Colorado Healthcare Affordability and Sustainability Enterprise

Federal Fiscal Year (FFY) 2023-24 Healthcare Affordability & Sustainability (HAS) Provider Fees & Supplemental Payments

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Contents

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I. Provider Fee and Supplemental Payment Overview

A. Provider Fee

- FFY 2023-24 Total Fee: $1,249,460,402
- FFY 2022-23 Total Fee: $1,230,051,582
- Total Fee Change: $ 19,408,820 (1.58%)
    - Percent of Inpatient Fee to Total Fee: 43.16%
    - Percent of Outpatient Fee to Total Fee: 56.84%

B. Supplemental Payment

- FFY 2023-24 Total Payment: $1,725,313,380
- FFY 2022-23 Total Payment: $1,694,189,821
- Total Payment Change: $31,123,560 (1.84%)

C. Net Reimbursement

- FFY 2023-24 Net Reimbursement: $475,852,978
- FFY 2022-23 Net Reimbursement: $464,138,238
- Net Reimbursement Change: $11,714,740 (2.52%)

II. Provider Fee

The inpatient fee is $473.90 per non-managed care day. (The FFY 2022-23 inpatient fee was $510.05 per non-managed care day - a $36.15 decrease.)

The inpatient fee for managed care days is discounted 77.63% the inpatient fee for non-managed care days, resulting in a $106.01 fee per managed care day. (The FFY 2022-23 fee was $114.10 per Managed Care Day – a $8.09 decrease.)

The outpatient fee is 1.6625% of total outpatient charges. (The FFY 2022-23 percent of total outpatient charges was 1.8705% – a 0.2080% decrease.)

A. 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 supplemental payments if they choose to participate in Medicaid.

B. Hospitals Assessed a Discounted Provider Fee

The inpatient fee for high-volume Medicaid and Colorado Indigent Care Program (CICP) hospitals is discounted 47.79%, resulting in a $247.42 fee per non-managed care day and a $55.35 fee per managed care day. (The FFY 2022-23 high-volume Medicaid and CICP hospital fee was $266.30 per non-managed care day and $59.57 per managed care day - a $18.88 and $4.22 decrease, respectively.)

- High volume Medicaid and CICP hospitals are hospitals with at least 30,000 Medicaid patient days for CRYE 2021 that provide over 35% of total days to Medicaid and CICP clients.

The inpatient fee for Essential Access hospitals is discounted 60.00%, resulting in a $189.56 fee per non-managed care day and a $42.40 fee per managed care day. (The FFY 2022-23 Essential Access fee was $204.02 per non-managed care day and $45.64 per managed care day - a $14.46 and $3.24 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 as designated by the United States Office of Management & Budget (MSA).

The outpatient fee for high-volume Medicaid and CICP hospitals is discounted 0.84%, resulting in a fee of 1.6485% of total outpatient charges. (The FFY 2022-23 percent of total outpatient charges was 1.1923% - a .4562% decrease.)

- 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.

C. 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) 2021.

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 2021, including these plans: Health Maintenance Organization, Preferred Provider Organization, and Exclusive Provider Organization.

Note: The Accountable Care Collaborative (ACC) administered by a Regional Accountable Entity (RAE) 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 2021.

D. Provider Fee Reductions due to Enhanced Federal Matching Funds

Enhanced federal matching funds are drawn down for the portion of supplemental payments attributable to Affordable Care Act (ACA) expansion populations, reducing the provider fee funding obligation for hospitals. For FFY 2023-24, enhanced federal matching funds reduced the provider fee funding obligation for hospitals by approximately $174 million. The total provider fee funding obligation reduction for the previous five years equals approximately $753 million.

FFY	Benefit to Hospital
FFY 19-20	$ 126,556,000
FFY 20-21	$ 140,934,000
FFY 21-22	$ 151,794,000
FFY 22-23	$ 159,793,000
FFY 23-24	$ 174,164,000
Total	**$ 753,241,000**

Table 1 - 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

III. Inpatient Supplemental Payment

The Inpatient supplemental payment is calculated by multiplying a hospital's Medicaid patient days by an adjustment factor. The adjustment factor is a per-diem rate that varies depending on the hospital's adjustment group. There are thirteen adjustment groups for FFY 2023-24, each with their own definition. A hospital is compared to each adjustment group in a predetermined order and is assigned to the first adjustment group whose definition it meets. The corresponding per-diem rate (adjustment factor) for the adjustment group is then applied to the hospital. Once a hospital is assigned to an adjustment group, it is not compared to any further adjustment groups.

