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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-09-039

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

Mr. John Bartholomew, Director
Budget and Finance Office
Department of Health Care Policy
& Financing
1570 Grant Street
Denver, CO 80203-1818

MAR 3 0 2010

Re: Colorado 09-039

Dear Mr. Bartholomew:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-039. Effective for services on or after July 1, 2009, this amendment implements supplemental Medicaid inpatient hospital and disproportionate share hospital (DSH) reimbursements related to payments authorized under the Colorado Health Care Affordability Act of 2009.

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 09-039 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,

[redacted]

Cindy Mann
Director
Center for Medicaid and State Operations

cc: Chris Underwood, CO HCPF

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: **09--039**	2. STATE: **COLORADO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES 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 CFR 42 Section 447.272	7. FEDERAL BUDGET IMPACT a. FFY 09 $34,972,657 b. FFY 10 $104,917,972
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19A page 17-19, 22, 29, 29a-c, 34, 36-53	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* Attachment 4.19A page Modifies pages 17-19, 22, 29, 34, 36-39, 40a-d, new pages

10. SUBJECT OF AMENDMENT

Supplement Medicaid Inpatient Hospital and Disproportion Share Hospital Payments Revised

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 26 January 2009

12. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	16. RETURN TO **Colorado Department of Health Care Policy and Financing** **1570 Grant Street** **Denver, CO 80203-1818** **Attn: Rachel Gibbons**
13. TYPED NAME **John Bartholomew**	
14. TITLE ***Director, Budget and Finance Office***	
15. DATE SUBMITTED **September 30, 2009**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED 3-30-10
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL JUL - 1 2009	[redacted]
21. TYPED NAME William Lasowski	22. TITLE Deputy Director, CMSO

23. REMARKS

FORM CMS-179 *(07/92)* *Instructions on Back*

The funds available for the Low-Income Shortfall payment under the Disproportionate Share Hospital Allotment are limited by the regulations set by and federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	$66,710
State Fiscal Year 2004-05	$113,312
State Fiscal Year 2005-06	$145,470
State Fiscal Year 2006-07	$189,588
State Fiscal Year 2007-08	$530
State Fiscal Year 2008-09	$176,324

11. Effective July 1, 2009, the payment adjustment, as described above in this subsection and commonly known as Low-Income Shortfall payment, is suspended.

12. Effective July 1, 2009, Hospitals deemed eligible for minimum disproportionate share payment and participate in the Colorado Indigent Care Program will receive a CICP Disproportionate Share Hospital payment.

13. Effective July 1, 2009, Hospitals deemed eligible for minimum disproportionate share payment and do not participate in the Colorado Indigent Care Program will receive an Uninsured Disproportionate Share Hospital payment.

C. Colorado determination of Individual Hospital Disproportionate Payment Adjustment Associated with the Colorado Indigent Care Program and Bad Debt.

1. Effective July 1, 1993 Component 1 shall be superceded by a Disproportionate Share Adjustment payment method (herein described as Component 1a) which shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, disproportionate Share Hospital Adjustments, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

   a. Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Programs reimbursements.

   b. For each hospital that qualifies under this section D, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year. This cost data will be inflated forward from the year of the most recent available report (using the CPI-W, Medical Care for Denver) through June 30 of the fiscal year payment period. The Colorado Indigent Care Program costs, patient payments, and Program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Program, subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care, and/or independent audit. Aggregate disproportionate share hospital payments will not exceed the published disproportionate share hospital limitations.

2. Effective for the period from June 1, 1994 to June 30, 1994: each facility will receive a payment proportional to the level of low income care services provided, as measured by the percent of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program Patient payments and Colorado Indigent Care Program reimbursements, that will allow the State to approach but not exceed the State's Federal Fiscal Year 1994 Disproportionate Share Hospital allotment as published in the May 2, 1994 Federal Register. If these reimbursements exceed the federal allotment limits, they will be recovered

proportionately from all participating hospitals. The State will use historical data from the SFY 91/92 Colorado Indigent Care Program Annual Report to develop the prospective payment rate. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State, (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)).

3. Effective for the period from July 1, 1994 to June 30, 1995, each facility will receive a payment proportional to the level of low income care services provided, as measured by 200% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, disproportionate Share Hospital Adjustments, paragraph (A)).

