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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-14-0045

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 & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region VIII

January 13, 2015

Susan E. Birch, MBA, BSN, RN, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203-1818

RE: Colorado #14-0045 – Correction to Approval Letter

Dear Ms. Birch:

We reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 14-0045. This amendment addresses reimbursement to specified government-operated providers for costs of professional services. It is necessary due to a legal change in the name of Memorial Health System, Colorado Springs to University of Colorado Health - Memorial Health System.

This State Plan Amendment was approved December 16, 2014 with an effective date of July 1, 2014. It has been brought to our attention that the reference to the Form CMS-64.9 VIII should not have been included in the original letter and the incorrect reporting line was given. The corrected reporting information is outlined below.

In order to track expenditures associated with this amendment, Colorado should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM).

This amendment would affect expenditures reported on Line–5B, Physician & Surgical Services Supplemental Payments.

We regret any confusion this caused and thank Cindy Arcuri for finding the errors. If you have any questions concerning this amendment or correction, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Suzanne Brennan
Frank Herbst
Pat Connally
John Bartholomew
Barb Prehmus

DEPARTMENT OF HEALTH AND HUMAN SERVICES
APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES
0938-0193

FORM

OMB NO.

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**	1. TRANSMITTAL NUMBER: **14-045**	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 **42 CFR 447.200-201**	7. FEDERAL BUDGET IMPACT **FFY 2013-14: $ 0** **FFY 2014-15: $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **Supplement to Attachment 4.19B, Pages 1, 2, 3, 4, 5, 6, 7**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* **Supdersedes TN 13-007, Supplement to Attachment 4.19B, Pages 1, 2, 3, 4, 5, 6, 7**

10. SUBJECT OF AMENDMENT

Reimbursement To Specified Government-Operated Providers For Costs Of Professional Services

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 [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 **9/26/14**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 9/26/14	18. DATE APPROVED 12/17/14

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 7/1/14	20. SIGNATURE OF REGIONAL OFFICIAL /s/
21. TYPED NAME Richard C. Allen	22. TITLE ARA, DMCHO

23. REMARKS

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

REIMBURSEMENT TO SPECIFIED GOVERNMENT-OPERATED PROVIDERS FOR COSTS OF PROFESSIONAL SERVICES

This segment of Attachment 4.19-B provides reimbursement to eligible government-operated hospitals or the government entities with which they are affiliated (including affiliated government-operated physician practice groups), for the uncompensated Medicaid costs of providing physician and specified non-physician practitioner professional services to Medicaid beneficiaries. Only the otherwise uncompensated costs of professional services not claimed by the hospital as Medicaid inpatient hospital services, outpatient hospital services or government operated clinic services set forth in other sections of Attachments 4.19A and 4.19-B, are eligible for reimbursement under this segment of Attachment 4.19B.

Eligible professional costs are reported on the designated hospitals' CMS-2552-10 cost report.

A. General Reimbursement Requirements

1. The government-operated hospitals identified in Section B of this attachment, and the government operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, are eligible providers that will receive supplemental payments for the un-reimbursed Medicaid costs specified in Section C of this attachment below.

2. Eligible providers will receive Medicaid fee-schedule payments for professional services. In addition, the eligible providers will receive supplemental payments up to cost as specified in Section C of this attachment. The reimbursement under this segment of Attachment 4.19-B is available only for Medicaid costs that are in excess of Medicaid fee schedule payments.

3. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid services described in this segment of Attachment 4.19B, that are provided to Medicaid patients by physicians and non-physician practitioners of government-operated hospitals or the government entities with which they are affiliated, will be governed by this segment of Attachment 4.19-B.

4. Professional costs incurred by freestanding clinics that are not recognized as hospital outpatient departments on the CMS-2552-10 and are reimbursable as clinic costs are not included in this protocol.

5. The supplemental payments determined under this segment of Attachment 4.19-B will be paid on an annual basis.

B. Eligible Providers

1. The physician and non-physician practitioner professional costs being addressed in this protocol are limited to professional costs incurred by the governmental hospitals listed below and their affiliated government physician practice groups (i.e., practice group that is owned and operated by the same government entity that owns and operates the hospital). These professional costs are reported on the designated hospitals' CMS-2552-10 cost report.

Non-State Government-operated:

Denver Health Medical Center
University of Colorado Health – Memorial Health System

C. Reimbursement Methodology

This interim supplemental payment will approximate the difference between the fee-for-service (FFS) payment and the allowable Medicaid costs related to the professional component of physician or non-physician practitioner services eligible for Federal financial participation. This computation of establishing the interim Medicaid supplemental payments must be performed on an annual basis and in a manner consistent with the instructions below.

a. The professional component of physician costs are identified from each hospital's most recently filed CMS-2552-10 cost report Worksheet A-8-2, Column 4. These professional costs are:

