Colorado Healthcare Affordability and Sustainability Enterprise

Federal Fiscal Year 2019-20 Healthcare Affordability and Sustainability (HAS) Fees & Supplemental Payments

CHASE

Colorado Healthcare Affordability and Sustainability Enterprise

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Provider Fee and Supplemental Payment Overview

Provider Fee

- FFY 2019-20 Total Fee: **$ 1,014,762,908**
- FFY 2018-19 Total Fee: **$ 917,879,440**
- Total Fee Change: **$ 96,883,468**
- Percent of Inpatient Fee to Total Fee: **45.87%**
- Percent of Outpatient Fee to Total Fee: **54.13%**

Supplemental Payment

- FFY 2019-20 Total Payment: **$ 1,407,494,785**
- FFY 2018-19 Total Payment: **$ 1,328,097,712**
- Total Payment Change: **$ 79,397,073**

Net Reimbursement

- FFY 2019-20 Net Reimbursement: **$ 392,731,877**
- FFY 2018-19 Net Reimbursement: **$ 410,218,272**
- Net Reimbursement Change: **$ (17,486,395)**

Provider Fee

The inpatient fee is $408.56 per Non-Managed Care Day. (The FFY 2018-19 inpatient fee was $416.07 per Non-Managed Care Day - a $7.51 decrease.)

The outpatient fee is 1.8664% of Total Outpatient Charges. (The FFY 2018-19 percent of Total Outpatient Charges was 1.8119% – a 0.0545% increase.)

Hospitals Exempt from Provider Fee

- Medicare Certified Psychiatric (Psychiatric) hospitals. State mental hospitals and private stand-alone psychiatric facilities that meet the definition of Institutions for Mental Diseases (IMDs) under 42 CFR 435.1010.
    - The policy reason for this exemption is due to Federal Financial Participation (FFP) not being available for Medicaid clients from age 22 through age 64 who are patients in an IMD, as noted under 42 CFR 435.1009(a)(2).
- Medicare Certified Long Term Care (LTC) and State Licensed and Medicare Certified Rehabilitation (Rehabilitation) hospitals.
    - The policy reason for this exemption is to incentivize the reduction in uncompensated care cost and to increase access for Medicaid and uninsured clients. Both hospital types receive reimbursement via the supplemental payments if they choose to participate in Medicaid.

Hospitals Assessed a Discounted Provider Fee

- The inpatient fee for Managed Care Days is discounted 77.63%, resulting in a $91.39 fee per Managed Care Day. (The FFY 2018-19 fee was $93.07 per Managed Care Day – a $1.68 decrease.)
- The inpatient fee for high-volume Medicaid and Colorado Indigent Care Program (CICP) hospitals is discounted 47.79%, resulting in a $47.71 fee per Managed Care Day and a $213.31 fee per Non-Managed Care Day. (The FFY 2018-19 high-volume Medicaid and CICP hospital fee was $48.59 per Managed Care Day and $217.23 per Non-Managed Care Day - a $.88 and $3.92 decrease, respectively.)
    - High volume Medicaid and CICP hospitals are hospitals with at least 27,500 Medicaid days per year that provide over 30% of total days to Medicaid and CICP clients.
- The inpatient fee for Essential Access hospitals is discounted 60.00%, resulting in a $36.56 fee per Managed Care Day and a $163.42 fee per Non-Managed Care Day. (The FFY 2018-19 Essential Access fee was $37.23 per Managed Care Day and $166.43 per Non-Managed Care Day - a $.67 and $3.01 decrease, respectively.)

- An Essential Access hospital is a hospital with 25 or less beds that is also a Critical Access or a Rural hospital.
    - A Critical Access hospital is a hospital that is certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital CoP.
    - A Rural hospital is a hospital that is not located within a Metropolitan Statistical Area (MSA) as designated by the United States Office of Management & Budget.