4. Effective July 1, 1995, each facility will receive a Component Ia payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).

5. Effective July 1, 2003 the Disproportionate Share Hospital adjustment commonly refereed to as "Component Ia" is suspended.

The amount of available federal funds remaining under the Disproportionate Share Hospital allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt Costs for qualified providers. Available Bad Debt charges are converted to Bad Debt costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

Available funds under the Disproportionate Share Hospital Allotment are multiplied by the percentage resulting from dividing the hospital specific Bad Debt costs by the sum of all Bad Debt costs for qualified providers to calculate the Bad Debt payment for the specific provider. As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific Bad Debts costs.

The funds available for the Bad Debt payment under the Medicare Disproportionate Share Hospital Allotment are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	$4,591,800
State Fiscal Year 2004-05	$1,857,450
State Fiscal Year 2005-06	$280,832
State Fiscal Year 2006-07	$448,474
State Fiscal Year 2007-08	$113,045
State Fiscal Year 2008-09	$756,931

10. Effective July 1, 2009 the Disproportionate Share Hospital adjustment commonly refereed to as "Bad Debt payment" is suspended.

The funds available for the Low-Income payment under the Medicare Disproportionate Share Hospital Allotment are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	$163,616,330
State Fiscal Year 2004-05	$172,284,442
State Fiscal Year 2005-06	$173,828,898
State Fiscal Year 2006-07	$173,679,266
State Fiscal Year 2007-08	$174,000,854
State Fiscal Year 2008-09	$181,190,648

7. Effective July 1, 2009 the Disproportionate Share Hospital adjustment commonly refereed to as "Low-Income payment" is suspended.

8. Effective July 1, 2009, hospitals that participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "CICP Disproportionate Share Hospital payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal monthly installments.

   To qualify for the CICP Disproportionate Share Hospital payment a Colorado hospital shall meet the following criteria:

   a. Is licensed or certified as a General Hospital or Critical Access Hospital by the Colorado Department of Public Health and Environment; and

   b. Does participate in the Colorado Indigent Care Program.

   The CICP Disproportionate Share Hospital payment is a prospective payment calculated using historical data, with no reconciliation to actual data or costs for the payment period. Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific

audited cost-to-charge ratio (as calculated from the audited Medicare/Medicaid cost report [CMS 2552]) available as of May 1 each fiscal year. Medically indigent costs are inflated forward to payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

Qualified hospitals shall receive a payment calculated as a percent of inflated medically indigent costs. There will be three categories for qualified hospitals: state-owned government hospitals, non-state-owned government hospitals, and private-owned hospitals. The percent of inflated medically indigent costs shall be calculated for each category. The percent of inflated medically indigent costs shall be the aggregate of all inflated medically indigent costs for qualified providers in the category divided State's annual Disproportionate Share Hospital allotment allocated to the CICP Disproportionate Share Hospital payment for that category.

	Percent of the State's annual Disproportionate Share Hospital Allotment allocated to the CICP Disproportionate Share Hospital payment by category		
	State-owned government hospitals	non-state -owned government hospitals	Private- owned hospitals
State Fiscal Year 2009-10	5.06%	40.00%	35.00%

No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit (as specified in federal regulations). If upon review, the CICP Disproportionate Share Hospital payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific DSH limit retroactively. The amount of the retroactive reduction shall be then retroactively distributed to the other qualified hospitals in the category based on the qualified hospital proportion of medically indigent cost relative to the aggregate of medically indigent costs of all qualified providers in the category who do not exceed their hospital-specific Disproportionate Share Hospital limit.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after an CICP Disproportionate Share Hospital payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

E. Colorado determination of Individual Hospital Disproportionate Payment Adjustment Associated with providers who do not participate in Colorado Indigent Care Program

1. Effective July 1, 2009, Colorado hospitals that do not participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "Uninsured Disproportionate Share Hospital payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal monthly installments.

