



**State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and
Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions**

UPDATED – April 2014

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
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Introduction

The Department of Health Care Policy and Financing (the Department), the Colorado Hospital Association (CHA), Public Consulting Group (PCG), and hospital stakeholders worked together to create a Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Cost Report, herein referred to as the Uniform Cost Report (UCR). This report is completed by the every Colorado hospital and submitted to the Department for purposes of the Hospital Provider Fee Model and Disproportionate Share Hospital (DSH) Audits. The UCR combines information from a number of different sources, including:

- Hospital Medicare Cost Reports (CMS-2552-10 or CMS-2552-96);
- Colorado Medicaid Managed Information System (MMIS) data;
- Audited hospital financial statements;
- Other hospital records; and
- Other data sources, as necessary

The goal of this project was to streamline data aggregation and validation for both hospitals and the Department. PCG worked carefully with CHA and the Department in order to create the UCR Web-Based Cost Report and Web-Based Cost Report Instructions, which hospitals can use as a reference throughout the UCR submission process. This process allows hospitals to submit the required data electronically for the Hospital Provider Fee Model and for DSH Audits. This should reduce the administrative burden on hospitals that occurs when fulfilling different, disparate data requests from the Department each year. If a hospital correctly follows the directions in this manual (for completing, submitting, and maintaining the records and data needed for the UCR), then it should be able to demonstrate its compliance with state and federal auditing requirements enabling them to retain the financial support provided through the UCR process.

Colorado Hospitals submit data using the UCR web-based cost report system each spring. Data from the current submission reflects the time period from the State Medicaid Plan rate year of 2012 (July 1, 2011 through June 30, 2012). This information will be audited by the Department's contracted DSH auditor and submitted to the Centers for Medicare and Medicaid Services (CMS) in 2015.

In order to understand the UCR, it is important to understand the Medicare Cost Report (CMS-2552), Medicaid DSH, and the Hospital Provider Fee Model and how these work together. Colorado hospitals will submit data online for the Hospital Provider Fee Model and DSH in the UCR Web-Based cost report system, but most of the information they supply or verify for the UCR Template will come from Medicare Cost Reports since the CMS-2552 supplies a wide array of audited or auditable data and documentation.

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Where to Go for Assistance

If you have any questions or need assistance with the UCR online system, please contact PCG at:
CO_UCR@pcgus.com.

- Laura Scott: lscott@pcgus.com / 617-717-1219
- Mekayla Cortez: mcortez@pcgus.com / 303-357-4640
- Julia Sun: jsun@pcgus.com / 617-717-1495

Acronyms *(More detailed definitions are found in the Glossary attached to the end of this document)*

CCR: Cost to Charge Ratio

CHA: Colorado Hospital Association

CMS: Centers for Medicare and Medicaid Services

CHCAA: Colorado Health Care Affordability Act

COFRS: Colorado Financial Reporting System

CRY: Cost Report Year

Department: Colorado Department of Health Care Policy and Financing

DSH: Disproportionate Share Hospital

FFS: Fee-for-Service

HFY: Hospital Fiscal Year

IP: Inpatient

PCG: Public Consulting Group

LIUR: Low-Income-Utilization Rate

MIUR: Medicaid Inpatient Utilization Rate

MCO: Managed Care Organization

MMIS: Medicaid Management Information System

MRY: Medicaid Rate Year

OP: Outpatient

SFY: State Fiscal Year

UCR: Uniform Cost Report

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UCR Worksheets

The UCR is designed to facilitate the collection of actual cost data that, after the close of a fiscal year, can be used to determine inpatient and outpatient Medicaid and uninsured care costs incurred by hospitals. The following pages describe each worksheet of the cost report and instruct the user on how to input necessary data elements. Some data will be pre-populated by the Department and PCG. If the pre-populated data needs to be edited, the hospital must contact PCG using the contact information found in the prior *Where to Go for Assistance* section.

The UCR is broken up into three main sections:

1. Hospital Input Reports
 - a. Hospital Information;
 - b. Inpatient Ancillary Charges by Payer;
 - c. Inpatient Payments by Payer;
 - d. Inpatient Routine Days by Payer;
 - e. Outpatient Charges by Payer;
 - f. Outpatient Payments by Payer;
 - g. Provider Fee Model Statistics;
 - h. Disproportionate Share Hospital (DSH) Qualifications;
 - i. Disproportionate Share Hospital (DSH) Statistics;
 - j. Organ Transplants Costs Reimbursement by Payer; and
 - k. Cost Report Certification Statement

2. Calculation Reports
 - a. Hospital per Diem Calculations;
 - b. Hospital Cost-to-Charge Ratio Calculations;
 - c. Inpatient Routine Costs by Payer;
 - d. Inpatient Ancillary Costs by Payer; and
 - e. Outpatient Costs by Payer

3. Summary Reports
 - a. Disproportionate Share Hospital (DSH) Summary

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This section provides a brief summary of each worksheet. Later sections of this document provide specific instructions for completing each page in the UCR online system for which data entry is required.

Hospital Input Report: Hospital Information

This worksheet of the UCR captures the basic information of your facility: Medicaid and Medicare provider numbers, cost report year begin and end dates, hospital address, and contact information for the preparer and certifier must be entered.

Hospital Input Report: Inpatient Ancillary Charges by Payer

This worksheet of the UCR accumulates each hospital's inpatient ancillary charges by payer, for specific payer types. The cost report preparer must input Inpatient Ancillary Charges by Payer according to the Medicare ancillary cost centers.

Hospital Input Report: Inpatient Payments by Payer

This worksheet of the UCR captures all Inpatient Payments by Payer made to hospitals.

Hospital Input Report: Inpatient Routine Days by Payer

This worksheet of the UCR is for the cost report preparer to input Inpatient Routine Days by Payer according to the Medicare cost centers.

Hospital Input Report: Outpatient Charges by Payer

This worksheet of the UCR is for the cost report preparer to input outpatient charges by payer, according to the Medicare cost centers.

Hospital Input Report: Outpatient Payments by Payer

This worksheet of the UCR captures all Outpatient Payments by Payer made to hospitals

Hospital Input Report: Provider Fee Model Statistics

This worksheet of the UCR serves to collect the data required only for the Provider Fee Model. This data may change from year-to-year as the Provider Fee Model changes.

Hospital Input Report: Disproportionate Share Hospital (DSH) Qualifications

This worksheet of the UCR contains a series of questions that will determine whether the hospital meets the DSH Obstetrician requirement.

Hospital Input Report: Disproportionate Share Hospital (DSH) Statistics

This worksheet of the UCR is the calculation of the Medicaid Inpatient Utilization Rate and Low Income Utilization Rate for the facility

Hospital Input Report: Organ Transplant Costs and Reimbursement by Payer

This worksheet of the UCR captures the Organ Transplant Costs of the hospital that are specifically related to the Medicaid, the Uninsured and Dual Eligible populations.

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Hospital Input Report: Cost Report Certification Statement

This worksheet of the UCR is for hospitals to attest to specific statements regarding the UCR report. This attestation must be completed by an authorized hospital signatory and is required.

Calculation Report: Hospital per Diem Calculation

This worksheet of the UCR calculates the Cost per Day for different inpatient cost centers. There is no data input from the cost report preparer required on this worksheet. The total costs and days come from each hospital's Medicare (CMS 2552-10, previously CMS 2552-96) cost report.

Calculation Report: Hospital Cost-to-Charge Ratio Calculations

This worksheet of the UCR calculates the Hospital Cost-to-Charge Ratio for each hospital ancillary and outpatient cost center using total costs and charges from each hospital's Medicare (CMS 2552-10 previously CMS 2552-96) cost report. There is no data input from the cost report preparer required on this worksheet.

Calculation Report: Inpatient Routine Costs by Payer

Calculation Report Inpatient Ancillary Costs by Payer

Calculation Report: Outpatient Costs by Payer

There is no data input from the cost report preparer required on these reports. These worksheets of the UCR calculate the inpatient routine, inpatient ancillary, and outpatient costs by payer.

Summary Report: Disproportionate Share Hospital (DSH) Summary

This worksheet of the UCR provides the user with the DSH Summary of all the data entered in the UCR. The first part of this worksheet consists of certification information and statistics related to DSH and the second part shows the comparison of hospital cost to hospital payments.

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Getting Started

Before beginning, make sure that you have access to the following data:

- Hospital financial statements and other auditable hospital accounting records as source for inpatient and outpatient days and charges by payer and
- Cost and revenue data by payer.

The payers for which hospitals need to report data are:

- Medicaid Managed Care;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

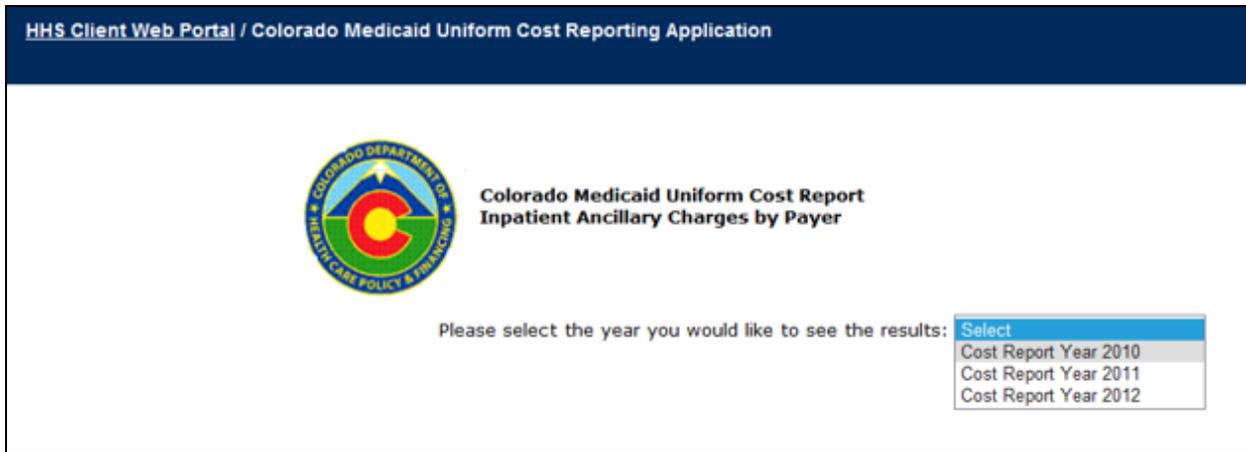
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What's New for Spring 2014?

There are several enhancements to the UCR web-based system for spring 2014. These enhancements include:

Changing the dropdown for reports years from Year 1 and Year 2 to Cost Report Year 2010, Cost Report Year 2011, and Cost Report Year 2012.

- Hospitals will find that their data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If hospitals need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, they must contact PCG.
- Hospitals are to submit data for Cost Report Year 2012.



Example 1: Cost Report Year 2010 report is certified and can no longer be edited.

		CMS 2552-96 Line	CMS 2552-10 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Plan
<input type="checkbox"/>	Operating Room	37.00	50.00	\$1,378,402.00	
<input type="checkbox"/>	Recovery Room	38.00	51.00	\$277,712.00	
<input type="checkbox"/>	Delivery Room and Labor Room	39.00	52.00	\$875,993.00	

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Example 2: Cost Report Year 2010 report is certified and can no longer be edited.



**Colorado Medicaid Uniform Cost Report
DSH Qualifications**

Please select the year you would like to see the results: Cost Report Year 2010 ▼

The report is certified and can no longer be edited.

DSH Qualifications

Obstetrician Care and Certification Statements

1 Do you certify that your hospital had at least two obstetricians with staff privileges who agreed to provide non-emergency obstetric services to Medicaid-eligible individuals during the DSH rate year? Yes
 No

If you answered Yes to Questions 1 or 2 above, provide the name and NPI/UPIN of two obstetricians or rural physicians who provided the required obstetric services during the DSH year.

Obstetrician Name NPI/UPIN

Obstetrician Name NPI/UPIN

Locking row and column headers on input pages.

- To assist with accurate data input, the row and column headers are locked on pages that require scrolling down and/or across to access all cost centers and all payer types.



**Colorado Medicaid Uniform Cost Report
Outpatient Ancillary Charges by Payer**

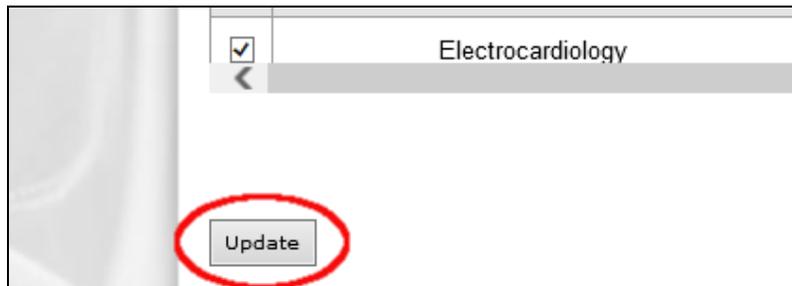
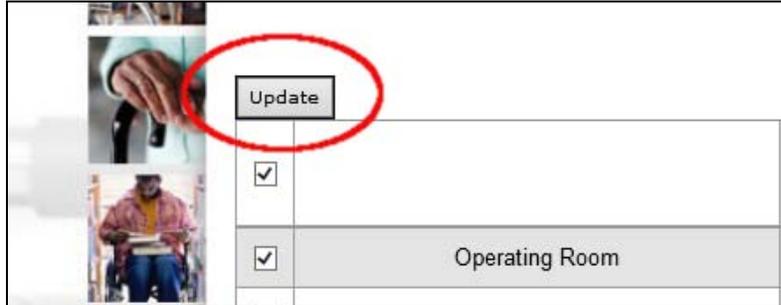
Please select the year you would like to see the results: Cost Report Year 2012 ▼

		52-10 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Managed Care
<input type="checkbox"/>	Anesthesiology	53.00	\$0.00			
<input type="checkbox"/>	Radiology-Diagnostic	54.00	\$0.00			
<input type="checkbox"/>	Radiology-Therapeutic	55.00	\$0.00			
<input type="checkbox"/>	Radioisotope	56.00				
<input type="checkbox"/>	Computed Tomography (CT) Scan					
<input type="checkbox"/>	Magnetic Resonance Imaging (MRI)	58.00				
<input type="checkbox"/>	Cardiac Catheterization	59.00				
<input type="checkbox"/>	Laboratory	60.00	\$0.00			

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Adding save functionality to the top and bottom of Hospital Input reports.

- In addition to the update button in the bottom left hand corner of Hospital Input reports, there is an update button in the top left hand corner as well.



Pre-populating information on the Provider Fee Model Stats report.

