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State/Territory Name: CO

State Plan Amendment (SPA) CO: 23-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

February 9, 2024

Bettina Schneider, Chief Financial Officer
Attn: Alex Lyons
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Re: Colorado 23-0003

Dear Bettina Schneider,

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 23-0003. Effective for services on or after July 1, 2023, this amendment revises the inpatient hospital base rate methodology, and provides for additional add-on payments for inpatient hospital services. In addition, it revises language for outpatient hospital services to reflect the use of the most recent available Medicare cost report and updates factors used in the outpatient calculation.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 23-0003 is approved effective July 1, 2023. The CMS- 179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at Christine.storey@cms.hhs.gov or LaJoshica Smith at lajoshica.smith@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0003

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act, Section 1905(a)(1) / 42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A -- Pages 3-4b, 10b-d

Attachment 4.19-B -- Pages 6-8 (TN 21-0032, 19-0018)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A -- Pages 3-4a, 10b-d (TN 22-0021, 20-0027, 12-016, 21-0032, 19-0018)

Attachment 4.19-B -- Pages 6-8 (TN 21-0032, 19-0018)

9. SUBJECT OF AMENDMENT
Revises the inpatient hospital base rate methodology.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED
08/01/2023

15. RETURN TO
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Alex Lyons

FOR CMS USE ONLY

16. DATE RECEIVED
08/01/2023

17. DATE APPROVED
February 9, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
07/01/2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rowry Howe

21. TITLE OF APPROVING OFFICIAL
Director

22. REMARKS

Instructions on Back

7. Budget Neutrality: Budget Neutrality for PPS Hospitals is defined as no change in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated. The estimated hospital specific payment is calculated by using hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix, multiplied by the Medicaid base rate. Effective July 1, 2020 Budget Neutrality is defined as a 1.1308% increase in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated. For State Fiscal Year 2022, the Medicaid Inpatient Base Rates from State Fiscal Year 2021 will be increased by 2.0%. Starting in State Fiscal Year 2023-24, the budget neutrality factor will be expressed as a percent of the estimated payments to Colorado DRG in-state hospitals from the prior year applied to the expected discharges and hospital specific average Medicaid case mix multiplied by all rebased hospital base rates. The rebased hospital base rates used in this calculation are adjusted such that hospital rate changes do not exceed a 10% gain or loss from the prior year's rates. Effective July 1, 2023 the budget neutrality factor is defined as a reduction of calculated rates by 79.91%.

8. Medicaid Base Rate or Base Rate: An estimated cost per Medicaid discharge.

   a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate

   In rebasing years, for in-state Colorado DRG Hospitals (both PPS and non-PPS hospitals as categorized by Medicare), the starting point shall be the hospital-specific Medicare Federal base rate with the specific adjustments listed. The Operating Federal Portion and Federal Capital Rate (source: CMS Tables 1A-1B & IE) will be adjusted by the Wage Index and Geographic Adjustment Factor (GAF) from the CMS IMPACT File. For CAH and Pediatric hospitals (non-PPS Medicare hospitals), both adjustment factors as listed above will be set to 1.0 and the corresponding labor and non-labor related amounts will be applied because these factors are not available from CMS. Additionally, the Quality and Meaningful Electronic Health Records (EHR) User adjustments will be applied to all PPS hospitals as indicated on the CMS corrected IMPACT file, while all non-PPS hospitals are assumed to have submitted Quality Data and be meaningful EHR users since no data exists for them**.** The corrected Medicare base rate IMPACT File shall be used to set the Federal Base Rate and other adjustments detailed above effective on October 1 of the previous fiscal year.

   b. Policy Adjustments

   Indirect Medical Education (IME) / Value Based Purchasing Adjustment (VBP) Factor / Readmission Adjustment Factor and Hospital Acquired Conditions (HAC) Reduction:

      1. For PPS hospitals, Operating IME% will be multiplied by Adjusted Operating Federal Portion and the Capital IME% will be multiplied by the Adjusted Federal Capital Rate. The VBP Adjustment Factor and Readmission Adjustment Factor taken from CMS Final Rule Correcting Amendment Tables 16B and 15 respectively will be multiplied by the Adjusted Operating Federal Portion. The Hospital Acquired Conditions Reduction taken from the most recent CMS.gov Data Set as of January 1

will be applied against the Medicare Federal Base Rate with Wage Index/GAF Adjustments.