- The outpatient fee for high-volume Medicaid and CICP hospitals is discounted 0.84%, resulting in a fee of 1.8507% of Total Outpatient Charges. (The FFY 2018-19 percent of Total Outpatient Charges was 1.7967% - a 0.0540% increase.)
    - The policy reason for discounting fees for Managed Care Days, high-volume CICP hospitals, and Essential Access hospitals is to offset the impact of the managed care days fees discount and meet the B1/B2 test as required by 42 CFR 433.68(e)(2).
    - Fee discount percentages are fixed as they were established with the Center for Medicare and Medicaid Services (CMS) in a tax waiver approval letter.

Data Elements used in Provider Fee Calculation

- **Total Days** – From the Medicare cost report (Worksheet S-3, Part 1, Column 8) for Cost Report Year End (CRYE) 2017.

- **Managed Care Days** – Sum of days for which the primary payer is a managed care health plan reported on the Data Aggregation Survey for CRYE 2017, including these plans: Health Maintenance Organization, Preferred Provider Organization, and Exclusive Provider Organization.

  Note: The Accountable Care Collaborative (ACC) administered by a Regional Care Collaborative Organization (RCCO) or a Regional Accountable Entity (RAE) after July 1, 2018 is not Managed Care.

- **Non-Managed Care Days** – Calculated by subtracting Managed Care Days from Total Days.

- **Total Outpatient Charges** – From the Medicare cost report (Worksheet C, Part 1, Column 7) for CRYE 2017.

Provider Fee Calculation Example

Row	Description	Amount	Calculation
Row 1	Managed Care Days	5,000	
Row 2	Fee Per Managed Care Day	$ 100.00	
Row 3	Managed Care Day Fee	$ 500,000	Row 1 * Row 2
Row 4	Non-Managed Care Days	10,000	
Row 5	Fee Per Non-Managed Care Day	$ 350.00	
Row 6	Non-Managed Care Day Fee	$ 3,500,000	Row 4 * Row 5
Row 7	Total Inpatient Fee	$ 4,000,000	Row 3 + Row 6
Row 8	Outpatient Charges	$ 50,000,000	
Row 9	Fee Percentage	1.5000%	
Row 10	Total Outpatient Fee	$ 750,000	Row 8 * Row 9
Row 11	**Total Provider Fee**	**$ 4,750,000**	**Row 7 + Row 10**

Note: Calculations may not match due to rounding

Supplemental Payments

Inpatient Supplemental Payment

- The Inpatient Supplemental Payment equals a qualified hospital's Medicaid Days multiplied by an Adjustment Factor.

- The Adjustment Factor varies depending on a hospital's qualifications. A hospital's Adjustment Factor is based on the criteria using the following list. The order of hospital qualifications and corresponding Adjustment Factors are:

    1) Rehabilitation / Long Term Acute – $50.00,
    2) State Teaching – $596.00,
    3) Non-state Government Teaching – $10.00,
    4) Non-State Government Rural / Critical Access – $1,518.00,
    5) Non-State Government – $1,070.00,
    6) Private New – $455.00,
    7) Private Rural / Critical Access – $1,650.00,
    8) Private Pediatric Specialty – $120.00,
    9) Private NICU – $1,195.00,
    10) Private Independent Metro – $1,290.00, and
    11) Private – $700.00.

- The total FFY 2019-20 Inpatient Supplemental Payment is $522,846,670. (The total FFY 2018-19 Inpatient Base Rate Supplemental Payment was $471,933,209 - a $50,913,461 increase.)

Note: The Inpatient Supplemental Payment replaces the Inpatient Base Rate Supplemental Payment. The increase includes $92,978,828 previously reimbursed through the Uncompensated Care Cost (UCC) Supplemental Payment in FFY 2018-19.

Hospital Qualifications used in Inpatient Supplemental Payment

- Psychiatric hospitals do not qualify for this payment.

- A Teaching hospital is a high-volume Medicaid & CICP hospital that provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education. More than 50% of its credentialed physicians are members of the faculty at a state institution of higher education.