The per-diem rates for the adjustment groups are detailed below. The assignment of an adjustment group will follow the provided order starting with Row 1 - Rehabilitation Hospital or LTAC Hospital and ending with Row 13 - Private Hospital. The definitions of the adjustment groups are provided on the subsequent page.

Row	Adjustment Group	Inpatient Adjustment Factor
1	Rehabilitation Hospital or LTAC Hospital	$ 16.00
2	State Government Teaching Hospital	$ 618.75
3	Non-State Government Teaching Hospital	$ 676.00
4	Non-State Government Rural Hospital or CAH	$ 1,040.00
5	Non-State Government General Hospital	$ 720.00
6	Private Rural Hospital or CAH	$ 485.00
7	Private Heart Institute Hospital	$ 1,310.00
8	Private Pediatric Specialty Hospital	$ 755.00
9	Private High Medicaid Utilization Hospital	$ 1,118.00
10	Private NICU Hospital	$ 1,675.00
11	Private Independent Metropolitan Hospital	$ 1,395.00
12	Private Safety Net Metropolitan Hospital	$ 1,395.00
13	Private Hospital	$ 536.00

The total FFY 2023-24 Inpatient supplemental payment is $674,501,355. (The total FFY 2022-23 Inpatient supplemental payment was $631,995,568, a $42,505,787 Increase.)

A. Hospital Qualifications used in Inpatient Supplemental Payment

Psychiatric hospitals do not qualify for this payment. Hospital adjustment group definitions are provided below.

Rehabilitation Hospital or Long Term Acute Care (LTAC) Hospital - A rehabilitation hospital or a LTAC hospital certified by the Colorado Department of Public Health and Environment (CDPHE).

State Government Teaching Hospital - A High-Volume Medicaid and CICP hospital within the state government ownership Upper Payment Limit (UPL) category that provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent of its credentialed physicians are members of the faculty at a state institution of higher education.

Non-State Government Teaching Hospital - A High-Volume Medicaid and CICP hospital within the non-state government ownership UPL category that provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent of its credentialed physicians are members of the faculty at a state institution of higher education.

Non-State Government Rural Hospital or Critical Access Hospital (CAH) - A hospital within the non-state government ownership UPL category that is not located within a MSA or is certified as a CAH by the CDPHE.

Non-State Government General Hospital - A hospital within the non-state government ownership UPL category not meeting any other adjustment group definitions.

Private Rural Hospital or CAH - A hospital within the non-state government ownership UPL category that is not located within a MSA or is certified as a CAH by the CDPHE.

Private Heart Institute Hospital - A hospital within the private ownership UPL category that is recognized as a HeartCARE Center by the American College of Cardiology (ACC) with a least 25,000 Medicaid non-managed care days for CRYE 2021.

Private Pediatric Specialty Hospital - A hospital within the private UPL ownership category that provides care exclusively to pediatric populations.

Private High Medicaid Utilization Hospital - A hospital within the private UPL ownership category with a Medicaid payer mix greater than twenty-five percent and a Medicaid non-managed care patient days utilization rate greater than forty percent for CRYE 2021.

Private Neonatal Intensive Care Unit (NICU) Hospital - A hospital within the private UPL ownership category with a NICU classification of Level III or Level IV according to the guidelines published by the American Academy of Pediatrics (AAP).

Private Independent Metropolitan Hospital - An independently owned or operated hospital located within a MSA with greater than 1,500 Medicaid patient days for CRYE 2021.

Private Safety Net Metropolitan Hospital - A hospital within the private ownership UPL category that provides services in the Pueblo MSA with more than 15,000 Medicaid non-managed care patient days for CRYE 2021.

Private Hospital - A hospital within the private ownership UPL category not meeting any other adjustment factor category definitions.

B. Data Elements used in Inpatient Supplemental Payment

Medicaid Days – Sum of in-state & out-of-state (OOS) fee-for-service (FFS) Medicaid days.

- **In-State FFS Medicaid Day** - From the Colorado interChange (iC) for CRYE 2021.
- **OOS FFS Medicaid Day** – Reported by hospital for CRYE 2021

Inpatient Supplemental Payment Calculation

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

Note: Calculations may not match due to rounding

IV. Outpatient Supplemental Payment

The Outpatient supplemental payment is calculated by multiplying a hospital's estimated Medicaid outpatient costs by an adjustment factor. The adjustment factor is a percentage rate that varies depending on the hospital's adjustment group. There are thirteen adjustment groups for FFY 2023-24, each with their own definition. A hospital is compared to each adjustment group in a predetermined order and is assigned to the first adjustment group whose definition it meets. The corresponding percentage rate (adjustment factor) for the adjustment group is then applied to the hospital. Once a hospital is assigned to an adjustment group, it is not compared to any further adjustment groups.

