

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

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I. Methods and Standards for Establishing Prospective Payment Rates – Inpatient Hospital Services

A. Payment Methods for Hospitals

Effective December 15, 1989 (unless otherwise specified in this plan) the following prospective payment method shall apply to all Colorado participating hospitals except those specialty hospitals and units within general acute care hospitals designated by the State agency as exempt.

B. Definitions

1. **Diagnosis Related Group (DRG):** A patient classification system that reflects clinically cohesive groupings of inpatient hospitalizations utilizing similar hospital resources. Colorado will adopt the Medicare classification system as a base for the DRG payment system. The State Agency has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid.
2. **Principal Diagnosis:** The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.
3. **Relative Weight:** A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases.

Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The State Agency shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.

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4. Hospital Peer Groups: A grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups are defined as follows:
- a. Pediatric Specialty Hospitals: all hospitals providing care exclusively to pediatric populations.
 - b. Rehabilitation and Specialty-Acute Hospitals: all hospitals providing rehabilitation or specialty-acute care (hospitals with average lengths of stay greater than 25 days).
 - c. Rural Hospitals: Colorado Hospitals not located within a federally designated Metropolitan Statistical Area (MSA).
 - d. Urban Hospitals: all Colorado hospitals in MSA's including those in the Denver MSA. Also included would be the Rural Referral Centers in Colorado, as defined by HCFA. (SSAS, 1886 (d) (5) (c) (I); Reg. 412.90 (c) and 412.96).

Facilities which do not fall into the peer groups described in a. or b. will default to the peer groups described in c. and d. based on geographic location.

5. Medicare Base Rate: The hospital specific Medicare base rate, which will be obtained directly from the Medicare Intermediaries, represents the payment a hospital would receive from Medicare for a DRG with a weight equal to one. The Medicare base rate used for rate setting each State Fiscal Year (July 1 through June 30) will be those effective on each October 1 prior to the beginning of the State Fiscal Year.
6. Disproportionate Share Hospital (DSH) factors: These factors are specific payments made by Medicare to Disproportionate Share Hospitals within the Medicare base rate. The operating and capital Disproportionate Share Hospital factors will be obtained from the Medicare Intermediaries. The operating Disproportionate Share Hospital factor is multiplied by the federal portion of the operating subtotal to get the operating Disproportionate Share Hospital amount. The capital Disproportionate Share Hospital factor is multiplied by the capital portion of the federal payment to get the capital Disproportionate Share Hospital amount.

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7. **Budget Neutrality:** Budget Neutrality for PPS Hospitals is defined as no change in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated. The estimated hospital specific payment is calculated by using hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix, multiplied by the Medicaid base rate. Effective July 1, 2015 Budget Neutrality is defined as 1.104261% increase in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated.

8. **Medicaid Base Rate or Base Rate:** An estimated cost per Medicaid discharge.

For PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by modifying the Medicare base rate by a set percentage equally to all PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals. This percentage will be determined to maintain Budget Neutrality for all PPS Hospitals, including Rehabilitation and Specialty-Acute Hospitals.

For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the Medicaid base rate used will be the average Medicaid base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty Medicaid discharges in the previous fiscal year.

Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge amount for Nursery, Neo-Natal, Intensive Care Units, and Graduate Medical Education obtained directly from the most recently audited Medicare/Medicaid cost report. Ten percent of each of these cost per discharge amounts will be added on to the base rate.

Effective May 23, 2008, the Graduate Medical Education add-on will not be applied directly to the Medicaid inpatient base rate for Denver Health Medical Center and University of Colorado Hospital. These hospitals will receive reimbursement for Graduate Medical Education costs through a direct payment as they qualify to receive

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a State University Teaching Hospital payment as specified under this Attachment 4.19A.

Pediatric Specialty Hospitals will receive an adjustment factor of 0.681330 effective July 1, 2015.

Effective July 1, 2008 Urban Center Safety Net Specialty Hospitals will receive their hospital specific Medicare base rate adjusted by the percentage applied to all other hospitals plus 10 percent to account for the specialty care provided. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent. Add-ons are included in the final rate. To qualify as an Urban Center Safety Net Specialty Hospital, the urban 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. Medicaid 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. If the provider fails to report the requested days, the days used shall be collected from data published by the Colorado Hospital Association in its most recent annual report available on March 1 of each year. The CICP days shall be those reported in the most recently available CICP Annual Report as of March 1 of each year.

Beginning July 1, 2015 for PPS Rehabilitation and Specialty-Acute Hospitals including acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries, the hospital specific Medicaid base rate will be equal to each hospital's July 1, 2014 Medicaid base rate increased by one half of one percent (0.5%).

Hospital specific Medicaid base rates are adjusted annually (rebased) and are effective each July 1. Medicaid base rates will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. For instances where the General Assembly appropriates a change in funding during the State Fiscal Year, the hospital specific Medicaid base rates will be adjusted to allow for the change in funding.

Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year.

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Rate letters will document the Medicaid base rate and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology.

9. Effective for inpatient hospital claims with discharge dates on or after October 1, 2009, Serious Reportable Events will not be used for Colorado Medicaid DRG assignment when the condition was not present on admission. When applicable, reimbursement to a hospital will be adjusted automatically or via retrospective reviews.

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Payment Adjustment for Provider Preventable Conditions

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care Acquired Conditions for non-payment under Section 4.19-A of this State plan, which apply to all inpatient care except for inpatient psychiatric hospitals.

Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider Preventable Conditions for non-payment under Section 4.19-A of this State plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below: None. The State is adopting the baseline approach.

Adjustment Methodology

The State uses the following methodology to adjust payments for the occurrence of provider-preventable conditions:

1. For Health Care Acquired Conditions (HCAC): The State reviews claims to ensure that there was no reimbursement for a secondary diagnosis that is on the list of HCACs, and that was not present on admission. If the State finds any HCAC that was not present on admission, reimbursement will be adjusted automatically at the time of claim adjudication, or after a retrospective review is complete.

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Payment Adjustment for Provider Preventable Conditions (cont'd)

2. No payment is made for inpatient services billed for Other Provider Preventable Conditions, as described in the "Other Provider Preventable Conditions" section. If, during retrospective review, the State finds any Other Provider Preventable Condition that was billed and reimbursed, the State will recover the reimbursement through a claim adjustment.

In the event that individual cases are identified before the provider-preventable conditions policy is fully implemented on July 1, 2012, the State will adjust reimbursements according to the methodology above.

In compliance with 42 CFR 447.26(c), the State assures the following:

1. There is no reduction in payment for a Provider Preventable Condition that existed before treatment had begun for that patient by that provider.
2. The State reduces provider payment for Provider Preventable Conditions only when:
 - a. The identified Provider Preventable Condition would otherwise result in an increase in payment.
 - b. The State can reasonably isolate for nonpayment the portion of the payment directly related to the Provider Preventable Condition and its treatment.
3. Non-payment for Provider Preventable Conditions does not prevent access to services for Medicaid beneficiaries.

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10. **Outlier Days:** The days in a hospital stay which occur after the trim point. The trim point is that day which would occur at 1.94 standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations may be adjusted when changes are made to the DRG grouper methodology. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.
11. **Infant Cost Outlier.** To address the need for adequate payment for pediatric hospitalization involving exceptionally high costs or long lengths of stay, the State established day outlier payment at 80% of the hospital DRG per diem (rather than 60%, the Medicare rate) rather than to establish a separate cost outlier mechanism.

C. DRG Method of Payment

1. The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the patient was treated, surgical procedures involved, and complication of the illness. Every DRG has been assigned a relative weight and trim point, based primarily on Colorado-specific cost data. The State Agency shall periodically rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG.
2. The DRG relative weight will be multiplied by the base rate for the hospital to generate the payment amount.
3. When approved outlier days occur, 80% of the DRG per diem will be paid for each additional outlier day. The DRG per diem is the total DRG payment divided by the average length of stay. The percentage will be determined by the State Agency.
4. All State-operated facilities will be exempt from the DRG-based prospective payment system.
5. Abbreviated patient stays will be paid as follows:
 - a. The hospital will receive the full DRG payment for all patient deaths and cases in which the patient left against medical advice.

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- b. In cases involving transfers, each hospital involved, excluding rehabilitation and specialty-acute hospitals, will be paid a DRG per diem for each case based upon the full DRG payment divided by the average length of stay for the DRG (up to a maximum of one full DRG payment.) These discharges may also qualify for outlier payment.
- c. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility. Documented emergency cases are exempt from prior authorization.

