

UTAH STATE PLAN ATTACHMENT 4.19-A

INPATIENT HOSPITAL

T.N. # 01-030

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INPATIENT HOSPITAL

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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INPATIENT HOSPITAL
Section 100 Payment Methodology

110 Introduction -- Under a Diagnostic Related Group (DRG) system, hospitals are paid a prospectively determined amount for each qualifying patient discharge. DRG weights are established to recognize the relative amount of resources consumed to treat a particular type of patient. The DRG classification scheme assigns each hospital patient to one of over 500 categories or DRGs based on the patient's diagnosis, age and sex, any surgical procedures performed, complicating conditions, and discharge status. Each DRG is assigned a weighting factor which reflects the quantity and type of hospital services generally needed to treat a patient with that condition. Preset or prospective prices are assigned to each DRG. The DRG system allows for outliers for those discharges that have significant variance from the norm. Each DRG has an outlier threshold.

121 DRG Weights and Outliers -- The DRG weights reflect relative resource consumption. To establish DRG weights, data used was extracted from the Utah paid claims history files for a two-year period. Where the history did not contain a sufficient number of claims to adequately address the variance in charges and patient lengths of stay, CMS or Medicare weights, and average length of stay (ALOS) were adjusted and used. Future updates that are required due to changes in the CMS grouper, any new DRGs or both will necessarily involve the use of this same data or any combination thereof.

The Utah DRG weights were calculated from paid claims history data when there more than 15 cases. Outliers were excluded in calculating the ALOS. Claims were also excluded from rural hospitals. The geometric mean charge is calculated for each DRG. A statewide geometric mean charge for all cases is also calculated. The relative weight of each DRG is a function of the relationship between the geometric mean charge for each DRG and the geometric mean charge for all applicable DRGs. To determine the relative weight, the geometric mean charge for each DRG is divided by the statewide geometric mean charge per discharge. The Department also considers DRG weights when the database does not contain 15 entries of DRG history for a newly developed DRG, which usually occurs when Medicare establishes a new DRG for which the Department has little or no claims history. This is accomplished by adjusting the Medicare weight to reflect the overall difference between the Medicaid weights and the Medicare weights taken as a whole.

The outlier payment threshold limit is a multiple of the base DRG payment. Additional payments are paid for charges in excess of the threshold at a percentage of charges adjusted by a case mix and hospital charge structure differential. A case mix index is calculated from the sum of Medicaid weights (excluding outliers) divided by hospital cases for each hospital. The case mix index is normalized. The normalized case mix index is adjusted for the average charge per case (hospital CMI adjusted charge per case), by hospital. The final adjustment factor is then calculated by dividing the hospital CMI adjusted charge per case by the statewide CMI adjusted charge per case.

There is a special calculation for DRGs 433 through 437 involving alcohol and drugs. Because the Medicaid scope of service is limited to detoxification, the payment rate for these DRGs is based on an average length of stay of three days.

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INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

122 Dollar Multiplier, Outlier Tables, etc. -- The dollar multiplier, commonly referred to as the "DRG base rate" is the rate by which the DRG weight is multiplied in order to determine the DRG(s) payment rate. This base rate, which was initially determined to reflect a payment level required to encourage hospitals to treat the Utah Medicaid eligible population is updated annually. Outlier tables or factors are designed to compensate providers for DRG services they provide that require resources far in excess of the intended requirements of the DRG. The outlier factor payment is not initiated unless the total charges exceed 250% of the DRG average payment rate. This overall factor is updated annually and is a function of the average overall DRG changes and the related DRG payment amounts. This adjustment is designed to limit outlier growth to not exceed the limit on spending that is imposed by state government. Additionally, each hospital is issued its own "outlier payment factor," which normalizes a hospital's charges to a level of no more than the average charge structures of all hospitals. This ensures that hospitals with higher than average charges are not paid an outlier amount higher than other hospitals. DSH or disproportionate share factor(s) payments are awarded to hospitals that qualify for DSH payments. The dollar multiplier (base rate), outlier factors, and DSH factors are adjusted periodically and posted on the [agency's website](#).

