Estimated Hospital Provider Fee Model Fees a
as of March 24, 2010
Colorado General Hospital

CICP Provider Meeting
March 19, 2010

Handout 3a

Hospital Fee/Payment	Amount
Provider Fees for State Fiscal Year 2009-10	
Inpatient Hospital Fee	$451,683
Outpatient Hospital Fee	$157,469
Total Hospital Provider Fees	**$609,152**
Supplemental Payments for State Fiscal Year 2009-10	
Supplemental Medicaid Base Rate Payment	$120,000
Supplemental Medicaid Outpatient Hospital Payment	$95,000
Colorado Indigent Care Program (CICP) Disproportionate Share Hospital Payment/CICP Supplemental Medicaid Payment	$200,000
Uninsured Disproportionate Share Hospital Payment	Not Qualified
Rural and Critical Access Hospital Supplemental Medicaid Payment	$350,000
Denver Metro Supplemental Payment[1]	Not Qualified
Metropolitan Statistical Area Payment[2]	Not Qualified
Neonatal Intensive Care Unit Supplemental Payment	$150,000
Total Supplemental Payments	**$940,000**

[1] Hospitals located in the following counties receive the Denver Metro Supplemental Payment: Denver, Jefferson, Douglas, Boulder, Broomfield, Adams and Arapahoe

[2] Hospitals in the following counties receive the Metropolitan Statistical Area Payment: El Paso, Larimer, Mesa, Pueblo and Weld.

Your facility's fees and payments under the Hospital Provider Fee Model are summarized in the table above. Final federal approval of the model is anticipated by April 2010. There will be no changes to the model unless required by CMS. In the event that changes are necessary, you will be notified in writing. Fees will be assessed and payments will be made be retroactive to the beginning of the state fiscal year, July 1, 2009. Fees will be collected and payments will be made in four equal installments and are planned to occur on or about April 16, April 30, May 14, and June 11, 2010.

For a detailed description and calculation of each fee and payment that applies to your hospital, please refer to each specific payment description and methodology sheet included in this packet. The "Provider Fee Model Overview" provides a general narrative of the entire model; the specific payment description and methodology sheets provide information about each fee and payment using data applicable to your hospital.

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Inpatient Hospital Fee

Your Facility will be assessed an Inpatient Fee for Fiscal Year 2009-10 in the amount of:

$609,152

The Inpatient Fee is a per day charge assessed on commercial and non-commercial days.
Commercial days are assessed at $50 dollars per day.
Non-commercial days are assessed at $230 dollars per day.

Total Days: 4,000
Managed Care Days: 3,000
Non-Managed Care Days: 1,000

Managed Care Day Fee: $181,425
Non-Managed Care Day Fee: $270,258

3,000 * $60.47 = $181,425
1,000 * $270.26 = $270,258
$181,425 + $270,258 = **$609,152**

Outpatient Fee

Your Facility will be assessed an Inpatient Fee for Fiscal Year 2009-10 in the amount of:

$157,469

The Outpatient Fee is assessed as a percentage of a provider's charges for outpatient services. The percentage for Fiscal Year 2009-10 is 0.35% of outpatient charges.

Outpatient Charges (2007 HCRIS cost report): $45,000,000

$45,000,000 * 0.35% = **$157,469**

Supplemental Medicaid Base Rate Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Supplemental Medicaid Base Rate Payment is:

$590,770

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For each qualified hospital, this payment shall be calculated by using the difference between the Medicare Base Rate and the Medicaid Base Rate, multiplied by the hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix.

Estimated Number of Medicaid Discharges: 200
Current Medicaid Base Rate per Discharge: $4,583
Medicare Rate per Discharge: $5,313
Medicaid Case Mix: .822

($5,313–$4,583) * 200 * .822 = **$120,000**

Supplemental Medicaid Outpatient Hospital Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Supplemental Medicaid Outpatient Hospital Payment is:

$95,000

Outpatient billed costs are inflated to the payment year and multiplied by 29.3667%. The result is the difference between the inflated estimated billed costs and the amount reimbursed by Medicaid having taken rate cuts into account on a weighted basis.

Inflated Billed Costs: $325,000
Estimated Payment at current Medicaid Reimbursement: $230,000

$325,000 – $230,000 = **$95,000**
Or
$325,000 * 29.3667% = **$95,000**

Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment is:

Not Applicable

Your facility does not qualify for this payment. In order to qualify for this payment a provider must be a rural or critical access provider with 20 or fewer licensed beds and earn more than 80% of Medicaid payments for outpatient services.

Rural/CAH: Yes

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Your facility Does Not have fewer than 20 Licensed Beds
Your ratio of Outpatient Medicaid to Total Medicaid: 50%

Colorado Indigent Care Program (CICP) Disproportionate Share Hospital Payment/CICP Supplemental Medicaid Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the CICP Disproportionate Share Hospital Payment and the CICP Supplemental Medicaid Payment is:

$200,000

Rural and Critical Access Hospitals receive 100% of their CICP Write-off Costs.

High Volume Medicaid and CICP Providers receive 80% of their CICP Write-off Costs or approximately 42% of their Uncompensated Uninsured Costs.

All other qualified CICP Hospitals receive 90% of their CICP Write-off Costs or approximately 42% of their Uncompensated Uninsured Costs.

Estimated CICP costs: $200,000
Uncompensated Uninsured Costs: $80,000
Your Facility will receive: 100% of CICP Costs

100% of CICP Costs = **$200,000**

Large Rural Hospital Supplemental Medicaid Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Large Rural Hospital Supplemental Medicaid Payment is:

$350,000

For Rural hospitals with over 25 licensed beds this payment is calculated by multiplying Total Medicaid Days by $315 per day.

County: Jackson
Total Medicaid Days: 1,111

1,111 * 315 **= $350,000**

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Neonatal Intensive Care Unit Supplemental Payment

Your Fiscal Year 2009-10 (July 1, 2009-June 30, 2010) reimbursement for the Neonatal Intensive Care Unit Supplemental Payment is:

$150,000

For hospital providers with a level IIIb or IIIc Neonatal Intensive Care Unit, the payment is calculated by multiplying Medicaid Nursery Days by $450 per day.

NICU level: IIIb
Medicaid Nursery Days: 333

$450 * 333 = **$150,000**

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