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**State/Territory Name:** Colorado

**State Plan Amendment (SPA) #:** CO-09-019

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) 179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



**Center for Medicaid and State Operations, CMSO**

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OCT 29 2009

Mr. John Bartholomew, Director  
Budget and Finance Office  
Department of Health Care Policy  
& Financing  
1570 Grant Street  
Denver, CO 80203-1818

Re: Colorado 09-019

Dear Mr. Bartholomew:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-019. Effective for services on or after September 1, 2009, this amendment suspends the Public Hospital Payment for Public Hospitals that are State owned and non-State owned government hospitals that provide inpatient hospital services to Medicaid and low-income populations.

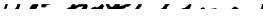

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 09-019 is approved effective September 1, 2009. The HCFA-179 and the amended plan page are attached.

If you have any questions, please call Christine Storey at (303) 844-7044.

Sincerely,

.....  
Cindy Mann  
Director  
Center for Medicaid and State Operations

cc: Chris Underwood, CO HCPF

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  09 - 019	2. STATE:  COLORADO
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE September 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One):  NEW STATE PLAN                      AMENDMENT TO BE CONSIDERED AS A NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION  CFR 42 Section 447.272		7. FEDERAL BUDGET IMPACT a. FFY 09 \$ (354,450) b. FFY 10 \$ (1,063,351)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  Attachment 4.19A page 40d		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  Attachment 4.19A page 40d	
10. SUBJECT OF AMENDMENT  Suspension of the Supplemental Medicaid Public Hospital Payment			
11. GOVERNOR'S REVIEW (Check One)  GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED  COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Governor's letter dated 26 January 2009 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL  		16. RETURN TO  Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818  Attn: Rachel Gibbons	
13. TYPED NAME  John Bartholomew			
14. TITLE  Director, Budget and Finance Office			
15. DATE SUBMITTED September 30, 2009			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED 10-29-09	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL  SEP - 1 2009		20. SIGNATURE OF REGIONAL OFFICIAL  	
21. TYPED NAME  William Lasowski		22. TITLE  Deputy Director, CMSO	
23. REMARKS			

TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19A

State of Colorado

Page 40d

I. Public Hospital Payment

Effective July 1, 2007, State owned and non-state owned government hospitals, when they meet the criteria for being a Public Hospital Provider, will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the Inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who participate in the Colorado Indigent Care Program. This additional supplemental Medicaid reimbursement will be commonly referred to as the "Public Hospital payment" which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

The Public Hospital payment is made only if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program), the Rural Hospital payment, and the Pediatric Major Teaching payment.

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

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

The Public Hospital payment is distributed based on a qualifying hospital's prior year Weighted Medically Indigent Costs relative to the sum of total Weighted Medically Indigent Costs for all qualifying hospitals, multiplied by the appropriation for the related State Fiscal Year, as defined for the High-Volume payment. Weighted Medically Indigent Costs will be inflated forward to the payment year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average. The funds available for the Public Hospital payment under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

Total funds available for this payment equal:

State Fiscal Year 2007-08	\$1,455,954
State Fiscal Year 2008-09	\$2,500,000
State Fiscal Year 2009-10	\$0

Effective September 1, 2009, this payment is suspended.

TN No. 09-019

Supersedes

TN No. 09-012

OCT 29 2009

Approval Date      Effective Date 9/1/09