Table of Contents

State/Territory Name: Utah

State Plan Amendment (SPA) #: 18-0004

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
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

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

September 21, 2018

Dear State Medicaid Director:

On September 18, 2018, CMS approved UT SPA 18-0004. The initial approval package included the wrong version of pages that pertain to Section 1195. Enclosed are the corrected pages.

If you have any questions in reference to this letter 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

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

1. TRANSMITTAL NUMBER: 18-0004-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, 2018

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. FFY 2018 $+368,800
b. FFY 2019 $+1,106,400

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 1195 of Attachment 4.19-D

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Section 1195 of Attachment 4.19-D

10. SUBJECT OF AMENDMENT: Capital Improvement Incentive

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: Joseph K. Miner, M.D.

14. TITLE: Executive Director, Utah Department of Health

15. DATE SUBMITTED: April 9, 2018

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: SEP 18 2018

FOR REGIONAL USE ONLY

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

PLAN APPROVED – ONE COPY ATTACHED

23. REMARKS

1195 INCENTIVES

In order for an ICF/ID to qualify for any Quality Improvement Incentive or Initiative in Subsections (1) or (2):

- The ICF/ID must submit all required documentation;
- The ICF/ID must clearly mark and organize all supporting documentation to facilitate review by Department staff;
- The ICF/ID must submit the application form and all supporting documentation for that incentive or initiative via email, to qii_dmhf@utah.gov, or U.S. mail with a timestamp during the incentive period.
- ICF/IDs 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) The Department shall set aside $200,000 annually from the base rate budget for incentives to current Medicaid-certified ICF/IDs. In order for an ICF/ID to qualify for an incentive:
      i) The application form and all supporting documentation for this incentive must be emailed or mailed with a postmark during the incentive period. Failure to include all required supporting documentation precludes an ICF/ID from qualification.
      ii) The ICF/ID must clearly mark and organize all supporting documentation to facilitate review by Department staff.
   b) In order to qualify for an incentive, an ICF/ID must have:
      i) A meaningful quality improvement plan which includes the involvement of residents and family with a demonstrated means to measure that plan (weighting of 50%);
      ii) Four quarterly customer satisfaction surveys conducted by an independent third party with the final quarter ending on March 31 of the incentive period, along with an action plan that addresses survey items rated below average for the year (weighting of 25%);
      iii) An employee satisfaction program (weighting of 25%); and
      iv) 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.
      v) An ICF/ID 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 ICF/IDs based on the proportionate share of the total Medicaid patient days in qualifying ICF/IDs.
   d) If an ICF/ID 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 ICF/ID. If the survey findings are upheld, the Department shall distribute the remaining incentive payments to all qualifying ICF/IDs.
   e) This QII1 period is from July 1st through May 31st of each State Fiscal Year for that State Fiscal Year.

2) Capital Improvement Incentive (CII)
   a) In addition to the above incentive, funds in the amount of $2,116,209 has been allocated to fund the CII for improvements made in State Fiscal Year 2019.
   b) Qualifying, current Medicaid-certified providers may receive an upper bound limit amount called CII limit amount which is equal to the CII total funds divided by the total number of qualifying Medicaid-certified beds as of July 1, 2018.
   c) This CII period is for improvements made from July 1, 2018 until June 30, 2019.
   d) In order to qualify for the CII:
      i) An ICF/ID must demonstrate proof of purchase and installation of the capital asset by June 30, 2019;
      ii) Applications, except the ICF/ID's final application, must be for at least 25% of the ICF/ID's base maximum allowable reimbursement.
      iii) An ICF/ID may submit applications between October 1, 2018 and June 30, 2019;
      iv) The ICF/ID's application must include a detailed description of how the capital improvement may support an individual's rights to privacy, dignity, respect, or autonomy;
      v) The ICF/ID's applications must include a detailed description of the capital item(s) purchased, attesting to its meeting the criteria for the initiative. Capital items must meet the ICF/ID company policy for capital, are as defined in CMS Publication 15-1, and include the following:
         (1) Buildings;
         (2) Building Equipment;
         (3) Major Movable Equipment;
         (4) Land Improvements; or
         (5) Leasehold Improvements;
      vi) An ICF/ID, with its application, must submit detailed documentation that supports all purchases and installation of the capital item. 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 ICF/ID must provide detail to indicate the other purchases that were made with the payment, or that only a partial payment was made;
      vii) An ICF/ID must clearly mark and organize all supporting documentation to facilitate review by Department staff.
      viii) A facility may not receive more for this initiative than its documented costs for this initiative.
   e) Any funds that have not been disbursed for the CII are available to reimburse qualifying ICF/IDs that spent more than the base maximum allowable reimbursement noted in Subsection (2)(b) above.
   f) The Department shall distribute incentive payments to qualifying, current Medicaid-certified ICF/IDs based on the following example which is for illustrative purposes only:

1100 ICF/IDs (Continued)

					CII Pool	$2,116,209.00
					Beds	310
					Base amount per bed	$6,826.48
Facility	**Beds**	**Max Allowed**	**Actual**	**Over/(Under)**	**Percent of Over**	**Allocation of Under**
1	16	$109,223.69	$100,000.00	($9,223.69)	0.0%	$0.00
2	80	$546,118.45	$565,000.00	$18,881.55	33.7%	$18,881.55
3	100	$682,648.06	$700,000.00	$17,351.94	30.9%	$17,351.94
4	50	$341,324.03	$350,000.00	$8,675.97	15.5%	$8,675.97
5	24	$163,835.54	$175,000.00	$11,164.46	19.9%	$11,164.46
6	40	$273,059.23	$225,000.00	($48,059.23)	0.0%	$0.00
Totals	**310**	**$2,116,209.00**	**Over Spend**	**$56,073.92**	**100.0%**	**$56,073.92**
			Under Spend	**($57,282.92)**		

Example Narrative

Column 1: This represents the distinct ICF/ID.
Column 2: This represents the number of Medicaid-certified beds in the distinct ICF/ID.
Column 3: This represents the maximum amount of money allowed to be reimbursed through the CII to an ICF/ID based on the number of Medicaid-certified beds (Base amount per bed multiplied by the number of beds).
Column 4: This represents the actual amount of reimbursed capital expenses received by an ICF/ID.
Column 5: "Over/(Under)" represents the amount of over or under spend of an ICF/ID (Actual minus Max Allowed).
Column 5: "Over Spend" represents the sum for just the facilities that were over the max allowed.
Column 5: "Under Spend" represents the sum for just the facilities that were under the max allowed.
Column 6: "Percent of Over" represents the facility's proportion of the "Over Spend".
Column 7: "Allocation of Under" is the product of multiplying the facility's "Percent of Over" by the absolute value of the "Under Spend" amount. This is the additional amount the facility may receive based on other facilities underspending.