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: **11-032**

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, 2011

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

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS A NEW PLAN | **X AMENDMENT**

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

6. FEDERAL STATUTE/REGULATION CITATION

42 CFR 440.20

7. FEDERAL BUDGET IMPACT
a. FFY 2011: ($154,010)
b. FFY 2012: ($653,026)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-B: Methods and Standards for Establishing Payment Rates – Other Types of Care – 2a. Outpatient Hospital Services

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-B: Methods and Standards for Establishing Payment Rates – Other Types of Care – Outpatient Hospital Reimbursement (TN 10-023)

10. SUBJECT OF AMENDMENT

Methods and standards for establishing payment rates for clinic services, reflecting the rate reductions effective July 1, 2011. In addition, this SPA adds a reference to the CMS-2552-10 in the cost reporting instructions.

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 11 February 2011

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Robert C. Douglas

14. TITLE
Legal Division Director

15. DATE SUBMITTED
June 30, 2011

16. RETURN TO

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

Attn: Barbara Prehmus

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 6/30/11

18. DATE APPROVED 7/29/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/11

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Richard C. Allen

22. TITLE
ARA, DMCHO

23. REMARKS

FORM CMS-179 *(07/92)*

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

2a. OUTPATIENT HOSPITAL SERVICES

1. Medicaid Outpatient Hospital Reimbursements for Colorado Providers.

Prior to September 1, 2009, Outpatient hospital services are reimbursed on an interim basis of actual billed charges times 72% of the Medicare cost to charge ratio. A periodic cost audit is performed and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less twenty eight percent (28%) or billed charges less twenty eight percent (28%).

For September 1, 2009 through December 31, 2009, outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.0 percent (30.0%). A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.0 per cent (30.0%) or billed charges less 30.0 percent (30.0%).

Effective July 1, 2010, outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). A cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 per cent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). A cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%). For interim payments, the Medicare cost-to-charge ratio is provided by the hospital from the Medicare fiscal intermediary. When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

OUTPATIENT HOSPITAL SERVICES (continued)

The cost audit corresponding to the hospital's fiscal year is initiated when the audited CMS-2552-96 or CMS-2252-10 Cost Report and the applicable billed charges and payment information from the MMIS are available. Actual audited costs are determined by using the computation of the ratio of costs to charges from the CMS-2552-96, or CMS-2552-10, Cost Report, Special Title XIX Worksheet C Part 1, column 9 which flows to Title XIX - O/P Worksheet D, Part V, Column 1. Actual Medicaid billed charges from the MMIS are input into Worksheet D, Part V, Column 5. Medicaid actual costs are computed in Worksheet D, Part V. Column 9.

2. Out-of-state outpatient hospital services are reimbursed at seventy percent (70%) of billed charges for covered services. Effective July 1, 2009, out-of-state outpatient hospital services are reimbursed at actual billed charges times the statewide average cost-to-charge ratio as of July 1, 2009 less 25 percent (25%).

3. Outpatient laboratory services shall be reimbursed at the lower of the following:
   1. Submitted charges or
   2. Fee schedule as determined by the Department of Health Care Policy and Financing.

4. Outpatient physical therapy and occupational therapy services shall be reimbursed at the lower of the following:
   a. Submitted charges or
   b. Fee schedule as determined by the Department of Health Care Policy and Financing.

5. Non-brokered emergent medical transportation provided by hospitals shall be reimbursed at the lower of the following:
   a. Submitted charges or
   b. Fee schedule as determined by the Department of Health Care Policy and Financing.

6. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for dates of service on or after July 1, 2010, and dates of service on or after July 1, 2011, for these services can be found on the official Web site of the Department of Health Care Policy and Financing at www.colorado.gov/hcpf.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

OUTPATIENT HOSPITAL SERVICES (continued)

7. Public Hospital Outpatient Adjustment

Effective October 10, 2001, all publicly owned (state and local) hospitals shall qualify for a public hospital outpatient rate adjustment up to the allowable percentage of each hospital's outpatient Medicare Upper Payment Limit. For purposes of this rate adjustment, the Medicare Upper Payment Limit will be equal to a reasonable estimate of the amount that would be paid for these services using Medicare payment principles.

The payment will be calculated based on each hospital's inflated outpatient charges, times the Medicare ratio of cost to charges, times the net difference between the allowable percentage of the Medicare Upper Payment Limit and the Medicaid outpatient reimbursement percentage of 72%.

This is a prospective payment system. The charge and payment data will be two-year old historical data available at the time of rate setting. This cost and payment data will be inflated forward to the payment period using the most recent available CPI-W, Medical Care for Denver. The cost to charge ratios will be historical data from the most recently audited Medicare cost reports available at the time of rate setting.

