Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-13-033

This file contains the following documents in the order listed:

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 & CHIP SERVICES

FEB 20 2014

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

Re: Colorado 13-033

Dear Ms. Prehmus:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-033. Effective for services on or after October 1, 2013, this amendment amends the supplemental and DSH payments for inpatient hospitals services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 13-033 is approved effective October 1, 2013. 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]

Cindy Mann
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: 13-033	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 10/1/2013	

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__2012-13___ $_0.00_____ b. FFY__2013-14___ $_0.00_____
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **Attachment 4.19A – Pages 29a, 29b, 29c, 38, 38a, 42, 43, 49, 49a, 50, 50a, 51a, 52a, 53, 53a, 54, 56, 57**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* **Attachment 4.19A – Pages 29a, 29b, 29c, 38, 42, 43, 49, 50, 50a, 51a, 53, 54, 56, 57**

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 | **X OTHER, AS SPECIFIED**

Governor's letter dated 01 September 2011

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
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	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED FEB 20 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL OCT 01 2013	20. SIGNATURE OF REGIONAL OFFICIAL [redacted]
21. TYPED NAME Penny Thompson	22. TITLE Deputy Director, Policy + Financial Mgmt CMS

23. REMARKS

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%
Federal Fiscal Year 2013-14	19.67%	49.18%	29.51%

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.

E. Colorado determination of Individual Hospital Disproportionate Payment Adjustment Associated with providers who do not participate in Colorado Indigent Care Program

1. Effective July 1, 2009, Colorado hospitals that do not participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "Uninsured Disproportionate Share Hospital 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 Uninsured Disproportionate Share Hospital payment will be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

   To qualify for the Uninsured Disproportionate Share Hospital 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;
   b. Is not licensed or certified as Psychiatric or Rehabilitation Hospital, nor is licensed as a General Hospital with a Medicare Certification Long Term by the Colorado Department of Public Health and Environment;
   c. Does not participate in the Colorado Indigent Care Program;
   d. Reports charges for services provided to low-income, uninsured persons to the Department; and
   e. Has an estimated Medicaid Inpatient Utilization Rate (MIUR) equal to or greater than the mean plus one standard deviation for all Colorado hospitals.

   The Uninsured Disproportionate Share Hospital payment is a prospective payment calculated using historical data, with no reconciliation to actual data or costs for the payment period. Available charges for services provided to low-income, uninsured persons (as reported to the Department annually) are converted to uninsured 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. Uninsured costs are inflated forward to the payment period 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 uninsured cost. The percent of estimated uninsured costs shall be the aggregate of all inflated uninsured costs for qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital payment.

	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%
Federal Fiscal Year 2013-14	1.64%

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.

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.

   Effective October 1, 2013, Qualified hospitals that are classified as High Volume Medicaid and CICP Hospitals will receive 52.45% 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.

   Effective October 1, 2013, 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 77.45% 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.

Effective October 1, 2013, All other qualified hospitals will receive 52.45% 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
FY 2013-14	$17,919,698

Effective October 1, 2013, an additional $1,000,000 Pediatric Major Teaching payment will be made to qualifying providers on a Federal Fiscal Year (FFY) basis.

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	FY 2013-14 $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

Effective October 1, 2013:

1. Pediatric Specialty Hospitals shall have a 9.50% increase
2. State University Hospitals shall have a 20.00% increase
3. Urban Safety Net Hospitals shall have a 36.00% increase
4. Rehabilitation and Specialty Acute Hospitals shall have a 10.00% increase
5. Rural hospitals and Critical Access Hospitals in Teller County shall have a 73.00% increase
6. Urban Hospitals shall have a 38.00% 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.

c. Effective October 1, 2013, qualified hospitals shall receive $2,400 per Medicaid NICU day. A Medicaid NICU day is a paid Medicaid non-managed care day for APR-DRGs 588 (Neonate, w/ ECMO), 591 (Neonate, Birthwt 500-749G w/o Major Procedure), 593 (Neonate, Birthwt 750-999G w/o Major Procedure), 602 (Neonate, Birthwt 1000-1249G w/ Resp Dist Synd/Oth Maj Resp

Or Maj Anom), 609 (Neonate, BWT 1500-2499G W Major Procedure), 630 (Neonate, BWT > 2499G W Major Cardiovasc Procedure), and 631 (Neonate, BWT > 2499G W Other Major Procedure) up to the average length of stay.

