Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: 20-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

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

Medicaid and CHIP Operations Group

April 24, 2020

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Bimestefer:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 20-0002. This amendment updates outdated language: replacing offensive terminology with person-centered terminology, updating agency and organizational names, correcting typos, reorganizing language, and removing outdated terminology.

Please be informed that this State Plan Amendment was approved on April 2, 2020, with an effective date of January 1, 2020. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2020.04.24 14:46:44 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Dr. Tracy Johnson, Colorado
Laurel Karabatsos, Colorado
John Bartholomew, Colorado
Russell Ziegler, Colorado
Whitney McOwen, Colorado
Jami Gazarro, Colorado

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: **20 –0002**

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: **January 1, 2020**

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:

42 CFR § 430.10

7. FEDERAL BUDGET IMPACT:

a. FFY 2019-20: $ 0
b. FFY 2020-21: $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.11-A – Relations with Standard-Setting and Survey Agencies – Standards for Institutions

Attachment 4.14-B – Utilization Control – Multiple Utilization Review Methods for Intermediate Care (ICF/IID) and Nursing Facilities

Attachment 4.19-D – Nursing Facility Benefits – Pages 15a-17a, 19-20, 26, 29, 31-31a, 41, 44

Section 4.11 – Relations with Standard-Setting and Survey Agencies

Section 4.13 – Required Provider Agreement

Section 4.15 – Inspection of Care in Intermediate Care Facilities for the Individuals with Intellectual or Developmental Disabilities, Facilities Provide Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

Section 4.24 – Standards for Payments for Nursing Facility and Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities

Section 4.39 – Pre-admission Screening and Annual Resident Review in Nursing Facilities

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

Attachment 4.11-A – Relations with Standard-Setting and Survey Agencies – Standards for Institutions (TN 74-92)

Attachment 4.14-B – Utilization Control – Multiple Utilization Review Methods for Intermediate Care (ICF/MR) and Nursing Facilities (TN 92-22)

Attachment 4.19-D – Nursing Facility Benefits – Pages 15a-17, 19-20, 26, 29, 31-31a, 41, 44 (TN 13-038, 08-007, 09-013)

Section 4.11 – Relations with Standard-Setting and Survey Agencies (TN 74-20)

Section 4.13 – Required Provider Agreement (TN 92-12)

Section 4.15 – Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Provide Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals (TN 94-003)

Section 4.24 – Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services (TN 94-013)

Section 4.39 – Pre-admission Screening and Annual Resident Review in Nursing Facilities – Pages 79s-79t (TN 93 –012)

10. SUBJECT OF AMENDMENT:

This amendment updates outdated language: replacing offensive terminology with person-centered terminology, updating agency and organizational names, correcting typos, reorganizing language, and removing outdated terminology.

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 11 October, 2019**

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Colorado Department of Health Care Policy and Financing** **1570 Grant Street** **Denver, CO 80203-1818** **Attn: Lauren Reveley**
13. TYPED NAME: **Tracy Johnson**	
14. TITLE: **Medicaid Director**	
15. DATE SUBMITTED: March 24, 2020 Update #1: March 27, 2020	
FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED March 24, 2020	18. DATE APPROVED April 2, 2020
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL January 1, 2020	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME James G. Scott	22. TITL[redacted] Digitally signed by James G. Scott -S Date: 2020.04.24 14:48:41 -05'00' Director, Division of Program Operations
23. REMARKS	

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 4.11-A
MEDICAL ASSISTANCE PROGRAM

State of Colorado

STANDARDS FOR INSTITUTIONS

TN# 20-0002
Effective Date 1-1-20
Superseded TN# 74-92
Approval Date 4/2/2020

The Following Items are placed in State Plan Book No. II

1. Standards for Hospitals and Health Facilities
2. Chapter I - Definitions
3. Chapter II - Licensure
4. Chapter III - General Building and Fire Safety
5. Chapter IV - General Hospitals
6. Chapter V - Nursing Care Facility
7. Chapter VI - Intermediate Health Care Facility
8. Chapter VII - Residential Care Facility
9. Chapter VIII - Intermediate Care Facility for Individuals with Intellectual Disabilities
10. Chapter IX - Community Clinic and Emergency Center
11. Chapter XI - Convalescent Centers
12. Chapter XIV - Maternity Hospitals

TN# 20-0002
Effective Date 1-1-20
Superseded TN# 74-92
Approval Date 4/2/2020

State of Colorado

MULTIPLE UTILIZATION REVIEW METHODS FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