22 (B) Example of a DRG payment calculation:

EXAMPLE OF DRG PAYMENT (Including Outlier and DSH Portion)			
Example: (Assuming no DSH payment)	Provider A	Ref.	Source or Formula
Base Rate: (Applicable to All Providers for all DRGs this year)	\$6,197.32	1	Dollar Unit Multiplier
DRG No.	1	2	DRG Listing
DRG Weight (specific to this DRG)	2.3928	3	Dollar Unit Multiplier
Outlier Threshold Applicable to all providers for this year	2.7730	4	Dollar Unit Multiplier
DRG Average Length of Stay (specific to this DRG)	6.51	5	2003 DRG Listing
Outlier Adjustment Factor (Adjusts Provider's charges to "normalized" level)	0.8598	6	Hospital Outlier Factor (Sample case not shown)
Base DRG Payment Rate (Weight X Base Rate)	\$14,828.95	7	= (1) x (4) - calculated
DRG Outlier Threshold (Outlier Threshold Factor X Base DRG Payment Rate)	\$41,120.67	8	= (4) x (7) - calculated
Total Charges (Provider's specific Charge for this claim)	\$50,000	9	Provider Records
Charges in Excess of Threshold	\$8,879.33	10	= (9) - (8) - calculated
Payment for this DRG		11	Calculated Below
DRG Base Amount	\$14,828.95	12	= (7) - calculated
Outlier Payment	\$7,634.45	13	= (6) x (10) - calculated
Total Base Payments	\$22,463.39	14	= (12) + (13) - calculated
DSH Payment Factor Add On	.0058	15	Factor for this provider
DSH Amount	\$130.29	16	=(14) x (15)
Calculated DRG Payment (Including DSH)	\$22,593.68	17	=(14) +(16)

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INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

123 Effective Dates for Rates - Payment rates will be effective based on "date of discharge." When a patient is transferred from another hospital, as opposed to discharged, the payment will be calculated using the rate in effect at the time of the discharge. This is standard in the industry.

130 Property and Education - The Medicaid DRG payment rates are all inclusive. There are no designated pass-through costs or other add-on factors for costs such as capital, or other expenditures. However, these factors are reflected in the hospital charge structure used to calculate the DRG payment.

TABLES USED IN DRG RATE CALCULATIONS: These tables are updated annually and can be found at the website referenced in Section 122.

140 Transfer Patients -- Except as otherwise specified in the State Plan, the federal Medicare methodology will be followed for transfer patients. The hospital which transfers the patient will be paid the DRG per diem fee for each day of care. The per diem is determined by calculating the DRG payment, dividing by the ALOS, and adding one day. Except as provided in the State Medicaid Plan, payment to the transferring hospital may not exceed the full prospective DRG payment rate. In cases of distinct rehabilitation units and hospitals excluded from the DRG prospective payment system, the transfers will be considered discharges and the full DRG payment, including outliers, will be paid. To be eligible for Medicaid payments, the exempt distinct rehabilitation unit must be part of an acute hospital. When a person is appropriately admitted and cared for in an acute hospital and is appropriately transferred to another hospital for extended specialized service and later transferred back to the first hospital, the first hospital is paid the full DRG for the combined stays while the other hospital is paid a per diem under the transfer payment policy. Such per diem payments are not restricted by the DRG payment limitation. Transfers involving hospitals excluded from DRGs will also be paid based on their respective payment methodology.

145 Split Eligibility -- When a Medicaid patient is eligible for only part of the hospital stay, the Medicaid payment will be calculated by the following formula:

$$\text{Claim Payment} = \text{Medicaid Eligible Days divided by Total Hospital Days} \times \text{Full Medicaid Payment}$$

The split eligible payment constitutes payment in full for all services rendered on those days on which the patient was eligible for Medicaid and must be accepted as such by the provider hospital. The hospital may not bill the patient for any services rendered on those days. In contrast, the hospital can bill the patient full charges for services rendered during those days that the patient is not eligible for Medicaid. When both third-party payments and split eligibility are involved, the third-party payment will first be applied to the period prior to eligibility. Any remaining TPL will be used to reduce the Medicaid payment.

160 Services Covered by DRG Payments -- Medicaid adopts the general provision of the bundling concepts used by Medicare. Physicians, including resident physicians and nurse anesthetists may bill separately under their own provider numbers. Such billings are in addition to the DRG payment. All other inpatient hospital services, as defined by Medicare, are covered by the DRG system. DRGs are paid for inpatient hospital admissions when a baby is delivered even though the mother or baby is discharged in less than 20 hours.

161 Donor Organs -- Medicaid adopts the general Medicare definitions to determine payment for approved donor organs. Medicare regulations and guidelines are used to establish payment amounts for donated organs.

162 Shaken Baby Syndrome Project -- In accordance with a national initiative to educate parents to the dangers of shaken baby syndrome, Utah will participate in an educational effort

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INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

provided through hospitals. Payment for this educational effort is calculated at \$6.00 per delivery in the state. Utah Medicaid will reimburse each DRG hospital \$6.00 for all identified Medicaid deliveries (including Medicaid HMO deliveries). Payment will be made to each DRG hospital on a quarterly or annual basis based upon claims data. Rural hospitals receive payment for this project as a percentage of their charges.

