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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-11-006

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

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 and CHIP Services

OCT 19 2011

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

Re: Utah 11-006

Dear Mr. Hales:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-006. Effective for services on or after July 1, 2011, this amendment continues the Quality Improvement (QI) Incentive programs for State Fiscal Year 2012 for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICF/MRs).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) 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 11-006 is approved effective July 1, 2011. We are enclosing the CMS-179 and the amended plan pages.

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

Sincerely,

[redacted]

Cindy Mann
Director, CMCS

cc: Craig Devashrayee, UT DOH

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: 11-006-UT
2. STATE: Utah
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIA SECURITY ACT (MEDICAID)

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

4. PROPOSED EFFECTIVE DATE
July 1, 2011

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X 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. FFY 2011 $0
b. FFY 2012 $0

BCB

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Sections 420, 430, 927, and 1195 of Attachment 4.19-D;

Removes Section 600(ii) of Attachment 4.19-D because the information is duplicated elsewhere in the State Plan.

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Sections 420, 430, 927, and 1195 of Attachment 4.19-D.

10. SUBJECT OF AMENDMENT:
Quality Improvement Incentive

11. GOVERNOR'S REVIEW *(Check One)*:
X 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:
W. David Patton, PhD.

14. TITLE:
Executive Director, Utah Department of Health

15. DATE SUBMITTED:
August 15, 2011

16. RETURN TO:

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

17. DATE RECEIVED:

18. DATE APPROVED:
OCT 13 2011

FOR REGIONAL USE ONLY

19. EFFECTIVE DATE OF APPROVED MATERIAL:
[redacted]

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
[redacted]

22. TITLE:
Deputy Director, CMCS

PLAN APPROVED – ONE COPY ATTACHED

23. REMARKS

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, bandaids, 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 item 3.

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, but should be billed directly. Such billings are to be made by the supplier and not the long-term care 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. Eye glasses, 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, therm al-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, canni ster, and associated dressings); and
    f. CPAP/Bi-PAP machine rental.

    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. Spec ifically 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.

927 QUALITY IMPROVEMENT INCENTIVE

In order for a facility to qualify for any Quality Improvement Incentive or Initiative in Subsections (3) or (4):

- The facility must submit all required documentation;
- The facility must clearly mark and organize all supporting documentation to facilitate review by Department staff;
- The facility must submit the application form and all supporting documentation for that incentive or initiative via fax or mail with a timestamp during the incentive period.
- Facilities that choose to mail in applications and supporting documentation are responsible to ensure that they submit the documents to the correct address, as follows:

Via United States Postal Service
Utah Department of Health
DMHF, BCRP
Attn: Reimbursement Unit
P.O. Box 143102
Salt Lake City, UT 84114-3102

Via United Parcel Service or Federal Express
Utah Department of Health
DMHF, BCRP
Attn: Reimbursement Unit
288 North 1460 West
Salt Lake City, UT 84116-3231

(1) Quality Improvement Incentive 1 (QII1):
  (a) Upon federal approval of the Nursing Care Facilities State Plan Amendment for the quality program outlined in this subsection (1), funds in the amount of $1,000,000 shall be set aside from the base rate budget annually to reimburse current Medicaid-certified non-ICF/MR facilities that have:
    (i) A meaningful quality improvement plan that includes the involvement of residents and family;
    (ii) A demonstrated process of assessing and measuring that plan;
    (iii) Customer satisfaction surveys conducted by an independent third party in each quarter of the incentive period, along with an action plan that addresses survey items rated below average for the year;
    (Iv) A plan for culture change along with an example of how the facility has implemented culture change;
    (v) An employee satisfaction program;
    (vi) No violations that are at an "immediate jeopardy" level as determined by the Department at the most recent re-certification survey and during the incentive period;
    (vii) A facility that receives a substandard quality of care level F, H, I, J, K, or L during the incentive period is eligible for only 50% of the possible reimbursement. A facility that receives substandard quality of care in F, H, I, J, K, or L in more than one survey during the incentive period is ineligible for reimbursement under this incentive.
  (b) The Department shall distribute incentive payments to qualifying, current Medicaid-certified facilities based on the proportionate share of the total Medicaid patient days in qualifying facilities.
  (c) If a facility seeks administrative review of the determination of a survey violation, the incentive payment will be withheld pending the final administrative adjudication. If violations are found not to have occurred, the Department will pay the incentive to the facility. If the survey findings are upheld, the Department will distribute the remaining incentive payments to all qualifying facilities.
  (d) This QII1 period is from July 1, 2011, through May 31, 2012.

