UTAH STATE PLAN ATTACHMENT 4.19-D

NURSING HOME REIMBURSEMENT

FOR SERVICES AFTER JUNE 30, 1981

NURSING HOME REIMBURSEMENT

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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STATE PLAN

100 GENERAL DESCRIPTION

110 INTRODUCTION

Attachment 4.19-D covers two types of providers. One is a licensed nursing facility (NF). The other is an intermediate care facility for individuals with intellectual disability (ICF/IID). The cost definition and reporting are similar.

200 DEFINITIONS

FACILITY means:	An institution that furnishes health care to residents.
PROVIDER means:	A licensed facility or practitioner who provides services to Medicaid clients.
STATE means:	The State of Utah, Department of Health and Human Services, Division of Integrated Healthcare.
ACCRUAL BASIS means:	That method of accounting wherein revenue is reported in the period when it is earned, regardless of when it is collected and expenses are reported in the period in which they are incurred, regardless of when they are paid.
PLAN means:	The Medicaid plan prepared by the State of Utah in response to Federal program requirements for Title XIX, ATTACHMENT 4.19-D.
CMS - PUB. 15-1 means:	The Medicare Provider Reimbursement Manual published by the U.S. Department of Health and Human Services that defines allowable cost and provides guidance in reporting costs.
RESIDENT DAYS means:	Care of one resident during a day of service. In maintaining statistics, the day of admission is counted as a day of care, but the day of discharge is not counted as a day of resident care.
FCP means:	The Facility Cost Profile (FCP) is the report filed by providers, containing revenue, cost and resident day data by financial classification, and bed data.
DEPARTMENT means:	Utah State Department of Health and Human Services.
NURSING FACILITY:	A licensed nursing facility (NF) that provides long term care.
ICF/IID means:	A licensed Intermediate Care Facility for individuals with intellectual disabilities that provides long term care.
ID/RC means:	Individuals with Intellectual Disabilities or Related Conditions
FRV means:	This is the Fair Rental Value of the facility as calculated each July 1. It reflects the fair rental market value of the facility. (See Section 634)

200 DEFINITIONS (Continued)

FRV DATA REPORT means:	The Fair Rental Value Data report is an optional report that provides the State with more timely information for inclusion in the FRV calculation.
LABOR COSTS means:	Labor costs as reported on the FCPs, but not including FCP reported management, consulting, director, and home office fees.
BED REPLACEMENT means:	As used in the fair rental value calculation, a capitalized project that furnishes a bed in the place of another, previously existing, bed. Room remodeling is not a replacement of beds. This must be new and complete construction.
MAJOR RENOVATION means:	As used in the fair rental value calculation, a capitalized project with a cost equal to or greater than $500 per licensed bed. A renovation extends the life, increases the productivity, or significantly improves the safety (such as by asbestos removal) of a facility as opposed repairs and maintenance which either restore the facility to, or maintain it at, its normal or expected service life. Vehicle costs are not a major renovation capital expenditure.
BED ADDITION means:	As used in the fair rental value calculation, a capitalized project that adds additional beds to the facility. This must be new and complete construction. An increase in total licensed beds and new construction costs support a claim of additional beds.
BED REDUCTION means:	As used in the fair rental value calculation, a reduction in licensed beds based on delicensing beds or transferring licensed beds to another facility.
URBAN PROVIDER means:	A facility located in a Weber, Davis, Utah, Salt Lake, Cache, or Washington county.
RURAL PROVIDER means:	A facility that is not an urban provider.

300 REPORTING AND RECORDS

310 INTRODUCTION

This section of the State Plan addresses five major areas: (1) the accrual basis of accounting; (2) reporting and record keeping requirements; (3) FCP reporting periods; (4) State audits; and (5) federal reporting.

320 BASIS FOR ACCOUNTING

Long-term care providers must submit financial cost reports which are prepared using the accrual basis of accounting in accordance with Generally Accepted Accounting Principles. To properly facilitate auditing and rate calculations, the accounting system must be maintained so that expenditures can be grouped in accounting classifications specified in the facility cost profile (FCP).

330 REPORTING AND RECORD KEEPING

The FCP is the basic document used for reporting historical costs, revenue and resident census data. The FCP is sent to providers at least 60 days prior to the due date.

The Fair Rental Value Data Report is used for reporting capital improvements and related items for use in the FRV calculation.

331 FACILITY COST PROFILES

The FCP represents the presentation of the costs involved in providing resident care. Therefore, it is essential that the FCPs are filed with accurate and complete data. The provider, and not the auditor authorized by the State, is responsible for the accuracy and appropriateness of the reported information.

331b FAIR RENTAL VALUE DATA REPORT

In order to recognize, in a timely manner, facility construction costs, this optional report must be submitted if the facility wishes the Department to include that information in calculating its Fair Rental Value.

332 REPORTING

FCP: The FCP is due three months after the end of the reporting period. (See Section 340). Failure to file timely FCPs may result in the withholding of payments as described in section 720.

300 REPORTING AND RECORDS (Continued)

FRV Data Report: This report is due on the first business day of March. This report is optional. It must be submitted for the data to be used in the following July 1 FRV calculation. Failure to submit this report, or having submitted it late, will preclude the information from being used in the following July 1 FRV calculation.

333 RECORD RETENTION

The State is responsible for keeping the FCPs on file for at least four years following the date of submission. The provider is responsible for maintaining sufficient financial, resident census, statistical, and other records for at least four years following the date of the FCP submission. These records are to be made available to representatives of the State and Federal Government. The records must be in sufficient detail to substantiate the data reported on the FCP.

