Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: 19-0003

This file contains the following documents in the order listed:

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

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

Financial Management Group

JAN 2 3 2020

John Bartholomew
Chief Financial Officer
Colorado Department of Health Care
Policy and Financing
1570 Grant Street
Denver, Co 80203-1818

Re: Colorado: 19-0003

Dear Mr. Bartholomew:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 19-0003. Effective for services on or after July 1, 2019, this amendment revises the reimbursement methodology for nursing facility MMIS claims based and supplemental Medicaid payments. Specifically, the amendment clarifies the various calculations as well as removes obsolete language.

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 19-0003 is approved effective July 1, 2019. The CMS-179 and the plan pages are attached.

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

Sincerely,

[redacted]

Kristin Fan
Director

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:	2. STATE:
19 – 0003	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, 2019

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:
Social Security Act 1905(a)(4)(A) / 42 CFR 440.155

7. FEDERAL BUDGET IMPACT:
a. FFY 2019-20: $12,000,000
b. FFY 2020-21: $12,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D – Nursing Facility Benefits – Pages 1-4a, 15 – 15a, 34-39a, and 44

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D – Nursing Facility Benefits – Pages 1-4a, 15-15a, 34-39c, and 44-47 (TN 09-013, 13-038, 08-0007)

9. SUBJECT OF AMENDMENT:
Revision to the nursing home MMIS claims based reimbursement rate and supplemental Medicaid payments intended to clarify the calculation of the rate/payment and to remove outdated language.

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

GOVERNOR'S OFFICE REPORTED NO COMMENT | **X OTHER, AS SPECIFIED**
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | **Governor's letter dated 29 March, 2018**
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
John Bartholomew

14. TITLE:
Chief Financial Officer

15. DATE SUBMITTED: Initial: May 22, 2019
Update #1: October 28, 2019

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

Attn: Lauren Reveley

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED
July 1, 2019	1/23/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL
	[redacted]
21. TYPED NAME: KRISTIN FAN	22. TITLE

23. REMARKS

FORM CMS-179 (07/92) *Instructions on Back*

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 but 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 FACLITY 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 improvements 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 an independent nationally recognized valuation system as determined by the Department. The valuation system used by the Department can be found in 10 CCR 2505-10 8.443.9.A.1(b) (2019).

3. "Array of facility providers" means a listing in order from the 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. a. "Base value" means:

   i) For the fiscal year 1986-87 and every fourth year thereafter, the appraised value of 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.

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

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

7. "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.

8. "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.

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

10. "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.

11. "Class I nursing facility provider" 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.

12. "Core Component per diem rate" means the per diem rate for direct and indirect health care services costs, administrative and general services costs, and fair rental allowance for capital-related assets for Class 1 nursing facility providers.

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, p
    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 provider 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 thal 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 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. "MMIS per diem reimbursement rate" means the per diem rate used for Medicaid Management Information Systems (MMIS) claims based reimbursement.

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

24. "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.

25. "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.

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

27. "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.

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

29. "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 on-quarter percent

30. "Resource utilization groups" means the system for grouping a nursing facility provider'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.

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

SERVICES AND ITEMS INCLUDED IN REIMBURSEMENT

Reimbursement to skilled and intermediate nursing facility providers shall be all inclusive. This shall cover 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.

Effective July 1 of each year, a MMIS per diem reimbursement rate for Class 1 nursing facility providers shall be established for reimbursement of billed claims.

1. The MMIS per diem reimbursement rate shall equal a nursing facility provider's Core Component per diem rate multiplied by a percent factor. The percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by 3.00%.

2. For State Fiscal Year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement or the SFY 2019-20 Core Component per diem rate.

3. A nursing facility provider shall be notified, in writing or by electronic notification, at least ten business day before any change to their Core Component per diem rate, MMIS per diem reimbursement rate or percent factor.

The Core Component per diem rate shall be determined using information on the MED-13, the Minimum Data Set (MDS) resident assessment information and information obtained by the Department or its designee retained for cost auditing purposes.

The Core Component per diem rate includes the following components:

1. Health Care,

2. Administrative and General, and

3. Fair Rental Allowance for Capital-Related Assets.

In addition to the MMIS per diem reimbursement rate, a Class I nursing facility provider may be reimbursed the following supplemental Medicaid payments.

1. Medicaid Utilization Supplemental Medicaid Payment,
2. Acuity Adjusted Core Component Supplemental Medicaid Payment,
3. Pay-for-Performance Supplemental Medicaid Payment,
4. Cognitive Performance Scale Supplemental Medicaid Payment,
5. Preadmission Screening & Resident Review II Resident Supplemental Medicaid Payment,
6. Preadmission Screening & Resident Review II Facility Supplemental Medicaid Payment, and
7. Core Component Supplemental Medicaid Payment.

