Colorado Healthcare Affordability and Sustainability Enterprise

Federal Fiscal Year (FFY) 2024-25 Healthcare Affordability & Sustainability (HAS) Provider Fees & Supplemental Payments

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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I. Provider Fee and Supplemental Payment Overview

A. Provider Fee

- FFY 2024-25 Total Fee: $1,379,034,913
- FFY 2023-24 Total Fee: $1,260,436,914
- Total Fee Change: $118,597,999 (9.41%)
    - Percent of Inpatient Fee to Total Fee: 40.85%
    - Percent of Outpatient Fee to Total Fee: 59.15%

B. Supplemental Payment

- FFY 2024-25 Total Payment: $1,890,238,878
- FFY 2023-24 Total Payment: $1,754,978,030
- Total Payment Change: $135,260,878 (7.71%)

C. Net Reimbursement

- FFY 2024-25 Net Reimbursement: $511,203,965
- FFY 2023-24 Net Reimbursement: $494,541,116
- Net Reimbursement Change: $16,662,849 (3.37%)

II. Provider Fee

The inpatient fee is $487.20 per non-managed care day. (The FFY 2023-24 fee was $477.70 - a $9.50 increase.)

The inpatient fee for managed care days is discounted by 77.63%, resulting in a fee of $108.99 per managed care day. (The FFY 2023-24 fee was $106.86 – a $2.13 increase.)

The outpatient fee is 1.6910% of total outpatient charges. (The FFY 2023-24 fee was 1.6739% – a 0.0171% increase.)

A. Fee Exemptions

Psychiatric hospitals certified by the Colorado Department of Public Health and Environment (CDPHE).

- The policy reason for this exemption is that Federal Financial Participation (FFP) is not available for Medicaid clients from age 22 through age 64 who are patients in an Institutes for Mental Disease (IMD), as noted under 42 CFR 435.1009(a)(2).

Certified Long-Term Acute Care (LTAC) and Rehabilitation hospitals certified by CDPHE.

- The policy reason for this exemption is to promote the reduction in uncompensated care costs and to enhance access for Medicaid and uninsured clients. Both hospital types are eligible for supplemental payments if they choose to participate in Medicaid.

B. Fee Discounts

The inpatient fee for high-volume Medicaid hospitals is discounted by 47.79%, resulting in a fee of $254.37 per non-managed care day and $56.90 per managed care day. (The FFY 2023-24 fee was $249.40 per non-managed care day and $55.79 per managed care day - a $4.97 and $1.11 increase, respectively.)

- High-volume Medicaid hospitals are hospitals with at least 35,000 Medicaid patient days for cost report year end (CRYE) 2022.

The inpatient fee for Essential Access hospitals is discounted by 60.00%, resulting in a fee of $194.88 per non-managed care day and $43.60 per managed care day. (The FFY 2023-24 fee was $191.08 per non-managed care day and $42.74 per managed care day - a $3.80 and $0.86 increase, respectively.)

- An Essential Access hospital is a hospital with 25 or fewer beds that is also designated as either a CAH or a Rural hospital.
    - A Critical Access hospital is a hospital certified under a set of Medicare Conditions of Participation (CoP), which differ from the CoP for acute care hospital.
    - 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 (OMB).

The outpatient fee for high-volume Medicaid hospitals is discounted by 0.84%, resulting in a fee of 1.6768%. (The FFY 2023-24 fee was 1.6598% - a 0.0171% increase.)

- The policy reason for discounting fees for managed care days, high-volume Medicaid hospitals, and Essential Access hospitals is to offset the impact of the managed care day fee discount and to meet the uniform and broad-based fee requirements, as outlined in 42 CFR 433.68(e)(2).
- Fee discount percentages are fixed, as they were established with the Centers for Medicare and Medicaid Services (CMS).

C. Data Elements

Total Days – From the Medicare cost report (Worksheet S-3, Part 1, Column 8) for CRYE 2022.

Managed Care Days – The total of days for which the primary payer is a managed care health plan, as reported on the Data Aggregation Survey for CRYE 2022. This includes these plans: Health Maintenance Organization (HMOs), Preferred Provider Organization (PPOs), and Exclusive Provider Organization (EPOs).

*Note: The Accountable Care Collaborative (ACC), administered by a Regional Accountable Entity (RAE), is **not** Managed Care.*

Non-Managed Care Days – Total days minus managed care days.