165 DRG Determinations -- The Medicare DRG " grouper" software will be used for Medicaid. When changes are made, Utah Medicaid will adopt the changes within 31 days of the Medicare implementation date.

180 Utilization Review and Control of Inpatient Hospital Services -- Payment may be denied or withheld for inpatient hospital services which do not meet Medicaid regulations or criteria for medical necessity and appropriateness. Medicare regulations and guidelines apply when additional clarification or explanation is required. In the event payment is made and the services are subsequently deemed inappropriate or unnecessary, the payment(s) can be recovered through offsets to future payments. Payment may be denied or withheld in the following circumstances:

1. The inpatient care provided in an acute care facility is not medically necessary based on InterQual Criteria for inpatient admission.
2. The claim is based on an incorrect principal diagnosis.
3. The services or procedures requiring prior authorization have been provided without obtaining the appropriate prior authorization.
4. The patient is transferred when there is no medical justification. In the case of inappropriate transfers, the discharging hospital receives the full DRG and the transferring hospital is denied payment.
5. The patient has been readmitted within 30 days of discharge for the same or similar diagnosis. Except for cases related to pregnancy, neonatal jaundice, or chemotherapy, all readmissions within 30 days of a previous discharge will be reviewed to ensure that Medicaid criteria have been met for: 1) severity of illness, 2) intensity of service, 3) appropriate discharge planning, and 4) financial impact to the State. Outlier days will be paid where appropriate. In addition, all claims are subject to post payment review.

Determinations of medical necessity and appropriateness will be made in accordance with, but not limited to, the following criteria and protocols:

1. The Diagnostic Related Group (DRG) system that was established to recognize the relative amount of resources consumed to treat a specific type of patient. The Utah

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INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

DRG weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files, where available, or from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA).

2. The comprehensive, clinically-based, patient-focused medical review criteria and system developed by InterQual, Inc.
3. The appropriate, Utah-specific Administrative Rules or criteria developed through the Utilization Review Committee for programs and services not otherwise addressed.
4. The determination, where deemed necessary, of the Utilization Review Committee. The Committee must include at least two physicians and two registered nurses. The Committee will review and make recommendation on complicated or questionable individual cases.

185 Hospital Acquired Conditions (HAC): Effective October 1, 2008, inpatient hospital Medicare crossover discharges submitted to Utah Medicaid for payment will be adjusted to remove the effects of certain HACs. The Utah Medicaid Hospital Services Manual contains a list of diagnoses for these potential HACs. If a Medicare crossover claim has an HAC diagnosis and it was not present on admission, then the diagnosis will be excluded from the payment calculation. This change is in accordance with adopted Medicare policy for "never events."

190 Exempt Hospitals -- Two categories of hospitals are exempt from DRGs:

The State Hospital will continue to be reimbursed per diem cost for each operating unit. The per diem is calculated using Medicare regulations to definite allowable costs. In applying cost reimbursement principles, the Utah State Hospital is required to capitalize only those assets costing more than \$5,000.00. A separate per diem is calculated for each operating unit. Therapeutic leave days are included in the total count of Medicaid days, unless the patient was discharged. However, if a patient is admitted as an inpatient to a second hospital, the patient is deemed to be discharged from the State hospital and the days are not counted. The day count used in the Medicaid cost settlement must be consistently applied for all admissions for all classes and/or groups of patients. Because of their unique patient population, the Utah State Hospital is not part of the DRG system. Medicaid does not use the Medicare methodology to pay an average cost per discharge.

TEFRA limits do not apply because of long lengths of stay experienced by many of the patients.

Rural hospitals located in rural areas of the state are exempt from DRG. Medicare definition of "rural hospital" is adopted by Medicaid. Rural hospitals are paid 93 percent of charges.

194 Specialty Out-Of-State Hospitals -- These hospitals provide inpatient services that are not available in the State of Utah. To qualify for this special payment provision, prior authorization must be obtained from the Utah State Department of Health, Division of Health Care Financing. The payment amount will be established by direct negotiations for each approved patient. The DRG method may or may not be used depending on the negotiated payment. Typically, the Medicaid rate in the State where the hospital is located is paid.

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196 Short Stays -- Generally patients discharged from the hospital in less than 24 hours are classified and billed as "outpatient." An exception to this policy involves maternity care. DRGs 370-375 and 388-391 cover deliveries and babies. These services are paid as inpatient services under the DRG system.

INPATIENT HOSPITAL
Section 200 Other Payments

210 Small Volume Utah and Out-of-State Hospitals -- Except as provided in Section 190, payment will be made under the same DRG methodology as in-state urban hospitals.

