

UTAH STATE PLAN ATTACHMENT 4.19-A

INPATIENT HOSPITAL

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T.N. # 01-030

Approval Date 3-19-02

Supersedes T.N. # New

Effective Date 10-1-01

INPATIENT HOSPITAL

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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

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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 based on the DRG utilized for each case. Preset or prospective baseline prices are assigned to each DRG. In addition to the base DRG payment amount, the DRG system evaluates each claim for a potential outlier payment. Outlier payments are for those discharges that have significant variance (based on covered charges) from the norm relative to the base DRG payment amount.

121 DRG Weights and Outliers – Each DRG has an associated weight which is multiplied by the base rate to determine each base DRG payment rate.

In cases where a provider's charges significantly exceed the base DRG payment rate, an outlier enhancement may be included in the payment of a claim to the provider. A claim is determined to meet outlier criteria when the total net covered charges exceed the DRG specific threshold (base DRG payment rate multiplied by the outlier threshold). When the total net covered charges exceed the outlier threshold, the difference is then calculated and multiplied by an outlier adjustment factor. This amount is added to the base DRG payment amount and paid to the provider.

Also see Section 122.

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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. 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 net covered total charges exceed the outlier threshold of the DRG average payment rate. This outlier threshold factor is a function of the average overall DRG charges 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. The DRGs, dollar multiplier (base rate), and outlier factors are adjusted periodically and posted on the agency's website at <http://health.utah.gov/medicaid/stplan/Inpatient/Factors.htm>.

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 (3) - calculated
DRG Outlier Threshold (Outlier Threshold Factor X Base DRG Payment Rate)	\$41,120.67	8	= (4) x (7) - calculated
Net Covered** Total Provider Charges	\$50,000	9	Provider Records
Net Covered** 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 Payments	\$22,463.39	14	= (12) + (13) - calculated

\*\* "Net covered charges" are the total submitted charges less the non-covered claim detail lines and the submitted "non-covered charges."

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INPATIENT HOSPITAL  
Section 100 Payment Methodology (Continued)

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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.

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:

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

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.

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INPATIENT HOSPITAL  
Section 100 Payment Methodology (Continued)

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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 provided through hospitals. Payment for this educational effort is calculated at \$6.00 per delivery in the state. Utah Medicaid will reimburse Utah hospitals \$6.00 for all identified Utah Medicaid deliveries (including Utah Medicaid MCO deliveries). Payment will be made to each qualifying hospital on an annual basis. The payment will be based upon claims with service end dates in the previous state fiscal year. The payments are made between 6 and 12 months following the end of the state fiscal year.

165 DRG Determinations -- The Medicare DRG “grouper” software will be used for Medicaid. Annually, typically each October 1, Utah Medicaid will adopt the DRG “grouper” software update.

166 Long-Acting Reversible Contraceptive (LARC) Post-Delivery – Effective for discharge dates on or after January 1, 2019, LARC devices, inserted following a delivery and prior to discharge, will be excluded from the DRG reimbursement calculation and will be paid separately based on the lesser of the established fee schedule or the amount billed as an additional amount to the DRG reimbursement calculation. All rates can be found in the [Coverage and Reimbursement Code Lookup](#) (<https://health.utah.gov/stplan/lookup/CoverageLookup.php>).

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INPATIENT HOSPITAL  
Section 100 Payment Methodology (Continued)

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

- The State Hospital: Because of its unique patient population, the Utah State Hospital (USH) is not part of the Diagnostic Related Group (DRG) system under which inpatient hospitals are reimbursed. Instead, the State hospital receives an interim per diem rate per patient category (i.e., forensic, adult, and youth) throughout the fiscal year, and a final cost settlement is subsequently performed by comparing Medicaid service costs to the interim payments received by the hospital. Medicare regulations and the Provider Reimbursement Manual - Part 1 (CMS Pub. 15-1) are used to determine allowable costs. The State hospital's Medicare cost methodology pays an average cost per discharge. However, for purposes of measuring Medicaid costs, a separate routine per diem cost is calculated for each patient category within the State hospital and applied to Medicaid eligible hospital days. Ancillary costs are separately allocated based on patient days. 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 is consistently applied for all admissions for all patient categories in establishing the State hospital's per diem costs.
- Rural Hospitals: Hospitals located in rural areas of the state are exempt from the DRG reimbursement methodology. (Urban counties are Cache, Davis, Salt Lake, Utah, Washington and Weber. Rural counties are all other Utah counties.) Rural hospitals are paid 89 percent of net covered charges. "Net covered charges" are defined on Page 4.

