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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-09-013

This file contains the following documents in the order listed:

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

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations, CMSO

Dr. Sandeep Wadhwa, MD, MBA
Medicaid Director
Department of Health Care Policy
& Financing
1570 Grant Street
Denver, CO 80203-1818

DEC 17 2009

Re: Colorado 09-013

Dear Dr. Wadhwa:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-013. Effective for services on or after July 1, 2009, this amendment modifies the nursing facility reimbursement methodology. Specifically, the amendment reinstates the eight percent growth limitation on allowable health care services costs; and, revises the methodology for quality performance measures, cognitive loss/dementia or acquired brain injury, PASRR Level II residents, and the provider fee offset, from a per diem add-on payment to a supplemental monthly payment.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 09-013 is approved effective July 1, 2009. The HCFA-179 and the amended plan pages are attached.

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

Sincerely,

Cindy Mann
Director
Center for Medicaid and State Operations

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: 0 9 – 0 1 3
2. STATE: **COLORADO**
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS A NEW PLAN | **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

7. FEDERAL BUDGET IMPACT
a. FFY_2008-2009 $__(3,306,995)____
b. FFY_2009-2010 $_(13,227,979)_____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D
Pages 1 - 4a, 15, 15a 23, 23a, 31, 31a, 34-39a, 45 and 46

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D
Pages 1 - 4a, 15, 15a 23, 23a, 31, 31a, 34-39a, 45 and 46

10. SUBJECT OF AMENDMENT To bring the State Plan into compliance with SB 09-263, to be codified at 25.5-6-201 – 25.5-6-203, C.R.S. relating to reinstating the 8% growth limitation on health care services costs and changing from per diem to supplemental payments for cognitive loss/dementia, Level II PASRR residents, quality performance, provider fee offset and base rate per diem payments exceeding the statutory limitation on growth in the general fund.

11. GOVERNOR'S REVIEW *(Check One)*

GOVERNOR'S OFFICE REPORTED NO COMMENT | **X OTHER, AS SPECIFIED**

Governor's letter dated January 26, 2009

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Sandeep Wadwha, MD MBA

14. TITLE
Medicaid Director, Medical and Child Health Plan *Plus* Program Administration Office

15. DATE SUBMITTED

16. RETURN TO
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818
Attn: Rachel Gibbons

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED 12-17-09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
JUL 1 - 2009

20. SIGNATURE

21. TYPED NAME
William Lasowski

22. TITLE
Deputy Director, CMSO

The State of Colorado hereby finds and assures that the rates for long term care facilities are reasonable and adequate to meet the costs that efficiently and economically operated facilities must incur. A facility is considered to be operated efficiently and economically when it complies with the State and Federal licensing and certification requirements, applicable State reporting requirements at a patient per diem cost equal to or less than the maximum reasonable allowable cost ceilings, fair rental allowance payments and other payments standards specified in this Attachment 4.19-D.

NURSING FACILITY BENEFITS

Special definitions relating to nursing facility reimbursement.

1. "Acquisition Cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

2. "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the "Boechk Commercial Underwriter's Valuation System for Nursing Homes."

3. "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility providers in the state.

4. "Base rate" means the nursing facility per diem components of allowable health care, administrative and general and capital costs.

5. a. "Base value" means:

   i) For the fiscal year 1986-87 and every fourth year thereafter, the appraised value of a capital-related asset;

   ii) For each year in which an appraisal is not done pursuant to subparagraph (I) of this paragraph (a), the most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index.

b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

c. An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

6. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

7. "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

8. "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to registered nurses, licensed practical nurses, and nurses' aides.

9. "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.

10. "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.

11. "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of Medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's Medicaid residents as further specified in this section.

12. "Class I facility" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia.

13. "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.

