
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE – SECTION 8.2000

10 CCR 2505-10 8.2000

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

8.2000: HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3, authorizes the Department of Health Care Policy and Financing (Department) to assess a hospital provider fee, pursuant to rules adopted by the State Medical Services Board, to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program (CICP). In addition, the Act requires the Department to use the hospital provider fee to expand health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without dependent children; to provide a Medicaid buy-in program for people with disabilities; to implement twelve month continuous eligibility for Medicaid eligible children; and to pay the Department's administrative costs of implementing and administering the Act.

8.2001: DEFINITIONS

“Act” means the Colorado Health Care Affordability Act, C.R.S. § 25.5-4-402.3.

“APR-DRG” means all patient refined-diagnosis related group.

“Bad Debt” means the unpaid dollar amount for services rendered from a patient or third party payer, for which the hospital expected payment, excluding Medicare bad debt.

“Charity Care” means health care services resulting from a hospital's policy to provide health care services free of charge, or where only partial payments are expected, (not to include contractual allowances for otherwise insured patients) to individuals who meet certain financial criteria. Charity Care does not include any health care services rendered under the CICP or those classified as Bad Debt.

“Charity Care Day” means a day for a recipient of the hospital's Charity Care.

“Charity Care Write-Off Charges” means the hospital's charges for Charity Care less payments from a primary payer, less any copayment due from the client, less any other third party payments

“CICP” means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

“CICP Day” means a day for a recipient enrolled in the CICP.

“CICP Write-Off Charges” means those charges reported to the Department by the hospital in accordance with 10 CCR 2505-10, Section 8.903.C.5.

“CMS” means the federal Centers for Medicare and Medicaid Services.

“Cost-to-Charge Ratio” means the sum of the hospital's total ancillary costs and physician costs divided by the sum of the hospital's total ancillary charges and physician charges.

“Critical Access Hospital” means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

“Diagnosis Related Group” or “DRG” means a cluster of similar conditions within a classification system used for hospital reimbursement. It reflects clinically cohesive groupings of inpatient hospitalizations that utilize similar amounts of hospital resources.

“Essential Access Hospital” means a Critical Access Hospital or General Hospital located in a Rural Area with 25 or fewer licensed beds.

“Fund” means the hospital provider cash fund described in C.R.S. § 25.5-4-402.3(4).

“General Hospital” means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

“High Volume Medicaid and CICIP Hospital” means a hospital with at least 30,000 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICIP clients.

“HMO” means a health maintenance organization that provides health care insurance coverage to an individual.

“Hospital-Specific Disproportionate Share Hospital Limit” means a hospital’s maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

“Inpatient Services Fee” means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

“Inpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

“Long Term Care Hospital” means a General Hospital that is certified as a long term care hospital by the Colorado Department of Public Health and Environment.

“Managed Care Day” means a day listed as HMO or PPO Days on the hospital’s patient census.

“Medicaid Day” means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

“Medicaid Fee-for-Service Day” means a Non-Managed Care Day for which Medicaid is the primary payer. For these days the hospital is reimbursed directly through the Department’s fiscal agent.

“Medicaid Managed Care Day” means a Managed Care Day for which the primary payer is Medicaid.

“Medicaid NICU Day” means a Medicaid Fee-for-Service Day in a hospital’s neo-natal intensive care unit, reimbursed under APR-DRG 588, 591, 593, 602, 609, 630, or 631 up to the average length of stay.

“Medicaid Nursery Day” means a Managed Care Day or Non-Managed Care Day provided to Medicaid newborns while the mother is in the hospital.

“Medicaid Psychiatric Day” means a Managed Care Day or Non-Managed Care Day provided to a Medicaid recipient in the hospital’s sub-acute psychiatric unit.

“Medicaid Rehabilitation Day” means a Managed Care Day or Non-Managed Care Day provided to a Medicaid recipient in the hospital’s sub-acute rehabilitation unit.