191 Payment Adjustments – Effective July 1, 2010, urban hospitals will have their calculated DRG payment reduced by 14.3 percent. This reduction to the calculated paid amount will occur after all calculated payments (base payment, outlier, etc.) and before third party liability and co-pay are applied to the payment.

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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INPATIENT HOSPITAL  
Section 200 Other Payments

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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/swing-bed rate is calculated using the criteria specified in Attachment 4.19-D of the State Plan.
- 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.
- Services provided in hospitals licensed as long term acute care or rehabilitation will be paid the nursing facility intensive skilled rate as defined in Attachment 4.19-D of the State Plan. Rehabilitation days require prior approval to qualify for payment.

241 Insignificant Billing Variances -- When the Medicaid payment is determined using the billed usual and customary net covered 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 net covered detailed charges or the net covered total charges, if the difference is ten dollars or less.

“Net covered charges” are defined on Page 4. “Net covered charges” are the total submitted charges less the non-covered claim detail lines and the submitted “non-covered charges.”

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INPATIENT HOSPITAL  
Section 200 Other Payments (Continued)

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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 geometric 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 -- Hospital stays in excess of 90 days may be billed under the DRG system prior to discharge with prior approval. The hospital requesting the interim payment must be able to document a cash flow problem that could impair patient care.

The interim bill is paid by calculating the DRG payment using the claim information from admission date to the date agreed upon by the Medicaid agency. Upon the patient's discharge and receipt of a replacement claim for all services incurred during the stay, the interim payment will be retracted and the claim processed according to standard processes.

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INPATIENT HOSPITAL  
Section 300 Supplemental Payments for Private Hospitals

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[Deleted 7-1-2013]

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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. Out-of-state hospitals are not eligible to receive DSH payments.

Funds from facilities not qualifying for the total annual supplemental payment amounts under Section 415 and 419 will be pooled together for redistribution to other qualifying hospitals under Section 415 and 419. Qualifying hospitals having maximized their annual supplemental DSH payment amount and that have not exceeded their uncompensated care cost will share in the pool based on each hospital's portion of the remaining uncompensated care costs. For example:

HOSP	Supple- mental CAP	Uncomp. Care Cost (UCC)	Supple- mental Payment to CAP	Room to Supple- mental CAP (Pool)	Remaining UCC	% of Remaining UCC	Additional DSH from Pool	Total Supple- mental DSH Paid
A	\$862,000	\$200,000	\$200,000	(\$662,000)	\$0	0%	\$0	\$200,000
B	\$862,000	\$862,000	\$862,000	\$0	\$0	0%	\$0	\$862,000
C	\$862,000	\$900,000	\$862,000	\$0	\$38,000	16%	\$38,000	\$900,000
D	\$1,000,000	\$1,200,000	\$1,000,000	\$0	\$200,000	84%	\$200,000	\$1,200,000
<b>Total</b>	<b>\$3,586,000</b>	<b>\$3,162,000</b>	<b>\$2,924,000</b>	<b>(\$662,000)</b>	<b>\$238,000</b>	<b>100%</b>	<b>\$238,000</b>	<b>\$3,162,000</b>

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.

Redistribution of disallowed monies:

For the purposes of this section, there are two pools of DSH monies available for potential redistribution of funds: 1) monies paid as lump-sum supplemental payments, and 2) monies paid to the state psychiatric hospital (no redistribution of these funds). If any payments made under this section are disallowed in future periods by CMS or any other audit, 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.

Annual DSH Audits:

In addition to any other audits which may occur, independent certified audits of the DSH payments shall be conducted annually in accordance with 42 CFR 455.301 and 42 CFR 455.304. Reporting of the audit shall follow the guidelines stated in 42 CFR 447.299. In accordance with 42 CFR 455.304(e), findings for federal fiscal years 2005-2010 shall not be used for disallowing federal funds. For federal fiscal years 2011 and forward, any overpayments of DSH funds shall be redistributed as described above. Additionally, DSH funds not otherwise paid to qualifying hospitals shall be available, subject to the uncompensated care cost limits, to the State Teaching Hospital.

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INPATIENT HOSPITAL  
Section 400 Adjustments for Disproportionate Share Hospitals

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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 calculated as described in Section 1923(b)(3) of the Social Security Act.
- 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).

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 or 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)

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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. The hospital is located in a rural county. (Urban counties are Cache, Davis, Salt Lake, Utah, Washington and Weber.)

