative Mike May, House Minority Leader
John Ziegler, JBC Staff Director
Melodie Beck, JBC Analyst
Linda M. Andre, Medical Services Board
Jeffrey J. Cain, Medical Services Board
Kathleen Chitty, Medical Services Board
Alan Eisenberg, Medical Services Board
Richard D. Markley, Medical Services Board
Paul Melinkovich, Vice President, Medical Services Board
Wendell Phillips, Medical Services Board
Ginny Riley, President, Medical Services Board
Sally Schaefer, Medical Services Board
Mary Trujillo-Young, Medical Services Board
Joan Henneberry, Executive Director
John Bartholomew, Budget Director
Sue Williamson, Deputy Director, Client & Community Relations Office
Sandeep Wadhwa, Deputy Director, Medical & CHP+ Program Administration Office
Ginny Brown, Legislative Liaison
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COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Hospital Provider Fee Oversight and Advisory Board 2009 Annual Report

January 15, 2010

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Executive Summary

The Colorado Health Care Affordability Act (the Act) authorizes the Department of Health Care Policy and Financing (the Department) pursuant to federal approval to assess a hospital provider fee to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients serviced by public health insurance programs, increase funding for hospital care for Medicaid and uninsured clients, and to reduce cost-shifting to private payers.

A thirteen member Oversight and Advisory Board (the Board) appointed by the Governor provides oversight and makes recommendations to the Department and the Medical Services Board on the implementation of the Act. On September 15, 2009, the Board approved the submission of the hospital provider fee and payment methodologies to the federal Centers for Medicare and Medicaid Services (CMS) for their review and approval.

Upon CMS approval, fee collection, hospital payment increases, and coverage expansions will begin. In FY 2009-10, approximately $335 million in fees will be collected from hospitals that, in combination with federal matching funds, will fund health coverage expansions, payments to hospitals, and the Department's administrative expenses. The estimated results for FY 2009-10 are listed below:

- Approximately $60 million will be available for health coverage expansions for 20,000 children and parents under the Children's Health Plan *Plus* and Medicaid,
- More than $580 million will be paid directly to Colorado hospitals, of which $80 million will be new federal funds, and
- $7.5 million will be available to pay the Department's administrative expenses for implementing the Act and expanding health care coverage to low-income populations.

As federal approval has not been obtained, this annual report provides a summary of the implementation process to date. An addendum to this report will be published after CMS has approved the model, anticipated in April 2010.

Colorado Health Care Affordability Act Overview

On April 21, 2009, Colorado Governor Bill Ritter, Jr. signed House Bill 09-1293 to enact the Colorado Health Care Affordability Act of 2009 (the Act). The Act authorizes the Department of Health Care Policy and Financing (the Department) to assess a hospital provider fee to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program (CICP). In addition, the Act authorizes the Department to expand health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan *Plus* (CHP+), and for low-income adults without dependent children; to provide a Medicaid buy-in program for people with disabilities; and to implement twelve month continuous eligibility for Medicaid eligible children.

A thirteen member Oversight and Advisory Board (the Board) appointed by the Governor provides oversight and makes recommendations to the Department on the implementation of the Act, including how fees are assessed and hospital payments are calculated.

Upon approval by the federal Centers for Medicare and Medicaid Services (CMS) of the hospital provider fee and payments, which is anticipated prior to April 1, 2010, fees will be collected from and payments will be made to hospitals effective retroactively to July 1, 2009. Implementation of two of the health coverage expansions will begin upon CMS approval, with implementation of additional expansion programs anticipated over the next two years.

Beginning in 2010, the Act requires the Board to submit an annual report on January 15 to the Health and Human Services Committees of the Colorado Senate and House of Representatives, the Joint Budget Committee of the General Assembly, the Governor, and the Medical Services Board. This annual report is to include:

- Recommendations to the Medical Services Board;
- How the provider fee is calculated, assessed, and collected;
- For each hospital, the total amount of provider fee paid and revenue expected to be received;
- Increased Medicaid and CICP payments to hospitals and quality incentive payments;
- The number of clients enrolled in health coverage expansions; and
- Estimates of the differences between the cost of care and the payment received by hospitals for clients covered by Medicaid, Medicare, and other payers.