340 REPORTING PERIODS

FCP: Generally, the FCP reporting period is for 12 months. However, when there is a new facility or a change in owners or operators, there may be reporting periods of less than 12 months. The reporting period is July 1 through June 30 for NFs and ICF/IIDs. Other reporting periods must be approved by the Department. For exceptions to the designated reporting period, the provider must submit a written request 60 days prior to the first day of the reporting period and have the request approved by Utah Medicaid.

FRV Data Report: Generally, the FRV Data Report reporting period is for 12 months. However, when there is a new facility or a change in owners or operators, there may be reporting periods of less than 12 months. Normally, the reporting period is March 1 through February 28 or 29.

350 STATE AUDITS

The State will desk review all FCPs and perform selective audits. In completing the audits, the State, either directly or through contract, will provide for an audit of selected FCPs. The auditor is responsible for verifying the reported allowable costs. The appropriateness of these costs is judged in accordance with the intent of the guidelines established in CMS-Pub. 15-1, except as otherwise stated in this plan. The agreed upon procedures, desk reviews, and selective audits are conducted in accordance with applicable standards established by the American Institute of Certified Public Accountants (AICPA). Audits are primarily oriented toward verification of costs reported on the FCP. In determining if the costs are allowable, the auditor examines documentation for expenditures, revenues, resident census, and other relevant data.

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 residents. 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 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, assisting with feeding, incontinency care, tray service, and enemas.

2. Items furnished routinely and relatively uniformly to all residents, such as resident 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 residents 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.

400 ROUTINE SERVICES (Continued)

7. Transportation to meet the medical needs of the resident, 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/IID residents 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 residents only).

2. Dental services (except annual examinations for ICF/IID residents).

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 resident care.

7. Laboratory and radiology.

8. Emergency ambulance for life threatening or emergency situations.

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

400 ROUTINE SERVICES (Continued)

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.

500 ALLOWABLE COSTS

501 GENERAL

Allowable costs will be determined using the Medicare Provider Reimbursement Manual (CMS-Pub. 15-1), except as otherwise provided in this Plan.

520 OWNERS COMPENSATION

Owners and their families may claim salary costs as permitted by CMS-Pub. 15-1.

530 FRINGE BENEFITS

Benefits are allowed as permitted by CMS-Pub. 15-1.

540 ALTERNATIVE PROGRAMS

Some long-term care providers provide specialized programs which are not covered by Medicaid. One such program is day care for older people living in their own homes. Such programs are carved out of the FCP as non-allowable costs. In completing the cost finding for the Medicaid program, two alternatives are available. First, at the election of the provider or when prior approval is not obtained, Medicare cost-finding methodology will apply. Under Medicare cost-finding the specialized program receives its share of overhead allocation on a step-down schedule incorporated in the annual cost report. However, the provider may submit and the State may approve, alternative revenue offsets as opposed to cost finding. Advance approval must be obtained prior to the beginning of the reporting period.

600 PROPERTY

600 INTRODUCTION

The purpose of this Section is to explain the calculation of the property component of the nursing care facility reimbursement rate. The property component will be calculated each July 1 using a Fair Rental Value methodology as discussed in Section 634.

600 PROPERTY (Continued)

634 FAIR RENTAL VALUE FOR PROPERTY

Property costs will be calculated and reimbursed as a component of the facility rate based on a Fair Rental Value (FRV) System.

(a) Under this FRV system, the Department reimburses a facility based on the estimated value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent or lease expenses. The FRV system establishes a nursing facility's bed value based on the age of the facility.

(i) The initial age of each nursing facility used in the FRV calculation is determined as of September 15, 2004, using each facility's initial year of construction.

(ii) The age of each facility is adjusted each July 1 to make the facility one year older.

(iii) The age is reduced for replacements, major renovations, or additions placed into service since the facility was built, provided there is sufficient documentation to support the historical changes.

A. If a facility adds new beds, these new beds are averaged into the age of the original beds to arrive at the facility's age. The number of beds added is obtained through the State’s facility licensing entity prior to calculating the FRV for the new rate period.

B. If a facility reduces beds, the reduced beds are subtracted from the total beds used. The number of beds added or reduced is obtained through the State’s facility licensing entity prior to calculating the FRV for the new rate period.

C. If a facility has replacement beds, these replacement beds are averaged into the age of the original beds to arrive at the facility's age.

I. The project must have been completed during a 24-month period, except during an emergency as declared by the president of the United States or the governor, affecting the building or renovation of the physical facility which may extend up to 24 additional months as approved by the Utah Medicaid director or designee, 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.

D. If a facility completed a major renovation, the cost of the project is represented by an equivalent number of new beds.

600 PROPERTY (Continued)

(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.

600 PROPERTY (Continued)

(ii) A nursing facility's annual FRV is calculated by multiplying the facility's newly calculated bed value times a rental factor. The rental factor is 9 percent.

(iii) The facility's annual FRV is divided by the greater of:

(A) the facility's annualized actual resident days during the cost reporting period; and
(B) for rural providers, 65 percent of the annualized licensed bed capacity of the facility and, for urban providers, 85 percent of the annualized licensed bed capacity of the facility.

(iv) The FRV per diem determined under this fair rental value system shall be no lower than $8.

(c) A pass-through component of the rate is applied and is calculated as follows:

(i) The nursing facility's per diem real property tax and real property insurance cost is determined by dividing the sum of the facility's allowable real property tax and real property insurance costs, as reported in the most recent FCP or FRV Data Report, as applicable, by the facility's actual total resident days.

(ii) For a newly constructed facility that has not submitted an FCP or FRV Data Report, the per diem real property tax and real property insurance is the average daily real property tax and real property insurance cost of all facilities in the FRV calculation.

For examples of fair rental value calculations, please go to https://medicaid.utah.gov/stplan/longtermcare/.

700 PAYMENT TO PROVIDERS

710 INTRODUCTION

Payments for routine nursing facility services will be made weekly as billed. These payments will be based on the established rate.

