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State/Territory Name: Utah

State Plan Amendment (SPA) #: 19-0012

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
1961 Stout Street, Room 08-148
Denver, CO 80294

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

Denver Regional Operations Group

November 27, 2019

Nathan Checketts, Medicaid Director
Utah Department of Health
P.O. Box 141000
Salt Lake City, UT 84114-1000

Dear Mr. Checketts:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 19-0012. This SPA clarifies hospice payment policy relative to intermediate care facilities for individuals with intellectual disabilities (ICF/IID), freestanding hospice inpatient facilities, nursing facilities, and inpatient care facilities. It also aligns a cap period date range with Medicare.

Please be informed that this State Plan Amendment was approved today with an effective date of October 1, 2019. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Mandy Strom at (303) 844-7068.

Sincerely,

[redacted]

Richard C. Allen
Director, Western Regional Operations Group
Denver Regional Office
Centers for Medicaid and CHIP Services

cc: Kevin Bagley, Utah
Craig Devashrayee, Utah

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: 19-0012-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
October 1, 2019

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 1905(o) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2020 $0
b. FFY 2021 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Pages 28 and 28a of ATTACHMENT 4.19-B

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Pages 28 and 28a of ATTACHMENT 4.19-B

10. SUBJECT OF AMENDMENT: Payment for Hospice Services

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: September 30, 2019

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:
September 30, 2019

18. DATE APPROVED:
November 27, 2019

FOR REGIONAL USE ONLY

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Richard C. Allen

22. TITLE:
Director, WROG

PLAN APPROVED – ONE COPY ATTACHED

23. REMARKS

FORM HCFA-179 (07-92)

PAYMENT FOR HOSPICE SERVICES

Medicaid payments for hospice services will be made at one of five predetermined rate categories that coincide with the categories established under Medicaid. The Medicaid hospice rates will be equal to the Medicaid hospice rates published annually by the Centers for Medicare and Medicaid Services (CMS). Additionally, the hospice payments will be adjusted to specify the differences in the hospice wage index as published by CMS. For each day that an individual is under the care of a Medicaid-certified hospice agency, the hospice agency will be paid in accordance with the established Medicaid fee schedule. Payment rates are based on the type and intensity of the services furnished to the individual for a given day according to one of the following levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care. All of these levels of care are paid on a per diem basis other than continuous home care that is paid on an hourly basis. Routine home care services are divided into two discrete levels of care that include: Routine Home Care, Days 1-60; and Routine Home Care, 61+. Payments are made according to the area in which the service was provided, not according to the billing office location. Payment to the hospice agency may be considered retroactive to allow the hospice eligibility date to coincide with the Medicaid eligibility date, if the hospice service met the prior authorization criteria at the time service was delivered, and if no other provider was reimbursed by Medicaid for care related to the individual's terminal illness. The hospice agency must provide documentation to the Medicaid agency that demonstrates its service met all prior authorization criteria at the time of delivery.

Concurrent Care for Recipients Under 21 Years of Age

Concurrent treatment allowed under the State Plan for a terminal illness and other related conditions is available to recipients who are under 21 years of age and elect to receive Medicaid hospice care. For life-prolonging treatment provided to these recipients, Medicaid shall reimburse the appropriate Medicaid-enrolled medical care providers directly through the usual and customary Medicaid billing procedures.

Agency Services Delivered in Conjunction with Nursing Home Services

For a recipient in a nursing facility, Intermediate Care Facility for Individuals with Intellectual disability (ICF/ID), or freestanding hospice inpatient facility who elects to receive hospice service from a Medicare-certified hospice agency, Medicaid will pay the hospice agency an additional per diem (for routine home care days only) to cover the cost of room and board in the nursing facility. The room and board rate will be 95 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider (facility/provider "specific rate") if the recipient had not elected to receive hospice care. For freestanding hospice inpatient facilities, the room and board rate is 95 percent of the statewide average paid by Medicaid for nursing facility services.

For a recipient who is under 21 years of age, the room and board rate will be 100 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider if the recipient had not elected to receive hospice care. For freestanding hospice inpatient facilities, the room and board rate is 100 percent of the statewide average paid by Medicaid for nursing facility services. With the election to receive hospice services, Medicaid payment to the nursing facility discontinues and the hospice agency pays the nursing facility the cost of room and board. In this context, room and board costs are for the performance of personal care services that include daily living assistance, social activities, administration of medication, room maintenance, supervising and assisting in the use of durable medical equipment and prescribed therapies, and other services associated with a nursing home inpatient stay. The hospice provider is responsible for passing the room and board payment through to the nursing facility.

PAYMENT FOR HOSPICE SERVICES (Continued)

Service Intensity Add-On

Effective for dates of service on and after January 1, 2016, Medicaid hospice providers may receive a Service Intensity Add-On payment (SIA) for client's receiving routine home care by the registered nurse and the clinical social worker during the last seven days of the recipient's life. The SIA payment is provided under the following conditions:

1) SIA payment is provided in addition to the routine home care rate.

2) To qualify for SIA payment, the SIA visit must be a minimum of 15 minutes but not more than four hours combined for both nurse and social worker per day.

3) SIA rates will be equal to the rates established by CMS for each geographical area of the state. The SIA payment amount is calculated by multiplying the Continuous Home Care (CHC) rate per 15 minutes by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages.

Limitation for Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning October 1 of each year and ending September 30 (cap period), the aggregate number of inpatient days (both for general inpatient care and inpatient respite care may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied on an agency-wide basis and is not applied to individual patient stay services. At the end of each cap period, the Department calculates a limitation on payment of inpatient care for each hospice, to ensure that Medicaid payment is not made for days of inpatient care (including inpatient respite and general inpatient care) that exceed 20 percent of the total number of days of hospice care furnished to Medicaid recipients. The hospice agency then repays the Medicaid program a "prorated" share of total inpatient payment. This repayment will be computed as follows: [("Excess" Medicaid inpatient days/total paid Medicaid inpatient days) X (payment rate per diem)]. The inpatient care limitation does not apply to individuals with AIDS or to individuals who are under 21 years of age and receiving life-prolonging treatment for a terminal illness.