- Hospitals will need to report only Managed Care Days on the Provider Fee Model Stats page. The Department will calculate Non-Managed Care Days by subtracting the reported Managed Care Days from the Total Days on each hospital's Medicare 2552 cost report.
- The Department has also answered the question for hospitals related to being a CICP provider. That is, the Department answered Yes or No for all hospitals. Only those hospitals that are not CICP providers will need to report information related to charity care write-offs.

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**Colorado Medicaid Uniform Cost Report
Provider Fee Model Statistics**

Please select the year you would like to see the results: ▼

Commercial Managed Care Days

Medicaid Managed Care Days

Medicare Managed Care Days

Other Managed Care Days

Total Managed Care Days

Total Days

Non-Managed Care Days

Charity Care Write-Off Charges

Does your facility participate in the CICP program? Yes No

Charity Care Write-Off Charges

Does your facility participate in the CICP program? Yes No

If your facility answered "No" to the previous question, please report your facility's total charity care write-off charges based on the definition below.

Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain

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Login

To access the UCR online system, open your web browser and type the following URL:

<https://web.pcgus.com/HHSPortal>

If you completed the UCR in a prior year, your user name and password will still be active. Your user name is your email address.

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Username:
Password:
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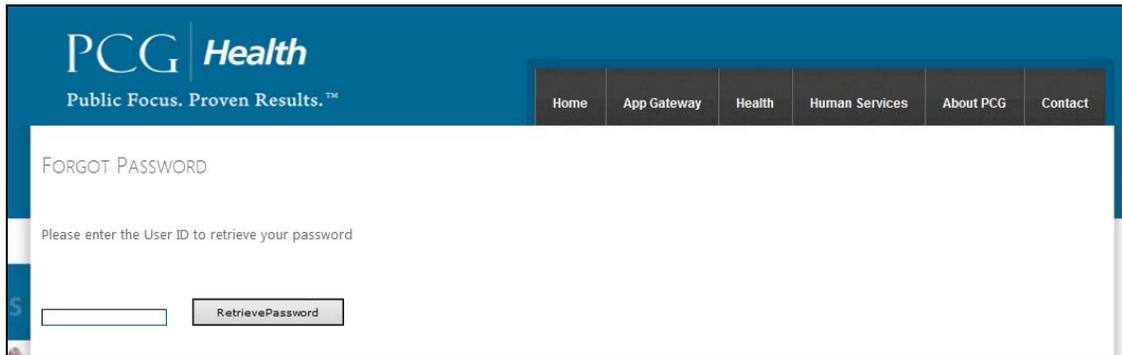
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Forgot Password?

If you forgot your password, you can use the “Forgot your password feature, illustrated below.

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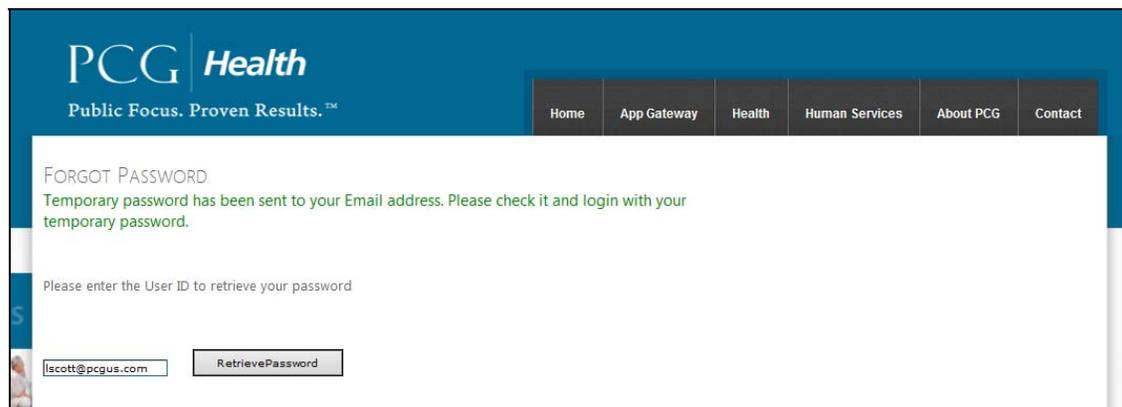
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FORGOT PASSWORD

Please enter the User ID to retrieve your password

RetrievePassword



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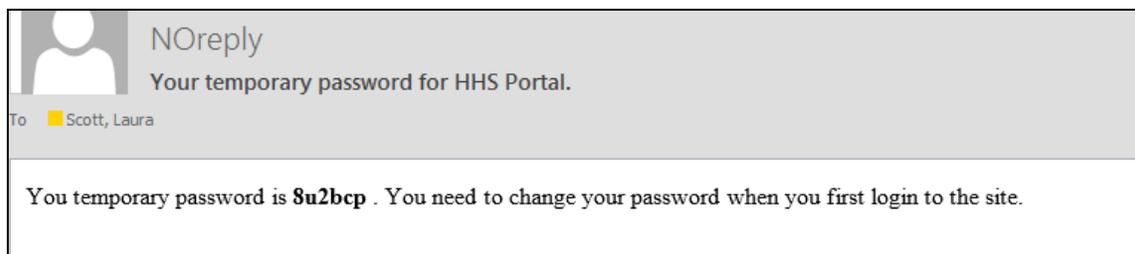
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FORGOT PASSWORD

Temporary password has been sent to your Email address. Please check it and login with your temporary password.

Please enter the User ID to retrieve your password

RetrievePassword



 NOreply
Your temporary password for HHS Portal.

To  Scott, Laura

You temporary password is **8u2bcp** . You need to change your password when you first login to the site.

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CHANGE PASSWORD

USE THE FORM BELOW TO CHANGE YOUR PASSWORD.
New Password should meet the following rules ...

1. At least one lower case letter
2. At least one upper case letter
3. At least one special character
4. At least one number
5. At least 8 characters length

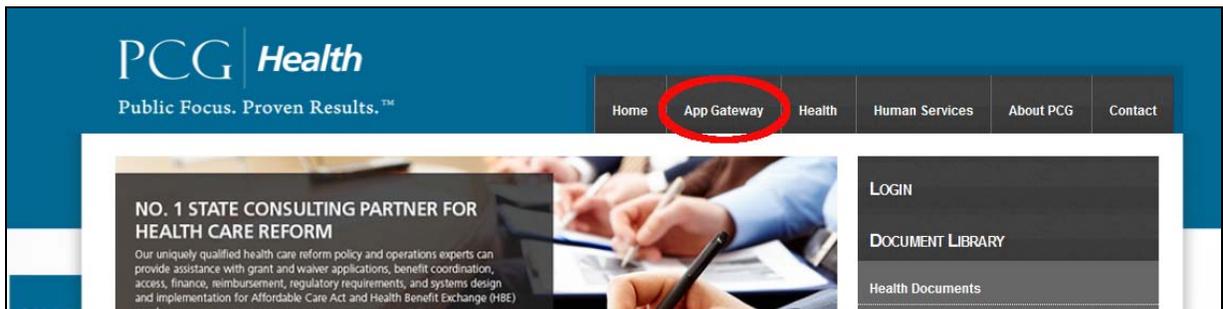
ACCOUNT INFORMATION

Old Password:

New Password:

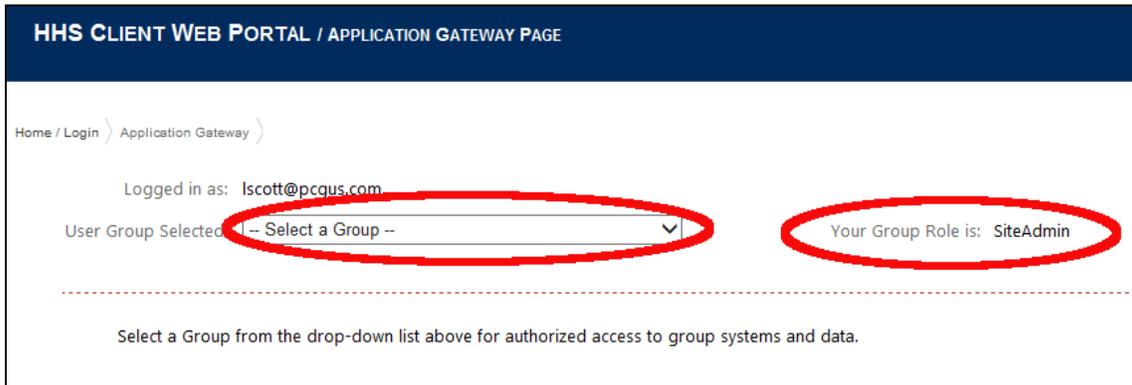
Confirm New Password:

Once logged in the UCR online system, you will need to click on “App Gateway” at the top of the screen. See the illustration below.



You will then need to select the hospital for which you are completing the UCR.

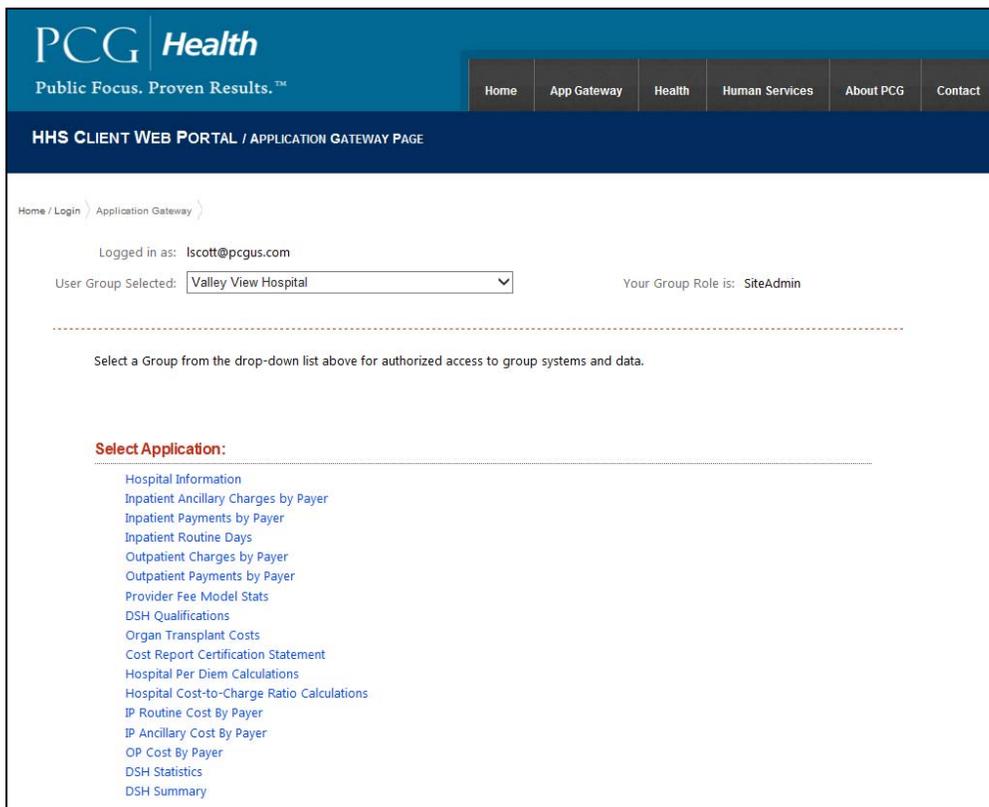
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After selecting your hospital, all reports will be displayed in a menu (see below).

Please note that “Group Role” will be displayed next to the hospital drop down menu.

- An “Administrator” has the credentials to edit and certify the UCR;
- An “Editor” has the credentials to only make edits to the report.



You are now ready to begin reporting. In order to return to this page at any time, click on “HHS Client Web Portal” or “App Gateway.”

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Detailed Worksheet Instructions

Hospital Input Report: Hospital Information

This worksheet of the UCR captures the basic information of your facility. The facility's address and contact information should be entered here. Specifically, the following data items are captured on this page:

Hospital Information

- Hospital Name
 - Please enter the most common name for your hospital
 - The Hospital DBA (Doing Business As) and Hospital Legal names are prepopulated based on Department records

Address

- Street Address
- City, State, and Zip Code
- Medicare Provider Number
- Medicaid Provider Number

Contact Information

- Preparer's Name
- Preparer's Address
- Preparer's Email Address
- Preparer's Phone Number
- Certifier's Name
- Certifier's Title
- Certifier's Address
- Certifier's Email Address
- Certifier's Phone Number
- Type of Report

Other Information

- CRY Begin Date (Cost Report Year 2012);
- CRY End Date (Cost Report Year 2012);

If your hospital has more than one cost report for any twelve month period please contact PCG before beginning to complete the UCR.

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Below are the screenshots of the Hospital Information page in the UCR online system. Please note that all editable fields require the user to input information. If you do not fill in required information and press the "Submit" button, you will receive an error message at the top of the screen identifying the missing information and a red asterisk (*) will appear next to the corresponding field.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If hospitals need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, they must contact PCG.

Hospital Information

Hospital Name: *

Hospital DBA Name: Valley View Hospital

Hospital Legal Name: Valley View Hospital Association

Address

Street: *

City: *

State: *

Zip Code: *

Medicare Provider Number: *

Medicaid Provider Number: *

Contact Information

Preparer's Name: *

Preparer's Address: *

Preparer's Email Address: *

Preparer's Phone Number: *

Certifier's Name: *

Certifier's Title: *

Certifier's Address: *

Certifier's Email Address: *

Certifier's Phone Number: *

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Type of Report:

Medicaid Rate Year Begin Date(State Fiscal Year Beginning): 07/01/2010
Medicaid Rate Year End Date (State Fiscal Year End): 06/30/2011

Hospital Fiscal Year 2010 Begin Date:
Hospital Fiscal Year 2010 End Date:

Does your Hospital Fiscal Year 2010 Cost Report include the hospital provider fee as an allowable expense? Yes No

Hospital Fiscal Year 2011 Begin Date:
Hospital Fiscal Year 2011 End Date:

Does your Hospital Fiscal Year 2011 Cost Report include the hospital provider fee as an allowable expense? Yes No

Hospital Fiscal Year 2012 Begin Date:
Hospital Fiscal Year 2012 End Date:

Cost Report Year 2010 Weight: 50.41%
Cost Report Year 2011 Weight: 49.59%

Please remember to save your data before returning to the main menu.

