O. Public High Volume Medicaid and CICP Hospital Payment

Effective July 1, 2010, Colorado public hospitals that meet the definition of a High Volume Medicaid and CICP Hospital shall qualify to receive an additional supplemental Medicaid reimbursement for uncompensated inpatient hospital care for Medicaid clients. This additional supplemental shall commonly be referred to as the "Public High Volume Medicaid and CICP Hospital Payment."

To qualify for the Public High Volume Medicaid and CICP Hospital Payment, a hospital shall meet the following criteria:

1. Licensed as a General Hospital by the Colorado Department of Public Health and Environment.
2. Classified as a state-owned government or non-state owned government hospital.
3. Is a High Volume Medicaid and CICP Hospital, defined as those hospitals which participate in the Colorado Indigent Care Program (CICP), whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and CICP days combined equal at least 30% of their total inpatient days.
4. Maintain the hospital's percentage of Medicaid inpatient days compared total days at or above the prior State Fiscal Year's level.

The Public High Volume Medicaid and CICP Hospital Payments will only be 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, the State Teaching Hospital Supplemental Medicaid payment, the Acute Care Psychiatric Supplemental Medicaid payment, the Large Rural Supplemental Medicaid payment, the Denver Metro Supplemental Medicaid payment and the Metropolitan Statistical Area Supplemental Medicaid payment.

The Interim Payment to qualified providers will be calculated for the actual expenditure period using the filed CMS 2552-96 Medicare Cost Report, or its successor, and disbursed biannually after the actual expenditure period. Interim Payments for uncompensated Medicaid inpatient hospital costs for Cost Report Year 2010 will be made by June 30, 2012. Interim payments for uncompensated Medicaid inpatient hospital costs for Cost Report Years 2011 and thereafter, will be calculated each year and paid by the following October 31st of each year for hospitals with cost reporting periods ending December 31st and by the following April 30th for those hospitals with cost reporting periods ending June 30th. Uncompensated costs for providing inpatient hospital services for Medicaid clients will be calculated according to the methodology outlined below, using the filed CMS 2552-96 Medicare Cost Report, or its successor.

Final payments will be made biannually. Final payments will be made by October 31st of each year for those qualified hospitals that have submitted their audited CMS 2552-96 Medicare Cost Report for the actual expenditure period, or its successor, to the Department between January 1st and June 30th of that same calendar year. Final payments will be made by April 30th of the following year for those qualified hospitals

that have submitted their audited CMS 2552-96 Medicare Cost Report for the actual expenditure period, or its successor, to the Department between the July 1st through December 30th period of the preceding calendar year.

Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed to each provider for purposes of authorizing certification. Each qualified provider shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Public High Volume Medicaid and CICP Hospital Payment. The Public High Volume Medicaid and CICP Hospital Payment will be distributed to qualified providers based on each provider's proportion of uncompensated costs for qualified providers in the class, multiplied by the available Upper Payment Limit for the class. A qualified provider shall not receive aggregated inpatient hospital Medicaid payments that exceed its certified uncompensated costs.

Final Payments will serve to adjust the Interim Payment such that the sum of the Interim and Final Payments to each provider shall equal the lower of the Payment amount calculated based on uncompensated costs calculated through audited cost reports or the available amount remaining of the Medicare Upper Payment Limit for inpatient hospital services for that provider class. In the event that data entry errors are detected after the Final Payment has been made, or other unforeseen payment calculation errors are detected after the Final Payment has been made, reconciliations and adjustments to impacted provider payments will be made retroactively. The Federal share of Final Payments made in excess of the cost of Medicaid services will be returned to CMS on the CMS-64 quarterly expenditure report within one year after reconciliations and adjustments to impacted provider payments have been made.

Methodology for Calculating Uncompensated Costs for Medicaid Inpatient Hospital Services:

Calculating Total Inpatient Hospital Costs

Total Inpatient Hospital Routine Costs equal costs as reported on CMS 2552-96 (or its successor) Worksheet C, Part I, Column 1, lines 25 – 33, plus allowable costs for interns and residents costs reported on Columns 22 and 23 of Worksheet B, Part I. For hospitals that use the Special Title XIX Worksheet, which adds back the allowable interns and residents costs from Columns 22 and 23 of Worksheet B, Part I to the costs reported on the regular Worksheet C, Part I, Column 1, only the costs as reported on Special Title XIX Worksheet C, Part 1, Column 1 are used. (Costs recorded on lines 34 – 36 are excluded because they pertain to nursing facilities, skilled nursing facilities and long term care—none of which are inpatient hospital services.)

Total Inpatient Days by Routine Cost Center are reported on Worksheet S-3, Part 1, Column 6. Observation Bed Days, cost center 62, are to be reclassified to be included in Adults and Pediatrics (cost center 25).

The Cost Per-Diem by Routine Cost Center equals Total Inpatient Hospital Routine Costs divided by Total Inpatient Days. The Adult and Pediatric Routine Center Cost Per Diem includes Observation

Bed Days. Swing Beds Nursing Facility Costs and non-medically necessary Private Room Differential Costs are excluded.

