



Revised Federal Fiscal Year 2014-15 Hospital Provider Fee and Supplemental Payments

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Hospital Provider Fee and Supplemental Payment Overview

Provider Fee

- FFY 2014-15 Total Fee: \$688,506,704
- FFY 2013-14 Total Fee: \$534,833,982
- Total Fee Change: \$153,672,722
- Percent of Inpatient Fee to Total Fee: 52.92%
- Percent of Outpatient Fee to Total Fee: 47.08%

Supplemental Payment

- FFY 2014-15 Total Payment: \$1,186,189,476
- FFY 2013-14 Total Payment: \$913,111,826
- Total Payment Change: \$273,077,650

Total Payment less Total Fee

- FFY 2014-15 Total Payment less Total Fee: \$497,682,773
- FFY 2013-14 Total Payment less Total Fee: \$378,277,844
- Total Payment less Total Fees Change: \$119,404,929

Hospital Provider Fee

Hospital Provider Fees

- The inpatient fee charged per Managed Care Day is \$76.16. (The FFY 2013-14 inpatient fee charged per Managed Care Day was \$71.34, for an increase of \$4.82.)
- The inpatient fee charged per Non-Managed Care Day is \$340.39. (The FFY 2013-14 inpatient fee charged per Non-Managed Care Day was \$318.83, for an increase of \$21.56.)
- The Outpatient Fee is 1.9477% of Total Outpatient Charges. (The FFY 2013-14 percent of total outpatient charges was 1.5939%, for an increase of 0.3538%.)

Hospitals Exempt from Hospital Provider Fees

State licensed or 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 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 create an incentive to reduce uncompensated costs and increase access for Medicaid and uninsured clients. These facilities will not pay the hospital fee, but will receive an increased Medicaid Inpatient Hospital payment if they choose to participate in Medicaid. This will increase access for Medicaid clients.

Hospitals Assessed Discounted Hospital Provider Fees

The Inpatient Fee per Managed Care Day is discounted by 77.63%, equaling a \$76.16 per Managed Care Day fee. (The FFY 2013-14 inpatient fee charged per Managed Care Day was \$71.34, for an increase of \$4.82.)

The Inpatient Fee for High Volume Medicaid and Colorado Indigent Care Program (CICP) providers is discounted by 47.79%, equaling a \$39.76 per day Managed Care Day fee and \$177.72 per day Non-Managed Care Day fee. (The FFY 2013-14 High Volume Medicaid and CICP Managed Care Day Fee was \$37.24 and Non-Managed Care Day was \$166.46, for a \$2.52 and an \$11.26 fee increase respectively.)

- High Volume Medicaid and CICP providers are those providers with at least 30,000 Medicaid days per year that provide over 30% of their total days to Medicaid and CICP clients.
- The policy reason for this discount is that due to Psychiatric, Long Term Care and Rehabilitation Hospitals being excluded from the provider fee and commercial inpatient days are assessed a discounted fee, the B1/B2 test is required to be passed by 42 CFR 433.68(e)(2). In order to meet this

requirement, high volume Medicaid and CICP providers will pay a discounted fee.

The Inpatient Fee for Essential Access providers is discounted by 60.00%, equaling a \$30.46 per day Managed Care Day fee and \$136.16 per day for Non-Managed Care Day fee. (The FFY 2013-14 Essential Access Managed Care Day Fee was \$28.53 and non-Managed Care Day was \$127.53, for a \$1.93 and an \$8.63 fee increase respectively.)

- Essential Access providers are those providers that are Critical Access Hospitals and other rural hospitals with 25 or fewer beds.

The Outpatient Fee for High Volume Medicaid and CICP providers is discounted by 0.84%, equaling 1.9314% of Total Outpatient Charges. (The FFY 2013-14 High Volume Medicaid and CICP outpatient fee was 1.5810% of Total Outpatient Charges, for a .3504% increase.)

- The policy reason for this discount is that due to Psychiatric, Long Term Care and Rehabilitation Hospitals being excluded from the provider fee and commercial inpatient days are assessed a discounted fee, the B1/B2 test is required to be passed by 42 CFR 433.68(e)(2). In order to meet this requirement, high volume Medicaid and CICP providers will pay a discounted fee.

Data Elements Used in Provider Fee Calculation

- **Total Days** – Total days of service provided by a facility. From the Medicare Cost Report (Worksheet S-3, Part 1, Column 8) for CRYE 2012.
- **Managed Care Day** – Medicaid Health Maintenance Organization (HMO) Medicare HMO, and any Commercial Preferred Provider Organization (PPO)/HMO days provided by a facility. From the Uniform Cost Report (UCR) for CRYE 2012.
- **Non-Managed Care Day** – All other days (i.e., fee for service, normal Diagnosis Related Group (DRG) or indemnity plan days) provided by a facility. Calculated by subtracting Managed Care Days from Total Days.
- **Total Outpatient Charges** – The price a facility sets for its Outpatient services. From the Medicare Cost Report CRYE 2012 (Worksheet C, Column 7, Ancillary Service Cost Centers & Outpatient Service Cost Centers).