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Hospital Input Report: Inpatient Ancillary Charges by Payer

This worksheet of the UCR accumulates each hospital's inpatient ancillary charges by payer, for specific payer types. The cost report preparer must input Inpatient Ancillary Charges by Payer according to the Medicare ancillary cost centers. These cost centers are:

	CMS-2552-96 Reference	CMS-2552-10 Reference
Operating Room	37.00	50.00
Recovery Room	38.00	51.00
Delivery Room and Labor Room	39.00	52.00
Anesthesiology	40.00	53.00
Radiology-Diagnostic	41.00	54.00
Radiology-Therapeutic	42.00	55.00
Radioisotope	43.00	56.00
Computed Tomography (CT) Scan		57.00
Magnetic Resonance Imaging (MRI)		58.00
Cardiac Catheterization		59.00
Laboratory	44.00	60.00
PBP Clinic Laboratory Services-Program Only	45.00	61.00
Whole Blood and Packed Red Blood Cells	46.00	62.00
Blood Storing, Processing, & Transfusing	47.00	63.00
Intravenous Therapy	48.00	64.00
Respiratory Therapy	49.00	65.00
Physical Therapy	50.00	66.00
Occupational Therapy	51.00	67.00
Speech Pathology	52.00	68.00
Electrocardiology	53.00	69.00
Electroencephalography	54.00	70.00
Medical Supplies Charged to Patients	55.00	71.00
Implantable Devices Charged to Patients	55.30	72.00

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	CMS-2552-96 Reference	CMS-2552-10 Reference
Drugs Charged to Patients	56.00	73.00
Renal Dialysis	57.00	74.00
ASC (Non-Distinct Part)	58.00	75.00
Other Ancillary (Specify)	59.00	0.00
Other Ancillary (Specify)	59.XX	0.00
Other Ancillary (Specify)	59.XX	0.00
Other Ancillary (Specify)	59.XX	0.00
Clinic	60.00	90.00
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Emergency	61.00	91.00
Observation Beds	62.00	92.00
Rural Health Clinic	63.5X	88.00
Federally Qualified Health Center (FQHC)	63.5X	89.00
Other Outpatient Service (specify)	XX.XX	XX.XX

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The Inpatient Ancillary Charges listed above are needed from the following payers:

- Colorado Medicaid Fee-for-Service (FFS);
- Medicaid/Medicare Dual Eligible FFS;
- Medicaid Managed Care;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The source for the Colorado Medicaid FFS and Medicaid/Medicare Dual Eligible FFS inpatient ancillary charges will be Colorado MMIS claims data. The Department will populate this data for each hospital at a later date.

Each hospital will be responsible for reporting Inpatient Ancillary Charges for the following payers:

- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The source of the inpatient ancillary charges by payer will be provider records and remittance advices, where applicable and available. Please refer to *Appendix A: Glossary of Terms* for a detailed definition of each payer type.

When completing the Inpatient Ancillary Charges by Payer report in the UCR online system, please select the correct cost report year for the data you are reporting.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If hospitals need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, they must contact PCG.

Before entering Inpatient Ancillary Charges data, the user is able to make ALL of the fields on this page editable by checking the box located at the top, left side of table.

State of Colorado
 Department of Health Care and Policy and Financing
 Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
 Web-Based Cost Report Instructions


**Colorado Medicaid Uniform Cost Report
 Inpatient Ancillary Charges by Payer**

Please select the year you would like to see the results: Cost Report Year 2012 ▾

Update

<input checked="" type="checkbox"/>		Out-of-State Medicaid Fee-For-Service	Out-of-State Medicaid Managed Care	Medicaid Fee-for-Service NOT Billed to Medicaid	Total Medicaid Only Charges
<input checked="" type="checkbox"/>	Operating Room	<input style="border: 1px solid red;" type="text"/>	<input type="text"/>	<input type="text"/>	\$0.00
<input checked="" type="checkbox"/>	Recovery Room	<input type="text"/>	<input style="border: 1px solid red;" type="text"/>	<input type="text"/>	\$0.00
<input checked="" type="checkbox"/>	Delivery Room and Labor Room	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$0.00

The user is also able to make specific rows editable one at a time by checking the box for a specific row.


**Colorado Medicaid Uniform Cost Report
 Inpatient Ancillary Charges by Payer**

Please select the year you would like to see the results: Cost Report Year 2012 ▾

Update

<input type="checkbox"/>		CMS 2552-96 Line	CMS 2552-10 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan
<input checked="" type="checkbox"/>	Operating Room	37.00	50.00	\$0.00	<input style="border: 1px solid red;" type="text"/>
<input type="checkbox"/>	Recovery Room	38.00	51.00	\$0.00	
<input type="checkbox"/>	Delivery Room and Labor Room	39.00	52.00	\$0.00	

Note that the Colorado Medicaid Fee-for-Service column is not editable. This information, as well as Medicaid/Medicare Dual Eligible FFS come from the Department and will be populated at a later date.

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

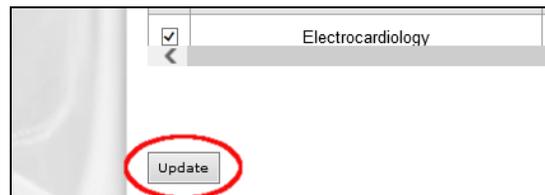
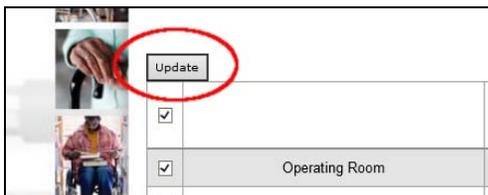
<input checked="" type="checkbox"/>		Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Medicaid Managed Care	M Ser
<input checked="" type="checkbox"/>	Radiisotope		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Computed Tomography (CT) Scan		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Magnetic Resonance Imaging (MRI)		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Cardiac Catheterization		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Laboratory	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	PBP Clinic Laboratory Services-Program Only		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Whole Blood and Packed Red Blood Cells		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Blood Storing, Processing, & Transfusing	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Intravenous Therapy	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Respiratory Therapy	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Physical Therapy	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Occupational Therapy	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Speech Pathology	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Electrocardiology	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Electroencephalography	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Medical Supplies Charged to Patients	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Implantable Devices Charged to Patients		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Drugs Charged to Patients	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Renal Dialysis		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	ASC (Non-Distinct Part)		<input type="text"/>	<input type="text"/>	<input type="text"/>	

Update

It is important to note that all columns are not displayed on the screen. Please scroll to the right in order to see the additional columns.

Finally, please remember to save all data in the UCR online system by clicking the “Update” button located at the upper left and bottom left corner of the screen.

Please remember to save your data before returning to the main menu.



State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

Hospital Input Report: Inpatient Payments by Payer

This worksheet of the UCR captures all **Inpatient Payments by Payer** made to hospitals. The following types of Inpatient Payments are reported:

- Primary Payer Payments;
- Medicare Payments;
- Medicare Transplant Reimbursement for Dual Eligible;
- Medicare Bad Debt Reimbursement for Dual Eligible;
- Patient Payments;
- Payments From Medicaid Agency;
- Uninsured Payments;
- Section 1011 Payments; and
- Cash subsidies for patient services

The Inpatient Payments can be from the following payers:

- Colorado Medicaid Fee-for-Service (FFS);
- Medicaid/Medicare Dual Eligible Fee-for-Service;
- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The source for the Colorado Medicaid FFS and Medicaid/Medicare Dual Eligible FFS payments will be Colorado MMIS claims data. The Department will populate this data for each hospital at a later date.

Each hospital will be responsible for reporting payments for the following payers:

- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

When completing the Inpatient Payments by Payer report in the UCR online system, please select the correct cost report year for the data you are reporting.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If hospitals need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, they must contact PCG.

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

Before entering Inpatient Payments data, the user is able to make ALL of the fields on this page editable by checking the box located at the top, left side of table.

 **Colorado Medicaid Uniform Cost Report**
Inpatient Payments by Payer

Please select the year you would like to see the results: Cost Report Year 2012

<input checked="" type="checkbox"/>		Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Medic Managed Care
<input checked="" type="checkbox"/>	Primary Payer Payments	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	Medicare Payments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	Medicare Transplant Reimbursement for Dual Eligibles				
<input checked="" type="checkbox"/>	Medicare Bad Debt Reimbursement for Dual Eligibles				
<input checked="" type="checkbox"/>	Patient Payments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	Payments From Medicaid Agency	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	Uninsured Payments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	Section 1011 Payments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/>	Cash subsidies for patient services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	Total	\$0.00	\$0.00	\$0.00	\$0.00

Update

The user is also able to make specific rows editable one at a time by checking the box for a specific row.

 **Colorado Medicaid Uniform Cost Report**
Inpatient Payments by Payer

Please select the year you would like to see the results: Cost Report Year 2012

<input type="checkbox"/>		Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Medic Managed Care
<input checked="" type="checkbox"/>	Primary Payer Payments	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	Medicare Payments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	Medicare Transplant Reimbursement for Dual Eligibles				
<input type="checkbox"/>	Medicare Bad Debt Reimbursement for Dual Eligibles				
<input type="checkbox"/>	Patient Payments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	Payments From Medicaid Agency	\$0.00	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	Uninsured Payments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	Section 1011 Payments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	Cash subsidies for patient services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	Total	\$0.00	\$0.00	\$0.00	\$0.00

Update

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

It is important to note that all columns are not displayed on the screen. Please scroll to the right in order to see the additional columns. Finally, please remember to save all data in the UCR online system by clicking on the “Update” button located at the upper left and bottom left corner of the screen.

Please remember to save your data before returning to the main menu.

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

Hospital Input Report: Inpatient Routine Days by Payer

This worksheet of the UCR is for the cost report preparer to input Inpatient Routine Days by Payer according to the Medicare cost centers. These cost centers are:

	CMS-2552-96 Reference	CMS-2552-10 Reference
Adults & Pediatrics	25.00	30.00
Intensive Care Unit	26.00	31.00
Coronary Care Unit	27.00	32.00
Burn Intensive Care Unit	28.00	33.00
Surgical Intensive Care Unit	29.00	34.00
Other Special Care (Specify)	30.00	
Other Special Care (Specify)	30.XX	
Other Special Care (Specify)	30.XX	
Other Special Care (Specify)	30.XX	
Other Special Care (Specify)	30.XX	
Other Special Care (Specify)	30.XX	
Nursery	33.00	43.00
Subprovider I	31.00	41.00
Subprovider II	31.01	42.00
Skilled Nursing Facility	34.00	44.00
Nursing Facility	35.00	45.00
Other Long Term Care	36.00	46.00
Other Routine (Specify)	XX.XX	XX.XX
Other Routine (Specify)	XX.XX	XX.XX
Other Routine (Specify)	XX.XX	XX.XX

The Inpatient Routine Days listed above are needed from the following payers:

- Colorado Medicaid Fee-for-Service (FFS);
- Medicaid/Medicare Dual Eligible Fee-for-Service;
- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The source for the Colorado Medicaid FFS and Medicaid/Medicare FFS days will be Colorado MMIS claims data. The Department will populate this data for each hospital at a later date.

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

Each hospital will be responsible for reporting inpatient routine days for the following payers:

- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The source of the inpatient days by payer will be provider records and remittance advices, where applicable and available. Please refer to **Appendix A: Glossary of Terms** for a detailed definition of each payer type.

When completing the Inpatient Routine Days by Payer report in the UCR online system, please select the correct cost report year for the data you are reporting.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If hospitals need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, they must contact PCG.

The user is also able to make specific rows editable one at a time by checking the box for a specific row.


Colorado Medicaid Uniform Cost Report
Inpatient Routine Days by Payer*

Please select the year you would like to see the results: Cost Report Year 2012

Update

<input type="checkbox"/>	0 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Medicaid Managed Care
<input checked="" type="checkbox"/>	Adults & Pediatrics	0			
<input type="checkbox"/>	Intensive Care Unit	0			
<input type="checkbox"/>	Coronary Care Unit				
<input type="checkbox"/>	Burn Intensive Care Unit				
<input type="checkbox"/>	Surgical Intensive Care Unit				

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

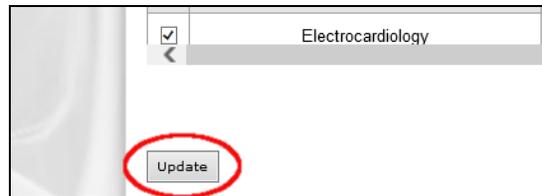
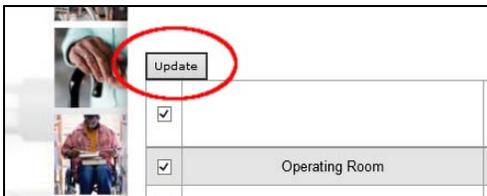
Before entering Inpatient Routine Days data, the user is able to make ALL of the fields on this page editable by checking the box located at the top, left side of table.

Please select the year you would like to see the results: Cost Report Year 2012

<input checked="" type="checkbox"/>	Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Medicaid Managed Care	N Ser
<input checked="" type="checkbox"/>	Adults & Pediatrics	0	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Intensive Care Unit	0	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Coronary Care Unit		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Burn Intensive Care Unit		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input checked="" type="checkbox"/>	Surgical Intensive Care Unit		<input type="text"/>	<input type="text"/>	<input type="text"/>	

It is important to note that all columns are not displayed on the screen. Please scroll to the right in order to see the additional columns. Finally, please remember to save all data in the UCR online system by clicking on the “Update” button located at the upper left and bottom left corner of the screen.

Please remember to save your data before returning to the main menu.



State of Colorado
 Department of Health Care and Policy and Financing
 Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
 Web-Based Cost Report Instructions

Hospital Input Report: Outpatient Charges by Payer

This worksheet of the UCR is for the cost report preparer to input outpatient charges by payer, according to the Medicare cost centers. These cost centers are:

	CMS-2552-96 Reference	CMS-2552-10 Reference
Operating Room	37.00	50.00
Recovery Room	38.00	51.00
Delivery Room and Labor Room	39.00	52.00
Anesthesiology	40.00	53.00
Radiology-Diagnostic	41.00	54.00
Radiology-Therapeutic	42.00	55.00
Radioisotope	43.00	56.00
Computed Tomography (CT) Scan		57.00
Magnetic Resonance Imaging (MRI)		58.00
Cardiac Catheterization		59.00
Laboratory	44.00	60.00
PBP Clinic Laboratory Services-Program Only	45.00	61.00
Whole Blood and Packed Red Blood Cells	46.00	62.00
Blood Storing, Processing, & Transfusing	47.00	63.00
Intravenous Therapy	48.00	64.00
Respiratory Therapy	49.00	65.00
Physical Therapy	50.00	66.00
Occupational Therapy	51.00	67.00
Speech Pathology	52.00	68.00
Electrocardiology	53.00	69.00
Electroencephalography	54.00	70.00
Medical Supplies Charged to Patients	55.00	71.00
Implantable Devices Charged to Patients	55.30	72.00

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

	CMS-2552-96 Reference	CMS-2552-10 Reference
Drugs Charged to Patients	56.00	73.00
Renal Dialysis	57.00	74.00
ASC (Non-Distinct Part)	58.00	75.00
Other Ancillary (Specify)	59.00	0.00
Other Ancillary (Specify)	59.XX	0.00
Other Ancillary (Specify)	59.XX	0.00
Other Ancillary (Specify)	59.XX	0.00
Clinic	60.00	90.00
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Emergency	61.00	91.00
Observation Beds	62.00	92.00
Rural Health Clinic	63.5X	88.00
Federally Qualified Health Center (FQHC)	63.5X	89.00
Other Outpatient Service (specify)	XX.XX	XX.XX

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

The outpatient charges listed above are needed from the following payers:

- Colorado Medicaid Fee-for-Service (FFS);
- Medicaid/Medicare Dual Eligible Fee-for-Service;
- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The source for the Colorado Medicaid FFS and Medicaid/Medicare Dual Eligible FFS outpatient charges will be Colorado MMIS claims data. The Department will populate this data for each hospital at a later date.

