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State/Territory Name: Utah

State Plan Amendment (SPA) #: 24-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

August 12, 2026

Julie Ewing
Director
Division of Integrated Healthcare
Utah Department of Health and Human Services
PO Box 143101
Salt Lake City, UT 84114-3101

Re: Utah State Plan Amendment (SPA) 24-0003

Dear Director Ewing:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0003. This amendment proposes to add Non-State Government Owned or Operated (NGSO) Nursing Facility Upper Payment Limits and Routine Services Updates.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter informs you that Utah Medicaid SPA TN 24-0003 was approved on August 11, 2026, with an effective date of July 1, 2026.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Utah State Plan.

If you have any questions, please contact Lee Herko at (570) 230-4048 or via email at Lee.Herko@cms.hhs.gov.

Sincerely,

Mandy L Strom
Acting Deputy Director, Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

08/11/2026

Julie Ewing
State Medicaid Director
Utah Department of Health & Human Services
P.O. Box 143102
Salt Lake City, UT 84114-4102
RE: TN UT-24-0003

Dear Director Julie Ewing:

The Centers for Medicare & Medicaid Services (CMS) is sending this letter as a companion to our approval of Utah Medicaid state plan Amendment (SPA) 24-0003, submitted on March 29, 2024. CMS issued a formal request for additional information (RAI) to the state on June 25, 2024 and the state responded to the RAI on May 14, 2026. The state's proposed effective date for the SPA is July 1, 2026.

Utah submitted the amendment to align the state's nursing facility payment methodology, including base and supplemental payments, under the state plan with Medicare's Patient Driven Payment Model (PDPM) for skilled nursing facility services. Specifically, SPA 24-0003 proposed to align the state's nursing facility payments with State Medicaid Director (SMD) letter #22-005, wherein CMS provided guidance to states regarding Medicaid nursing facility upper payment limits (UPL) that are based on the PDPM methodology. The non-federal share of the proposed supplemental payments are funded through inter-governmental transfers (IGTs) from local government entities.

During CMS's review of SPA 24-0003, CMS identified concerns regarding the administrative fee arrangement associated with Utah's IGT arrangement under a contract between the Utah Department of Health and Human Services (UDHHS) and the University of Utah Medical Group (UUMG). Specifically, CMS identified concerns regarding the state's collection of contractual administrative charges from UUMG, a public entity serving as the IGT contributor, as a condition of participation in the supplemental payment program. In response to these concerns, the state has committed to CMS that it will sunset the IGT administrative fee arrangements program-wide by December 31, 2027.

Based on CMS's review of the information provided through SPA 24-0003, CMS identified the following concerns under applicable federal authorities:

> (1) Section 1902(a)(2) of the Social Security Act (the Act) establishes requirements for state and local financial participation in the non-federal share of Medicaid expenditures. CMS is concerned that the administrative fee arrangement may affect the amount or characterization of UUMG's actual governmental contribution toward the non-federal share. Since the state is requiring the collection of an administrative fee from UUMG as a condition of IGT participation and a condition on the receipt of a Medicaid supplemental payment, the net effect of the administrative fee may result in the reduction in the amount, amount, duration, scope, or quality of care and services available under the plan

as the provider is obligated to forfeit a portion of their revenue from the payment in the form of an administrative fee.

(2) Section 1902(a)(4) of the Act requires the state plan to provide for methods of administration the Secretary finds necessary for the proper and efficient operation of the plan. The amounts received by the state as a percentage of a provider's payment appear to have no clear relationship to the state's cost of IGT processing, which should not vary based on the amount of a provider's payment and may also be matched as a Medicaid administrative expenditure. CMS is concerned that, to the extent the administrative fee is calculated as a percentage of the amount of the funds received through an IGT to support the supplemental payment, the amounts collected are not proper and efficient consistent with section 1902(a)(4) of the Act.

(3) Section 1902(a)(30)(A) of the Act requires the state plan to provide methods and procedures related to the payment for care and services that assure that Medicaid payments are consistent with efficiency and economy, as well as quality of care and sufficient access. Administrative fees imposed on IGT contributors to cover the state's operations raise concerns that the net payment received by a provider is less than the amount of the payment that is approved under the Medicaid state plan which is approved on the basis that the payments are for care and services and the establish methods of payment are economic and efficient.