Hospital Provider Fee Calculation Example

Row	Description	Amount	Calculation
Row 1	Managed Care Days:	6,000	
Row 2	Fee Per Managed Care Day:	\$76.16	
Row 3	Managed Care Day Fee:	\$456,960	Row 1 multiplied by Row 2
Row 4	Non-Managed Care Days:	30,000	
Row 5	Fee Per Non-Managed Care Day:	\$340.39	
Row 6	Non-Managed Care Day Fee:	\$10,211,700	Row 4 multiplied by Row 5
Row 7	Total Inpatient Fee:	\$10,668,660	Row 3 plus Row 6
Row 8	Outpatient Charges:	\$50,000,000	
Row 9	Fee Percentage:	1.9477%	
Row 10	Total Outpatient Fee:	\$973,850	Row 8 multiplied by Row 9
Row 11	Total Fee:	\$11,642,510	Row 7 plus Row 10

Calculations may not match exactly due to rounding

Hospital Provider Fee Supplemental Payments

Inpatient Base Rate Hospital Supplemental Medicaid Payment

The Inpatient Base Rate Hospital Supplemental Medicaid Payment equals the difference between the Estimated MMIS Inpatient Payment and the Estimated Medicaid Payment with Adjusted Base Rate. The Percentage Adjustment Factor varies depending on a hospital's classification. The hospital classifications and corresponding Percentage Adjustment Factors are:

- General Hospital – 156.67%,
- Other High Volume Hospital – 99.00%,
- Rehabilitation/LTC Hospital – 5.00%, and
- Pediatric Hospital – 13.24%.

Certain hospitals will have a different Percentage Adjustment Factor so that their Upper Payment Limit (UPL) group's total payment equals the group's available Inpatient UPL minus the Uncompensated Care and Disproportionate Share Hospital (DSH) Payments (Explained on Page 8 & Page 9 of this document). The hospital's and their corresponding Percentage Adjustment Factors are:

- Non-state Government Owned Hospital – 149.89%, and
- State University Teaching Hospital – 62.00%.

The FFY 2013-14 Inpatient Base Rate Supplemental Medicaid Payment hospital classifications and Percentage Adjustment Factors were:

- Regular Hospital – 38.00%,
- Urban Safety Net – 36.00%,
- Rehabilitation/LTC Hospital – 10.00%,
- Pediatric Hospital – 9.50%,
- University Hospital – 20.00%, and
- Rural – 73.00%.

Psychiatric Hospitals do not qualify for this payment.

The Inpatient Base Rate Hospital Supplemental Payment is \$606,802,346. (The FFY 2013-14 Inpatient Base Rate Hospital Supplemental Payment was \$147,945,059, for a \$458,857,287 increase.)

Data Elements Used in Inpatient Base Rate Supplemental Hospital Payment Calculation

- **Estimated MMIS Inpatient Payment** – Medicaid Base Rate per Discharge, multiplied by Estimated Medicaid Discharges, multiplied by Case Mix.
- **Estimated MMIS Inpatient Payment with Adjusted Base Rate** – Medicaid Base Rate per Discharge increased by the Percentage Adjustment Factor, multiplied by Estimated Medicaid Discharges, multiplied by Case Mix.
 - **Medicaid Base Rate Per Discharge** – Estimated cost per Medicaid discharge. Calculated by multiplying a facility’s October 1, 2013 Medicare Rate by the FY 2014-15 Medicaid-Medicare rate ratio of 84.92%. Facilities without an October 1, 2013 Medicare rate have the average Medicaid Base Rate per Discharge for hospitals within their respective peer group having an October 1, 2013 Medicare rate and more than twenty-one Medicaid discharges.
 - **Estimated Medicaid Discharge** – Estimated number of Medicaid client discharges by a facility. Calculated using MMIS caseload data for Fiscal Year (FY) 2012-13, inflated by estimated Medicaid caseload growth: 28.82% for FY 2013-14 and 18.90% for FY 2014-15.
 - **Case Mix** – Unit measurement weighing the nature and complexity of care provided by a facility. MMIS data for FY 2012-13 run through the All Patient Refined (APR)-DRG grouper.

Inpatient Base Rate Hospital Supplemental Medicaid Payment Calculation Example

Row	Description	Amount	Calculation
Row 1	Medicaid Base Rate per Discharge:	\$6,000	
Row 2	Estimated Medicaid Discharges:	1,000	
Row 3	Case Mix:	1.05	
Row 4	Estimated MMIS Inpatient Payment:	\$6,300,000	Row 1 multiplied by Row 2 multiplied by Row 3
Row 5	Medicaid Base Rate per Discharge:	\$6,000	
Row 6	Percentage Adjustment Factor:	156.67%	
Row 7	Adjusted Medicaid Base Rate Per Discharge:	\$15,400	Row 5 multiplied by (100% plus Row 6)
Row 8	Estimated Medicaid Discharges:	1,000	
Row 9	Case Mix:	1.05	
Row 10	Estimated MMIS Inpatient Payment with Adjusted Base Rate:	\$16,170,210	Row 7 multiplied by Row 8 multiplied by Row 9
Row 11	Inpatient Base Rate Hospital Supplemental Medicaid Payment:	\$9,870,210	Row 10 minus Row 4

Calculations may not match exactly due to rounding

Outpatient Hospital Supplemental Medicaid Payment

The Outpatient Hospital Supplemental Medicaid Payment equals Medicaid Outpatient billed costs multiplied by a Percentage Adjustment Factor. The Percentage Adjustment Factor varies depending on a hospital's classification. The hospital classifications and corresponding percentage adjustment factors are:

- General Hospital – 28.17%,
- Rural Hospital – 65.00%, and
- Respiratory Specialist Hospital – 100%.