- A Rural hospital is a hospital not located within a MSA as designated by the United States Office of Management & Budget. A Critical Access hospital (CAH) is a hospital qualified as a CAH under 42 U.S.C. § 1395i-4(c)(2) and certified by the Colorado Department of Public Health and Environment (CDPHE).

- A Pediatric Specialty hospital is a hospital that provides care exclusively to pediatric populations.

- A Neonatal Intensive Care Unit (NICU) hospital is a hospital with a level 3 or 4 NICU designation.

- An Independent Metro hospital is an independently owned/operated hospital located within a MSA as designated by the United States Office of Management & Budget with greater than 1,500 Medicaid Days.

- A Self-Reported hospital is a hospital which does not have a 2017 cost report and self-reported their data.

Data Elements used in Inpatient Supplemental Payment

- **Medicaid Days** – Sum of In-State Fee-for-Service (FFS) Medicaid Days, Out-of-State (OOS) FFS Medicaid Days, and Managed Care Medicaid Days.

    - **In-State FFS Medicaid Day** - From the Colorado interChange (iC) for CRYE 2017.

    - **OOS FFS Medicaid Day -** From the Data Aggregation Survey for CRYE 2017.

    - **In-State Managed Care Day** – Sum of In-State and OOS Managed Care Days from the Data Aggregation Survey for CRYE 2017.

Inpatient Supplemental Payment Calculation

Row	Description	Amount	Calculation
Row 1	Medicaid Days	25,000	
Row 2	Adjustment Factor	$ 100.00	
Row 3	**IP Supplemental Payment**	**$ 2,500,000**	**Row 1 * Row 2**

Note: Calculations may not match due to rounding

Outpatient Supplemental Payment

- The Outpatient Supplemental Payment equals a qualified hospital's Estimated Medicaid Outpatient FFS Cost multiplied by a Percentage Adjustment Factor.

- The Percentage Adjustment Factor varies depending on a hospital's qualifications. A hospital's Percentage Adjustment Factor is based on the criteria first met using the following list. The order of hospital qualifications and corresponding Percentage Adjustment Factors are:

    1) Rehabilitation / Long Term Acute – 50.00%,
    2) State Teaching – 35.55%,
    3) Non-state Government Teaching – 5.75%,
    4) Non-State Government Rural / Critical Access – 74.50%,
    5) Non-State Government – 36.55%,
    6) Private New – 25.00%,
    7) Private Rural / Critical Access – 74.00%,
    8) Private Pediatric Specialty – 17.25%,
    9) Private NICU – 78.25%,
    10) Private Independent Metro – 92.00%, and
    11) Private – 38.50%.

- The total FFY 2019-20 Outpatient Supplemental Payment is $558,646,359. (The total FFY 2018-19 Outpatient Supplemental Payment was $444,811,120 - a $113,835,239 increase.)

Hospital Qualifications used in Outpatient Payment

- Psychiatric hospitals do not qualify for this payment.

- A Teaching hospital is a high-volume Medicaid & CICP hospital that provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education. More than 50% of its credentialed physicians are members of the faculty at a state institution of higher education.

- A Rural hospital is a hospital not located within a MSA as designated by the United States Office of Management & Budget. A CAH is a hospital qualified as a CAH under 42 U.S.C. § 1395i-4(c)(2) and certified by the CDPHE.

- A Pediatric Specialty hospital is a hospital that provides care exclusively to pediatric populations.

- A NICU hospital is a hospital with a level 3 or 4 NICU designation.

- An Independent Metro hospital is an independently owned/operated hospital located within a MSA as designated by the United States Office of Management & Budget with greater than 1,500 Medicaid Days.

- A Self-Reported hospital is a hospital which does not have a 2017 cost report and self-reported their data.