Hospitals desiring to receive DSH monies are required to complete the state's "Disproportionate Share Hospital Survey & Uncompensated Care Survey." The survey shall be based upon the hospital's most recently filed Medicare Cost Report. Completed surveys are to be submitted annually to the state and must be postmarked by August 1. The survey gathers hospital volume, revenues, LIUR information, estimates of uncompensated care costs, and other qualification information. The survey is available on the Medicaid website at <http://health.utah.gov/medicaid>. Hospitals that do not submit this required survey, as outlined above, will be ineligible for DSH payments in the subsequent federal fiscal year.

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 according to Section 421.

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

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415 Payment Adjustment for General Acute Rural

General Acute Rural Hospitals will receive payments as outlined in Section 421. Qualifying rural hospitals will also be allowed to participate in a special DSH allotment set aside for current government-owned rural hospitals or rural private hospitals that were government-owned rural hospitals as of January 1, 2011.

Effective beginning federal fiscal year 2022, this additional DSH payment will be based on the lesser of 3.0% of the total federal funds available, rounded to the nearest dollar, per federal fiscal year per hospital or the hospital's uncompensated care cost to Medicaid and the uninsured.

Any hospital that qualifies for additional DSH payments under Section 419 of the State Plan is not eligible for this, Section 415, additional DSH payment.

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 an "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 <https://medicaid.utah.gov>. 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)

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416 Payment Adjustment for State Psychiatric Hospital -- The State Psychiatric Hospital is reimbursed on a retrospective annual cost settlement basis.

The annual limit for State Psychiatric Hospital DSH payments is the lesser of (1) the annual federal DSH limit for institutions for mental disease (IMD) or (2) the amount of uncompensated care costs. The method and timing of these DSH payments will be according to the following:

1. In order to receive Supplemental payments, the State Psychiatric Hospital must submit an "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 <https://medicaid.utah.gov>. The State Psychiatric Hospital may submit their survey monthly, quarterly, semi-annually, annually, or any combination thereof. The State Psychiatric Hospital 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 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. The State Psychiatric Hospital DSH payments will not exceed the total allowed as described above. The State Psychiatric Hospital 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 the State Psychiatric Hospital has reached the annual IMD allotment maximum, no additional payments will be made.

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## INPATIENT HOSPITAL

### Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

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417 Payment Adjustment for State Teaching Hospital -- The State Teaching Hospital will receive a claims add-on payment as outlined in Section 421.

In order to receive Supplemental payments, the State Teaching Hospital must submit an "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>. The State Teaching Hospital may submit their survey monthly, quarterly, semi-annually, annually, or any combination thereof. The State Teaching Hospital 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 60 days of the end of the federal fiscal period. A final payment for the federal fiscal period just ended will then be made.

The State Teaching Hospital may elect to receive prospective supplemental DSH payments based on the most recent survey submitted under Section 413. If this option is elected, then the State Teaching Hospital may receive lump-sum payments at the beginning of each federal fiscal year or at different times within the federal fiscal year along with a reconciliation payment following the end of the federal fiscal period after the other qualifying facilities have been paid.

In addition to the above, any DSH monies not paid to other qualifying hospitals will be paid to the State Teaching Hospital as noted in Section 409.

418 Payment Adjustment for Children's Hospital – The Children's Hospital will receive a claims add-on payment as outlined in Section 421.

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## INPATIENT HOSPITAL

### Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

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419 Depressed Frontier County Hospitals - Will receive a claims add-on payment as outlined in Section 421. Depressed Frontier County Hospitals are also eligible for a Supplemental DSH payment cap (Frontier County Cap), which is higher than the Supplemental DSH payment cap for other rural hospitals. Effective beginning federal fiscal year 2022, this additional DSH payment will be based on the lesser of 3.5% of the total federal funds available, rounded to the nearest dollar, per federal fiscal year per hospital or the hospital's uncompensated care cost to Medicaid and the uninsured.

A hospital will qualify for the Frontier County if it:

1. Is a rural hospital;
2. Is a government-owned hospital; and
3. Is located in a county having the lowest per capita personal income in the State.

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

1. Each qualifying hospital must submit an "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 <https://medicaid.utah.gov>. 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)

**421 Method and Timing of DSH Claims Supplemental Payments** – DSH payments under this section will be made via lump-sum supplemental payments. For each federal fiscal year, 12.5 percent of the CMS preliminary annual Utah federal funds allotment is the basis for the payments made under this section. Each qualifying hospital is assigned to a hospital category (i.e., rural and frontier, urban, children’s, and teaching). The supplemental funds are divided by the State to the hospital categories. Within each hospital category, each hospital receives a portion of the hospital category’s funds based on its percentage of the total adjusted Medicaid reimbursement for a prior 12-month period. Adjusted Medicaid reimbursement is calculated by multiplying Medicaid reimbursement for the prior year by its ratio of Medicaid days to total days for the same year.

