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State/Territory Name: Colorado

State Plan Amendment (SPA)#: 18-0017

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

October 15, 2018

Kim Bimestefer, Executive Director
Department of Health Care Policy &
Financing 1570 Grant Street
Denver, CO 80203

Dear Ms. Bimestefer:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 18-0017. This amendment creates a supplemental payment to reimburse uncompensated costs incurred in providing Emergency Medical Services (EMS) to Medicaid recipients. Public-owned providers that do not receive supplemental payments for EMS services will be eligible for this payment.

Please be informed that this State Plan Amendment was approved October 15, 2018, with an effective date of January 1, 2018. We are enclosing the CMS-179 and the amended plan page(s).

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).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage, expenditures should be reported on the Form CMS-64.9 VIII; for those not enrolled in the new adult group, claims thereon should be reported on the Form CMS-64.9 Base.

This amendment would affect expenditures reported on Line 36- Emergency Hospital Services.

If you have any questions concerning this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

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

cc:
Laurel Karabatsos
John Bartholomew
David DeNovellis
Russell Ziegler
Whitney McOwen

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL O STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **18 – 0017**

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: **January 1, 2018**

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:

SECTION 1905(a) OF THE SOCIAL SECURITY ACT

7. FEDERAL BUDGET IMPACT:

a. FFY 2017-18: $6,750,000
b. FFY 2018-19: $9,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 4.19-B – METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE – 24a. – TRANSPORTATION-SUPPLEMENTAL PAYMENT FOR AMBULANCE SERVICES – PAGES 1-6 OF 6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

ATTACHMENT 4.19-B – METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE – 24a. – TRANSPORTATION-SUPPLEMENTAL PAYMENT FOR AMBULANCE SERVICES – PAGES 1-2 OF 2 (TN 15-0007)

10. SUBJECT OF AMENDMENT:

Create a supplemental payment to reimburse uncompensated costs incurred in providing Emergency Medical Services (EMS) to Medicaid recipients. Public-owned providers that do not receive supplemental payments for EMS services will be eligible for this payment.

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 29 March, 2018

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Gretchen Hammer**

14. TITLE: **Medicaid Director**

15. DATE SUBMITTED: Initial: March 28, 2018
Update #1: May 7, 2018 Update #2: October 11, 2018

16. RETURN TO:

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

Attn: David DeNovellis

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 28, 2018

18. DATE APPROVED: October 15, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2018

20. SI[redacted] OFFICIAL

21. TYPED NAME: Richard C. Allen

22. TITLE: ARA, DMCHO

23. REMARKS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

24a. TRANSPORTATION – SUPPLEMENTAL PAYMENT FOR AMBULANCE SERVICES

Effective January 1, 2015, Denver Health and Medical Center will receive supplemental Medicaid payments (Denver Health Ambulance Services Payment) to provide reimbursement for uncompensated costs incurred by Medicaid clients receiving ambulance services owned and operated by Denver Health and Hospital Authority. Denver Health will certify their uncompensated cost for providing ground emergency medical transportation (GEMT) ambulance services for Medicaid fee-for-service clients based on the Department's demonstration of the uncompensated Medicaid cost calculation.

Interim Payments for the Payment calendar year (January through December) will be made by June 30 of the following calendar year using as-filed cost reports to calculate uncompensated costs.

Uncompensated costs will be calculated for Final Payments using audited cost reports. Final Payments will be made by June 30 for Denver Health audited cost reports received by the Department between the previous November 2 and May 1. Final Payments will be made by December 31 for Denver Health audited cost reports received by the Department between the previous May 2 and November 1. Final payments will serve to adjust the Interim Payment such that the sum of the Interim and Final Payments to Denver Health shall equal the Payment amount calculated based on uncompensated costs calculated through audited cost reports.

Prior to making the Final Payment, the Department will present to Denver Health a demonstration of the uncompensated Medicaid costs calculations for purposes of authorizing certification. Denver Health shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Payment.

Uncompensated Ambulance Medicaid fee for service costs are calculated as follows:

1. Total Medicaid Ambulance Fee for Service Charges for Denver Health for the previous calendar year will be pulled from the Colorado Medicaid Management Information System (MMIS).
2. The Cost to Charge Ratio (CCR) for Denver Health will be calculated using their as-filed cost report for the Interim Payment and their audited cost report for the Final Payment. The CCR is found in CMS 2552-10, Worksheet C, Part I, column 8, line 95.

3. The Total Medicaid Ambulance Fee for Service Charges will be multiplied by the CCR to calculate the Total Medicaid Ambulance Costs.
4. Total Medicaid Ambulance Fee for Service Payments for Denver Health for the previous calendar year will be pulled from the Colorado MMIS.
5. The Total Medicaid Ambulance Fee for Service Payments will be subtracted from the Total Medicaid Ambulance Fee for Service Costs to calculate the Total Uncompensated Medicaid Fee for Service Ambulance Costs.

The Interim Payment will be equal to the Total Uncompensated Medicaid Fee for Service Ambulance Costs. The Final Payment will be the difference between the Total Uncompensated Medicaid Fee for Service Ambulance Costs calculated using the as-filed cost report and the audited cost report. Any excess payments determined in the reconciliation processes are recouped and the Federal share is returned to CMS on the quarterly expenditure report in which the recoupment is made.

TRANSPORTATION – SUPPLEMENTAL PAYMENT FOR GOVERNMENT AMBULANCE SERVICE PROVIDERS

Effective January 1, 2018, governmental ambulance service providers that do not receive supplemental payments for Emergency Medical Services (EMS) services, meet the specified requirements outlined in section A below, and provide ground or air emergency medical transportation services to Medicaid beneficiaries will be eligible for this payment. This supplemental payment applies to EMS rendered to Medicaid beneficiaries by eligible governmental ambulance service providers on or after January 1, 2018. Denver Health and Medical Center is excluded from receiving the Supplemental Payment for Government Ambulance Service Providers, unless the above section 24a Transportation – Supplemental Payment for Ambulance Services is eliminated.