Colorado Health Care Affordability Act Benefits

Increase the Number of Insured Coloradans

Medicaid and CHP+ eligibility expansions will be implemented through an amendment to Colorado's Medicaid State Plan. Medicaid expansions include parents of Medicaid eligible children, buy-in programs for people with disabilities, and twelve month continuous eligibility for children. Medical benefits for low-income adults without dependent children will be implemented through a demonstration waiver under Section 1115 of Title XIX of the Social Security Act.

Health coverage expansions will be implemented according to the approximate timeline as follows:

1) *Spring 2010.* Medicaid eligibility for parents increasing from 60% to 100% of the federal poverty level (FPL) and increasing CHP+ eligibility for children and pregnant women to 250% of the FPL.
2) *Summer 2011.* Medicaid buy-in programs to people with disabilities up to 450% of the FPL.
3) *Early 2012.* Medical benefits for adults without dependent children up to 100% of the FPL.
4) *Spring 2012.* Continuous Medicaid eligibility of 12-months for children.

In FY 2009-10, the implementation of the hospital provider fee will expand Medicaid and CHP+ eligibility coverage to an estimated 20,000 Coloradans. The number of people covered by these expansions will continue to rise in future years as individuals enroll and the next coverage expansions are implemented. Over the next three years as the program reaches full implementation, more than 100,000 Coloradans will have health care coverage who otherwise would be uninsured.

Increase Funding for Hospital Care for Medicaid and CICP Clients

Under the Act, hospital provider fee revenue will be used to draw down federal matching funds to increase Medicaid and CICP hospital payments as follows:

- Increase Medicaid hospital inpatient rates up to 100% of Medicare rates
- Increase Medicaid hospital outpatient rates up to 100% of costs
- Increase CICP hospital rates up to 100% of costs

In FY 2009-10, upon approval of federal matching funds, approximately $335 million in fees will be collected from hospitals that, in combination with federal matching funds, will fund health coverage expansions, payments to hospitals, and the Department's administrative expenses. Payments to hospitals will total more than $580 million, of which $80 million will be new federal funds.

Improve the Quality of Health Care for Medicaid Clients

The Hospital Quality Incentive Payment (HQIP) is a mechanism under the Act that will be used to incent hospitals serving Medicaid clients for delivering high quality care that yields positive health outcomes. A stakeholder group comprised of representatives from the Department, Colorado hospitals, and from the general community was established as an ad hoc committee of the Board and tasked with determining and developing the measures that will be used for the HQIP as required by the Act.

The Department, in conjunction with the Board, will determine the amount of funding pursuant to the percentages allowable in statute to be allocated to the payment and the methodology for distributing those funds. The Department anticipates having a rule establishing the measure and a payment timeline for review and approval by the Medical Services Board by late Spring 2010.

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

The implementation of the Hospital provider fee will reduce the need for hospital providers to shift uncompensated care costs to private payers in the following ways:

1) *Higher rates for public insurance clients*. By raising the rates paid to hospital providers, the need to shift costs is reduced. The hospital provider fee increases rates paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the Colorado Indigent Care Program.
2) *Reducing the number of uninsured*. Fewer uninsured Coloradans leads to lower uncompensated costs by creating a funding source for these clients. In the first year, the hospital provider fee will increase eligibility for parents of Medicaid covered children, prenatal care, and CHP+.
3) *Measurement of cost to payment ratio by payer*. The Board has authorized a workgroup to determine what data will be collected by hospitals to fulfill the legislative requirement to report the difference between costs and payments for each of Medicare, Medicaid, and private insurance. This workgroup is planned to convene in Spring 2010 and to complete its work in time for data to be collected for the January 2011 Annual Report.

Stakeholder Remarks

Robert W. Ladenburger, President/CEO, St. Mary's Hospital & Medical Center, Grand Junction:

"As a member of the first work group that was constituted as the Provider Fee Task Force in 2008, I've been a strong proponent of Colorado's adoption of a provider fee that is truly designed to be win-win for the healthcare recipients and providers through three principle goals:

- To create a new, dedicated source of funding to pay for expanded healthcare coverage for the uninsured;

- To cover more Coloradans under Medicaid and CHP+;
- To increase payments that hospitals receive for patients treated through Medicaid and the Colorado Indigent Care Program.

