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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-14-0052

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
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

Financial Management Group

MAY 18 2015

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

Re: Colorado 14-0052

Dear Ms. Prehmus:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-0052. Effective for services on or after October 1, 2014, revises inpatient supplemental Medicaid payments to Colorado hospitals. Specifically, this amendment suspends several supplemental payments, as well as updates the payment pools for existing supplemental payments.

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 14-0052 is approved effective October 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,

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: 14-052

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: 10/1/2014

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

CFR 42 Section 447.272

7. FEDERAL BUDGET IMPACT
   a. FFY__2013-14___ $_0.00____________
   b. FFY__2014-15___ $_0.00____________

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19A – Pages 17, 29a, 29b, 29c, 29d, 38a, 42, 43, 48, 48a, 49, 49a, 50a, 51, 51b, 52, 52a, 53a, 54, 56, 57, 57a, 58

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19A – Pages 17, 29a, 29b, 29c, 38a, 42, 43, 48, 49, 49a, 50a, 51, 52, 52a, 53a, 54, 56, 57, 58

10. SUBJECT OF AMENDMENT

Supplemental Medicaid Inpatient and Disproportionate Share Hospital Payments Revised

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

GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED

Governor's letter dated 01 September 2011

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: **John Bartholomew**

14. TITLE: **Director, Finance Office**

15. DATE SUBMITTED: 12/30/14

16. RETURN TO

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

Attn: Barbara Prehmus

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED: MAY 18 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 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*

The funds available for the Low-Income Shortfall payment under the Disproportionate Share Hospital Allotment are limited by the regulations set by and 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 the payment equal:

State Fiscal Year 2003-04	$66,710
State Fiscal Year 2004-05	$113,312
State Fiscal Year 2005-06	$145,470
State Fiscal Year 2006-07	$189,588
State Fiscal Year 2007-08	$530
State Fiscal Year 2008-09	$176,324

11. Effective July 1, 2009, the payment adjustment, as described above in this subsection and commonly known as Low-Income Shortfall payment, is suspended.

12. Effective July 1, 2009, Hospitals deemed eligible for minimum disproportionate share payment and participate in the Colorado Indigent Care Program will receive a CICP Disproportionate Share Hospital payment.

13. Effective July 1, 2009, Hospitals deemed eligible for minimum disproportionate share payment and do not participate in the Colorado Indigent Care Program will receive an Uninsured Disproportionate Share Hospital payment.

14. Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "CICP Disproportionate Share Hospital payment" is suspended.

15. Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Uninsured Disproportionate Share Hospital payment" is suspended.

16. Effective October 1, 2014, Hospitals deemed eligible for the minimum disproportionate share payment shall receive a Disproportionate Share Hospital payment.

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 Fiscal Year	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.

9. Effective October 1, 2014, the Disproportionate Share Hospital adjustment commonly referred to as "CICP Disproportionate Share Hospital payment" is suspended.

10. Effective October 1, 2014, qualified hospitals shall receive a disproportionate share hospital payment commonly referred to as the "Disproportionate Share Hospital Supplemental payment", 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 Disproportionate Share Hospital payment a Colorado hospital shall meet either of the following criteria:

    a. Is not a licensed or certified Psychiatric Hospital, is a Colorado Indigent Care Program provider, and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act; or

    b. Is not a licensed or certified Psychiatric Hospital, has a Medicaid Inpatient Utilization Rate equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act.

    Qualified hospitals shall receive a payment calculated as a percent of uninsured costs multiplied by the state's annual Disproportionate Share Hospital allotment. The percent of uninsured costs shall be the total of all uninsured costs for a qualified hospital divided by the total uninsured costs for all qualified hospitals.

    No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit as specified in federal regulation. If upon review, the Disproportionate Share Hospital Supplemental payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific Disproportionate Share Hospital limit. The reduction shall then be redistributed to the other qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital Limit.

    The state will not exceed the total of all the hospital-specific Disproportionate Share Hospital Limits even if the total is below the state's annual Disproportionate Share Hospital allotment.

    In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a 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.

Fiscal Year	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.

2. Effective October 1, 2014, the Disproportionate Share Hospital adjustment commonly referred to as "Uninsured Disproportionate Share Hospital payment" is suspended.

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 50% of their inflated medically indigent costs.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "CICP Supplemental Medicaid payment" is suspended.