(4) Section 1903(a)(1) of the Act provides federal financial participation based on the applicable federal percentage of the "total amount expended" as medical assistance under the state plan. The administrative fees imposed on IGT contributors as a condition of payment raises concerns that the state may report and claim the full supplemental payment even though the related administrative fee returns a portion of that amount to the state or otherwise reduces the state's actual net expenditure. Further, conditioning a provider's service payment based on receipt of the IGT administrative fees may result in a reduction in amount, duration, scope, or quality of care and services under the plan because the source of non-federal share is only available if the provider also furnishes the administrative fee. As a result, the arrangement appears inconsistent with section 1902(a)(2) of the Act.

CMS acknowledges Utah's formal commitment to sunset the IGT administrative fee arrangement program-wide by December 31, 2027 and this letter memorialize our acceptance of that compliance timeline. We understand this time is necessary to allow the state to phase out the administrative fee collection in an orderly manner that minimizes disruption to Medicaid administrative operations while transitioning away from the arrangement identified in this letter.

We are committed to provide technical assistance as Utah transitions away from the current administrative fee arrangement and explores permissible alternative financing mechanisms consistent with federal requirements. If you have any questions regarding this companion letter, please contact Tom Caughey at Tom.caughey@cms.hhs.gov and Monica Neiman at monica.neiman@cms.hhs.gov.

Sincerely

Rory Howe
Director
Financial Management Group

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24-0003

2. STATE: UT

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.150

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 14,536,600
b. FFY 2027 $ 58,146,300

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

ATTACHMENTS 3.1- A and 3.1-B, Attachment #4a

ATTACHMENT 4.19-B, Page 0

ATTACHMENT 4.19-D, Pages 9, 10, 11, 20, and Section 942

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

ATTACHMENTS 3.1- A and 3.1-B, Attachment #4a (T.N. ~~24-0003~~) T.N. 14-011
ATTACHMENT 4.19-D, Pages 9, 10, 11, 20 (T.N. 23-0006)
ATTACHMENT 4.19-D, Section 942 (T.N. 13-007)

9. SUBJECT OF AMENDMENT

NF NSGO UPL and Routine Services Updates - In accordance with SMD# 22-005, Utah is electing to define the scope of its nursing facility benefit to include services currently considered as non-routine to define a comprehensive benefit like Medicare's.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Julie Ewing

13. TITLE
Division Director, Utah Division of Integrated Healthcare (DHHS)

14. DATE SUBMITTED
May 14, 2026

15. RETURN TO

Craig Devashrayee
Utah Department of Health & Human Services
Division of Integrated Healthcare
cdevashrayee@utah.gov

FOR CMS USE ONLY

16. DATE RECEIVED
March 19, 2024

17. DATE APPROVED
August 11, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2026

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Mandy L. Strom

21. TITLE OF APPROVING OFFICIAL
Acting Deputy Director, Division of Program Operations

22. REMARKS

State authorizes pen and ink change on August 10, 2026 to update Box 8 to reflect T.N. 14-011.

Instructions on Back

SKILLED NURSING FACILITY SERVICES

LIMITATIONS

1. In accordance with section 1919(f)(7) of the Act, Residents may be charged for the following personal hygiene items and services:
   a. Cosmetic and grooming items and services in excess of those included in the basic service including specialized or professional beauty salon/barber services requested by the resident (i.e., specialized hair styling, perms, hair coloring, or barber services beyond routine hygienic grooming, etc.);
   b. Private room, except when therapeutically required (e.g., isolation for infection control).;
   c. Specially prepared alternative food and meals requested for personal preference instead of the food and meals generally prepared by the facility to the extent allowed under 42 CFR 483.10;
   d. Telephone, television, radio, personal computer, and cellular phone;
   e. Personal comfort items including tobacco products and confections;
   f. Personal clothing;
   g. Personal reading materials;
   h. Gifts purchased on behalf of a resident;
   i. Flowers and plants;
   j. Social events and activities beyond the facility's activities program, provided under Activities within 42 CFR 483.24; and
   k. Non-covered special care services not included in the facility's Medicaid payment such as privately hired nurses or aides.