240 Sub-acute Care and Swing-beds -- This policy pertains to patients that do not require acute hospital care.

- When sub-acute care patients receive medically necessary services in an inpatient hospital setting, payment is made at the swing-bed rate. Because sub-acute patients require a lower level of care, the rate is lower than the rate paid for acute hospital services. The sub-acute rate is calculated using the criteria specified in 42 CFR 447.280(a)(1).
- When nursing home beds are not immediately available in the community, patients may receive skilled or intermediate nursing care in a bed of a qualified hospital. Rural hospitals typically qualify for the swing bed program. Payment is made at the swing-bed rate using the criteria specified in 42 CFR 447.280(a)(1). Patients are transferred to licensed nursing home beds in certified facilities when such beds are available in the community.
- Services provided in hospitals licensed as long term acute care or rehabilitation will be paid the nursing facility intensive skilled rate defined in Section 1000 of Attachment 4.19-D of the State Plan. Rehabilitation days require prior approval to qualify for payment. Intensive skilled rates are negotiated for individual patients. In determining the intensive skilled rates for hospital rehabilitation units, therapy costs are allowed to be included with nursing costs referenced in therapy costs are allowed to be included with nursing costs referenced in Attachment 4.19-D, Section 1000.

241 Insignificant Billing Variances -- When the Medicaid payment is determined using the billed usual and customary charges (i.e. rural hospitals), insignificant billing errors may be processed. To expedite payment and to reduce administrative effort, Medicaid pays the lesser of the detailed charges or the total charges, if the difference is ten dollars or less.

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INPATIENT HOSPITAL
Section 200 Other Payments (Continued)

250 Payment for Emergency Days -- Emergency days for inpatient psychiatric services cover the time between admission and the first service date authorized by the Medicaid prior authorization staff. Emergency days under the DRG system will be paid a per diem for each approved day. As with transfer patients, the DRG per diem will be calculated by dividing the DRG payment by the arithmetic mean length of stay.

251 Third-party Payment -- When insurance or other third-party payors have responsibility for payment, Medicaid is the payor of last resort. The amount paid by Medicaid is limited to the patient's liability. Further, Medicaid payment for specified Medicare crossover claims will be the lower of: (1) the allowed Medicaid payment rate less the amounts paid by Medicare and other payors, or (2) the Medicare co-insurance and deductibles.

252 Interim Payments -- There are two types of interim payments for DRG hospitals. First, hospital stays in excess of 90 days may be billed under the DRG system prior to discharge with prior approval. The interim bill is paid at 60% of the allowed charge. Second, an interim payment may be granted when the lag time between the date of service and the date of payment for a specific hospital is above the "mean" processing time for all DRG hospitals. In addition, the hospital requesting the interim payment must be able to document a cash flow problem that could impair patient care. The amount of the interim payment is based on the cash flow needs of the hospital not to exceed the Medicaid interim payment limit. The interim payment limit is calculated by multiplying the number of days above the "mean" processing time by the average daily Medicaid payment.

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INPATIENT HOSPITAL
Section 400 Adjustments for Disproportionate Share Hospitals

409 Introduction -- This section establishes criteria for identifying and paying disproportionate share hospitals (DSH). For the purpose of paying disproportionate share hospitals, there are six types of hospitals: first, private hospitals licensed as general acute hospitals located in urban counties; second, general acute hospitals located in rural counties; third, the State Psychiatric Hospital; fourth, the State Teaching Hospital; fifth, children's hospital; and sixth, frontier county hospitals in economically depressed areas. DSH funds not otherwise paid to qualifying hospitals shall be available, subject to the uncompensated care cost limits, to the State Teaching Hospital. DSH payments will not exceed the federal allotment and match amounts for any given period.

If any payments made under this section are disallowed in future periods, those disallowed amounts will be redistributed to other qualifying facilities. The redistribution of those payments will be based on the amount of remaining uncompensated care costs in the period of the disallowance and paid proportionally to the amounts previously paid for the period. Redistributions will not be counted against a facility's current year uncompensated care costs, unless the disallowance was for the current year.

410 Definitions – For purposes of this section, the following definitions apply:

- A. Medicaid Inpatient Utilization Rate (MIUR) is the percentage derived by dividing Medicaid hospital Inpatient days (including Medicaid managed care inpatient days) by total inpatient days.
- B. Low Income Utilization Rate (LIUR) is the percentage derived by dividing total Medicaid revenues (including Medicaid managed care revenues) plus PCN revenues by total revenues and adding that percentage to the percentage derived from dividing total charges for charity care by total charges.
- C. Indigent patient days is the total of Medicaid patient days (including managed care days) plus PCN (see description in Section D which follows) patient days and other documented charity care days.
- D. PCN is a term used to describe the Utah Primary Care Network plan operated for low income recipients. The PCN became effective on July 1, 2002.
- E. Uncompensated Care means the amount of non-reimbursed costs written-off as non-recoverable for services rendered to the uninsured and includes the difference between the cost of providing services to those eligible for medical assistance under the State Plan and the payment for those services by the State, by Medicaid, or any other payer. (Uninsured is defined as any individual who does not have any credible third-party coverage for hospital services covered in this section. Qualifying hospitals should make every reasonable effort to determine if an individual has credible third-party coverage. The hospitals are the definitive source for uninsured information).