Although more than 20 states had implemented hospital-specific provider fees before Colorado adopted the Colorado Healthcare Affordability Act of 2009, our goal went beyond increasing payments to hospitals to reduce the cost shift resulting from underpayment from Medicaid, but also sought to expand coverage and shrink the number of uninsured Coloradans. Most importantly, the task force agreed the hospital provider fee would supplement, not replace, existing Medicaid and CHP+ funding, ensuring that funding would definitely increase.

With the establishment of the Oversight and Advisory Board to provide oversight and recommendations on how the Act is implemented, our work continues into 2010. The goals remain firm: to improve access to healthcare, increase reimbursement rates and reduce the cost shift. I believe the strong leadership and collaboration between the state and the Colorado Hospital Association and its members that brought about the passage of this Act, will continue to put in place the mechanisms to accomplish these goals."

Tom Mingen, Administrator, Delta County Memorial Hospital, Delta:

"With the passage of the Colorado Healthcare Affordability Act of 2009, our state is able to preserve access and coverage to affordable healthcare to Coloradans while helping to ensure the fiscal health of Colorado hospitals. We recognize how important hospitals are within each community and the critical roles they perform in maintaining the physical and economic stability, particularly during tough times. Through the provider fee legislation, Colorado hospitals will gain additional funding to help keep them financially sound and enabling them to serve every patient who comes through their doors.

Most importantly, the provider fee provides a sustainable, ongoing funding source that benefits hospitals, and ultimately their communities, across the state for years to come. As the Act is implemented, Colorado hospitals and the patients they serve will see the benefits in a healthcare system that provides quality healthcare for all through a fiscally sound delivery system that can be maintained."

Hospital Provider Fee Oversight and Advisory Board

A thirteen member Board appointed by the Governor provides oversight and makes recommendations to the Department and the Medical Services Board on the implementation of the Act. (See Appendix A for a list of Board members.)

As required in the Act, the Board is comprised of the following:

- Five hospital members including at least one rural hospital representative and one safety-net hospital representative;
- One statewide hospital organization member;
- One health insurance organization or carrier member;
- One health care industry member who does not represent a hospital or health insurance carrier;
- One health care consumer who does not represent employees of a hospital, health insurance carrier, or other health care industry entity;
- One representative of persons with disabilities who does not represent employees of a hospital, health insurance carrier, or other health care industry entity;
- One business representative who purchases health insurance for employees; and
- Two Department members.

The Act outlines the specific duties of the Board, including:

- Recommend to the Department the method of calculating the provider fee, the amount of the provider fee, and changes in the provider fee that increase the number of hospitals benefitting from the fee;
- As requested, consult with the Health and Human Services Committees of the Colorado Senate and House of Representatives;
- Recommend to the Department changes to Medicaid inpatient and outpatient hospital payments and quality incentive payments to increase hospital accountability, performance, and reporting;
- Recommend to the Department the approach to health coverage expansions; and
- Monitor the impact of the hospital provider fee on the broader health care marketplace.

After House Bill 09-1293 was signed into law in April 2009, applications for the Board were solicited and the Governor appointed Board members and designated Mr. Bruce Alexander as the chairman of the Board. The Board began meeting in June 2009 and met every two weeks beginning through September 2009. The Board's regular meetings have been scheduled monthly since that time. (For a list of Board meeting dates through March 2010 and major topics, see Appendix B.) At every meeting, time is reserved on the agenda for public comment, which has proved informative and helpful to the Board.

Over the summer 2009, the Board reviewed the Act and developed a timeline and work plan to fulfill its duties in order to allow that the Hospital Provider Fee Model[1] could be implemented on schedule. To guide their work, the Board agreed on core principles and assumptions of the goals of the Act and the stakeholders who will be affected by it.

Those core principles and assumptions are as follows:

- Exclude long term care, rehabilitation, and freestanding psychiatric hospitals;
- Rural hospitals will net gains as possible and any losses will be minimized;
- High-volume Medicaid providers will net gains;
- Low-volume Medicaid providers, non-CICP hospitals will net losses;
- Minimize number of losing hospitals and size of losses;
- Sustainable source of new funding for hospital care for Medicaid and uninsured;
- Improve the quality of health care services;
- Reduce cost-shifting to private payers;
- Secure new source of revenue to expand access to health care services; and
- Obtain federal approval.

The Board approved the Hospital Provider Fee Model for submission to CMS during its September 15, 2009 meeting. Subsequently, on September 30, 2009, the Department submitted the fee and payment methodologies to CMS for their review and approval.