720 WITHHOLDING PAYMENTS

To assure compliance with selected policy and to assure collection of outstanding obligations, the State may withhold payment for the following reasons:

1. Shortages in Resident Trust Accounts

   Upon written notification that an examination of a resident trust fund account revealed an irreconcilable shortage, the facility must make a cash deposit in the full amount of the shortage within 10 days of notification. Within 30 days of such notification, documentary evidence must be presented to Utah Medicaid attesting to this deposit. Failure to comply with this requirement will result in the withholding of the Title XIX payments. The cash transaction to transfer cash to the resident's account is not an allowable cost.

2. Untimely or inaccurate Facility Cost Profile (FCP) or FRV Data reports.

   If the provider fails to meet reporting period requirements, the State may withhold payment until such time as an acceptable FCP is filed. FCPs must be complete before they are considered filed. Reporting period requirements are specified in Section 332 titled "Reporting."

   If the facility fails to respond within ten business days to requests for information relating to desk review or audit findings relating to the facility's submitted FCP or FRV Data Report, the State may withhold payment until such time as an acceptable response is received.

3. Liabilities to the State

   When the State has established an overpayment, payments to the provider may be withheld. For ongoing operations, the Department will provide notice before withholding payments. The Department and provider may negotiate a repayment schedule acceptable to the Department for monies owed to the Department. The repayment schedule may not exceed 180 days.

700 PAYMENT TO PROVIDERS (Continued)

4. Failure to submit timely and/or accurate Minimum Data Set (MDS) data

MDS data is used in calculating each facility's quarterly case mix index. The State may withhold Title XIX payments until such time as the facility:

(a) becomes current in their MDS data submission as described in the Long-Term Care Facility Resident Assessment Instrument User's Manual; and/or
(b) corrects accuracy issues within their MDS data as described in the Long-Term Care Facility Resident Assessment Instrument User's Manual.

5. When the Department rescinds withholding of payments to a facility, it will resume payments according to the regular claims payment cycle.

730 LIMITATIONS ON PAYMENT

Payments will not exceed the upper limit for specific services as defined in 42 CFR 447.272.

800 APPEALS

810 RATE DISAGREEMENTS

Providers may challenge the payment rate established pursuant to Section 900 using the Administrative Hearing Procedures as contained in Administrative Rules (R410-14). This applies to which rate methodology is used as well as to the specifics of implementation of the methodology. Providers must exhaust administrative remedies before challenging rates in State or Federal Court.

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.

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).

900 RATE SETTING FOR NFs (Continued)

921 Case Mix Component

Minimum Data Set (MDS) data is used in calculating each facility's case mix index. This information is submitted by each facility and, as such, each facility is responsible for the accuracy of its data. (Inaccurate or incomplete data will be excluded from the calculation.) Case mix is determined by establishing a Case Mix weight for each Medicaid resident. Available Case Mix scores for each resident are combined with the scores of all other residents to establish a facility-wide case mix for all Medicaid residents in the facility. The facility-wide case mix is multiplied by a dollar conversion factor to arrive at a per diem amount for the facility payment rate. The "dollar conversion factor" is defined as the rate is established quarterly by the state. Raw food is considered to be included in this component.

The per resident day base rate, on average, for all facilities is composed of the three components; property component, Case Mix component and the flat rate component. An example of these components is as follows:

Component Amounts for July 1, 2022 (illustrative purposes only)

Property component:	$21.80
Case Mix Component:	$103.10
Flat Rate Component:	$92.67
Total Average Rate:	$217.57

Rates will be adjusted each July 1, based on the inflation factors adopted by the legislature, as set forth in Section 900, and FRV data that affect each of the components.

In addition to the base rate, the following add-on payments will be applied to qualifying facility payment rates in the proportion that the facility qualifies for the add-on factor. For example (as of 7/1/2022):

SRS	$21.88
Behavioral Complex	$7.52

Note: A resident may only be eligible for one add-on amount at any particular time. The facility case mix and resulting rate change will be computed quarterly.

900 RATE SETTING FOR NFs (Continued)

922 FLAT RATE COMPONENT

The flat rate is a fixed amount paid for all Medicaid residents and reflects the proportion of the overall nursing home rate that is considered to not be variable in nature. The flat rate category is increased periodically for inflation. The flat rate component includes:

(1) general and administrative,
(2) plant operation and maintenance,
(3) dietary (except raw food which is included in the Case Mix component including dietary supplements),
(4) laundry and linen,
(5) housekeeping, and
(6) recreational activities.

900 RATE SETTING FOR NFs (Continued)

924 NEW FACILITIES

Newly constructed or newly certified facilities' rates will be calculated as follows:

Property component: For a newly constructed or newly certified facility that has not submitted an FCP or FRV Data Report, the per diem property tax and property insurance is the average daily property tax and property insurance cost of all facilities in the FRV calculation.

Case Mix rate component: Newly constructed or newly certified facilities' Case Mix component of the rate shall be paid using the average case mix index. This average rate shall remain in place for a new facility until such time as adequate MDS data exists for the facility, whereupon the provider's case mix index is established. At the following quarter's rate setting, the Department shall issue a new case mix adjusted rate.

Flat rate component: The flat rate component will be the same for all facilities.

An existing facility acquired by a new owner will continue at the same case mix index and property cost payment established for the facility under the previous ownership.

(a) Subsequent quarter's case mix index will be established using the prior ownership facility MDS data combined with the new facility ownership MDS data.

(b) The property component will be calculated for the facility at the beginning of the next SFY as noted in Section 634.

900 RATE SETTING FOR NFs (Continued)

927 QUALITY IMPROVEMENT INCENTIVE

In order for a facility to qualify for any Quality Improvement Incentive or Initiative in Subsections (1) or (2) or (3):

- 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 email, to qii @utah.gov, no later than May 31st of each year.