D. Adjustments To The Payment Formula

- 1. Adjustments to the DRG classification system, weights, and trim points will be made when appropriate.
- 2. In order to continue to meet the Federal Boren Amendment requirements, the information used to calculate each prospective payment system (PPS) facility's cost per discharge will be updated. The following rebasing and payment protocol for payments is established:
 - a. Effective September 19, 1990, the base rate for each facility shall be calculated based upon the most recently audited cost report available for each facility (as of 12/31/87). Changes made to audited cost reports after the rebasing calculations will not constitute the basis for a provider appeal. For the time period between July 1, 1990 and September 18, 1990, those hospital whose base rate increased by 7% or less as a result of the implementation of State Plan Amendment 90-02, should be assured a rate increase of at least 7% (not to exceed their FY 91 payment rate) during this 80 day period (July 1, 1990 to September 18, 1990).
 - b. Beginning July, 1991, an annual inflator shall be applied to each facility's cost per discharge. This annual inflator shall be derived as follows:
 - i. The HCFA Hospital Market Basket Index for the most recent year (in this case FY 1990-91) shall be used as the basis for the inflator.

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- ii. The HCFA Hospital Market Basket Index will be compared to the weighted average increase in the cost per discharge for each peer group. The weighted average increase will be determined by comparing the increase in costs from cost reports available for FYE 12/31/88. (In each subsequent fiscal year, the cost reports used for making the comparison shall be rolled forward by one year.)
 - iii. If the weighted average increase within each peer group in the cost per discharge is greater than the HCFA Hospital Market Basket Index, the difference between the figures will be added to the Market Basket Index to derive the annual inflator.
 - iv. Under no circumstances shall the annual weighted average increase in cost within any peer group driven by this calculation exceed a 7% limit.
 - v. The annual inflator is subject to changes in appropriations made by the General Assembly and the annual inflator may be adjusted by the Department accordingly. Prior to the start of the State Fiscal Year providers will receive a letter from the Department describing how the rate, including inflation, was calculated.
- c. On the third year (July, 1993) rates shall be calculated based upon the audited cost reports available for each facility for FYE 12/31/90. If the audited cost data show that the annual inflators were too high, or if they show the inflators were too low, the actual cost from the reports available for FYE 12/31/90 shall be used. There shall be NO retrospective changes to the rates if/when the "third year" rebased rates show that the 7% annual inflator was inaccurate.
- d. Beginning July, 1993, rates shall be recalculated or rebased every third year and the annual inflator shall be used to increase the rates in the interim years.
- e. In rebasing years, the initial base rate for pediatric specialty hospitals will be attributed to the routine, ancillary, capital, and medical education cost centers, proportionally, based on the actual costs from the most recently audited cost report. The cost per discharge for the medical education cost center, which is capped at 100 percent, will be deducted from the initial base rate and the remainder will be attributed to the other three costs centers in proportion to actual costs. These figures, which will add up to the total base rate, will represent the pediatric specialty hospital peer group caps for the routine, ancillary, and capital cost centers. These figures will be used as the starting point for subsequent payment cap adjustments as described in the previous definition of Base Rate.

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- f. Effective July 1, 2003 all adjustments outlined in number 2. of this section (Adjustments To The Payment Formula) are suspended.

E. Adjustments For Exempt Providers

1. Exempt hospitals will receive annual modifications to per diem rates based on inflationary adjustments as determined by the Medicare Economic Index. In no case shall the per diem rate granted to an exempt hospital exceed the facility's allowable Medicaid cost per day.
2. Effective October 1, 2001, government-owned mental health institutes shall receive annual modifications to the per diem rates. The rates shall be established to cover 100 percent of the total allowable cost to treat Medicaid clients. Payments are calculated using interim rates and later adjusted to a final rate, as described below:
 - a. **Interim Rates.** The Colorado Department of Human Services (CDHS) files by November 30 of each year (5 months before the end of the fiscal year) the Medicare cost report for the state mental health institutes. CDHS calculates the interim per diem rates using a 9-month cost report that is identical to the first portion of the Medicare cost report. CDHS divides the total allowable costs (contained in the report) by the number of patient days for each unit in the mental health institutes. Once the CDHS Director of Hospital Services approves this report, the rates are sent to the Department, where the educational component of the rate is "carved out" and the resulting interim rates are put into the MMIS with an effective date of July 1.
 - b. **Final Rates and Reconciliation.** A Medicare audit is initiated after the Medicare cost report is submitted. Once the Medicare audit is complete, CDHS files the Medicaid cost report, a state-developed report based on the 2552 with some minor adjustments. The state mental health institutes must file the Medicaid cost report four months after the Medicare audit is finalized. The Department initiates the Medicaid audit once the Medicaid cost report has been filed and the Department has access to the necessary expenditure summary data from the MMIS. After the Medicaid audit has been completed, the Department calculates retroactive per diem rates for each of the units in the mental health institutes. These are the state's final rates and are used to complete the cost settlements.
3. Exempt hospitals are eligible for the Major Teaching Hospital and Disproportionate Share Payments.

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F. Adjustments For Out-of-State Providers

1. Non-emergent inpatient medical care rendered at an out-of-state hospital to a Colorado Medicaid patient must be prior authorized by the Department, based upon review and recommendation by the Peer Review Organization (PRO).
2. Payment for out-of-state and non-participating Colorado Hospital inpatient services shall be at a rate equal to 90% of the average Colorado Urban or Rural DRG payment rate. Out-of State urban hospitals are those hospitals located within the Metropolitan Statistical Areas (MSA) as designated by the U.S. Department of Health and Human Services.
3. Effective January 1, 1992: When needed inpatient transplant services are not available at a Colorado Hospital, payment can be made at a higher rate (than 90% of the average Colorado Urban or Rural DRG payment rate) for non-emergent services if the provider chooses this payment method. When not reimbursed at a DRG payment rate the out-of-state hospital will be paid based upon the following criteria:
 - a. Payment shall be 100% of audited Medicaid costs.
 - b. In no case shall payment exceed \$1,000,000 per admission.
4. All hospitals participating in the Medicaid program will submit Medicaid and total hospital utilization, statistical, and financial data to the Colorado Hospital Association Data Bank Program. If a hospital does not report to the Colorado Hospital Association Data Bank, the State agency will send the required format for reporting this data.

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G. Free-Standing Psychiatric Hospitals (Excluding State Institutions):

1. Care provided in free-standing hospitals to Medicaid clients under the age of 21 is reimbursed using two per diem rates:
 - (a) The initial per diem rate is paid during the first seven days of a client's stay.
 - (b) The second per diem rate begins on the eighth day of a client's stay and is paid for the remainder of the stay. This rate is lower than the initial per diem rate.
 - (c) Rationale: The Department analyzed historical Medicaid payment rate data and evaluated the relationship between hospital cost data and patient length of stay. Medicaid cost data from FY1987 revealed that costs for the first seven days of care were 38% higher than costs for the remainder of the certified stay. Based upon this cost relationship, the existing per diem payments made to these facilities were recalibrated to reflect a "step down" in payment after day 7. The two per diem rates, when paid for the entire 42-day average length of stay, will pay an average amount equal to previous payments to these facilities. This revision in payment methodology is designed to be revenue neutral while providing incentives for cost containment.
2. Free-standing psychiatric hospital rates may be updated annually by the methodology outlined in Section E (Adjustments For Exempt Providers), paragraph 1.
3. Effective October 1, 2010, any psychiatric hospital in the state of Colorado that meets all hospital enrollment requirements may be enrolled and eligible for reimbursement as a Colorado Medicaid provider.