Department and Medical Services Board Roles

The Medical Services Board, in consultation with the Board, is responsible for promulgating rules related to implementing the Act, including the calculation, assessment, and timing of the Hospital Provider Fee; the reports that hospitals will be required to report to the Department; and other rules necessary to implement the Act.

The Department administers and provides technical and regulatory expertise to the Board. Department staff will prepare and present proposed rule changes as recommended by the Board to the Medical Services Board. The Department is responsible for calculating the fee and assessing the fee on a schedule established in rule by the Medical Services Board. The Department implements and calculates the hospital payments, and also administers the public health care expansion programs.

[1] The hospital provider fee and resulting hospital payments are referred to in general as the "Hospital Provider Fee Model".

Department's Estimated Expenditures for FY 2009-10

The Act appropriated funding to the Department for administrative expenses on a bottom-line basis giving the Department flexibility to distribute and utilize resources as effectively as possible. The Department's appropriation is contingent upon the approval date of the fee model by the CMS. Depending on the date of federal approval, there are two different potential amounts that could be appropriated to the Department. The Department has budgeted to Section 13 of HB 09-1293 which assumes that CMS will not approve the waiver until after April 1, 2010.

The total appropriated to the Department's Executive Director's Office long bill group in Section 13 is $5,157,450 with $1,815,723 as the state share and $3,341,727 as the federal share. In addition to the Executive Director's Office long bill group, funding was appropriated to the Department of Human Services Medicaid-Funded Programs long bill group for necessary changes to the Colorado Benefits Management System (CBMS) in the amount of $123,228 with a 50% federal financial participation rate.

A majority of the Department's efforts during the first year of implementation are focused on ramp-up activities. The costs associated with these activities are end-loaded such that FTE are hired first to develop procurement documents with clearly defined scopes of work, issue requests for proposals and evaluate submissions for the hiring of contractors. In addition, FTE were necessary in both the Department's Human Resources and Contracts and Purchasing sections in order to hire FTE and address the volume of necessary procurement documents. Now that the FTE are in place in both Sections, there will be an increase in the pace of new hires and execution of procurement documents. To date, the Department has hired 11 positions that are all working on various phases of implementation, including procurement of contractors, establishing internal capacity to support expansion populations, and compiling information needed for state plan amendments and waiver submissions. Once the necessary contractors are procured, subsequent activities will commence and result in a concentration of expenditures during the last quarter of the fiscal year.

In addition to the activities described above, the Department is currently hiring the remaining FTE needed for start-up activities, finalizing the financing model for federal approval, and preparing for timely implementation once approval is received. The Department anticipates that resources will be allocated appropriately in order to assure the appropriation is fully expended by the end of the year. The following table details actual Department expenditures and current encumbrances by line item through the end of November 2009:

Expenditures through November 30, 2009			
	Actual Expenditures	**Encumbered Funds**	**Total**
1) Executive Director's Office; (A) General Administration, Personal Services	$117,714	$ -	$117,714
(1) Executive Director's Office; (A) General Administration: Operating Expenses	$2,929	$ 64,196	$67,125
(1) Executive Director's Office; (A) General Administration: Leased Space	$ -	$ -	$ -
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$23,773	$134,674	$158,447
(1) Executive Director's Office; (C) Information Technology Contracts and Projects: Information Technology Contracts	$ -	$698,955	$698,955
TOTAL EDO Expenditures	**$144,416**	**$897,825**	**$1,042,241**
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Mgmt System (CBMS)	$ -	$ -	$ -
TOTAL	**$144,416**	**$897,825**	**$1,042,241**

Federal Requirements Overview

Provider fees are a funding source eligible for federal matching funds when used to reimburse Medicaid covered services as allowed under 42 CFR 433.68(d). Through this regulation, revenue collected from provider fees may serve as state share of Medicaid expenditures to draw a federal match. In general, to be eligible for federal financial participation (FFP), provider fees must:

(1) Be imposed on a permissible class of health care services, including, but not limited to, inpatient hospital services and outpatient hospital services.

(2) Be broad-based, such that the fee is imposed on all providers within a class.

(3) Be imposed uniformly throughout a jurisdiction, such that all providers within a class are assessed at the same rate.

(4) Avoid hold harmless arrangements where the non-Medicaid payments reimbursement amount is positively correlated to the assessment paid by the provider, either directly or indirectly, or where the Medicaid payments vary based only on the tax amount. In other words, there will be winners and losers, where some providers will receive proportionately less in reimbursement compared to their assessed amount.