Certain hospitals will have a different Percentage Adjustment Factor so that their UPL group's total payment equals the group's available Outpatient UPL. The hospitals and their corresponding Percentage Adjustment Factors are:

- Non-State Government Owned General Hospital – 18.00%,
- Non-State Government Owned Rural Hospital – 51.00%,
- Private General Hospital – 27.01%, and
- Private Rural Hospital – 64.00%.

The FFY 2013-14 Outpatient Hospital Supplemental Medicaid Payment hospital classifications and Percentage Adjustment Factors were:

- General Hospital – 28.00%,
- Pediatric Specialty Hospital – 30.00%,
- Urban Safety Net Hospital – 25.00%,
- Rehabilitation/LTC Hospital – 15.00%, and
- Rural Hospital – 40.00%.

Psychiatric Hospitals do not qualify for this payment.

The Outpatient Hospital Supplemental Medicaid Payment is \$207,556,537. (The FFY 2013-14 Outpatient Hospital Supplemental Medicaid Payment was \$138,022,390, for a \$69,534,147 increase.)

Data Elements Used in Outpatient Supplemental Hospital Payment Calculation

Estimated Medicaid Outpatient Cost – CRYE 2012 Medicaid Outpatient Costs inflated to FFY 2014-15, by the Outpatient Utilization Inflation Factor and the MEI – Hospital Market Basket.

Outpatient Hospital Supplemental Medicaid Payment Calculation Example

Row	Description	Amount	Calculation
Row 1	Estimated FY 15 Medicaid OP Cost:	\$7,531,789	
Row 2	Percentage Adjustment Factor:	20.00%	
Row 3	Outpatient Hospital Supplemental Medicaid Payment:	\$1,506,358	Row 1 multiplied by Row 2

Calculations may not match exactly due to rounding

Uncompensated Care Hospital Supplemental Medicaid Payment

The Uncompensated Care Hospital Supplemental Medicaid Payment for qualified hospitals with 25 or fewer beds equals the hospital’s percent of beds compared to total beds for all qualified hospitals with 25 or fewer beds multiplied by \$33,500,000. The Uncompensated Care Hospital Supplemental Medicaid Payment for qualified hospitals with greater than 25 beds is the hospitals’ percent of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals with greater than 25 beds multiplied by \$81,980,176.

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

The Uncompensated Care Hospital Supplemental Medicaid Payment is \$115,480,176. (This payment can be compared to the FFY 2013-14 CICP UPL Hospital Supplemental Medicaid Payment of \$115,480,176, a \$0 increase.)

Data Elements Used in Uncompensated Care Hospital Supplemental Medicaid Payment Calculation

- **Bed Count** – Number of patient beds in a facility using data from Colorado Department of Public Health and Environment (CDPHE).
- **Total Uninsured Cost** – Total Uninsured Cost with the uninsured portion Provider Fee incurred by a facility. From the UCR for CRYE 2012.

**Uncompensated Care Hospital Supplemental Medicaid Payment Calculation
Example for a Hospital with less than 25 beds**

Row	Description	Amount	Calculation
Row 1	Bed Count:	20	
Row 2	Total Beds for Qualified Hospitals with 25 or Fewer Beds:	645	
Row 3	Percent of Beds to Total Beds for Qualified Hospitals with 25 or Fewer Beds:	3.10%	Row 1 divided by Row 2
Row 4	Total Available Funds:	\$33,500,000	
Row 5	Uncompensated Care Hospital Supplemental Medicaid Payment:	\$1,038,500	Row 3 multiplied by Row 4

Calculations may not match exactly due to rounding

**Uncompensated Care Hospital Supplemental Medicaid Payment Calculation
Example for a Hospital with more than 25 beds**

Row	Description	Amount	Calculation
Row 1	Bed Count:	30	
Row 2	Total Uninsured Cost:	\$4,000,000	
Row 3	Total Uninsured Cost for Qualified Hospitals with greater than 25 beds:	\$500,000,000	
Row 4	Percent of Total Uninsured Cost to Total Uninsured Cost for Qualified Hospitals with greater than 25 beds:	.80%	Row 2 divided by Row 3
Row 5	Total Available Funds:	\$81,980,176	
Row 6	Uncompensated Care Hospital Supplemental Medicaid Payment:	\$655,841	Row 4 multiplied by Row 5

Calculations may not match exactly due to rounding

Disproportionate Share Hospital Supplemental Payment

The Disproportionate Share Hospital (DSH) Supplemental Payment equals the percent of Uninsured Costs to total Uninsured Costs of all qualified hospitals, multiplied by the DSH Allotment in Total Computable of \$196,484,793. No hospital will receive a DSH Supplemental Payment greater than their Estimated DSH Limit. Hospitals with a DSH Supplemental Payment greater than or equal to their Estimated DSH Limit will have their DSH Supplemental Payment reduced to the Estimated DSH Limit. The reduction will be redistributed to other qualified hospitals not exceeding their Estimated DSH Limit based on their percentage of Uninsured Costs to total Uninsured Costs for all qualified hospitals not exceeding their Estimated DSH Limit.