Each hospital will be responsible for reporting outpatient charges for the following payers:

- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The source for Outpatient Charges by Payer will be provider records and remittance advices, where applicable and available. Please refer to ***Appendix A: Glossary of Terms*** for a detailed definition of each payer type.

When completing the Outpatient Ancillary Charges by Payer in the UCR online system, please select the correct cost report year for the data being reported.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If hospitals need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, they must contact PCG.

State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

Before entering the Charges data, the user is able to make ALL of the fields on this page editable by checking the box located at the top, left side of table.



**Colorado Medicaid Uniform Cost Report
Outpatient Ancillary Charges by Payer**

Please select the year you would like to see the results: Cost Report Year 2012

<input checked="" type="checkbox"/>		CMS 2552-96 Line	CMS 2552-10 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan
Update					
<input checked="" type="checkbox"/>	Operating Room	37.00	50.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Recovery Room	38.00	51.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Delivery Room and Labor Room	39.00	52.00	\$0.00	<input type="text"/>

<input checked="" type="checkbox"/>		Medicaid/Medicare Dual Eligible Managed Care	Total Medicaid/Medicare Dual Eligible Charges	Total Medicaid Charges	Uninsured
Update					
<input checked="" type="checkbox"/>	Radioisotope	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Computed Tomography (CT) Scan	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Magnetic Resonance Imaging (MRI)	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Cardiac Catheterization	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Laboratory	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	PBP Clinic Laboratory Services-Program Only	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Whole Blood and Packed Red Blood Cells	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Blood Storing, Processing, & Transfusing	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Intravenous Therapy	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Respiratory Therapy	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Physical Therapy	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Occupational Therapy	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Speech Pathology	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Electrocardiology	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Electroencephalography	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Medical Supplies Charged to Patients	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Implantable Devices Charged to Patients	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Drugs Charged to Patients	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	Renal Dialysis	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>
<input checked="" type="checkbox"/>	ASC (Non-Distinct Part)	<input type="text"/>	\$0.00	\$0.00	<input type="text"/>

Update

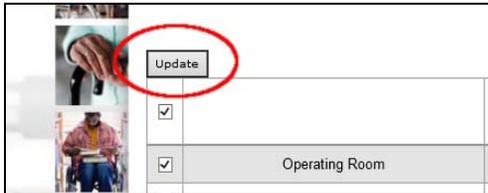
State of Colorado
Department of Health Care and Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Web-Based Cost Report Instructions

The user is able to make specific rows editable one at a time by checking the box for a specific row.

	10 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Manage
<input checked="" type="checkbox"/>	Operating Room	\$0.00			
<input type="checkbox"/>	Recovery Room	\$0.00			
<input type="checkbox"/>	Delivery Room and Labor Room	\$0.00			

It is important to note that all columns are not displayed on the screen. Please scroll to the right in order to see the additional columns. Finally, please remember to save all data in the UCR online system by clicking on the “Update” button located at the top left or bottom left corner of the screen.

Please remember to save your data before returning to the main menu.



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Hospital Input Report: Outpatient Payments by Payer

This worksheet of the UCR captures all Outpatient Payments by Payer made to hospitals. The following types of Outpatient Payments are reported:

- Primary Payer Payments;
- Medicare Payments;
- Patient Payments;
- Payments From Medicaid Agency;
- Uninsured Payments;
- Section 1011 Payments; and
- Cash subsidies for patient services.

The Outpatient Payments can be from the following payers:

- Colorado Medicaid Fee-for-Service (FFS);
- Medicaid/Medicare Dual Eligible Fee-for-Service;
- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The source for the Medicaid FFS and Medicaid/Medicare Dual Eligible FFS payments will be Colorado MMIS claims data. The Department will populate this data for each hospital at a later date.

Each hospital will be responsible for reporting payments for the following payers:

- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured

When completing the Outpatient Payments by Payer page in the UCR online system, please select the correct cost report year of the data being entered.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If hospitals need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, they must contact PCG.

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Before entering Outpatient Payment data, the user is able to make ALL of the fields on this page editable by checking the box located at the top, left side of table.

 **Colorado Medicaid Uniform Cost Report
Outpatient Payments by Payer**

Please select the year you would like to see the results: Cost Report Year 2012 ▾

<input checked="" type="checkbox"/>		Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Managed Care
<input checked="" type="checkbox"/>	Primary Payer Payments	\$0.00	[]	[]	[]
<input checked="" type="checkbox"/>	Medicare Payments	[]	[]	[]	[]
<input checked="" type="checkbox"/>	Medicare Transplant Reimbursement for Dual Eligibles				
<input checked="" type="checkbox"/>	Medicare Bad Debt Reimbursement for Dual Eligibles				
<input checked="" type="checkbox"/>	Patient Payments	0.00	[]	[]	[]
<input checked="" type="checkbox"/>	Payments From Medicaid Agency		[]	[]	[]
<input checked="" type="checkbox"/>	Uninsured Payments	[]	[]	[]	[]
<input checked="" type="checkbox"/>	Section 1011 Payments	[]	[]	[]	[]
<input checked="" type="checkbox"/>	Cash subsidies for patient services	[]	[]	[]	[]
Total		\$0.00	\$0.00	\$0.00	\$0

< [Update] >

The user is also able to make specific rows editable one at a time by checking the box for a specific row.

 **Colorado Medicaid Uniform Cost Report
Outpatient Payments by Payer**

Please select the year you would like to see the results: Cost Report Year 2012 ▾

<input type="checkbox"/>		Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Medicaid Fee-For-Service	Out-of-State Managed Care
<input checked="" type="checkbox"/>	Primary Payer Payments	\$0.00	[]	[]	[]
<input type="checkbox"/>	Medicare Payments				
<input type="checkbox"/>	Medicare Transplant Reimbursement for Dual Eligibles				
<input type="checkbox"/>	Medicare Bad Debt Reimbursement for Dual Eligibles				
<input type="checkbox"/>	Patient Payments	\$0.00			
<input type="checkbox"/>	Payments From Medicaid Agency				
<input type="checkbox"/>	Uninsured Payments				
<input type="checkbox"/>	Section 1011 Payments				
<input type="checkbox"/>	Cash subsidies for patient services				
Total		\$0.00	\$0.00	\$0.00	\$0

< [Update] >

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It is important to note that all columns are not displayed on the screen. Please scroll to the right in order to see the additional columns. Finally, please remember to save all data in the UCR online system by clicking on the “Update” button located at the upper left or bottom left corner of the screen.

Please remember to save your data before returning to the main menu.

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Hospital Input Report: Provider Fee Model Statistics

This worksheet of the UCR captures data for Managed Care Days, Distinct Part Psychiatric Units, and Charity Care Write-Off Charges.

Please refer to ***Appendix A: Glossary of Terms*** for a detailed definition terms on this page.

Managed Care Days

The Total Managed Care and Non-Managed Care Days for Cost Report Year 2012 are captured in this page. The following Managed Care Days data is needed:

- Commercial Managed Care Days;
- Medicare Managed Care Days; and
- Other Managed Care Days

Medicaid Managed Care Days data will be pre-populated from the Inpatient Routine Days page.

Total Days will be pre-populated by the UCR tool, using Medicare cost report data. Then, Non-Managed Care Days will automatically calculate as the difference between the Total Days and the Total Managed Care Days.

Distinct Part Psychiatric Unit

The following question requires a “Yes” or “No” answer from the facility:

- Does your facility have a **currently** active psychiatric unit?

Note: In this case, **currently** is define as the time that the UCR is being certified. Therefore, answer “yes” if your facility has an active psychiatric unit at the time you certify the UCR. If “Yes,” the facility will be required to report their Distinct Psychiatric Unit Medicaid Days.

Charity Care Write-Off Charges

The following question requires a “Yes” or “No” answer from the facility:

- Does your facility participate in the CICP program?
- This answer is pre-populated by the Department.

If “No,” the facility will be required to report their Charity Care Write-Off Charges. Below is a detailed definition.

- Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital’s charity care criteria

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(measured at full charges); for care delivered during this cost reporting period for the entire facility. For uninsured patients, this is the patient's total charges. For patients covered by a public program, these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If hospitals need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, they must contact PCG.

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**Colorado Medicaid Uniform Cost Report
Provider Fee Model Statistics**

Please select the year you would like to see the results:

Commercial Managed Care Days

Medicaid Managed Care Days 0

Medicare Managed Care Days

Other Managed Care Days

Total Managed Care Days 0

Total Days 0

Non-Managed Care Days

Distinct Part Psychiatric Unit

Does your facility have a currently active psychiatric unit? Yes
 No

Charity Care Write-Off Charges

Does your facility participate in the CICP program? Yes
 No

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**Colorado Medicaid Uniform Cost Report
Provider Fee Model Statistics**

Please select the year you would like to see the results:

Commercial Managed Care Days

Medicaid Managed Care Days

Medicare Managed Care Days

Other Managed Care Days

Total Managed Care Days

Total Days

Non-Managed Care Days

Distinct Part Psychiatric Unit

Does your facility have a currently active psychiatric unit?
 Yes
 No

Charity Care Write-Off Charges

Does your facility participate in the CICP program?
 Yes
 No

If your facility answered "No" to the previous question, please report your facility's total charity care write-off charges based on the definition below.

Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain

Please remember to save your data before returning to the main menu.

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***Hospital Input Report: Disproportionate Share Hospital (DSH)
Qualifications***

This worksheet of the UCR report contains a series of questions that will determine whether the hospital meets the DSH Obstetrician requirement.

First, hospitals will need to answer the Obstetrician Care and Certification Statement:

1. Do you certify that your hospital had at least two obstetricians with staff privileges who agreed to provide non-emergency obstetric services to Medicaid-eligible individuals during the DSH rate year?

If the facility answers "No" to the previous Question 1, then the answers to the following questions will determine if the hospital qualifies for one of the exceptions to the obstetrician requirement:

2. Do you certify that your hospital is located in a rural area with two physicians on staff that agreed to provide non-emergency obstetric services to Medicaid-eligible individuals during the DSH year?
3. Do you certify that your hospital had an inpatient population that was predominantly under 18 years of age during the Medicaid State Plan Rate Year?
4. Do you certify that your hospital qualifies for an exception under the obstetrician rule because the hospital did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

Please note that if you answer "Yes" to the first question, "No" will be automatically entered to questions 2, 3 and 4.

Additionally, if your facility answers "Yes" to Questions 1 or 2, then the name and NPI/UPIN of two obstetricians or rural physicians who provided the required obstetric services during the DSH year will need to be provided.

- Below are the screenshots of the DSH Qualifications page of the UCR online system. There are a total of four questions. Follow up questions will appear on the screen according to responses from the user. Please remember to click on the "Submit" button in order for your responses to be saved in the UCR online system.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If you need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, you must contact PCG.

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Colorado Medicaid Uniform Cost Report
DSH Qualifications
Valley View Hospital

Please select the year you would like to see the results: Cost Report Year 2012 ▼

DSH Qualifications

Obstetrician Care and Certification Statements

1 Do you certify that your hospital had at least two obstetricians with staff privileges who agreed to provide non-emergency obstetric services to Medicaid-eligible individuals during the DSH rate year? Yes
 No

If your facility answered "No" to the previous question, does your hospital qualify for one of the exceptions to the obstetrician requirement?

2 Do you certify that your hospital is located in a rural area with two physicians on staff that agreed to provide non-emergency obstetric services to Medicaid-eligible individuals during the DSH year? Yes
 No

3 Do you certify that your hospital had an inpatient population that was predominantly under 18 years of age during the Medicaid State Plan Rate Year? Yes
 No

4 Do you certify that your hospital qualifies for an exception under the obstetrician rule because the hospital did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987? Yes
 No

If you answered Yes to Questions 1 or 2 above, provide the name and NPI/UPIN of two obstetricians or rural physicians who provided the required obstetric services during the DSH year.

Obstetrician Name	<input type="text"/>	NPI/UPIN	<input type="text"/>
Obstetrician Name	<input type="text"/>	NPI/UPIN	<input type="text"/>

SubmitCancel

Please remember to save your data before returning to the main menu.

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Hospital Input Report: Disproportionate Share Hospital (DSH) Statistics

This worksheet of the UCR is the facility calculations for the Medicaid Inpatient Utilization Rate and Low Income Utilization Rate.

Please refer to ***Appendix A: Glossary of Terms*** for a detailed definition terms on this page.

Medicaid Inpatient Utilization Rate

This requires no input from the hospital.

Low Income Utilization Rate

Part I

- Total revenues paid to the hospital for patient services under the Medicaid state plan (Fee-for-service or managed care)
 - **Reported Inpatient and Outpatient Payments**
- Cash subsidies received directly from state and local governments for patient services in the hospital's fiscal year
 - **Reported by the facility**
- Total Medicaid Cash Revenues and Subsidies
 - **Calculated by the UCR tool**
- Total revenues of the hospital for patient services, including the amount of such cash subsidies
 - **Reported by the facility**

Part II

- Hospital's charges for inpatient hospital services which are attributable to charity care in the hospital's fiscal year
 - **Reported by the facility**
- Cash subsidies received directly from state and local governments for patient services in the hospital's fiscal year
 - **Reported by the facility**
- Hospital inpatient charges for charity care less cash subsidies from state and local governments
 - **Calculated by the UCR tool**
- Hospital's total charges for inpatient hospital services in the hospital's fiscal year
 - **Reported by the facility**

The total Low Income Utilization Rate is calculated in the UCR tool by adding Part I and Part II.

