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State/Territory Name: CO

State Plan Amendment (SPA) #: 25-0017

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850



Financial Management Group

May 7, 2026

Adela Flores-Brennan,
State Medicaid Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

RE: Colorado 25-0017

Dear Director Flores-Brennan:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Colorado state plan amendment (SPA) to Attachment 4.19-A CT 25-0017, which was submitted to CMS on August 27, 2025. This plan amendment removes references to the Colorado Indigent Care Program (CICP) consistent with its legislative repeal effective June 30, 2025, and aligns Disproportionate Share Hospital (DSH) eligibility with participation in the Hospital Discounted Care (HDC) program, the remaining state-only Qualified Charity Care Program.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), and 1923 of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of a July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at 617-565-1291 or via email at Novena.JamesHailey@cms.hhs.gov.

Sincerely,



Rory Howe
Director
Financial Management Group

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 5 — 0 0 1 7

2. STATE

CO

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION

Social Security Act, Section 1923 / 42 CFR 294-299

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2025 \$ 0
b. FFY 2026 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Att. 4.19A 29b-29f, Att. 4.19A 41-41a, Att. 4.19A 43-43a, Att. 4.19A 58-58a

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

Att. 4.19A 29b-29f, Att. 4.19A 41-41a, Att. 4.19A 43-43a, Att. 4.19A 58-58a

9. SUBJECT OF AMENDMENT

This Amendment would remove references to the Colorado Indigent Care Program (CICP) and replace with status as a Disproportionate Share Hospital where applicable due to the CICP being sunset in accordance with House Bill 24-1399, effective July 1, 2025. The proposed State Plan Amendment would modify certain 4.19-A Payment Pages.

10. GOVERNOR'S REVIEW (Check One)

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

OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED
8-27-25

15. RETURN TO

Colorado Department of Health Care Policy and Financing
303 E. 17th Avenue, Suite 1100
Denver, CO 80203

Attn: Rachel Larson

FOR CMS USE ONLY

16. DATE RECEIVED
August 27, 2025

17. DATE APPROVED
May 7, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Pen and ink changes in box #6 per state request 5/5/2026

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2. Effective October 1, 2014, qualified hospitals shall receive a disproportionate share hospital payment commonly referred to as the “Disproportionate Share Hospital Supplemental payment”, which shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments.

To qualify for the Disproportionate Share Hospital payment a Colorado hospital shall meet one of the following criteria:

- a. Is not a licensed or certified Psychiatric Hospital, is a Colorado Indigent Care Program (CICP) provider, and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act; or
- b. Is not a licensed or certified Psychiatric Hospital, has a Medicaid Inpatient Utilization Rate equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act; or
- c. Effective October 1, 2019, is a Critical Access Hospital and has at least two Obstetricians or is Obstetrician exempt pursuant to 42 U.S.C. 1396r-4 Section 1923(d)(2)(A) of the Social Security Act.

Effective July 1, 2025, to qualify for the Disproportionate Share Hospital payment a Colorado hospital shall meet the following criteria:

- a. Is not a licensed or certified Psychiatric Hospital, and has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients, or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A), and
- b. Have a Qualified Charity Care Program; or
- c. Have a Medicaid Inpatient Utilization Rate (MIUR) equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals, or
- d. Are Critical Access Hospitals or Rural Hospitals and designated as Sole Community Hospitals pursuant to 42 U.S.C. § 1395ww(d)(5)(D)(iii).

A Qualified Charity Care Program means an approved program which at a minimum includes discounted Emergency Hospital Services for patients with incomes up to and including 250% of the FPG throughout the year,

- a. Where a patient’s copayment is determined by a qualified sliding fee scale,
- b. Where a patient’s copayment amount is valid for one year from the date of service or data of income determination, whichever is earlier, and
- c. Which exempt patient debts from permissible collection activities for patients who were determined eligible for the hospital’s Qualified Charity Care Program and have an FPG level

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at or below 250% or for those eligible patients for whom the hospital failed to meet the Patient Contact Best Effort requirements.

- d. A Hospital's Qualified Charity Care Program must comply with all other requirements under Hospital Discount Care including but not limited to requirements to provide information in the patients preferred language, screening an application requirements, and allowing patient payment plans not exceeding the amount and duration required in Hospital Discounted Care.