Supplemental payments provided by this program are available only for allowable costs that are in excess of Medicaid reimbursement rates paid to other ambulance services providers in accordance with Attachment 4.19-B – Methods and Standards for Establishing Payment Rates-Other Types of Care – 24a. Transportation, Non-Brokered Transportation that eligible entities receive for emergency medical transportation services to Medicaid eligible recipients. The Department of Health Care Policy and Financing (The Department) will cap the total reimbursements from Medicaid (including supplemental payment) at one hundred percent of actual costs. The Department will recognize, on a voluntary basis, a supplemental payment equal to the total allowable Medicaid costs of approved governmental ambulance service providers for providing services as set forth below.

A. To qualify for supplemental payments, providers must meet all of the following:

1. Be enrolled as a Medicaid provider for the period being claimed on their annual cost report;
2. Provide ground or air emergency medical transport services to Medicaid enrollees; and
3. Be organizations owned or operated by the state, city, county, fire protection district, community services district, health care district, federally recognized Indian tribe or any unit of government as defined in 42 C.F.R. Sec. 433.50.

B. Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation an apportioning those expenses to the Medicaid program, except as expressly modified below.
2. The total uncompensated care costs of each eligible provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each eligible provider providing EMS to Colorado Medicaid beneficiaries, net of the amounts received and payable from the Colorado Medicaid program and all other sources of reimbursement for such services provided to Colorado Medicaid beneficiaries. If the eligible providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

C. Cost Determination Protocols

1. An eligible provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the state approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.

2. Direct costs for providing medical transport services include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.
3. The total percentage of time spent on medical calls throughout the cost reporting period will be calculated using Computer Aided Dispatch (CAD)/Trip statistics and used as an allocation methodology for those costs "shared" between Medical Transportation Services (MTS) vs. Non-MTS divisions. Providers will allocate shared Capital Related and Salaries & Benefits (CRSB) costs based on CAD/Trip Statistics.
4. Indirect costs are determined in accordance to one of the following options.
    a. Eligible providers that receive more than $35 million in direct federal awards must either have a Cost Allocation Plan (CAP) or a cognizant agency approved indirect rate agreement in place with its federal cognizant agency to identify indirect cost. If the Eligible provider does not have a CAP or an indirect rate agreement in place with its federal cognizant agency and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.
    b. Eligible providers that receive less than $35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, Eligible providers may use methods originating from a CAP to identify its indirect cost. If the Eligible provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost.
    c. Eligible providers which receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
        i. A CAP with its local government
        ii. An indirect rate negotiated with its local government
        iii. Direct identification through use of a cost report
    d. If the Eligible provider never established any of the above methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost.

D. Cost Settlement Process

1. The payments and the number of transport data reported in the as-filed cost report will be reconciled to the Colorado MMIS reports generated for the cost reporting period within 10 months of the as-filed cost report deadline. The Department will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.
2. Each eligible provider will receive an annual lump sum payment in an amount equal to the total of the uncompensated care costs as defined in the above Supplemental Reimbursement Methodology – General Provisions Section B.2.
3. The Department will perform a final reconciliation where it will settle the provider's annual cost report as audited within the following calendar year. The Department will compute the net EMS allowable costs using audited per-medical transport cost, and the number of fee-for-service EMS transports data from the updated MMIS reports. Actual net allowable costs will be compared to the Medicaid reimbursement rates paid to other ambulance services providers in accordance with Attachment 4.19-B – Methods and Standards for Establishing Payment Rates-Other Types of Care – 24a. Transportation, Non-Brokered Transportation and settlement payments made, and any other source of reimbursement received by the provider for the period. If, at the end of the final reconciliation, it is determined that the eligible provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the eligible provider will receive an interim supplemental payment in the amount of the underpayment.

E. Eligible Provider Reporting Requirements

1. The cost report will be completed on a state fiscal year basis and will be due to the Department of Health Care Policy and Financing no later than 150 calendar days following the last day of the state fiscal year.
2. "Governmental ambulance services provider" means a provider of ambulance services that is a unit of government specified in 42 CFR 433.50.
3. Participating governmental ambulance services provider who meets the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with (a) through (d) for services provided on or after January 1, 2018.

a. The governmental ambulance services provider will be paid interim rates equal to the Medicaid reimbursement rates paid to other ambulance services providers in accordance with Attachment 4.19-B – Methods and Standards for Establishing Payment Rates-Other Types of Care – 24a. Transportation, Non-Brokered Transportation. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.
b. The governmental ambulance services provider will submit a state approved cost report annually, on a form approved by the Department of Health Care Policy and Financing. The cost report will be completed on a state fiscal year basis and will be due to the Department of Health Care Policy and Financing no later than 150 calendar days following the last day of the state fiscal year.
c. "Allowable costs" will be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 CFR, part 200 as implemented by HHS at 45 CFR, part 75.
    i. "Direct costs" are those costs that are identified by 45 CFR 75.413 that:
        1. Can be identified specifically with a particular final cost objective (to meet emergency medical transportation requirements), such as a federal award, or other internally or externally funded activity; or
        2. Can be directly assigned to such activities relatively easily with a high degree of accuracy.
    ii. "Indirect costs" means the costs that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes.

d. The provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio, to Medicaid charges associated with paid claims for the dates of service covered by the submitted cost report.