14. "Direct or indirect health care services costs" means the costs incurred for patient support services, including the following:

    a. Salaries, payroll taxes, workers' compensation payments, training, and other employee benefits for registered nurses, licensed practical nurses, aides, medical records librarians, social workers, and activity personnel.

    b. Nonprescription drugs ordered by a physician.

    c. Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians, and therapies.

    d. Purchases, rentals, and costs incurred to operate, maintain, or repair health care equipment.

    e. Supplies for nurses, medical records personnel, social workers, activity personnel, and therapy personnel.

    f. Medical director fees.

    g. Therapies and other medically related services.

    h. Other patient support services determined and defined by the state board pursuant to rule.

15. "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each resource utilization group as of a specific point in time.

16. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

17. "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.

18. "Index" means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.

19. "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.

20. "Median per diem cost" means the average daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.

21. "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the federal Medicare and Medicaid programs.

22. "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.

23. "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.

24. "Nursing facility provider" means a facility provider that meets the state nursing home licensing standards established pursuant to section 25-1.5-103 (1) (a), C.R.S., and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

25. "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse's aides.

26. "Nursing weights" means numeric scores assigned to each category of the resource utilization groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.

27. "Provider fee" means a licensing fee, assessment, or other mandatory payment that is related to health care items or services as specified under 42 CFR 433.55.

28. "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

29. "Resource utilization groups" means the system for grouping a nursing facility's residents according to their clinical and functional statuses as identified from data supplied by the facility's minimum data set as published by the United States Department of Health and Human Services.

30. "Supplemental Medicaid payment" means a lump sum payment that is made in addition to a provider's per diem rate. A supplemental medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

SERVICES AND ITEMS INCLUDED IN THE PER DIEM PAYMENT

Payment to skilled and intermediate nursing facilities shall be an all inclusive per diem rate. This rate covers the necessary services to the resident, including room and board, as

1. Medicare statutes.

2. Medicare regulations.

3. Medicaid and Medicare guidelines.

4. Generally accepted accounting principles.

For class I nursing facilities, a payment rate for each participating nursing facility shall be determined on the basis of information on the MED-13, the Minimum Data Set (MDS) resident assessment information and information obtained by the Department or its designee retained for the purpose of cost auditing.

The nursing facility prospective per diem rate includes the following components:

1. Health Care.

2. Administrative and General.

3. Fair Rental Allowance for Capital-Related Assets.

In addition to the above per diem reimbursement components, a nursing facility prospective supplemental payment shall be made for:

1. Residents who have moderately to very severe mental health conditions, cognitive dementia or acquired brain injury.

2. Residents who have severe mental health conditions that are classified at Level II by the Medicaid program's Preadmission Screening and Resident Review assessment tool (PASRR).

3. Care and services rendered to Medicaid residents to recognize the costs of the provider fee. Only Medicaid's portion of the provider fee will be included in the supplemental payment. The provider fee supplemental payment shall not be equal to the amount of the fee charged and collected but shall be an amount equal to a calculated per diem fee charged multiplied by the number of Medicaid resident days for that facility. Costs associated with the provider fee are not an allowable cost on the MED-13.

4. Facilities that have implemented a program meeting specified performance criteria beginning July 1, 2009.

For class II and privately-owned class IV intermediate care facilities for the mentally retarded, a payment rate for each participating facility shall be determined on the basis of the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

The facility's prospective per diem rate includes the following components:

1. Health Care.

that, for state veteran nursing homes, the health care limit will be one hundred thirty percent (130%) of the median cost.

a. In determining the median cost, the cost of direct health care shall be case-mix neutral.

b. Actual days of care shall be counted, not occupancy-imputed days of care, for purposes of calculating the health care limit.

c. Amounts contained in cost reports used to determine the health care limit shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

i). The percentage change shall be rounded at least to the fifth decimal point.

ii). The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

6. Annually, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

7. The health care limit for health care reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent (8%) per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight-percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND MEDICAID CASE MIX INDEX (CMI):

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups

Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8. For each succeeding fourth year, the Department shall re-determine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

9. The reasonable price established by the median per diem costs determined each succeeding fourth year will be adjusted annually at July 1st for the three intervening years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

10. For fiscal years commencing on and after July 1, 2008, through the fiscal year commencing July 1, 2014, the state department shall compare a nursing facility provider's administrative and general per diem rate to the nursing facility provider's administrative and general services per diem rate as of June 30, 2008, and the state department shall pay the nursing facility provider the higher per diem amount for each of the fiscal years.