CMS may grant waivers of the broad-based and uniformity provisions if the net impact of the fee is generally redistributive, as demonstrated via statistical tests described in regulation. On September 30, 2009, the Department submitted a request to CMS to waive the "uniform" and "broad-based" requirements for a provider fee under 42 CFR § 433.68(e)(2) and submitted a State Plan Amendment for supplemental Medicaid and Disproportionate Share Hospital (DSH) payments for hospitals.

Health care related fees may be based on a licensing fee on a class of health care services, on a fee per bed, on revenues or other general statistic with respect to a class of services. Per federal law and regulations, the amount assessed on providers of a class of services may not exceed 5.5% of the net patient revenue for that class of services. Congress capped health care related taxes at 6% and temporarily reduced the cap to 5.5% from January 1, 2008 through September 30, 2011.

Fees can be collected and payments can be made only after approval of the Hospital Provider Fee Model is obtained from CMS and only to the extent FFP is available under the Upper Payment Limit (UPL) for inpatient and outpatient hospital services after Medicaid reimbursement. Distribution of funds under a provider fee model may be made through supplemental DSH payments, increased Medicaid rates, supplemental Medicaid payments, a combination of methods, or other methodologies approved by CMS.

FY 2009-10 Hospital Provider Fee Model – Fee and Payment Methodologies

The Hospital Provider Fee Model is currently under review by CMS. The Department and CMS staff are currently working together both informally and formally during this process. As discussions progress, the Department may need to adjust fee and/or payment methodologies to meet federal requirements. Therefore, the exact fee and payment methodologies and amounts are not known at this time.

An addendum to this report will be delivered after the hospital provider fee has been approved by CMS. The addendum will include the approved fee and payment methodologies and the fee amounts and payments by hospital. The Department will work with the hospitals to successfully operationalize fee collections and payments for FY 2009-10 upon CMS approval.

As currently proposed, fees are calculated on inpatient and outpatient hospital services. Hospital payments will be increased for Medicaid and CICP inpatient and outpatient hospital services through supplemental inpatient and outpatient Medicaid payments and DSH payments. These supplemental payments include targeted payments to hospitals to ensure access for Medicaid clients in rural and metropolitan areas of the state. As allowed under the Act and federal regulations, the Board approved the Department's recommendations to exclude psychiatric, long term care, and rehabilitation hospitals.

The Hospital Provider Fee Model is a dynamic model and fee assessment and payment methodologies will be calculated, reviewed and approved on an annual basis. Data to calculate the fees and resultant payments will be compiled annually. Changes to fee rates or methodology and/or payment methodologies may be needed to respond to changing Medicaid and low-income client utilization patterns, Medicaid caseload, strategic goals of the Department, the health care market, or other factors.

APPENDIX A: Hospital Provider Fee Oversight and Advisory Board Members

Board Members by Term Expiration Date

For terms expiring May 15, 2011:

Philip B. Kalin of Denver
Thomas N. Henton of Monte Vista
Ann King of Denver
Janet E. Pogar of Monument

For terms expiring May 15, 2012:

Robert W. Omer of Meeker
Randolph W. Safady of Parker
Menda K. Warne of Gilcrest

For terms expiring May 15, 2013:

Bruce K. Alexander of Englewood to serve as chairman
Dr. Jeremiah A. Bartley of Brighton
Flora Rodriguez Russel of Lakewood
Madeline L. Roberson of Greenwood Village to serve as vice-chair
James E. Shmerling of Denver
Christopher W. Underwood of Evergreen

APPENDIX B: Hospital Provider Fee Oversight and Advisory Board Meeting Schedule

Meeting Date	Purpose
June 8, 2009	Overview General Housekeeping
June 23, 2009	Hospital Provider Fee Model (Model) Assumptions
July 7, 2009	Overview of Rate Modernization Processes Overview of Quality Measures Processes Review Model and Assumptions
July 21, 2009	Review Model and Assumptions
August 4, 2009	Review Model Review Payment Scenarios
August 18, 2009	Review Recommended Model Time Reserved for Public Comment
September 1, 2009	Continued Public Comment Board Discussion of the Model
September 15, 2009	Review Model Approval for Submission to CMS
September 29, 2009	Stakeholder Forums Update Revised Work Plan Schedule Future Meetings
October 20, 2009	Consultants' Presentation Cost-Shift Working Group Discussion
November 17, 2009	Model Update Cost Shift Workgroup Presentation
December 15, 2009	Annual Report Review Request for Additional Information from CMS Model Revisions By-laws
January 12, 2010	OAB Annual Report Approval
January 26, 2010	Hospital Survey Review CMS Update
February 23, 2010	Draft State Rules CMS Update
March 23, 2010	Modeling Updates for FY 2010-11

APPENDIX C: Hospital Provider Fee Oversight and Advisory Board – FAQs

How is the Upper Payment Limit defined?