To qualify for the Disproportionate Share Hospital Supplemental Payment a Colorado hospital shall meet either of the following criteria:

- i. Is not a Psychiatric Hospital, is a Colorado Indigent Care Program provider, and has at least two Obstetricians or is Obstetrician exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act; or
- ii. Is not a Psychiatric Hospital, has a Medicaid Inpatient Utilization Rate equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and has at least two Obstetricians or is Obstetrician exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act.

The DSH Supplemental Payment is \$194,901,544. This is a new payment and cannot be directly compared to previous DSH supplemental payment methodologies.

Data Elements Used in DSH Hospital Supplemental Payment Calculation

- **DSH Allotment in Total Computable** – \$196,484,793. Calculated using the FFY 2015 DSH allotment of \$100,226,893 FFP, increased by the FFY 2015 Federal Medical Assistance Percentage (FMAP) of 51.01%.
- **Estimated DSH Limit** – Total Medicaid Costs plus Uninsured Costs minus Estimated Inpatient and Outpatient Medicaid FFS payments, Hospital Provider Fee Supplemental Payments, and Other Supplemental Payments, multiplied by 99.92%.
 - **Total Medicaid Cost** – Total Inpatient and Outpatient Medicaid costs including the Medicaid portion the Provider Fee incurred by a facility. Calculated by converting Medicaid days and charges to costs using the per diem and CCRs calculated from each hospital's CRYE 2012 CMS 2552-10 cost report.
 - **Uninsured Cost** – Total Uninsured Costs including the Uninsured portion the Provider Fee incurred by a facility. Calculated by converting Uninsured days and charges to costs using the per diem and CCRs calculated from each hospital's CRYE 2012 CMS 2552-10 cost report.
 - **Estimated MMIS Inpatient Medicaid Payment** – Medicaid Base Rate per Discharge, multiplied by Estimated Medicaid Discharges, multiplied by Case Mix.
 - **Estimated MMIS Outpatient Medicaid Payment** – Medicaid Outpatient Billed Costs multiplied by 71.60%.

- **Hospital Provider Fee Supplemental Payment** – Inpatient Base Rate Hospital Medicaid Supplemental Payment, Outpatient Hospital Medicaid Supplemental Payment, Uncompensated Care Hospital Supplemental Medicaid Payments and Hospital Quality Incentive Care Payments (HQIP).
 - **Other Hospital Supplemental Payment** – Non-Provider Fee funded supplemental payments including Family Medicaid/GME, Rural Family Medicine, Clinic Based Indigent Care, Pediatric Specialty Hospital, and State University Teaching Supplemental Payments.
- **Medicaid Inpatient Utilization Rate** – Ratio of Medicaid Patient Days to Total Patient Days.
 - **Total Patient Day** – Total days of service provided by a facility. From the Medicare Cost Report (Worksheet S-3, Part I) for CRYE 2012.
 - **Medicaid Patient Day** – Total days of service provided to Medicaid patients by a facility. Includes Managed and Non-Managed Care Patient Days from MMIS and from UCR for CRYE 2012.

DSH Allotment in Total Computable Calculation

Row	Description	Amount	Calculation
Row 1	FY 2014 DSH Allotment:	\$100,226,893	
Row 2	FMAP:	51.01%	
Row 3	DSH Allotment in Total Computable:	\$196,484,793	Row 1 divided by Row 2

Calculations may not match exactly due to rounding

DSH Supplemental Payment Calculation Example for hospital with DSH Supplemental Payment less than the Estimated DSH Limit

Row	Description	Amount	Calculation
Row 1	Total Medicaid Cost:	\$15,000,000	
Row 2	Uninsured Cost:	\$1,000,000	
Row 3	Estimated Inpatient Medicaid FFS Payments:	\$3,000,000	
Row 4	Estimated Outpatient Medicaid FFS Payments:	\$3,000,000	
Row 5	Supplemental Payments:	\$1,000,000	
Row 6	Other Supplemental Payments:	\$3,000,000	
Row 7	Percent DSH Funded:	99.92%	
Row 8	Estimated DSH Limit:	\$5,995,200	(Row 1 plus Row 2 minus Row 3,4,5, and 6) multiplied by Row 7
Row 9	Uninsured Cost:	\$1,000,000	
Row 10	Total Uninsured Cost for all Qualified Hospitals:	\$50,000,000	
Row 11	Percent of Uninsured Cost to Total Uninsured Cost for all Qualified Hospitals:	2.0%	Row 9 / Row 10
Row 12	DSH Allotment in Total Computable:	\$196,484,793	
Row 13	DSH Supplemental Payment:	\$ 3,929,696	Row 11 * Row 12
Row 14	Is DSH Supplemental Payment Less than Estimated DSH Limit:	Yes	Is Row 13 Less Than Row 8?
Row 15	Final DSH Supplemental Payment:	\$ 3,929,696	Lesser of Row 13 and Row 8

Calculations may not match exactly due to rounding

DSH Supplemental Payment Calculation Example for hospital with DSH Supplemental Payment more than the Estimated DSH Limit