The payment calculation is as follows:

Adjusted Medicaid Reimbursement = Hospital’s Medicaid Reimbursement Net of DSH\* (Hospital’s Medicaid Days / Total Days).

Hospital Ratio = Adjusted Medicaid Reimbursement / Sum of the Adjusted Medicaid Reimbursement specific to the hospital category.

Hospital Category Supplemental Funds: The total supplemental funds assigned by the State to a hospital category representing hospital types (e.g. rural, urban, children’s, and teaching).

Hospital Distribution Amount = Hospital Category’s Supplemental Funds\* Hospital Ratio.

Following is an example, for one hospital category, of the calculation outlined above:

Hospital Category Section 421 Funds:							\$100
Hospital	Medicaid Days	Total Days	Medicaid Days % of Total Days	Medicaid Reimb.	Adjusted Medicaid Reimb.	Hospital Ratio	Hospital Distribution Amount
a	100	200	50.0%	\$1,000.00	\$500.00	0.1224	\$12.24
b	200	300	66.7%	\$2,000.00	\$1,333.33	0.3265	\$32.65
c	300	400	75.0%	\$3,000.00	\$2,250.00	0.5510	\$55.10
<b>Total</b>	<b>600</b>	<b>900</b>		<b>\$6,000.00</b>	<b>\$4,083.33</b>		<b>\$100.00</b>

If the CMS final annual Utah allotment is more than the preliminary allotment, the additional allotment will be allocated to the teaching hospital category. If the CMS final annual Utah allotment is less than the preliminary allotment, the reduced allotment will be recovered from the teaching hospital category.

For each federal fiscal year, payments will be made no earlier than the beginning of each federal fiscal year. Payments will be made within six months after receiving the preliminary allotment amount or within six months after the beginning of the federal fiscal year, whichever is later.

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INPATIENT HOSPITAL  
Section 500 Inpatient Rehabilitation Services

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Deleted July 1, 2015

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INPATIENT HOSPITAL  
Section 600 Inpatient Medicaid DRG Refinement

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601 General – Due to the unique nature of the Medicaid population, selected Medicare DRGs have been refined and expanded into additional DRGs. See Section 122 for more information.

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INPATIENT HOSPITAL  
Section 600 Inpatient Medicaid DRG Refinement (Continued)

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[Deleted 7/1/2013]

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INPATIENT HOSPITAL  
Section 700 Health Profession Education

701 General – Utah Department of Health shall support the education of health professionals through the use of Medicaid funds to make direct graduate medical education payments (DGME).

702 Payment Pool – The annual DGME payment pool will be determined for each state fiscal year (SFY) and will be finalized prior to making any payments for the SFY. The payments will be calculated each year by using State Funds equal to \$1,836,000. That amount will be used to generate additional matching Federal Funds. The State Funds and the matching Federal Funds combined will equal the Total Amount that will be distributed. The matching Federal Funds will be determined by the FMAP Rate for the then current period. The calculation for the matching Federal Funds = (State Funds Amount / (1 – FMAP Rate) X FMAP Rate). The following example is for illustrative purposes only:

Total State Fund Amount	\$ 1,836,000	Quarterly Distribution (Total/4)	\$ 459,000
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State Fiscal Quarter	Q1 (Jul – Sep)	Q2 (Oct – Dec)	Q3 (Jan – Mar)	Q4 (Apr – Jun)	Year Total
FMAP	71%	70%	70%	70%	
State Funds	\$459,000.00	\$459,000.00	\$459,000.00	\$459,000.00	\$1,836,000.00
Federal Funds	\$1,123,758.62	\$1,071,000.00	\$1,071,000.00	\$1,071,000.00	\$4,336,758.62
Total Funds	\$1,582,758.62	\$1,530,000.00	\$1,530,000.00	\$1,530,000.00	\$6,172,758.62

DGME payments will be distributed quarterly, typically at the beginning of each quarter, in accordance with the calculated quarterly distribution amounts.

