II. Family Medicine Program

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 as a Teaching Hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Family Medicine Commission and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the Major Teaching Hospital program, it is not eligible for this program. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Program will be $213,195. Effective July 1, 1999, the annual payment for each Family Medicine Residency Program will be $228,379. The annual payment shall change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

The Family Medicine Residency Program payment is calculated on a State Fiscal Year (July 1 through June 30) basis and is distributed equally to all qualified providers in 12 equal monthly installments. Payments 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. 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 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. 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. Total funds available by state fiscal year (SFY) for this payment are as follows.

SFY 2003-04: $1,524,626	SFY 2004-05: $1,444,944	SFY 2005-06: $1,576,502
SFY 2006-07: $1,703,558	SFY 2007-08: $1,868,307	SFY 2008-09: $1,798,015
SFY 2009-10: $1,738,846	SFY 2010-11: $1,738,846	SFY 2011-12: $1,391,077

Effective May 23, 2008, the Family Medicine Residency Program payment for providers that qualify to receive the State University Teaching Hospital payment is suspended.

Effective May 23, 2008, state owned government hospitals, non-state owned government hospitals and privately owned hospitals, when they meet the criteria for being a State University Teaching Hospital, will qualify to receive additional Medicaid reimbursement for services provided to Medicaid recipients. The additional Medicaid reimbursement will be commonly referred to as the "State University Teaching Hospital payment", which will be established on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The State University Teaching 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).

A State University Teaching Hospital is defined as a Colorado hospital which meets the following criteria:

1. Provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and

2. In which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

Qualified providers and the total yearly payments to those are as follows.

SFY 2007-08	SFY 2008-09
Denver Health Medical Center: $410,000	Denver Health Medical Center: $1,829,008
University of Colorado Hospital: $95,251	University of Colorado Hospital: $697,838

SFY 2009-10	SFY 2010-11
Denver Health Medical Center: $1,831,714	Denver Health Medical Center: $1,831,714
University of Colorado Hospital: $700,935	University of Colorado Hospital: $676,785

SFY 2011-12	
Denver Health Medical Center: $1,831,714	
University of Colorado Hospital: $633,314	

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.

   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%	25.00%

Effective October 1, 2011, the amount remaining of the State's annual Disproportionate Share Hospital allotment after the Uninsured Disproportionate Share Hospital payment will be allocated to the CICP Disproportionate Share Hospital payment by category as indicated in the following table:

	State-owned government hospitals	non-state -owned government hospitals	Private- owned hospitals
Federal Fiscal Year 2011-12	18.75%	52.50%	28.75%

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.

	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%

For Federal Fiscal Year 2011-12, $37,039,406 of the State's annual Disproportionate Share Hospital allotment will be allocated to the Uninsured Disproportionate Share Hospital payment

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.

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.

   Effective October 1, 2011, Qualified hospitals that are classified as High Volume Medicaid and CICP Hospitals will receive 52.5% 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.

   Effective October 1, 2011, 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 75% 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.

   Effective October 1, 2011, All other qualified hospitals will receive 60% 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.

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
FY 2010-11	$48,810,278
FY 2011-12	$38,977,698

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	March 1, 2010 – June 30, 2010 $5,410,049
FY 2010-2011 $6,217,131	FY 2011-12 $4,702,000

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.

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

Effective October 1, 2011:

1. Pediatric Specialty Hospitals shall have a 20.00% increase
2. State University Teaching Hospitals shall have a 31.30% increase
3. Rehabilitation and Specialty Acute Hospitals shall have a 25.00% increase
4. Rural hospitals shall have a 60.00% increase
5. Urban Hospitals shall have a 51.30% 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. Effective October 1, 2011, qualified hospitals shall receive $2,500 per Medicaid NICU day.

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.

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). Effective October 1, 2011, qualified hospitals shall receive $100 per Medicaid day.

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.

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.

Effective October 1, 2010, Qualified hospitals shall receive $150 per Medicaid psychiatric day, including inpatient psychiatric care for Medicaid fee-for-service and Medicaid managed care days.

Effective October 1, 2011,to qualify for the Acute Care Psychiatric Supplemental Medicaid Payment, a hospital must have a licensed distinct-part psychiatric unit. Qualified hospitals shall receive $200 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.

c. Effective October 1, 2011, qualified hospitals shall receive $750 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 October 1, 2011, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of $800 per Medicaid day

d. 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.

e. 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.

f. Effective October 1, 2011, qualified hospitals located in Boulder County, Broomfield County, Jefferson County, or Douglas County shall receive an additional $1100 per Medicaid day.

g. Effective October 1, 2011, qualified hospitals located in Denver County shall receive an additional $900 per Medicaid day.

OS Notification

State/Title/Plan Number: **Colorado 11-040**

Type of Action: **SPA Approval**

Required Date for State Notification: December 22, 2011

Fiscal Impact:

FFY 2011	**($2,817,722)**
FFY 2012	**$7,861,838**

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, 2011, this inpatient hospital amendment modifies the payment pool amounts and percentages for multiple existing supplemental payments (including DSH). Specifically, the amendment decreases payment pool amounts for four supplemental payment pools for SFY 2012, but increases the payment pool amounts for seven supplemental payment pools effective with FFY 2012.

The net FFP impact for FFY 2011 is a reduction of $2,817,722. The net FFP impact for FFY 2012 is an increase of $7,861,838.

The source of non-Federal share for DSH and supplemental payments are derived from General Funds and a CMS permissible provider tax. Public notice/process requirements were met. The UPL was reviewed and deemed to be acceptable with adequate room to accommodate the proposed payments. Tribal consultation requirements were met. Responses to the funding questions were adequate.

Colorado experienced a one percent reduction to their Medicaid base rate last year (SFY 2011). There are no reductions to the Medicaid base rate for SFY 2012. With regard to access to care, the State has been actively engaged with providers, provider organizations, client advocacy groups and other stakeholders. The various organizations and groups

appreciated the efforts the State has made to keep them informed and expressed commitment to continue to work with Medicaid. To date, the State has not seen a decrease in providers willing to care for Medicaid clients, nor client's complaints regarding access to care. The State plans on modifying the plan in the future to implement the Accountable Care Collaboration (ACC) initiative. The State intends to implement numerous strategies to increase access to care, if this were to become an issue. They provided an extensive list of these strategies.

Other Considerations: This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

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National Institutional Reimbursement Team