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
FY 2014-15	$19,574,772

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.

Effective October 1, 2014, the additional $1,000,000 Pediatric Major Teaching payment is suspended.

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

This payment is no longer funded and the information contained in this section is for historical record only.

J. Inpatient Hospital Base Rate Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals paid on the Medicaid Prospective Payment System (PPS Hospitals) 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 "Inpatient Hospital Base Rate 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 Inpatient Hospital Base Rate Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

The Inpatient Hospital Base Rate 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 and the CICP Supplemental Medicaid payment.

Effective October 1, 2014 the Inpatient Hospital Base Rate Supplemental Medicaid Payment shall be only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), Pediatric Major Teaching payment, State University Teaching Hospital payment, and Family Medicine Residency payment.

To qualify for the Inpatient Hospital Base Rate Supplemental Medicaid payment a hospital shall meet the following criteria:

1. Has an established Medicaid base rate, as specified under 4.19A I. Methods and Standards for Established Prospective Payments Rates – Inpatient Hospital Services of this State Plan; and
2. Is not a free-standing psychiatric facility, which is exempt from the DRG-based prospective payment system.

The Inpatient Hospital Base Rate 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 by using hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix, multiplied by the hospital specific differential Medicaid base rate.

The hospital specific differential Medicaid base rate is the difference between Medicaid base rate calculated prior to any Medicaid hospital specific cost add-ons and the Medicare Base Rate as specified under 4.19A I. Methods and Standards for Established Prospective Payments Rates – Inpatient Hospital Services of this State Plan.

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

Effective October 1, 2014 for each qualified hospital, the percentage adjustment factor shall vary for state-owned, non-state government owned, and private hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Safety Net Specialty Hospitals, or for other hospital classifications such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

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.

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.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "High-Level NICU Supplemental Medicaid payment" is suspended.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a High-Level NICU Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

L. State Teaching Hospital Supplemental Medicaid Payment

Effective July 1, 2009, Colorado hospitals qualify as a State Teaching Hospital shall receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments shall not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). This additional supplemental Medicaid reimbursement shall be commonly referred to as the "State Teaching Hospital Supplemental Medicaid payment" which shall be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in monthly installments.

Effective October 1, 2010, the State Teaching Hospital Supplemental Medicaid payment shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

The State Teaching Hospital Supplemental Medicaid payment is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment, the Inpatient Hospital Base Rate Supplemental Medicaid payment and High-Level NICU Supplemental Medicaid payment.

To qualify for the State Teaching Hospital Supplemental Medicaid payment a hospital shall meet the following criteria:

a. Is a State University Teaching Hospital, as defined under Attachment 4.19A, Section II Family Medicine Program of this State Plan;
b. Is a High Volume Medicaid and CICP Hospital, as defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and Colorado Indigent Care Program days combined equal at least 30% of their total inpatient days; and
c. Is licensed or certified as a General Hospital by the Colorado Department of Public Health Environment.

The State Teaching Hospital Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each qualified hospital, this payment shall be calculated on a per Medicaid day basis as follows:

a. Effective July 1, 2009, qualified hospitals shall receive $75 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days).
b. Effective October 1, 2010, qualified hospitals shall receive $125 per Medicaid day, including Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days). Effective October 1, 2011, qualified hospitals shall receive $100 per Medicaid day. Effective October 1, 2012, the State Teaching Supplemental Medicaid payment is $0.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a State Teaching Hospital Supplemental Medicaid payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "State Teaching Hospital Supplemental Medicaid payment" is suspended.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Acute Care Psychiatric Supplemental Medicaid payment" is suspended.

N. Effective October 1, 2014, qualified hospitals with uninsured costs shall receive an additional supplemental Medicaid reimbursement commonly referred to as "Uncompensated Care Supplemental Hospital Medicaid payment" which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

The Uncompensated Care 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 Uncompensated Care Supplemental Medicaid payment a hospital shall meet the following criteria:

1. 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.

Qualified hospitals with twenty-five or fewer beds shall receive a payment calculated as the percentage of beds to total beds for qualified hospitals with twenty-five or fewer beds multiplied by $33,500,000. Qualified hospitals with greater than twenty-five beds shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for qualified hospitals with greater than twenty-five beds multiplied by $81,980,176.

