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**State/Territory Name:** Colorado

**State Plan Amendment (SPA) #:** CO-09-020

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

OCT 29 2009

Re: Colorado 09-020

Dear Mr. Bartholomew:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-020. Effective for services on or after September 1, 2009, this amendment suspends the existing supplemental Medicaid payment for inpatient hospitals for health care services that provide reimbursement for uncompensated care costs related to Medicaid and Colorado Indigent Care Program clients.

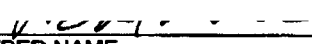
We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 09-020 is approved effective September 1, 2009. The HCFA-179 and the amended plan pages 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: <b>09 - 020</b>	2. STATE: <b>COLORADO</b>
		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 <b>X</b> 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 \$ (525,248) b. FFY 10 \$ (1,575,745)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  Attachment 4.19A page 40b		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  Attachment 4.19A page 40b	
10. SUBJECT OF AMENDMENT  Suspension of the Supplemental Medicaid Inpatient Hospital Payment for Health Care Services to provide reimbursement for uncompensated costs related to Medicaid and Colorado Indigent Care Program clients.			
11. GOVERNOR'S REVIEW (Check One)			
GOVERNOR'S OFFICE REPORTED NO COMMENT <b>X</b> 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

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**G. Inpatient Hospital Payment for Health Care Services**

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

The qualifying criteria for the payment will not directly correlate to the distribution methodology of the payment. The Inpatient Hospital Payment for Health Care Services is only made if there is available federal financial participation under the Upper Payment Limit for inpatient hospital services after the Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program) and the Pediatric Major Teaching payment.

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

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

The funds available for the Inpatient Hospital Payment for Health Care Services under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

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

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

TN No. 09-020  
Supersedes  
TN No. 08-010

OCT 29 2009  
Approval Date     

Effective Date 9/1/09

TITLE XIX OF THE SOCIAL SECURITY ACT  
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ATTACHMENT 4.19A  
Page 40b (continued)

clients who received primary care services for all qualified Hospital Providers in the previous State fiscal year multiplied by the appropriation for the related State Fiscal Year.

Total funds available for this payment equal:

State Fiscal Year 2006-07	\$1,104,226
State Fiscal Year 2007-08	\$4,428,000
State Fiscal Year 2008-09	\$3,690,000
State Fiscal Year 2009-10	\$0

Effective September 1, 2009, this payment is suspended.

TN No. 09-020  
Supersedes  
TN No. 08-010

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