   To qualify for the Uninsured Disproportionate Share Hospital payment a Colorado hospital shall meet the following criteria:

   a. Is licensed or certified as a General Hospital or Critical Access Hospital by the Colorado Department of Public Health and Environment;

   b. Is not licensed or certified as Psychiatric or Rehabilitation Hospital, nor is licensed as a General Hospital with a Medicare Certification Long Term by the Colorado Department of Public Health and Environment;

   c. Does not participate in the Colorado Indigent Care Program; and

   d. Reports charges for services provided to low-income, uninsured persons to the Department

   The Uninsured Disproportionate Share Hospital payment is a prospective payment calculated using historical data, with no reconciliation to actual data or costs for the payment period. Available charges for services provided to low-income, uninsured persons (as reported to the Department annually) are converted to uninsured costs using the most recent provider specific audited cost-to-charge ratio (as calculated from the audited Medicare/Medicaid cost report [CMS 2552]) available as of May 1 each fiscal year. Uninsured costs are inflated forward to the payment period year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

   Qualified hospitals shall receive a payment calculated as a percent of inflated uninsured cost. The percent of estimated uninsured costs shall be the aggregate of all inflated uninsured costs for qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital payment.

	Percent of the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital payment
State Fiscal Year 2009-10	19.94%

No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit (as specified in federal regulations). If upon review or audit, the Uninsured Disproportionate Share Hospital payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific DSH limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to the other qualified hospitals based on the qualified hospital proportion of uninsured cost relative to aggregate of uninsured costs of all qualified providers who do not exceed their hospital-specific Disproportionate Share Hospital limit.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after an Uninsured Disproportionate Share Hospital payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

For this section, Medicaid days, medically indigent days and total inpatient days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report the requested Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

The term allotment in this section refers to the funds available under the three different Medicare UPL provider categories of state owned government hospitals, non-state owned government hospitals and privately owned hospitals. The funds available for the High-Volume payment under the Medicare Upper Payment Limit are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	$96,515,460
State Fiscal Year 2004-05	$81,026,824
State Fiscal Year 2005-06	$113,040,874
State Fiscal Year 2006-07	$105,677,834
State Fiscal Year 2007-08	$105,953,937
State Fiscal Year 2008-09	$114,495,800

Effective July 1, 2009 the Supplemental Medicaid Payment commonly referred to as "High-Volume payment" is suspended.

The term allotment in this section refers to the funds available under the two different Medicare UPL provider categories of state owned government hospitals and non-state owned government hospitals. The funds available for the UPL payment under the Medicare UPL are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that the provider may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	$0
State Fiscal Year 2004-05	$0
State Fiscal Year 2005-06	$0
State Fiscal Year 2006-07	$0
State Fiscal Year 2007-08	$0
State Fiscal Year 2008-09	$0

Effective July 1, 2009 the Supplemental Medicaid Payment commonly refereed to as "UPL payment" is suspended.

3. Effective July 1, 2009, state-owned government hospitals, non-state-owned government hospitals and private-owned hospitals, which participate in the Colorado Indigent Care Program (CICP), will qualify to receive additional Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the inpatient Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "CICP Supplemental Medicaid payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal monthly installments.

   The CICP Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

   To qualify for the CICP Supplemental Medicaid payment a Colorado hospital shall meet the following criteria:

   a. Is licensed or certified as a General Hospital or Critical Access Hospital by the Colorado Department of Public Health and Environment; and

   b. Does participate in the Colorado Indigent Care Program.

   The CICP Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data or costs for the payment period. Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio (as calculated from the audited Medicare/Medicaid cost report [CMS 2552]) available as of May 1 each fiscal year. Medically indigent costs are inflated forward to payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

   Qualified hospitals shall receive a payment equal to the percent of inflated medically indigent costs multiplied by the hospital specific inflated medically indigent costs minus the hospital specific payment received under the CICP Disproportionate Share Hospital Payment (as described under Attachment 4.19A, Section III.D.8 Colorado Determination of Individual Hospital Disproportionate Payment Adjustment Associated with the Colorado Indigent Care Program). The percent of inflated medically indigent costs shall be:

a. Qualified hospitals that are classified as High Volume Medicaid and CICP Hospitals will receive 75% of their inflated medically indigent costs. High Volume Medicaid and CICP Hospitals are defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days.

b. Qualified hospitals in a rural area (a hospital not located within a federally designated Metropolitan Statistical Area) or classified as a Critical Access Hospital will receive 100% of their inflated medically indigent costs.

c. All other qualified hospitals will receive 90% of their inflated medically indigent costs.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a CICP Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

C. [Historical Reference: effective July 1, 2003 this section moved from Attachment 4.19A, Page 5-6, number 7.A. Original TN No. 97-007, superseded TN No. 95-002, Approved 11/5/97, effective 7/1/97]

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies a Major Teaching Hospital when its Medicaid days combined with indigent care days (days of care provided under Colorado's Indigent Care Program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available.

