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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-12-023

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

DEC 13 2012

Ms. Barbara Prehmus
Colorado Department of Health Care
Policy & Financing
1570 Grant Street
Denver, CO 80203-1818

Re: Colorado 12-023

Dear Ms. Prehmus:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-023. Effective for services on or after July 1, 2012, this amendment revises supplemental Medicaid inpatient and Disproportionate Share Hospital payments to Colorado hospitals.

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 12-023 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

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: **12-023**	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 7/1/2012	

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 CFR 42 Section 447.272	7. FEDERAL BUDGET IMPACT a. FFY 2011-12 ($3,124,704) b. FFY 2012-13 $461,342
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **Attachment 4.19A, pages 11, 11a, 29a, 29c, 37, 37a, 38, 42, 43, 49, 50, 51, 52, 53, 53a, 56, 57, 58, 59, 60, 61, 62, 63, 64**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* **Attachment 4.19A, pages 11, 11a, 29a, 29c, 37, 38, 42, 43, 49, 50, 51, 52, 53, 56, 57, 58, 59, 60, 61, 62**

10. SUBJECT OF AMENDMENT

Supplemental Medicaid Inpatient and Disproportionate Share Hospital Payments Revised

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 01 September 2011

12. SIGNATURE OF STATE AGENCY OFFICIAL JBartholomew	16. RETURN TO **Colorado Department of Health Care Policy and Financing** **1570 Grant Street** **Denver, CO 80203-1818** **Attn: Barbara Prehmus**
13. TYPED NAME **John Bartholomew**	
14. TITLE **Director, Finance Ofice**	
15. DATE SUBMITTED **9/28/2012**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED DEC 13 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

FORM CMS-179 *(07/92)*

Instructions on Back

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
SFY 2012-13: $1,741,077		

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	SFY 2012-13
Denver Health Medical Center: $1,831,714	Denver Health Medical Center: $1,831,714
University of Colorado Hospital: $633,314	University of Colorado Hospital: $633,314

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%
Federal Fiscal Year 2011-12	15.00%	42.00%	23.00%
Federal Fiscal Year 2012-13	20.47%	32.28%	25.98%

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%
Federal Fiscal Year 2011-12	20.00%
Federal Fiscal Year 2012-13	21.28%

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.

   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). Effective October 1, 2012, hospitals can qualify for up to two increases to weight their inflated CICP costs. Weighted CICP costs are calculated separately for Urban and Rural hospitals. Urban hospitals are defined as those hospitals that are located within a federally

designated Metropolitan Statistical Area. Rural hospitals are defined as those hospitals that are not located within a federally designated Metropolitan Statistical Area. Qualifying for, and weighting inflated CICP costs for are determined and calculated as follows:

1. CICP Cost as a Percentage of Total Cost
   a. Urban hospitals whose CICP costs as a percentage of Total Costs is greater than the mean plus one standard deviation percentage for all Urban hospitals will have their inflated CICP costs increased by 2% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.
   b. Rural hospitals whose CICP costs as a percentage of Total Costs is greater than the mean plus one standard deviation percentage for all Rural hospitals will have their inflated CICP costs increased by 2% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.
2. Medicaid and CICP Days as a Percentage of Total Days
   a. Urban hospitals whose combined Medicaid and CICP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all Urban hospitals will have their inflated CICP costs increased by 5% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.
   b. Rural hospitals whose combined Medicaid and CICP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all Rural hospitals will have their inflated CICP costs increased by 5% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.
   c. For those facilities that qualify for both CICP Inflated Cost weightings, the inflated CICP cost will be increased by 2% first, and the resulting weighted CICP costs will then be increased by 5%.

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.

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.

Effective October 1, 2012, Qualified hospitals that are classified as High Volume Medicaid and CICP Hospitals will receive 53.0% 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.

Effective October 1, 2012, 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 70% 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.

Effective October 1, 2012, All other qualified hospitals will receive 54% 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
FY 2012-13	$18,919,698

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
FY 2012-13 $0	

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

Effective October 1, 2012:

1. Pediatric Specialty Hospitals shall have a 16.00% increase
2. State University Hospitals shall have a 23.00% increase
3. Urban Safety Net Hospitals shall have a 15.00% increase
4. Rehabilitation and Specialty Acute Hospitals shall have a 10.00% increase
5. Rural hospitals shall have a 75.00% increase
6. Urban Hospitals shall have a 45.00% 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. Effective October 1, 2012, High Volume Medicaid and CICP Hospitals can qualify for the High-Level NICU Supplemental payment if the other qualifying criteria are met.

