
Table of Contents

State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-16-0009

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

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



Financial Management Group

APR 07 2016

Mr. Nate Checketts, Director
Division of Health Care Financing
Utah Department of Health
P.O. Box 143101
Salt Lake City, UT 84114-3101

Re: Utah 16-0009

Dear Mr. Checketts:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 16-0009. Effective for services on or February 1, 2016, this amendment updates the methodology for supplemental disproportionate share hospital (DSH) payments.

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 and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 16-0009 is approved effective February 1, 2016. The HCFA-179 and the amended plan page are attached.

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

Sincerely,



Kristin Fan
Director

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

1. TRANSMITTAL NUMBER:
16-0009-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
February 1, 2016

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 455.304

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 \$0
b. FFY 2017 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 11a(2) of Attachment 4.19-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Page 11a(2) of Attachment 4.19-A

10. SUBJECT OF AMENDMENT: Disproportionate Share Hospital Payments

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

[Redacted Signature]

13. TYPED NAME: Dr. Joseph K. Miner, MD

14. TITLE: Executive Director, Utah Department of Health

15. DATE SUBMITTED: February 3, 2016

16. RETURN TO:

Craig Devashrayee, Manager
Technical Writing Unit
Utah Department of Health
PO Box 143102
Salt Lake City, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

~~APR 07 2016~~
APR 07 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
FEB 01 2016

20. SIGNATURE: [Redacted Signature]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMC

23. REMARKS:

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 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
Total	600	900		\$6,000.00	\$4,083.33		\$100.00

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.

T.N. No. 16-0009

Approval Date APR 07 2016

Supersedes T.N. # 11-005

Effective Date 2-1-16