1. A Major Teaching Hospital is defined as a Colorado hospital which meets the following criteria:

   a. Maintains a minimum of 110 total Intern and Resident F.T.E.'s.

   b. Maintains a minimum ratio of .30 Intern and Resident F.T.E.'s per licensed bed.

   c. Meets the Department's eligibility requirement for disproportionate share payment.

2. The additional major teaching payment is calculated as follows:
   MTHR = ((ICD+MD)/TPD) x MIAF

   Where:

   MTHR = Major Teaching Hospital Rate
   ICD =Indigent Care Days
   MD = Medicaid Days
   TPD =Total Patient Days
   MIAF = Medically Indigent Adjustment Factor

   To further clarify this formula the State describes the MIAF as follows:

It is the State's intention to pay no hospital a Major Teaching Hospital Allocation that would cause a qualifying hospital to receive an average payment per Medicaid discharge which would exceed the facility's Medicare payment. The MIAF is a number which when multiplied by the numerical quotient derived from ((MD+ICD)/TPD) results in a rate which permits the State to pay a Major Teaching Hospital Allocation at a payment amount which, by design, will not exceed each individual facility's Medicare payment (applied by the State as an individual facility upper limit). The MIAF is derived from calculation of the amount determined by subtracting the average Medicaid payment per case from the average Medicare payment per case for the calculation period, and multiplying this amount by the number of Medicaid patient discharges occurring during that period.

The MIAF is based on the facility's Intern and Residents FTEs:

Intern and Resident FTEs	MIAF - 7/1/93 to 6/30/94	7/1/94 to 6/30/95
110 TO 150	.7209	.5683
151 TO 190	.3301	.9352

3. Payment calculation for hospitals which qualify for the additional Major Teaching Hospital payment shall be as follows:

   a. Based upon data available at the beginning of each fiscal year, Colorado shall determine each hospital's ICD, MD and TPD. ICD will be extracted from the most recent available Colorado Indigent Care Program Interim Report to the Colorado General Assembly, submitted by the University of Colorado Health Sciences Center. MD and TPD will be extracted from the most recent available Colorado Hospital Association annual Data Bank information subject to validation through use of data from the Department and the Colorado Foundation for Medical Care. In addition, each hospital's Medicaid payment for the previous fiscal year shall be estimated.

   b. Multiply the Medicaid payment by the calculated MTHR to determine the additional major teaching hospital payment.

   c. Payment shall be made monthly. [End of Historical Reference]

Effective July 1, 2003 the Major Teaching Hospital payment described in this section is suspended.

D. Effective July 1, 2003 state owned government hospitals, non-state owned government hospitals and privately owned hospitals, when they meet the criteria for being a Pediatric Major Teaching Hospital will qualify to receive additional Medicaid reimbursement, such that the total of all payments will not exceed the inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "Pediatric Major Teaching Hospital payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

As required by federal regulations, there will be three allotments of the Pediatric Major Teaching Hospital payment: state owned government hospitals, non-state owned government hospitals and privately owned hospitals. In no case will the Pediatric Major Teaching payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) exceed any of these allotments. The Pediatric Major Teaching payment is only made if there is available federal financial participation under these allotments after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program.)

On an annual State Fiscal Year (July 1 through June 30) basis, those hospitals that qualify for a Major Pediatric Teaching Hospital payment will be determined. The determination will be made prior to the beginning of each State Fiscal Year. A Major Pediatric Teaching Hospital is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and

2. The hospitals Medicaid days combined with indigent care days (days of care provided under Colorado's Indigent Care Program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available; and

3. Has a percentage of Medicaid days relative to total days that exceed one standard deviation above the mean for the prior state fiscal year, or the most recent year for which data are available; and

4. Maintains a minimum of 110 total Intern and Resident F.T.E.'s; and

5. Maintains a minimum ratio of .30 Intern and Resident F.T.E.'s per licensed bed; and

6. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

The Pediatric Major Teaching payment is distributed equally to all qualified providers. The funds available for the Pediatric Major Teaching payment under the Medicare Upper Payment Limit are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services. Payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year. Rate letters will be distributed to providers qualified to receive the payment each fiscal year and 30 days prior to any adjustment in the payment. Rate letters will document any change in the total funds available, the payment specific to each provider and other relevant figures for the specific provider so that providers may understand and independently calculate their payment.