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As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If you need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, you must contact PCG.



Colorado Medicaid Uniform Cost Report
DSH Statistics

Please select the year you would like to see the results: Cost Report Year 2011-2012

DSH Statistics

Medicaid Inpatient Utilization Rate

	2011	2012	Total - Medicaid Rate Year
Total Medicaid Days	7,799	0	3,931
Total Days	9,636	1	4,858
<i>Medicaid Inpatient Utilization Rate</i>	80.94%	0%	80.92%

Low Income Utilization Rate

	2011	2012	Total - Medicaid Rate Year
Total revenues paid to the hospital for patient services under the Medicaid state plan (Fee-for-service or managed care)	5,599,298.70	0.00	2,822,606.47
Cash subsidies received directly from state and local governments for patient services in the hospital's fiscal year	0.00	0.00	0.00
Total Medicaid Revenues and Cash Subsidies	5,599,298.70	0.00	2,822,606.47
Total revenues of the hospital for patient services, including the amount of such cash subsidies	0.00	0.00	0.00
<i>Low Income Utilization Rate - Part One</i>	0%	0%	0%
Hospital's charges for inpatient hospital services which are attributable to charity care in the hospital's fiscal year	0.00	0.00	0.00
Cash subsidies received directly from state and local governments for inpatient patient services in the hospital's fiscal year	0.00	0.00	0.00
Hospital inpatient charges for charity care less cash subsidies from state and local governments	0.00	0.00	0.00
Hospital's total charges for inpatient hospital services in the hospital's fiscal year	0.00	0.00	0.00
<i>Low Income Utilization Rate - Part Two</i>	0%	0%	0%
Low Income Utilization Rate	0%	0%	0%

Submit
Cancel

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Hospital Input Report: Organ Transplant Costs and Reimbursement by Payer

This worksheet of the UCR captures the Organ Transplant Costs of the hospital that are specifically related to the Medicaid, the Uninsured, and Dual Eligible populations. Most of the data is available in the Medicare cost report. The Organ Transplant Costs are reported separately for the following:

- Kidney;
- Heart;
- Lung;
- Liver;
- Pancreas; or
- Other.

In order for the **“Total Pre-Acquisition Cost with Graduate Medical Education”** to be calculated, hospitals will need to gather the Organ Transplant Costs from the list above by using the following sources:

- Worksheet D-6, Part III Line 53;
- Worksheet B Part I, Column 22; and
- Worksheet B Part I, Column 23.

Then, to calculate the **Pre-Acquisition Cost per Organ**, data for **Total Usable Organs** (Worksheet D-6, Part III, Line 54) will need to be entered in to the UCR tool.

Additionally, the following data items are required to be reported:

- Medicaid Organs Transplanted For Cost Reporting Period;
- Uninsured Organs Transplanted For Cost Reporting Period; and
- Dual Eligible Organs Transplanted For Cost Reporting Period

This worksheet of the report will calculate the Medicaid Pre-Acquisition Cost, the Uninsured Pre-Acquisition Cost, and the Dual Eligible Acquisition Reimbursement.

As a reminder, data from Cost Report Year 2010 and Cost Report Year 2011 is locked and cannot be edited. If you need to make changes to data reported for Cost Report Year 2010 or Cost Report Year 2011, you must contact PCG.

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If your hospital does not perform organ transplants, you will see the following message when choosing any Cost Report Year for this report.



**Colorado Medicaid Uniform Cost Report
Organ Transplant Costs and Reimbursement by Payer***

This page does not apply to your facility

Please select the year you would like to see the results: Cost Report Year 2012 ▼

If your hospital does perform organ transplants, you will be able to view and edit organ transplant related data. Please see the examples below.



**Colorado Medicaid Uniform Cost Report
Organ Transplant Costs and Reimbursement by Payer***

Please select the year you would like to see the results: Cost Report Year 2012 ▼

Update

		Lung	Kidney	Liver	Heart	Pancreas	Other	Total
<input type="checkbox"/>								
<input type="checkbox"/>	Worksheet D-6 Part III, Column 1, Line 53 (Worksheet D-4, Part III, Column 1, Line 61)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input type="checkbox"/>	Worksheet B Part I, Column 22, Line 82 - 86 (for Specific Organ Acquisition) (Line 105 - 112)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input type="checkbox"/>	Worksheet B Part I, Column 23, Line 82 - 86 (for Specific Organ Acquisition) (Line 105 - 112)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input type="checkbox"/>	Total Pre-Acquisition Cost With Graduate Medical Education	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input type="checkbox"/>	Total Usable Organs (Worksheet D-6, Part III, Line 54) (Worksheet D-4, Part III, Line 53)	0	0	0	0	0	0	0
<input type="checkbox"/>	Pre-Acquisition Cost Per Organ	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Medicaid Organs Transplanted For Cost Reporting Period	<input style="border: 1px solid red;" type="text" value="0"/>	<input style="border: 1px solid red;" type="text" value="0"/>	<input style="border: 1px solid blue;" type="text" value="0"/>	0			
<input type="checkbox"/>	Medicaid Pre-Acquisition Cost	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input type="checkbox"/>	Uninsured Organs Transplanted For Cost Reporting Period	0	0	0	0	0	0	0

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**Colorado Medicaid Uniform Cost Report
 Organ Transplant Costs and Reimbursement by Payer***

Please select the year you would like to see the results: Cost Report Year 2012

Update

<input checked="" type="checkbox"/>		Lung	Kidney	Liver	Heart	Pancreas	Other	Total
<input checked="" type="checkbox"/>	Worksheet D-6 Part III, Column 1, Line 53 (Worksheet D-4, Part III, Column 1, Line 61)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Worksheet B Part I, Column 22, Line 82 - 86 (for Specific Organ Acquisition) (Line 105 - 112)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Worksheet B Part I, Column 23, Line 82 - 86 (for Specific Organ Acquisition) (Line 105 - 112)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Total Pre-Acquisition Cost With Graduate Medical Education	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Total Usable Organs (Worksheet D-6, Part III, Line 54) (Worksheet D-4, Part III, Line 53)	0	0	0	0	0	0	0
<input checked="" type="checkbox"/>	Pre-Acquisition Cost Per Organ	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Medicaid Organs Transplanted For Cost Reporting Period	<input style="border: 1px solid red;" type="text" value="0"/>	0					
<input checked="" type="checkbox"/>	Medicaid Pre-Acquisition Cost	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Uninsured Organs Transplanted For Cost Reporting Period	<input style="border: 1px solid red;" type="text" value="0"/>	0					
<input checked="" type="checkbox"/>	Uninsured Pre-Acquisition Cost	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Net Organ Acquisition Cost Per Worksheet D-6 Part III, Line 61 (Worksheet D-4, Part III, Line 61)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Medicare Usable Organs (Worksheet D-6 Part III, Line 55) (Worksheet D-4, Part III, Line 55)	0	0	0	0	0	0	0
<input checked="" type="checkbox"/>	Medicare Reimbursement Per Organ	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<input checked="" type="checkbox"/>	Medicaid Organs Transplanted That Were Dual Eligible	<input style="border: 1px solid red;" type="text" value="0"/>	0					
<input checked="" type="checkbox"/>	Medicare Reimbursement Related To Medicaid Dual Eligible Cost	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Update

Please remember to save your data before returning to the main menu.

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Hospital Input Report: Cost Report Certification Statement

The Cost Report Certification Statement is for the hospitals to attest to specific statements regarding the UCR report. This attestation is required and must be completed by an authorized hospital signatory.

I hereby attest that to the best of my knowledge and belief, the data reported by my hospital on this UCR are true and correct statements. My hospital prepared this information from the books and records of the Hospital, in accordance with applicable instructions, as of the date indicated below.

The utilization data and charges reported by my hospital and included in this UCR are based on actual Hospital records. The Hospital will retain all support and backup documentation for this UCR for the current year plus six years, for a total of seven years. In the case that the UCR is under audit after 7 years, the Hospital will retain the documentation until after the audit and subsequent appeal period have closed.

Additionally, as required by 42 CFR §455.304(d)(1), I confirm that for Medicaid Rate Year 2011-2012 (July 1, 2011 – June 30, 2012), my hospital received the amount of XXXXXX of Disproportionate Share Hospital (DSH) payments to offset its uncompensated care cost of rendering inpatient and outpatient hospital services to Medicaid eligible individuals, Colorado Indigent Care Program (CICP) individuals and individuals with no source of third party insurance.

Furthermore, my hospital had no restrictions on the retaining of funds by the State.

Name:

Title:

Date:

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**Colorado Medicaid Uniform Cost Report
Cost Report Certification Statement**

I hereby attest that to the best of my knowledge and belief, the data reported by my hospital on this UCR are true and correct statements. My hospital prepared this information from the books and records of the Hospital, in accordance with applicable instructions, as of the date indicated below.

The utilization data and charges reported by my hospital and included in this UCR are based on actual Hospital records. The Hospital will retain all support and backup documentation for this UCR for the current year plus six years, for a total of seven years. In the case that the UCR is under audit after 7 years, the Hospital will retain the documentation until after the audit and subsequent appeal period have closed.

Additionally, as required by 42 CFR §455.304(d)(1), I confirm that for Medicaid Rate Year 2011-12 (July 1, 2011 – June 30, 2012), my hospital received the amount listed below from the Disproportionate Share Hospital (DSH) payments to offset its uncompensated care cost of rendering inpatient and outpatient hospital services to Medicaid eligible individuals, Colorado Indigent Care Program (CICP) individuals and individuals with no source of third party insurance.

DSH Payments for Medicaid Rate Year 2011-12 (July 1, 2011 - June 30, 2012)

Furthermore, my hospital had no restrictions on the retaining of funds by the State.

Name

Title

Certify Reports

If you have any questions about the UCR, please contact the Department or PCG.

Important: Only the Hospital Administrator will have the credentials to certify the UCR. As always, please remember to save your data before returning to the main menu.

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Calculation Report: Hospital per Diem Calculation

This worksheet of the UCR calculates the Cost per Day for different inpatient cost centers. **There is no data input from the cost report preparer required on this worksheet.** The total costs and days from the following departments will come from your facility's Medicare (CMS 2552-10, previously CMS 2552-96) cost report:

	CMS-2552-96 Reference	CMS-2552-10 Reference
Adults & Pediatrics	25.00	30.00
Intensive Care Unit	26.00	31.00
Coronary Care Unit	27.00	32.00
Burn Intensive Care Unit	28.00	33.00
Surgical Intensive Care Unit	29.00	34.00
Other Special Care (Specify)	30.00	
Other Special Care (Specify)	30.XX	
Other Special Care (Specify)	30.XX	
Other Special Care (Specify)	30.XX	
Other Special Care (Specify)	30.XX	
Other Special Care (Specify)	30.XX	
Nursery	33.00	43.00
Subprovider I	31.00	41.00
Subprovider II	31.01	42.00
Skilled Nursing Facility	34.00	44.00
Nursing Facility	35.00	45.00
Other Long Term Care	36.00	46.00
Other Routine (Specify)	XX.XX	XX.XX
Other Routine (Specify)	XX.XX	XX.XX
Other Routine (Specify)	XX.XX	XX.XX

The Total Cost data items are available in the Medicare cost report in the following worksheets:

- Total Cost (Worksheet C, Part I, Column 1);
- Total Cost (Worksheet B Part I, Column 22);
- Total Cost (Worksheet B Part I, Column 23); and
- Swing Bed Adjustment (Worksheet D-1, Line 26) [for Adults and Pediatrics].

The Total Days data is available in the Medicare cost report in *Worksheet S-3, Part I, Col. 6* while Total Observation Days is available in *Worksheet S-3 Part I, Line 26, Col. 6*.

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The Calculation Reports only display data for Cost Report Year 2010 and Cost Report Year 2011. After hospitals submit Cost Report Year 2012 related data, the Department will populate and display Cost Report Year 2012 data and the resulting cost calculations.



**Colorado Medicaid Uniform Cost Report
Hospital Per Diem Calculations**

Please select the year you would like to see the results: Cost Report Year 2011 ▼

	Worksheet Part I (2552-96)	CMS 2552-10 Line	Worksheet S-3 Part I Line (2552-10)	Total Cost (Worksheet C, Part I, Column 1)	Total Cost (Worksheet B Part I, Column 22)	Total Cost (Worksheet B Part I, Column 23)	Swing Bed Adjustment (Worksheet D-1, Line 26)	Total Costs	Total Days (Worksheet S-3, Part I, Col 6)	Total Observation Days (Worksheet S-3 Part I, Line 26, Column 6)	Cost Per Day
Adults & Pediatrics	1.00	30.00	1.00	\$11,604,156.00	\$0.00	\$0.00	\$0.00	\$11,604,156.00	6,064	500	\$1,767.85
Intensive Care Unit	5.00	31.00	8.00	\$3,883,196.00	\$0.00	\$0.00	\$0.00	\$3,883,196.00	1,573		\$2,468.66
Nursery	1.00	43.00	13.00	\$2,237,518.00	\$0.00	\$0.00	\$0.00	\$2,237,518.00	1,999		\$1,119.32

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Calculation Report: Hospital Cost-to-Charge Ratio Calculations

This worksheet of the UCR calculates the Hospital Cost-to-Charge Ratio for different departments using the Total Cost and Total Charges data. **There is no data input from the cost report preparer required on this worksheet.** The total costs and charges from the following departments will come from your facility's new Medicare (CMS 2552-10 previously CMS 2552-96) cost report:

	CMS-2552-96 Reference	CMS-2552-10 Reference
Operating Room	37.00	50.00
Recovery Room	38.00	51.00
Delivery Room and Labor Room	39.00	52.00
Anesthesiology	40.00	53.00
Radiology-Diagnostic	41.00	54.00
Radiology-Therapeutic	42.00	55.00
Radioisotope	43.00	56.00
Computed Tomography (CT) Scan		57.00
Magnetic Resonance Imaging (MRI)		58.00
Cardiac Catheterization		59.00
Laboratory	44.00	60.00
PBP Clinic Laboratory Services-Program Only	45.00	61.00
Whole Blood and Packed Red Blood Cells	46.00	62.00
Blood Storing, Processing, & Transfusing	47.00	63.00
Intravenous Therapy	48.00	64.00
Respiratory Therapy	49.00	65.00
Physical Therapy	50.00	66.00
Occupational Therapy	51.00	67.00
Speech Pathology	52.00	68.00
Electrocardiology	53.00	69.00
Electroencephalography	54.00	70.00
Medical Supplies Charged to Patients	55.00	71.00
Implantable Devices Charged to Patients	55.30	72.00
Drugs Charged to Patients	56.00	73.00
Renal Dialysis	57.00	74.00
ASC (Non-Distinct Part)	58.00	75.00
Other Ancillary (Specify)	59.00	0.00
Other Ancillary (Specify)	59.XX	0.00
Other Ancillary (Specify)	59.XX	0.00
Other Ancillary (Specify)	59.XX	0.00
Clinic	60.00	90.00

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	CMS-2552-96 Reference	CMS-2552-10 Reference
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Other Clinic (specify)	60.XX	90.XX
Emergency	61.00	91.00
Observation Beds	62.00	92.00
Rural Health Clinic	63.5X	88.00
Federally Qualified Health Center (FQHC)	63.5X	89.00
Other Outpatient Service (specify)	0	0

The Total Cost data items are available in the Medicare cost report in the following sections:

- Total Cost (Worksheet C, Part I, Column 1);
- Total Cost (Worksheet B Part I, Column 22); and
- Total Cost (Worksheet B Part I, Column 23).