H. Public Process for Hospital Rate-Setting

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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II. Family Medicine Program

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies as a Teaching Hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Family Medicine Commission and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the Major Teaching Hospital program, it is not eligible for this program. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Program will be \$213,195. Effective July 1, 1999, the annual payment for each Family Medicine Residency Program will be \$228,379. The annual payment shall change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

The Family Medicine Residency Program payment is calculated on a State Fiscal Year (July 1 through June 30) basis and is distributed equally to all qualified providers in 12 equal monthly installments. Payments will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, 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. Rate letters allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology. Total funds available by state fiscal year (SFY) for this payment are as follows:

SFY 2003-04: \$1,524,626	SFY 2004-05: \$1,444,944	SFY 2005-06: \$1,576,502
SFY 2006-07: \$1,703,558	SFY 2007-08: \$1,868,307	SFY 2008-09: \$1,798,015
SFY 2009-10: \$1,738,846	SFY 2010-11: \$1,738,846	SFY 2011-12: \$1,391,077
SFY 2012-13: \$1,741,077		

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I. Family Medicine Program

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies as a Teaching Hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Family Medicine Commission and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. Family Medicine programs meeting these criteria shall be eligible for an additional payment adjustment as follows:

The Family Medicine Residency Program Payment is calculated on a state fiscal year (July 1 through June 30) basis and is distributed to all qualified providers in monthly installments. Payments will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, 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 specific to each provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the basis that the payment was not calculated correctly given the established funds and rate setting methodology. Total funds available by state fiscal year (SFY) for this payment are as follows:

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SFY 2006-07: \$1,703,558	SFY 2007-08: \$1,868,307	SFY 2008-09: \$1,798,015
SFY 2009-10: \$1,738,846	SFY 2010-11: \$1,738,846	SFY 2011-12: \$1,391,077
SFY 2012-13: \$1,741,077	SFY 2013-14: \$2,371,077	SFY 2014-15: \$2,371,077
SFY 2015-16: \$5,114,422		

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Effective May 23, 2008, the Family Medicine Residency Program Payment for providers that qualify to receive the State University Teaching Hospital Payment is suspended.

Effective May 23, 2008, when state owned government hospitals, non-state owned government hospitals, and privately owned hospitals meet the criteria for being a State University Teaching Hospital, they will qualify to receive additional Medicaid reimbursement for services provided to Medicaid recipients. The additional Medicaid reimbursement will be commonly referred to as the "State University Teaching Hospital Payment", which will be established on an annual state fiscal year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The State University Teaching Hospital Payment is made only 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).

A State University Teaching Hospital is defined as a Colorado hospital which meets the following criteria:

1. Provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education.
2. More than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

Qualified providers and the total yearly payments to those are as follows:

SFY 2008-09	SFY 2009-10
Denver Health Medical Center: \$1,829,008	Denver Health Medical Center: \$1,831,714
University of Colorado Hospital: \$697,838	University of Colorado Hospital: \$700,935

SFY 2010-11	SFY 2011-12
Denver Health Medical Center: \$1,831,714	Denver Health Medical Center: \$1,831,714
University of Colorado Hospital: \$676,785	University of Colorado Hospital: \$633,314

SFY 2012-13	SFY 2013-14
Denver Health Medical Center: \$1,831,714	Denver Health Medical Center: \$1,831,714
University of Colorado Hospital: \$633,314	University of Colorado Hospital: \$633,314

SFY 2014-15	SFY 2015-16
Denver Health Medical Center: \$2,804,714	Denver Health Medical Center: \$2,804,714
University of Colorado Hospital: \$633,314	University of Colorado Hospital: \$633,314

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Effective July 1, 2013, a privately-owned hospital that receives the Family Medicine Residency Payment or the Pediatric Major Teaching Payment authorized in this Attachment 4.19A, and is selected by the Commission on Family Medicine Residency Training Programs for the development and maintenance of family medicine residency training programs in rural areas, will qualify to receive additional Medicaid reimbursement. This reimbursement will be commonly referred to as the "Rural Family Medicine Residency Development Payment". The Rural Family Medicine Residency Development Payment is made only 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 Rural Family Medicine Residency Development Payment is disbursed on a state fiscal year basis (July 1 – June 30). The Rural Family Medicine Residency Development Payment will be paid quarterly. Total funds available for this payment per state fiscal year are as follows:

SFY 2013-14	SFY 2014-15
\$1,000,000	\$3,030,766
SFY 2015-16	
\$3,030,766	

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III. Disproportionate Share Hospital Adjustment

A. Federal regulations require that hospitals which provide services to a disproportionate share of Medicaid recipients, shall receive an additional payment amount to be based upon the following minimum criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and
2. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area, (that is an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
3. Number 2 above does not apply to a hospital in which:
 - a. The inpatients are predominantly under 18 years of age; or
 - b. Does not offer non-emergency obstetric services as of December 21, 1987.

The Medicaid inpatient utilization rate for a hospital shall be computed as the total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.

The calculation of the Medicaid inpatient utilization rate will include managed care patient days.

4. For purposes of paragraph 8.A.1., the term "low income utilization rate" means, for a hospital, the sum of:
 - a. The fraction (expressed as a percentage)
 - i. The numerator of which is the sum (for a period) of (I) total revenues paid the hospital for patient services under a State Plan under this title and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

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ii. The denominator of which is the total amount of revenues of the hospital for patient service (including the amount of such cash subsidies) in the period; and

b. The fraction (expressed as a percentage)

i. The numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (i) (ii) of subparagraph (A) (of section 1923 of the Social Security Act) in the period reasonably attributable to inpatient hospital services, and

ii. The denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approach under this title).

5. The calculation of the low income utilization rate will include revenues paid the hospital from managed care entities on behalf of Medicaid beneficiaries.

B. Colorado determination of Individual Hospital Disproportionate Payment Adjustment.

Effective January 1, 1991, hospitals deemed eligible for minimum disproportionate share payment will receive the following payment adjustment:

1. Hospitals with a Medicaid inpatient utilization rate in excess of one standard deviation above the State's mean Medicaid patient day utilization rate will receive a minimum of a 2 1/2% increase in the calculated base or per diem rate. To pay hospitals proportionally for their level of Medicaid inpatient utilization the following schedule will be applied to each specific Medicaid utilization rate:

<u>STANDARD DEVIATION LEVEL ABOVE MEAN</u>	<u>INCREASE IN MEDICAID PAYMENT</u>
1.0-1.19	2.5%
1.2-1.39	3.0%
1.4 -1.59	3.5%
1.6 -1.79	4.0%
1.8 -1.99	4.5%
2.0 -2.19	5.0%

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2.2 -2.39	5.5%
2.4 -2.59	6.0%
2.6 -2.79	6.5%
2.8 -2.99	7.0%
3.0 -3.19	7.5%
3.2 -3.39	8.0%
3.4 -3.59	8.5%
3.6 -3.79	9.0%
3.8 -3.99	9.5%
4.0 +	10.0%

2. Hospitals qualifying under the low-income utilization rate formula, but not under the Medicaid inpatient utilization rate formula, will receive at a minimum 0.1% increase in payment. To pay hospitals proportionately for their level of low-income utilization, the following schedule will be applied to each specific low-income utilization rate:

<u>LOW-INCOME UTILIZATION PERCENT</u>	<u>INCREASE IN MEDICAID PAYMENT</u>
25% - 49.99%	0.10%
50% - 74.99%	0.15%
75% - 99.99%	0.20%
100% +	0.25%

3. Hospitals qualifying under both formulae will receive only the Medicaid inpatient utilization adjustment.
4. Effective January 1, 1994, no hospital can be considered to be a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of at least one-percent.

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5. Disproportionate share amounts shall be based upon the recalculated base rate for affected facilities (prospectively determined annually in conjunction with base rate changes.) The percentage of Medicaid patients in each facility used to calculate the appropriate disproportionate share payments (if any) shall be based upon the most recent Colorado Hospital Association Data Bank information available, and information from hospitals not participating in the Data Bank describing total patient days and Medicaid days. This information received by the department will be used to assure that all Colorado hospitals receiving Medicaid payments will be included in the calculation of disproportionate share amounts. Data Bank information will be subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care.
6. Effective February 22, 2002, the payment adjustment, as described above in this subsection and commonly known as Pre-Component 1, is suspended.
7. Effective July 1, 2002, the Individual Hospital Disproportionate Share Payment Adjustment calculation, as described above in this subsection and commonly known as Pre-Component 1, is superseded by a new payment method. Hospitals with a Medicaid inpatient utilization rate in excess of one standard deviation above the State's Medicaid patient day utilization rate will receive a predetermined reimbursement for the entire fiscal year distributed on a quarterly basis. This predetermined yearly reimbursement will be based on self-pay and others patient day utilization, excluding Colorado Indigent Care Program days, adjusted for each facility's Colorado Medicaid fee-for-service case mix and the appropriated dollars by the General Assembly. Self-pay and others patient day utilization will be as reported by the most recently available Colorado Hospital Association Data Bank information. Others patient day utilization excludes clients reported as Medicare, Medicaid, Champus, Managed Care and Commercial. The Colorado Indigent Care Program days will be as reported in the corresponding Colorado Indigent Care Program annual report. The Colorado Medicaid fee-for-service case mix will be obtained from the Colorado Foundation for Medical Care corresponding submitted report to the Department and will be set equal to one if unavailable. If the eligible hospital does not report to the Colorado Hospital Association Data Bank, the self-pay and others patient day utilization will be directly reported by the hospital to the Department. An eligible hospital will receive a percentage of the appropriated dollars equal to that hospital's percentage of the self-pay and others patient day utilization, excluding Colorado Indigent Care Program days, adjusted for each facility's Colorado Medicaid fee-for-service case mix relative to all eligible hospitals.