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. Effective October 1, 2012, the State Teaching Supplemental Medicaid payment is $0.

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.

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.

d. Effective October 1, 2012, qualified hospitals shall receive $750 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICP Days to Total Days is in the top 25% of all providers will receive an additional $100 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 October 1, 2012, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of $800 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICP Days to Total Days is in the top 25% of all providers will receive an additional $100 per Medicaid Day.

e. 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.

f. 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.

g. 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.

h. Effective October 1, 2012, qualified hospitals located in Boulder County, Broomfield County, Jefferson County, or Douglas County shall receive an additional $1075 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICP Days to Total Days is in the top 25% of all providers will receive an additional $100 per Medicaid Day.

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

j. Effective October 1, 2012, qualified hospitals located in Denver County shall receive an additional $865 per Medicaid day, and qualified hospitals whose percentage of Medicaid Days plus CICP Days to Total Days is in the top 25% of all providers will receive an additional $100 per Medicaid Day.

O. Hospital Quality Incentive Payments

The Hospital Quality Incentive 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, the Acute Care Psychiatric Supplemental Medicaid payment, and the Supplemental Medicaid Payments.

Effective October 1, 2012, Colorado hospitals that provide services to improve the quality of care and health outcomes for their patients, with the exception of inpatient psychiatric hospitals and out-of-state hospitals (in both bordering and non-bordering states), may qualify to receive additional monthly 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 (UPL) 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 "Hospital Quality Incentive Payment" (HQIP) which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments. To qualify for the HQIP supplemental Medicaid payment a hospital must meet the minimum criteria for no less than two of the selected measures for the most recently completed reporting year. Data used to calculate the HQIP supplemental payments will be collected annually.

For each qualified hospital, this payment will be calculated as follows:

1. Determine Available Points by hospital, subject to a maximum of 10 points per measure
    a. Available Points are defined as the number of measures for which a hospital qualifies multiplied by 10
2. Determine points earned per measure by hospital
3. Adjust the points earned per measure to total possible points for all measures
4. Calculate adjusted discharges by hospital
    a. The adjusted discharge factor shall be no greater than 5
5. Calculate Total Discharge Points
    a. Discharge Points are defined as the number of points earned per measure multiplied by the number of adjusted discharges for a given hospital
6. Calculate Dollars per Discharge Point

a. Dollars per Discharge Point will be calculated by dividing the total funds available under the inpatient UPL by the total number of Discharge Points

7. Determine HQIP payout by hospital by multiplying the total Discharge Points for that hospital by the Dollars per Discharge Point.

In step (2) described above, the 10 points earned may come from a combination of achievement and improvement points. The maximum points that a hospital may earn is 10 points per measure.

Effective October 1, 2012, the measures for the HQIP supplemental payments are:

1. Central Line-Associated Blood Stream Infections (CLABSI)
2. Elective deliveries between 37 and 39 weeks gestation
3. Post-Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT)
4. Structured efforts to reduce readmissions and improve care transitions

Total Funds for this payment equal:

FFY 2012-13 $32,000,000	

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, and the Hospital Quality Incentive 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 Using the CMS 2552-96:

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.

Methodology for Calculating Uncompensated Costs for Medicaid Inpatient Hospital Services Using the CMS 2552-10:

Calculating Total Inpatient Hospital Costs

Total Inpatient Hospital Routine Costs equal costs as reported on CMS 2552-10 Worksheet C, Part I, Column 1, lines 30 – 43, plus allowable costs for interns and residents costs reported on Columns 21 and 22 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 21 and 22 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 44 – 46 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 8. Observation Bed Days, cost center 92, are to be reclassified to be included in Adults and Pediatrics (cost center 30). Labor and Delivery Days are also to be included in the Adults and Pediatrics cost center.

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 50 - 92. For hospitals that use the Special Title XIX Worksheet, which adds back the allowable interns and residents costs from Columns 21 and 22 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 50 – 92.

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 92. 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 92) 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-4, Part III under the Part B cost column line 62.

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-4, Part III, under the Part A cost column line 61.

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 2552-10 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 8.

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 2552-10 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.