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INPATIENT HOSPITAL
Section 400 Adjustments for Disproportionate Share Hospitals

410.1 Uncompensated Care Cost (UCC) Calculation — For each qualifying hospital, the Department will calculate UCC by applying the provider-specific cost-to-charge ratios to charges for services provided to Title XIX and uninsured patients, and subtracting applicable payments from the costs of those services. For purposes of the cost-to-charge ratio calculation, the Department will use the then most recently filed and available provider-specific cost report ratio information.

411 Obstetrical Services Requirement — Hospitals offering non-emergency obstetrical services must have at least two obstetricians providing such services. For rural hospitals, an “obstetrician” is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital. This requirement does not apply to children’s hospitals nor to hospitals which did not offer non-emergency obstetrical services as of December 22, 1987.

412 Minimum Utilization Rate — All DSH hospitals must maintain a minimum of 1% Medicaid Inpatient Utilization Rate.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

413 Hospitals Deemed Disproportionate Share -- A hospital is deemed a disproportionate share provider if, in addition to meeting the obstetrical (Section 411) and the minimum utilization rate requirements (Section 412), it meets at least one of the following five conditions:

- A. The hospital's MIUR is at least one standard deviation above the mean MIUR. The disproportionate share computed percentage is based on the number of percentage points that an individual hospital indigent patient days exceeds the statewide average plus one standard deviation.
- B. The hospital's LIUR rate exceeds 25 percent.
- C. The hospital's MIUR exceeds 14 percent.
- D. The hospital's PCN participation is at least 10 percent of the total of all Utah hospitals PCN patient care charges.
- E. Hospitals located in rural counties qualify because they are sole community hospitals. A sole community hospital is defined as a hospital that is located more than 29 miles from another hospital.

414 Payment Adjustment for General Acute Urban (excluding State Teaching Hospital and Childrens' Hospital) -- General Acute Urban Hospitals (Paid by DRGs) and meeting the qualifying DSH criteria are paid a DSH amount on each inpatient claim. The DSH Factor is derived by dividing the indigent inpatient days by the total general acute days for each hospital and multiplying by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting percentage (DSH Factor) is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor.

415 Payment Adjustment for General Acute Rural -- General Acute Rural Hospitals are paid at a DSH payment amount on each inpatient claim. The hospital must qualify based on the criteria shown in section 413 above. The DSH factor is derived by dividing the indigent patient days by the total general acute days for each hospital and multiplying by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting percentage (DSH factor) is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid payment times the DSH factor. Qualifying rural hospitals will be allowed to participate in a special DSH allotment set aside for government-owned rural hospitals.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

This additional DSH payment will be based on the lesser of \$862,000 per federal fiscal year per hospital or the hospital's uncompensated care. Annually, the additional DSH payment will be adjusted proportionally to reflect increases or decreases in the DSH allotment provided by the Centers for Medicare and Medicaid Services to the Department.

Any government-owned hospital that can demonstrate a level of uncompensated care that is a minimum equal to these amounts may qualify. The exception to this is any hospital that has previously qualified for additional DSH payments under Section 419 of the State Plan.

The actual yearly amounts available to each hospital will vary depending on the Federal Medical Assistance Percentages (FMAP) rate in effect for the period involved and the amount of DSH funding available.

The method and timing of the payment of this additional DSH will be according to the following:

1. Each qualifying hospital must submit a "Rural Uncompensated Care and DSH Survey" documenting the level of uncompensated care they provided. This survey is developed and communicated by the Utah Department of Health and is available on the Medicaid website at <http://health.utah.gov/medicaid>. Qualifying hospitals may submit their surveys monthly, quarterly, semi-annually, annually, or any combination thereof. Qualifying hospitals may also amend previously submitted data, in the fiscal period, to reflect updated information in that period. The final, or annual survey if elected, must be submitted to the Department within sixty (60) days of the end of the federal fiscal period. A final payment for the federal fiscal period just ended will then be made.
2. These DSH payments will not exceed the total allowed for each facility. A facility may, however, reach its maximum payout prior to the end of the federal fiscal year if there is adequate, documented uncompensated care in early quarters. Payments will be made following the receipt of the qualifying facility's uncompensated care survey, as such, this may be monthly, quarterly, semi-annually, annually, or any combination thereof. Once a facility has reached the annual allotment maximum, no additional payments will be made.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

416 Payment Adjustment for State Psychiatric Hospital -- The State Psychiatric Hospital is reimbursed on a retrospective annual cost settlement basis. Its DSH payment is calculated on the proportion of indigent days to total inpatient days. The indigent proportion is multiplied by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The result is the DSH factor which in turn is applied to the cost settlement amount. The DSH payment will necessarily be adjusted to reflect Federal DSH limit amounts. The DSH is paid as an interim payment during the year, with a final computation being completed with the settlement of the annual cost report.