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8. Effective July 1, 2003, the payment adjustment, as described above in this subsection and commonly known as Pre-Component 1, is suspended.
9. Effective July 1, 2003, Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a Low-Income payment.
10. Effective July 1, 2003, Hospitals deemed eligible for minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "Low-Income Shortfall payment," which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

As required by federal regulations this payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low-Income Shortfall payment for the specific provider. Self Pay Days, Other Days and Medicaid Days will be reported by the provider for the most recent year for which data are available. As required by Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific uncompensated costs.

For this section, Self Pay Days, Other Paid Days, Medicaid Days and Total Days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report the requested Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

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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 CICIP 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 "CICIP 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.

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C. Colorado determination of Individual Hospital Disproportionate Payment Adjustment Associated with the Colorado Indigent Care Program and Bad Debt.

1. Effective July 1, 1993 Component 1 shall be superseded by a Disproportionate Share Adjustment payment method (herein described as Component 1a) which shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, disproportionate Share Hospital Adjustments, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

a. Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Programs reimbursements.

b. For each hospital that qualifies under this section D, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year. This cost data will be inflated forward from the year of the most recent available report (using the CPI-W, Medical Care for Denver) through June 30 of the fiscal year payment period. The Colorado Indigent Care Program costs, patient payments, and Program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Program, subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care, and/or independent audit. Aggregate disproportionate share hospital payments will not exceed the published disproportionate share hospital limitations.

2. Effective for the period from June 1, 1994 to June 30, 1994: each facility will receive a payment proportional to the level of low income care services provided, as measured by the percent of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program Patient payments and Colorado Indigent Care Program reimbursements, that will allow the State to approach but not exceed the State's Federal Fiscal Year 1994 Disproportionate Share Hospital allotment as published in the May 2, 1994 Federal Register. If these reimbursements exceed the federal allotment limits, they will be recovered

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proportionately from all participating hospitals. The State will use historical data from the SFY 91/92 Colorado Indigent Care Program Annual Report to develop the prospective payment rate. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State, (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)).

3. Effective for the period from July 1, 1994 to June 30, 1995, each facility will receive a payment proportional to the level of low income care services provided, as measured by 200% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).
4. Effective July 1, 1995, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).
5. Effective July 1, 2003 the Disproportionate Share Hospital adjustment commonly referred to as "Component 1a" is suspended.

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6. Effective June 1 through June 30, 1995, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 200% of the hospital's reported Colorado Hospital Association bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report available before rate setting by the Department, inflated from the year of the annual report to June, 1995 using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, and reduced by estimated patient payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)).

7. Effective from July 1, 1998, through September 30, 1998, and from October 1, 1998 through September 30, 1999, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of \$93 million in Federal Fiscal Year 1998, and \$85 million in Federal Fiscal Year 1999. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)).

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8. Effective from September 1, 2000, through September 30, 2000, each government hospital will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of \$79 million in Federal Fiscal Year 2000. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any government disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustments, paragraph (A)). Effective June 1, 2001, this bad debt Disproportionate Share Adjustment payment to government hospitals is extended to an annual basis, and is subject to the Federal Funds limits of the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The limit for 2001 is \$81.765 million.
9. Effective July 1, 2003 the Bad Debt Disproportionate Share Adjustment payment to government hospitals is modified as follows and is commonly referred to as the "Bad Debt payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed as an annual payment prior to June 30 of each state fiscal year. This payment is available to non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals whose percent of Medicaid days relative to total days equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association.

As required by federal regulations the sum of this payment, the Low-Income Shortfall payment and the Low-Income payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The Bad Debt payment is only made if there is available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment and the Low-Income payment.

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The amount of available federal funds remaining under the Disproportionate Share Hospital allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt Costs for qualified providers. Available Bad Debt charges are converted to Bad Debt costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the request budget 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.

Available funds under the Disproportionate Share Hospital Allotment are multiplied by the percentage resulting from dividing the hospital specific Bad Debt costs by the sum of all Bad Debt costs for qualified providers to calculate the Bad Debt payment for the specific provider. As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific Bad Debts costs.

The funds available for the Bad Debt payment under the Medicare Disproportionate Share Hospital Allotment 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 the payment equal:

State Fiscal Year 2003-04	\$4,591,800
State Fiscal Year 2004-05	\$1,857,450
State Fiscal Year 2005-06	\$280,832
State Fiscal Year 2006-07	\$448,474
State Fiscal Year 2007-08	\$113,045
State Fiscal Year 2008-09	\$756,931

10. Effective July 1, 2009 the Disproportionate Share Hospital adjustment commonly referred to as "Bad Debt payment" is suspended.

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D. Colorado determination of Individual Hospital Disproportionate Payment Adjustment
Associated with the Colorado Indigent Care Program

1. Effective July 1, 1994, an additional Disproportionate Share Adjustment payment method will apply to any Outstate Disproportionate Share hospitals meeting the Medicaid inpatient utilization rate formula. Effective February 26, 1997, an additional Disproportionate Share Adjustment payment method will apply to any Specialty Hospital meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one percent. These hospitals do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition, and if they do, they are excluded from receiving this adjustment. Providers currently participating in other disproportionate share refinancing programs, or who are not participating in the Colorado Indigent Care Program, are excluded from receiving this adjustment. Outstate hospitals are defined as those Colorado hospitals that are outside the City and County of Denver, and who participate in the Colorado Indigent Care Program. Specialty Indigent Care Program providers are defined by the Colorado Indigent Care Program as those providers which either offer unique specialized services or serve a unique population.
2. Effective July 1, 2001, Outstate Disproportionate Share hospitals which do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition will be separated into the Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals. Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are owned by a state, county or local government entity. Non-Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are not owned by a state, county or local government entity.

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3. These hospitals must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area, (that is, an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.
4. Hospitals must participate in the Colorado Indigent Care Program, and must meet the separate annual audit requirements of the Colorado Indigent Care Program; and must supply data per the Colorado Indigent Care Program guidelines on total charges, total third party collections, total patient liability and write-off charges to the Colorado Indigent Care Program. Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

Each facility will receive a payment proportional to its uncompensated medically indigent costs, as calculated by the Colorado Indigent Care Program. These uncompensated costs will be calculated by taking total medically indigent charges, subtracting total third party collections and total patient liability to obtain write-off charges, and then multiplying write-off charges by the cost-to-charge ratio as defined by the Colorado Indigent Care Program, to calculate medically indigent write-off costs. The cost-to-charge ratio is defined by the Colorado Indigent Care Program as that cost-to-charge ratio calculated using the most recently submitted Medicare Cost Report for each hospital.

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For each hospital which qualifies under this section, these payments for indigent care costs will be calculated based upon historical data and the amount of funds appropriated annually by the General Assembly. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year. This cost data will be inflated forward from the year of the most recent available report (using the CPI-W, Medical Care for Denver) through June 30 of the fiscal year payment period. The percentage of uncompensated cost reimbursed will be based on appropriations for Outstate Medically Indigent hospitals, but Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals may have different calculated total reimbursement percentages of uncompensated costs. The Disproportionate Share hospital payment will not exceed uncompensated costs as defined in the Social Security Act, SEC.1923(g)(1)(A). Adjustments will be made to the monthly payments based on interim recalculations performed by the Colorado Indigent Care Program.

5. Effective July 1, 2003, payments under this section D are suspended.
6. Effective July 1, 2003, hospitals with a percent of Medicaid days relative to total days equal to or greater than 1% and participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "Low-Income payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent 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 March 1 each fiscal year. Medically indigent costs are inflated forward to the request budget 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.

