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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-14-0043

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

DEC 10 2014

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

Re: Colorado 14-043

Dear Ms. Prehmus:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-043. Effective for services on or after July 1, 2014, this amendment updates the reimbursement methodology for the existing supplemental payment to public high-volume Medicaid hospitals for uncompensated inpatient hospital care provided to Medicaid recipients.

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 14-043 is approved effective July 1, 2014. The CMS-179 and the amended plan pages are attached.

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

Sincerely,

[redacted]

Timothy Hill
Director

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: **14-043**	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, 2014**	

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	7. FEDERAL BUDGET IMPACT **FFY 2013-14: $ 0** **FFY 2014-15: $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **Attachment 4.19A, Pages 56, 57, 58, 59, 60, 61, 62**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* **Attachment 4.19A, Pages 56, 57, 58, 59, 60, 61, 62**

10. SUBJECT OF AMENDMENT

Public High Volume Medicaid and CICP Hospital Payment

11. GOVERNOR'S REVIEW *(Check One)*

GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
X Other as Specified
Governor's Letter Dated 01 September 2011

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	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 Office**	
15. DATE SUBMITTED 9/29/14	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED DEC 10 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JUL 01 2014	20. SIGNATURE OF REGIONAL OFFICIAL [redacted]
21. TYPED NAME Kristin FAN	22. TITLE Deputy Director, FMG

23. REMARKS

FORM CMS-179 *(07/92)* *Instructions on Back*

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".

Effective July 1, 2014, 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, as defined in Attachment 4.19A, p. 38, letter (a).

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, the Hospital Quality Incentive Payment, the Family Medicine Residency Program payment, the Pediatric Major Teaching payment, the State University Teaching Hospital payment, the Rural Family Medicine Residency Development payment and the Metropolitan Statistical Area Supplemental Medicaid payment.

The Interim Payment to qualified providers will be calculated for the actual expenditure period using the filed CMS 2552-96 Medicare Cost Report, or its successor, and disbursed annually after the actual expenditure period. Interim payments for uncompensated Medicaid inpatient hospital costs will be calculated each year and paid by the following October 31st of each year. 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 for qualified hospitals within six months after all eligible providers have submitted their audited CMS 2552-96 Medicare Cost Report, or its successor, for the actual expenditure period.

Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed for 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 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). Labor and Deliver Days, cost center 39, are also 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 Header Number of Service Days as reported in the MMIS for dates of service that correspond to the hospital's cost report period. The Total Header Number of Service Days is then multiplied by the percentage of Total Inpatient Days by Routine Cost Center for each cost center using Title XIX Days, Worksheet S-3, Pt. 1, Column 5, from CMS 2552-96, or its successor, to allocate inpatient days to the appropriate cost centers. University Hospital is on a State Fiscal Year, Denver Health is on a calendar year, and University of Colorado Health – Memorial Health System (UCH-MHS) is on a State Fiscal 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.

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 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 Deliver Days, cost center 52, are also to be reclassified to be included in Adults and Pediatrics (cost center 30).

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 Header Number of Service Days as reported in the MMIS for dates of service that correspond to the hospital's cost report period. The Total Header Number of Service Days is then multiplied by the percentage of Total Inpatient Days by Routine Cost Center for each cost center using Title XIX Days, Worksheet S-3, Pt. 1, Column 7, from CMS 2552-10, or its successor, to allocate inpatient days to the appropriate cost centers. University Hospital is on a State Fiscal Year, Denver Health is on a calendar year, and University of Colorado Health – Memorial Health System (UCH-MHS) is on a State Fiscal 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.

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.