Row	Description	Amount	Calculation
Row 1	Total Medicaid Cost:	\$10,000,000	
Row 2	Uninsured Cost:	\$1,000,000	
Row 3	Estimated Inpatient Medicaid FFS Payments:	\$3,000,000	
Row 4	Estimated Outpatient Medicaid FFS Payments:	\$3,000,000	
Row 5	Supplemental Payments:	\$1,000,000	
Row 6	Other Supplemental Payments:	\$3,000,000	
Row 7	Percent DSH Funded:	99.92%	
Row 8	Estimated DSH Limit:	\$999,200	(Row 1 plus Row 2 minus Row 3,4,5, and 6) multiplied by Row 7
Row 9	Uninsured Cost:	\$1,000,000	
Row 10	Total Uninsured Cost for all Qualified Hospitals:	\$50,000,000	
Row 11	Percent of Uninsured Cost to Total Uninsured Cost for all Qualified Hospitals:	2.0%	Row 9 divided by Row 10
Row 12	DSH Allotment in Total Computable:	\$196,484,793	
Row 13	DSH Supplemental Payment:	\$3,929,696	Row 11 multiplied by Row 12
Row 14	Is DSH Supplemental Payment Less than Estimated DSH Limit:	No	Is Row 13 Less Than Row 8?
Row 15	Final DSH Supplemental Payment:	\$999,200	Lesser of Row 13 and Row 8

Calculations may not match exactly due to rounding

Hospital Quality Incentive Payment

Hospital Quality Incentive Payment (HQIP) is a payment to Colorado hospitals that provide services to improve the quality of care and health outcomes for their patients.

The measures are:

- Rate of Non-Emergent Emergency Room Visits,
- Rate of elective deliveries between 37 and 39 weeks gestation,
- Rate of Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT),
- Rate of thirty (30) day all-cause hospital readmissions, and
- Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position.

The HQIP Hospital Supplemental Medicaid Payment is \$61,448,873. (This payment can be compared to the FFY 2013-14 HQIP Hospital Supplemental Medicaid Payment of \$34,388,388, a \$27,060,485 increase.)

Reduction in Number of Supplemental Payments in FFY 2014-15

The number of supplemental payments in the FFY 2014-15 Hospital Provider Fee model is reduced from twelve to five. The FFY 2014-15 and FFY 2013-14 supplemental payments are:

- FFY 2014-15 Supplemental Payments
 - Inpatient Base Supplemental Payment,
 - Outpatient Base Supplemental Payment,
 - Uncompensated Care Supplemental Payment,
 - DSH Supplemental Payment, and
 - Hospital Quality Incentive Payment.

- FFY 2013-14 Supplemental Payments
 - Inpatient Base Supplemental Payment,
 - Outpatient Base Supplemental Payment,
 - CICP DSH Payment,
 - CICP Supplemental Medicaid Payment,
 - Uninsured DSH Payment,
 - Large Rural Hospital Supplemental Medicaid Payment,
 - Denver Metro Supplemental Medicaid Payment,
 - Metropolitan Statistical Area Supplemental Medicaid Payment,
 - State Teaching Hospital Supplemental Medicaid Payment,
 - High Level Neonatal Intensive Care Unit (NICU) Supplemental Medicaid Payment,
 - Pediatric Specialty Hospital Provider Fee Payment, and
 - Medicaid Psychiatric Inpatient Payment.

Hospital Upper Payment Limit Overview

Inpatient Upper Payment Limit

- FFY 2014-15 Inpatient Upper Payment Limit: \$1,701,147,825
- FFY 2013-14 Inpatient Upper Payment Limit: \$1,018,148,625
- Inpatient Upper Payment Limit Change: \$682,999,200

Available Funding for Inpatient Hospital Provider Fee Supplemental Medicaid Payments

- FFY 2014-15 Inpatient Available Funding: \$850,655,162
- FFY 2013-14 Inpatient Available Funding: \$604,570,454
- Inpatient Available Funding Change: \$246,094,708

Outpatient Upper Payment Limit

- FFY 2014-15 Outpatient Upper Payment Limit: \$746,342,972
- FFY 2013-14 Outpatient Upper Payment Limit: \$495,936,505
- Outpatient Upper Payment Limit Change: \$250,406,467

Available Funding for Outpatient Hospital Provider Fee Supplemental Medicaid Payments

- FFY 2014-15 Outpatient Available Funding: \$232,787,272
- FFY 2013-14 Outpatient Available Funding: \$162,593,814
- Outpatient Available Funding Change: \$70,193,458

The Upper Payment Limit (UPL) is the maximum the Colorado Department of Health Care Policy & Financing (HCPF) can reimburse hospital providers and still receive Federal Financial Participation (FFP). The UPL is completed for both Inpatient and Outpatient hospital services, separated into three separate UPL provider groups: state owned government hospitals, non-state owned government hospitals, and privately owned hospitals.

For each UPL provider group, the available funding for FFY 2014-15 Hospital Provider Fee Supplemental Payments equals their FFY 2014-15 UPL minus their Estimated FY 2014-15 Medicaid Management Information System (MMIS) claims reimbursement and other State Fiscal Year (SFY) non-Hospital Provider Fee Supplemental Payments.

Data Elements Used in Inpatient Hospital Upper Payment Limit Calculation

- **Inpatient Upper Payment Limit** – Sum of Estimated FFY 2014-15 Medicaid Inpatient Costs and FFY 2014-15 Medicaid Inpatient Provider Fees.
 - **Estimated Medicaid Inpatient Cost** –CRYE 2012 Medicaid Inpatient Costs inflated to FFY 2014-15, by the Medicaid Caseload Utilization and the MEI – Hospital Market Basket.
 - **Medicaid Inpatient Cost** – Calculated by converting Medicaid Inpatient days and charges to costs using the per diem and CCRs calculated from each hospital’s CRYE 2012 CMS 2552-10 cost report.