“Medicare Fee-for-Service Day” means a Non-Managed Care Day for which Medicare is the primary payer and the hospital is reimbursed on the basis of a DRG.

“Medicare HMO Day” means a Managed Care Day for which the primary payer is Medicare.

“Medicare-Medicaid Dual Eligible Day” means a day for which the primary payer is Medicare and the secondary payer is Medicaid.

“Medicare Cost Report” means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

“MMIS” means the Medicaid Management Information System, the Department’s Medicaid claims payment system.

“MIUR” means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospital days.

“Non-Managed Care Day” means a day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO or PPO.

“Non-State-Owned Government Hospital” means a hospital that is either owned or operated by a local government.

“Other Payers Day” means a day where the primary payer is not Medicaid or Medicare, which is not a CICP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care Day.

“Outpatient Services Fee” means an assessment on hospitals based on outpatient hospital charges

“Outpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

“Oversight and Advisory Board” means the hospital provider fee oversight and advisory board described in C.R.S. § 25.5-4-402.3(6).

“Pediatric Specialty Hospital” means a hospital that provides care exclusively to pediatric populations.

“PPO” means a preferred provider organization that is a type of managed care health plan.

“Privately-Owned Hospital” means a hospital that is privately owned and operated.

“Psychiatric Hospital” means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

“Rehabilitation Hospital” means an inpatient rehabilitation facility.

“Rural Area” means a county outside a Metropolitan Statistical Area designated by the United States Office of Management and Budget.

“State-Owned Government Hospital” means a hospital that is either owned or operated by the State.

“State University Teaching Hospital” means a High Volume Medicaid and CICP Hospital which 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 (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

“Third-Party Medicaid Day” means a day for which third party coverage, other than Medicare, is the primary payer and Medicaid is the secondary payer.

“Uncompensated CICIP Costs” means CICIP Write-Off Charges multiplied by the most recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment year.

“Uncompensated Charity Care Costs” means Charity Care Write-Off Charges multiplied by the most recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment year.

“Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report” or “Uniform Cost Report” means the online hospital data reporting system which combines information from hospitals’ Medicare Cost Reports, the MMIS, hospital financial statements, and other hospital records.

“Uninsured Cost” means uninsured charges multiplied by the most recent provider-specific audited Cost-to-Charge ratio from the cost reports applicable to the Uniform Cost Report.

“Uninsured/Self Pay Day” means a day for self-pay patients and patients without third party health insurance coverage. Uninsured/Self Pay Day does not include Charity Care Days or CICIP Days.

“Uninsured/Self Pay Write Off Charges” means charges for self-pay patients and those with no third party coverage less adjustments for a hospital’s courtesy or uninsured or self-pay policy discounts.

“Urban Center Safety Net Specialty Hospital” means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICIP Days relative to total days, rounded to the nearest percent, equals or exceeds 65%.

8.2002: RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS

DATA REPORTING

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Department shall distribute a Uniform Cost Report to all hospitals no later than April 30 of each year. The Department shall include instructions for completing the Uniform Cost Report, including definitions and descriptions of each data element to be reported in the Uniform Cost Report. Hospitals shall submit the Uniform Cost Report, as requested, to the Department by May 31 of each year. The Department may estimate any data element not provided directly by the hospital.
2. Hospitals shall submit the following data elements and any additional elements requested by the Department: (a) Managed Care Days, (b) Non-Managed Care Days, (c) Medicaid Fee-for-Service Days, (d) Medicaid Nursery Days, (e) Medicaid Managed Care Days, (f) Medicaid Psychiatric Days, (g) Medicaid Rehabilitation Days, (h) Medicare Non-Managed Care Days, (i) Medicare HMO Days, (j) CICIP Days, (k) Charity Care Days, (l) Uninsured/Self-Pay Days, (m) Other Payers Days, (n) Total days reported on the patient census, (o) Charity Care Write-Off Charges, (p) Bad Debt, (q) Uninsured/Self Pay Write-Off Charges, (r) Medicare-Medicaid Dual Eligible Days, and (s) Third Party Medicaid Days.
3. The Department shall distribute a data confirmation report to all hospitals annually. The data confirmation report shall include a listing of relevant data elements used by the Department in calculating the Outpatient Services Fee, the Inpatient Services Fee and the supplemental payments. The data confirmation report shall clearly state the manner and timeline in which hospitals may request revisions to the data elements recorded by the Department. Revisions to the data will not be permitted by a hospital after the dates outlined in the data confirmation report.
4. An authorized hospital signatory shall certify that the data included in the Uniform Cost Report are correct, are based on actual hospital records, and that all supporting documentation will be maintained for a minimum of seven years.