The per-diem rates for the adjustment groups are detailed below. The assignment of an adjustment group will follow the provided order starting with Row 1 - Rehabilitation Hospital or LTAC Hospital and ending with Row 13 - Private Hospital. The definitions of the adjustment groups are provided on the subsequent page.

Row	Adjustment Group	Outpatient Adjustment Factor
1	Rehabilitation Hospital or LTAC Hospital	16.00%
2	State Government Teaching Hospital	47.14%
3	Non-State Government Teaching Hospital	9.70%
4	Non-State Government Rural Hospital or CAH	94.00%
5	Non-State Government General Hospital	10.00%
6	Private Rural Hospital or CAH	88.25%
7	Private Heart Institute Hospital	72.50%
8	Private Pediatric Specialty Hospital	5.65%
9	Private High Medicaid Utilization Hospital	41.00%
10	Private NICU Hospital	84.45%
11	Private Independent Metropolitan Hospital	88.00%
12	Private Safety Net Metropolitan Hospital	88.00%
13	Private Hospital	28.45%

The total FFY 2023-24 Outpatient supplemental payment is $627,222,890. (The total FFY 2022-23 Outpatient supplemental payment was $667,614,563, a $40,391,673 decrease.)

A. Hospital Qualifications used in Outpatient Supplemental Payment

Psychiatric hospitals do not qualify for this payment. Hospital adjustment group definitions are provided below.

Rehabilitation Hospital or LTAC Hospital - A rehabilitation hospital or a LTAC hospital certified by the CDPHE.

State Government Teaching Hospital - A High-Volume Medicaid and CICP hospital within the state government ownership UPL category that provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent of its credentialed physicians are members of the faculty at a state institution of higher education.

Non-State Government Teaching Hospital - A High-Volume Medicaid and CICP hospital within the non-state government ownership UPL category that provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent of its credentialed physicians are members of the faculty at a state institution of higher education.

Non-State Government Rural Hospital or CAH - A hospital within the non-state government ownership UPL category that is not located within a MSA or is certified as a CAH by the CDPHE.

Non-State Government General Hospital - A hospital within the non-state government ownership UPL category not meeting any other adjustment factor category definitions.

Private Rural Hospital or CAH - A hospital within the non-state government ownership UPL category not meeting any other adjustment factor category definitions.

Private Heart Institute Hospital - A hospital within the private ownership UPL category that is recognized as a HeartCARE Center by the ACC with at least 25,000 Medicaid non-managed care days for CRYE 2021.

Private Pediatric Specialty Hospital - A hospital within the private UPL ownership category that provides care exclusively to pediatric populations.

Private High Medicaid Utilization Hospital - A hospital within the private UPL ownership category with a Medicaid payer mix greater than twenty-five percent and a Medicaid non-managed care patient days utilization rate greater than forty percent for CRYE 2021.

Private NICU Hospital - A hospital within the private UPL ownership category with a NICU classification of Level III or Level IV according to the guidelines published by the AAP.

Private Independent Metropolitan Hospital - An independently owned or operated hospital located within a MSA with greater than 1,500 Medicaid patient days for CRYE 2021.

Private Safety Net Metropolitan Hospital - A hospital within the private ownership UPL category that provides services in the Pueblo MSA with more than 15,000 Medicaid non-managed care patient days for CRYE 2021.

Private Hospital – A hospital within the private ownership UPL category not meeting any other adjustment factor category definitions.

B. Data Elements used in Outpatient Supplemental Payment

Estimated Medicaid Outpatient FFS Cost – CRYE 2021 Medicaid outpatient FFS cost, forecasted to FFY 2023-24 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 2021.
- **Total Ancillary CCR** – Total ancillary cost divided by total ancillary charges.
- **Total Ancillary Cost** – From the Medicare cost report (Worksheet C, Part 1, Title XIX, Column 1) for CRYE 2021.
- **Total Ancillary Charges** – From the Medicare cost report (Worksheet C, Part 1, Title XIX, Column 8) for CRYE 2021.
- **Outpatient Utilization Inflation Factor** – The percent change in Medicaid outpatient visits as a function of Medicaid caseload growth for SFY 2021-22, SFY 2022-23, SFY 2023-24, and SFY 2024-25.