1. limited to allowable and auditable physician compensations that have been incurred by the hospital;
2. for the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service, including sites that are not owned or operated by an affiliated government entity;
3. identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment;
4. supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians
5. removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with the average rates paid to the provider by commercial payers. There will be revenue offsets to account for revenues received for services furnished by such professionals to non-patients (patients whom the hospital does not directly bill for) and any other applicable non-patient care revenues that were not previously offset or accounted for by the application of time study.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the CMS-2552-10 cost report. The practitioner types to be included are:

Certified Registered Nurse Anesthetists
Physician Assistants
RN Clinical Nurse Specialists
RN Nurse Midwives
Supervisor, Nurse Midwives
RN Nurse Practitioners
Psychologists
Licensed Clinical Social Workers
Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the cost report, these costs may be recognized if they meet the following criteria:

1. the practitioners must engage in the direct provision of care in addition to being Medicaid qualified practitioners for whom the services are billable under Medicaid separate from hospital services;
2. for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
3. a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs;
4. the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with average rates paid to the provider by commercial payers and offset of revenues received for services furnished by such practioners to non-patients (patients for whom the hospital does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs for this section of Attachment 4.19-B. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are separately reimbursable as clinic costs and therefore should not be included in this protocol.

f. Hospitals may additionally include physician support staff compensation, data processing, office and patient accounting costs as physician-related costs to the extent that :

1. these costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
2. they are directly identified on Worksheet A-8 or Worksheet B, Part 1 as adjustments to hospital costs;
3. they are otherwise allowable and auditable provider costs; and
4. they are further adjusted for any non-patient-care activities such as research based on physician time studies.

If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed for the purposes of this section of 4.19-B.

g. Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from hospital records.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f by the total billed professional charges for each cost center as established in paragraph g. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f by the total billed professional charges for each practitioner type as established in paragraph g.

i. The total professional charges for each cost center related to covered Medicaid fee-for-service physician services, billed directly by the hospital, are identified using paid claims data from the State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and does not track claims on a cost center basis, the total professional charges related to Medicaid fee-for-service physician services must be allocated to the hospital cost centers using information from the hospital's billing system. These charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the covered Medicaid fee-for-service professional charges, billed directly by the hospital, are identified using paid claims data from State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and may not track claims by non-physician practitioner type, hospitals must map the charges to non-physician practitioner type using information from their hospital billing systems. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

j. The total Medicaid costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid fee-for-service charges as established in paragraph i by the respective cost to charge ratio for the cost center as established in paragraph h.

For each non-physician practitioner type, the total Medicaid costs related to non-physician practitioner professional services are determined by multiplying total Medicaid fee-for-service charges as established in paragraph i by the respective cost to charge ratios as established in paragraph h.

k. The total Medicaid costs eligible for Medicaid supplemental payment are determined by subtracting all Medicaid fee-for-service physician/practitioner payments received from the Medicaid fee-for-service costs as established in paragraph j. The amount of the Medicaid interim supplemental payment will be based on the Medicaid fee schedule payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS/claims system and auditable provider records. All revenues received (other than the Medicaid physician supplemental payments being computed here in this section) for the Medicaid professional services will be

offset against the computed cost; these revenues include payments from the State, patient co-payments, and payments from other payers.

l. The Medicaid physician/practitioner amount computed in paragraph k above can be trended to current year based on Market Basket update factor(s) or other medical care-related indices as approved by CMS. The Medicaid amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1). Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.

(2). Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the hospital and subject to review by the State and CMS. The result is the Medicaid physician/practitioner amount to be used for interim Medicaid supplemental payment purposes.

D. Interim Reconciliation

The physician and non-physician practitioner interim supplemental payments determined under Section C above which are paid for services furnished during the applicable calendar year are reconciled to the as-filed CMS-2552-10 cost report for the same year once the cost report has been filed with the State. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, the provider will receive an adjusted payment amount. For purposes of this reconciliation the same steps as outlined for the interim payment method are carried out except as noted below:

1. For the determinations made under paragraphs a through h of Section C, the costs and charges from the as-filed CMS-2552-10 cost report for the expenditure year are used.

2. For the determinations made under paragraph i of Section C, Medicaid fee-for-service professional charges for covered services furnished during the applicable fiscal year are

used and are identified using paid claims data from the State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and does not track claims on a cost center basis, the total professional charges related to Medicaid fee-for-service physician services must be allocated to the hospital cost centers using information from the hospital's billing system. These charges must be associated with paid claims for services furnished during the applicable fiscal year covered by the as-filed cost report for the same fiscal year.

3. For the determinations made under paragraph k of Section C, Medicaid fee-for-service payments for professional services furnished during the applicable fiscal year from the State's MMIS/claims system are used. All revenues received (other than the Medicaid physician supplemental payments being computed here in this section) for the Medicaid professional services will be offset against the computed cost; these revenues include payments from the State, patient co-payments, and payments from other payers.

E. Final Reconciliation

Once the CMS-2552-10 cost report for the expenditure year has been finalized by the State, a reconciliation of the finalized costs to all Medicaid payments made for the same period will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized CMS-2552-10 cost amounts and updated Medicaid data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. The final reconciliation adjustments will be made within one year of the date the cost report for the expenditure year is finalized.