Data Elements used in Outpatient Supplemental Payment

- **Estimated Medicaid Outpatient FFS Cost** – CRYE 2017 Medicaid Outpatient FFS Cost forecasted to FFY 2019-20 using Outpatient Utilization Inflation and Cost Inflation Factors.
    - **Medicaid Outpatient FFS Cost** – Medicaid Outpatient FFS Charges multiplied by the total Ancillary Cost to Charge ratio (CCR).
        - **Medicaid Outpatient FFS Charges** – From the iC for CRYE 2017.
        - **Total Ancillary CCR** – Total Ancillary Cost divided by total Ancillary Charges.
            i. **Total Ancillary Cost** – From the Medicare cost report (Worksheet C, Part 1, Title XIX, Column 1) for CRYE 2017.
            ii. **Total Ancillary Charges** – From the Medicare cost report (Worksheet C, Part 1, Title XIX, Column 8) for CRYE 2017.
- **Outpatient Utilization Inflation Factor** – The percent change in Medicaid outpatient visits as a function of Medicaid caseload growth for SFY 2017-18, SFY 2018-19, and SFY 2019-20.

  The Outpatient Utilization Inflation Factors are:

State Fiscal Year	2017-18	2018-19	2019-20
Percent Adjustment	-9.24%	4.22%	4.42%

- **Cost Inflation Adjustment Factor** – The percent change in projected market basket increases to Hospital Prospective Payment System (PPS) rates.

  Cost Inflation adjustments are:

State Fiscal Year	2017-18	2018-19	2019-20
Percent Adjustment	2.70%	2.80%	2.95%

Outpatient Supplemental Payment Calculation

Row	Description	Amount	Calculation
Row 1	Estimated Medicaid OP Cost	$ 4,000,000	
Row 2	Percentage Adjustment Factor	50.00%	
Row 3	**OP Supplemental Payment**	**$ 2,000,000**	**Row 1 * Row 2**

Note: Calculations may not match due to rounding

Essential Access Supplemental Payment

- The Essential Access Supplemental Payment equals a qualified hospital's percent of beds to total beds for all qualified hospitals, multiplied by $19,000,000.

- The total FFY 2019-20 Essential Access Supplemental Payment is $19,000,000. (The total FFY 2018-19 Uncompensated Cost Care (UCC) Supplemental Payment was $107,980,176 - a $88,980,176 decrease.)

Note: The Essential Access Payment replaces the UCC Supplemental Payment. The Essential Access was a component of the UCC Supplemental Payment with $15,000,000 paid to Essential Access hospitals in FFY 2018-19. The listed $88,980,176 decrease is reimbursed through the Inpatient Supplemental Payment in FFY 2019-20.

Hospital Qualifications used in Essential Access Supplemental Payment

- Psychiatric hospitals, LTC hospitals, and Rehabilitation hospitals do not qualify for this payment.

- Hospital must be an Essential Access hospital to receive this payment. An Essential Access hospital is a hospital with less than or equal to 25 beds, and is a Critical Access or rural hospital.

    - A Critical Access hospital is a hospital certified under a set of Medicare CoP, which are structured differently than the acute care hospital CoP.

    - A Rural hospital is a hospital that is not located within a MSA as designated by the United States Office of Management & Budget.

Data Elements used in Essential Access Supplemental Payment

- **Bed Count** – Maximum number of patient beds a hospital holds a license to operate using data from the Colorado Department of Public Health and Environment.

Essential Access Supplemental Payment Calculation

Row	Description	Amount	Calculation
Row 1	Essential Access Hospital	Yes	
Row 2	Bed Count	20	
Row 3	Total Beds for All Essential Access Hospitals	500	
Row 4	Percent of Beds to Total Beds for Essential Access Hospitals	4.00%	Row 2 / Row 3
Row 5	Total Available Funds	$ 22,500,000	
Row 6	**Essential Access Supplemental Payment**	**$ 900,000**	**Row 4 * Row 5**

Note: Calculations may not match due to rounding

Disproportionate Share Hospital (DSH) Supplemental Payment

- The DSH Supplemental Payment equals a qualified hospital's percent of Uninsured Cost to total Uninsured Cost for qualified hospitals, multiplied by the state's DSH Allotment in Total.

- No qualified hospital receives a payment exceeding 96.00% of their Estimated DSH Limit.