Total Inpatient Hospital Ancillary Costs are reported on Worksheet C, Part 1, Column 1, lines 37 - 68. For hospitals that use the Special Title XIX Worksheet, which adds back the allowable interns and residents costs from Columns 22 and 23 of Worksheet B, Part I to the costs reported on the regular Worksheet C, Part I, Column 1, only the costs as reported on Special Title XIX Worksheet C, Part 1, Column 1 are used.

Total Inpatient Hospital Ancillary Charges are reported on Worksheet C, Part 1, Column 8, lines 37 – 68.

The Cost-to Charge Ratio by Inpatient Hospital Ancillary Cost Center is calculated by dividing each cost center's Inpatient Hospital Ancillary Costs by its Inpatient Hospital Ancillary Charges.

Calculating Medicaid Costs

Medicaid Patient Days for Inpatient Hospital Services are defined as paid days as reported in the MMIS for dates of service that correspond to the hospital's cost report period. University is on a State Fiscal Year; Denver and Memorial are on a calendar year. Secondary Medicaid Days are defined as those days paid for Medicaid clients with a non-Medicare third party payer and are included for allowed Medicaid services under State Plan Amendment Attachment 4.19A. Medicare-Medicaid Dual Eligible Days are excluded for those days for which Medicaid reimburses only its share of the Medicare coinsurance or deductible. These days are mapped from the revenue code identified in the MMIS to the CMS cost report routine cost center.

Medicaid Allowable Charges for Inpatient Hospital Services are as reported in the MMIS for dates of service that correspond to the hospital's cost report period for paid charges for allowable inpatient hospital services under State Plan Amendment Attachment 4.19A. Medicaid allowable charges for Observation Beds are included in line 62. Charges for outpatient hospital services, professional services or non-hospital component services such as hospital-based providers are excluded. Allowable charges are mapped from the revenue code identified in the MMIS to the CMS cost report ancillary cost center. Medicaid Observation Bed outpatient charges that have been inaccurately recorded in inpatient cost centers are to be reclassified under Observation Bed (cost center 62) outpatient charges.

Medicaid Routine Cost Center Costs are calculated by multiplying Medicaid Patient Days by the Cost Per-Diem by Routine Cost Center.

Medicaid Ancillary Cost Center Costs are calculated by multiplying the Cost-to Charge Ratio by Inpatient Hospital Ancillary Cost Center by the Medicaid Allowable Charges.

Medicaid Organ Acquisition Costs

Medicaid Usable Organs are identified in the provider's records as the number of Medicaid recipients who received an organ transplant.

Total Usable Organs are as reported from Worksheet D-6, Part III under the Part B cost column line 54.

Medicaid Usable Organs Ratio is calculated by dividing Medicaid Usable Organs, by the hospital's Total Usable Organs.

Total Organ Acquisition Costs are from Worksheet D-6, Part III, under the Part A cost column line 53.

Medicaid Organ Acquisition Costs equal the Medicaid Usable Organs Ratio multiplied by Total Organ Acquisition Costs.

Medicaid Inpatient Hospital Provider Fee Costs

For those hospitals that do not include hospital provider fees as an expense in their CMS 2552-96 Medicare Cost Report, or its successor, Medicaid Inpatient Provider Fee Costs are calculated separately by multiplying the total inpatient hospital provider fees collected by the State from the qualified provider multiplied by the ratio of Medicaid Patient Days for Inpatient Hospital Services as reported in the MMIS to Total Inpatient Days by Routine Cost Center as reported on Worksheet S-3, Part 1, Column 6.

Medicaid Uncompensated Inpatient Hospital Costs

Total Medicaid Inpatient Hospital Costs are the sum of Medicaid Routine Cost Center Costs, Medicaid Ancillary Cost Center Costs, Medicaid Organ Acquisition Costs, and Medicaid Inpatient Hospital Provider Fee Costs. (Medicaid Inpatient Hospital Provider Fee Costs are calculated separately only for those hospitals that do not include hospital provider fees as an expense in their CMS 2552-96 Medicare Cost Report, or its successor.)

Medicaid Uncompensated Inpatient Hospital Costs equal Total Medicaid Inpatient Hospital Costs less Medicaid payments from the MMIS, Medicaid supplemental payments referenced in this Attachment 4.19A, third party liability reported in the MMIS, client payments reported in the MMIS, and patient Medicaid copayments reported in the MMIS.

OS Notification

State/Title/Plan Number: Colorado 10-038

Type of Action: SPA Approval

Required Date for State Notification: March 1, 2012

Fiscal Impact: FFY 2011-2012 $4,235,595

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective July 1, 2010, this amendment implements a supplemental payment provision for State owned and non-State owned high volume Medicaid hospital providers. The purpose of this payment is to provide for reimbursement for uncompensated costs for providing inpatient hospital services for Medicaid clients. The non-Federal share is derived via Certified Public Expenditures (CPEs). CMS provided technical assistance to Colorado State staff on the development of an acceptable CPE protocol, which is also incorporated as part of this amendment. Colorado utilizes the Medicare 2552 cost report for purposes of determining uncompensated Medicaid costs. Hospitals receive 90 percent and the State retains 10 percent of Federal Financial Participation (FFP). Only one hospital currently qualifies for this payment. Public notice requirements were met. Tribal consultation was not applicable. The UPL was reviewed and deemed to be acceptable. Responses to the funding questions were adequate.

Other Considerations: This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor. This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

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National Institutional Reimbursement Team