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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-16-0007

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

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

Financial Management Group

JUL 26 2016

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

Re: Utah 16-0007

Dear Mr. Checketts:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-0007. Effective for services on or after July 1, 2016, this amendment updates the quality incentive (QI) payment amount amounts, as well as provides for other administrative corrections and modifications. Please note that expenditures for services provided for the qualify incentives should be claimed on line 3B on the Form CMS-64 expenditure report.

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 6-0007 is approved effective July 1, 2016. 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]

Kristin Fan
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: 16-0007-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, 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:

Section 1902(a)(13)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. SFY 2017 $0
b. SFY 2018 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

The third page of Section 200 is deleted to remove unnecessary definitions from Attachment 4.19-D;

Sections 410, 420 and 430 of Attachment 4.19-D;

Section 634 of Attachment 4.19-D;

Page 3 within Section 927 of Attachment 4.19-D;

Section 942 of Attachment 4.19-D.

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

The third page of Section 200 is deleted to remove unnecessary definitions from Attachment 4.19-D;

Sections 410, 420 and 430 of Attachment 4.19-D;

Section 634 of Attachment 4.19-D;

Page 3 within Section 927 of Attachment 4.19-D;

Section 942 of Attachment 4.19-D.

10. SUBJECT OF AMENDMENT: Non-Routine Services, QI Incentive, and Other Clarifications

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:
Joseph K. Miner, MD

13. TYPED NAME: Joseph K. Miner, M.D.

14. TITLE: Executive Director, Utah Department of Health

15. DATE SUBMITTED: May 5, 2016

16. RETURN TO:

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

16.

17. DATE RECEIVED:

18. DATE APPROVED: JUL 26 2016

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2016

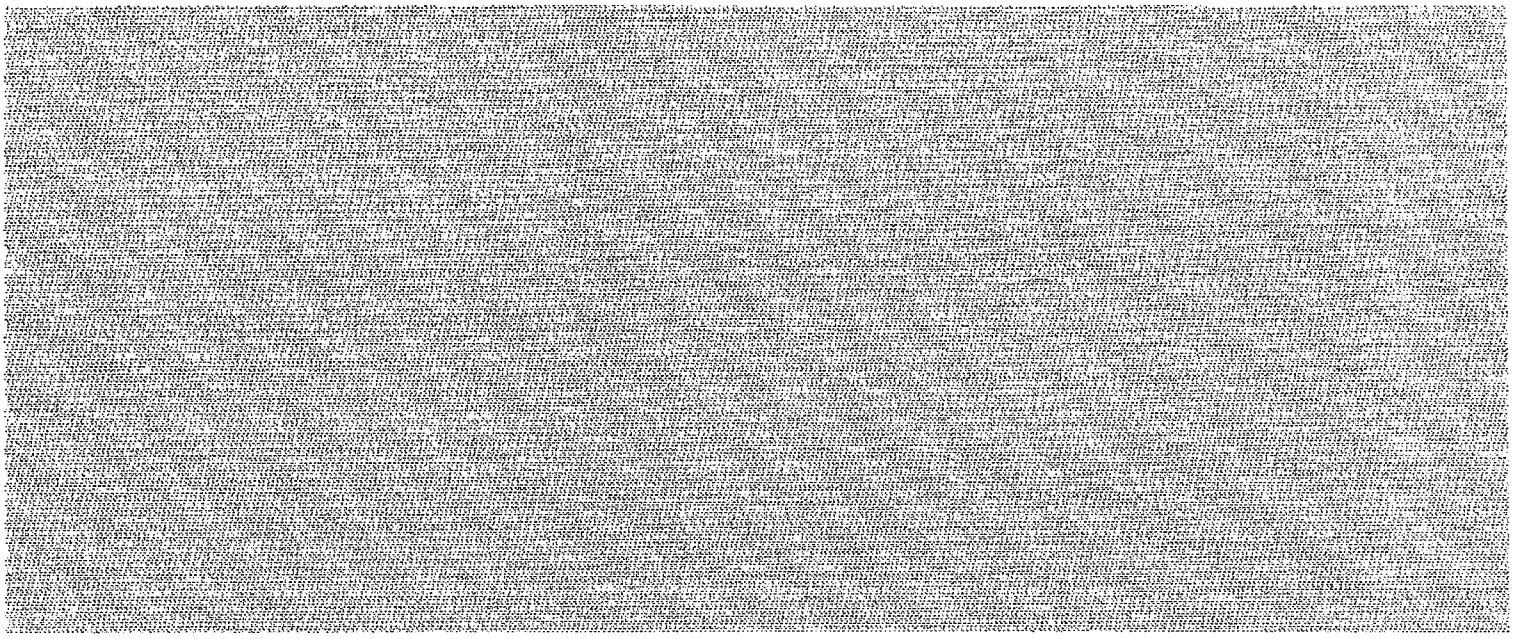
20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:	22. TITLE:
Kristin Fan	Fm G Director