Total funds available for this payment equal:

FY 2003-04 $6,119,760	FY 2004-05 $6,119,760
FY 2005-06 $11,571,894	FY 2006-07 $13,851,832
FY 2007-08 $34,739,562	FY 2008-09 $39,851,166
FY 2009-10 as follows:	
July 1, 2009–February 28, 2010	$14,098,075
March 1, 2010–June 30, 2010	$33,689,236
FY 2009-10 total payment:	$47,787,311

E. Urban Safety Net Provider Payment

Effective April 1, 2007, non-state owned government hospitals, when they meet the criteria for being an Urban Safety Net Provider, will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide a partial reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. The additional supplemental Medicaid reimbursement will be commonly referred to as the "Urban Safety Net Provider payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Urban Safety Net Provider payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

The qualifying criteria for the Urban Safety Net Provider payment will not directly correlate to the distribution methodology of the payment. On an annual State Fiscal Year (July 1 through June 30) basis, those hospitals that qualify for an Urban Safety Net Provider payment will be determined. The determination will be made prior to the beginning of each State Fiscal Year. An Urban Safety Net Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. The 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; and
3. Medicaid days 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.

The Urban Safety Net Provider payment is distributed equally among all qualified providers. The funds available for the Urban Safety Net Provider payment under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services

Total funds available for this payment equal:

FY 2006-07 $2,693,233	FY 2007-08 $5,400,000
FY 2008-09 $5,400,000	FY 2009-10 $0

Effective September 1, 2009, this payment is suspended.

MAR 3 0 2010

G. Inpatient Hospital Payment for Health Care Services

Effective April 1, 2007, State-owned government hospitals, non-State owned government hospitals, and private hospitals, when they meet the criteria for being a Provider of Inpatient Hospital Health Care Services, shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide reimbursement for uncompensated care costs related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. The additional supplemental Medicaid reimbursement will be commonly referred to as the "Inpatient Hospital Payment for Health Care Services", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The qualifying criteria for the payment will not directly correlate to the distribution methodology of the payment. The Inpatient Hospital Payment for Health Care Services is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

A Provider of Inpatient Hospital Health Care Services is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. Owns and operates primary care clinics.

The funds available for the Inpatient Hospital Payment for Health Care Services under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

Payments shall be distributed based on a qualified Hospital Provider ratio of unique low-income clients who received primary care services in the previous State fiscal year relative to the total unique number of low-income clients who received primary care services for all qualified Hospital Providers in the previous State fiscal year multiplied by the appropriation for the related State Fiscal Year.

Effective July 1, 2008, payments shall be distributed based on a qualified Hospital Provider ratio of unique low-income clients who received primary care services in the previous State fiscal year and their number of visits relative to the total unique number of low-income clients who received primary care services for all qualified Hospital Providers in the previous State fiscal year multiplied by the appropriation for the related State Fiscal Year.

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Total funds available for this payment equal:

State Fiscal Year 2006-07	$1,104,226
State Fiscal Year 2007-08	$4,428,000
State Fiscal Year 2008-09	$3,690,000
State Fiscal Year 2008-09	$0

Effective September 1, 2009, this payment is suspended.

MAR 3 0 2010

H. Rural Hospital Payment

Effective July 1, 2007, non-state owned governmental hospitals and privately owned hospitals, when they meet the criteria for being a Rural Hospital Provider, will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. This additional supplemental Medicaid reimbursement will be commonly referred to as the "Rural Hospital payment" and will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Rural Hospital payment is made only if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

The qualifying criteria for the Rural Hospital payment will not directly correlate to the distribution methodology of the payment. A Rural Hospital Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. Is not located within a federally designated Metropolitan Statistical Area (MSA); and
3. Has 60 or fewer beds.