2. In accordance with ATTACHMENT 4.19-D, Nursing Home Reimbursement, each nursing facility must provide the following personal hygiene items and services (and residents may not be charged for):
   a. Nursing and related services;
   b. Specialized services as noted in 42 CFR 483.65;
   c. Pharmaceutical services (with assurance of accurate acquiring, receiving, dispensing, and administering of drugs and biologicals);
   d. Food and nutrition services as required under 42 CFR 483.60;
   e. Professionally directed program of activities to meet the interests and needs for well-being of each resident provided under 42 CFR 483.24(c);
   f. Emergency dental services (and routine dental services to the extent covered under the State Plan);
   g. Room and bed maintenance services;
   h. Routine personal hygiene items and services as required to meet the needs of residents as described in 42 CFR 483.10.; and
   i. Hospice services elected by the residents as noted in 42 CFR 483.10.

3. In accordance with ATTACHMENT 4.19-D, Nursing Home Reimbursement, the Routine and Non-Routine Services sections describe services included and excluded from the daily rate.

4. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. the proposed services are medically appropriate; and
   b. the proposed services are more cost effective than alternative services.

5. In accordance with 42 CFR 440.40, nursing facility services must be ordered by and provided under the direction of a physician.

6. In accordance with 42 CFR 483 Subpart C, a preadmission screening and resident review (PASRR) is required for admission and continued stay at a nursing facility.

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General Reimbursement Exception

Services noted as "routine" in Attachment 4.19-D, Section 920, which are rendered by providers in this Attachment, are not reimbursable during the duration of the Medicaid member's stay in the facility. The daily rate paid to the nursing facility covers the "routine" services.

Due to differences in timing of claims submission, a provider may be reimbursed for a "routine" service from Attachment 4.19-D, which will later be denied and monies recovered.

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 the routine services, Section 430 provides a comprehensive list of non-routine services that may be billed directly. Any services, equipment or supplies not specifically identified in Section 430 are considered a routine service covered by the per diem rate 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 residents. The following list of items and services is intended to be illustrative and is not an all-inclusive list of routine services. 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 resident. The following types of items are 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, the administration of oxygen and related medications, assisting with feeding, incontinency care, tray service, and enemas.

2. Items furnished routinely and relatively uniformly to all residents, such as resident gowns, 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 expected to be available for use by individual residents 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.

6. Laundry services.

400 ROUTINE SERVICES (Continued)

7. Physical therapy, occupational therapy, speech language pathology services, including functional therapy assessments and plan-of-care examinations performed by a physical therapist, occupational therapist, or speech-language pathologist.

8. Non-emergency medical transportation.

9. 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).

10. Medical consultants providing administrative or facility-wide consultations.

11. All other services and supplies that are normally provided by long-term care providers that are not listed as non-routine in Section 430.

12. ICF/IID residents only: annual dental examination.

430 NON-ROUTINE SERVICES

These services are considered ancillary for Medicaid payment and constitute a comprehensive list of services and supplies that may be billed outside of the per diem rate. 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. Dental services (except annual examinations for ICF/IID residents).

2. Oxygen gas, liquid oxygen, and oxygen concentrators and associated supplies.

3. Prescription drugs.

4. Prosthetic devices as defined in Section 431.

5. Outpatient medical services provided for direct resident care by a qualified healthcare professional (QHP) practicing within their scope of licensure, education, and practice. This includes, but is not limited to, services provided by physicians, physician assistants, nurse practitioners, psychologists, podiatrists, optometrists, and audiologists. For the purposes of this section, these services explicitly exclude physical therapy, occupational therapy, and speech-language pathology services.

6. Laboratory and radiology.

7. Emergency ambulance transportation.

400 ROUTINE SERVICES (Continued)

8. Eyeglasses, dentures, and hearing aids.

9. Specialized equipment approved by Medicaid for individual residents. This equipment is currently limited to:

   a. customized wheelchairs: meaning a wheelchair measured, fitted, or adapted to an individual's body size, disability, and intended use, featuring customized modifications or components ordered by a physician or qualified healthcare professional (QHP);

   b. power wheelchairs.

10. Hyperbaric Oxygen Therapy.

11. Recreational Therapy when providing mental health services as prescribed by a mental health therapist.

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.