Additionally, the Total Charges data items are available in the Medicare cost report in the following worksheets:

- Inpatient Charges (Worksheet C, Column 5) and
- Outpatient Charges (Worksheet C, Column 6).

The Calculation Reports only display data for Cost Report Year 2010 and Cost Report Year 2011. After hospitals submit Cost Report Year 2012 related data, the Department will populate and display Cost Report Year 2012 data and the resulting cost calculations.

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**Colorado Medicaid Uniform Cost Report
Hospital Cost-to-Charge Ratio Calculations**

Please select the year you would like to see the results: Cost Report Year 2011

	CMS 2552- 96 Line	CMS 2552- 10 Line	Total Cost (Worksheet C, Part I, Column 1)	Total Cost (Worksheet B Part I, Column 22)	Total Cost (Worksheet B Part I, Column 23)	Total Costs	Inpatient Charges (Worksheet C, Column 5)	Outpatient Charges (Worksheet C, Column 6)	Charges	Cost to Charge Ratio
Operating Room	37.00	50.00	\$7,685,056.00	\$0.00	\$0.00	\$7,685,056.00	\$18,145,432.00	\$23,085,514.00	\$41,230,946.00	0.1864
Recovery Room	38.00	51.00	\$1,058,624.00	\$0.00	\$0.00	\$1,058,624.00	\$1,888,820.00	\$3,356,237.00	\$5,245,057.00	0.2018
Room and Labor Room	39.00	52.00	\$1,060,149.00	\$0.00	\$0.00	\$1,060,149.00	\$1,000,000.00	\$894,600.00	\$1,894,600.00	0.5596
Anesthesiology	40.00	53.00	\$190,852.00	\$0.00	\$0.00	\$190,852.00	\$2,702,429.00	\$3,939,974.00	\$6,642,403.00	0.0287
Immunology-Diagnostic	41.00	54.00	\$6,271,081.00	\$0.00	\$0.00	\$6,271,081.00	\$4,705,783.00	\$24,727,133.00	\$29,432,916.00	0.2131
Radioisotope	43.00	56.00	\$607,677.00	\$0.00	\$0.00	\$607,677.00	\$282,644.00	\$2,707,541.00	\$2,990,185.00	0.2032
Catheterization	0.00	59.00	\$2,631,517.00	\$0.00	\$0.00	\$2,631,517.00	\$1,864,624.00	\$1,450,347.00	\$3,314,971.00	0.7938
Laboratory	44.00	60.00	\$5,819,722.00	\$0.00	\$0.00	\$5,819,722.00	\$7,390,091.00	\$17,795,597.00	\$25,185,688.00	0.2311
Unfractionated Packed Red Blood Cells	46.00	62.00	\$485,294.00	\$0.00	\$0.00	\$485,294.00	\$1,111,919.00	\$392,239.00	\$1,504,158.00	0.3226
Respiratory Therapy	49.00	65.00	\$1,837,210.00	\$0.00	\$0.00	\$1,837,210.00	\$1,799,653.00	\$2,230,372.00	\$4,030,025.00	0.4559
Physical Therapy	50.00	66.00	\$3,035,752.00	\$0.00	\$0.00	\$3,035,752.00	\$556,399.00	\$3,801,852.00	\$4,358,251.00	0.6966
Occupational Therapy	51.00	67.00	\$1,238,218.00	\$0.00	\$0.00	\$1,238,218.00	\$493,384.00	\$1,011,279.00	\$1,504,663.00	0.8229
Clinical Pathology	52.00	68.00	\$514,747.00	\$0.00	\$0.00	\$514,747.00	\$103,557.00	\$346,912.00	\$450,469.00	1.1427
Services Charged to Patients	55.00	71.00	\$4,549,594.00	\$0.00	\$0.00	\$4,549,594.00	\$4,346,167.00	\$4,176,732.00	\$8,522,899.00	0.5338
Services Charged to Patients	55.30	72.00	\$3,425,498.00	\$0.00	\$0.00	\$3,425,498.00	\$3,870,043.00	\$1,293,333.00	\$5,163,376.00	0.6634
Services Charged to Patients	56.00	73.00	\$5,898,456.00	\$0.00	\$0.00	\$5,898,456.00	\$11,492,300.00	\$13,794,867.00	\$25,287,167.00	0.2333
Outpatient Clinic	60.00	90.00	\$830,153.00	\$0.00	\$0.00	\$830,153.00	\$0.00	\$517,696.00	\$517,696.00	1.6036
Emergency	61.00	91.00	\$4,099,810.00	\$0.00	\$0.00	\$4,099,810.00	\$1,497,295.00	\$10,118,189.00	\$11,615,484.00	0.3530

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Calculation Report: Inpatient Routine Costs by Payer

Calculation Report: Inpatient Ancillary Costs by Payer

Calculation Report: Outpatient Costs by Payer

There is no data input from the cost report preparer required on these reports. These worksheets calculate the inpatient routine, inpatient ancillary, and outpatient costs by payer.

The Inpatient Routine Costs by Payer is calculated for different departments using the Hospital Per Diem (Hospital Input Reports) and Inpatient Routine Days (Hospital Input Reports) data.

The Inpatient Ancillary Costs by Payer is calculated for different departments using the Hospital Cost-to-Charge Ratios (Calculation Reports) and Inpatient Ancillary Charges (Hospital Input Reports) data.

The Outpatient Costs by Payer is calculated for different departments using the Hospital Cost-to-Charge Ratios (Calculation Reports) and Outpatient Charges (Hospital Input Reports) data.

The costs by payer calculations include the following payers:

- Colorado Medicaid Fee-for-Service;
- Medicaid Managed Care Plan;
- Out-of-State Medicaid Fee-For-Service;
- Out-of-State Medicaid Managed Care;
- Medicaid Fee-for-Service NOT Billed to Medicaid;
- Medicaid/Medicare Dual Eligible Fee-for-Service;
- Medicaid/Medicare Dual Eligible Managed Care; and
- Uninsured.

The Calculation Reports only display data for Cost Report Year 2010 and Cost Report Year 2011. After hospitals submit Cost Report Year 2012 related data, the Department will populate and display Cost Report Year 2012 data and the resulting cost calculations.



**Colorado Medicaid Uniform Cost Report
Inpatient Routine Cost by Payer***

Please select the year you would like to see the results: Cost Report Year 2011 ▼

	CMS 2552-96 Line	CMS 2552-10 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan	Out-of-State Mer Fee-For-Serv
Adults & Pediatrics	25.00	30.00	\$7,163,328.20	\$2,280,526.50	\$37,124.85
Intensive Care Unit	26.00	31.00	\$441,890.14	\$0.00	\$0.00
Coronary Care Unit	27.00	32.00	\$0.00	\$0.00	\$0.00
Burn Intensive Care Unit	28.00	33.00	\$0.00	\$0.00	\$0.00
Surgical Intensive Care Unit	29.00	34.00	\$0.00	\$0.00	\$0.00

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**Colorado Medicaid Uniform Cost Report
Inpatient Ancillary Cost by Payer**

Please select the year you would like to see the results:

	CMS 2552-96 Line	CMS 2552-10 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan
Operating Room	37.00	50.00	\$258,125.79	\$0.00
Recovery Room	38.00	51.00	\$49,111.26	\$0.00
Delivery Room and Labor Room	39.00	52.00	\$415,771.05	\$2,752.67
Anesthesiology	40.00	53.00	\$7,027.86	\$0.00



**Colorado Medicaid Uniform Cost Report
Outpatient Cost by Payer**

Please select the year you would like to see the results:

	CMS 2552-96 Line	CMS 2552-10 Line	Colorado Medicaid Fee-for-Service	Medicaid Managed Care Plan
Operating Room	37.00	50.00	\$220,741.40	\$7,703.17
Recovery Room	38.00	51.00	\$98,055.63	\$620.54
Delivery Room and Labor Room	39.00	52.00	\$57,003.65	\$0.00
Anesthesiology	40.00	53.00	\$5,807.19	\$86.73
Radiology-Diagnostic	41.00	54.00	\$368,541.32	\$928.26

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Summary Report: Disproportionate Share Hospital (DSH) Summary

This worksheet of the UCR provides the user with the DSH Summary of all the data entered in the UCR. **There is no data input from the cost report preparer required on this worksheet.**

The first part of this worksheet consists of certification information and statistics related to DSH. Specifically, the following statistics are shown to the user:

- Fulfillment of Obstetrician Requirement;
- Medicaid Inpatient Utilization Rate (MIUR);
- MIUR Greater than 1% (Yes or No);
- Low Income Utilization Rate (LIUR);
- Use LIUR to Qualify for DSH (Yes or No); and
- MIUR/LIUR Requirement Met (Yes or No).

The source of the above data elements is *DSH Statistics*.

The second part of the worksheet consists of the summary of DSH allowable costs and payments separated by inpatient and outpatient.

Inpatient Costs

- IP Medicaid Only Cost
 - Includes IP Routine Cost by Payer, IP Ancillary Cost by Payer, and Organ Transplant Costs.
- IP Medicaid/Medicare Dual Eligible Cost
 - Includes IP Routine Cost by Payer, IP Ancillary Cost by Payer, and Organ Transplant Costs.
- IP Uninsured Cost
 - Includes IP Routine Cost by Payer, IP Ancillary Cost by Payer, and Organ Transplant Costs.
- Total Inpatient Cost
 - Sum of IP Medicaid Only Cost, IP Medicaid/Medicare Dual Eligible Cost and IP Uninsured Cost.

Outpatient Costs

- OP Medicaid Only Cost
 - Includes OP Cost by Payer.
- OP Medicaid/Medicare Dual Eligible Cost
 - Includes OP Cost by Payer.
- OP Uninsured Cost
 - Includes OP Cost by Payer.
- Total Outpatient Cost

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- Sum of OP Medicaid Only Cost, OP Medicaid/Medicare Dual Eligible Cost and OP Uninsured Cost.
- Total Medicaid Only Cost, Medicaid/Medicare Dual Eligible Cost, and Uninsured Cost.

Inpatient Payments

- IP Medicaid Only Payments
- IP Medicaid/Medicare Dual Eligible Payments
- Uninsured IP Payments
- Total Inpatient Payments
 - Sum of IP Medicaid Only Payments, IP Medicaid/Medicare Dual Eligible Payments, and Uninsured IP Payments.

Outpatient Payments

- OP Medicaid Only Payments
- OP Medicaid/Medicare Dual Eligible Payments
- Uninsured OP Payments
- Total Outpatient Payments
 - Sum of Medicaid Only Payments, OP Medicaid/Medicare Dual Eligible Payments, and Uninsured OP Payments
- Total Medicaid Only, Medicaid/Medicare Dual Eligible, and Uninsured Payments
- Total Cost Eligible for DSH Reimbursement
 - Total Medicaid Only, Medicaid/Medicare Dual Eligible, and Uninsured Costs subtracted from Medicaid Only, Medicaid/Medicare Dual Eligible, and Uninsured Payments

Below are sample screen shots of *DSH Summary*.

The Calculation Reports only display data for Cost Report Year 2010 and Cost Report Year 2011. After hospitals submit Cost Report Year 2012 related data, the Department will populate and display Cost Report Year 2012 data and the resulting cost calculations.

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Colorado Medicaid Uniform Cost Report
 DSH Summary

Disproportionate Share Hospital Summary	Year 2010	Year 2011	Total - Medicaid Rate Year
Obstetrician Requirement Met?	Yes	Yes	Yes
Medicaid Inpatient Utilization Rate (MIUR)	65.72%	80.94%	73.16%
MIUR Greater than 1%?	Yes	Yes	Yes
Low Income Utilization Rate (LIUR)	0.00%	0.00%	0.00%
Use LIUR to Qualify for DSH?	N/A	N/A	N/A
LIUR Greater than 25%?	No	No	No
MIUR/LIUR Requirement Met?	Yes	Yes	Yes
<i>Costs</i>			
IP Medicaid Only Cost	\$11,932,656.71	\$13,099,551.09	\$12,511,319.63
IP Medicaid/Medicare Dual Eligible Cost	\$2,206,473.76	\$3,047,805.05	\$2,623,689.95
IP Uninsured Cost	\$0.00	\$0.00	\$0.00
Total Inpatient Cost	\$14,139,130.47	\$16,147,356.14	\$15,135,009.58
OP Medicaid Only Cost	\$2,225,909.17	\$2,471,485.01	\$2,347,690.23
OP Medicaid/Medicare Dual Eligible Cost	\$612,731.97	\$621,154.42	\$616,908.66
OP Uninsured Cost	\$0.00	\$0.00	\$0.00
Total Outpatient Cost	\$2,838,641.14	\$3,092,639.43	\$2,964,598.89
Total Medicaid FFS, Medicaid MCO, and Uninsured Cost	\$16,977,771.61	\$19,239,995.57	\$18,099,608.47

<i>Payments</i>			
IP Medicaid Only Payments	\$3,558,434.15	\$3,683,392.00	\$3,620,400.75
IP Medicaid/Medicare Dual Eligible Payments	\$2,042,445.57	\$1,235,938.00	\$1,642,498.47
Uninsured IP Payments	\$0.00	\$0.00	\$0.00
Total Inpatient Payments	\$5,600,879.72	\$4,919,330.00	\$5,262,899.22
OP Medicaid Only Payments	\$1,638,458.69	\$1,965,793.70	\$1,800,784.12
OP Medicaid/Medicare Dual Eligible Payments	\$744,998.70	\$672,385.68	\$708,989.90
Uninsured OP Payments	\$0.00	\$0.00	\$0.00
Total Outpatient Payments	\$2,383,457.39	\$2,638,179.38	\$2,509,774.02
Total Medicaid Only, Medicaid/Medicare Dual Eligible, and Uninsured Payments	\$7,984,337.11	\$7,557,509.38	\$7,772,673.24
Total Cost Eligible for DSH Reimbursement	\$8,993,434.50	\$11,682,486.19	\$10,326,935.23

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Appendix A: Glossary of Terms

Cash Subsidies from State and Local Governments are funds for inpatient and outpatient services that were provided to non-Medicaid eligible individuals during the hospital's fiscal year.¹ Providers should obtain and report information about these funding sources using their audited financial statements and records. This information is used to calculate the Low Income Utilization Rate (LIUR) for Disproportionate Share Hospital (DSH) requirements. Please note that this category may not apply to your hospital.