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

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

Effective October 26, 2016, all qualified hospitals shall receive a payment calculated as a percent of uninsured costs multiplied by the state's annual Disproportionate Share Hospital allotment. The percent of uninsured costs shall be the total of all uninsured costs for a qualified hospital divided by the total uninsured costs for all remaining qualified hospitals.

No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit as specified in federal regulation. A respiratory hospital's Disproportionate Share Hospital limit shall be limited to 60%. A new CICIP hospital's Disproportionate Share Hospital limit shall be limited to 20%. If upon review, the Disproportionate Share Hospital Supplemental payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific Disproportionate Share Hospital limit. The reduction shall then be redistributed to the other qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital Limit.

Effective October 1, 2017, total funds for the Disproportionate Share Hospital (DSH) payment shall be \$172,633,510.

CICIP-participating hospitals with CICIP write-off costs, as published in the most recent CICIP Annual Report, greater than or equal to 950% of the statewide average shall receive a payment equal to 85.5% to their estimated hospital-specific DSH limit. A Respiratory Hospital shall receive a payment equal to 45% of their estimated hospital-specific DSH limit.

A Respiratory Hospital is defined as a hospital primarily specializing in respiratory related diseases.

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All remaining qualified hospitals shall receive a payment calculated as their percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. A hospital's uninsured costs shall be for their Cost Report Year End 2015 period.

Effective July 1, 2018, an additional DSH payment shall be made such that Colorado will fully expend its final DSH allotment for federal fiscal year 2017-18.

The additional DSH payment shall be made only to qualified hospitals below 96% of their estimated hospital-specific DSH limit allocated such that hospitals with CICP write-off costs greater than 900% of the statewide average shall receive 92% of their estimated hospital-specific DSH limit, hospitals with CICP write-off costs greater than 400% of the statewide average and a Medicaid Inpatient Utilization Rate (MIUR) greater than 35% shall receive 92% of their estimated hospital-specific DSH limit, Pediatric Specialty Hospitals and hospitals with CICP write-off costs between 105% and 400% of the statewide average shall receive 30% of their estimated hospital-specific DSH limit, Critical Access Hospitals shall receive 96% of their estimated hospital-specific DSH limit, and Respiratory Hospitals shall receive 49.5% of their estimated hospital-specific DSH limit. Any remaining available DSH funds shall be allocated to qualified hospitals proportionate to their uninsured costs to total uninsured costs for all remaining qualified hospitals.

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Effective October 1, 2018, total funds for the DSH payment shall be \$212,928,574.

A Respiratory Hospital shall receive a payment equal to 75% of their estimated hospital-specific DSH limit. A Pediatric Specialty Hospital shall receive a payment equal to 45% of their estimated hospital-specific DSH limit. A hospital with a MIUR less than or equal to 15% shall receive a payment equal to 10% of their estimated hospital-specific DSH limit. New CICIP-participating hospitals shall receive a payment equal to 10% of their estimated hospital-specific DSH limit.

All remaining qualified hospitals shall receive a payment calculated as their percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. A hospital's uninsured costs shall be for their Cost Report Year End 2016 period.

Effective October 1, 2019, total funds for the DSH payment shall equal an amount such that federal DSH funds shall not exceed the allowable FFY 2019-20 Colorado DSH allotment.

Qualified hospitals with CICIP write-off costs greater than or equal to 1,000% of the statewide average and qualified Critical Access Hospitals shall receive a payment equal to at least 90% of their estimated hospital-specific DSH limit but not exceeding 100% of their estimated hospital-specific DSH limit.

Remaining qualified hospitals shall receive a payment equal to their percent of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. No remaining qualified hospital shall receive a payment exceeding 96% of their hospital-specific DSH limit as specified in federal regulation. If a remaining qualified hospital's DSH Supplemental payment exceeds 96.00% of their hospital-specific DSH limit, the payment shall be reduced to 96.00% of their hospital-specific DSH limit. The reduction shall then be redistributed to other remaining qualified hospitals not exceeding 96.00% of their hospital-specific DSH limit based on the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals not exceeding their hospital-specific DSH limit.