11. For fiscal years commencing on or after July 1, 2009, through the fiscal year commencing July 1, 2014, if a reallocation of management costs between the administrative and general costs and the direct and indirect health care costs causing a nursing facility provider's administrative and general costs to exceed the reasonable price established by the state department, a nursing facility provider may receive a higher per diem payment for administrative and general services than provided for in number 2 above.

For the purpose of reimbursing class II and privately-owned class IV intermediate care facilities for the mentally retarded a per diem rate for the cost of administrative and general services, the Department shall establish an annually readjusted schedule to reimburse each facility, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health care services costs and a fair rental allowance for capital-related assets.

1. In computing per diem cost, each intermediate care facility for the mentally retarded provider shall annually submit cost reports to the Department.

2. The per diem reimbursement rate will be total allowable costs for administrative and general and health care services (actual or the limit) divided by the higher of actual resident days or occupancy imputed days.

3. An inflation adjustment will be applied to the per diem administrative and general and health care reimbursement rates.

4. An incentive allowance for administrative and general costs may be included.

5. Each facility will be paid a per diem for capital-related assets.

percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

SUPPLEMENTAL MEDICAID PAYMENT FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES

In addition to the reimbursement components paid under Health Care Services and Administrative and General Costs and Fair Rental Allowance for Capital-Related Assets, the state department shall make a supplemental Medicaid payment to nursing facility providers who have residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. To reimburse the nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury, the state department shall calculate the payment based upon the resident's score on the Cognitive Performance Scale (CPS) used in the RUG-III Classification system and reported on the MDS form. Resident CPS scores range from zero (intact) to six (very severe impairment). The Department will compute the payment annually as of July 1, 2009, and each July 1 thereafter, and it shall be not less than one percent of the statewide average per diem base rate.

1. Annually the Department will identify those Medicaid residents with a CPS score of 4, 5, or 6 for each nursing facility. They will then calculate the percent of Medicaid residents with a CPS score of 4, 5, or 6 as a percentage of all Medicaid residents for the facility. This amount is the facility's CPS percentage. Annual Medicaid days for all Medicaid residents with CPS scores of 4, 5 or 6 are summed. These total days are multiplied by one percent of the statewide average nursing per diem base rate to determine the total payment required. That total required payment is then tiered to pay out based on one, two or three standard deviations from the mean.

2 The MDS for residents on the January roster will be the source data used in these calculations.

3. The state-wide mean (average) CPS percentage will be determined, along with the standard deviation from the mean.

4. Those facilities with a CPS percentage greater than the mean plus one, two or three standard deviations will receive a supplemental payment for their Medicaid residents with a CPS score of 4, 5, or 6 in accordance with the following table:
Mean plus one standard deviation $1.00

Mean plus two standard deviations $2.00
Mean plus three standard deviations $3.00

5. If the expected average supplemental payment for those residents receiving this payment is more or less than one percent of the average nursing facility base rate, the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid supplemental payment equal to one percent of the average nursing facility base rate.

6. These calculations will be performed annually to coincide with the July 1st rate setting process. Each facility's annual CPS supplemental payment will be calculated by taking the payment of $1, $2, or $3 multiplied by the number of Medicaid days for residents with a CPS score of 4, 5 or 6. The total annual payment is divided into twelve monthly supplemental payments.

7. If it is determined by the state department that the case-mix reimbursement includes a factor for nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury, the state department may eliminate the supplemental Medicaid payment to those providers who serve residents with severe cognitive dementia or acquired brain injury.