Inpatient Utilization Inflation Factor – Changes in Inpatient utilization (hospital days) as a function of the change in Medicaid caseload. The percentage adjustment for each Fiscal Year for Medicaid Inpatient Costs are:

Fiscal Year	FY 13	FY 14	FY 15
Percent Adjustment	11.32%	43.98%	36.81%

Medicaid Economic Index – Hospital Market Basket –Projected market basket increases to Hospital Prospective Payment System (PPS) rates. The percentage adjustment for each Fiscal Year for Medicaid Inpatient Costs are:

Fiscal Year	FY 13	FY 14	FY 15
Percent Adjustment	3.0%	2.60%	2.50%

- **CRYE to FFY Adjustment Factor** – FFY End Date minus Cost Report Year End (CRYE), divided by 365 days, plus 1.
- **Medicaid Inpatient Provider Fee** – Percentage of Medicaid Patient Days to Total Patient Days multiplied by the FFY 2014-15 Inpatient Provider Fee.
 - **Medicaid Patient Day** – Total days of service provided by a facility to Medicaid clients. From the UCR for CRYE 2012.
 - **Total Patient Day** – From the Medicare Cost Report (Worksheet S-3, Part I, Col 8) for CRYE 2012.
 - **Total Provider Fee** – Total Provider Fee calculated for FFY 2014-15.

- **Estimated Medicaid Inpatient Management Information System Claims Reimbursement** – MMIS data for Calendar Year (CY) 2011-12, inflated to FFY 2014-15 by the Inpatient Utilization Inflation Factor and Medicaid Rate Inflation.

Inpatient Utilization Inflation Factor – Changes in Inpatient utilization (hospital days) as a function of the change in Medicaid caseload. The percentage adjustment for each Fiscal Year for Medicaid Inpatient claims reimbursement are:

Fiscal Year	FY 13	FY 14	FY 15
Percent Adjustment	11.32%	43.98%	36.81%

Medicaid Rate Inflation – Estimated Medicaid rate growth based on historical Medicaid rates. The rate adjustment percentage for each Fiscal Year for Inpatient Medicaid claims reimbursement are:

Fiscal Year	FY 13	FY 14	FY 15
Percent Adjustment	3.0%	2.00%	2.00%

- **Other Hospital Supplemental Medicaid Payments** – Other funded supplemental payments including Family Medicaid/GME, Rural Family Medicine, Clinic Based Indigent Care, Pediatric Specialty Hospital, and State University Teaching Supplemental Payments.

Data Elements Used in Outpatient Hospital Upper Payment Limit Calculation

- **Outpatient Upper Payment Limit** – Sum of Estimated FFY 2014-15 Medicaid Outpatient Costs and FFY 2014-15 Medicaid Outpatient Provider Fees.
 - **Estimated Medicaid Outpatient Cost** – CRYE 2012 Medicaid Outpatient Costs inflated to FFY 2014-15, by the Outpatient Utilization Inflation Factor and the MEI – Hospital Market Basket.
 - **Medicaid Outpatient Cost** – Charges from the MMIS for CRYE 2012, multiplied by the hospital’s CRYE 2012 CCR.

Outpatient Utilization Inflation Factor – Changes in Outpatient utilization (hospital visits) as a function of change in Medicaid caseload. The percentage adjustment for each Fiscal Year for Medicaid Outpatient Costs are:

Fiscal Year	FY 13	FY 14	FY 15
Percent Adjustment	10.27%	27.47%	23.67%

Medicaid Economic Index – Hospital Market Basket – Projected market basket increases to Hospital Prospective Payment System (PPS) rates. The market basket adjustment percentage for each Fiscal Year for Medicaid Outpatient Costs are:

Fiscal Year	FY 13	FY 14	FY 15
Percent Adjustment	3.0%	2.60%	2.50%

- **CRYE to FFY Adjustment Factor** – FFY End Date minus CRYE, divided by 365 days, plus 1.
- **Medicaid Outpatient Provider Fee** – Percentage of FFY 2014-15 Medicaid Outpatient Charges to FFY 2014-15 Total Outpatient Charges multiplied by the FFY 2014-15 Outpatient Provider Fee.
 - **Medicaid Outpatient Charges** – Charges from the MMIS for CRYE 2012.
 - **Total Outpatient Charges** – Charges from the MMIS for CRYE 2012.
 - **Total Provider Fee** – Total Provider Fee calculated for FFY 2015.
- **Estimated Medicaid Outpatient Management Information System Claims Reimbursement** – Estimated FFY 2014-15 Medicaid Outpatient multiplied by 71.60%.