- a. The request budget year medically indigent costs are weighted (increased) by the following factors to measure the relative Medicaid and low-income care to total care provided. Each provider's specific medically indigent costs are inflated (increased) by the following factors:

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- i. Percent of Medicaid (fee-for-service and managed care) days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.
 - ii. Percent of medically indigent days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.
- b. The request budget year provider specific medically indigent costs are weighted (increased) by the following factors, if they qualify, to account for disproportionately high volumes of Medicaid and low-income care provided. If the provider qualifies, the provider specific medically indigent costs are further inflated (increased) by the following factors:
- i. Disproportionate Share Hospital Factor. To qualify for the Disproportionate Share Hospital Factor, the provider's percent of Medicaid days relative to total days must equal or exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.

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If the provider does qualify, then the Disproportionate Share Hospital Factor will equal the provider's specific percent of Medicaid days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Disproportionate Share Hospital Factor is equal to the provider's specific percent of Medicaid days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of the Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services. If the provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.

- ii. **Medically Indigent Factor.** To qualify for the Medically Indigent Factor, the provider's percent of medically indigent days relative to total inpatient days must equal or exceed the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.

If the provider does qualify, then the Medically Indigent Factor equals the provider specific percent of medically indigent days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Medically Indigent Factor is equal to the provider's specific percent of medically indigent days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government

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hospitals, the Medically Indigent Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services. If the provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.

There will be two allotments for the Low-Income payment: state owned government hospitals plus non-state owned government hospitals, and privately owned hospitals. For state-owned government hospitals plus non-state owned government hospitals, the allotment is the available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment, while for privately owned hospitals the allotment is further limited by the level of General Fund established and amended by the General Assembly.

The available allotments under the Disproportionate Share Hospital Allotment are multiplied by the hospital specific Weighted Medically Indigent Costs divided by the summation of all Weighted Medically Indigent Costs for qualified providers in each specific allotment to calculate the Low-Income payment for the specific provider. As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment to a provider will exceed 100% of hospital specific medically indigent costs, as defined in this section, inflated forward to the request budget 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.

For this section, Medicaid days, medically indigent days and total inpatient days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

As required by federal regulations the sum of this payment and the Low-Income Shortfall payment will not exceed the federal financial participation under the Disproportionate Share Hospital Allotment. The Low-Income payment is made only if there is available federal financial participation under the Disproportionate Share Hospital Allotment after the Low-Income Shortfall payment.

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The funds available for the Low-Income payment under the Medicare Disproportionate Share Hospital Allotment 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 the payment equal:

State Fiscal Year 2003-04	\$163,616,330
State Fiscal Year 2004-05	\$172,284,442
State Fiscal Year 2005-06	\$173,828,898
State Fiscal Year 2006-07	\$173,679,266
State Fiscal Year 2007-08	\$174,000,854
State Fiscal Year 2008-09	\$181,190,648

7. Effective July 1, 2009 the Disproportionate Share Hospital adjustment commonly referred to as "Low-Income payment" is suspended.
8. Effective July 1, 2009, hospitals that participate in the Colorado Indigent Care Program will qualify to receive a disproportionate share hospital payment commonly referred to as the "CICP 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 CICP Disproportionate Share Hospital payment will be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

To qualify for the CICP 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; and
- b. Does participate in the Colorado Indigent Care Program.

The CICP 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 medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent costs using the most recent provider specific

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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 CICIP Disproportionate Share Hospital payment for that category.

Percent of the State's annual Disproportionate Share Hospital Allotment allocated to the CICIP 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 CICIP 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 CICIP 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 "CICIP Disproportionate Share Hospital payment" is suspended.

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2. 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 (CICP) 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.

Effective October 26, 2015, CICP-participating hospitals with CICP write-off costs as published in the most recent CICP Annual Report greater than or equal to 750% of the statewide average will receive a payment equal to their estimated hospital-specific Disproportionate Share Hospital limit. CICP-participating hospitals with CICP write-off costs as published in the most recent CICP Annual Hospital Report less than 750% but greater than 200% of the statewide average will receive a payment equal to 96% of their estimated hospital-specific Disproportionate Share Hospital limit.

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

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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.

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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.

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II. MEDICARE UPPER PAYMENT LIMIT

A. Effective July 1, 2001, non-state owned Government hospitals will receive additional Medicaid reimbursement up to the allowable percentage of each hospital's inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The payment will be calculated based on each hospital's inpatient Medicare base rate multiplied by the allowable Medicare Upper Payment Limit percentage, less the Medicaid base rate, times the Medicaid case mix index times the number of Medicaid discharges. In no case will the payment plus the Medicaid reimbursement exceed the funds appropriated by the Colorado General Assembly in the fiscal year for which the payments are made. Additional payments made to Government Outstate Disproportionate Share Hospitals which participate in the Colorado Indigent Care Program as defined in Attachment 4.19A (subsection Disproportionate Share Hospital Adjustments) will reduce the Disproportionate Share Hospital payments to these Government Outstate Disproportionate Share hospitals by an equal amount. Effective July 1, 2003 the payment described in this section is suspended.

B. Colorado Determination of Individual Hospital Inpatient Medicare Upper Payment Limit Addition Reimbursement who Participate in the Colorado Indigent Care Program

1. Effective July 1, 2003 state owned government hospitals, non-state owned government hospitals and privately owned hospitals, which participate in the Colorado Indigent Care Program, will qualify to receive additional Medicaid reimbursement, such that the total of all payments will not exceed the inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "High-Volume payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

As required by federal regulations, there will be three allotments of the High-Volume payment: state owned government hospitals, non-state owned government hospitals and privately owned hospitals. In no case will the High-Volume payment plus 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 exceed any of these allotments. The High-Volume payment is only made if there is available federal financial participation under these allotments 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 High-Volume payment calculation process is outlined as follows:

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Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent 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 March 1 each fiscal year. Medically indigent costs are inflated forward to the request budget 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.

- a. The request budget year medically indigent costs are weighted (increased) by the following factors to measure the relative Medicaid and low-income care to the total care provided. Each provider's specific medically indigent costs are inflated (increased) by the following factors:
 - i. Percent of Medicaid (fee-for-service and managed care) days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.
 - ii. Percent of medically indigent days relative to total inpatient days. For state owned government hospitals, this percent is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.
- b. The request budget year provider specific medically indigent costs are weighted (increased) by the following factors, if they qualify, to account for disproportionately high volumes of Medicaid and low-income care provided. If the provider qualifies, the provider specific medically indigent costs are further inflated (increased) by the following factors:

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- i. **Disproportionate Share Hospital Factor.** To qualify for the Disproportionate Share Hospital Factor, the provider's percent of Medicaid days relative to total days must equal or exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services.

If the provider does qualify, then the Disproportionate Share Hospital Factor will equal the provider's specific percent of Medicaid days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Disproportionate Share Hospital Factor is equal to the provider's specific percent of Medicaid days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of Medicaid days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of Medicaid days relative to total inpatient days by the number of quantities in the set, such that the set contains all Medicaid providers that provide inpatient hospital services. If the provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.

- ii. **Medically Indigent Factor.** To qualify for the Medically Indigent Factor, the provider's percent of medically indigent days relative to total inpatient days must equal or exceed the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services.

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If the provider does qualify, then the Medically Indigent Factor equals the provider specific percent of medically indigent days relative to total inpatient days. For non-state owned government hospitals with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and privately owned hospitals, the Medically Indigent Factor is equal to the provider's specific percent of medically indigent days relative to total inpatient days doubled. For non-state owned government hospitals with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state owned government hospitals, the Medically Indigent Factor is not allowed to exceed one standard deviation above the arithmetic mean of the percent of medically indigent days relative to total inpatient days. The arithmetic mean is mathematically calculated by dividing the sum of the set of the percent of medically indigent days relative to total inpatient days by the number of quantities in the set, such that the set contains all Colorado Indigent Care Program providers that provide inpatient hospital services. If the provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.

The available allotments under the Medicare Upper Payment Limit are multiplied by the hospital specific Weighted Medically Indigent Costs divided by the summation of all Weighted Medically Indigent Costs for qualified providers in each specific allotment to calculate the High-Volume payment for the specific provider.

The High-Volume payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) plus any Pediatric Major Teaching payment will not exceed inpatient hospital Medicaid costs for Non-state owned and state owned government hospitals. Inpatient hospital Medicaid costs will be the larger of the amount of the billed charges from inpatient claims paid in the most recently available State Fiscal Year multiplied by the cost-to-charge ratio (as defined in this section) or an amount certified by the provider for the most recently available State Fiscal Year, such that both figures will be inflated forward to the request budget 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. Any amount of the calculated High-Volume payment, as defined above, that exceeds inpatient hospital Medicaid costs will be added to the Low-Income payment.