The Rural Hospital payment is distributed based on a qualifying hospital's prior year Weighted Medically Indigent Costs relative to the sum of the total Weighted Medically Indigent Costs for all qualifying hospitals, multiplied by the appropriation for the related State Fiscal Year, as defined for the High-Volume payment. Weighted Medically Indigent Costs will be inflated forward to the payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average. The funds available for the Rural Hospital payment under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

Total funds available for this payment equal:

State Fiscal Year 2007-08	$1,455,954
State Fiscal Year 2008-09	$2,500,000
State Fiscal Year 2008-09	$0

Effective September 1, 2009, this payment is suspended.

MAR 3 0 2010

I. Public Hospital Payment

Effective July 1, 2007, State owned and non-state owned government hospitals, when they meet the criteria for being a Public Hospital Provider, will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. This additional supplemental Medicaid reimbursement will be commonly referred to as the "Public Hospital payment" which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Public Hospital payment is made only if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Rural Hospital payment, and the Pediatric Major Teaching payment.

The qualifying criteria for the Public Hospital payment will not directly correlate to the distribution methodology of the payment. A Public Hospital Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and

2. Is a State-owned or non-state owned government hospital.

The Public Hospital payment is distributed based on a qualifying hospital's prior year Weighted Medically Indigent Costs relative to the sum of total Weighted Medically Indigent Costs for all qualifying hospitals, multiplied by the appropriation for the related State Fiscal Year, as defined for the High-Volume payment. Weighted Medically Indigent Costs will be inflated forward to the payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average. The funds available for the Public Hospital payment under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

Total funds available for this payment equal:

State Fiscal Year 2007-08	$1,455,954
State Fiscal Year 2008-09	$2,500,000
State Fiscal Year 2008-09	$0

Effective September 1, 2009, this payment is suspended.

MAR 3 0 2010

J. Inpatient Hospital Base Rate Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals paid on the Medicaid Prospective Payment System (PPS Hospitals) shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Inpatient Hospital Base Rate Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

The Inpatient Hospital Base Rate Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment and the CICP Supplemental Medicaid payment.

To qualify for the Inpatient Hospital Base Rate Supplemental Medicaid payment a hospital shall meet the following criteria:

1. Has an established Medicaid base rate, as specified under 4.19A I. Methods and Standards for Established Prospective Payments Rates - Inpatient Hospital Services of this State Plan; and
2. Is not a free-standing psychiatric facility, which is except from the DRG-based prospective payment system.

The Inpatient Hospital Base Rate Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be calculated by using hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix, multiplied by the hospital specific differential Medicaid base rate.

The hospital specific differential Medicaid base rate is the difference between Medicaid base rate calculated prior to any Medicaid hospital specific cost add-ons and the Medicare Base Rate as specified under 4.19A I. Methods and Standards for Established Prospective Payments Rates – Inpatient Hospital Services of this State Plan.

1. Pediatric Specialty Hospitals shall have a 13.756% increase
2. Urban Center Safety Net Specialty Hospitals shall have a 5.830% increase
3. Rehabilitation, Specialty Acute, Rural and Urban Hospitals shall have a 18.100% increase

Hospital specific data used in the calculation of the Inpatient Hospital Base Rate Supplemental Medicaid payment (expected discharges, average Medicaid case mix, and the Medicaid base rate) shall be the same as that used to calculate Budget Neutrality under 4.19A I. Methods and Standards for Established Prospective Payments Rates - Inpatient Hospital Services of this State Plan.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after an Inpatient Hospital Base Rate Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

K. High-Level NICU Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are certified as Level IIIb or IIIc Neo-Natal Intensive Care Unit (NICU) shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "High-Level NICU Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

The High-Level NICU Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment and the Inpatient Hospital Base Rate Supplemental Medicaid payment.

To qualify for the High-Level NICU Supplemental Medicaid payment a hospital shall meet the following criteria:

a. Is certified as Level IIIb or IIIc Neo-Natal Intensive Care Unit (NICU) according to American Academy of Pediatrics guidelines by the Colorado Perinatal Care Council;

b. Is not a High Volume Medicaid and CICP Hospital, as defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days; and

c. Is licensed or certified as a General Hospital or Critical Access Hospital by the Colorado Department of Public Health Environment.