    - If a qualified hospital's DSH Supplemental Payment exceeds 96.00% of their estimated DSH limit, the hospital's DSH Supplemental Payment is reduced to 96.00% of the Estimated DSH Limit. The reduction is then redistributed to other qualified hospitals below 96.00% of their Estimated DSH Limit based on the proportion of Uninsured Cost to total Uninsured Cost for all qualified hospitals within this group.

    - A qualified hospital with CICP write-off cost greater than 1,000% of the average state-wide CICP Write-Off Cost has a DSH Supplemental Payment equal to 96.00% of their estimated DSH limit.

        - CICP write-off cost is from the most recent CICP annual report.

    - A qualified Critical Access hospital has a DSH Supplemental Payment equal to 96.00% of their estimated DSH limit.

        - A Critical Access hospital is a hospital that is certified under a set of Medicare CoP, which are structured differently than the acute care hospital CoP.

    - A new CICP hospital has an Estimated DSH Limit equal to 10%.

        - A new CICP hospital is a hospital built within the last year and participates in CICP.

    - A hospital with a Medicaid Inpatient Utilization Rate (MIUR) less than 15% has an Estimated DSH limit equal to 10%.

- The total FFY 2019-20 DSH Supplemental Payment is $216,338,549. (The total FFY 2018-19 DSH Supplemental Payment was $212,928,574 – a $3,409,975 increase.)

Hospital Qualifications used in DSH Supplemental Payment

- To qualify for the DSH Supplemental Payment a Colorado hospital meets either of the following criteria:

    1. Is not a psychiatric hospital, is a CICP hospital, and has at least two Obstetricians or is Obstetrician exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act (SSA); or

2. Is not a psychiatric hospital, has a MIUR 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 Section 1923(d)(2)(A) of the SSA: or

3. Is a Critical Access hospital and has at least two Obstetricians or is Obstetrician exempt pursuant to Section 1923(d)(2)(A) of the SSA.

Data Elements used in DSH Supplemental Payment

- **DSH Allotment in Total** – Calculated using the FFY 2018 Federal DSH allotment of $108,169,274, increased by the 50.00% State Share.

- **Estimated DSH Limit** – Medicaid & Uninsured Cost minus Medicaid & Uninsured Payment.

  - **Medicaid & Uninsured Cost** – Sum of Medicaid Inpatient Cost, Medicaid Outpatient Cost, Uninsured Cost, and Provider Fee Cost.

    - **Medicaid Inpatient Cost** – Sum of Medicaid Inpatient Cost and Inpatient Dual Eligible Cost from the Data Aggregation Survey for CRYE 2017.

    - **Medicaid Outpatient Cost** – Sum of Medicaid Outpatient Cost and Outpatient Dual Eligible Cost from the Data Aggregation Survey for CRYE 2017.

    - **Uninsured Cost** – Sum of Inpatient Uninsured Cost and Outpatient Uninsured Cost from the Data Aggregation Survey for CRYE 2017.

    - **Provider Fee Cost** – Percent of Inpatient Medicaid & Uninsured Days to Total Days multiplied by the FFY 2016-17 Inpatient Provider Fee, plus the percent of Outpatient Medicaid & Uninsured Charges to Total Charges multiplied by the FFY 2016-17 Outpatient Provider Fee.

  - **Medicaid & Uninsured Payment** – Sum of Medicaid Inpatient Payment, Medicaid Outpatient Payment, Uninsured Payment, HAS Supplemental Payments, and Non-HAS Fee Supplemental Payments.

    - **Medicaid Inpatient Payment** – Sum of Medicaid Inpatient Payment and Inpatient Dual Eligible Payment from the Data Aggregation Survey for CRYE 2017.

    - **Medicaid Outpatient Payment** – Sum of Medicaid Outpatient Payment and Outpatient Dual Eligible Payment from the Data Aggregation Survey for CRYE 2017.

    - **Uninsured Payment** – Sum of Inpatient Uninsured Payment and Outpatient Uninsured Payment from the Data Aggregation Survey for CRYE 2017.