2. For non-PPS hospitals, Operating & Capital IME % are not calculated in the IMPACT File so the Department's Contractor will compute their Operating and Capital IME using the most recently available cost report as of January 1 in rebasing years and will require that hospitals have a CMS approved teaching program as detailed below in Section 4.19A.8.e.1-2 The VBP Adjustment Factor, Readmission Adjustment Factor and HAC Reduction will not be applied to non-PPS hospitals since they are not calculated by CMS.

c. Mutually Exclusive Medicaid Add-ons:

Four Add-ons will be mutually exclusive and applied as a percentage against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments as detailed below.

1. Critical Access Hospital (CAH) Add-on will be set at 25% and is only open to those hospitals categorized as CAH by Medicare,
2. Sole Community Hospital (SCH)/Medicare Dependent Hospital (MDH) will be set at 20% and is only open those hospitals categorized as SCH/MDH by Medicare,
3. Low Discharge Add-on based on the average of up to three years of Total Discharges of most recently available full-year cost reports on HCRIS as of January 1 of rebasing years and excludes hospitals that are classified as Pediatric, SCH/MDH or CAH.
4. The Pediatric Add-on is open only to hospitals defined as a Pediatric by Medicare and the percentage add-on is set at 25%.

d. Remaining Medicaid Add-ons:

The remaining add-ons are open to all hospitals who qualify and are applied as a percentage of the Medicare Federal Base Rate with Wage Index/GAF Adjustments and distributed on a sliding scale.

1. Payer Mix Add-on is based on the percentage of Medicaid patient days treated at the hospital using up to three years of the most recently available full-year cost reports. The add-on is set at up to 10%.
2. Operating Cash Flow Margin Percent Add-on (also known as the solvency metric) is set at 20%. The source for this data is up to 3 years of Hospital Transparency Data that is generated by each hospital and sent into the Department. The Operating Cash Flow Margin Percent Add-on is calculated for all hospitals and is based on the maximum of the hospital or the hospital system's operating cash flow margin percent. System hospital list can be found on the Department's website. Operating Cash Flow Margin Percent is calculated by taking (Total Operating Net Income + Depreciation Expense) / Total Operating Revenue.

e. Application of Graduate Medical Education (GME) Cost Add-on to Determine Medicaid

Inpatient Base Rate:

The Medicaid Inpatient base rate shall be equal to the rate as calculated in Section 4.19A.8.a - d plus the GME Medicaid hospital-specific cost add-on. The GME Medicaid hospital-specific cost add-on is calculated from the most recently available Medicare/Medicaid cost report (CMS 2552) worksheet B, Part I. Partial year cost reports shall not be used to calculate the GME cost add-on. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals.
State University Teaching Hospitals shall receive reimbursement for GME costs as follows. Effective May 23, 2008, the Graduate Medical Education add-on will not be applied directly to the Medicaid inpatient base rate for Denver Health Medical Center and University of Colorado Hospital. These hospitals will receive reimbursement for Graduate Medical Education costs through a direct payment as they qualify to receive a State University Teaching Hospital payment as specified under this Attachment 4.19A. The State University Teaching Hospital payment is a fixed amount subject to annual appropriation by the Colorado General Assembly.

The GME Medicaid hospital-specific cost add-on shall be an estimate of the cost per discharge for GME based on: Medicare approved GME program where legitimate GME expenses have been reported in accordance with Medicare's rules detailed in 42 C.F.R. § 413.75, et. seq. Ten percent of the GME Medicaid hospital-specific cost add-on shall be applied when the following two criteria are met:

1. Hospitals that appear on the most recent list as of January 1 of CMS qualified teaching hospitals on the CMS Open Payments website or the hospital will need to provide documentation to the State by proving Medicare approval of the GME program.
2. Have countable GME costs in the most recent cost report available as of January 1 of rebasing years in worksheet B, part 1 and discharges from worksheet S-3, part I.

f. Application of Adjustment Based on General Assembly Funding

In rebasing years, for all in-state, Colorado DRG Hospitals (both PPS and non-PPS), the starting point for the Medicaid Inpatient base rate, as determined in Section 4.19A.8.a - e, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Additionally, a 10% corridor has been implemented to prevent any hospital's inpatient base rate from increasing or decreasing more than 10% each rebasing year.

g. Annual Adjustments

Rebasing years are every other odd year starting in state fiscal year 2023-24. Non-rebasing years are every other even year starting in state fiscal year 2024-25. The Medicaid Inpatient base rates are rebased every other year as described in Section 4.19A.8.a - f and are effective each July 1. In non-rebasing years, the Medicaid Inpatient base rates will be adjusted by the State Budget Action as set by Legislature and are effective each July 1. The Medicaid base rate shall be adjusted during

the fiscal year, if necessary, based on appropriations available to the Department and/or adjustments necessary to balance the DRG payment equation.

Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rates will be posted to the Department website.

Posted rates will document the Medicaid base rate and other relevant figures for the specific providers so that providers may understand and independently calculate their payment. Posted rates allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology.

9. Effective for inpatient hospital claims with discharge dates on or after October 1, 2009, Serious Reportable Events will not be used for Colorado Medicaid DRG assignment when the condition was not present on admission. When applicable, reimbursement to a hospital will be adjusted automatically or via retrospective reviews.

H. Public Process for Hospital Rate-Setting

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

I. Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

GME costs incurred by an individual hospital for Medicaid managed care clients are carved out of managed care payments and shall be paid directly to Hospitals with a Graduate Medical Education program rather than to managed care organizations (MCOs) and regional accountable entities (RAEs) for Inpatient Services. GME, like other allowable costs, is a component of the hospital base rate. State University Teaching Hospitals' GME Inpatient costs are also carved out of managed care payments and paid through Family Medicine Program's State University Teaching Hospital Payment.

1. The most recently available Hospital Medicare/Medicaid Cost Report (CMS 2552) available as of January 1 of rebasing years shall be used to determine the Medicaid Inpatient GME cost per day for each Hospital that has GME costs in its fee-for-service base rate, excluding State University Teaching Hospitals. Each Hospital's GME cost per day shall be computed when Hospital rates are rebased according to the schedule outlined in Item I.B.7 ("Budget Neutrality" definition). Years when rates are updated with the State Budget Action (annual state Long Bill) as set by the Colorado General Assembly, GME cost per day will remain the same from the cost report rebasing.

2. MCOs and RAEs shall provide reports to the Department consisting of Inpatient day utilization by Hospital for discharges (net of adjustments) on a quarterly basis. To provide more time for claim runout, these reports shall be provided to the Department no later than 120 days after the close of each calendar year quarter (see table below for exact dates).

Calendar Year - Quarter	**Reports contain utilization for**	**Due Date:** (120 days after end of quarter)
Calendar Year-Q1	January - March	July 31st
Calendar Year-Q2	April - June	October 31st
Calendar Year-Q3	July - September	January 31st
Calendar Year-Q4	October - December	April 30th

3. The Medicaid managed care Inpatient days for each Hospital shall be the total of the Inpatient days for each Hospital received from the MCOs and RAEs for each quarter. That total shall be multiplied by the GME cost per day to determine the Inpatient GME reimbursement for each Hospital per quarter. Please see tables 1 and 2 which identify the data sources and calculations used to create GME MCO hospital payments.

The GME reimbursement will be paid at least annually through a lump sum payment to each Hospital by June 30th of each year.

TABLE 1: Calculations for Outpatient (OP) Cost to Charge Ratio, Inpatient (IP) Graduate Medical Education (GME) Cost/Day and Inflation Factor for Current Year			
Data Point	**Data Point Name**	**Sample Data**	**Data Source / Calculations**
F	Total GME Routine Costs	$75,000.00	CMS 2552: Worksheet B Part I, Columns 21 and 22 (Interns and Residents), Inpatient Routine Service Cost Centers.
G	Total GME Ancillary Costs	$24,000.00	CMS 2552: Worksheet B Part I, Columns 21 and 22 (Interns and Residents), Ancillary Service Cost Centers plus Outpatient Service Cost Centers (allowable cost centers only).
H	Inpatient Ratio	0.247101	CMS 2552: Equals: Worksheet C Part I, Title XIX, Column 6 (Inpatient Charges) Line 202 (Total) divided by Worksheet C Part I, Title XIX, Column 8 (Total Charges) Line 202 (Total).
I	Inpatient Ancillary Costs	$5,930.42	CMS 2552: Equals: Column **G** (Total GME IP Ancillary Costs) times Column **H** (IP Ratio).
J	Total GME Costs	80,930.42	CMS 2552: Equals: Column **F** (Total GME Routine Costs) plus Column **I** (IP Ancillary Costs).
N	Total Inpatient Days	1,000	CO MMIS: Medicaid Internal Reports Total IP Days on Paid Claims based on same time period of most recently available CMS 2552.
O	Total Billed Charges	16,836,437	CO MMIS: CO MMIS Internal Reports Total OP Charges on Paid Claims based on same time period of most recently available CMS 2552.
Q	Outpatient Cost to Charge Ratio	.00481	Calculation: Outpatient Cost to Charge Ratio (Column J / Column O)
R	Inpatient Graduate Medical Expense Cost/Day	$80.93	Calculation: Inpatient GME Cost/Day (Column J / Column N)
S	Inflation Factor Current Year	1.03	Calculation: Actual Regulation Market Basket Updates from CMS (Inpatient Hospital PPS Table)
This report includes input from hospitals' most recently available CMS 2552 cost report as of January 1 in rebasing years as well as Medicaid program days from the State's MMIS system.			