A supplemental Medicaid payment shall be made to nursing facility providers who serve residents who have severe mental health conditions that are classified at Level II by the Medicaid program's preadmission screening and resident review assessment tool (PASRR). The Department shall compute this payment annually as of July 1, 2009, and each July 1 thereafter.

1. Annually the Department will identify those Medicaid residents meeting the PASRR II criteria for each nursing facility.

2. The Department will determine the number of PASRR II days eligible for the PASRR II supplemental payment by taking the number of PASRR II residents in each facility on May 1st times 365 days. The Department will then calculate the aggregate PASRR II payment for each facility by taking the number of PASRR II eligible days times the PASRR II rate. That aggregate payment shall be divided by twelve for a monthly supplemental payment.

3. The per diem PASRR II rate will be calculated as two percent of the statewide average base rate.

4. These calculations will be performed annually to coincide with the July 1 rate setting process.

An additional payment will be made to facilities that offer specialized behavioral services to residents who have severe mental health conditions that are classified at a PASRR Level II. Specialized services include, but are not limited to, enhanced staffing in social services and activities, specialized training for staff on behavior management, creating resident specific written guidelines with positive reinforcement, crisis intervention and psychotropic medication training. Specialized programs also include daily therapeutic groups such as anger management, conflict resolution, effective communication skills, hygiene, art therapy, goal setting, problem solving, Alcoholics Anonymous and Narcotics Anonymous, in addition to stress management/relaxation groups such as Yoga, Tai Chi and drumming. Therapeutic work programming, community safety training, and life skills training that include budgeting and learning how to navigate public transportation and shopping, for example, are also required to increase the resident's skills for successful community reintegration.

In addition to the reimbursement rate components paid pursuant to Health Care Services and Administrative and General Costs and Fair Rental Allowance for Capital-Related Assets the state department shall pay a nursing facility provider a supplemental Medicaid payment for care and services rendered to Medicaid residents to offset payment of the provider fee. The Department shall compute this payment annually, as of July 1, 2009, and each July 1 thereafter.

1. Except for changes in the number of patient days, each July 1st the Department will estimate the funding obligation required to pay for the supplemental Medicaid payments related to Pay for Performance, CPS, PASRR II and will fund the base rate components of administrative and general, health care and capital to the extent the base rate exceeds the statutory limit on annual growth in the general fund share of the aggregate statewide average per diem rate described below.

2. Once the funding obligation is determined, that amount will be divided into twelve (12) supplemental monthly payments.

The following example illustrates how the state department will calculate the provider offset amount to be paid monthly to each facility:

Example Facility's Provider Fee Medicaid Supplemental Payment

7/1/xx provider fee per diem required to cover funding obligation	$7.30
TIMES: Expected non-Medicare patient days during the state fiscal year	17,000

EQUALS: 7/1/xx FY actual facility provider fees that will be paid	$124,100
MULTIPLIED BY: Percent of Medicaid days (15,000) to total patient days (20,000) during the state fiscal year	75%
EQUALS: Annual supplemental payment to offset the provider fee	$ 93,075
DIVIDED BY: Twelve (12) monthly supplemental payments	$ 7,756

The general fund share of the aggregate statewide average of the per diem base rate net of patient payment shall be limited to the statutory increase. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation on the annual increase. In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers being greater than the statutory increase in the general fund share of the aggregate statewide average of the per diem base rate net of patient payment, the amount of the average statewide per diem rate that exceeds the general fund share shall be paid as a supplemental Medicaid payment using the provider fee. If the provider fee is insufficient to fully fund the supplemental Medicaid payment, the supplemental Medicaid payment shall be reduced to all providers proportionately. The percentage will be determined in accordance with the following fraction: Legislative appropriations / The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for all Class I Nursing Facilities.