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For this section, Medicaid days, medically indigent days and total inpatient days will be submitted to the Department directly by the provider by April 30 of each year. If the provider fails to report the requested Medicaid days, medically indigent days or total days to the Department the information will be collected from data published by the Colorado Health and Hospital Association in its most recent annual report available on April 30 of each year.

The term allotment in this section refers to the funds available under the three different Medicare UPL provider categories of state owned government hospitals, non-state owned government hospitals and privately owned hospitals. The funds available for the High-Volume 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 the payment equal:

State Fiscal Year 2003-04	\$96,515,460
State Fiscal Year 2004-05	\$81,026,824
State Fiscal Year 2005-06	\$113,040,874
State Fiscal Year 2006-07	\$105,677,834
State Fiscal Year 2007-08	\$105,953,937
State Fiscal Year 2008-09	\$114,495,800

Effective July 1, 2009 the Supplemental Medicaid Payment commonly referred to as "High-Volume payment" is suspended.

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2. Effective July 1, 2003, state owned and non-state owned Government hospitals, which participate in the Colorado Indigent Care Program, will qualify to receive additional Medicaid reimbursement, such that the total of all payments will not exceed the inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). This additional Medicaid reimbursement will be commonly referred to as the "UPL payment" which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed as an annual payment prior to June 30 of each state fiscal year.

As required by federal regulations, there would be two allotments for the UPL payment: state owned government hospitals and non-state owned government hospitals. In no case will the UPL payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the High Volume payment and the Pediatric Major Teaching payment exceed any of these allotments. The UPL payment is made only if there is available federal financial participation under these allotments 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 High Volume Payment and the Pediatric Major Teaching payment.

The UPL payment is calculated as the difference between the Medicare UPL provider specific allotment minus 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 High Volume payment. The Medicare UPL provider specific allotment is a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare Payment Principles. The Medicare UPL provider specific allotment is made on an annual State Fiscal Year (July 1 through June 30) basis.

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The term allotment in this section refers to the funds available under the two different Medicare UPL provider categories of state owned government hospitals and non-state owned government hospitals. The funds available for the UPL payment under the Medicare UPL 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 the provider may understand and independently calculate their payment.

Total funds available for the payment equal:

State Fiscal Year 2003-04	\$0
State Fiscal Year 2004-05	\$0
State Fiscal Year 2005-06	\$0
State Fiscal Year 2006-07	\$0
State Fiscal Year 2007-08	\$0
State Fiscal Year 2008-09	\$0

Effective July 1, 2009 the Supplemental Medicaid Payment commonly referred to as "UPL payment" is suspended.

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3. Effective July 1, 2009, state-owned government hospitals, non-state-owned government hospitals and private-owned hospitals, which participate in the Colorado Indigent Care Program (CICP), will qualify to receive additional 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 (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "CICP Supplemental Medicaid 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 CICP Supplemental Medicaid payment will be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis.

The CICP 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) and the Pediatric Major Teaching payment.

To qualify for the CICP Supplemental Medicaid 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; and
- b. Does participate in the Colorado Indigent Care Program.

The CICP Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data or costs for the payment period. Available medically indigent charges (as published in the most recently available Colorado Indigent Care Program Annual Report) are converted to medically indigent 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. 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 equal to the percent of inflated medically indigent costs multiplied by the hospital specific inflated medically indigent costs minus the hospital specific payment received under the CICP Disproportionate Share Hospital Payment (as described under Attachment 4.19A, Section III.D.8 Colorado Determination of Individual Hospital Disproportionate Payment Adjustment Associated with the Colorado Indigent Care Program). Effective October 1, 2012, hospitals can qualify for up to two increases to weight their inflated CICP costs. Weighted CICP costs are calculated separately for Urban and Rural hospitals. Urban hospitals are defined as those hospitals that are located within a federally

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designated Metropolitan Statistical Area. Rural hospitals are defined as those hospitals that are not located within a federally designated Metropolitan Statistical Area. Qualifying for, and weighting inflated CIGP costs for are determined and calculated as follows:

1. CIGP Cost as a Percentage of Total Cost

a. Urban hospitals whose CIGP costs as a percentage of Total Costs is greater than the mean plus one standard deviation percentage for all Urban hospitals will have their inflated CIGP costs increased by 2% for the purposes of calculating the CIGP Supplemental Medicaid Payment and CIGP Disproportionate Share Hospital Payment.

b. Rural hospitals whose CIGP costs as a percentage of Total Costs is greater than the mean plus one standard deviation percentage for all Rural hospitals will have their inflated CIGP costs increased by 2% for the purposes of calculating the CIGP Supplemental Medicaid Payment and CIGP Disproportionate Share Hospital Payment.

2. Medicaid and CIGP Days as a Percentage of Total Days

a. Urban hospitals whose combined Medicaid and CIGP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all Urban hospitals will have their inflated CIGP costs increased by 5% for the purposes of calculating the CIGP Supplemental Medicaid Payment and CIGP Disproportionate Share Hospital Payment.

b. Rural hospitals whose combined Medicaid and CIGP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all Rural hospitals will have their inflated CIGP costs increased by 5% for the purposes of calculating the CIGP Supplemental Medicaid Payment and CIGP Disproportionate Share Hospital Payment.

c. For those facilities that qualify for both CIGP Inflated Cost weightings, the inflated CIGP cost will be increased by 2% first, and the resulting weighted CIGP costs will then be increased by 5%.

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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.

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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.

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- C. [Historical Reference: effective July 1, 2003 this section moved from Attachment 4.19A, Page 5-6, number 7.A. Original TN No. 97-007, superseded TN No. 95-002, Approved 11/5-97, effective 7/1/97]

Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A hospital qualifies a Major Teaching Hospital when its Medicaid days combined with indigent care days (days of care provided under Colorado's Indigent Care Program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available.

1. A Major Teaching Hospital is defined as a Colorado hospital which meets the following criteria:
 - a. Maintains a minimum of 110 total Intern and Resident F.T.E.'s.
 - b. Maintains a minimum ratio of .30 Intern and Resident F.T.E.'s per licensed bed.
 - c. Meets the Department's eligibility requirement for disproportionate share payment.
2. The additional major teaching payment is calculated as follows:
$$\text{MTHR} - ((\text{ICD} + \text{MD}) \text{TPD}) \times \text{MIAF}$$

Where:

MTHR - Major Teaching Hospital Rate
ICD - Indigent Care Days
MD - Medicaid Days
TPD - Total Patient Days
MIAF - Medically Indigent Adjustment Factor

To further clarify this formula the State describes the MIAF as follows:

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It is the State's intention to pay no hospital a Major Teaching Hospital Allocation that would cause a qualifying hospital to receive an average payment per Medicaid discharge which would exceed the facility's Medicare payment. The MIAF is a number which when multiplied by the numerical quotient derived from ((MD+ICD)/TPD) results in a rate which permits the State to pay a Major Teaching Hospital Allocation at a payment amount which, by design, will not exceed each individual facility's Medicare payment (applied by the State as an individual facility upper limit). The MIAF is derived from calculation of the amount determined by subtracting the average Medicaid payment per case from the average Medicare payment per case for the calculation period, and multiplying this amount by the number of Medicaid patient discharges occurring during that period.

The MIAF is based on the facility's Intern and Residents FTEs:

Intern and Resident FTEs	MIAF - 7/1/93 to 6/30/94	7/1/94 to 6/30/95
110 TO 150	.7209	.5683
151 TO 190	.3301	.9352

3. Payment calculation for hospitals which qualify for the additional Major Teaching Hospital payment shall be as follows:
 - a. Based upon data available at the beginning of each fiscal year, Colorado shall determine each hospital's ICD, MD and TPD. ICD will be extracted from the most recent available Colorado Indigent Care Program Interim Report to the Colorado General Assembly, submitted by the University of Colorado Health Sciences Center. MD and TPD will be extracted from the most recent available Colorado Hospital Association annual Data Bank information subject to validation through use of data from the Department and the Colorado Foundation for Medical Care. In addition, each hospital's Medicaid payment for the previous fiscal year shall be estimated.
 - b. Multiply the Medicaid payment by the calculated MTHR to determine the additional major teaching hospital payment.
 - c. Payment shall be made monthly. [End of Historical Reference]

Effective July 1, 2003 the Major Teaching Hospital payment described in this section is suspended.