TABLE 2: SAMPLE GRADUATE MEDICAL EDUCATION PAYMENT FOR MANAGED CARE UTILIZATION		
Provider Name	**HOSPITAL ABC**	**Calculations & Data Sources used to create MCO utilization GME payment**
Provider Number	99999999	Colorado Medicaid Provider Number
NPI	99999999999	National Provider Identifier (NPI)
Quarter/Year	Q1-2019	Quarter and Year based on Calendar Year
MCO A Inpatient Days	1	Number produced from quarterly utilization reports created by Managed Care Organization A
MCO A Outpatient Charges	$10,000.00	Number produced from quarterly utilization reports created by Managed Care Organization A
MCO B Inpatient Days	1	Number produced from quarterly utilization reports created by Managed Care Organization B
MCO B Outpatient Charges	$10,000.00	Number produced from quarterly utilization reports created by Managed Care Organization B
Total Inpatient Days	2	Add all inpatient days from MCE utilization for Hospital ABC together here
Total Outpatient Charges	$20,000.00	Add all outpatient charges from MCE utilization for Hospital ABC together here
Inpatient Rate	$80.93	IP GME Cost/Day from Table 1
Outpatient Reimbursement Rate	72%	Percentage of reimbursement see Attachment 4.19-B; Item 2a. Outpatient Hospital Services; paragraph 10.c.
Outpatient Cost to Charge Ratio	0.00481	OP Cost to charge Ratio from Table 1
Inflation Factor	1.03000	Inflation Factor Current Fiscal Year from Table 1
Inflated Inpatient Rate	$83.36	Inflated Inpatient Rate (Inpatient Rate * Inflation Factor)
GME Inpatient Payment	$166.72	Total Inpatient Days * Inflated Inpatient Rate
GME Outpatient Payment	$69.22	Total Outpatient Charges *Outpatient Reimbursement Rate * Outpatient Cost to Charge Ratio
GME TOTAL PAYMENT	**$235.94**	**Hospital ABC's Total Payment for Quarter**
The calculation includes input from the hospitals' most recently available CMS 2552 cost report as of January 1 in rebasing years as well as Medicaid program days from the State's MMIS system.		

OUTPATIENT HOSPITAL SERVICES (continued)

9. Supplemental Medicaid Outpatient High-Volume Small Rural Hospital Payment

Effective October 1, 2011, the Supplemental Medicaid Outpatient High-Volume Small Rural Hospital Payment is suspended.

10. Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

GME costs incurred by an individual hospital for Medicaid managed care clients are carved out of managed care payments and shall be paid directly to Hospitals with a Graduate Medical Education program rather than to regional accountable entities (RAEs) and managed care organizations (MCOs) for Outpatient Services. GME, like other allowable costs, is a component of the hospital base rate.

a. The most recently available Hospital Medicare/Medicaid Cost Report (CMS 2552) available as of January 1 of rebasing years shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's Outpatient cost-to-charge ratio shall be computed when Hospital rates are rebased according to the schedule outlined in Item I.B.7 ("Budget Neutrality" definition). Years when rates are updated with the State Budget Action (annual state Long Bill) as set by the Colorado General Assembly, the Outpatient GME cost-to-charge per day will remain the same from the cost report rebasing.

b. MCOs and RAEs shall provide reports to the Department consisting of Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service on a quarterly basis. To provide more time for claim runout, these reports shall be provided to the Department no later than 120 days after the close of each calendar year quarter (see table below for exact dates).

Calendar Year - Quarter	**Reports contain utilization for**	**Due Date:** (120 days after end of quarter)
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c. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs and RAEs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per quarter. Please see tables 1 and 2 which identify the data sources and calculations used to create GME MCO hospital payments.

The GME reimbursement shall be paid at least annually through a lump sum payment to each Hospital by June 30th of each year.

OUTPATIENT HOSPITAL SERVICES (continued)

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OUTPATIENT HOSPITAL SERVICES (continued)

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MCO B Outpatient Charges	$10,000.00	Number produced from quarterly utilization reports created by Managed Care Organization B
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