FOR REGIONAL USE ONLY
PLAN APPROVED – ONE COPY ATTACHED

23. REMARKS

FORM HCFA-179 (07-92)



200 DEFINITIONS (Continued)

Deleted July 1, 2016

400 ROUTINE SERVICES

410 INTRODUCTION

This section specifies the services covered in the per diem payment rate and the ancillary services that are billed separately. Because of the difficulty of defining all of the routine services, Section 430 specifies those services that are billed directly. Other services are covered by the routine payment rates paid to long-term care providers.

420 ROUTINE SERVICES

The Medicaid per diem payment rate covers routine services. Such routine services cover the hygienic needs of the patients. Supplies such as toothpaste, shampoo, facial tissue, disposable briefs, and other routine services and supplies specified in 42 CFR 483.10 are covered by the Medicaid payment rate and cannot be billed to the patient. The following types of items will be considered to be routine for purposes of Medicaid costs reporting, even though they may be considered ancillary by the facility:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas.

2. Items furnished routinely and relatively uniformly to all patients, such as patient gown, water pitchers, basins, and bedpans.

3. Items stocked at nursing stations or on the floor in gross supply, such as alcohol, applicators, cotton balls, band aids, suppositories, and tongue depressors.

4. Items used by individual patients which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.

5. Special dietary supplements used for tube feeding or oral feeding except as provided in Section 430.

6. Laundry services.

7. Transportation to meet the medical needs of the patient, except for emergency ambulance.

8. Medical supplies and non-prescription pharmacy items. Supplies include, but are not limited to: syringes, ostomy supplies, irrigation equipment, routine dressings (i.e., band-aid, gauze, etc. - does not include specialized dressings such as negative pressure wound therapy dressings), catheters, elastic stockings, test tape, IV set-up colostomy bags, oxygen tubing /masks, CPAP/Bi-PAP supplies, etc.

9. Medical consultants.

10. All other services and supplies that are normally provided by long-term care providers except for the non-routine services in Section 430.

11. ICF/MR patients only:
    a. Annual dental examination.
    b. Physical therapy, occupational therapy, speech therapy and audiology examinations.

430 NON-ROUTINE SERVICES

These services are considered ancillary for Medicaid payment. The costs of these services should not be included on the FCP. Non-routine services may be billed by either the nursing facility or the direct service provider. These services are:

1. Physical therapy, speech therapy, and audiology examinations (nursing facility patients only).

2. Dental services (except annual examinations for ICF/MR patients).

3. Oxygen.

4. Prescription drugs (legend drugs) plus antacids, insulin and total nutrition, parenteral or enteral diet given through gastrostomy, jejunostomy, IV or stomach tube. In addition, antilipemic agents and hepatic agents or high nitrogen agents are billed by pharmacies directly to Medicaid.

5. Prosthetic devices to include (a) artificial legs, arms, and eyes and (b) special braces for the leg, arm, back, and neck.