  The utilization inflation factors are:

State Fiscal Year	2021-22	2022-23	2023-24	2024-25
Percent Adjustment	5.02%	3.00%	5.58%	3.86%

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

  Cost inflation adjustments are:

State Fiscal Year	2021-22	2022-23	2023-24	2024-25
Percent Adjustment	2.20%	2.90%	3.19%	2.58%

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	**Supplemental Payment**	**$ 2,000,000**	**Row 1 * Row 2**

Note: Calculations may not match due to rounding

V. Rural Support Program (RSP) Supplemental Payments

The RSP supplemental payment equals $12,00,000 divided by the number of qualified hospitals.

The total FFY 2034-24 RSP supplemental payment is $12,000,000. This payment is part of a five-year initiative to support rural hospitals in their efforts to implement and succeed in the Hospital Transformation Program (HTP). FFY 2023-24 is the fourth year of the payment.

A. Hospital Qualifications used in RSP Supplemental Payment

Hospital must be a Critical Access Hospital or Rural Hospital, a non-profit hospital, and meet one of the following criteria:

1. Their average net patient revenue for the three-year 2016, 2017, and 2018 cost report period is in the bottom ten percent for all Critical Access hospitals and rural hospitals, or
2. Their funds balance for the 2019 cost report is in the bottom two and one-half percent for all Critical Access hospitals and rural hospitals not in the bottom 10% of the three-year average net patient revenue for all Critical Access Hospitals and rural hospitals.

RSP Supplemental Payment Calculation

Row	Description	Amount	Calculation
Row 1	Critical Access Hospital or Rural Hospital	Yes	
Row 2	Non-Profit Hospital	Yes	
Row 3	Average NPR in Bottom 10%	Yes	
Row 4	Fund Balance in Bottom 2.5%	No	
Row 5	Number of Qualified hospitals	23	
Row 6	Total Funds	$ 12,000,000	
Row 7	**Supplemental Payment**	**$ 522,000**	**Row 6 / Row 5**

Note: Calculations may not match due to rounding

VI. Essential Access Supplemental Payment

The Essential Access supplemental payment equals $26,000,000 divided by the total number of Essential Access hospitals.

The total FFY 2023-24 Essential Access supplemental payment is $26,000,000. (The total FFY 2022-23 Essential Access supplemental payment was $20,000,000, a $6,000,000 increase)

A. Hospital Qualifications used in Essential Access Supplemental Payment

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

A 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 by the CDPHE.
- A rural hospital is a hospital that is not located within a MSA.

Essential Access Supplemental Payment Calculation

Row	Description	Amount	Calculation
Row 1	Essential Access Hospital	Yes	
Row 2	Total Available Funds	$26,000,000	
Row 3	Total Number of Essential Access Hospitals	34	
Row 4	**Supplemental Payment**	**$ 764,706**	**Row 2 / Row 3**

Note: Calculations may not match due to rounding

VII. Disproportionate Share Hospital (DSH) Supplemental Payment

The DSH supplemental payment equals a qualified hospital's percent of uninsured cost to total uninsured cost for all qualified hospitals, multiplied by total available DSH funds.

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 their proportion of uninsured cost to total uninsured cost for all qualified hospitals below 96.00% of their estimated DSH limit.

A qualified hospital with CICP write-off cost greater than 700% 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 Rural hospital or Critical Access hospital has a DSH supplemental payment equal to 86.00% of their estimated DSH limit.

A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than 2,700 Medicaid patient days has a DSH supplemental payment equal to 80.00% of their estimated DSH limit.

A qualified hospital with a Medicaid Inpatient Utilization Rate (MIUR) less than 22.5% has an estimated DSH limit equal to 10%.

The total FFY 2023-24 DSH supplemental payment is $257,231,667. (The total FFY 2023-23 DSH supplemental payment was $244,068,958, a $13,162,709 increase.)

A. 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.

B. Data Elements used in DSH Supplemental Payment

Total Available DSH Funds – Calculated using the estimated $128,615,834 FFY 2023-24 federal DSH allotment, increased by the 50.00% HAS funding obligation.

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 in-state and OOS Medicaid FFS and MCO inpatient cost from the Data Aggregation Survey for CRYE 2021.
    - **Medicaid Outpatient Cost** – Sum of in-state and OOS Medicaid FFS and MCO outpatient cost from the Data Aggregation Survey for CRYE 2021.
    - **Uninsured Cost** – Sum of inpatient and outpatient uninsured cost from the Data Aggregation Survey for CRYE 2021.
    - **Provider Fee Cost** – Percent of inpatient Medicaid and uninsured patient days to total patient days multiplied by the FFY 2021

inpatient provider fee, plus the percent of outpatient Medicaid & uninsured charges to total charges multiplied by the FFY 2021 outpatient provider fee.