FEE ASSESSMENT AND COLLECTION

1. Establishment of Electronic Funds Process. The Department shall utilize an Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental payments in financial accounts authorized by hospitals. The Department shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.
2. Fee Collection and Payment Disbursement. In state fiscal year (SFY) 2009-10 Outpatient Services Fee and Inpatient Services Fee (collectively referred to as “fee”) will be assessed on an annual basis and collected in four installments on or about, April 16, 2010; April 30, 2010; May 14, 2010 and June 11, 2010.

For those hospitals that participate in the electronic funds process utilized by the Department, payments will be calculated on an annual basis and disbursed in four installments on the same date the fee is assessed.

3. Beginning in SFY 2010-11 the Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve monthly installments. Payments to hospitals will be calculated on an annual basis and disbursed in twelve monthly installments.
 - a. For those hospitals that participate in the electronic funds process utilized by the Department , fees will be assessed and payments will be disbursed on the second Friday of the month, except when State offices are closed during the week of the second Friday, then fees will be assessed and payment will be disbursed on the following Friday of the month If the Department must diverge from this schedule due to unforeseen circumstances, the Department shall notify hospitals in writing or by electronic notice as soon as possible.
 - i. The Department may assess fees and disburse payments for Urban Center Safety Net Specialty Hospitals on an alternate schedule determined by the Department.
 - b. At no time will the Department assess fees or disburse payments prior to the state fiscal year for which they apply.
4. Payments to hospitals shall be processed by the Department within two business days of receipt of a warrant (paper check) or wire transfer to pay the Outpatient Services Fee and Inpatient Services Fee from hospitals that do not participate in the ACH debit process utilized by the Department. Payments through a warrant (paper check) will be processed by the Department within two business days of receipt of the Outpatient Services Fee or Inpatient Services Fee for those hospitals that do not participate in the EFT payment process utilized by the Department to deposit supplemental payments in financial accounts authorized by hospitals.
5. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Department for the collection of fees and the disbursement of payments unless the Department has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Department describing an alternative fee collection process and/or payment process. The Department shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

8.2003: HOSPITAL PROVIDER FEE

OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).
2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.
3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.9447% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).
2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.
3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of \$76.16 per day for Managed Care Days and \$340.39 per day for all other Days as reported to the Department by each hospital by April 30 with the following exceptions:
 - a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to \$39.76 per day for Managed Care Days and \$177.72 per day for all other Days, and.
 - b. Essential Access Hospitals' Inpatient Services Fee is discounted to \$30.46 per day for Managed Care Days and \$136.16 per day for all other Days.

ASSESSMENT OF FEE

1. The Department shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Oversight and Advisory Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Department shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed.
2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Department will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

REFUND OF EXCESS FEES

1. If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Department shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Department shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.2002.B.
2. After the close of each State fiscal year and no later than the following August 31, the Department shall present a summary of fees collected, expenditures made or encumbered, and interest earned in the Fund during the State fiscal year to the Oversight and Advisory Board.
 - a. If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Department has not expended or encumbered those fees at the close of each State fiscal year:
 - i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less four percent of the estimated expenditures for health coverage expansions authorized by the Act for the subsequent State fiscal year as most recently published by the Department.
 - ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the State fiscal year.
 - iii. The Department shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.2002.B.