Total Outpatient Charges – From the Medicare cost report (cost center lines 50-76 and 90-92 of Worksheet C, Part 1, Column 7) for CRYE 2022.

D. Provider Fee Reductions

Enhanced federal matching funds are drawn down for the portion of supplemental payments attributable to Affordable Care Act (ACA) expansion populations, thereby reducing the provider fee funding obligation for hospitals. For FFY 2024-25, these enhanced federal matching funds reduced the provider fee obligation by approximately $211 million. Over the past six years, the total provider fee funding obligation reduction has been reduced by approximately $975 million.

FFY	Benefit to Hospitals
FFY 19-20	$ 126,556,000
FFY 20-21	$ 140,934,000
FFY 21-22	$ 151,794,000
FFY 22-23	$ 166,505,000
FFY 23-24	$ 178,021,000
FFY24-25	$ 211,187,000
Total	**$ 974,997,000**

The following table provides an example calculation.

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 2024-25, 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 pages.

Row	Adjustment Group	Inpatient Adjustment Factor
1	Rehabilitation Hospital or LTAC Hospital	$ 16.50
2	State Government Teaching Hospital	$ 821.25
3	Non-State Government Teaching Hospital	$ 195.75
4	Non-State Government Rural Hospital or CAH	$ 1,389.35
5	Non-State Government General Hospital	$ 875.75
6	Private Rural Hospital or CAH	$ 400.00
7	Private Heart Institute Hospital	$ 1,605.00
8	Private Pediatric Specialty Hospital	$ 752.25
9	Private High Medicaid Utilization Hospital	$ 1,345.00
10	Private NICU Hospital	$ 2,001.00
11	Private Independent Metropolitan Hospital	$ 1,690.00
12	Private Safety Net Metropolitan Hospital	$ 1,690.00
13	Private Hospital	$ 722.25

The FFY 2024-25 Inpatient supplemental payment is $826,467,959. (The FFY 2023-24 payment was $698,204,739, a $128,263,220 Increase.)

A. Hospital Qualifications

General, Children's, CAH, Rehabilitation, and LTAC hospitals qualify for this payment. Psychiatric hospitals do not qualify.

The hospital adjustment groups for qualifying hospitals are outlined below:

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

State Government Teaching Hospital - A High-Volume Medicaid 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 50% 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 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 50% 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.

Non-State Government 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 private government ownership UPL category that is not located within a MSA or is certified as a CAH.

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 2022.

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

Private High Medicaid Utilization Hospital - A hospital within the private ownership UPL category with a Medicaid payer mix greater than 25% and a Medicaid non-managed care patient days utilization rate greater than 40% for CRYE 2022.

Private Neonatal Intensive Care Unit (NICU) Hospital - A hospital within the private ownership UPL 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 - A hospital within the private ownership UPL category independently owned or operated within a MSA with greater than 1,500 Medicaid patient days for CRYE 2022.

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 2022.

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

B. Data Elements

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 2022.
- **OOS FFS Medicaid Day** – Reported by hospitals for CRYE 2022.

The following table provides an example calculation.

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 2024-25, 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 pages.

Row	Adjustment Group	Outpatient Adjustment Factor
1	Rehabilitation Hospital or LTAC Hospital	16.10%
2	State Government Teaching Hospital	51.73%
3	Non-State Government Teaching Hospital	2.85%
4	Non-State Government Rural Hospital or CAH	105.00%
5	Non-State Government General Hospital	16.80%
6	Private Rural Hospital or CAH	116.65%
7	Private Heart Institute Hospital	60.00%
8	Private Pediatric Specialty Hospital	4.50%
9	Private High Medicaid Utilization Hospital	37.75%
10	Private NICU Hospital	81.40%
11	Private Independent Metropolitan Hospital	107.00%
12	Private Safety Net Metropolitan Hospital	107.00%
13	Private Hospital	35.35%

The FFY 2024-25 Outpatient supplemental payment is $633,168,220. (The FFY 2023-24 payment was $633,184,156, a $15,936 decrease.)

A. Hospital Qualifications

General, Children's, CAH, Rehabilitation, and LTAC hospitals qualify for this payment. Psychiatric hospitals do not qualify.

The hospital adjustment groups for qualifying hospitals are outlined below:

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

State Government Teaching Hospital - A High-Volume Medicaid 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 50% 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 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 50% 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.

