Table of Contents

State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-13-028

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

DEC 27 2013

Mr. Michael T. Hales, Director
Division of Health Care Financing
Utah Department of Health
P.O. Box 143101
Salt Lake City, Utah 84114-3101

Re: Utah 13-028

Dear Mr. Hales:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-028. Effective for services on or after July 1, 2013, this amendment modifies the reimbursement methodology for inpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 13-028 is approved effective July 1, 2013. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

[redacted]

Cindy Mann
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-028-UT
2. STATE: Utah
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTHCARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 412.60

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $0
b. FFY 2014 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 3, 4, 5, 6, 7, 8, 9, 9.1, 11b, 12, and 13 of ATTACHMENT 4.19-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Pages 3, 4, 5, 6, 7, 8, 9, 9.1, 11b, 12, and 13 of ATTACHMENT 4.19-A

10. SUBJECT OF AMENDMENT: Inpatient Hospital Payments

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Michael Hales

14. TITLE: Deputy Director, Utah Department of Health

15. DATE SUBMITTED: September 30, 2013

16. RETURN TO:
Craig Devashrayee, Manager
Technical Writing Unit
Utah Department of Heath
PO Box 143102
Salt Lake City, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: DEC 27 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: [redacted]

22. TITLE: Center Director, CMCS

23. REMARKS:

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 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.

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 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. 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."

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.

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:

Claim Payment = Medicaid Eligible Days divided by Total Hospital Days x 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.

INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

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.

180 Utilization Review and Control of Inpatient Hospital Services -- All claims are subject to post payment review. Payment may be denied or withheld for inpatient hospital services which do not meet Medicaid regulations or criteria for medical necessity and appropriateness. 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. In accordance with the Superior Systems Waiver, 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 selected for review through the Superior Systems Waiver 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 when appropriate.

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 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 Centers for Medicare and Medicaid Services data.

INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

2. The comprehensive, evidence-based, patient-focused medical review criteria and system developed by McKesson known as InterQual.

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.

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.

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/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."

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 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.

INPATIENT HOSPITAL
Section 300 Supplemental Payments for Private Hospitals

[Deleted 7-1-2013]

INPATIENT HOSPITAL
Section 500 Inpatient Rehabilitation Services

501 General -- Because of the wide variation in the length of stay for rehabilitation services there is a need to refine the DRG criteria. Rehabilitative 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 this Attachment. 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 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 DRGs have been refined and expanded into additional DRGs. See Section 122 for more information.

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.

INPATIENT HOSPITAL
Section 600 Inpatient Medicaid DRG Refinement (Continued)

[Deleted 7/1/2013]