900 RATE SETTING FOR NFs

900 GENERAL INFORMATION

Rate setting is completed by Utah Medicaid. Cost and utilization data is evaluated from facility cost profiles. The annual Medicaid budget requests include inflation factors for nursing facilities based on the Producer Price Index published by the U.S. Department of Labor, Bureau of Labor Statistics, with consideration given to the inflation adjustments given in prior years relative to the Producer Price Index. The actual inflation will be established by the Utah State Legislature.

Effective July 1, 2026, the routine and non-routine services (see Section 400) are updated to align – with some exceptions – with Medicare's services covered under its Patient Driven Payment Model (PDPM) rates. Therefore, the Case Mix component of the Medicaid rates will be increased to account for the services moved from non-routine services to routine services. The increased amount will be based on the net cost of those newly designated services from services provided in calendar year 2025. The changes in the routine and non-routine services are also effective beginning July 1, 2026.

920 RATE SETTING

The base line per diem rate for all residents in the facility consists of:

1) a Case Mix component (See Section 921),
2) a flat rate component (See Section 922), and
3) a property component (See Section 600).

942 SUPPLEMENTAL PAYMENTS TO PARTICIPATING NON-STATE GOVERNMENT-OWNED (NSGO) NURSING FACILITIES

In addition to the uniform Medicaid rates for nursing facilities, any nursing facility that is owned by a non-state governmental entity and has an agreement with the Division of Medicaid and Health Financing ("Division") to participate in the supplemental payment program may receive a supplemental payment, which shall not exceed its upper payment limit pursuant to 42 CFR 447.272.

UPL Calculation Overview

The Division shall calculate a supplemental payment amount for all non-state governmental nursing facilities that will not exceed the aggregate upper payment limit found at 42 CFR 447.272. For purposes of calculating the Medicaid nursing facility upper payment limits for non-State government-owned nursing facilities, the state shall utilize nursing facility specific Medicare PDPM rates calculated using the MDS data. The Medicare rates in effect at the start of each SFY for each component of PDPM using the Urban/Rural rate differentials, CBSA wage index adjustments, and the 100th day value will be used. The non-therapy ancillary (NTA) component of PDPM will be adjusted annually to exclude the estimated portion of payments related to pharmacy, laboratory, radiology, and oxygen services based on a statewide percentage derived from available Medicare cost report data to account for differences between Medicare and Medicaid coverage. The Medicaid upper payment limits for non-state government-owned nursing facilities are independently calculated. Each Medicaid upper payment limit shall be offset by nursing facility Medicaid and other third-party nursing facility payments to determine the available spending room (i.e., the gap) applicable to each Medicaid upper payment limit. In the future, if the Medicare PDPM reimbursement includes payment for services not covered by the State's nursing facility benefit, those costs will be removed from the PDPM rates if the State does not make comparable changes to the scope of its nursing facility benefit. Those costs will be removed in the same manner as the pharmacy, laboratory, radiology, and oxygen services. If the NTA component of the rate is not the appropriate component to reduce, the correct PDPM rate component will be adjusted. The state's UPL calculation will comply with the SMD #22-005.

Following is the data used to calculate the UPL for each payment period:

- MDS (Minimum Data Set) from the previously completed state fiscal year
- Medicare Rate Comparison from the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities
- Medicaid revenue – Paid nursing facility claims, including third party payment amounts, client contribution to care, Medicaid payments, and quality incentives from a previously completed state fiscal year as determined by the Division.

The facility-specific NSGO UPL per diem gap shall be calculated by subtracting the Medicaid weighted average per diem from the weighted average Medicare per diem the Division reasonably estimates would have been paid using Medicare payment principles. The data for the per diem gap calculation will come from the previously completed state fiscal year.

The difference between the annual estimated Medicare per diem rate and the adjusted annual Medicaid per diem rate is the per diem rate UPL gap.The facility-specific NSGO UPL per diem gap for facilities that were not Medicaid certified during the period of the UPL calculation shall be the weighted average per diem gap for the NSGO grouping.

The facility-specific NSGO UPL per diem gap for facilities that were not Medicaid certified during the period of the UPL calculation shall be the weighted average per diem gap for the NSGO grouping.