(1) Quality Improvement Incentive 1 (QII1):

(a) 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/IID facilities that have:

(i) A meaningful quality improvement plan that includes the involvement of residents and family, which includes the following (weighting of 50%);

1) A demonstrated process of assessing and measuring that plan; and

2) 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;

(ii) A plan for culture change along with an example of how the facility has implemented culture change (weighting of 25%);

(iii) An employee satisfaction program (weighting of 25%);

(iv) No violations that are at an "immediate jeopardy" level as determined by the Department during the incentive period; and

(v) 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 resident 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 1st through June 30th of each State Fiscal Year for that State Fiscal Year.

(2) Quality Improvement Incentive 2 (QII2):

(a) In addition to the above incentive, funds in the amount of $4,275,900 shall be set aside from the base rate budget in each State Fiscal Year to fund the quality improvement incentive for that state fiscal year.

(b) Qualifying, current Medicaid-certified providers may receive an upper bound limit dollar amount called QII2 limit amount, which is equal to the QII2 total funds divided by the total number of qualifying Medicaid-certified beds at the beginning of that State Fiscal Year 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 1st of one year prior to the current State Fiscal Year through May 31st of the current State Fiscal Year.

(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 facilities to purchase new resident lift systems capable of lifting residents weighing up to 400 pounds each. Qualifying Medicaid providers may receive $45 for each Medicaid-certified bed per resident lift, with a maximum of $90 for each Medicaid-certified bed.

(iii) Incentive for facilities to purchase new resident bathing systems. Qualifying Medicaid providers may receive $110 for each Medicaid-certified bed. To qualify, a facility must purchase resident 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; and
(D) General improvements to the resident bathing/shower area(s).

(iv) Incentive for facilities to purchase or enhance resident life enhancing devices. Qualifying Medicaid providers may receive the QII2 limit amount for each Medicaid-certified bed. Resident life enhancing devices are restricted to:
(A) Telecommunication enhancements primarily for resident 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 resident security enhancement devices (e.g., cameras, access control systems, access doors, etc.);
(C) Computers, game consoles, or personal music system for resident use;
(D) Garden enhancements;
(E) Furniture enhancements for residents;
(F) Wheelchair washers;
(G) Automatic doors;
(H) Flooring enhancements;
(I) Automatic Electronic Defibrillators (AED devices);
(J) Energy efficient windows with a U-factor rating of 0.35 or less;
(K) Exercise equipment for group fitness classes (e.g., weights, exercise balls, exercise bikes, etc.);
(L) Environmental management programs (e.g. water management programs, disinfectant fogger, etc.); and
(M) Fall-reduction beds.

(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 resident 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 resident 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 resident 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 resident dignity devices. Qualifying Medicaid providers may receive $100 for each Medicaid-certified bed. Resident dignity devices are restricted to:
(A) Bladder scanner.
(B) Bariatric scale capable of weighing residents up to at least 600 pounds.

(xiii) Incentive for facilities to provide COVID-19 vaccinations for its employees with a minimum incentive value of $50 (e.g., cash, gift card, etc.) to each employee who received the full vaccination regimen. Qualifying Medicaid providers may receive $50 for each employee who received the full vaccination regimen not to exceed $300 per Medicaid-certified bed. The application must include a list of employees who received the full vaccination regimen, verification the employee received the incentive and each employee's signature attesting to each person's having met the parameters.

900 RATE SETTING FOR NFs (Continued)

(3) Quality Improvement Incentive 3 (QII3):

(a) Any funds that have not been disbursed annually for the Quality Improvement Incentive 2 (QII2) shall be set aside to reimburse current Medicaid-certified, non-ICF/IID, facilities that have:

(i) Current incentive period application with 100 percent qualification for the Quality Improvement Incentive 1 (QII1);

(ii) Applied for and received at least one of the QII2 reimbursements; and

(iii) Demonstrated culture change specific to resident choice and preferences. The facility must document how the following three resident choice areas have been implemented:

1) Awake time (when the resident wants to wake up and/or go to sleep);

2) Meal time; and

3) Bath time.

(b) The Department shall distribute incentive payments to qualifying, current Medicaid-certified, non-ICF/IID facilities based on the proportionate share of the total Medicaid resident days in qualifying facilities. This is similar to the distribution for QII1.

(c) This QII3 period is from July 1st through May 31st of each State Fiscal Year for that State Fiscal Year.

900 RATE SETTING FOR NFs (Continued)

930 BEHAVIORALLY CHALLENGING PATIENT ADD-ON

Non ICF/IID nursing facilities that document residents who have behaviorally challenging problems will be paid an “add-on” rate. The rate is $7.52 effective July 1, 2022. This add-on amount will be updated on an “as needed” basis or as noted in Section 900. A resident who qualifies for the Behaviorally Challenging Patient add-on rate shall not receive any other add-on amount (i.e., Specialized Rehabilitation Services, etc.). It is the responsibility of the provider to notify the department if the individual has a change in condition and may no longer qualify for this add-on rate.