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- D. Effective July 1, 2003 state owned government hospitals, non-state owned government hospitals and privately owned hospitals, when they meet the criteria for being a Pediatric Major Teaching Hospital will qualify to receive additional Medicaid reimbursement, such that the total of all payments will not exceed the inpatient Medicare Upper Payment Limit (as defined by the Centers for Medicare and Medicaid Services). The additional Medicaid reimbursement will be commonly referred to as the "Pediatric Major Teaching Hospital payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

As required by federal regulations, there will be three allotments of the Pediatric Major Teaching Hospital payment: state owned government hospitals, non-state owned government hospitals and privately owned hospitals. In no case will the Pediatric Major Teaching payment plus the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) exceed any of these allotments. The Pediatric Major Teaching payment is only made if there is available federal financial participation under these allotments after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program.)

On an annual State Fiscal Year (July 1 through June 30) basis, those hospitals that qualify for a Major Pediatric Teaching Hospital payment will be determined. The determination will be made prior to the beginning of each State Fiscal Year. A Major Pediatric Teaching Hospital 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 combined with indigent care days (days of care provided under Colorado's Indigent Care Program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available; and
3. Has a percentage of Medicaid days relative to total days that exceed one standard deviation above the mean for the prior state fiscal year, or the most recent year for which data are available; and

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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 specific to the provider so that providers may understand and independently calculate their payment.

Total funds available for this payment are as follows:

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
FY 2015-16	\$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.

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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.

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G. Inpatient Hospital Payment for Health Care Services

Effective April 1, 2007, State-owned government hospitals, non-State owned government hospitals, and private hospitals, when they meet the criteria for being a Provider of Inpatient Hospital Health Care Services, shall 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 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 reimbursement for uncompensated care costs 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 "Inpatient Hospital Payment for Health Care Services", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The qualifying criteria for the payment will not directly correlate to the distribution methodology of the payment. The Inpatient Hospital Payment for Health Care Services 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.

A Provider of Inpatient Hospital Health Care Services is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. Owns and operates primary care clinics.

The funds available for the Inpatient Hospital Payment for Health Care Services 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.

Payments shall be distributed based on a qualified Hospital Provider ratio of unique low-income clients who received primary care services in the previous State fiscal year relative to the total unique number of low-income clients who received primary care services for all qualified Hospital Providers in the previous State fiscal year multiplied by the appropriation for the related State Fiscal Year.

Effective July 1, 2008, payments shall be distributed based on a qualified Hospital Provider ratio of unique low-income clients who received primary care services in the previous State fiscal year and their number of visits relative to the total unique number of low-income clients who received primary care services for all qualified Hospital Providers in the previous State fiscal year multiplied by the appropriation for the related State Fiscal Year.

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Total funds available for this payment equal:

State Fiscal Year 2006-07	\$1,104,226
State Fiscal Year 2007-08	\$4,428,000
State Fiscal Year 2008-09	\$3,690,000
State Fiscal Year 2008-09	\$0

Effective September 1, 2009, this payment is suspended.

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H. Rural Hospital Payment

Effective July 1, 2007, non-state owned governmental hospitals and privately owned hospitals, when they meet the criteria for being a Rural Hospital 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 reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. This additional supplemental Medicaid reimbursement will be commonly referred to as the "Rural Hospital payment" and will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Rural Hospital payment is made only 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 Rural Hospital payment will not directly correlate to the distribution methodology of the payment. A Rural Hospital Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. Is not located within a federally designated Metropolitan Statistical Area (MSA); and
3. Has 60 or fewer beds.

The Rural Hospital payment is distributed based on a qualifying hospital's prior year Weighted Medically Indigent Costs relative to the sum of the total Weighted Medically Indigent Costs for all qualifying hospitals, multiplied by the appropriation for the related State Fiscal Year, as defined for the High-Volume payment. Weighted Medically Indigent Costs will be inflated forward to the payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average. The funds available for the Rural Hospital 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:

State Fiscal Year 2007-08	\$1,455,954
State Fiscal Year 2008-09	\$2,500,000
State Fiscal Year 2008-09	\$0

Effective September 1, 2009, this payment is suspended.

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I. Public Hospital Payment

Effective July 1, 2007, State owned and non-state owned government hospitals, when they meet the criteria for being a Public Hospital 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 reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. This additional supplemental Medicaid reimbursement will be commonly referred to as the "Public Hospital payment" which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Public Hospital payment is made only 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 Rural Hospital payment, and the Pediatric Major Teaching payment.

The qualifying criteria for the Public Hospital payment will not directly correlate to the distribution methodology of the payment. A Public Hospital Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. Is a State-owned or non-state owned government hospital.

The Public Hospital payment is distributed based on a qualifying hospital's prior year Weighted Medically Indigent Costs relative to the sum of total Weighted Medically Indigent Costs for all qualifying hospitals, multiplied by the appropriation for the related State Fiscal Year, as defined for the High-Volume payment. Weighted Medically Indigent Costs will be inflated forward to the payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average. The funds available for the Public Hospital 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:

State Fiscal Year 2007-08	\$1,455,954
State Fiscal Year 2008-09	\$2,500,000
State Fiscal Year 2008-09	\$0

Effective September 1, 2009, this payment is suspended.

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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.

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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 equal to the Medicaid Base Rate without Add-ons, multiplied by a percentage adjustment factor, multiplied by Medicaid discharges, multiplied by average Medicaid case mix.

Hospital specific data used in the calculation of the Inpatient Hospital Base Rate Supplemental Medicaid payment (expected Medicaid discharges, average Medicaid case mix, and the Medicaid base rate calculated prior to any Medicaid hospital specific cost add-ons) 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.

For the Inpatient Hospital Base Rate Supplemental Medicaid payment, the following definitions apply:

1. “Medicaid Base Rate without Add-ons” means the Medicaid base rate calculated prior to any Medicaid hospital specific cost add-ons.

In the event that Inpatient Hospital Base Rate Supplemental Medicaid 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.

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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

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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 effective October 26, 2015 shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at www.colorado.gov/hcpf/bulletins.

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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

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Or Maj Anom), 609 (Neonate, BWT 1500-2499G W Major Procedure), 630 (Neonate, BWT > 2499G W Major Cardiovase 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.

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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.

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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.

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

- J. Effective October 26, 2015, 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:

- I. 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 \$23,500,000. 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 \$91,980,176.

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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 CICIP Days to Total Days is in the top 25% of all providers will receive an additional \$100 per Medicaid Day.

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- 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.

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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

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- 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.

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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.

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4. Supplemental Medicaid Payments Conditions

For the Supplemental Medicaid Payments listed in this Section (Rural Hospital Supplemental Medicaid payment, Denver Metro Supplemental Medicaid payment and Metropolitan Statistical Area Supplemental Medicaid payment) the following shall apply:

- a. The Supplemental Medicaid 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, and the Acute Care Psychiatric Supplemental Medicaid payment.
- b. Medicaid days include 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).
- c. Hospitals that qualify to receive a Supplemental Medicaid Payment shall only receive payment from one Supplemental Medicaid Payment described in this Section.
- d. Hospitals licensed or certified as psychiatric or rehabilitation, or are licensed as General Hospital with a Medicare Certification Long Term, shall not qualify to receive a Supplemental Medicaid Payment described in this Section.
- e. High Volume Medicaid and CICP Hospitals shall not qualify to receive a Supplemental Medicaid Payment described in this Section. 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.
- f. A hospital located in the Denver Metro Area is a hospital that is located in one of the following counties: Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County, or Douglas County.
- g. In calculating the Supplemental Medicaid Payments, Medicaid days for the prior calendar year will be submitted by hospitals to the Department by April 30 of each year.
- h. In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after a Supplemental Medicaid Payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

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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.

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- 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

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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.

Effective October 26, 2015, dollars per discharge point will be tiered such that hospitals with higher quality point scores will receive higher points per discharges. The dollar amount per discharge point for five (5) tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	\$13.18
2	11-20	\$14.50
3	21-30	\$15.82
4	31-40	\$17.13
5	41-50	\$18.45

Effective October 26, 2015, HQIP measures include five (5) base measures and four (4) optional measures. Hospitals can report data on up to five (5) measures annually. Hospitals that choose to participate in HQIP must report all of the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed.

