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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-10-022

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
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

Centers for Medicaid, CHIP, and Survey & Certification

DEC - 8 2010

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

Re: Colorado 10-022

Dear Mr. Bartholomew:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-022. Effective for services on or after July 1, 2010, this amendment revises reimbursement for inpatient hospital services. Specifically, the amendment implements a reduction to inpatient hospital base rates by one percent, effective July 1, 2010. In addition, supplemental inpatient Medicaid and Disproportionate Share Hospital payments are modified, effective October 1, 2010.

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 now ready to approve Medicaid State plan amendment TN 10-022 effective July 1, 2010. 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, CMCS

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: 10-022	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, 2010	

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	7. FEDERAL BUDGET IMPACT
CFR 42 Section 447.272	a. FFY 10 ($603,088) b. FFY 11 $75,253,444
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19A pages 3, 4, 4a, 29, 29a-c, 37, 38, 41, 42, 48-51, 51a, 52-55	Attachment 4.19A page Modifies pages 3, 4, 4a, 29, 29a-c, 37, 38, 41, 42, 48-51, 51a, 52-55

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

X OTHER, AS SPECIFIED

Governor's letter dated 26 January 2009

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL /s/	16. RETURN TO
13. TYPED NAME **John Bartholomew**	**Colorado Department of Health Care Policy and Financing** **1570 Grant Street** **Denver, CO 80203-1818** **Attn: David Smith**
14. TITLE **Director, Budget and Finance Office**	
15. DATE SUBMITTED **September 30, 2010**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED 12-08-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JUL - 1 2010	20. SIGNATURE OF REGIONAL OFFICIAL
21 TYPED NAME William Lasowski	Deputy Director, CMCS

23. REMARKS

FORM CMS-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. Effective July 1, 2010 Budget Neutrality is defined as two and one twentieth 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..4335 effective July 1, 2010.

Effective July 1, 2008 Urban Center Safety Net Specialty Hospitals will receive their hospital specific Medicare base rate plus add-ons to account for the specialty care provided. 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, 2010 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 December 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 automatically or via retrospective reviews.

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.

   Effective October 1, 2010, the CICP Disproportionate Share Hospital payment will be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in equal monthly installments. Payment to Urban Center Safety Net Specialty hospitals may be dispensed such that more than one installment may be paid in one month. At no time will payments be disbursed prior to the state fiscal year or federal fiscal year for which they apply.

   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%
State Fiscal Year 2010-11 July 1 – September 30, 2010	5.06%	40.00%	35.00%
Federal Fiscal Year 2010-11	9.86%	45.00%	22.00%

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.

   Effective October 1, 2010, the Uninsured Disproportionate Share Hospital payment will be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

   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%
State Fiscal Year 2010-11 July 1 – September 30, 2010	19.94%
Federal Fiscal Year 2010-11	23.14%

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.

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.

   Effective October 1, 2010, the CICP Supplemental Medicaid payment will be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis. Payment to Urban Center Safety Net Specialty hospitals may be dispensed such that more than one installment may be paid in one month. At no time will payments be disbursed prior to the state fiscal year or federal fiscal year for which they apply.

   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. Effective July 1, 2009, Qualified hospitals that are classified as High Volume Medicaid and CICP Hospitals will receive 75% of their inflated medically indigent costs.

   Effective October 1, 2010, Qualified hospitals that are classified as High Volume Medicaid and CICP Hospitals will receive 64% 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. Effective July 1, 2009, 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. Effective July 1, 2009, All other qualified hospitals will receive 90% of their inflated medically indigent costs.

   Effective October 1, 2010, All other qualified hospitals will receive 75% 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.

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.

Effective October 1, 2010, the Inpatient Hospital Base Rate Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis. Payment to Urban Center Safety Net Specialty hospitals may be dispensed such that more than one installment may be paid in one month. At no time will payments be disbursed prior to the state fiscal year or federal fiscal year for which they apply.

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 exempt 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.

Effective July 1, 2009:

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

Effective October 1, 2010:

1. Pediatric Specialty Hospitals shall have a 16.80% increase
2. State University Teaching Hospitals shall have a 16.0% increase
3. Rehabilitation, Specialty Acute, Rural and Urban Hospitals shall have a 35.0% 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.

Effective October 1, 2010, the High-Level NICU Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

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. Effective July 1, 2009, qualified hospitals shall receive $450 per Medicaid Nursery day, which includes Medicaid fee for service days and Medicaid managed-care days.

b. Effective October 1, 2010, qualified hospitals shall receive $2,100 per Medicaid NICU day. A Medicaid NICU day is a paid Medicaid non-managed care day for DRG 801 up to the average length of stay.

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.

Effective October 1, 2010, the State Teaching Hospital Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis. Payment to Urban Center Safety Net Specialty hospitals may be dispensed such that more than one installment may be paid in one month. At no time will payments be disbursed prior to the state fiscal year or federal fiscal year for which they apply.

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. Effective July 1, 2009, 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).

b. Effective October 1, 2010, qualified hospitals shall receive $125 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. Acute Care Psychiatric Supplemental Medicaid Payment

Effective October 1, 2010, Colorado hospitals shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient psychiatric 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 "Acute Care Psychiatric Supplemental Medicaid payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments. Payment to Urban Center Safety Net Specialty hospitals may be dispensed such that more than one installment may be paid in one month. At no time will payments be disbursed prior to the state fiscal year or federal fiscal year for which they apply.

The Acute Care Psychiatric 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, the High-Level NICU Supplemental Medicaid payment, and the State Teaching Hospital Supplemental Medicaid payment.

The Acute Care Psychiatric Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the Acute Care Psychiatric Supplemental Medicaid payment a hospital shall meet the following criteria:

1. Licensed as a General Hospital by the Colorado Department of Public Health Environment.
2. Is not a free-standing psychiatric facility, which is exempt from the DRG-based prospective payment system.

Qualified hospitals shall receive $150 per Medicaid psychiatric day, including inpatient psychiatric care for Medicaid fee-for-service and Medicaid managed care days.

N. 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.

Effective October 1, 2010, the Large Rural Hospital Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

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. Effective July 1, 2009, qualified hospitals shall receive $315 per Medicaid day.
b. Effective October 1, 2010, qualified hospitals shall receive $600 per Medicaid day.

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.

Effective October 1, 2010, the Denver Metro Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

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. Effective July 1, 2009, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of $400 per Medicaid day.
b. Effective October 1, 2010, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of $675 per Medicaid day
c. Effective July 1, 2009, qualified hospitals located in Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County shall receive an additional $510 per Medicaid day.
d. Effective October 1, 2010, qualified hospitals located in Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County shall receive an additional $700 per Medicaid day.

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.

Effective October 1, 2010, the Metropolitan Statistical Area Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

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. Effective July 1, 2009, qualified hospitals shall receive $310 per Medicaid day
b. Effective October 1, 2010, qualified hospitals shall receive $600 per Medicaid day.

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, the State Teaching Hospital Supplemental Medicaid payment, and the Acute Care Psychiatric Supplemental Medicaid payment.

   b. Medicaid days include 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).

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

   d. 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.

   e. 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.

   f. 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.

   g. 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.

   h. 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.