Any other Medicare Upper Payment Limit reimbursements and Disproportionate Share Hospital reimbursements to that hospital for the same services will be subtracted from the amount available for additional reimbursement. The reimbursement will be an amount that will not exceed the allowable percentage of the Medicare Upper Payment Limit for outpatient services. The allowable percentage of the Medicare Upper Payment Limit will not exceed 100%, unless a higher percentage is allowed by an Act of Congress or the Centers for Medicare and Medicaid Services.

Effective July 1, 2009 the Outpatient Hospital adjustment commonly referred to as "Public Hospital Outpatient Adjustment" is suspended.

8. Supplemental Medicaid Outpatient Hospital Payment

Effective July 1, 2009, Colorado hospitals shall qualify to receive an additional supplemental Medicaid reimbursement for outpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Upper Payment Limit for outpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

OUTPATIENT HOSPITAL SERVICES (continued)

"Supplemental Medicaid Outpatient Hospital payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

The Supplemental Medicaid Outpatient Hospital payment is only made if there is available federal financial participation under the Upper Payment Limit for outpatient hospital services after the Medicaid reimbursement (as defined under number 1 of this Section of attachment 4.19B as a Medicaid Outpatient Hospital Reimbursements for Colorado Providers).

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

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

b. Is not a free-standing psychiatric facility or is licensed as a General Hospital with a Medicare Certification Long Term by the Colorado Department of Public Health and Environment.

The Supplemental Medicaid Outpatient Hospital payment is a prospective payment calculated using historical data with no reconciliation to actual data for the payment period. Hospital specific outpatient billed charges (as published in the COLD reporting system from the Department's MMIS) are converted to hospital specific outpatient billed 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. Hospital specific outpatient billed costs are inflated forward to payment year using the most recently available Outpatient Hospital PPS Market Basket and adjusted for changes in utilization.

Effective July 1, 2009, for each qualified hospital, this payment shall be calculated by using inflated hospital specific outpatient billed costs multiplied by 29.4%. If the hospital qualifies as a Major Pediatric Teaching Hospital (as defined under Attachment 4.19A of this State Plan) this payment shall be calculated by using inflated hospital specific outpatient billed costs multiplied by 16.8%.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

OUTPATIENT HOSPITAL SERVICES (continued)

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

Effective October 1, 2010, for each qualified hospital, this payment shall be calculated by using inflated hospital specific outpatient billed costs multiplied by 30.70%. If the hospital qualifies as a Major Pediatric Teaching Hospital (as defined under Attachment 4.19A of this State Plan) this payment shall be calculated by using inflated hospital specific outpatient billed costs multiplied by 20.45%. If the hospital qualifies as an Urban Center Safety Net Specialty Hospital (as defined under Attachment 4.19A of this State Plan) this payment shall be calculated by using inflated hospital specific outpatient billed costs multiplied by 25.00%. 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.

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.

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

Effective July 1, 2009, Colorado hospitals that have a high-volume of outpatient hospital services, are located in a rural area and have 20 or fewer licensed beds shall qualify to receive an additional supplemental Medicaid reimbursement for outpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Upper Payment Limit for outpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "Supplemental Medicaid Outpatient High-Volume Small Rural Hospital payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

The Supplemental Medicaid Outpatient High-Volume Small Rural Hospital payment is only made if there is available federal financial participation under the Upper Payment Limit for outpatient hospital services after the Medicaid reimbursement (as defined under number 1 of this Section of attachment 4.19B as a Medicaid Outpatient Hospital Reimbursements for Colorado Providers) and the Supplemental Medicaid Outpatient Hospital Payment.

To qualify for the Supplemental Medicaid Outpatient High-Volume Small Rural Hospital

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

OUTPATIENT HOSPITAL SERVICES (continued)

payment a hospital shall meet the following criteria:

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

b. Has 20 or fewer licensed beds;

c. Medicaid accounts for more than 80% of the hospital Medicaid payments for Outpatient Hospital services;

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

e. Is not a free-standing psychiatric facility or is licensed as a General Hospital with a Medicare Certification Long Term by the Colorado Department of Public Health and Environment.

The Supplemental Medicaid Outpatient High-Volume Small Rural Hospital payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. Hospital specific outpatient billed charges (as published in the COLD reporting system from the Department's MMIS) are converted to hospital specific outpatient billed 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. Hospital specific outpatient billed costs are inflated forward to payment year using the most recently available Outpatient Hospital PPS Market Basket and adjusted for changes in utilization.

Effective July 1, 2009, for each qualified hospital, this payment shall be calculated by using inflated hospital specific outpatient billed costs multiplied by 46%.
Effective October 1, 2010, the Supplemental Medicaid Outpatient High-Volume Small Rural Hospital payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

Effective October 1, 2010, for each qualified hospital, this payment shall be calculated by using inflated hospital specific outpatient billed costs multiplied by 50%.

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.