Notwithstanding the above, a qualified hospital with a MIUR less than or equal to 15% shall have their hospital-specific DSH limit equal to 10%. A qualified new CICIP-participating hospital shall have their hospital-specific DSH limit equal to 10%.

Effective October 1, 2020, total funds for the DSH payment shall equal an amount such that federal DSH funds shall not exceed the allowable federal fiscal year Colorado DSH allotment.

Certain hospital groups shall receive a DSH payment equal to a percentage of their estimated hospital-specific DSH limit, not exceeding 100% of their estimated hospital-specific DSH limit. The hospital groups, requirements for a hospital to be included in each hospital group, and the percentage of hospital-specific DSH limit reimbursed through the DSH payment for each group shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at: www.colorado.gov/hcpf/bulletins.

Remaining qualified hospitals shall receive a payment equal to their percent of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. No remaining qualified hospital shall receive a payment exceeding 96% of their hospital-specific DSH limit as specified in federal regulation. If a remaining qualified hospital's DSH Supplemental payment exceeds 96.00% of

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their hospital-specific DSH limit, the payment shall be reduced to 96.00% of their hospital- specific DSH limit. The reduction shall then be redistributed to other remaining qualified hospitals not exceeding 96.00% of their hospital-specific DSH limit based on the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals not 96.00% of exceeding their hospital-specific DSH limit.

The state shall not exceed the total of all the hospital-specific DSH limits even if the total reimbursement is below the state's annual DSH allotment.

Uninsured Disproportionate Share Hospital Payment

Fiscal Year	Percent of the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital payment
State Fiscal Year 2009-10	19.94%
State Fiscal Year 2010-11 July 1 - September 30, 2010	19.94%
Federal Fiscal Year 2010-11	23.14%
Federal Fiscal Year 2011-12	20.00%
Federal Fiscal Year 2012-13	21.28%
Federal Fiscal Year 2013-14	1.64%

No hospital shall receive a payment exceeding its hospital-specific Disproportionate Share Hospital limit (as specified in federal regulations). If upon review or audit, the Uninsured Disproportionate Share Hospital payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified provider, that provider's payment shall be reduced to the hospital-specific DSH limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to the other qualified hospitals based on the qualified hospital proportion of uninsured cost relative to aggregate of uninsured costs of all qualified providers who do not exceed their hospital-specific Disproportionate Share Hospital limit.

In the event that data entry or reporting errors, or other unforeseen payment calculation errors, are realized after an Uninsured Disproportionate Share Hospital payment has been made, reconciliations and adjustments to impacted hospital payments will be made retroactively.

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

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

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

On an annual State Fiscal Year (July 1 through June 30) basis, those hospitals that qualify for a Major Pediatric Teaching Hospital payment will be determined. The determination will be made prior to the beginning of each State Fiscal Year. A Major Pediatric Teaching Hospital is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. The hospital Medicaid days combined with indigent care days (days of care provided under Colorado's Indigent Care Program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available; and
3. Has a percentage of Medicaid days relative to total days that exceed the mean for the prior slate fiscal year, or the most recent year for which data are available; and
4. Maintains a minimum of 110 total Intern and Resident F.T.E.s; and
5. Maintains a minimum ratio of .30 Intern and Resident F.T.E.s per licensed bed; and
6. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

Effective July 1, 2025 a Major Pediatric Teaching Hospital is defined as a hospital that meets the following criteria:

1. Receives a Disproportional Share Hospital (DSH) supplemental payment; and
2. The hospital Medicaid days equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available; and

3. Has a percentage of Medicaid days relative to total days that exceed the mean for the prior state fiscal year, or the most recent year for which data are available; and
4. Maintains a minimum of 110 total Intern and Resident F.T.E.s; and
5. Maintains a minimum ratio of .30 Intern and Resident F.T.E.s per licensed bed; and
6. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

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E. Urban Safety Net Provider Payment

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

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

The qualifying criteria for the Urban Safety Net Provider payment will not directly correlate to the distribution methodology of the payment. On an annual State Fiscal Year (July 1 through June 30) basis, those hospitals that qualify for an Urban Safety Net Provider payment will be determined. The determination will be made prior to the beginning of each State Fiscal Year. An Urban Safety Net Provider is defined as a hospital that meets the following criteria:

1. Participates in the Colorado Indigent Care Program; and
2. The hospital's Medicaid days plus Colorado Indigent Care Program (CICP) days relative to total days, rounded to the nearest percent, shall be equal to or exceed sixty-seven percent; and
3. Medicaid days and total days shall be Medicaid eligible inpatient days and total inpatient days from the most recent survey requested by the Department prior to March 1 of each year for July 1 rates.

