Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-09-016

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

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

Center for Medicaid and State Operations, CMSO

Dr. Sandeep Wadhwa, MD, MBA
Medicaid Director
Department of Health Care Policy
& Financing
1570 Grant Street
Denver, CO 80203-1818

DEC 17 2009

Re: Colorado 09-016

Dear Dr. Wadhwa:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-016. Effective for services on or after July 1, 2009, this amendment modifies the specialty percentage adjustments for Pediatric Specialty Hospitals; modifies the reimbursement methodology for Prospective Payment System (PPS) Rehabilitation Hospitals and Specialty-Acute Hospitals; revises the definition of budget neutrality; and, denies reimbursement for Serious Reportable Events not present on admission.

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 (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 09-016 is approved effective July 1, 2009. The HCFA-179 and the amended plan pages are attached.

If you have any questions, please call Christine Storey at (303) 844-7044.

Sincerely,

Cindy Mann
Director
Center for Medicaid and State Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09 - 016

2. STATE: CO

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2009

5. TYPE OF PLAN MATERIAL (*Check one*):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS A NEW PLAN X☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. 447.253

7. FEDERAL BUDGET IMPACT:
a. FFY_2009 Q4 $___(1,287,379)___
b. FFY_2010 $___(8,121,658)___
c. FFY_2011 $___(9,444,136)___

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 3, 4, 4a and 4b Attachment 4.19-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*if applicable*):
Pages 3, 4 and 4a Attachment 4.19-A

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement Methodology

11. 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
☐X OTHER AS SPECIFIED
Governor's letter dated 29 July 2009

12. SIGNATURE OF STATE AGENCY OFFICIAL: [signature] 11-30-09

13. TYPED NAME:
Sandeep Wadhwa, MD

14. TITLE:
Medicaid Director;
Medical & Child Health Plan *Plus* Program Administration Office

15: DATE SUBMITTED:

16. RETURN TO:
Colorado Department of Health Care Policy and Financing
1570 Grant
Denver, Colorado 80203

Attn: Rachel Gibbons

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 12-17-09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 1 - 2009

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (*07-92*) *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 payments 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, 2004 Budget Neutrality is defined as a one percent decrease 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. Effective July 1, 2005 Budget Neutrality is defined as a four percent 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. Effective April 1, 2006 Budget Neutrality is defined as a four and a half percent 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. Effective July 1, 2007 Budget Neutrality is defined as a one and three fifths percent 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. Effective July 1, 2008 Budget Neutrality is defined as a one and two thirds percent 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. Effective July 1, 2009 Budget Neutrality is defined as two and two fifths percent decrease 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. Effective September 1, 2009 Budget Neutrality is defined as three and nine tenths percent decrease 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. Effective December 1, 2009 Budget Neutrality is defined as four and nine tenths percent decrease 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.

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

   For PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by modifying the Medicare base rate by a set percentage equally to all PPS Hospitals, excluding Rehabilitation and Specialty-Acute

Hospitals. This percentage will be determined to maintain Budget Neutrality for all PPS Hospitals, including Rehabilitation and Specialty-Acute Hospitals.

For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the Medicaid base rate used will be the average Medicaid base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty Medicaid discharges in the previous fiscal year.

Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge amount for Nursery, Neo-Natal, Intensive Care Units, and Graduate Medical Education obtained directly from the most recently audited Medicare/Medicaid cost report. Ten percent of each of these cost per discharge amounts will be added on to the base rate.

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.

Pediatric Specialty Hospitals will receive an adjustment factor of 0.88975 effective July 1, 2009. Effective September 1, 2009, Pediatric Specialty Hospitals will receive an adjustment factor of 0.8757 Effective December 1, 2009, Pediatric Specialty Hospitals will receive an adjustment factor of 0.8665.

Effective July 1, 2008 Urban Center Safety Net Specialty Hospitals will receive their hospital specific Medicare base rate adjusted by the percentage applied to all other hospitals plus 10 percent to account for the specialty care provided. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent. Add-ons are included in the final rate. To qualify as an Urban Center Safety Net Specialty Hospital, the urban hospital's Medicaid days plus Colorado Indigent Care Program (CICP) days relative to total days, rounded to the nearest percent, shall be equal to or exceed sixty-seven percent. Medicaid and total days shall be Medicaid eligible inpatient days and total inpatient days from the most recent survey requested by the Department prior to March 1 of each year for July 1 rates. If the provider fails

to report the requested days, the days used shall be collected from data published by the Colorado Hospital Association in its most recent annual report available on March 1 of each year. The CICP days shall be those reported in the most recently available CICP Annual Report as of March 1 of each year.

Beginning July 1, 2009 for PPS Rehabilitation and Specialty-Acute Hospitals including acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries, the hospital specific Medicaid base rate will be equal to each hospital's July 1, 2008 Medicaid base rate decreased by two percent. Beginning September 1, 2009 for PPS Rehabilitation and Specialty-Acute Hospitals including acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries, the hospital specific Medicaid base rate will be equal to each hospital's July 1, 2009 Medicaid base rate decreased by one and a half percent. Beginning December 1, 2009 for PPS Rehabilitation and Specialty-Acute Hospitals including acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries, the hospital specific Medicaid base rate will be equal to each hospital's September 1, 2009 Medicaid base rate decreased by one percent.

Hospital specific Medicaid base rates are adjusted annually (rebased) and are effective each July 1. Medicaid base rates will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. For instances where the General Assembly appropriates a change in funding during the State Fiscal Year, the hospital specific Medicaid base rates will be adjusted to allow for the change in funding.

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, rate letters will be distributed to providers qualified to receive the payment each fiscal year.

Rate letters will document the Medicaid base rate and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters 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 via retrospective reviews.

These Serious Reportable Events will be published in the Department's website and updated annually as needed:

a. Foreign object inadvertently left in patient after surgery;
b. Death/disability associated with intravascular air embolism;
c. Death/disability associated with incompatible blood;
d. Stage 3 or 4 pressure ulcers after admission;
e. Hospital-acquired injuries: fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes;
f. Catheter-associated urinary tract infection;
g. Vascular catheter-associated infection;
h. Mediastinitis after coronary artery bypass graft surgery;
i. Manifestations of poor glycemic control;
j. Surgical site infection following certain orthopedic procedures;
k. Surgical site infection following bariatric surgery for obesity; and
l. Deep vein thrombosis & pulmonary embolism following certain orthopedic procedures.

10. Non-exempt hospitals shall not receive reimbursement for an inpatient stay where the following occurred:

a. Surgery performed on the wrong body part;
b. Surgery performed on the wrong patient;
c. Wrong surgical procedure on a patient.

11. Exempt hospitals are those hospitals which are designated by the Department to be exempt from the DRG-based prospective payment system. The Department may designate facilities as exempt or non-exempt providers. Non-exempt providers shall be reimbursed using the DRG-based prospective payment system (PPS). Exempt hospitals will be paid a per diem for inpatient hospital services. As of July 1, 2003 free-standing psychiatric facilities shall be the only exempt providers.