Inpatient UPL Calculation Example

Row	Description	Amount	Calculation
Row 1	Federal Fiscal Year End Date:	9/30/2012	
Row 2	Cost Report Begin Date:	1/1/2012	
Row 3	Cost Report End Date:	12/31/2012	
Row 4	Days Included in Cost Report:	366	(Row 3 minus Row 2) plus 1
Row 5	CRYE to FFY Adjustment Factor:	.75	((Row 1 minus Row 3) divided by 365) plus 1
Row 6	CRYE 2012 Medicaid IP Cost:	\$50,000,000	
Row 7	FY 13 Medicaid Caseload Utilization:	11.32%	
Row 8	CRYE 12 Medicaid IP Costs Adjusted For FY 13 Utilization:	\$55,660,000	Row 6 multiplied by (100% plus Row 7)
Row 9	FY 13 Medicaid Economic Index:	3.00%	
Row 10	CRYE 12 Medicaid IP Costs Adjusted For FY 13 Inflation and Utilization:	\$57,329,800	Row 8 multiplied by (100% plus Row 9)
Row 11	FY 14 Medicaid Caseload Utilization:	43.98%	
Row 12	Estimated FY 13 Medicaid IP Costs Adjusted for FY 14 Utilization	\$82,543,446	Row 10 multiplied by (100% plus Row 11)
Row 13	FY 14 Medicaid Economic Index:	2.60%	
Row 14	Estimated FY 13 Medicaid IP Costs Adjusted for FY 14 Inflation and Utilization:	\$84,689,576	Row 12 multiplied by (100% plus Row 13)
Row 15	FY 15 Medicaid Caseload Utilization:	36.81%	
Row 16	Estimated FY 14 Medicaid IP Costs Adjusted for FFY 15 Utilization:	\$108,070,251	Row 14 multiplied by (100% plus (Row 5 multiplied by Row 15))
Row 17	FY 15 Medicaid Economic Index:	2.50%	
Row 18	Estimated FY 14 Medicaid IP Costs Adjusted for FFY 15 Inflation and Utilization:	\$110,096,568	Row 16 multiplied by (100% plus (Row 5 multiplied by Row 17))
Row 19	Estimated FFY 15 Medicaid IP Cost:	\$110,096,568	Row 18
Row 20	Medicaid Patient Day:	30,000	
Row 21	Total Patient Day:	130,000	
Row 22	Percentage of Medicaid Patient Day to Total Patient Day:	23.08%	Row 20 divided by Row 21
Row 23	FFY 15 Total IP Provider Fee:	\$15,000,000	
Row 24	FFY 15 Medicaid IP Provider Fee:	\$3,462,000	Row 22 multiplied by Row 23
Row 25	FFY 2015 IP UPL:	\$113,558,568	Row 19 plus Row 24

Calculations may not match exactly due to rounding

Outpatient UPL Calculation Example

Row	Description	Amount	Calculation
Row 1	Federal Fiscal Year End Date:	9/30/2012	
Row 2	Cost Report Begin Date:	1/1/2012	
Row 3	Cost Report End Date:	12/31/2012	
Row 4	Days Included in Cost Report:	366	(Row 3 minus Row 2) plus 1
Row 5	CRYE to FFY Adjustment Factor:	.75	((Row 1 minus Row 3) divided by 365) plus 1
Row 6	CRYE 2012 Medicaid OP Cost:	\$4,000,000	
Row 7	FY 13 Medicaid Caseload Utilization:	10.27%	
Row 8	CRYE 12 Medicaid OP Costs Adjusted For FY 13 Utilization:	\$4,410,800	Row 6 multiplied by (100% plus Row 7)
Row 9	FY 13 Medicaid Economic Index:	3.00%	
Row 10	CRYE 12 Medicaid OP Costs Adjusted For FY 13 Inflation & Utilization:	\$4,543,124	Row 8 multiplied by (100% plus Row 9)
Row 11	FY 14 Medicaid Caseload Utilization:	43.98%	
Row 12	Estimated CRYE 13 Medicaid OP Costs Adjusted for FY 14 Utilization	\$5,794,120	Row 10 multiplied by (100% plus Row 11)
Row 13	FY 14 Medicaid Economic Index:	2.60%	
Row 14	Estimated CRYE 13 Medicaid OP Costs Adjusted for FY 14 Inflation & Utilization:	\$5,941,689	Row 12 multiplied by (100% plus Row 13)
Row 15	FY 15 Medicaid Caseload Utilization:	36.81%	
Row 16	Estimated CRYE 14 Medicaid OP Costs Adjusted for FFY 15 Utilization:	\$7,582,041	Row 14 multiplied by (100% plus (Row 5 multiplied by Row 15))
Row 17	FY 15 Medicaid Economic Index:	2.50%	
Row 18	Estimated CRYE 14 Medicaid OP Costs Adjusted for FFY 15 Inflation & Utilization:	\$7,724,204	Row 16 multiplied by (100% plus (Row 5 multiplied by Row 17))
Row 19	Estimated FY 15 Medicaid OP Cost:	\$7,724,204	Row 18
Row 20	CRYE 2012 Medicaid Outpatient Charges:	\$8,000,000	
Row 21	CRYE 2012 Total Outpatient Charges:	\$40,000,000	
Row 22	Percentage of Medicaid Outpatient Charges to Total Outpatient Charges:	20.00%	Row 20 divided by Row 21
Row 23	FFY 15 Total OP Provider Fee:	\$1,000,000	
Row 24	FFY 15 Medicaid OP Provider Fee:	\$200,000	Row 22 multiplied by Row 23
Row 25	FFY 2015 OP UPL:	\$7,924,204	Row 19 plus Row 24

Calculations may not match exactly due to rounding

Available Funding For Inpatient Hospital Provider Fee Supplemental Payment Calculation Example