6. Physician services for direct patient care.

7. Laboratory and radiology.

8. Emergency ambulance for life threatening or emergency situations.

9. Other professional services for direct patient care, including psychologists, podiatrists, optometrists, and audiologists.

10. Eyeglasses, dentures, and hearing aids.

11. Special equipment approved by Medicaid for individual clients is covered. This equipment is currently limited to:

    a. air or water flotation beds (self-contained, thermal-regulated, or alarm-regulated);
    b. mattresses and overlays specific for decubitus care;
    c. customized (Medicaid definition) wheelchairs;
    d. power wheelchairs;
    e. negative pressure wound therapy (vacuum, cannister, and associated dressings); and
    f. CPAP/Bi-PAP machine rental.

12. Hyperbaric Oxygen Therapy.

Medicaid criteria, applicable at the time services are rendered, applies to the above items.

431 DEFINITION OF PROSTHETIC DEVICES

Medicaid defines prosthetic devices to include (1) artificial legs, arms, and eyes; (2) special braces for the leg, arm, back, and neck; and (3) internal body organs. Specifically excluded are urinary collection and other retention systems. This definition requires catheters and other devices related to be covered by the per diem payment rate.

(I) The project must have been completed during a 24-month period and reported on the FRV Data Report for the reporting period used for the July 1 rate year and be related to the reasonable functioning of the nursing facility. Renovations unrelated to either the direct or indirect functioning of the nursing facility shall not be used to adjust the facility's age.

(II) The equivalent number of new beds is determined by dividing the cost of the project by the accumulated depreciation per bed of the facility's existing beds immediately before the project.

(III) The equivalent number of new beds is then subtracted from the total actual beds. The result is multiplied by the difference in the year of the completion of the project and the age of the facility, which age is based on the initial construction year or the last reconstruction or renovation project. The product is then divided by the actual number of beds to arrive at the number of years to reduce the age of the facility.

(b) A nursing facility's fair rental value per diem is calculated as follows:

As used in this subsection (b), "capital index" is the percent change in the Salt Lake City Location Factor as found in the two most recent annual R.S. Means Data.

(i) On July 1, 2004, the buildings and fixtures value per licensed bed is $50,000. To this $50,000 is added 10% ($5,000) for land and 10% ($5,000) for movable equipment. Each nursing facility's total licensed beds are multiplied by this amount to arrive at the "total bed value." The total bed value is trended forward by multiplying it by the capital index and adding it to the total bed value to arrive at the "newly calculated total bed value." The newly calculated total bed value is depreciated, except for the portion related to land, at 1.50 percent per year according to the weighted age of the facility. The maximum age of a nursing facility shall be 35 years. There shall be no recapture of depreciation. The base value per licensed bed is updated annually using the R.S. Means Data as noted above. Beginning July 1, 2008, the 2007 base value per licensed bed is used for all facilities, except facilities having completed a qualifying addition, replacement or major renovation. These qualifying facilities have that year's base value per licensed bed used in its FRV calculation until an additional qualifying addition, replacement or major renovation project is completed and reported, at which time the base value is updated again.

900 RATE SETTING FOR NFs (Continued)

(A) A new side-entry bathing system that allows the resident to enter the bathing system without having to step over or be lifted into the bathing area;
(B) Heat lamps or warmers (e.g. blanket or towel);
(C) Bariatric equipment (e.g. shower chair, shower gurney; and
(D) General improvements to the patient bathing/shower area(s).

