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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-12-016

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) 179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and CHIP Services

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

SEP 21 2012

Re: Colorado 12-016

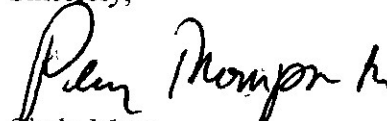
Dear Ms. Prehmus:


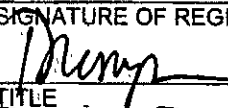
We have reviewed the proposed amendment to Attachment 4 19-A of your Medicaid State plan submitted under transmittal number (TN) 12-016. Effective for services on/or after July 1, 2012, this amendment modifies the methods and standards for establishing prospective payment rates for inpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 12-016 is approved effective July 1, 2012. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,


Cindy Mann
Director, CMCS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 12-016	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, 2012	
5. TYPE OF PLAN MATERIAL (Check One): NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS A NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION 42 CFR 440.10		7. FEDERAL BUDGET IMPACT a. FFY12 _____ \$0 _____ b. FFY13 _____ \$0 _____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A: Methods and Standards for Establishing Prospective Payment Rates - Inpatient Hospital Services, pages 3, 4, and 4a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19-A: Methods and Standards for Establishing Prospective Payment Rates - Inpatient Hospital Services, pages 3, 4, and 4a (TN 11-031)	
10. SUBJECT OF AMENDMENT Methods and standards for establishing prospective payment rates for inpatient hospital services, reflecting the Federal updates for Medicaid rates effective July 1, 2012.			
11. GOVERNOR'S REVIEW (Check One) GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Governor's letter dated 01 September 2011			
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 Attn: Barbara Prehmus	
13. TYPED NAME Suzanne Brennan			
14. TITLE Medicaid Director			
15. DATE SUBMITTED June 30, 2012			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED SEP 21 2012	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL JUL - 1 2012		20. SIGNATURE OF REGIONAL OFFICIAL 	
21. TYPED NAME Penny Thompson		22. TITLE Deputy Director, CMCS	
23. REMARKS			

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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, 2012 Budget Neutrality is defined as one and one eighteenth 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.
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

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a State University Teaching Hospital payment as specified under this Attachment 4.19A.

Pediatric Specialty Hospitals will receive an adjustment factor of 0.655615 effective July 1, 2012.

Effective July 1, 2008 Urban Center Safety Net Specialty Hospitals will receive their hospital specific Medicare base rate adjusted by the percentage applied to all other hospitals plus 10 percent to account for the specialty care provided. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent. Add-ons are included in the final rate. 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, 2012 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 July 1, 2011 Medicaid base rate.

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.

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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.

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