(2) Quality Improvement Incentive (QII2):
- (a) Upon federal approval of the Nursing Care Facilities State Plan Amendment for the quality program outlined in this subsection (2) and in addition to the above incentive, funds in the amount of $4,275,900 shall be set aside from the base rate budget in State Fiscal Year 2012 to fund the quality improvement incentive for that state fiscal year.
- (b) Qualifying, current Medicaid-certified providers may receive $590.43 total, across all initiatives in this subsection (2), for each Medicaid-certified bed. The Medicaid-certified bed count used for each facility for this incentive and for each initiative in this incentive is the count in the facility at the beginning of the incentive period.
- (c) A facility may not receive more for any initiative than its documented costs for that initiative.
- (d) This QII2 period is from July 1, 2010, through May 31, 2012.
- (e) In order to qualify for any of the quality improvement initiatives in this subsection:
  - (i) A facility must purchase each item by the end of the incentive period, and install each item during the incentive period;
  - (ii) Applications must include a detailed description of the functionality of each item that the facility purchases, attesting to its meeting all of the criteria for that initiative;
  - (iii) A facility, with its application, must submit detailed documentation that supports all purchase, installation and training costs for that initiative. This documentation must include invoices and proof of purchase (i.e. copies of cancelled checks, credit card slips, etc.). If proof of purchase and invoice amounts differ, the facility must provide detail to indicate the other purchases that were made with the payment, or that only a partial payment was made;
  - (iv) A facility must clearly mark and organize all supporting documentation to facilitate review by Department staff.
- (f) Each Medicaid provider may apply for the following quality improvement initiatives:
  - (i) Incentive for facilities to purchase or enhance nurse call systems. Qualifying Medicaid providers may receive $391 for each Medicaid-certified bed. Qualifying criteria include the following:
    - (A) The nurse call system is compliant with approved "Guidelines for Design and Construction of Health Care Facilities;"
    - (B) The nurse call system does not primarily use overhead paging; rather a different type of paging is used. The paging system could include pagers, cellular phones, personal digital assistant devices, hand-held radio, etc. If radio frequency systems are used, consideration should be given to electromagnetic compatibility between internal and external sources;
    - (C) The nurse call system shall be designed so that a call activated by a resident will initiate a signal distinct from the regular staff call system, and can only be turned off at the resident's location;
    - (D) The signal shall activate an annunciator panel or screen at the staff work area or other appropriate location, and either a visual signal in the corridor at the resident's door or other appropriate location, or staff pager indicating the calling resident's name and/or room location, and at other areas as defined by the functional program;
    - (E) The nurse call system must be capable of tracking and reporting response times, such as the length of time from the initiation of the call to the time a nurse enters the room and answers the call.
  - (ii) Incentive for facilites to purchase new patient lift systems capable of lifting patients weighing up to 400 pounds each. Qualifying Medicaid providers may receive $45 for each Medicaid-certified bed per patient lift, with a maximum of $90 for each Medicaid-certified bed.
  - (iii) Incentive for facilities to purchase new patient bathing systems. Qualifying Medicaid providers may receive $110 for each Medicaid-certified bed. To qualify, a facility must purchase patient bathing improvements that may be one or more of the following:

(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, etc.

(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;
(C) Computers and game consoles for patient use;
(D) Garden enhancements;
(E) Furniture enhancements for patients;
(F) Wheelchair washers;
(G) Automatic doors;
(H) Flooring enhancements; and
(I) Automatic Electronic Defibrilators (AED devices).

(v) Incentive for facilities to educate staff on quality. Qualifying Medicaid providers may receive $110 for each Medicaid-certified bed. The education or training must:
(A) Be by an industry-recognized organization; and
(B) Have a patient-centered perspective focused on improving quality of life or care for the patients.

(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. Qualifying Medicaid providers may receive $590.43 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 $111 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.

1195 QUALITY IMPROVEMENT INCENTIVE

(1) The incentive period is from July 1, 2011, through May 31, 2012.

(2) (a) The Department shall set aside $200,000 annually from the base rate budget for incentives to current Medicaid certified facilities. In order for a facility to qualify for an incentive:

(i) The application form and all supporting documentation for this incentive must be faxed in or mailed with a postmark during the incentive period. Failure to include all required supporting documentation precludes a facility from qualification.

(ii) Facilities choosing to mail in applications and supporting documentation are in addition responsible to ensure that documents are mailed to the correct address, as follows:
Via United States Postal Service
Utah Department of Health
DMHF, BCRP
Attn: Reimbursement Unit
P.O. Box 143102
Salt Lake City, UT 84114-3102
Via United Parcel Service or Federal Express
Utah Department of Health
DMHF, BCRP
Attn: Reimbursement Unit
288 North 1460 West
Salt Lake City, UT 84116-3231

(iii) The facility must clearly mark and organize all supporting documentation to facilitate review by Department staff.

(b) In order to qualify for an incentive, a facility must have:

(i) A meaningful quality improvement plan which includes the involvement of residents and family;

(ii) A demonstrated means to measure that plan;

(iii) Customer satisfaction surveys conducted by an independent third-party in each quarter of the incentive period along with an action plan that addresses survey items rated below average for the year;

(iv) An employee satisfaction program; and

(v) No violations, as determined by the Department, that are at an "immediate jeopardy" level at the most recent re-certification survey and during the incentive period.

(vi) A facility receiving a condition level deficiency during the incentive period is eligible for only 50% of the possible reimbursement.

(c) The Department shall distribute incentive payments to qualifying facilities based on the proportionate share of the total Medicaid patient days in qualifying facilities.

(d) If a facility seeks administrative review of a survey violation, the incentive payment will be withheld pending the final administrative determination. If violations are found not to have occurred at a severity level of immediate jeopardy or higher, the incentive payment will be paid to the facility. If the survey findings are upheld, the Department shall distribute the remaining incentive payments to all qualifying facilities.