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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 22-0017

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

Financial Management Group

May 1, 2023

Adela Flores-Brennan
Medicaid Director
Colorado Department of Health Care
Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Re: Colorado 22-0017

Dear Ms. Flores-Brennan,

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 22-0017. Effective for services on or after July 1, 2022, this amendment implements supplemental payments to nursing facilities based on discharges and staff wages.

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 and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 22-0017 is approved effective July 1, 2022. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at Christine.storey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
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: 22-0017

2. STATE: CO

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act, Section 1905(a)(4)(A) / 42 CFR 440.155

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 2,476,490
b. FFY 2023 $ 4,359,960

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D -- Nursing Facility Benefits -- Pages 12-14a, ~~30a~~ 39a-b

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D -- Nursing Facility Benefits -- Pages 12-14, 39a-c (TN 08-007, 20-0034)

9. SUBJECT OF AMENDMENT
Amends Attachment 4.19-D to allow the Department to issue supplemental payments to nursing facilities, pursuant to Colorado House Bill 22-1247, and House Bill 22-1333, based on discharges and staff wages.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Governor's letter dated 14 July 2021

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED
September 29, 2022

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

Attn: Amy Winterfeld

FOR CMS USE ONLY

16. DATE RECEIVED
September 29, 2022

17. DATE APPROVED
May 1, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

OXYGEN

1. Only oxygen concentrator costs shall be allowable costs on the MED-13. Such costs include, but are not limited to, all supplies, equipment and servicing expenses.

2. Oxygen concentrators purchased by nursing facilities shall be capitalizedover the useful life of the asset. All supplies and service costs are allowable.

3. The nursing facilities shall have documented the costs incurred with the oxygen concentrators. These costs shall be segregated by costs associated with Medicaid residents and non-Medicaid residents.

4. Oxygen concentrators provided by medical supply companies to Medicaid nursing facility residents shall not be allowable costs and shall not be included on the MED-13.

LIMITATION ON MEDICARE PART A AND PART B COSTS

1. Only those Medicare costs that are reasonable, necessary and patient-related shall be included in calculating the allowable Medicaid reimbursement for class I nursing facilities.

2. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for a class I facility shall be: The level of Part A costs allowed in the facility's latest Medicare cost report submitted by the facility to the Department prior to July 1, 1997.

3. Part B direct costs for Medicare shall be excluded from the allowable Medicaid reimbursement for class I nursing facilities.

SUBMISSION OF COST REPORTING INFORMATION

Each nursing facility shall complete a Financial and Statistical Report for Nursing Facilities (MED-13) and submit it to the Department's designee at 12-month intervals within ninety (90) days of the close of the facility's fiscal year.

Failure of a nursing facility to submit its MED-13 within the required ninety (90) day period shall result in the Department withholding all warrants not yet released to the provider as described below:

1. When a nursing facility fails to submit a complete and auditable MED-13 (i.e., the information represented on the MED-13 can not be verified by reference to adequate documentation as required by generally accepted auditing standards) on time, the MED-13 shall be returned to the facility with written notification that it is unacceptable.

    a. The facility shall have either 30 days from the postmark date of the notice or until the end of the original 90-day submission period, whichever is later, to submit a corrected MED-13.

    b. If the corrected MED-13 is still determined to be incomplete or unauditable, the nursing facility shall be given written notification that it shall, at its own expense, submit a MED-13 that has been prepared by a certified public accountant (CPA). The CPA shall certify that the report is in compliance with all Department regulations and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

    c. The Department shall withhold all warrants not yet released to the provider once the original 90-day filing period and 30-day extension have expired and no acceptable MED-13 has been submitted.

2. If the audit of the MED-13 is delayed by the nursing facility's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall mean failure of the nursing facility to meet its responsibility to submit a timely MED-13 or failure to provide documents, personnel or other resources within its control and necessary for completion of the audit, within a reasonable time.

3. When the rate for the facility during a period of delay is found to have been higher than the new rate, the new rate shall be applied retroactively to this period and the Department shall make any adjustments and/or recoveries of overpayments.

4. The Department may waive cost report rate setting and instead use the statewide aggregate average rate for facilities that average 5 beds or less for Medicaid residents per day over the course of the facilities' fiscal year.

DELAYS OR CORRECTIONS IN MINIMUM DATA SET (MDS) SUBMITTAL

A nursing facility may request the Department accept late, completed and/or corrected MDS assessments for the purpose of recalculating quarterly resident case mix acuity calculations.

1. The Department shall only consider such a request if it pertains to MDS assessments which could affect the facility's per diem reimbursement for the rate year in which the request is made.

2. In addition, such a request shall only be approved if:

   a. The number of missing, incomplete, and/or inaccurate MDS assessments for one, or more, of the quarters is equal to, or greater than, 25% of the facility's total number of residents for that quarter.

   b. The facility transmits corrected complete MDS assessments for at least 95% of the total number of missing, incomplete, and/or inaccurate MDS assessments for the respective quarter.

   c. The request shall be made in writing and shall include such supporting information as is required by the Department.

   d. If the request is approved, all late, completed, or corrected MDS assessments shall be transmitted to, and accepted by, the MDS database maintained by the Colorado Department of Public Health and Environment.

Where the Department withholds warrants not yet released to the provider, the following shall apply:

1. The Department shall withhold all warrants not yet released to the provider for services rendered in the prior three calendar months (four months if an extension was granted) and thereafter until an acceptable MED-13 is received.

2. Once the Department determines that the MED 13 submitted is complete and auditable, the provider's withheld payments shall be released.

3. If an acceptable MED-13 has not been submitted within 90 days after the Department began withholding payments, the provider's participation in the Medicaid program shall be terminated and the payments withheld shall be released to the provider.

4. Interest paid by the provider on loans for working capital while payments are being withheld shall not be allowable costs for purposes of reimbursement under Medicaid.

5. When the delayed submission of the MED-13 causes the effective date of a new lower rate to be delayed, the new rate shall be applied retroactively to this period and the Department shall make recoveries of overpayments.

NURSING FACILITY REIMBURSEMENT

Where no specific Medicaid authority exists, the sources listed below shall be considered in reaching a rate determination:

Wage Enhancement Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to Class 1 nursing facility providers that pay their employees a base hourly wage of at least $15.00 per hour.

1. Annually, the Department shall calculate the payment by multiplying the percent of total Medicaid hours for all eligible nursing homes by $8,719,921.

    a. Medicaid hours are calculated as Medicaid patient days multiplied by total hours-per-day.

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

        ii. Total hours-per-day are calculated as total hours divided by total days.

            1. Total hours and total days are from the most recently filed unaudited MED-13 cost report.

2. Payments made to rural eligible Class 1 nursing facility providers shall be increased by an additional twenty percent (20%). Payments made to all other eligible Class 1 nursing facility providers shall be reduced by a corresponding amount. A rural eligible Class 1 nursing facility provider is located outside of a metropolitan statistical area as defined by the U.S. Office of Management and Budget.

3. For state fiscal year 2022-23, a Class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour as of April 30, 2023. For state fiscal year 2023-24, a Class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour for the period May 1, 2023 through December 31, 2023. For all subsequent state fiscal years, a Class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour for the previous calendar year.

4. Federal financial participation is available under the applicable aggregate Upper Payment Limit for nursing facilities after all other Fee-for-Service payments and Medicaid supplemental payments are considered.

5. The supplemental payment shall be reimbursed via ACH transaction or check to a Class 1 nursing facility provider a one-time payment on or before June 30 each year.

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.

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