- **HAS Supplemental Payments** – Sum of Inpatient, Outpatient, Essential Access, Hospital Quality Incentive Program (HQIP) Supplemental Payments for FFY 2019-20.

- **Non-HAS Supplemental Payments** – Sum of Family Medicaid / Graduate Medical Education (GME), Rural Family Medicine, Clinic Based Indigent Care, Pediatric Specialty Hospital, and State University Teaching Supplemental Payments for FFY 2019-20.

- **Uninsured Cost** – Sum of Inpatient Uninsured Cost and Outpatient Uninsured Cost from the Data Aggregation Survey for CRYE 2017.

DSH Supplemental Payment Calculation Example Where DSH Supplemental Payment is Less Than Estimated DSH Limit

Row	Description	Amount	Calculation
Row 1	Medicaid IP Cost	$ 6,000,000	
Row 2	Medicaid OP Cost	$ 3,000,000	
Row 3	Uninsured Cost	$ 500,000	
Row 4	Provider Fee Cost	$ 500,000	
Row 5	Medicaid & Uninsured Cost	$ 10,000,000	Sum Row 1 through Row 4
Row 6	Medicaid IP Payment	$ 1,000,000	
Row 7	Medicaid OP Payment	$ 750,000	
Row 8	Uninsured Payment	$ 250,000	
Row 9	HAS Supplemental Payment	$ 5,000,000	
Row 10	Non-HAS Supplemental Payment	$ 0	
Row 11	Medicaid & Uninsured Payment	$ 7,000,000	Sum Row 6 through Row 10
Row 12	Estimated DSH Limit	$ 3,000,000	Row 5 – Row 11
Row 13	Uninsured Cost	$ 500,000	
Row 14	Total Uninsured Cost for all Qualified Hospitals	$ 50,000,000	
Row 15	Percent of Uninsured Cost to Total Uninsured Cost for all Hospitals	1.00%	Row 13 / Row 14
Row 16	DSH Allotment in Total	$ 172,500,000	
Row 17	Not-Limited DSH Payment	$ 1,725,000	Row 15 * Row 16
Row 18	**DSH Supplemental Payment**	**$ 1,725,000**	**Lesser of Row 12 & Row 17**

Note: Calculations may not match due to rounding

DSH Supplemental Payment Calculation Example Where DSH Supplemental Payment is Greater Than Estimated DSH Limit

Row	Description	Amount	Calculation
Row 1	Medicaid IP Cost	$ 5,000,000	
Row 2	Medicaid OP Cost	$ 2,000,000	
Row 3	Uninsured Cost	$ 500,000	
Row 4	Provider Fee Cost	$ 500,000	
Row 5	Medicaid & Uninsured Cost	$ 8,000,000	Sum Row 1 through Row 4
Row 6	Medicaid IP Payment	$ 1,000,000	
Row 7	Medicaid OP Payment	$ 750,000	
Row 8	Uninsured Payment	$ 250,000	
Row 9	HAS Fee Supplemental Payment	$ 5,000,000	
Row 10	Non-HAS Supplemental Payment	$ 0	
Row 11	Medicaid & Uninsured Payment	$ 7,000,000	Sum Row 6 through Row 10
Row 12	Estimated DSH Limit	$ 1,000,000	Row 5 – Row 11
Row 13	Uninsured Cost	$ 500,000	
Row 14	Total Uninsured Cost for all Qualified Hospitals	$ 50,000,000	
Row 15	Percent of Uninsured Cost to Total Uninsured Cost for all Hospitals	1.00%	Row 13 / Row 14
Row 16	DSH Allotment in Total	$ 172,500,000	
Row 17	Not-Limited DSH Payment	$ 1,725,000	Row 15 * Row 16
Row 18	**DSH Supplemental Payment**	**$ 1,000,000**	**Lesser of Row 12 & Row 17**

Note: Calculations may not match due to rounding

Hospital Quality Incentive Program (HQIP) Supplemental Payment

- The HQIP Supplemental Payment equals Adjusted Discharge Points multiplied by Dollars Per-Adjusted Discharge Point.