To qualify for this add-on, a nursing facility must:

1) Demonstrate that the resident has a history of persistent disruptive behavior that is not easily altered and requires an increase in resources from nursing facility staff as documented by one or more of the following behaviors:
   a) The resident engages in wandering behavior with no rational purpose, is oblivious to their needs or safety, and places them self and others at significant risk of physical illness or injury;
   b) The resident engages in verbally abusive behavior where they threaten, scream or curses at others;
   c) The resident presents a threat of hitting, shoving, scratching, or sexually abusing other residents.
   d) The resident engages in socially inappropriate and disruptive behavior by doing of one of the following:
      i) Makes disruptive sounds, noises and screams;
      ii) Engages in self-abusive acts;
      iii) Inappropriate sexual behavior;
      iv) Disrobes in public;
      v) Smears or throws food or feces;
      vi) Hoards; or
      vii) rummages through others belongings.
   e) The resident refuses assistance with medication administration or activities of daily living ; or
   f) The resident's behavior interferes significantly with the stability of the living environment and interferes with other residents' ability to participate in activities or engage in social interactions.
2) Demonstrate that an appropriate behavioral intervention program has been developed for the resident.
   a) All behavior intervention programs shall:
   b) Be a precisely planned systematic application of the methods and experimental findings of behavioral science with the intent to reduce observable negative behaviors;

c) Incorporate processes and methodologies that are the least restrictive alternatives available for producing the desired outcomes;
d) Be conducted following only identification and, if feasible, remediation of environmental and social factors that likely precipitate or reinforce the inappropriate behavior;
e) Incorporate a process for identifying and reinforcing a desirable replacement behavior;
f) Include a program data sheet; and
g) Include a behavior baseline profile that consists of all of the following:
    i) Applicant name;
    ii) Date, time, location, and specific description of the undesirable behavior;
    iii) Persons and conditions present before and at the time of the undesirable behavior;
    iv) Interventions for the undesirable behavior and their results; and
    v) Recommendations for future action.
h) The interdisciplinary team shall include a behavior intervention plan that consists of all of the following:
    i) The applicant's name, the date the plan is prepared, and when the plan will be used;
    ii) The objectives stated in terms of specific behaviors;
    iii) The names, titles and signatures of persons responsible for conducting the plan; and
    iv) The methods and frequency of data collection and review.

931 SPECIALIZED REHABILITATION SERVICES (SRS) FOR INDIVIDUALS WITH ID/RC

Non ICF/IID nursing facilities with ID/RC clients who need specialized rehabilitative services may qualify for a special add-on payment rate. The rate is $21.88 effective July 1, 2022. This add-on amount will be updated on an “as needed” basis or as noted in Section 900. A resident who qualifies for the Behaviorally Challenging Patient add-on rate shall not receive any other add-on amount (i.e., Specialized Rehabilitation Services, etc.). It is the responsibility of the provider to notify the department if the individual has a change in condition and may no longer qualify for this add-on rate.

To qualify for this add-on, a nursing facility must demonstrate that the applicant meets the following criteria:

(1) The nursing facility must arrange for specialized rehabilitative services for residents with intellectual disabilities who are residing in nursing homes;
(2) The resident must meet the criteria for Nursing Facility III Level of Care (excluding residents who receive the intensive skilled or behaviorally complex rate);
(3) The resident must have a Preadmission Screening and Resident Review (PASRR) Level II Evaluation that indicates the resident needs specialized rehabilitation. The

900 RATE SETTING FOR NFs (Continued)

(4) nursing facility must assure that needed services are provided under the written order of a physician by qualified personnel; and
(5) The nursing facility must document the need for specialized rehabilitative services in the resident's comprehensive plan of care.
(6) Specialized rehabilitative services include but are not limited to:
    (a) Medication management and monitoring effectiveness and side effects of medications prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness;
    (b) The provision of a structured environment to include structured socialization activities to diminish tendencies toward isolation and withdrawal;
    (c) Development, maintenance, and implementation of programs designed to teach residents daily living skills that include but are not limited to:
        (i) Grooming and personal hygiene;
        (ii) Mobility;
        (iii) Nutrition, health and self-feeding;
        (iv) Medication management;
        (v) Mental health education;
        (vi) Money management;
        (vii) Maintenance of the living environment; and
        (viii) Occupational, speech, and physical therapy obtained from providers outside the nursing facility who specialize in providing services for persons with intellectual disabilities at the intensity level necessary to attain the desired goals of independence and self-determination.
    (d) Formal behavior modification programs;
    (e) Development of appropriate person support networks.

1000 SPECIAL RATES INTENSIVE SKILLED

1010 INTRODUCTION

The objective of this section of the State Plan is to provide incentives for skilled nursing facilities, long term acute care and rehabilitation hospitals to admit high cost residents from acute care hospitals. Typically, these residents are ventilator dependent or have a tracheostomy. Although the rate paid to a skilled nursing facility, long term acute care or rehabilitation hospital is much higher than the NF rate on average, it is less than the acute care hospital rate. A resident who qualifies for a special intensive skilled rate shall not receive any other add-on amount (i.e., Specialized Rehabilitation Services, Behaviorally Complex, etc.).

1020 RATE DETERMINATION

Each qualifying resident will have a contract rate which is determined by negotiations between the State and the skilled nursing facility, long term acute care or rehabilitation hospitals. The rate will consider specialized equipment and supplies as well as specialized care, including special rehabilitative needs. The rate will be in effect for a period specified in the contract.

1030 QUALIFYING RESIDENTS

To qualify for a special contract rate, the resident must meet the criteria of the intensive skilled level of care. Prior approval is required.

1100 ICF/IID FACILITIES

1101 INTRODUCTION

This section deals with two types of ICF/IID providers–community providers and the State Development Center.

1105 GENERAL INFORMATION

Rate setting for ICF/IID facilities is completed by Utah Medicaid. Cost and utilization data are evaluated from facility cost profiles. The annual Medicaid budget requests include inflation factors as noted in Section 900.

1110 BACKGROUND

As a result of the active treatment requirements imposed by federal regulations, special consideration is given to payment rates for ICF/IID. A specific all-inclusive flat rate is negotiated each year for the residents in each facility with the exception of the State Developmental Center (See Section 1190).