The State Agency has contracted with the a Federally certified Quality Improvement Organization (QIO) in accordance with 42 CFR 431.630 to assume direct responsibility for assuring that all the Utilization Control requirements at 42 CFR 456.350 - 438 are met for intermediate care facilities for individuals with intellectual disabilities (ICF/IID). As part of these functions, the QIO shall have binding authority in the admission certification and recertification of recipients under Medicaid; and, in addition, shall review plans of care. In order to assure the satisfactory performance of the QIO in these activities, the Director of the Office of Community Living of the Department of Health Care Policy and Financing or their appointee will be responsible for direct monitoring and evaluation of the QIO. This is accomplished through personal visits with the QIO, direct consultation and reviews of specific case records, submission by the QIO of monthly review activity reports, and the examination and approval of the review criteria developed and used by the QIO. Furthermore, the Office of Community Living or their appointee will be a participating member of the Coordinating Committee whose function it is to oversee the entire Utilization Control process.

Inspections of Care requirements for ICF/IID, at
42 CFR 456.600 will be conducted by the Colorado Department of Public Health and Environment under a separate contract with the State Agency. Inspections of Care requirements for institutions for mental diseases at 42 CFR 456.600 will be conducted by the Colorado Foundation for Medical Care, under a separate contract with the State Agency. These contracts specify that the U.S. Department of Health and Human Services (HHS) and the State Agency may monitor and evaluate the performance of these contracts and shall have access to all records maintained by the contractors pursuant to their agreements. Both contracts contain provisions for the termination of the contracts within 90 days of notification by the Colorado Department of Human Services. Furthermore, both contracts specify that all records are to be maintained in accordance with 42 CFR Part 74 and that the QIO and the Department of Public Health and Environment will safeguard recipient information as required by Subpart F, Part 431, of 42 CFR.

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

5. Changes in acuity or case-mix of patients.

6. The amount by which the average statewide per diem rate exceeds the general fund share.

For class II 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.

2. Administrative and General.

3. Fair Rental Allowance for Capital-Related Assets.

For state-operated 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 retrospective per diem rate includes the following components:

1. Health Care.

2. Administrative and General, which includes capital.

No nursing facility care shall receive reimbursement unless and until the nursing facility:

1. Has a license from the Colorado Department of Public Health and Environment (CDPHE).

2. Is a Medicaid participating provider of nursing care services.

3. Meets the requirements of the Department's regulations found at 10 CCR 2505-10, Medical Assistance, Health Care Policy and Financing Department Program Rules, Code of Colorado Regulations.

NURSING FACILITY CLASSIFICATIONS

1. Class I facilities are those facilities licensed and certified to provide general skilled nursing facility care.

2. Class II facilities are those facilities whose program of care is designed to treat individuals with intellectual disabilities who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program.

   a. Class II facilities shall be certified in accordance with 42 C.F.R. Part 442, Subpart C (2019), and 42 C.F.R. Part 483 (2019), and shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as a Class II facility. Class II facilities shall provide care and a program of services consistent with licensure and certification requirements.

   b. Class II facilities shall offer full-time, twenty-four (24)hour interdisciplinary and professional treatment by staff employed at such facility. Staff must be sufficient to implement and carry out a comprehensive program to include, but not be limited to, care, treatment, training and education for each individual.

c. Class II facilities shall provide care and services designed to maximize each resident's capacity for independent living and shall seek out and utilize other community programs and resources to the maximum extent possible according to the needs and abilities of each individual resident.

d. Class II facilities serve persons whose medical and psychosocial needs require services in an institutional setting and are expected to provide such services in an environment which approximates a home-like living arrangement to the maximum extent possible within the constraints and limitations inherent in an institutional setting.

3. Class IV facilities are those facilities whose program of care is designed to treat individuals with intellectual disabilities who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program.

a. Class IV facilities shall be certified in accordance with 42 C.F.R. Part 442, Subpart C (2019), and 42 C.F.R. Part 483 (2019), and shall be licensed by CDPHE as a Class IV Facility. Class IV facilities shall provide care and a program of services consistent with licensure and certification requirements.

b. Class IV facilities shall offer full-time, 24-hour interdisciplinary and professional treatment by staff employed at such facility. Staff must be sufficient to implement and carry out a comprehensive program to include, but not be limited to, care treatment, training and education for each individual.

c. Class IV facilities serve persons whose medical and psychosocial needs require services in an institutional setting and are expected to provide such services in an environment which approximates a home-like living arrangement to the maximum extent possible within the constraints and limitations inherent in an institutional setting.

d. State-administered, tax-supported facilities are not subject to the maximum reimbursement provisions and do not earn an incentive allowance.

e. Private, non-profit or proprietary facilities that are not tax-supported or state-administered are subject to the maximum reimbursement provisions and may earn an incentive allowance.