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

Private Rural Hospital or CAH - A hospital within the private ownership UPL category that is not located within a MSA or is certified as a CAH.

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 2022.

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

Private High Medicaid Utilization Hospital - A hospital within the private ownership UPL category with a Medicaid payer mix greater than 25% and a Medicaid non-managed care patient days utilization rate greater than 40% for CRYE 2022.

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

Private Independent Metropolitan Hospital - A hospital within the private ownership UPL category independently owned or operated within a MSA with greater than 1,500 Medicaid patient days for CRYE 2022.

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 2022.

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

B. Data Elements

Estimated Medicaid Outpatient FFS Cost – CRYE 2023 Medicaid outpatient FFS cost, forecasted to FFY 2024-25 using applicable 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 2023.
    - **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 2023.
        - **Total Ancillary Charges** – From the Medicare cost report (Worksheet C, Part 1, Title XIX, Column 8) for CRYE 2023.
- **Outpatient Utilization Inflation Factor** – The percent change in Medicaid outpatient visits based on Medicaid caseload growth for SFY 2023, SFY 2024, SFY 2025, and SFY 2026.

  The utilization inflation factors are:

State Fiscal Year	2023	2024	2025	2026
Percent Adjustment	3.21%	-9.30%	-6.24%	0.09%

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

  Cost inflation adjustments are:

State Fiscal Year	2023	2024	2025	2026
Percent Adjustment	2.90%	3.45%	3.00%	2.90%

The following table provides an example calculation.

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 $12,000,000 divided by the number of qualified hospitals.

The FFY 2024-25 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 2024-25 is the fifth year of the payment.

A. Hospital Qualifications

Hospital must be a CAH 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 CAH and rural hospitals, or

Their funds balance for the 2019 cost report is in the bottom two and one-half percent for all CAH and rural hospitals, not in the bottom 10% of the three-year average net patient revenue for CAH and rural hospitals.

The following table provides an example calculation.

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 is calculated by dividing $26,000,000 by the total number of Essential Access hospitals.

The FFY 2024-25 Essential Access supplemental payment is $26,000,000. (The FFY 2023-24 payment was $26,000,000, a $0.00 change.)

A. Hospital Qualifications

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 CAH or rural hospital.

- A Critical Access hospital is a hospital certified by the CDPHE.
- A rural hospital is a hospital not located within an MSA.

The following table provides an example calculation.

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 is calculated by multiplying a qualified hospital's percentage of uninsured costs, relative to the total uninsured costs for all qualified hospitals, by the total available DSH funds.

Maximum Payment - No qualified hospital receives a payment exceeding 96.00% of its estimated DSH limit. If a qualified hospital's DSH supplemental payment exceeds 96.00% of its estimated DSH limit, the payment is reduced to 96.00%. The reduction is then redistributed to other qualified hospitals that are below 96.00% of their estimated DSH limit, based on their proportion of uninsured costs relative to the total uninsured costs for all qualified hospitals below 96.00% of their estimated DSH limit.

Minimum Payment Floor - No qualified general, CAH, Rehabilitation, or LTAC hospital receives a payment of less than 15.00% of its estimated DSH limit. If a qualified hospital's payment is less than 15.00% of its estimated DSH limit, the payment is increased to 15.00%.

Certain hospitals receive a percentage of their estimated DSH limit as their DSH supplemental payment, while others have their estimated DSH limits capped. These hospitals include:

- A qualified hospital with uninsured patient write-off costs greater than 700% of the statewide average receives a payment equal to 90.00% of its estimated DSH limit.
- A qualified State University Hospital receives a payment equal to 96.00% of its estimated DSH limit.
- A qualified Rural hospital or CAH receives a payment equal to 86.00% of its estimated DSH limit.
- A qualified hospital that is not owned or operated by a healthcare system network, is located within an MSA, and has fewer than 2,700 total Medicaid patient days receives a payment equal to 55.00% of its estimated DSH limit.

- A qualified hospital with a Medicaid Inpatient Utilization Rate (MIUR) of less than 22.5% has its estimated DSH limit capped at 10%.

The FFY 2024-25 DSH supplemental payment is $265,720,314. (The FFY 2023-24 payment was $257,231,67, a $8,488,646 increase.)