Effective October 26, 2015, the base measures for HQIP are:

1. Emergency department process measure,
2. Rate of elective deliveries between 37 and 39 weeks gestation,
3. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,
4. Rate of thirty (30) day all-cause hospital readmissions, and
5. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.

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Effective October 26, 2015, the optional measures for HQIP are:

1. Culture of safety,
2. Active participation in the Regional Care Collaborative Organization (RCCO),
3. Advance care planning, and
4. Screening for tobacco use.

Total Funds for this payment equal:

FFY 2012-13	\$32,000,000	FFY 2015-16	\$84,810,386
FFY 2013-14	\$34,388,388		
FFY 2014-15	\$61,488,873		

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

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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

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Medicaid Usable Organs Ratio is calculated by dividing Medicaid Usable Organs by the hospital's Total Usable Organs.

Total Organ Acquisition Costs are from Worksheet D-6, Part III, under the Part A cost column line 53.

Medicaid Organ Acquisition Costs equal the Medicaid Usable Organs Ratio multiplied by Total Organ Acquisition Costs.

Medicaid Inpatient Hospital Provider Fee Costs

For those hospitals that do not include hospital provider fees as an expense in their CMS 2552-96 Medicare Cost Report, or its successor, Medicaid Inpatient Provider Fee Costs are calculated separately by multiplying the total inpatient hospital provider fees collected by the State from the qualified provider multiplied by the ratio of Medicaid Patient Days for Inpatient Hospital Services as reported in the MMIS to Total Inpatient Days by Routine Cost Center as reported on Worksheet S-3, Part 1, Column 6.

Medicaid Uncompensated Inpatient Hospital Costs

Total Medicaid Inpatient Hospital Costs are the sum of Medicaid Routine Cost Center Costs, Medicaid Ancillary Cost Center Costs, Medicaid Organ Acquisition Costs, and Medicaid Inpatient Hospital Provider Fee Costs. Medicaid Inpatient Hospital Provider Fee Costs are calculated separately only for those hospitals that do not include hospital provider fees as an expense in their CMS 2552-96 Medicare Cost Report, or its successor.

Medicaid Uncompensated Inpatient Hospital Costs equal Total Medicaid Inpatient Hospital Costs less Medicaid payments from the MMIS, Medicaid supplemental payments referenced in this Attachment 4.19A, third party liability reported in the MMIS, client payments reported in the MMIS, and patient Medicaid copayments reported in the MMIS.

Methodology for Calculating Uncompensated Costs for Medicaid Inpatient Hospital Services Using CMS 2552-10:

Calculating Total Inpatient Hospital Costs

Total Inpatient Hospital Routine Costs equal costs as reported on CMS 2552-10 Worksheet C, Part I, Column 1, lines 30 – 43, plus allowable costs for interns and residents costs reported on Columns 21 and 22 of Worksheet B, Part I. For hospitals that use the Special Title XIX Worksheet, which adds back the allowable interns and residents costs from Columns 21 and 22 of Worksheet B, Part I to the costs reported on the regular Worksheet C, Part I, Column 1, only the costs as reported on Special Title XIX Worksheet C, Part I, Column 1 are used. Costs recorded on lines 44 – 46 are excluded because they pertain to nursing facilities, skilled nursing facilities and long term care—none of which are inpatient hospital services.

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Total Inpatient Days by Routine Cost Center are reported on Worksheet S-3, Part 1, Column 8. Observation Bed Days, cost center 92, are to be reclassified to be included in Adults and Pediatrics (cost center 30). Labor and Deliver Days, cost center 52, are also to be reclassified to be included in Adults and Pediatrics (cost center 30).

The Cost Per-Diem by Routine Cost Center equals Total Inpatient Hospital Routine Costs divided by Total Inpatient Days. The Adult and Pediatric Routine Center Cost Per Diem includes Observation Bed Days. Swing Beds, Nursing Facility Costs and non-medically necessary Private Room Differential Costs are excluded.

Total Inpatient Hospital Ancillary Costs are reported on Worksheet C, Part 1, Column 1, lines 50 - 92. For hospitals that use the Special Title XIX Worksheet, which adds back the allowable interns and residents costs from Columns 21 and 22 of Worksheet B, Part I to the costs reported on the regular Worksheet C, Part I, Column 1, only the costs as reported on Special Title XIX Worksheet C, Part 1, Column 1 are used.

Total Inpatient Hospital Ancillary Charges are reported on Worksheet C, Part 1, Column 8, lines 50 - 92.

The Cost-to Charge Ratio by Inpatient Hospital Ancillary Cost Center is calculated by dividing each cost center's Inpatient Hospital Ancillary Costs by its Inpatient Hospital Ancillary Charges.

Calculating Medicaid Costs

Medicaid Patient Days for Inpatient Hospital Services are defined as paid Header Number of Service Days as reported in the MMIS for dates of service that correspond to the hospital's cost report period. The Total Header Number of Service Days is then multiplied by the percentage of Total Inpatient Days by Routine Cost Center for each cost center using Title XIX Days, Worksheet S-3, Pt. 1, Column 7, from CMS 2552-10, or its successor, to allocate inpatient days to the appropriate cost centers. University Hospital is on a State Fiscal Year, Denver Health is on a calendar year, and University of Colorado Health - Memorial Health System (UCH-MHS) is on a State Fiscal Year. Secondary Medicaid Days are defined as those days paid for Medicaid clients with a non-Medicare third party payer and are included for allowed Medicaid services under State Plan Amendment Attachment 4.19A. Medicare-Medicaid Dual Eligible Days are excluded for those days for which Medicaid reimburses only its share of the Medicare coinsurance or deductible.

Medicaid Allowable Charges for Inpatient Hospital Services are as reported in the MMIS for dates of service that correspond to the hospital's cost report period for paid charges for allowable inpatient hospital services under State Plan Amendment Attachment 4.19A. Medicaid allowable charges for Observation Beds are included in line 92. Charges for outpatient hospital services, professional services or non-hospital component services such as hospital-based providers are excluded. Allowable charges are mapped from the revenue code identified in the MMIS to the CMS cost report ancillary

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cost center. Medicaid Observation Bed outpatient charges that have been inaccurately recorded in inpatient cost centers are to be reclassified under Observation Bed (cost center 92) outpatient charges.

Medicaid Routine Cost Center Costs are calculated by multiplying Medicaid Patient Days by the Cost Per-Diem by Routine Cost Center.

Medicaid Ancillary Cost Center Costs are calculated by multiplying the Cost-to-Charge Ratio by Inpatient Hospital Ancillary Cost Center by the Medicaid Allowable Charges.

Medicaid Organ Acquisition Costs

Medicaid Usable Organs are identified in the provider's records as the number of Medicaid recipients who received an organ transplant.

Total Usable Organs are as reported from Worksheet D-4, Part III under the Part B cost column line 62.

Medicaid Usable Organs Ratio is calculated by dividing Medicaid Usable Organs by the hospital's Total Usable Organs.

Total Organ Acquisition Costs are from Worksheet D-4, Part III, under the Part A cost column line 61.

Medicaid Organ Acquisition Costs equal the Medicaid Usable Organs Ratio multiplied by Total Organ Acquisition Costs.

Medicaid Inpatient Hospital Provider Fee Costs

For those hospitals that do not include hospital provider fees as an expense in their CMS 2552-10 Medicare Cost Report, or its successor, Medicaid Inpatient Provider Fee Costs are calculated separately by multiplying the total inpatient hospital provider fees collected by the State from the qualified provider multiplied by the ratio of Medicaid Patient Days for Inpatient Hospital Services as reported in the MMIS to Total Inpatient Days by Routine Cost Center as reported on Worksheet S-3, Part 1, Column 8.

Medicaid Uncompensated Inpatient Hospital Costs

Total Medicaid Inpatient Hospital Costs are the sum of Medicaid Routine Cost Center Costs, Medicaid Ancillary Cost Center Costs, Medicaid Organ Acquisition Costs, and Medicaid Inpatient Hospital Provider Fee Costs. Medicaid Inpatient Hospital Provider Fee Costs are calculated separately only for those hospitals that do not include hospital provider fees as an expense in their CMS 2552-10 Medicare Cost Report, or its successor.

Medicaid Uncompensated Inpatient Hospital Costs equal Total Medicaid Inpatient Hospital Costs less Medicaid payments from the MMIS, Medicaid supplemental payments referenced in this Attachment

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4.19A, third party liability reported in the MMIS, client payments reported in the MMIS, and patient Medicaid copayments reported in the MMIS.

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