IMPUTED OCCUPANCY FOR CLASS II FACILITIES

The Department or its designee shall determine what audited allowable costs per patient

day are.

1. The Department shall utilize the total audited patient days on the MED-13 unless the audited patient days on the MED-13 constitute an occupancy rate of less than 85 percent of licensed bed day capacity when computing the audited allowable cost per patient day for all rates.
2. In such cases, the patient days shall be imputed to an 85 percent rate of licensed bed day capacity for the nursing facility and the per diem cost along with the resulting per diem rate shall be adjusted accordingly except that imputed occupancy shall not be applied in calculating the facility's health care services and food cost.

3. For the second cost report submitted by a new facility, imputed occupancy shall be applied but the rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in the monthly weighted average computation.

4. For the third cost report and cost reports thereafter, imputed occupancy shall be applied without exception.

Nursing facilities undergoing a state-ordered change in case mix or patient census that significantly reduces the level of occupancy in the facility shall:

1. Be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department for two cost reporting periods.

2. At the end of this period, the imputed occupancy calculation shall be applied when required.

INFLATION ADJUSTMENT

For class I nursing facilities, the per diem amount paid for direct and indirect health care services and administrative and general services costs shall include an allowance for inflation in the costs for each category using a nationally recognized service that includes the federal government's forecasts for the prospective Medicare reimbursement rates recommended to the United States Congress. Amounts contained in cost reports used to determine the per diem amount paid for each category shall be adjusted by the percentage change in this allowance measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

1. The percentage change shall be rounded at least to the fifth decimal point.
2. The index used for this allowance will be the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. The latest available publication prior to July 1 rate setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July I, and June 30.

For class II intermediate care facilities for Individuals with intellectual disabilities, at the beginning of each facility's new rate period, the inflation adjustment shall be applied to all costs except interest and costs covered by fair rental allowance.

1. The inflation adjustment shall equal the annual percentage change in the National Bureau of Labor Statistics Consumer Price Index (U.S. city average, all urban consumers), from the preceding year, times actual costs (less interest expense and costs covered by the fair rental allowance) or times reasonable cost for that class facility, whichever is less.

2. The annual percentage change in the National Bureau of Labor Statistics Consumer Price Index shall be rounded at least to the fifth decimal point.

3. The price indexes listing in the latest available publication prior to the July 1 limitation setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July l to be used for rate effective dates between July 1 and June 30.

4. The provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost repo1i period to the midpoint of the provider's rate period.

ADMINISTRATIVE COST INCENTIVE ALLOWANCE FOR CLASS II

FACILITIES

If the nursing facility's combined audited administration, property, and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) cost per patient day is less than the maximum reasonable cost for administration, property and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) costs for the class, the provider will earn an incentive allowance.

The incentive allowance for class II facilities shall be calculated at 25 percent of the difference between the facility's audited inflation adjusted cost and the maximum reasonable cost for that class. The incentive allowance will not exceed twelve percent of the reasonable cost.

No incentive allowance shall be paid on health care services, raw food, fair rental value allowance and leasehold costs.

CASE MIX ADJUSTMENTS

The resource utilization group-III (RUG-III) 34 category, index maximizer model, version 5.12b, as published by the Centers for Medicare and Medicaid Services (CMS), shall be used to adjust costs reported in the health care cost center in the determination of limits and in the rate calculation. No amendments or later editions are incorporated. The Department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

The Department shall distribute facility listings identifying current assessments for residents in the nursing facility on the 1st day of the first month of each quarter as reflected in the Department's MDS assessment database.

1. For class II facilities, one hundred twenty-five percent (125%) of the weighted actual costs of all class II facilities;

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2. State-administered class IV facilities shall not be subject to the health care limit.

3. The determination of the reasonable cost of services shall be made every 12 months.

4. Determination of the rates beginning on July 1 each year shall utilize the Medicaid population in each nursing facility class on May 1 and the most current MED-13 cost report submitted, in accordance with these regulations, by each facility on or before May 2.

5. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May2.

6. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

   a. Exclude part, or all, of a provider's MED-13 or

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report to May 2.

7. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling.

8. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

6. Repairs, betterments and improvements to property not covered by the fair rental allowance.

7. Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by the regulations regarding expensing of items.