(iv) Incentive for facilities to purchase or enhance patient life enhancing devices. Qualifying Medicaid providers may receive $495 for each Medicaid-certified bed. Patient life enhancing devices are restricted to:
(A) Telecommunication enhancements primarily for patient use. This may include land lines, wireless telephones, voice mail, and push-to-talk devices. Overhead paging, if any, must be reduced;
(B) Wander management systems and patient security enhancement devices (e.g., cameras, access control systems, access doors, etc.);
(C) Computers, game consoles, or personal music system for patient use;
(D) Garden enhancements;
(E) Furniture enhancements for patients;
(F) Wheelchair washers;
(G) Automatic doors;
(H) Flooring enhancements; and
(I) Automatic Electronic Defibrillators (AED devices); and
(J) Energy efficient windows with a U-factor rating of 0.35 or less; and
(K) Exercise equipment for group fitness classes (e.g., weights, exercise balls, exercise bikes, etc.).

(v) Incentive for facilities to educate staff as specified on the application form. Qualifying Medicaid providers may receive $110 for each Medicaid-certified bed.

(vi) Incentive for facilities to purchase or make improvements to van and van equipment for patient use. Qualifying Medicaid providers may receive $320 for each Medicaid-certified bed.

(vii) Incentive for facilities to purchase or lease new or enhance existing clinical information systems or software or hardware or backup power. Qualifying Medicaid providers may receive the QII2 limit amount for each Medicaid-certified bed.
(A) The software must incorporate advanced technology into improved patient care that includes better integration, captures more information at the point of care, and includes more automated reminders, etc. A facility must include the following tracking requirements in the software:
(I) Care plans:
(II) Current conditions;
(III) Medical orders;
(IV) Activities of daily living;
(V) Medication administration records;
(VI) Timing of medications;
(VII) Medical notes; and
(VIII) Point of care tracking.
(B) The hardware must facilitate the tracking of patient care and integrate the collection of data into clinical information systems software that meets the tracking criteria in Subsection A above.

(viii) Incentive for facilities to purchase a new or enhance its existing heating, ventilating, and air conditioning system (HVAC). Qualifying Medicaid providers may receive $162 for each Medicaid-certified bed.

(ix) Incentive for facilities to use innovative means to improve the residents' dining experience. These changes may include meal ordering, dining times or hours, atmosphere, more food choices, etc. Qualifying Medicaid providers may receive $200 for each Medicaid-certified bed.

(x) Incentive for facilities to achieve outcome proven awards defined by either the American Health Care Association Quality First Award program or the Malcolm Baldridge Award. Qualifying Medicaid providers may receive $100 per Medicaid-certified bed.

(xi) Incentive for facilities to provide flu or pneumonia immunizations for its employees at no cost to the workers. Qualifying Medicaid providers may receive $15 per Medicaid-certified bed. The application must include a signature list of employees who receive the free vaccinations.

(xii) Incentive for facilities to purchase new patient dignity devices. Qualifying Medicaid providers may receive $100 for each Medicaid-certified bed. Patient dignity devices are restricted to:
(A) Bladder scanner.
(B) Bariatric scale capable of weighing patients up to at least 600 pounds.

Supplemental Payment Amount

The payments will be distributed to each NSGO nursing facility based on the following example:

NF	Daily Rate UPL Gap	Period of Interest Paid Days	State Fiscal Quarter UPL Gap	Amount if UPL > 0	Amount if UPL > 0 percent of Total	UPL Gap Allocation
A	($5.00)	100	($500.00)	$0.00	0.00%	$0.00
B	$80.00	200	$16,000.00	$16,000.00	21.62%	$15,891.89
C	$120.00	300	$36,000.00	$36,000.00	48.65%	$35,756.76
D	$55.00	400	$22,000.00	$22,000.00	29.73%	$21,851.35
Totals		**1,000**	**$73,500.00**	**$74,000.00**	**100%**	**$73,500.00**

Supplemental Payment Frequency

Payments will be distributed in the form of supplemental Medicaid payments to each qualifying nursing facility that is owned by a non-state governmental entity. The state shall distribute the payment to the nursing homes for each quarter.

Payments for newly approved facilities will not include service dates prior to the Division approved effective date.

If new or corrected information is identified that would modify the amount of a previous payment, the Department may make a retroactive adjustment payment in addition to previously paid amounts.