Centers for Medicare and Medicaid Services (CMS) is a sub agency of the Federal Department of Health and Human Services with administrative oversight for Medicare and the federal portion of Medicaid programs.²

Colorado Health Care Affordability Act (CHCAA) is the law that authorizes the Colorado Department of Health Care Policy and Financing to assess the Hospital Provider Fee.³

Costs for Hospital Services are determined using the Medicare cost allocation process. A per diem is computed for each routine cost center and a cost-to-charge ratio is calculated for each ancillary/non-routine cost center. Then, each routine cost center's total allowable costs are apportioned to a specific program by applying that cost center's days to its calculated per diem and each ancillary/non-routine cost center's total allowable costs are apportioned to specific programs by applying the cost center's program charges to its calculated cost-to-charge ratio. Providers can verify information using their CMS-2552.⁴ This information is used to calculate a hospital's costs by patient payer type and it is used in the calculation of the Hospital Specific DSH Limit.

Cost per Diem calculations are used to determine the cost per day for each routine cost center service. These calculations are performed by taking the total cost for each routine cost center service and dividing it by the total days in the corresponding cost center. This information is used in the calculation of the Hospital Specific DSH Limit as required by the DSH Final Rule.⁵

Cost to Charge Ratio (CCR) is a calculated ratio used to determine a provider's cost for providing services to the charge the provider reports for services. A cost to charge ratio is found by taking the total costs of services for each line item in the ancillary cost center and dividing it by the corresponding total charges line item in the ancillary cost center (i.e. line 25, Column 3 Costs/line 25, Column 8 charges). This calculation is performed in Worksheet C of the CMS-2552 Form.⁶

Charges incurred for inpatient and outpatient services are used to apportion costs using cost to charge ratios for ancillary services. Providers should report or verify ancillary service cost centers for inpatient and

¹ Social Security Act §1923(b)(3)(A)(i)

² Federal Register. *Centers for Medicare and Medicaid Services*. Web. <<https://www.federalregister.gov/agencies/centers-for-medicare-medicaid-services>>

³ State of Colorado. *Colorado House Bill 09-1293*. Web.

<http://www.leg.state.co.us/Clis/CLICS2009A/csl.nsf/fsbillcont3/D71C48DD229F80CD872575540079F3A0?Open&file=1293_enr.pdf>

⁴ Medicaid. *General DSH Audit and Reporting Protocol*. Web. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/General_DSH_Audit_Reporting_Protocol.pdf>

⁵ *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77907 & 77921

⁶ Department of Health and Human Services & the Centers for Medicare and Medicaid Services. *Medicare Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10*. (December 2010). Web. <<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1P240.pdf>>

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outpatient charges by patient payer types in the UCR using Worksheet C of the CMS-2552 Form. Information about charges is used to calculate Hospital Specific DSH Limits and it is required by the DSH Final Rule.⁷

Coinsurance Payments are payments received from a patient for services provided. These payments should be reported by the hospital under the “Patient Payment” field.⁸ This information is used to calculate Hospital Specific DSH Limits.

Deductible Payments are required payments from eligible individuals. These payments are used as a cost sharing mechanism. Any deductible payments received from a patient for services reported should be recorded under the “Patient Payment” field.⁹ This information is used to calculate Hospital Specific DSH Limits.

Disproportionate Share Hospital (DSH) funds provide financial support to hospitals that serve a significantly disproportionate number of low-income patients. The Federal government assists the States by allocating this funding in order to reduce the cost of uncompensated care.¹⁰

DSH Payments are reported with the date and amount for each DSH payment received in the Medicaid State Plan rate year. Hospitals should also report any DSH payments received from other Medicaid State Agencies in the Medicaid State Plan rate year.¹¹ This information will be populated by the Department.

Dual Eligible (Medicaid/Medicare) patients are those covered by Medicare and Medicaid. Since Medicaid is the payer of last resort, dual eligible claims must first be billed to Medicare and then to Medicaid. Such claims are often referred to as crossover claims. Dual eligible/crossover claims are reimbursed by Colorado Medicaid based on whichever of the following two formulas results in a lesser amount: the sum of the reported Medicare coinsurance and deductible or the Colorado Medicaid-allowed benefit minus the Medicare payment.

Dual Eligible (Medicaid/Medicare) Days are service days provided to patients with Medicare primary and Medicaid secondary.¹² Providers should report or verify this information using audited financial records or remittance advices. These patient days are divided into FFS days and MCO days. This information is used in the calculation of Hospital Specific DSH Limits. This information will be populated by the Department.

Dual Eligible (Medicaid/Medicare) FFS Days are service days provided to patients with Medicare primary and Medicaid secondary plans, this includes patients with crossover status that have not been included in a previous category with a claim that was filed using Medicaid FFS. Providers should report and verify information on Dual Eligible FFS days using auditable records and remittance advices. This

⁷ *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Page 77907 and 77921; 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 2 and 5 through 8; CMS Publication 15-2 §3620.1

⁸ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(7)

⁹ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(7)

¹⁰ United States Department of Health and Human Services. Disproportionate Share Hospital (DSH). Web. <<http://www.hhs.gov/recovery/cms/dsh.html>>

¹¹ 42 CFR §447.299(c)(16)

¹² Social Security Act §1923(g)(1)(A); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77912; 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

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information is used to determine the cost of providing services to Medicaid eligible individuals for DSH.¹³ This information will be populated by the Department.

Dual Eligible (Medicaid/Medicare) MCO Days are service days provided to patients with Medicare primary and Medicaid secondary plans, this includes patients with crossover status that have not been included in a previous category with a claim that was filed using Medicaid Managed Care. Providers should report and verify information on Dual Eligible MCO days using auditable records and remittance advices. This information is used to determine the cost of providing services to Medicaid eligible individuals for DSH.¹⁴

Dual Eligible (Medicaid/Medicare) Organ Transplants are those provided to dual eligible recipients during the Medicaid State Plan rate year. Providers should report or verify the number of organs transplanted (kidney, heart, lung, liver, pancreas, and other) and the acquisition costs for these organs. Information on the number of transplants can be obtained using CMS-2552-96, Worksheet D-6, Part III, Line 54, Column 2 or CMS-2552-10, Worksheet D-4, Part III, Line 62, Column 2; while information on the acquisition costs for organs can be obtained using CMS-2552-96, Worksheet D-6, Part III, Line 61, Column 1 or CMS-2552-10, Worksheet D-4, Part III, Line 69, Column 1. Providers should also report information on Dual eligible individuals that received a transplant during the Medicaid State Plan rate year. Payments for these services must be offset against any previously received payments or reimbursements for dual eligible individuals. Any dual eligible transplant payments received by Medicare for these services should be included in the cost of Medicaid FFS activities.¹⁵ This information is used to determine the cost of providing services to Medicaid eligible individuals for DSH.

Graduate Medical Education Costs are excluded from Medicare cost report calculations used to determine cost per diem and cost to charge ratios; however, Medicaid cost reporting allows graduate medical education to be reimbursed under Medicare cost reporting principles for cost based reimbursements. Information on graduate medical education costs can be obtained or verified using CMS-2552-96, Worksheet B, Part I, Column 22 and Column 23 or CMS-2552-10, Worksheet B, Part I, Column 21 and Column 22. This information is used in the UCR to determine cost per diems and cost to charge ratios¹⁶ for the calculation of Hospital Specific DSH Limits.

An **Inpatient** is a patient who has an admission order given by a licensed physician or other individual who has been granted admitting privileges by the hospital. Observation patients are excluded from this category unless they are admitted.

Low-Income-Utilization Rate (LIUR) is one of the measures used to deem a hospital eligible for DSH. If a hospital does not meet the requirements of the Medicaid Inpatient Utilization Rate (MIUR), as defined below, a hospital must have a LIUR of at least twenty-five (25) percent in order to qualify for DSH

¹³ Social Security Act §1923(g)(1)(A); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77912; 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

¹⁴ Social Security Act §1923(g)(1)(A); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77912; 42 CFR §447.299(c)(7); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

¹⁵ 42 CFR §447.299(c)(6); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77912; CMS Additional Information on the DSH Reporting and Audit Requirements released February 22, 2010.

¹⁶ CMS Additional Information on the DSH Reporting and Audit Requirements released February 22, 2010.

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reimbursement.¹⁷ The LIUR is calculated as the sum of the ratio of total Medicaid revenue (including cash subsidies from State and Local Governments) to total hospital revenue (including cash subsidies from State and Local Governments) and the ratio of hospital inpatient charity charges (including cash subsidies from State and Local Governments) to total hospital charity care charges.

Managed Care Days are days related to consumers that are generally restricted to a specified or preferred network of providers. Examples of Managed Care plans include: AETNA (Aetna Quality POS, Aetna HMO, Aetna Managed Choice POS, Aetna Open Choice PPO), Anthem Wellpoint (Premier PPO, Lumenos HSA Plus, SmartSense Plus, CoreShare Plus, Clear Protection, Tonik, HMO Colorado) Blue Cross/Blue Shield (include plans that restrict clients to a preferred network of providers, and Blue Cross/Blue Shield has a contractual arrangement with the provider), Cigna/Great West (Cigna HMO, Cigna PPO, Cigna POS, Cigna OAP, Cigna Consumer Advantage, Great West Life PPO, Great West Life POS), Rocky Mountain Health Plan (SOLO Outlook PPO), Kaiser Permanente (Kaiser Traditional HMO, Kaiser Deductible/Coinsurance HMO, Kaiser HMO Plus, Kaiser Deductible/Coinsurance HMO Plus, Kaiser PPO, Kaiser Added Choice POS, Kaiser MultiChoice POS), Pacificare (PacifiCare Signature Value HMO, PacifiCare Signature POS, PacifiCare SignatureElite PPO), United Healthcare (United Choice Plus, United Options PPO, United Choice, United HMO, United Healthcare Core, United Healthcare Catalyst, United Healthcare EDGE, United Healthcare Tiered Benefits), Humana (Copay Plans, 100% After Deductible Plans), Other HMO (not listed elsewhere), Other PPO (not listed elsewhere), Other POS (not listed elsewhere), Other EPO (not listed elsewhere), Other Managed Care (not listed elsewhere). This category may also include TriCare and other government managed care plans.

Medicaid Fee-for-Service (FFS) Inpatient Days are days of service provided to Medicaid FFS patients for inpatient services. Medicaid FFS inpatient days does not include days covered by a Colorado Behavioral Health Organization (BHO); these days are to be reported in Medicaid Managed Care sections. CMS uses this information to calculate the cost of Medicaid eligible services by each cost center. Medicaid days are used in the calculation of Medicaid eligible costs and in the calculation of the Medicaid Inpatient Utilization Rate (MIUR), which is used to qualify a hospital as Medicaid DSH eligible.¹⁸ This information will be populated using paid claims from the Medicaid Management Information System (MMIS). Providers should verify information using CMS-2552-96, Worksheet S-3, Part I, Column 5.

Medicaid FFS Inpatient Costs are determined by computing per diem and cost-to-charge ratios for inpatient services provided to Medicaid FFS patients, these are computed for each ancillary/non-routine cost center. The total allowable costs from each ancillary/non-routine cost center are apportioned to the specific program by applying each cost center's program charges to the cost center's computed cost-to-charge ratio.¹⁹ This information is used to calculate Hospital Specific DSH Limits.

Medicaid FFS Not Billed to Medicaid Days are days of service provided to Medicaid FFS patients that were not billed to Medicaid or a fiscal intermediary; this includes Medicaid eligible patients that qualify for third party payments, deductibles, and coinsurance if they received services as an inpatient or outpatient. Providers should report information by line item as it is reported in the CMS-2552 Worksheet S-3, Part I, according to the line items included in the UCR Template, specific information for this patient payer category

¹⁷ Peters, Christie P. *The Basics. Medicaid Disproportionate Share Hospital (DSH) Payments*. The National Health Policy Forum. 15 June 2009. Web. <http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf>

¹⁸ Social Security Act §1923(b)(1)(A); §1923(b)(2), §1923(d)(3); §1923(g)(1)(A); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77921; 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 2 and 5 through 8

¹⁹ Medicaid. *General DSH Audit and Reporting Protocol*. Web. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/General_DSH_Audit_Reporting_Protocol.pdf>

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will be obtained from audited provider records. This information is used to determine the cost of services provided to Medicaid eligible individuals for DSH.²⁰

Medicaid FFS Not Billed to Medicaid Charges are charges for services provided to Medicaid FFS patients that were not billed to a fiscal intermediary; this includes Medicaid eligible patients that qualify for third party payments, deductibles, and coinsurance if they received services as an inpatient or outpatient. Providers should report information by line item as it is reported in the CMS-2552, Worksheet S-3, Part I, according to the line items included in the UCR, specific information for this patient payer category will be obtained from audited provider records. This information is used to determine the uncompensated cost of services for Medicaid eligible individuals for DSH.²¹

Medicaid FFS Not Billed to Medicaid Payments are those made for services provided to Medicaid FFS patients that were not billed to Medicaid or a fiscal intermediary; this includes third party payments for Medicaid FFS eligible patients, deductibles, and or coinsurance the hospital received for inpatient or outpatient services for these individuals. Providers should report information by line item as it is reported in the CMS-2552, Worksheet S-3, Part I, according to the line items included in the UCR, specific information for this patient payer category will be obtained from audited provider records. This information is used to determine the uncompensated cost of services for Medicaid eligible individuals for DSH.²²

Medicaid FFS Out-of-State Days are days of service provided to Medicaid FFS out-of-state patients. Providers should report information by line item according to the line items included in the UCR Template, specific information for this patient payer category will be obtained from audited provider records. This information is used to determine the cost of services provided to Medicaid eligible individuals for DSH.²³

Medicaid FFS Out-of-State Charges are charges for services provided to out-of-state Medicaid FFS patients. Providers should report information by line item according to the line items included in the UCR, specific information for this patient payer category will be obtained from audited provider records. This information is used to determine the uncompensated cost of services for Medicaid eligible individuals for DSH.²⁴

Medicaid FFS Out-of-State Payments are to be reported for FFS activities from other Medicaid State Agencies. Providers should obtain this information from audited financial statements and accounting records or remittance advices for services provided to Medicaid FFS out-of-state patients during the hospital's cost report fiscal year. This information is used to determine the uncompensated cost of services provided to Medicaid eligible individuals for DSH.²⁵

²⁰ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

²¹ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

²² Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

²³ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

²⁴ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

²⁵ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 3 and 5 through 8

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Medicaid Inpatient Charges are those incurred by Medicaid eligible inpatients. Providers will report charges according to cost center levels as they do on the CMS-2552 form. Medicaid charges are used in the calculation of Medicaid eligible costs for DSH.²⁶

Medicaid Inpatient Utilization Rate (MIUR) is one of the measures used to deem a hospital eligible for DSH. In order to qualify for DSH reimbursement, a hospital must have a MIUR of at least one percent.²⁷ The MIUR is calculated as the ratio of hospital Medicaid Days to Total Days. In the event that a hospital does not have a MIUR of at least one percent, the LIUR is used to deem a hospital eligible for DSH reimbursement.