The High-Level NICU Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be calculated on a per Medicaid day basis as follows:

a. Qualified hospitals shall receive $450 per Medicaid Nursery day, which includes Medicaid fee for service days and Medicaid managed-care days.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a High-Level NICU Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

L. State Teaching Hospital Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals qualify as a State Teaching Hospital shall receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "State Teaching Hospital Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

The State Teaching Hospital Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment, the Inpatient Hospital Base Rate Supplemental Medicaid payment and High-Level NICU Supplemental Medicaid payment.

To qualify for the State Teaching Hospital Supplemental Medicaid payment a hospital shall meet the following criteria:

a. Is a State University Teaching Hospital, as defined under Attachment 4.19A, Section II Family Medicine Program of this State Plan;

b. Is a High Volume Medicaid and CICP Hospital, as defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days; and

c. Is licensed or certified as a General Hospital by the Colorado Department of Public Health Environment.

The State Teaching Hospital Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be calculated on a per Medicaid day basis as follows:

a. Qualified hospitals shall receive $75 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days).

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a State Teaching Hospital Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

M. Additional Supplemental Medicaid Payments

1. Large Rural Hospital Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are located in a rural area and have 26 or more licensed beds shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Large Rural Hospital Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

To qualify for the Large Rural Hospital Supplemental Medicaid payment a hospital shall meet the following criteria:

a. Is located in a rural area (a hospital not located within a federally designated Metropolitan Statistical Area);

b. Have 26 or more licensed beds; and

c. Is licensed or certified as a General Hospital by the Colorado Department of Public Health Environment.

The Large Rural Hospital Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be calculated on a per Medicaid day basis as follows:

a. Qualified hospitals shall receive $315 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days).

2. Denver Metro Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are located in the Denver Metro Area will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement will be commonly referred to as the "Denver Metro Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

To qualify for the Denver Metro Supplemental Medicaid payment a hospital shall meet the following criteria:

a. Is located in the Denver Metro Area defined as Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County; and

b. Is licensed as a General Hospital by the Colorado Department of Public Health Environment.

The Denver Metro Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each hospital, this payment shall be calculated on a per Medicaid day basis as follows:

a. Qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of $400 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days).

b. Qualified hospitals located in Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County shall receive an additional $510 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days).

3. Metropolitan Statistical Area Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are located in a federally designated Metropolitan Statistical Area outside the Denver Metro Area shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Metropolitan Statistical Area Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

To qualify for the Metropolitan Statistical Area Supplemental Medicaid payment a hospital shall meet the following criteria:

a. Is located in a federally designated Metropolitan Statistical Area outside the Denver Metro Area; and

b. Is licensed as a General Hospital by the Colorado Department of Public Health Environment.

The Metropolitan Statistical Area Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each hospital, this payment shall be calculated on a per Medicaid day basis as follows:

a. Qualified hospitals shall receive $310 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days).

4. Supplemental Medicaid Payments Conditions

For the Supplemental Medicaid Payments listed in this Section (Rural Hospital Supplemental Medicaid payment, Denver Metro Supplemental Medicaid payment and Metropolitan Statistical Area Supplemental Medicaid payment) the following shall apply:

a. The Supplemental Medicaid Payments are only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment and the Inpatient Hospital Base Rate Supplemental Medicaid payment, High-Level NICU Supplemental Medicaid payment, and the State Teaching Hospital Supplemental Medicaid payment

b. Hospitals that qualify to receive a Supplemental Medicaid Payment shall only receive payment from one Supplemental Medicaid Payment described in this Section.

c. Hospitals licensed or certified as psychiatric or rehabilitation, or are licensed as General Hospital with a Medicare Certification Long Term, shall not qualify to receive a Supplemental Medicaid Payment described in this Section.

d. High Volume Medicaid and CICP Hospitals shall not qualify to receive a Supplemental Medicaid Payment described in this Section. High Volume Medicaid and CICP Hospitals are defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days.

e. A hospital located in the Denver Metro Area is a hospital that is located in one of the following counties: Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County.

f. In calculating the Supplemental Medicaid Payments, Medicaid days for the prior calendar year will be submitted by hospitals to the Department by April 30 of each year.

g. In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a Supplemental Medicaid Payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.