DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

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

1. TRANSMITTAL NUMBER: 10-006-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
Effective Dates as Noted on State Plan Pages

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)*

5. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.20

6. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 1 and 2d of Attachment 4.19-B

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $[$4,046,600]
b. FFY 2011 $[$5,822,000]

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Page 1 of Attachment 4.19-B

10. SUBJECT OF AMENDMENT:
Outpatient 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

13. TYPED NAME
David N. Sundwall, MD

14. TITLE
Executive Director, Utah Department of Health

15. DATE SUBMITTED
March 31, 2010

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

17. DATE RECEIVED
3/31/10

18. DATE APPROVED
12/20/10

FOR REGIONAL USE ONLY

19. EFFECTIVE DATE OF APPROVED MATERIAL
2/1/10

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME
Richard C. Allen

22. TITLE:
ARA, DMCHO

PLAN APPROVED - ONE COPY ATTACHED

23. REMARKS

A. OUTPATIENT HOSPITAL AND OTHER SERVICES

1. Except for emergency room, lithotripsy, Federally Qualified Health Centers, laboratory and radiology services, the payment level for outpatient hospital claims will be based on 69% allowed charges for urban hospitals and 83% allowed charges for rural hospitals.

2. Payments for emergency room services vary depending on urban/rural designation and whether the service is designated as "emergency" or "non-emergency." The "emergency" designation is based on the principal diagnosis (ICD-9 Codes). Rural hospitals will receive 88% of charges for emergency services and 58% for non-emergency use of the emergency room. Urban hospitals will receive 88% of charges for emergencies and 36% of charges for non-emergency use of the emergency room.

3. Payment for lithotripsy services is a fixed fee. The fee is all-inclusive except for physician services that are billed on the CMS-1500. The rate includes all services related to lithotripsy for 90 days. No additional payment will be made for repeat procedures within the 90-day period. Treatment of the kidney on the opposite side will be paid as a separate treatment, but is also subject to the 90-day restriction. The payment rate will be reviewed and updated annually using economic trends and conditions. The agency's rates were set as of 10/1/2003 and are effective for services on or after that date. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

4. Payment for laboratory and radiology services provided in a hospital to outpatients will be made based on HCPCS codes and an established fee schedule, unless a lesser amount is billed. The fee schedule used to pay physicians is used to establish payment rates. The agency's rates were set as of 5/25/2009 and are effective for services on or after that date. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

5. Billed charges shall not exceed the usual and customary charge to private pay patients.

6. Payments for all outpatient services are limited to the aggregate annual amount Medicare would pay for the same services as required by 42 CFR 447.321.

7. Payments for physical therapy/occupational therapy are based on the established fee schedule unless a lower amount is billed. Fees are established by discounting historical charge, by professional judgement, and by the physical therapy and occupational therapy fee schedule. Since the amount of physical therapy and occupational therapy is limited, the select case management committee of the facility will determine which type of service (physical therapy or occupational therapy) should be provided for the patient by the facility. The amount of physical therapy provided will affect the amount of occupational therapy available, and vice versa. The agency's rates were set as of 10/1/2008 and are effective for services on or after that date. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

8. Payment for partially completed services billed with a Modifier "73" shall be paid at 50% of the regularly schedule payment rate. This is to allow for the payment for the services that were rendered yet not completed due to a physician decision or for any other reason. This modifier is attached to the list of physician modifiers as per Attachment 4.19-B, Section D(6), Physicians special modifiers.

11. STATE TEACHING HOSPITAL SUPPLEMENTAL PAYMENTS

The State Teaching Hospital will be paid a supplemental payment for outpatient hospital services based on a reasonable cost methodology. Reasonable cost is determined using Medicare principles by applying a cost-to-charge ratio derived from the latest filed Medicare cost report to Medicaid claims data. The supplemental payment equals the difference between reasonable costs adjusted for inflation and utilization trends and claims payments made pursuant to otherwise applicable methodologies.

Quarterly interim payments will be made that will each be equal to one-fourth of the total projected supplemental payment. Prior to making the first interim supplemental payment in a state fiscal year, the total projected supplemental payment will be calculated using the most recently filed cost report prior to the beginning of the state fiscal year.

12. NON-STATE GOVERNMENT HOSPITALS SUPPLEMENTAL PAYMENTS

Government owned, other than state owned, hospitals shall be eligible to receive a supplemental payment for outpatient hospital services based on a reasonable cost methodology. Reasonable cost is determined using Medicare principles by applying a cost-to-charge derived from the latest filed Medicare cost report to Medicaid claims data. The supplemental payment equals the difference between reasonable costs adjusted for inflation and utilization trends and claims payments made pursuant to otherwise applicable methodologies.

Quarterly interim payments will be made that will each be equal to one-fourth of the total projected supplemental payment. Prior to making the first interim supplemental payment in a state fiscal year, the total projected supplemental payment will be calculated using the most recently filed cost report prior to the beginning of the state fiscal year. The payments will be distributed to each hospital based on the proportion of the hospital's UPL room that is greater than zero.

UPL Calculation Overview

For purposes of calculating the Medicaid outpatient hospital upper payment limits for State and non-State government owned hospitals, the state shall utilize hospital specific Medicare outpatient cost to charge ratios applied to Medicaid charges. The Medicaid upper payment limit for state hospitals and non-state government owned hospitals are independently calculated. Each Medicaid upper payment limit shall be offset by hospital Medicaid and other third party outpatient payments to determine the available spending room (i.e., the gap) applicable to each Medicaid upper payment limit. 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 calculated using the consumer price index available at the time of calculation for "Outpatient Hospital Services" as published in Table 5A of the Consumer Price Index Detailed Report Tables Annual Averages published by the U.S. Department of Labor, U.S. Bureau of Labor Statistics.

- Utilization trend shall be calculated using historical Utah Medicaid outpatient hospital services data.

Following is the data used to calculate the UPL for each state fiscal year:

Medicare Cost to Charge ratio:
- The hospitals in the analysis have fiscal year ends during the state fiscal year
- Costs are from Worksheet D, Part V, Columns 9, 9.01, 9.02, 9.03 line 104
- Charges are from Worksheet D, Part V, Columns 5, 5.01, 5.02, 5.03 line 104

Medicaid Charges and payments - Paid hospital outpatient claims from the same state fiscal period

Costs for critical access hospitals shall be inflated to 101 percent of cost.