703 Payment Pool Distribution – The FFS payment pool is distributed based upon allocation percentages for each eligible hospital as follows:

Hospital Name	Percentage
UNIVERSITY OF UTAH HOSP	74.45%
PRIMARY CHILDRENS MED CNTR	11.28%
LDS HOSPITAL	0.21%
INTERMOUNTAIN MEDICAL CENTER	8.23%
UTAH VALLEY REG MED CNTR	2.69%
MCKAY DEE HOSPITAL	1.96%
ST MARKS HOSPITAL	0.56%
SALT LAKE REG MED CNTR	0.11%
UNIVERSITY HOSPITAL PSYCH	0.51%
<b>Total</b>	<b>100.00%</b>

In no case shall total payments allocated exceed the annual DGME payment pool set for the SFY in accordance with Section 702.

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INPATIENT HOSPITAL  
Section 700 Health Profession Education

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704 Upper Payment Limit – The aggregate FFS Medicaid hospital payments, including the DGME payments covered in this section, will not exceed the amount that would be paid for the services furnished under Medicare payment principles in compliance with the 42 CFR 447.272 upper payment limit regulations for each category of hospitals.

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T.N. # 13-018 Approval Date 6-21-13  
Supersedes T.N. # 10-004 Effective Date 7-1-13

INPATIENT HOSPITAL  
Section 800 State Teaching Hospital Supplemental Payment

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800 State Teaching Hospital Payments – Effective for State Fiscal Year (SFY) 2010, state-owned or operated teaching hospitals shall be eligible for a State Teaching Hospital Payment. The amount of the payment shall equal the difference between the upper payment limit (UPL) described in 42 CFR 447.272 and other FFS payments (including DGME payments) made to such hospitals for inpatient services.

During each SFY, the State will make quarterly State Teaching Hospital Payments based on the projected gap of the UPL, adjusted for inflation and utilization trends, based on the most recently filed cost report data and total projected current year inpatient hospital services payments. The State will submit the projected UPL to CMS prior to making quarterly payments. Only data that relates to FFS inpatient hospital services will be used for purposes of the projected or actual UPL demonstration (the UPL demonstration will include FFS discharges for patients enrolled in any prepaid ambulatory health plan).

The base year utilized to determine each Medicaid upper payment limit shall be trended to the applicable spending year as follows:

- Inflation trend shall be an annual average calculated using the consumer price index available the December prior to the start of each state fiscal year for "Inpatient Hospital Services" as published by the U.S. Department of Labor, U.S. Bureau of Labor Statistics as compared to the previous December.
- Utilization trend shall be calculated using historical Utah Medicaid inpatient hospital services data.

801 Upper Payment Limit – The aggregate FFS Medicaid hospital payments, DGME payments and teaching hospital payments covered in this section, will not exceed the amount that would be paid for the services furnished under Medicare payment principles in compliance with the 42 CFR 447.272 upper payment limit regulations for each category of hospitals.

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INPATIENT HOSPITAL  
Provider-Preventable Conditions

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Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions (HCACs) for non-payment under Section 4.19-A.

X  Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric surgery and obstetric patients.

For claims with dates of service on or after July 1, 2011, Utah Medicaid will not reimburse providers for any of the HCACs indicated above. Payment will be denied for HCACs in any health care setting identified in Attachment 4.19-A. Denial of payment will be limited to the additional care required by the HCAC.

Utah Medicaid requires inpatient hospital providers to list any charges associated with HCACs not present on admission as non-covered charges on claims submitted for payment. Reimbursement for DRG-paid inpatient hospital claims will be based only on covered charges and shall be paid as though the HAC diagnosis is not present. Reimbursement for non-DRG-paid inpatient hospital claims will be based only on covered charges.

Inpatient hospital providers will be required to provide a valid Present-On-Admission (POA) indicator for each diagnosis submitted with their claim.

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INPATIENT HOSPITAL  
Provider-Preventable Conditions (Continued)

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Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-A.

X  Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

\_\_\_\_\_ Additional Other Provider-Preventable Conditions identified below:

For claims with dates of service on or after July 1, 2011, Utah Medicaid will not reimburse providers for any of the OPPCs indicated above. Payment will be denied for OPPCs in any health care setting identified in Attachment 4.19-A.

In compliance with 42 CFR §447.26(c):

1. No reduction in payment for a provider-preventable condition will be imposed on a provider when the condition defined as a PPC existed prior to the initiation of treatment for that patient by that provider.
2. The reductions in provider payment may be limited to the extent that the following apply:
  - a. The identified provider-preventable condition would otherwise result in an increase in payment.
  - b. The State can isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable condition.
3. The State provides assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursement according to the methodology above.

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