- The total FFY 2019-20 HQIP Supplemental Payment is $90,663,203. (The total FFY 2018-19 HQIP Supplemental Payment was $90,445,983, a $217,220 increase.)

Hospital Qualifications used in HQIP Supplemental Payment

- Psychiatric hospitals do not qualify for this payment.

Data Elements used in HQIP Supplemental Payment

- **Adjusted Discharge Points** – Total Normalized Points Awarded multiplied by Adjusted Medicaid Discharges.

    - **Total Normalized Points Awarded** – Sum of Total Points Awarded, normalized to 100 points to account for measure groups/measures a hospital is not eligible to complete.

        - **Total Points Awarded** – Points awarded based on established criteria for the following measure groups. Participating hospitals are requested to complete all measure groups they are eligible for. Each measure group has several corresponding measures. The HQIP measure groups and measures are:

            i. **Maternal Health and Perinatal Care**: Exclusive Breast Feeding, Cesarean Section, Perinatal Depression and Anxiety, Maternal Emergencies, Reproductive Life/Family Planning,
            ii. **Patient Safety**: Clostridium Difficile, Adverse Event, Falls with Injury, Culture of Safety Survey,
            iii. **Patient Experience**: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Advance Care Plan,
            iv. **Regional Accountable Entity (RAE) Engagement**: RAE engagement,
            v. **Substance Abuse**: Substance Use Disorder Composite, Alternatives to Opioids (ALTO), and
            vi. **Addressing Cost of Care**: Hospital Index.

    - **Adjusted Medicaid Discharges** – Total Medicaid Charges divided by Inpatient Medicaid Charges (equates to the Medicaid discharge adjustment factor), multiplied by Inpatient Medicaid Discharges.

        - **Total Medicaid Charges** – From the iC for CY 2018.

        - **Inpatient Medicaid Charges** – From the iC for CY 2018.

        - **Inpatient Medicaid Discharges – F**rom the iC for CY 2018.

Note – For hospitals with less than 200 Inpatient Medicaid Discharges, the total number of Inpatient Medicaid Discharges is multiplied by 125%. For hospitals with a Medicaid discharge adjustment factor greater than 5, the Medicaid discharge adjustment factor is limited to 5.

- **Dollars Per-Adjusted Discharge Point -** Dollars Per-Adjusted Discharge Point is tiered so that hospitals with more Total Normalized Points Awarded receive a greater per-unit reimbursement. The tiering of the Total Normalized Points Awarded and resulting Dollar Per-Adjusted Discharge Point is shown below:

Tier	Total Normalized Points Awarded	Dollars Per-Adjusted Discharge Point
0	0 - 19	$ 0.00
1	20 - 39	$ 1.99
2	40 - 59	$ 3.98
3	60 - 79	$ 5.97
4	80 - 100	$ 7.96

HQIP Supplemental Payment Calculation

Row	Description	Amount	Calculation
Row 1	Maternal Health & Perinatal Care	10	
Row 2	Patient Safety	20	
Row 3	Patient Experience	5	
Row 4	RAE Engagement	15	
Row 5	Substance Abuse	10	
Row 6	Addressing Cost of Care	15	
Row 7	Total Normalized Measure Points Awarded	75	Sum of Row 1 through Row 6
Row 8	Dollars Per-Adjusted Discharge Point	$ 6.00	If Row 7 between 1 & 19 = $ 0.00 If Row 7 between 20 & 39 = $ 2.00 If Row 7 between 40 & 59 = $ 4.00 If Row 7 between 60 & 79 = $ 6.00 If Row 7 above 80 = $ 8.00
Row 9	Adjusted Medicaid Discharges	5,000	
Row 10	Adjusted Discharge Points	375,000	Row 7 * Row 9
Row 11	**HQIP Supplemental Payment**	**$ 2,250,000**	**Row 8 * Row 10**

Note: Calculations may not match due to rounding