O. 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.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Large Rural Hospital Supplemental Medicaid payment" is suspended.

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.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Denver Metro Supplemental Medicaid payment" is suspended.

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.

Effective October 1, 2014, the Supplemental Medicaid Payment commonly referred to as "Metropolitan Statistical Area Supplemental Medicaid payment" is suspended.

P. 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 the number of points designated for the measure.
2. Determine points earned per measure by hospital based on established scoring criteria.
3. Normalize the total points earned for all measures by hospital to total possible points for all measures by hospital.
4. Calculate adjusted discharges by hospital.
    a. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by the Adjusted Discharge Factor.

b. For hospitals with less than 200 annual Medicaid discharges, the total number of discharges is multiplied by .25 to arrive at the number of Medicaid inpatient discharges for use in this calculation, consistent with the Medicare Prospective Payment System calculation.

c. The Adjusted Discharge Factor is defined as the most recently available annual total gross Medicaid billed charges divided by the inpatient gross Medicaid billed charges.

5. Calculate Total Discharge Points.

   a. Discharge Points are defined as the total number of points earned for all measures multiplied by the number of adjusted Medicaid 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 for all hospitals.

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

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), and
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, and

5. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position.

Effective October 1, 2014, the measures for the HQIP supplemental payments are:

1. Rate of Non-Emergent Emergency Room Visits,
2. Rate of elective deliveries between 37 and 39 weeks gestation,
3. Rate of Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT),
4. Rate of thirty (30) day all-cause hospital readmissions, and
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	
FFY 2014-15 $61,488,873	

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.

Q. Public High Volume Medicaid and CICP Hospital Payment

Effective July 1, 2010, Colorado public hospitals that meet the definition of a High Volume Medicaid and CICP Hospital shall qualify to receive an additional supplemental Medicaid reimbursement for uncompensated inpatient hospital care for Medicaid clients. This additional supplemental shall commonly be referred to as the "Public High Volume Medicaid and CICP Hospital Payment."

To qualify for the Public High Volume Medicaid and CICP Hospital Payment, a hospital shall meet the following criteria:

1. Licensed as a General Hospital by the Colorado Department of Public Health and Environment.
2. Classified as a state-owned government or non-state owned government hospital.
3. Is a High Volume Medicaid and CICP Hospital, defined as those hospitals which participate in the Colorado Indigent Care Program (CICP), whose Medicaid inpatient days per year total at least 35,000, and whose Medicaid and CICP days combined equal at least 30% of their total inpatient days.
4. Maintain the hospital's percentage of Medicaid inpatient days compared total days at or above the prior State Fiscal Year's level.

The Public High Volume Medicaid and CICP Hospital Payments will only be made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Pediatric Major Teaching payment, the CICP Supplemental Medicaid payment, the Inpatient Hospital Base Rate Supplemental Medicaid payment, the High-Level NICU Supplemental Medicaid payment, the State Teaching Hospital Supplemental Medicaid payment, the Acute Care Psychiatric Supplemental Medicaid payment, the Large Rural Supplemental Medicaid payment, the Denver Metro Supplemental Medicaid payment and the Metropolitan Statistical Area Supplemental Medicaid payment, and the Hospital Quality Incentive Payment

The Interim Payment to qualified providers will be calculated for the actual expenditure period using the filed CMS 2552-96 Medicare Cost Report, or its successor, and disbursed biannually after the actual expenditure period. Interim Payments for uncompensated Medicaid inpatient hospital costs for Cost Report Year 2010 will be made by June 30, 2012. Interim payments for uncompensated Medicaid inpatient hospital costs for Cost Report Years 2011 and thereafter, will be calculated each year and paid by the following October 31st of each year for hospitals with cost reporting periods ending December 31st and by the following April 30th for those hospitals with cost reporting periods ending June 30th. Uncompensated costs for providing inpatient hospital services for Medicaid clients will be calculated according to the methodology outlined below, using the filed CMS 2552-96 Medicare Cost Report, or its successor.

Final payments will be made biannually. Final payments will be made by October 31st of each year for those qualified hospitals that have submitted their audited CMS 2552-96 Medicare Cost Report for the actual expenditure period, or its successor, to the Department between January 1st and June 30th of that same calendar year. Final payments will be made by April 30th of the following year for those qualified hospitals