Effective July 1, 2025, non-state-owned government hospitals, when they meet the criteria for being an Urban Safety Net Provider, will qualify to receive an additional supplemental Medicaid reimbursement for inpatient hospital services provided to Medicaid clients, such that the total of all payments will not exceed the inpatient Upper Payment Limit for inpatient hospital services (as defined by the Centers for Medicare and Medicaid Services). The purpose of this payment is to provide a partial reimbursement for uncompensated care related to inpatient hospital services for Medicaid clients to those providers who receive a Disproportionate Share Hospital (DSH) supplemental payment. The additional supplemental Medicaid reimbursement will be commonly referred to as the "Urban Safety Net Provider payment", which will be calculated on an annual State Fiscal Year (July 1 through June 30) basis and dispensed in equal quarterly installments.

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

The qualifying criteria for the Urban Safety Net Provider payment will not directly correlate to the distribution methodology of the payment. On an annual State Fiscal Year (July 1 through June 30) basis, those hospitals that qualify for an Urban Safety Net Provider payment will be determined. The determination will be made prior to the beginning of each State Fiscal Year. An Urban Safety Net

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Provider is defined as a hospital that meets the following criteria:

1. Receives a Disproportionate Share Hospital (DSH) supplemental payment; and
2. The hospital is licensed as a general hospital; and
3. The hospital's Medicaid days relative to total days, rounded to the nearest percent, shall be equal to or exceed sixty percent; and
4. Medicaid days and total days shall be Medicaid eligible inpatient days and total inpatient days from the most recent survey requested by the Department prior to March 1 of each year for July 1 rates.

The Urban Safety Net Provider payment is distributed equally among all qualified providers. The funds available for the Urban Safety Net Provider payment under the Upper Payment Limit for inpatient hospital services are limited by the regulations set by and the federal funds allocated by the Centers for Medicare and Medicaid Services.

The maximum total funds available for this payment equal:

FY 2006-07 \$2,693,233	FY 2007-08 \$5,400,000
FY 2008-09 \$5,400,000	March 1, 2010-June 30, 2010 \$5,410,049
FY 2010-2011 \$6,217,131	FY 2011-12 \$4,702,000
FY 2012-13 \$0	FY 2013-14 \$0
FY 2021-22: \$9,685,579	FY 2022-23: \$11,390,145
FY 2023-24: \$12,095,246	

Effective October 01, 2014 through June 30, 2020 this payment was no longer funded and the information contained in this section was for historical record.

Effective July 01, 2021, the General Assembly restored funding allowing the Urban Safety Net Provider Payment to resume.

Effective July 1, 2024, the total payment amount for Urban Safety Net Provider shall equal an amount published in the provider bulletin each year found on the Department's website at www.colorado.gov/hcpf/bulletins.

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Q. Public High Volume Medicaid and CICP Hospital Payment

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

Effective July 1, 2017, Colorado public hospitals that meet the definition of a High Volume Medicaid and CICP Hospital shall qualify to receive an additional supplemental Medicaid reimbursement for uncompensated inpatient hospital care for Fee-For-Service (FFS) Medicaid clients, to qualify for the Public High Volume Medicaid and CICP Hospital Payment, a hospital shall meet the following criteria:

1. Licensed as a General Hospital by the Colorado Department of Public Health and Environment.
2. Classified as a state-owned government or non-state owned government hospital.
3. Have at least 27,000 Medicaid Inpatient Days per year that provide over 30% of total inpatient days to Medicaid and CICP patients.

The Public High Volume Medicaid and CICP Hospital Payments will only be made if uncompensated Medicaid costs for inpatient hospital services calculated on a federal fiscal year basis is available for a qualified Hospital provider. Uncompensated Medicaid inpatient costs for a qualified Hospital provider is calculated as the available Medicaid inpatient Hospital costs less Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program and payments defined in Attachment 4.19A pgs. 30-57c). Total Public High Volume Medicaid and CICP Hospital Payments will not exceed the Upper Payment Limit that has been demonstrated for the same federal fiscal year in which the uncompensated Medicaid inpatient costs has been calculated.