Medicaid Managed Care Days are service days provided to Medicaid Managed Care patients, these are days where Medicaid was the primary payer and it excludes Medicaid out-of-state days. Medicaid Managed Care Days includes days covered by a Colorado Behavioral Health Organization (BHO). Providers should verify or report this information using audited financial records and remittance advices. This information is used to determine Medicaid Managed Care Organization (MCO) uncompensated cost for services provided to Medicaid eligible individuals for DSH.²⁸

Medicaid Managed Care Payments are amounts paid to the hospital for inpatient or outpatient services for Medicaid eligible individuals that were paid by MCOs. Medicaid Managed Care Payments includes payments from a Colorado Behavioral Health Organization (BHO). Medicaid Managed Care Payments will be reported and verified using the providers audited financial statements and accounting records.²⁹ This information is used to determine Medicaid MCO uncompensated cost for services provided to Medicaid eligible individuals for DSH.

Medicaid MCO Out-of-State Days are service days provided to Medicaid MCO out-of-state patients. Providers should verify or report this information using audited financial records and remittance advices. This information is used to determine Medicaid MCO uncompensated cost for services provided to Medicaid eligible individuals for DSH.³⁰

Medicaid MCO Out-of-State Charges are charges for services provided to out-of-state Medicaid MCO patients. Providers should report information by line item according to the line items included in the UCR Template, specific information for this patient payer category will be obtained from audited provider records. This information is used to determine Medicaid Managed Care Organization uncompensated cost for services provided to Medicaid eligible individuals for DSH.³¹

Medicaid MCO Out-of-State Payments are amounts paid to the hospital for inpatient or outpatient services for Medicaid MCO out-of-state patients that were paid by out-of-state Medicaid Agencies. Medicaid MCO out-of-state Payments will be reported and verified using the providers audited financial statements and

²⁶ Social Security Act §1923(g)(1)(A); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77921; 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 2 and 5 through 8

²⁷ Peters, Christie P. *The Basics. Medicaid Disproportionate Share Hospital (DSH) Payments*. The National Health Policy Forum. 15 June 2009. Web. <http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf>

²⁸ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(7); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

²⁹ *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, <<http://www.gpo.gov/fdsys/pkg/FR-2008-12-19/pdf/E8-30000.pdf>>

³⁰ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(7); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 5 through 8

³¹ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(7); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 3 and 5 through 8

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accounting records. This information is used to determine Medicaid Managed Care Organization uncompensated cost for services provided to Medicaid eligible individuals for DSH.³²

Medicaid Outpatient Charges are those incurred by Medicaid eligible outpatients. These charges are determined using CMS guidelines for the CMS-2552 Medicare cost report. Providers will report charges according to their cost center level as they do on the CMS-2552 form. The Medicaid outpatient charges will be used in the calculation of Medicaid eligible cost for DSH.³³

Medicare Bad Debt Amount is the amount reported by a provider in the CMS-2552 Form. Medicare allowable bad debts are reimbursed to hospitals at 70% of what is reported in the CMS-2552 Form. A portion of the bad debts hospitals claim in this category are for Dual Eligible claims that Medicaid has not paid the full deductible or coinsurance for on the identified Medicare claim. The reimbursable amount of bad debts for Dual Eligibles must be included in the calculation of Medicaid payments under the FFS calculation of Medicaid payments.³⁴

Medicare Payments are those a provider received from Medicare. Providers should include the entire amount paid for Medicare claims in the appropriate field or category. For inpatient prospective payment claims, the payment would include base DRG payments, Medicare DSH add-ons, Medicare IME add-ons, new technology add-ons, outlier payments, capital base payments, capital Medicare DSH add-ons, capital Medicare IME add-ons, and so forth. Payments made under Outpatient PPS, Rehab PPS, Psych PPS, or Critical Access Hospital reimbursements would be reported under total payments made by Medicare. This payment information is used in the calculation of FFS and MCO payment fields for DSH.³⁵

Non-Managed Care Days are all inpatient hospital days that are not Managed Care days. Non-managed care days are calculated by subtracting Managed Care days from Total Days (as reported on hospital Medicare cost report).

Obstetrician Requirement is used to qualify a hospital for DSH allocations. In order for a hospital to qualify it must have 2 obstetricians with staff privileges at the hospital who agree to provide nonemergency obstetric services to Medicaid clients, or they must qualify for one of the exemptions to this requirement. If the hospital meets the general requirement or the rural exception, the names of two obstetricians or physicians for rural hospitals must be reported with their NPIs or UPINs.³⁶

Obstetrician Requirement Exemptions are used to qualify a hospital for DSH allocations. The Social Security Act Section 1923 “(d) does allow for the following exceptions to the obstetrician requirement: (1) if the hospital is located in a rural area, two physicians can be on staff that perform non-emergency obstetric services; (2) the hospital's inpatient population is predominately under the age of 18; or (3) the hospital did not provide non-emergency obstetric services prior to December 22, 1987.”³⁷

³² Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(7); 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 3 and 5 through 8

³³ Social Security Act §1923(g)(1)(A), *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77921; 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 2 and 5 through 8

³⁴ 42 CFR §447.299(c)(6); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77912; CMS Additional Information on the DSH Reporting and Audit Requirements released February 22, 2010.

³⁵ Social Security Act §1923(g)(1)(A); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77912; 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(7)

³⁶ Social Security Act § 1923(d); 42 U.S.C. 1396r-4 (d)

³⁷ Social Security Act §1923(d)(1)(2)(3)

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Outpatient a hospital patient who received services in one or more of the facilities of the hospital that is not an inpatient of the hospital at the time services were rendered.

Payments from a Medicaid Agency are reported in the appropriate patient payer category and should include regular payments, add-ons, supplemental and enhanced payments, non-state Medicaid payments, out-of-state Medicaid payments, and DSH payments. The UCR should be auto-populated with Colorado MMIS data first and then any categories of incomplete data should be reported using information from the provider's audited financial records or remittance advices. This information is reported in order to determine a hospital's Medicaid uncompensated care costs for DSH.³⁸

Pre-acquisition Transplant Cost are calculated for Medicaid eligible individuals and individuals with no source of third party insurance by adding graduate medical education cost to the pre-acquisition cost of each organ reported. The adjusted pre-acquisition cost is divided by the total number of organs transplanted in the fiscal year and then multiplied by the cost per organ to the number of organs transplanted for Medicaid eligible individuals and individuals with no source of third party insurance according to the hospital's financial records. Providers should obtain or verify this information using CMS-2552-96, Worksheet D-6, Part III, Line 53, and CMS-2552-96, Worksheet D-6, Part III, Line 54. ³⁹ This information is used to calculate the cost of providing services to Medicaid eligible individuals and the uninsured for DSH.

Primary Payer Payments are those made on claims for individuals that are Medicaid eligible. These payments should match the amount paid by the third party insurance and not necessarily the amount determined as the Medicaid liability. This information is used in the calculation of the FFS and MCO payment fields for DSH.⁴⁰

Section 1011 payments are provided to hospitals for costs incurred while delivering specific services to specific aliens as long as the provider was not otherwise reimbursed for such services. Section 1011 payments made on behalf of the uninsured, especially when the uninsured were used in the calculation of uncompensated care costs and the Hospital Specific DSH Limit, must be used to offset a hospital's uncompensated care costs.⁴¹ Please note that this category may not apply to your hospital.

Supplemental/Enhanced Medicaid Payments are additional reimbursements paid to providers above the traditional Medicaid FFS structured rate. Supplemental/Enhanced Medicaid Payments can be made by the State Medicaid Agency or by out-of-state Medicaid Agencies. These payments are based on qualifying criteria defined in the Medicaid State plan and they are not available to all Medicaid providers. Examples of Supplemental/Enhanced Medicaid Payments are UPL payments, cost report settlements, and Certified Public Expenditure (CPE) settlements. Supplemental/Enhanced Medicaid Payments do not include DSH payments, regular Medicaid FFS rate payments, or Medicaid MCO payments. ⁴² Supplemental/Enhanced Medicaid payment information will be auto-populated in the UCR with information from the Colorado Financial Reporting System (COFRS). This information is used in the calculation of Hospital Specific DSH Limits.

³⁸ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(7); CMS General DSH Audit and Reporting Protocol Pages 2 and 3

³⁹ 42 CFR §447.299(c)(10); 42 CFR §447.299(c)(15); CMS Regulation 15-2 §3625.3

⁴⁰ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(6); 42 CFR §447.299(c)(7)

⁴¹ Social Security Act §1923(g)(1)(A); 42 CFR §447.299(c)(13); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77916 through 77918

⁴² *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77920; 42 CFR §447.299(c)(8); CMS General DSH Audit and Reporting Protocol Page 5

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Total Charges for Inpatient hospital services are gross hospital charges for inpatient services provided in the hospital's fiscal year.⁴³ This information is used to calculate Hospital Specific DSH Limits.

Total Cost per Worksheet C allows CMS to determine a facilities total cost using Medicare cost reporting procedures. The total cost for routine and ancillary service cost centers are required for the calculation of cost per diems and cost to charge ratios. These calculations help CMS determine the cost of services for individuals who are either Medicaid eligible or without a source of third party insurance.⁴⁴ This information is used in the calculation of Hospital Specific DSH Limits.

Total Days are the total days of service provided by a facility during the hospitals fiscal year. Providers should verify or report total days using CMS-2552-96, Worksheet S-3, Part I, Column 6, or from CMS-2552-10, Worksheet S-3, Part I, Col 8. Total days assist CMS with determining a facilities cost for providing services. The DSH Final Rule requires providers to report cost per diem for routine services.⁴⁵

Total Medicaid Days are the total days of service provided to Medicaid patients during the hospitals fiscal year. Providers should report or verify this information using CMS-2552-96, Worksheet S-3, Part I, Column 5 or from CMS-2552-10, Worksheet S-3, Part I Column 7.

Total Observation Days are reported by hospitals with a non-distinct unit observation cost center who report days on CMS-2552. Observation days are added to the total days for Adults and Pediatrics in order to calculate the appropriate cost per diem for the Adults and Pediatrics cost center. The observation days are multiplied by the calculated cost per diem and used in the calculation of the cost to charge ratio. Providers should report or verify this information using CMS-2552-96 Worksheet S-3 Part I Line 26 Column 6 or CMS-2552-10 Worksheet S-3 Part I Line 28 Column 8. This information is used in the apportionment of cost using cost per diem for routine services as required by the DSH Final Rule.⁴⁶

Total Revenues for Patient Services, including Cash Subsidies are revenues paid (net revenue) for inpatient and outpatient services, and it includes cash subsidies received from state and local governments for patient services, if such subsidies are not included in the calculation of net revenue in the hospital's fiscal year.⁴⁷

Uninsured is any individual determined to have no source of third party insurance. Individuals with a policy that provides excepted benefits are included in this category unless their insurance actually pays for the coverage of a hospital stay.⁴⁸

Uninsured Costs are determined using the Medicare cost allocation process. A per diem is computed for each routine cost center, and a cost-to-charge ratio is calculated for each ancillary/non-routine cost center by patient payer type. Then, each routine cost center's total allowable costs are apportioned to a specific program

⁴³ Social Security Act §1923(b)(3)(B)(ii)

⁴⁴ *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77907 & 77921; 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 2 and 5 through 8; CMS Publication 15-2 §3620.1

⁴⁵ *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77907 and 77921; 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 2 and 5 through 8, and CMS Publication 15-2 §3622.2

⁴⁶ *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Page 77907 & 77921; 42 CFR §447.299(c)(10); CMS General DSH Audit and Reporting Protocol Pages 2 and 5 through 8; CMS Publication 15-2 §3622.2

⁴⁷ Social Security Act §1923(b)(3)(A)(ii)

⁴⁸ Social Security Act §1923(g)(1)(A); *Medicaid Program; Disproportionate Share Hospital Payments-Final Rule (December 18, 2008)* Federal Register Volume 73, No. 244, Pages 77909-77912

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by applying that cost center's days to its calculated per diem, and each ancillary/non-routine cost center's total allowable costs are apportioned to specific programs by applying the cost center's program charges to its calculated cost-to-charge ratio. Providers should report or verify information using CMS-2552 Worksheet D.⁴⁹ This information is used to calculate a hospital's costs by patient payer type and it is used in the calculation of the Hospital Specific DSH Limit.

Uninsured/Self Pay Days are service days provided to those with no source of third party insurance or those directly paying for the patient services they obtained as an inpatient or outpatient. Providers should report information for this category using auditable hospital accounting records.⁵⁰ This information is used in the calculation of Hospital Specific DSH Limits.

Uninsured Payments are payments and revenues received for individuals with no source of third party insurance, this excludes payments received for these individuals from state and local government programs. Providers should report this information using auditable financial statements and accounting records. Providers should report all payments made in the State plan rate year by or on the behalf of patients without a source of third-party coverage, even if they were for a previous reporting period, as revenue received.⁵¹ This information is used in the calculation of payments received for uninsured individuals for DSH.

⁴⁹ Medicaid. *General DSH Audit and Reporting Protocol*. Web. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/General_DSH_Audit_Reporting_Protocol.pdf>

⁵⁰ Medicaid. *General DSH Audit and Reporting Protocol*. Web. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/General_DSH_Audit_Reporting_Protocol.pdf>

⁵¹ Medicaid. *General DSH Audit and Reporting Protocol*. Web. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/General_DSH_Audit_Reporting_Protocol.pdf>