Room and board includes:

1. Dietary, other than raw, food and salaries related to dietary personnel including tray help, except registered dieticians which are health care.

2. Laundry and linen.

3. Housekeeping.

4. Plant operation and maintenance (except removal of infectious material or medical waste which is health care).

5. Repairs, betterments and improvements to equipment related to room and board services.

The maximum allowable reimbursement of administration, property and room and board costs, excluding raw food, land, buildings and fixed equipment, shall not exceed:

1. For class II facilities, one hundred twenty percent (120%) of the weighted average actual costs of all class II facilities.

2. For class IV facilities, one hundred twenty percent (120%) of the weighted average actual costs of all class IV facilities.

3. The determination of the reasonable cost of services shall be made every 12 months.

4. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling.

5. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

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 intermediate care facilities for individuals with intellectual disabilities 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 individuals with intellectual disabilities 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.

New nursing facilities shall submit MED-l 3s during their initial year of operation as follows:

1. The first cost report shall be for a period covering the first day of operation through the facility's fiscal year end.

    a. If the first cost report for the period covers a period of 90 days or more, imputed occupancy shall be applied as described under Imputed Occupancy for class II Facilities.

    b. If the first cost report for the period covers a period of 90 days or more, the first cost report shall set the base for limitations on growth of allowable costs as described under Limitation on Medicare Part A and Part B Costs.

2. If the first cost report for the period specified above covers a period of 89 days or less, the facility's first cost rep01i shall not be submitted until the next fiscal year end.

3. The next cost report shall be submitted for the twelve month period following the period of the first cost report.

4. A new nursing facility shall advise the Department of the date its fiscal year will end and of the reporting option selected.

RATES FOR RECEIVERSHIP

The following rate provisions apply for a facility where a receiver has been appointed by the Court, pursuant to Section 25-3-108, C.R.S., at the request of the CDPHE:

1. During the Receivership

    a. During the term of the receivership, the facility shall be reimbursed the rate payable to the previous operator.

        i) The Department may increase the rate if it finds that the patient-related, necessary and reasonable costs of the facility operation are not covered by the rate payable to the previous operator.

        ii) The Department's analysis of necessary, patient related and reasonable costs incurred by the receiver shall not include any previous unpaid expenses of the prior owner or the mortgage costs of the facility.

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 state where it is located, it shall submit to the Department an audited Medicare cost report. The payment shall not exceed 100 percent of audited Medicare costs.

STATE-OPERATED INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (CLASS IV)

State-operated intermediate care facilities for Individuals with Intellectual Disabilities (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 rate will be calculated as total allowable costs divided by total resident days.

PROVIDER FEES

The state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State of Colorado

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the Colorado State Department of Health Care Policy and Financing

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): the Colorado State Department of Health Care Policy and Financing

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Centers for Medicare and Medicaid Services on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State of Colorado

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11(d) **The Colorado State Department of Public Health and Environment (agency) which is the State agency responsible for licensing health institutions through contract with the Medicaid agency that provides the requirements necessary for participation. If institutions and agencies meet the requirements and are approved by the Medicaid agency, the provider may participate in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.**

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: Colorado

Citation		4.13 Required Provider Agreement
		With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:
42 CFR 431.107	(a)	For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
42 CFR Part 483 1919 of the Act	(b)	For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
42 CFR Part 483, Subpart D	(c)	For providers of ICF/IID services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
1920 of the Act	(d)	For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.
		☐ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: Colorado

Citation 4.15 Inspection of Care in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act

_____ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

____ ICFs/IID;

_____ Inpatient psychiatric facilities for recipients under age 21; and

____ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

__X__ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

_____ Not applicable with respect to intermediate care facilities for individuals with intellectual disabilities services; such services are not provided under this plan.

_____ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

_____ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

DEC 1 9 1993

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: COLORADO

Citation	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826		With respect to nursing facilities and intermediate care facilities for individuals with intellectual disabilities all applicable requirements of 42 CFR Part 442, Subparts B and C are met. Not applicable to intermediate care facilities for individuals with intellectual disabilities; such services are not provided under this plan.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Colorado

Citation
Secs.
1902(a)(28)(D)(i) and 1919(e)(7) of the Act;
P.L. 100-203 (Sec. 4211(c));
P.L. 101-508 (Sec.4801(b)).

4.39 Pre-admission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and individuals with intellectual disabilities authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The state operates a pre-admission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive pre-admission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

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State/Territory: Colorado

4.39 (Continued)

N/A (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or individuals with intellectual disabilities authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

X (g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.