- **Medicaid & Uninsured Payment** – Sum of Medicaid inpatient payment, Medicaid outpatient payment, uninsured payment, HAS supplemental payment, and non-HAS supplemental payment.
    - **Medicaid Inpatient Payment** – Sum of in-state and OOS Medicaid FFS and MCO inpatient payment from the Data Aggregation Survey for CRYE 2021.
    - **Medicaid Outpatient Payment** – Sum of in-state and OOS Medicaid FFS and MCO outpatient payment from the Data Aggregation Survey for CRYE 2021.
    - **Uninsured Payment** – Sum of Inpatient and Outpatient uninsured payment from the Data Aggregation Survey for CRYE 2021.
    - **HAS Supplemental Payment** – Sum of Inpatient, Outpatient, Essential Access, Rural Support Program, and Hospital Quality Incentive Program (HQIP) supplemental payments for FFY 2023-24.
    - **Non-HAS Supplemental Payment** – Sum of expected Family Medicine Residency, Rural Family Medicine Residency Development, Urban Safety Net Provider, Pediatric Major Teaching, and State University Teaching supplemental payments for FFY 2023-24.
- **Uninsured Cost** – Sum of inpatient and outpatient uninsured cost from the Data Aggregation Survey for CRYE 2021.

Note - DSH eligible hospitals had the opportunity to provide CRYE 2022 cost and payment data. The estimated DSH limit for FFY 2023-24 is determined using CRYE 2022 cost and payment data for those hospitals providing this data.

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	$ 200,000,000	
Row 17	Not-Limited DSH Payment	$ 2,000,000	Row 15 * Row 16
Row 18	**Supplemental Payment**	**$ 2,000,000**	**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	$ 200,000,000	
Row 17	Not-Limited DSH Payment	$ 2,000,000	Row 15 * Row 16
Row 18	**Supplemental Payment**	**$ 1,000,000**	**Lesser of Row 12 & Row 17**

Note: Calculations may not match due to rounding

VIII. 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 2023-24 HQIP Supplemental Payment is $128,357,467. (The total FFY 2022-23 HQIP Supplemental Payment was $118,510,744, a $9,846,723 increase.)

A. Hospital Qualifications used in HQIP Supplemental Payment

Psychiatric hospitals do not qualify for this payment.

B. 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 specific measure groups. Participating hospitals are requested to complete all measure groups for which they are eligible. Each measure group has several corresponding measures. The HQIP measure groups and measures are:
    - **Maternal Health and Perinatal Care**: Exclusive Breast Feeding, Cesarean Section, Perinatal Depression and Anxiety, Maternal Emergencies and Preparedness, Reproductive Life/Family Planning, and
    - **Patient Safety**: Zero Suicide, Reduction of Racial and Ethnic Disparities, Clostridium Difficile, Sepsis, Antibiotics Stewardship, Adverse Event Reporting, Culture of Safety Survey, Handoffs and Sign-Outs, and
    - **Patient Experience**: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Advance Care Planning.

- **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 2022.
- **Inpatient Medicaid Charges** – From the iC for CY 2022.
- **Inpatient Medicaid Discharges** – From the iC for CY 2022.

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	Hospital Count
0	0 - 19	$ 0.00	0
1	20 - 39	$ 2.07	5
2	40 - 59	$ 4.14	6
3	60 - 79	$ 6.21	17
4	80 - 100	$ 8.28	54

HQIP Supplemental Payment Calculation

Row	Description	Amount	Calculation
Row 1	Maternal Health & Perinatal Care	25	
Row 2	Patient Safety	20	
Row 3	Patient Experience	10	
Row 4	Total Normalized Measure Points Awarded	55	Sum of Row 1 through Row 3
Row 5	Dollars Per-Adjusted Discharge Point	$ 5.00	If Row 4 between 1 & 19 = $ 0.00 If Row 4 between 20 & 39 = $ 2.50 If Row 4 between 40 & 59 = $ 5.00 If Row 4 between 60 & 79 = $ 7.50 If Row 4 above 80 = $ 10.00
Row 6	Adjusted Medicaid Discharges	5,000	
Row 7	Adjusted Discharge Points	275,000	Row 4 * Row 6
Row 8	**Supplemental Payment**	**$ 1,375,000**	**Row 5 * Row 7**

Note: Calculations may not match due to rounding