416A Capitalization of Assets -- In establishing allowable cost, the Utah State Hospital is required to capitalize only those assets costing more than \$5,000.

417 Payment Adjustment for State Teaching Hospital -- The hospital's DSH factor is the ratio of indigent patient days to total patient days times a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limit amounts. The resulting DSH factor is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor. The DSH payment amount will necessarily be adjusted to reflect federal DSH limits.

418 Payment Adjustment for Childrens' Hospital -- The Childrens' hospital DSH factor will be computed as a separate category from other general acute hospitals. The DSH payment will necessarily be adjusted to reflect Federal DSH limit amounts. The hospital's DSH factor is the ratio of indigent inpatient days to total inpatient days times a "ceiling factor". This DSH factor is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor. The DSH payment for this category of hospitals will have a base year of 1999, i.e., DSH payments will not be less than the amount paid under a previous hospital category (General Acute Urban), subject to Federal DSH limit adjustment.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

419 Depressed Frontier County Hospitals - Rural government owned hospitals, which can establish that they meet all of the following conditions, will qualify for additional DSH payments:

- Is in an economically depressed area as determined by State and Federal definitions;
- Is a sole community provider as defined in "413" of State Plan of Utah'
- Has less than 30 acute (not including nursery) licensed beds (based on current licenser);
- Has a Medicaid census that totals a minimum of 33% of all patient (non nursery) days of service provided (based on last completed hospital fiscal year);
- Exhibits a population density of one-third of the population density qualification level necessary to qualify as a frontier area (that is, an area with fewer than two* residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.

Payment of this additional DSH payment will be \$1,000,000 per year (including both state and federal share and the uncompensated care (UC) that the hospital experiences, whichever is less. Annually, the additional DSH payment will be adjusted proportionally to reflect increases or decreases in the DSH allotment provided by the Centers for Medicare and Medicaid Services to the Department. Any participating hospital(s) will be entitled to its pro rata share of this amount depending on its relative percentage of documented UC when compared to all applying hospitals on a relative basis.

For example: Hospital A and Hospital B meet all qualifying criteria as mentioned above. Hospital A has \$600,000 in UC and Hospital B has \$400,000 in UC. These two hospitals will therefore share the allocated DSH of \$1,000,000 according to the following:

	<u>UC</u>	<u>UC %</u>	<u>Share of Augmented DSH</u>
Hospital A	\$600,000	60%	\$600,000 (60% of \$1,000,000)
Hospital B	\$400,000	40%	\$400,000 (40% of \$1,000,000)

*Population density to qualify as a frontier area is currently at 6 persons/sq. mile. One third of this is 2 persons/sq. mile.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

421 Method and Timing of DSH Payments -- Each claim for payment to qualified providers includes a percentage add-on at the level specified for that facility. Each quarter the total amount of DSH to all qualified facilities is calculated. The amount, along with any preceding quarters for the current fiscal year, is used to predict the total amount that will be paid. If this exceeds the current DSH allotment, the payment level will be adjusted in order to correct for any potential overpayment. This adjustment will be applied to all hospitals proportionally, except for Children’s hospital which will not be adjusted below the base year (see section 418). The state reserves the option to dispense funds via a lump sum payment should the need arise. This could occur where claims volume is not the best method or base upon which to distribute a special DSH payment; specifically the additional DSH afforded to hospitals meeting the criteria of “419” above, will be paid quarterly.

The percentage “add-on” for a facility is computed by the following formula:

(Facility’s Medical Assistance Days as a % of the facility’s total days (for prior year))
x (Yearly Qualifying factor (which for 2004 is 2.01%))
x (Facility’s Medicaid payments)
x .12 per \$1.00 (payment equalization factor for 2004 = Facility’s % “add-on” for the year.
This is rounded to the next highest %.