1111 RATE SETTING

A single per diem rate is paid for all residents in the facility. This rate consists of two components; namely, the property component computed by the Fair Rental Value (FRV) methodology explained in Section 600, and a flat rate (non-property) component covering all other costs. Individual facility rates will vary according to historical payment levels and reported FCP costs. Except as discussed below under “add-on payment for enhanced behavioral interventions,” the rate covers all services, including day training, normally provided by ICF/IID facilities. These rates will be adjusted periodically by inflation factors as discussed in Section 1105. These services are discussed in more detail in Section 400. In addition to Section 400, the following additional clarification is provided:

1. Psychological testing and evaluation, as well as brain stem tests, are covered in the flat rate.

2. Day treatment services are incorporated into the flat rate. These services may vary depending on the needs of the residents.

3. Transportation to day treatment centers is included in the ICF/IID flat rate.

1100 ICF/IID FACILITIES (Continued)

4. Add-on payment for enhanced behavioral interventions.

   The intent of the enhanced rate is to allow for the provision of additional habilitative services for a defined period of time (typically up to four weeks for individuals who have a primary diagnosis of ID/RC, and are experiencing significant behavioral difficulties within an ICF/IID facility setting). The additional habilitative services include, but are not limited, to the following:

   Crisis intervention (including one to one staff to resident ratio and intensified behavior management programming);

5. II. Psychiatric and other/additional professional consultations;

   III. Short-term crisis focused plan of care that accommodates the resident's on-going active treatment needs, while providing intensified services.

   Eligibility criteria for this add-on are as follows:

   I. Currently be a resident at the community based ICF/IID facility;

   II. Currently have resided in an ICF/IID for a minimum of 90 days (which will allow the facility to exhaust its normal habilitative service delivery systems);

   III. Identification by the facility's professional staff that the resident presents an imminent danger to self and others, as evidenced by assaultive behaviors, physical destruction of environment, acute psychosis, attempted suicide, identified clinical depression and other conditions that are not responsive to the individual's existing behavioral and medication program(s), as applicable, or to the facility's general behavior management approach(es) over a consistent and reasonable period of time.

   Facilities will be paid an add-on amount of $50.61 per resident day for those residents who have been approved for the Enhanced Behavioral Interventions add-on amount. This add-on amount will be updated annually in accordance with Section 1105. It is the responsibility of the provider to notify the department if the individual has a change in condition and may no longer qualify for this add-on rate.

6. ICF/IID Medically Complex Services Add-On rate.

   The Medically Complex Services add-on rate is designed to allow for the provision of additional services to ICF/IID residents that require an increase in resources due to the complexity of their medical condition.

   Medically Complex Services include the following:

I. Daily enteral feeding;
II. IV infusions with site monitoring;
III. Ostomy care;
IV. Wound treatment with daily monitoring of wounds; or
V. Insulin dependent diabetes

An ICF/IID must demonstrate that the resident meets the following criteria before the Department may authorize Medicaid coverage for the Medically Complex Services add-on rate.

Eligibility criteria for this add-on are as follows:

I. Daily enteral feeding;
II. IV infusions – at least daily IV or PICC line site monitoring and daily infusions;
III. Ostomy care – includes care for ileostomy, colostomy, and urostomy sites;
IV. Wound treatment – includes daily monitoring of open pressure ulcers, arterial wounds, or vascular wounds with dressing changes as ordered; and daily monitoring of a wound vac therapy site and replacing the dressing as ordered; or
V. Insulin dependent diabetes – glucose checks at least three times daily with sliding scale insulin order.

The provider must submit current documentation that the resident continues to require the medically complex services. Documentation must include, but is not limited to, the following:

I. Diagnosis of the primary condition which requires the medically complex services by a physician;
II. Current physician orders for treatment of the condition;
III. Medication administration records;
IV. Treatment records, both documented by the facility and any outside care specific to the medically complex condition;
V. Glucometer check records with sliding scale insulin administration;
VI. Wound care documentation including a description of the wound and status;
VII. Enteral feeding documentation, including dietician notes, how often and how the resident tolerated the treatment; and
VIII. Current medical care plan

Providers must notify the Department within 30 calendar days of a change in condition, change in treatment orders, and/or discontinuation of the medically complex services. It is the responsibility of the provider to notify the department if the individual has a change in condition and may no longer qualify for the add-on rate.

Facilities will be paid an add-on amount of $20.00 per resident day for those residents who have been approved for the Medically Complex Services add-on amount. This add-on amount will be updated annually in accordance with Section 1105.

1100 ICF/IID FACILITIES (Continued)

1112 INCORPORATION OF OTHER RULES

Facility Cost Profiles will continue to be required on an annual basis for reference and rate increase purposes. The reimbursement methodology for ICF/IID community providers incorporates sections 100 through 800 of Attachment 4.19-D to the State Plan.

1115 NEW OWNERS

An existing facility acquired by a new owner will continue with the same per diem payment rate established for the previous ownership.

1190 ICF/IID PUBLIC INSTITUTION

The ICF/IID public institution (Utah State Developmental Center) is to be reimbursed retrospectively. This institution stands alone as a special provider of services. The size and characteristics of this facility require an independent categorization.

The needs for this categorization include:

1. Its actual costs are not stated on a basis suitable for comparison with other ICF/IID.

2. It is approximately seven times larger than any other ICF/IID and, therefore, comparison between it and facilities which range in size from 15 to 83 beds is not appropriate.

3. The majority of the residents are profoundly impaired. They require more specialized and intensive services than ICF/IID residents in community facilities. The treatment of the ICF/IID public institution in a separate category was recommended by Lewin and Associates, a private consulting firm. In general, retrospective reimbursement uses an average per diem cost approach. Allowable costs are divided by resident days to determine the cost per resident day. Costs are reported on the facility cost profile (FCP). CMS Provider Reimbursement Manual (CMS-Pub. 15-1) is used to define allowable costs for FCP reporting purposes unless otherwise specified. One exception to the Provider Reimbursement Manual is the asset capitalization policy. This exception permits the ICF/IID public institution to only capitalize those assets costing more than $5,000.