The Interim Payment to qualified providers will be calculated using the filed CMS 2552-10 Medicare Cost Report, or its successor, for the actual expenditure period that corresponds to the federal fiscal year used in demonstrating the Upper Payment Limit for inpatient hospital services. The Interim Payment will be disbursed annually after the actual expenditure period. Interim Payments for uncompensated Medicaid inpatient hospital costs will be calculated each federal fiscal year and paid by the following September 30th of each federal fiscal year. Uncompensated costs for providing inpatient hospital services for Medicaid clients will be calculated according to the methodology outlined below, using the filed CMS 2552-10 Medicare Cost Report, or its successor.

Final payments will be made for qualified hospitals within six months after all eligible providers have submitted their audited CMS 2552-10 Medicare Cost Report, or its successor, for the actual expenditure period.

Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed for each provider for purposes of authorizing certification. Each qualified provider shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Public High Volume Medicaid and CICP Hospital Payment. The Public High Volume Medicaid and CICP Hospital Payment will be distributed to qualified providers based on each provider's proportion of uncompensated costs for qualified providers in the class, multiplied by the available Upper Payment Limit for the class. A qualified provider shall not receive aggregated inpatient hospital Medicaid payments that exceed its certified uncompensated costs.

TN No.25-0017
Supersedes
TN No.17-0035

Approval Date May 7, 2026 Effective Date 7/1/2025

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Effective July 1, 2025, Colorado public hospitals that meet the definition of a High Volume Medicaid Hospital shall qualify to receive an additional supplemental Medicaid reimbursement for uncompensated inpatient hospital care for Fee-For-Service (FFS) Medicaid clients, to qualify for the Public High Volume Medicaid Hospital Payment, a hospital shall meet the following criteria:

1. Licensed as a General Hospital by the Colorado Department of Public Health and Environment.
2. Classified as a state-owned government or non-state owned government hospital.
3. Have at least 27,000 Medicaid Inpatient Days per year that provide over 30% of total inpatient days to Medicaid patients.

The Public High Volume Medicaid Hospital Payments will only be made if uncompensated Medicaid costs for inpatient hospital services calculated on a federal fiscal year basis is available for a qualified Hospital provider. Uncompensated Medicaid inpatient costs for a qualified Hospital provider is calculated as the available Medicaid inpatient Hospital costs less Medicaid reimbursement (as defined in this attachment as a Diagnosis Related Group and/or per diem reimbursement paid under the Medicaid program and payments defined in Attachment 4.19A pgs. 30-57c). Total Public High Volume Medicaid Hospital Payments will not exceed the Upper Payment Limit that has been demonstrated for the same federal fiscal year in which the uncompensated Medicaid inpatient costs has been calculated.

The Interim Payment to qualified providers will be calculated using the filed CMS 2552-10 Medicare Cost Report, or its successor, for the actual expenditure period that corresponds to the federal fiscal year used in demonstrating the Upper Payment Limit for inpatient hospital services. The Interim Payment will be disbursed annually after the actual expenditure period. Interim Payments for uncompensated Medicaid inpatient hospital costs will be calculated each federal fiscal year and paid by the following September 30th of each federal fiscal year. Uncompensated costs for providing inpatient hospital services for Medicaid clients will be calculated according to the methodology outlined below, using the filed CMS 2552-10 Medicare Cost Report, or its successor.

Final payments will be made for qualified hospitals within six months after all eligible providers have submitted their audited CMS 2552-10 Medicare Cost Report, or its successor, for the actual expenditure period.

Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed for each provider for purposes of authorizing certification. Each qualified provider shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Public High Volume Medicaid Hospital Payment. The Public High Volume Medicaid Hospital Payment will be distributed to qualified providers based on each provider's proportion of uncompensated costs for qualified providers in the class, multiplied by the available Upper Payment Limit for the class. A qualified provider shall not receive aggregated inpatient hospital Medicaid payments that exceed its certified uncompensated costs.

TN No. 25-0017
Supersedes
TN No. 17-0035

Approval Date May 7, 2026 Effective Date 7/1/2025