For example: Hospital A has the following hospital specific information:
Facilities medical assistance days: 100
Facilities total days: 200
Yearly Qualifying Factor: 2.01%
Total yearly medical assistance payments: \$100,000.00
Payment equalization factor: 12% per \$1.00
This is rounded to the next higher % (with a ceiling of 4%)

The percentage “add-on” percentage is therefore the following:

$$(100/200) \times (2.01\%) \times (\$100,000.00) \times (.12/\$1.00) = 1.21\% \text{ rounded to } 2\%$$

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INPATIENT HOSPITAL
Section 500 Inpatient Rehabilitation Services

501 General -- Because of the wide variation in the length of stay for rehabilitation services under DRG 462, there is a need to refine the DRG criteria. Rehabilitative services under DRG 462 are subdivided into five groups. Each group has an established average length of stay and a base payment calculated in accordance with Section 122 of Attachment 4.19-A. Payments are made for outliers above the designated threshold consistent with other DRG payments.

510 Designated Groups -- Rehabilitation is subdivided into the following groups: (1) Spinal -- Para; (2) Spinal -- Quad; (3) Head; (4) Stroke; and (5) Other. "Spinal -- Para" includes patients with paraplegia who require an initial intensive inpatient rehabilitation program. "Spinal -- Quad" includes patients with quadriplegia who require an initial intensive inpatient rehabilitation program. "Head" includes patients with head trauma and with documented neurological deficits who require an initial intensive inpatient rehabilitation program. "Stroke" includes patients

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needing an initial intensive inpatient program because of disability due to a neurological deficit secondary to a recent cerebrovascular disease. "Other condition" includes patients with a neurological/neuromuscular disease or other disorder requiring intensive inpatient rehabilitation. The State Medicaid Agency requires prior approval of all classifications.

INPATIENT HOSPITAL
Section 600 Inpatient Medicaid DRG Refinement

601 General – Due to the unique nature of Medicaid population, selected Medicare DRG have been refined and expanded into additional DRGs.

610 Neonate DRGs – Discharges under DRGs 385, 386, and 387 for neonate DRGs are broken out as follows:

DRG	Description
850	DRG 385 - NEONATE XFERED OR EXPIRED (Died <=1 day)
851	DRG 385 - NEONATE XFERED OR EXPIRED (Died >=2 day)
852	DRG 385 - NEONATE XFERED OR EXPIRED (Transferred <= 10 days)
853	DRG 385 - NEONATE XFERED OR EXPIRED (Transferred >= 11 days)
860	DRG 386 - NEONATE EXTREM IMMATUR/RDS <500 grams
861	DRG 396 - NEONATE EXTREM IMMATUR/RDS -500 to 749 grams
862	DRG 386 - NEONATE EXTREM IMMATUR/RDS -750 to 999 grams
863	DRG 386 - NEONATE EXTREM IMMATUR/RDS -1000 to 1199 grams
864	DRG 386 - NEONATE EXTREM IMMATUR/RDS -1250 to 1499 grams
865	DRG 386 - NEONATE EXTREM IMMATUR/RDS -1500 to 1749 grams
866	DRG 386 - NEONATE EXTREM IMMATUR/RDS -1750 to 1999 grams
867	DRG 386 - NEONATE EXTREM IMMATUR/RDS -2000 to 2499 grams
868	DRG 386 - NEONATE EXTREM IMMATUR/RDS -2500 grams and over (with ICD9 Proc code = 9672)
869	DRG 386 - NEONATE EXTREM IMMATUR/RDS -2500 grams and over (w/o ICD9 Proc code = 9672)
880	DRG 387 - PREMATURE W/MAJ PROBLEMS - <500 grams
881	DRG 387 - PREMATURE W/MAJ PROBLEMS - 500 to 749 grams
882	DRG 387 - PREMATURE W/MAJ PROBLEMS - 750 to 999 grams
883	DRG 387 - PREMATURE W/MAJ PROBLEMS - 1000 to 1199 grams
884	DRG 387 - PREMATURE W/MAJ PROBLEMS - 1250 to 1499 grams
885	DRG 387 - PREMATURE W/MAJ PROBLEMS - 1500 to 1749 grams
886	DRG 387 - PREMATURE W/MAJ PROBLEMS - 1750 to 1999 grams
887	DRG 387 - PREMATURE W/MAJ PROBLEMS - 2000 to 2499 grams
888	DRG 387 - PREMATURE W/MAJ PROBLEMS - 2500 grams and over

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Section 600 Inpatient Medicaid DRG Refinement (Continued)

The fifth digit of ICD9-9-CM diagnosis codes 764 to 765 identifies birth weight. If no birth weight is provided in the medical record, the DRG with the highest birth weight will be paid.