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.

M. Acute Care Psychiatric Supplemental Medicaid Payment

Effective October 1, 2010, Colorado hospitals shall qualify to receive an additional supplemental Medicaid reimbursement for inpatient psychiatric 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 "Acute Care Psychiatric Supplemental Medicaid payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Acute Care Psychiatric 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, the High-Level NICU Supplemental Medicaid payment, and the State Teaching Hospital Supplemental Medicaid payment.

The Acute Care Psychiatric Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the Acute Care Psychiatric Supplemental Medicaid payment a hospital shall meet the following criteria:

1. Licensed as a General Hospital by the Colorado Department of Public Health Environment.
2. Is not a free-standing psychiatric facility, which is exempt from the DRG-based prospective payment system.

Effective October 1, 2010, Qualified hospitals shall receive $150 per Medicaid psychiatric day, including inpatient psychiatric care for Medicaid fee-for-service and Medicaid managed care days.

Effective October 1, 2011,to qualify for the Acute Care Psychiatric Supplemental Medicaid Payment, a hospital must have a licensed distinct-part psychiatric unit. Qualified hospitals shall receive $200 per Medicaid psychiatric day, including inpatient psychiatric care for Medicaid fee-for-service and Medicaid managed care days.

Effective October 1, 2013, qualified hospitals shall receive $100 per Medicaid psychiatric day, including inpatient psychiatric care for Medicaid fee-for-service and Medicaid managed care.

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.

e. Effective October 1, 2013, qualified hospitals shall receive $525 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 $50 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 October 1, 2013, qualified hospitals located in Adams County or Arapahoe County, shall receive a payment of $770 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 $50 per Medicaid Day.

f. 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

g. 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.

h. 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.

i. 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.

j. Effective October 1, 2013, qualified hospitals located in Boulder County, Broomfield County, Jefferson County, or Douglas County shall receive an additional $770 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 $50 per Medicaid Day.

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

l. 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.

m. Effective October 1, 2013, qualified hospitals located in Denver County shall receive an additional $755 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 $50 per Medicaid Day.

3. Metropolitan Statistical Area Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals that are located in a federally designated Metropolitan Statistical Area outside the Denver Metro Area 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 "Metropolitan Statistical Area 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 Metropolitan Statistical Area Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

To qualify for the Metropolitan Statistical Area Supplemental Medicaid payment a hospital shall meet the following criteria:

a. Is located in a federally designated Metropolitan Statistical Area outside the Denver Metro Area; and

b. Is licensed as a General Hospital by the Colorado Department of Public Health Environment.

The Metropolitan Statistical Area 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 shall receive $310 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 $650 per Medicaid day.

d. Effective October 1, 2013, qualified hospitals shall receive $550 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. Effective October 1, 2013, to qualify for the HQIP supplemental Medicaid payment a hospital must meet the minimum criteria for at least one 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

Effective October 1, 2013, the measures for the HQIP supplemental payments are:

1. Rate of Central Line-Associated Blood Stream Infections (CLABSI)
2. Rate of elective deliveries between 37 and 39 weeks gestation
3. Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT)
4. Rate of thirty (30) day all-cause readmissions
5. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position.

Total Funds for this payment equal:

FFY 2012-13 $32,000,000	
FFY 2013-14 $34,388,388	

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after HQIP payments have been made, reconciliations and adjustments to impacted hospitals will be made retroactively.