Row	Description	Amount	Calculation
Row 1	FFY 2015 IP UPL:	\$122,220,372	
Row 2	CY12 Medicaid MMIS Claims Reimbursement:	\$35,932,447	
Row 3	FY 13 Medicaid Caseload Utilization:	11.32%	
Row 4	CY 12 Medicaid IP Payments Adjusted for FY 13 Utilization:	\$40,000,000	Row 2 multiplied by (100% plus Row 3)
Row 5	FY 13 Medicaid Economic Index:	0.00%	
Row 6	CY 12 Medicaid IP Payments Adjusted for FY 13 Utilization & Inflation:	\$40,000,000	Row 4 multiplied by (100% plus Row 5)
Row 7	FY 14 Medicaid Caseload Utilization:	43.98%	
Row 8	Estimated FY 13 Medicaid IP Payments Adjusted for FY 14 Utilization:	\$57,592,000	Row 6 multiplied by (100% plus Row 7)
Row 9	FY 14 Medicaid Economic Index:	2.60%	
Row 10	Estimated FY 13 Medicaid IP Payments Adjusted for FY 14 Utilization & Inflation:	\$59,089,392	Row 8 multiplied by (100% plus Row 9)
Row 11	FY 15 Medicaid Caseload Utilization:	36.81%	
Row 12	Estimated FY 14 Medicaid IP Payments Adjusted for FY 15 Utilization:	\$80,840,197	Row 10 multiplied by (100% plus Row 11)
Row 13	FY 15 Medicaid Economic Index:	2.50%	
Row 14	Estimated FY 14 Medicaid IP Payments Adjusted for FY 15 Utilization & Inflation:	\$82,861,202	Row 12 multiplied by (100% plus Row 13)
Row 15	Estimated FY 15 Medicaid IP MMIS Claims Reimbursement:	\$82,861,202	Row 14
Row 16	Non-Hospital Provider Fee Supplemental Medicaid Payments:	\$600,000	
Row 17	Available Funding for FY 15 Inpatient Hospital Provider Fee Supplemental Medicaid Payment:	\$38,759,170	Row 1 minus Row 15 minus Row 16

Calculations may not match exactly due to rounding

Net Patient Revenue

The Inpatient and Outpatient Hospital Provider Fees are limited to a percentage of Net Patient Revenue (NPR). For FFY 2014-15, the Inpatient Hospital Provider Fee is calculated to equal 5.5% of Inpatient NPR for FFY 2014-15. The same is true for the FFY 2014-15 Outpatient Hospital provider Fee, also calculated to equal 5.5% of Outpatient NPR for FFY 2014-15.

Data Elements Used in Net Patient Revenue Calculation

- **Inpatient Net Patient Revenue** – Percentage of CRYE 2012 Inpatient Hospital Revenue to CRYE 2012 Total Hospital Revenue, multiplied by CRYE 2012 Total Hospital NPR, and inflated to FFY 2014-15 by an annual inflation rate of 5.64%.
 - **Inpatient Hospital Revenue** – From the Medicare Cost Report (Worksheet G-2, Parts I&II, Column 1, Line 1, 2, 3, 4, 16, 18, and 19) for CRYE 2012.
 - **Total Hospital Revenue** - Inpatient Hospital Revenue plus Outpatient Charges. Outpatient Charges are from the Medicare Cost Report (Worksheet G-2, Parts I&II, Column 2, Line 18 and 19) for CRYE 2012.
 - **Total Hospital NPR** – Net Patient Revenue multiplied the percentage of Total Hospital Revenue to Total Gross Revenue.
 - **Net patient Revenue** - From the Medicare Cost Report (Worksheet G-3, Line 3, Line 3) for CRYE 2012.
 - **Total Gross Revenue** – From the Medicare Cost Report (Worksheet G-2, Parts I&II, Column 3, Line 28) for CRYE 2012.
- **Outpatient Net Patient Revenue** – CRYE 2012 Total Hospital NPR minus CRYE 2012 Inpatient Net Patient Revenue, inflated to FY 2014-15 by an annual inflation rate of 5.64%.

Net Patient Revenue Provider Fee Limitation Calculation Example

Row	Description	Amount	Calculation
Row 1	CRYE 2012 IP Hospital Revenue:	\$15,000,000	
Row 2	CRYE 2012 Total Hospital Revenue:	\$15,500,000	
Row 3	IP to Total Revenue:	96.77%	Row 1 divided by Row 2
Row 4	CRYE 2012 Net Patient Revenue:	\$9,000,000	
Row 5	CRYE 2012 Total Gross Revenue:	\$16,000,000	
Row 6	Total Hospital Revenue to Total Gross Revenue:	96.88%	Row 2 divided by Row 5
Row 7	CRYE 2012 Total Hospital NPR:	\$8,719,200	Row 4 multiplied by Row 6
Row 8	CRYE 2012 IP NPR:	\$8,437,570	Row 3 multiplied by Row 7
Row 9	CRYE 2012 OP NPR:	\$281,630	Row 7 minus Row 8
Row 10	Inflation Rate:	5.64%	
Row 11	FFY 2014-15 IP NPR:	\$8,437,571	Row 8 multiplied by (100% plus Row 10) raised to the 3 rd power
Row 12	FFY 2014-15 OP NPR:	\$281,631	Row 9 multiplied by (100% plus Row 10) raised to the 3 rd power
Row 13	NPR Limitation:	5.50%	
Row 14	FFY 2014-15 Inpatient Fee Limit:	\$464,066	Row 11 multiplied by Row 13
Row 15	FFY 2014-15 Outpatient Fee Limit:	\$15,490	Row 12 multiplied by Row 13

Calculations may not match exactly due to rounding