1. Non-state and federal payment percent: Annually the Department will determine the percent of nursing facility per diem rates and supplemental payments paid by non-state and non-federal fund sources. This determination will be based on an analysis of Medicaid nursing facility class I paid claims. A sample period of claims may be used to perform this analysis. The analysis will be prepared prior to the annual July 1st rate setting.

2. Legislative appropriation base year amount: The base year will be the state fiscal year (SFY) ending June 30, 2008. The legislative appropriation for the base year will be determined by multiplying each nursing facility's time weighted average Medicaid per diem rate during the base year by their expected Medicaid case load (Medicaid patient days) for the base year. This amount will be reduced by the non-state and non-federal payment percentage, and then the residual will be split between state and federal sources using the time weighted Federal Medical Assistance Percentage (FMAP) during the base year.

3. Medicaid case load for each facility will be determined using Medicaid paid claims data for the calendar year ending prior to the July 1st rate setting. Providers with less than a full year of paid claims data will have their case load annualized.

4. Preliminary state share: Effective July 1, 2009 and each succeeding year the Department shall calculate a preliminary state share commitment towards the class I Medicaid nursing facility reimbursement system. The preliminary state share shall be calculated using the same methodology used to calculate the legislative appropriation base year amount. The Medicaid per diem rates used in this calculation are the preliminary rates that would be effective July 1st prior to any rate reduction provided for within this section of the plan.

5. For the fiscal year beginning July 1, 2009 and each succeeding year the final state share of Medicaid per diem rates will be limited to the legislative appropriation amount from the base year increased by the statutory limitation over the prior SFY. These determinations will made during the July 1st rate setting process each year. If the preliminary state share (less the amount applicable to provider fees) is greater than the indexed legislative base year amount, proportional reductions will be made to the preliminary nursing facility rates to reduce the state share to the indexed legislative appropriation base year amount.

6. For the fiscal year beginning July 1, 2009 and each succeeding year, if the provider fee is insufficient to fully fund the supplemental Medicaid payments for pay for performance, CPS, PASRR II and the provider fee offset, the state department may suspend or reduce the supplemental Medicaid payments.

7. Provider fee revenue will first be used to pay the provider fee offset payment, then the state share of the base rate exceeding the statutory limitation on annual growth in the general fund, then pay for performance, then PASRR II and CPS. Any difference between the amount of provider fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share above.

8. Notwithstanding any other provision of law or any federal law that temporarily increases the federal matching participation rate for any fiscal year, payments to nursing facility providers from the general fund share of the aggregate statewide average of the per diem rate shall be calculated based on a fifty-percent federal match.

Starting July 1, 2009, the Department shall a make a supplemental Medicaid payment based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents (pay for performance). The payment will be based on a nursing facility's performance in the domains of quality of life, quality of care and facility management.

1. The nursing facilities pay for performance application includes specific performance measures in each of the domains: quality of life, quality of care and facility management. The application includes the following:

   a. The number of points associated with each performance measure;

   b. The criteria the facility must meet or exceed to qualify for the points associated with each performance measure.

2. The prerequisites for participating in the program are as follows:

   a. No facility with substandard deficiencies on a regular annual, complaint, or any other Colorado Department of Public Health and Environment survey will be considered for pay for performance. Per State Operations Manual, this is generally no H level deficiencies or above. No F's or higher in 221 - 226, 240 – 258, 309 - 312, 314, 315, 317 – 334.

   b. The facility must perform a resident/family satisfaction survey. The survey must (a) be developed, recognized, and standardized by an entity external to the facility; and, (b) be administered on an annual basis with results tabulated by an agency external to the facility. The facility must report their response rate, and a summary report must be made publically available along with the facility's State's survey results.

3. To apply the facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The facility must maintain documentation supporting its representations for each performance measure the facility represents it meets or exceeds the specified criteria. The required documentation for each performance measure is identified on the matrix and must be submitted with its application. In addition, the facility must include a written narrative for each sub- category to be considered that describes the process used to achieve and sustain each measure.