1100 ICF/IIDICF/IID FACILITIES (Continued)

1195 INCENTIVES

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

- The ICF/IID must submit all required documentation;
- The ICF/IID must clearly mark and organize all supporting documentation to facilitate review by Department staff;

The ICF/IID must submit the application form and all supporting documentation for that incentive or initiative via email, to qii@utah.gov, no later than May 31st of each year.

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/IIDs. In order for an ICF/IID 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/IID from qualification.
      ii) The ICF/IID must clearly mark and organize all supporting documentation to facilitate review by Department staff.
   b) In order to qualify for an incentive, an ICF/IID 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 during the incentive period.
      v) An ICF/IID 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/IIDs based on the proportionate share of the total Medicaid resident days in qualifying ICF/IIDs.
   d) If an ICF/IID 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/IID. If the survey findings are upheld, the Department shall distribute the remaining incentive payments to all qualifying ICF/IIDs.

This QII1 period is from July 1st through June 30th of each State Fiscal Year for that State Fiscal Year.

1195 QUALITY IMPROVEMENT INCENTIVE

3) Quality Improvement Incentive 2 (QII2)
   a) In addition to the above incentives, funds in the amount of $967,700 have been allocated to fund the QII2 for facility improvements beginning in State Fiscal Year 2024.
   b) This QII2 period is for incentive programs completed from July 1 until May 31, of each State Fiscal Year.
   c) In order to qualify for the QII2:
      i) A facility must demonstrate proof of completing the incentive by the end of the defined period;
      ii) The facility's proposal and execution documentation must include a detailed description demonstrating how the selected categories were successfully implemented during the time period for which payment is being requested.
   d) Each Medicaid provider may apply for the following quality improvement incentives:
      ICF/IID
      i) Incentive for facilities to implement, for each resident, based upon the ability of the individual served, employment opportunity, work assessment, community integration or staff education programs. Qualifying ICF/IID facilities may receive a per bed amount calculated by dividing $967,700 by the sum of the ICF/IID Medicaid-certified beds as of July 1. An ICF/IID facility is limited to no more than 50 beds for this incentive. The sum of beds will not use more than 50 beds for any facility. The following qualifying criteria shall apply:
         (A) The facility shall select two programs under this Subsection (ii)(D), (E), (F), (G) or (H) to complete during the SFY;
         (B) The facility shall provide a proposal, no later than September 30 or within 30 days of approval of this State Plan amendment's (T.N. #23-0006) approval date, to the Department detailing how the QII(2)(d)(ii) payments will be utilized to establish and execute the selected programs during the SFY (25%);
         (C) The facility shall submit an application detailing the implementation of the proposal to the Department 30 days before the end of quarters 2, 3 and 4 or within 30 days of approval of this State Plan amendment's (T.N. #23-0006) approval date. The detail should denote how the selected QII(2)(ii) programs were successfully implemented during the quarter (25% for each quarter);

1195 QUALITY IMPROVEMENT INCENTIVE

(D) The proposal and execution applications for implementing an employment, vocational, orlife skills training opportunity program, uniquely tailored to each individual, shall include the following elements:

I. Employment opportunity (unless the individual is in school or of retirementage);
II. Vocational opportunity as required through the state vocational rehabilitationoffice (unless the individual is of retirement age); or
III. Life skills training or, for individuals of retirement age, retirement activities andoutings

(E) The proposal and execution applications for implementing a work assessment program shall address cognitive, physical, social, behavioral appropriateness, and communicationabilities appropriate for the work environment.

(F) The proposal and execution applications for implementing a community integration program shall address how the facility facilitates a community integration process with membership, community opportunity, normalized errands, housing, adaptive equipment, financial services, healthcare services, individualized interests, and transportation services.

(G) The proposal and execution application for implementing a staff education program shallinclude the following elements:

I. Resident rights; and
II. Community opportunity and integration resources;

(H) The proposal and execution application for implementing a COVID-19 staff vaccinationprogram including payment incentives of at least $50 for staff receiving the required dosage at the interval recommended by the manufacturer and booster or annual doses within 3 months of becoming eligible based on the most current CDC and ACIP recommendations. This includes staff who were fully vaccinated against COVID-19 prior to the start of SFY 2023. The application must include a list of employees who received the required dosage, verification the employee received the incentive and each employee's signature attesting to each person's having met the parameters.

(I) If COVID-19 restrictions interfere with the execution of the QII2(ii) program proposed forany given period, the ICF/IID may qualify for funds by demonstrating execution of the program with modifications appropriate during the national public health emergency as declared by the President of the United States for the program.

ii) Any funds having not been disbursed for the QII(2)(d)(ii) program are available to reimbursequalifying ICF/IID facilities having achieved 100% of eligible payment in QII(2)(d)(ii). The Department shall distribute incentive payments to qualifying ICF/IID facilities based on the proportionate share of unused funds divided by the number of Medicaid-certified beds as of July 1, not to exceed 50.

e) The Department shall distribute incentive payments to qualifying, current Medicaid-certified ICF/IID facilities based on the following example which is for illustrative purposes only:

1100 ICF/IIDs (Continued)

1195 QUALITY IMPROVEMENT INCENTIVE

ICF/ID QII(2)		
		Per Bed
QII Total	$967,700	
QII(2)(i)	$967,700	$2,389.38
QII(2)(ii)	$178,009	$717.78