620 Psychiatric DRGs – Psychiatric DRGs are as follows:

DRG	Description
900	SCHIZOPHRENIA (UNDER AGE 13)
901	SCHIZOPHRENIA (OVER AGE 13)
902	PSYCHOSIS (UNDER AGE 13)
903	PSYCHOSIS (OVER AGE 13)
904	NEUROTIC DEPRESSION (UNDER AGE 13)
905	NEUROTIC DEPRESSION OVER AGE 13)
906	ANXIETY (UNDER AGE 13)
907	ANXIETY (OVER AGE 13)
908	MISC. NEUROSIS (UNDER AGE 13)
909	MISC. NEUROSIS (OVER AGE 13)
910	PSYCHOPHYSIOLOGIC (UNDER AGE 13)
911	PSYCHOPHYSIOLOGIC (OVER AGE 13)
912	ADJUST. REACTIONS (UNDER AGE 13)
913	ADJUST. REACTIONS (OVER AGE 13)
914	MISC. DISORDERS (UNDER AGE 13)
915	MISC. DISORDERS (OVER AGE 13)

630 Rehab DRGs - Rehabilitation DRGs are as follows:

DRG	Description
800	REHAB - SPINAL/PARA
801	REHAB - SPINAL/QUAD
802	REHAB - HEAD
803	REHAB - STROKE
804	REHAB - OTHER

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INPATIENT HOSPITAL
Section 600 Health Profession Education

601 General -- Utah Department of Health shall support the education of health professionals through the use of Medicaid funds. All hospitals eligible for health profession education payments will be identified through the use of Medicare cost reports. Specifically, worksheets E and S will be utilized to identify the participating facilities. Both fee-for-service (FFS) and health maintenance organization (HMO) services will qualify for health professional education payments. Payments, as defined below, will be made quarterly through the state's MMIS payment system.

602 Payment Pool – The annual payment pool will be determined prior to the beginning of each year on July 1. Fiscal year 2001 was the first effective year of the “payment pool” and resulted in the payment of \$19,719,568 being allocated to the teaching providers. The amount in the payment pool will be adjusted annually by an amount not to exceed the consumer price index for the western region published by the U.S. department of Labor. Assuming a 3.8% annual CPI adjustment, the amount of the pool from fiscal year 2003 onward is estimated to be:

Fiscal Year Ending	Direct Graduate Medical Education Payments
6/30/2003	\$22,250,000
6/30/2004	\$23,095,500
6/30/2005	\$23,973,129
6/30/2006	\$24,884,108
6/30/2007	\$25,829,704

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INPATIENT HOSPITAL
Section 600 Health Profession Education

603 Pool Distribution – The pool will be distributed based upon the allocation percentage of each hospital. The hospital allocation percentage will be developed using prior year patient days (both HMO and FFS), and weighted intern and resident (I&R) full time equivalency (FTE). For example:

	(a) Weighted I & R <u>FTEs</u>	(b) Hospital Patient <u>Days</u>	(c) (a * b) Weighted <u>FTE Days</u>	(d) Hospital Allocation <u>Percentage</u>	Payment <u>Pool</u>
Hospital A	256	32,414	8,297,984	68.22%	13,508,170
Hospital B	62	10,611	657,882	5.41%	1,070,957
Hospital C	150	21,381	3,207,150	26.37%	5,220,874
	468	64,406	12,163,016		19,800,000

604 Weighted FTE – The Utah Medical Education Council (UMEC) will determine annually the weighting factor for each resident specialty that will be applied to the I&R FTEs as reported by each participating hospital.

605 Upper Payment Limit -- The aggregate Medicaid hospital payments, including health profession education payments will not exceed the amount that would be paid for the services furnished under Medicare payment principles in compliance with the 42 CFR 447 upper payment limit.

606 State Teaching Hospital – A separate funding pool will be established for payments to the state teaching hospital for Indirect Medical Education (“IME”). The state teaching hospital will receive an IME payment for each Medicaid discharge equal to the Medicare IME payment for the prior year without using the Medicare three-year rolling average. The annual IME payment will be made in four quarterly installments and will be equal to the per discharge IME amount times the hospital’s Medicaid discharges in the prior fiscal year. Payment under this section is in addition to payments described in §602 and §603. To the extent that such payments would cause the State to exceed the upper payment limit in §605, the IME per discharge amount will be ratably reduced so that aggregate payments to state hospitals shall not exceed the Medicare upper payment limit. It is estimated that the IME payments in the state fiscal year ending June 30, 2003 shall be \$14,892,745. The funding of these additional IME payments will be established yearly. The payment for the state fiscal year ending June 30, 2003 will be \$14,892,745.

The amount of the payment to the state teaching hospital will be computed utilizing Medicaid discharges outlined as follows: (Medicaid Discharges) X (IME - payment amount established on a per discharge basis). In 2003, this amount will be \$3,381.00 per discharge (14,892,745/3837). The actual rate calculation will be completed by means of the Medicare cost report form.

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