4. The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions. Applications and supporting documentation as received will be considered complete. No post receipt or additional information will be accepted for that application. Facilities will be selected for onsite verification of performance measures representations based on risk.

5. A nursing facility will accumulate a maximum of 100 points by meeting or exceeding all performance measures indicated on the application.

RATE EFFECTIVE DATE

For cost reports filed by all facilities except the State-administered class IV facilities, the rate shall be effective on the first day of the eleventh (11th) month following the end of the nursing facility's cost reporting period.

For 12-month cost reports filed by the State-administered class IV facilities, the rate shall be effective on the first day covered by the cost report.

The permanent rate shall be established, issued and shall pay Medicaid claims billed on and after the later of the following dates:

1. The beginning of the provider's new rate period, as set forth under Rate Effective Date.

financial participation under the state's medical assistance program. The provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

1. Each class I nursing facility that is licensed in this State shall pay a fee assessed by the state department.

2. The following nursing facility providers are excluded from the provider fee:

   a. A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living residences, or that provide assisted living services on-site, twenty-four hours per day, seven days per week, and skilled nursing care on a single, contiguous campus;
   b. A skilled nursing facility owned and operated by the state;
   c. A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and
   d. A facility that has forty-five or fewer licensed beds.

3. To determine the amount of the fee to assess pursuant to this section, the state department shall establish a rate per non-Medicare patient day that is equivalent to accrual basis gross revenue (net of contractual allowances) for services provided to patients of all class I nursing facilities licensed in this State. The percentage used to establish the rate must not exceed that allowed by federal law. For the purposes of this section, total annual accrual basis gross revenue does not include charitable contributions received by a nursing facility.

4. The state department shall calculate the fee to collect from each nursing facility during the July 1 rate-setting process.

   a. Each July 1, the state department will determine the aggregate dollar amount of provider fee funds necessary to pay for the following:
      (i) State department's administrative cost
      (ii) Provider Fee Offset Payment
      (iii) Excess of statutory limitation on growth in the general fund
      (iv) Pay for Performance
      (v) CPS
      (vi) PASRR

   b. This calculation will be based on the most current information available at the time of the July 1 rate-setting process.

c. The aggregate dollar amount of provider fee funds necessary will be divided by non-Medicare patient days for all class I nursing facilities to obtain a per day provider fee assessment amount for each of the two following categories:
(i) Nursing facilities with 55,000 non-Medicare patient days or more;
(ii) Nursing facilities with less than 55,000 non-Medicare patient days.

The state department will lower the amount of the provider fee charged to nursing facility providers with 55,000 non-Medicare patient days or more to meet the requirements of 42 CFR 433.68 (e).

d. Each facility's annual provider fee amount will be determined by taking the per day provider fee calculated above times the facility's reported annual non-Medicare patient days.

e. Each nursing facility will report monthly its total number of days of care provided to non-Medicare residents to the state department. Non-Medicare patient days reported in the year prior to the July 1 rate-setting process will be used as the facility's annual non-Medicare patient days for the provider fee calculation.

f. If a facility's actual non-Medicare patient days differ by more than 5% from the prior year reported non-Medicare patient days used to determine the provider's fee payment, the facility can request the state department, in writing, to review the facility's provider fee calculation. If the state department determines that the facility's actual non-Medicare patient days differ by more than 5% from the facility's non-Medicare patient days used to determine the facility's provider fee, an adjustment to the facility's annual provider fee payment will be made. The facility's annual provider fee will be based on actual non-Medicare patient days rather than reported days in the prior year.

g. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed the state department.

h. The state department shall assess the provider fee on a monthly basis.

i. The fee assessed pursuant to this section is due 30 days after the end of the month for which the fee was assessed.

All provider fees collected pursuant to this section by the state department shall be transmitted to the state treasurer, who shall credit the same to the Medicaid nursing facility cash fund, which fund is hereby created and referred to in this section as the 'fund'.