A. Hospital Qualifications

To qualify for the DSH Supplemental Payment, a hospital must meet one of the following criteria:

1. Is not a psychiatric hospital, has a qualified charity care program, and either 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 MIUR for Colorado hospitals, and either 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 either has at least two obstetricians or is obstetrician-exempt pursuant to Section 1923(d)(2)(A) of the SSA.

B. Data Elements

Total Available DSH Funds – Calculated using the estimated $132,860,157 FFY 2024-25 federal DSH allotment, increased by the 50.00% HAS funding obligation.

Estimated DSH Limit – Total Medicaid and uninsured costs, minus Medicaid and uninsured payments.

- **Medicaid & Uninsured Cost** – Sum of Medicaid inpatient costs, Medicaid outpatient costs, uninsured costs, and provider fee costs.
    - **Medicaid Inpatient Cost** – Sum of in-state and OOS Medicaid FFS and MCO inpatient costs from the Data Aggregation Survey for CRYE 2022.

- **Medicaid Outpatient Cost** – Sum of in-state and OOS Medicaid FFS and MCO outpatient costs from the Data Aggregation Survey for CRYE 2022.
- **Uninsured Cost** – Sum of inpatient and outpatient uninsured costs from the Data Aggregation Survey for CRYE 2022.
- **Provider Fee Cost** – The percentage of inpatient Medicaid and uninsured patient days relative to total patient days multiplied by the FFY 2022 inpatient provider fee, plus the percentage of outpatient Medicaid & uninsured charges relative to total charges multiplied by the FFY 2022 outpatient provider fee.

- **Medicaid & Uninsured Payment** – Sum of Medicaid inpatient payments, Medicaid outpatient payments, uninsured payments, HAS supplemental payments, and non-HAS supplemental payments.
  - **Medicaid Inpatient Payment** – Sum of in-state and OOS Medicaid FFS and MCO inpatient payments from the Data Aggregation Survey for CRYE 2022.
  - **Medicaid Outpatient Payment** – Sum of in-state and OOS Medicaid FFS and MCO outpatient payments from the Data Aggregation Survey for CRYE 2022.
  - **Uninsured Payment** – Sum of Inpatient and Outpatient uninsured payments from the Data Aggregation Survey for CRYE 2022.
  - **HAS Supplemental Payment** – Sum of Inpatient, Outpatient, Essential Access, RSP, and HQIP supplemental payments for FFY 2024-25.
  - **Non-HAS Supplemental Payment** – Sum of expected Family Medicine Residency, Rural Family Medicine Residency Development, State University Teaching, Pediatric Major Teaching, and Urban Safety Net Provider payments for SFY 2024-25.

- **Uninsured Cost** – Sum of inpatient and outpatient uninsured costs from the Data Aggregation Survey for CRYE 2022.

The following two tables provide example calculations.

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 of 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 of 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 of 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 of 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 is calculated by multiplying Adjusted Discharge Points by Dollars Per-Adjusted Discharge Point.

The FFY 2024-25 HQIP Supplemental Payment is $126,882,385. (The FFY 2023-24 payment was $128,357,467, a $1,475,082 decrease.)

A. Hospital Qualifications

General, Children's, CAH, Rehabilitation, and LTAC hospitals that complete the HQIP measure groups qualify for this payment. Psychiatric hospitals do not qualify.

B. Data Elements

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 measures in which a hospital is ineligible.
    - **Total Points Awarded** – Points are awarded based on established criteria for specific measures. Participating hospitals complete all measures for which they are eligible. Measures are grouped into one of three measure groups. The HQIP measures and measure groups are as follows:
        - **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, Antibiotic 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, multiplied by Inpatient Medicaid Discharges.
  - **Total Medicaid Charges** – From the iC for CY 2023.
  - **Inpatient Medicaid Charges** – From the iC for CY 2023.
  - **Inpatient Medicaid Discharges** – From the iC for CY 2023.

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 capped at 5.

Dollars Per-Adjusted Discharge Point – Tiered so that hospitals with higher Total Normalized Points Awarded receive a greater per-unit reimbursement. The tiers and corresponding Dollar Per-Adjusted Discharge Point are as follows:

Tier	Total Normalized Points Awarded	Dollars Per-Adjusted Discharge Point	Hospital Count
0	0 - 19	$ 0.00	1
1	20 - 39	$ 1.87	5
2	40 - 59	$ 3.74	3
3	60 - 79	$ 5.61	12
4	80 - 100	$ 7.48	61

The following tables provide an example calculation.

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