The Upper Payment Limit (UPL) is the maximum amount Medicaid can reimburse a provider and still receive the federal match rate (or federal financial participation). The three unique UPLs are calculated by the Department such that each must be a reasonable estimate of the amount Medicare would reimburse providers for providing Medicaid services. The Centers for Medicare and Medicaid Services (CMS) will also accept a UPL demonstration based on Medicaid cost.

What is the Disproportionate Share Hospital Allotment?

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. Disproportionate Share Hospital (DSH) payments are 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 a shift in costs to private payers. In subsequent legislation, Congress gave states a great deal of flexibility in the design and implementation of their DSH plans.

The federal Balanced Budget Act of 1997 (BBA97) established declining limits on the amount of federal funds available to states for DSH payments. These limits were established as allotments (or caps) for each state starting in Federal Fiscal Year (FFY) 1997-98. The DSH Allotment for FFY 2008-09 is $92.8 Million and $95.2 Million for FFY 2009-10. These amounts include a 2.5% increase from the American Recovery and Reinvestment Act of 2009 (ARRA). This amount is entirely federal funds. To draw the federal funds, the Department must have an equal state share (the FMAP on DSH for Colorado is 50%). As such, payments to offset the uncompensated costs of providing services to uninsured and underinsured patients cannot exceed $185.7 Million in FFY 2008-09 and $190.4 Million in FFY 2009-10.

What is the CICP?

The Colorado Indigent Care Program (CICP) distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding deliver discounted health care services to Colorado residents, migrant workers, and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Health Plan *Plus* (CHP+).

This is *not* a health insurance program. Services are restricted to participating hospitals and clinics throughout the state. In addition, medical services vary by participating health care provider. The responsible physician or health care provider determines what services will be covered. These services must include emergency care, and may include, but are not limited to, inpatient care, outpatient care and prescription drugs.

What is the Section 1115 Waiver or 1115 Demonstration Waivers?

Such waivers allow states to have a program which promotes the objectives of Medicaid, such as – in the case of Colorado – expanding eligibility to groups which do not qualify for Medicaid.

Section 1115 of Title XIX the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach has not been demonstrated on a widespread basis.

Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver.

What are the Patient Days used in the Hospital Provider Fee Model?

- **Commercial Managed Care**: Commercial managed care programs such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Does not include Medicare, Medicaid, or CHAMPUS managed care.
- **Other Commercial**: Indemnity insurance plans and other plans for which no discount arrangement exists.
- **CHAMPUS/TriCare**: A federal program for patients insured by the Civilian Health and Medical Program for the Uniformed Services.
- **Colorado Indigent Care Program (CICP)**: For CICP patient days report where CICP is primary payer and where CICP is secondary payer separately.
- **Section 1011**: Federal reimbursement of emergency services furnished to undocumented aliens under Section 1011 of the Medicare Modernization Act of 2003 (MMA).
- **Self Pay / Uninsured / Charity Care**: Patients with no third party coverage or in hospital's charity care program (does not include CICP).
- **Medicaid fee-for-service (FFS)**: Medicaid FFS is primary payer, does not include Medicaid HMO or dual eligibles.
- **Medicaid nursery days**: Days of care provided to Medicaid newborns while the mother is in the hospital.
- **Medicaid HMO**: Medicaid HMO is primary payer.
- **Medicaid dual eligible**: Patients with Medicare and Medicaid coverage.
- **Medicaid and other payer**: Patients with third party and Medicaid coverage (not Medicare/Medicaid).
- **Medicare fee-for-service:** Medicare is primary payer; does not include Medicare HMO.
- **Medicare HMO:** Medicare HMO is primary payer.
- **Medicare and other payer**: Medicare and third party coverage (not Medicaid/Medicare).