8.2004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

1. All supplemental payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Department.
2. No hospital shall receive a payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.2004.D, exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific Disproportionate Share Hospital Limit.
3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients shall receive this payment.
2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.
3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado MMIS are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient Hospital Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

INPATIENT HOSPITAL BASE RATE SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients shall receive this payment.
2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.
3. Calculation methodology for payment. For each qualified hospital, the annual payment equals the difference between the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate and the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate increased by a percentage adjustment factor. The percentage adjustment factor may vary by hospital such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.
 - a. Hospitals that are Colorado Indigent Care Program providers and have at least two Obstetricians or is Obstetrician-exempt pursuant to 42 U.S.C. § 1396r-4(d) shall receive this payment; or
 - b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two Obstetricians or is Obstetrician-exempt pursuant to 42 U.S.C. § 1396r-4(d) shall receive this payment.
2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.
3. Calculation methodology for payment. For each qualified hospital, the annual payment equals the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals multiplied by the State's total annual Disproportionate Share Hospital allotment in total computable published by the Center for Medicare and Medicaid Services in the Federal Register. No hospital shall receive a payment exceeding its Estimated Hospital-Specific Disproportionate Share Hospital Limit.

UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals that are not Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.

Calculation methodology for payment. For each qualified hospital with twenty-five or fewer beds, the annual payment equals the hospital's percentage of beds compared to total beds for all qualified hospitals with twenty-five beds or fewer multiplied by thirty three million five hundred thousand dollars (\$33,500,000). For each qualified hospital with greater than twenty-five beds, the annual payment equals the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals with greater than twenty-five beds multiplied by eighty one million nine hundred eighty thousand one hundred seventy six dollars (\$81,980,176).

HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals with an established Medicaid inpatient base rate, and that meet the minimum criteria for one or more of the selected measures, may qualify to receive this payment.
2. Excluded hospitals. Psychiatric Hospitals and Out-of-State Hospitals in both bordering and non- bordering states.
3. Measures. The measures for the Hospital Quality Incentive Payment are:
 - a. Rate of Non-Emergent Emergency Room Visits,
 - b. Rate of elective deliveries between 37 and 39 weeks gestation,
 - c. Rate of Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT),
 - d. Rate of thirty (30) day all-cause hospital readmissions, and
 - e. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position.
4. Calculation methodology for payment. Payments shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments. For each qualified hospital, this payment will be calculated as follows:
 - a. Determine Available Points by hospital, subject to a maximum of 10 points per measure.
 - i. Available Points are defined as the number of measures for which a hospital qualifies multiplied by the number of points designated for the measure.
 - b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department.
 - c. Normalize the total points earned per measure to total possible points for all measures by hospital.

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- d. Calculate Adjusted Medicaid Discharges by hospital
- i. Adjusted Medicaid Discharges are calculated by multiplying the number of Medicaid inpatient discharges by the Adjusted Discharge Factor.
- For hospitals with less than 200 annual Medicaid discharges, the total number of discharges multiplied by .25 to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare Prospective Payment System calculation.
- ii. The Adjusted Discharge Factor is defined as the most recently available annual total gross Medicaid billed charges divided by the inpatient gross Medicaid billed charges.
- e. Calculate Total Discharge Points
- i. Discharge Points are defined as the total number of points earned for all measures multiplied by the number of Adjusted Medicaid Discharges.
- f. Calculate the Dollars per Discharge Point
- i. Dollars per Discharge Point will be calculated by dividing the total HQIP funds available under the inpatient UPL by the total number of Discharge Points across qualified hospitals.
- g. Determine HQIP payout by hospital by multiplying the total Discharge Points for that hospital by the Dollars per Discharge Point.
5. The total funds for the Hospital Quality Incentive Payment for the Federal Fiscal Year beginning October 1, 2014 will be \$61,448,873.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 03/04/2007, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 03/04/2007, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]