For class II and privately-owned class IV intermediate care facilities for individuals with intellectual disabilities, 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,

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

SUPPLEMENTAL MEDICAID PAYMENTS FOR CLASS 1 NURSING FACILITY PROVIDERS

Cognitive Performance Scale Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to nursing facility providers who have residents with moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury based upon the resident's score on the Cognitive Performance Scale (CPS).

*(Medicaid CPS Resident Count * Days in Prior Calendar Year)*
** CPS Per Diem Rate*

1. Annually, the Department shall calculate the payment by multiplying a CPS per diem rate by CPS Medicaid days.

2. The CPS per diem rate shall be calculated based on the number of standard deviations a nursing facility provider's CPS percentage is above the statewide average CPS percentage. The CPS per diem rate shall be determined in accordance with the following table:

Standard Deviation Above Statewide Average	CPS Per Diem
Greater Than or Equal to Statewide Average + 1 Standard Deviation	1x
Greater Than or Equal to Statewide Average + 2 Standard Deviation	2x
Greater Than or Equal to Statewide Average + 3 Standard Deviation	3x

The CPS per diem rate multiplier (x) shall equal an amount such that the total statewide CPS supplemental Medicaid payment divided by total statewide CPS Medicaid days equal 1.00% of the statewide average MMIS per diem reimbursement rate as of July 1 of the state fiscal year.

3. The CPS percentage shall be the sum of Medicaid residents with a CPS score of 4, 5, or 6 divided by the sum of Medicaid residents.

4. CPS Medicaid patient days shall be the count of Medicaid residents with a CPS score of 4, 5, 6, or equivalent multiplied by the days in the calendar year ending prior to the state fiscal year.

5. A CPS score of 4, 5, or 6 shall be determined based on a Medicaid resident's score on the CPS used in the RUG-III classification system reported on the MDS assessment.

6. A Medicaid resident shall be included if they have an active MDS assessment on a nursing facility provider's most recent April roster.

7. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via Automated Clearing House (ACH) transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Preadmission Screening and Resident Review II Resident Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to nursing facility providers who serve residents with severe mental health conditions that are classified at Level II by the Medicaid program's Preadmission Screening and Resident Review (PASRR) tool.

*(Medicaid PASRR II Resident Count * Days in Prior Calendar Year) * (2.00% * Statewide Average MMIS Per Diem Reimbursement Rate)*

1. Annually, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.

2. The PASRR II per diem rate shall equal 2.00% of the statewide MMIS per diem reimbursement rate as of July 1 of the state fiscal year.

3. Medicaid PASRR II days shall be the count of Medicaid PASRR II residents multiplied by the days in the calendar year ending prior to the state fiscal year.

4. A Medicaid PASRR II resident shall be determined based on the most recently completed MDS assessment occurring during the previous 365 days ending May 1 of the prior state fiscal year.

5. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer..

Preadmission Screening and Resident Review II Facility Supplemental Medicaid Payment

The Department shall pay a supplemental Medicaid payment to facilities that offer specialized behavioral services to residents who have severe behavioral health needs. These services shall include enhanced staffing, training, and programs designed to increase the resident's skills for successful community reintegration.

If specialized behavioral services nursing facility provider then:
*(Medicaid PASRR II Resident Count * Days in Prior Calendar Year) **
*(2.00% * Statewide Average MMIS Per Diem Reimbursement Rate)*

1. Annually, the Department shall determine those nursing facility providers with a specialized behavioral services program. A nursing facility provider has a specialized behavioral services program if they can demonstrate annually that they provide additional staff training/credentialing, therapeutic groups and work programs, life skills training, community reintegration efforts, and a Memorandum of Understanding with local mental health providers in March of the prior state fiscal year.

2. For those nursing facility providers with a specialized behavioral services program, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.

3. The PASRR II per diem rate shall equal 2.00% of the statewide MMIS per diem reimbursement rate as of July 1 of the state fiscal year.

4 Medicaid PASRR II days shall equal the count of PASRR II residents on May 1, multiplied by the days in the calendar year ending prior to the state fiscal year.

5. A Medicaid PASRR II resident shall be determined based on the most recently completed MDS assessment occurring during the previous 365 days ending May 1 of the prior state fiscal year.

6. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Medicaid Utilization Supplemental Medicaid Payment

The Department shall pay a nursing facility provider a supplemental Medicaid payment for care and services rendered to Medicaid residents.

1. Annually, the Department shall calculate the percentage of Medicaid patient days to total patient days.

2. The percentage of Medicaid patient days shall then be multiplied by the Provider Fee.

3. Percentage of Medicaid patient days shall be Medicaid patient days divided by total patient days.

4. Medicaid patient days shall be from the MMIS for the calendar year prior the state fiscal year. Total patient days shall be from the nursing facility provider for the calendar year.

ending prior to the state fiscal year.

5. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Core Component Supplemental Medicaid Payment

The Department shall pay a nursing facility provider a supplemental Medicaid payment for the difference between their MMIS per diem reimbursement rate and Core Component per diem rate.

1. Annually, the Department shall calculate the difference between the MMIS per diem reimbursement rate and the Core Component per diem rate. The difference shall then be multiplied by applicable Medicaid patient days.

2. Applicable Medicaid patient days shall be Medicaid patient days divided by days in the calendar year ending prior to the state fiscal year, multiplied by the days the Core Component per diem rate was effective.

3. Medicaid patient days shall be from the MMIS for the calendar year ending prior to the state fiscal year the Core Component per diem rate was effective.

4. For SFY 2019-20, the Department shall include the difference between the SFY 2018-19 MMIS per diem reimbursement rate and the SFY 2018-19 Core Component per diem rate, multiplied by applicable Medicaid patient days.

5. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Pay-For-Performance Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to nursing facility providers that provide services resulting in better care and higher quality of life for their residents.

1. Annually, the Department shall calculate the payment by multiplying a Pay-for-Performance (P4P) per diem rate by Medicaid patient days.

2. The P4P per diem rate shall be calculated according to the following table:

P4P Points	Per Diem Rate
0 – 20 points	No add on
21 – 45 points	$1.00
46 – 60 points	$2.00
61 – 79 points	$3.00
80 – 100 points	$4.00

3. The P4P points shall be based on a completed and verified/audited application including 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.

4. 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. Substandard quality of care means one or more deficiencies related to participation requirements under Freedom from Abuse, Neglect, and Exploitation, Quality of Life quality of life, or quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

   b. The facility must perform n 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 publicly available along with the facility's State's survey results.

5. 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 measu

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6. 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

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

8. Medicaid patient days shall be from the MMIS for the calendar year ending prior to the state fiscal year.

9. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Acuity Adjusted Core Component Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to nursing facility providers for changes in resident acuity or case-mix.

1. Annually, the Department shall calculate the difference between the prior year Core Component per diem rate and the prior year Core Component per diem rate adjusted for changes in resident acuity or case-mix. The difference shall then be multiplied by applicable Medicaid patient days.

2. Applicable Medicaid patient days shall be Medicaid patient days divided by days in the calendar year ending prior to the state fiscal year, multiplied by the days the acuity adjusted Core Component per diem rate was effective.

3. Medicaid patient days shall be from the MMIS for the calendar year ending prior to the state fiscal year the acuity adjusted Core Component rate was effective.

4. For non-state administered nursing facility providers the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

Nursing Facility Rate Reduction

Effective for the State Fiscal Year beginning July 1, 2010, the aggregate state-wide nursing facility per diem rate will be reduced by two and three-tenths percent (2.3%).

Effective for the State Fiscal Year beginning July 1, 2011, the aggregate state-wide nursing facility per diem rate will be reduced by one and four-tenths percent (1.4%).

Effective for the State Fiscal Year beginning July 1, 2012, the aggregate state-wide nursing facility per diem rate will be reduced by one and fort-five-hundredths percent (1.45%).

Effective for the State Fiscal Year beginning July 1, 2013, and for each State Fiscal Year thereafter, each nursing facility's calculated MMIS per diem reimbursement rate will be reduced 1.5%.

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 (11^{th}) month following the end of the nursing facility's cost reporting period.

For the 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.

1. Enroll as a provider in the Colorado Medicaid Program;

2. Submit a copy of the re-certification survey yearly upon completion done by the survey and certification and/or licensure agency in their state;

3. Submit a copy of the following documentation with the claims;

   a. The current Medicaid provider agreement with the state where it is located;

   b. the provider number in the state where it is located; and

   c. their Medicaid rate, at the time services were rendered, in the state where it is located.

Payment shall not exceed 100 percent of audited Medicaid costs as determined by the Department or its designee. Audited costs shall be based on Medicaid costs in the state where the facility is located.

If the facility is not a Medicaid participant in the stat where it is located, it shall submit to he Department an audited Medicare cost report. The payment shall not exceed 100 percent of audited Medicare costs.

STATE-OPERATED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (CLASS IV)

State-operated intermediate care facilities for the mentally retarded (Class IV) shall be reimbursed based on the actual costs of administration, property, including capital-related assets and room and board, and the actual costs of providing health care services. Actual costs will be determined on the basis of information on the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

1. These costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period.

2. reimbursement to state-operated intermediate care facilities for the mentally retarded shall be adjusted retrospectively at the close of each twelve-month period.

3. The retrospective per diem will be calculated as total allowable costs divided by total resident days.

HOSPITAL BACK UP LEVEL OF CARE

This program provides extra reimbursement to nursing facilities for costly, heavy care patients admitted from the hospital. The program is limited to patients whose hospitalization is being paid by Medicaid. In addition, the Statewide Utilization Review.