			Quality Improvement QII(2)(i)						Remaining Balance QII(2)(ii)	
	# of Beds	Max # of Beds	QII2(i) Maximum Potential	QII2(i) Proposal	QII2(i)Q2	QII2(i)Q3	QII2(i)Q4	Not earned	Qualifying Bed Count	Total Award
A	12	12	$ 28,672.59	$ 7,168.15	$ 7,168.15	$ 7,168.15	$ 7,168.15	$ -	12	$ 8,613.34
B	15	15	$ 35,840.74	$ 8,960.19	$ 8,960.19	$ 8,960.19	$ 8,960.19	$ -	15	$ 10,766.67
C	16	16	$ 38,230.12	$ 9,557.53	$ 9,557.53	$ 9,557.53	$ 9,557.53	$ -	16	$ 11,484.45
D	16	16	$ 38,230.12	$ 9,557.53	$ 9,557.53	$ -	$ -	$ 19,115.06		$ -
E	16	16	$ 38,230.12	$ 9,557.53	$ -	$ 9,557.53	$ 9,557.53	$ 9,557.53		$ -
F	32	32	$ 76,460.25	$ 19,115.06	$ 19,115.06	$ -	$ -	$ 38,230.12		$ -
G	32	32	$ 76,460.25	$ 19,115.06	$ 19,115.06	$ 19,115.06	$ 19,115.06	$ -	32	$ 22,968.90
H	41	41	$ 97,964.69	$ 24,491.17	$ 24,491.17	$ 24,491.17	$ 24,491.17	$ -	41	$ 29,428.91
I	34	34	$ 81,239.01	$ 20,309.75	$ 20,309.75	$ 20,309.75	$ 20,309.75	$ -	34	$ 24,404.46
J	43	43	$ 102,743.46	$ 25,685.86	$ -	$ -	$ 25,685.86	$ 51,371.73		$ -
K	48	48	$ 114,690.37	$ 28,672.59	$ 28,672.59	$ 28,672.59	$ 28,672.59	$ -	48	$ 34,453.36
L	82	50	$ 119,469.14	$ 29,867.28	$ -	$ -	$ 29,867.28	$ 59,734.57		$ -
M	65	50	$ 119,469.14	$ 29,867.28	$ 29,867.28	$ 29,867.28	$ 29,867.28	$ -	50	$ 35,888.91
	452	405	$ 967,700.00	$241,925.00	$ 176,814.32	$ 157,699.26	$ 213,252.41	$ 178,009.01	248	$ 178,009.01

Example

Narrative

Column 1: This represents the distinct ICF/IID.
Column 2: This represents the number of Medicaid-certified beds in the distinct ICF/IID as of July 1, .
Column 3: This represents the number of Medicaid-certified beds in the distinct ICF/IID period allowed to be included in the payment calculation during theSFY.
Column 4: This represents the amount of money allowed for the distinct ICF/IID facility in QII(2)(i).
Column 5: This represents the amount of money earned by the distinct ICF/IID facility by successfully completing a proposal (25% of column 4).
Column 6: This represents the amount of money earned by the distinct ICF/IID facility by successfully executingthe proposal during quarter 2 (25% of column 4).
Column 7: This represents the amount of money earned by the distinct ICF/IID facility by successfully executingthe proposal during quarter 3 (25% of column 4).
Column 8: This represents the amount of money earned by the distinct ICF/IID facility by successfully executingthe proposal during quarter 4 (25% of column 4).
Column 9: This represents the amount of money not earned in QII(2)(i) by the distinct ICF/IID facility to be usedin QII(2)(ii).
Column 10: This represents the number of Medicaid-certified beds to be used as the denominator to calculatethe QII(2)(ii) amount awarded to the distinct ICF/IID facility.
Column 11: This represents the money awarded to the distinct ICF/IID facilities qualifying for QII(2)(ii).

1200 SUB-ACUTE CARE BEDS

The Department reimburses swing beds, transitional care unit beds, and small health care facility beds that are used as nursing facility beds, using the prior calendar year statewide average of the daily nursing facility rate.

1400 HOSPICE CARE

1410 INTRODUCTION

Hospice services are provided through home health agencies. The rates are described in Attachment 4.19-B Section DD.

2010 NURSING FACILITY EVACUATION PAYMENTS

For nursing facility evacuations due to a government declared disaster, the state agency shall make payments to evacuated facilities based on actual allowable costs incurred by the evacuating facilities as a result of the disaster, including payments made to receiving facilities for the care of evacuated residents. The allowable cost for payments made by an evacuating facility to a receiving facility shall be the lesser of actual payments to the receiving facility or the receiving facility's daily rate (based on the resident classification), less the property component of the rate. The allowable cost for payments made by an evacuating facility to a critical access hospital shall be the lesser of actual payments made to the critical access hospital or the Medicaid swing bed rate in effect during the period of the evacuation. The evacuating facility will continue to receive the daily rate (based on the resident classification) for the evacuated residents.

Payments made under this provision will not exceed, in the aggregate, the upper payment limit defined under 42 CFR 447.272. For the purposes of the upper payment limit calculation, a resident day shall only be counted once for any day that an evacuated resident is not in the evacuating facility but is in another location.

This provision will only be applicable during a government declared disaster. It begins when the government officially declares the disaster and lasts until the incident end date.

APPENDIX I

NURSING FACILITY - FACILITY COST PROFILE AND FRV DATA REPORT

The Facility Cost Profile and FRV Data Report are incorporated as part of this State Plan by reference. Copies of the forms are available, upon request, from division staff.

APPENDIX II

ICF/IID FACILITY COST PROFILE AND FRV DATA REPORT

The Facility Cost Profile and FRV Data Report are incorporated as part of this State Plan by reference. Copies of the forms are available, upon request, from division staff.

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 shall 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 RUG rates calculated using the MDS RUG data. 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.

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 Medicaid rate shall be adjusted to account for program differences in services between Medicaid and Medicare. A Medicaid inflation trend shall be determined based on the legislative appropriation adjustments as per Section 900 of this attachment. The appropriate trend, if any, used in the calculation shall be determined by the agency. 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.

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.