

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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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.

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- 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.

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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.

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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.

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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

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well as nursing and ordinary supplies and equipment related to the day-to-day care of the resident and the operation of the facility.

Each nursing facility shall furnish, within the per diem rate, equipment necessary to the operation of the facility and provide for necessary medical, nursing, respiratory and rehabilitation care.

SUBMISSION OF THE MED-13 COST REPORT AND MINIMUM DATA SET (MDS)

For purposes of completing the MED 13, each nursing facility shall:

1. Establish a 12-month period that is designated to the Department as the facility's fiscal year. The fiscal year shall remain the same as designated to the Department with two exceptions:
 - a. Providers seeking to coordinate their fiscal year with the fiscal year they have established with the Internal Revenue Service.
 - b. Subchapter "S" corporations required by law to have a fiscal year end of December 31.
2. Provide adequate cost data that:
 - a. Is based on their financial and statistical records. All financial and statistical records of the facility shall be maintained in accordance with generally accepted accounting principles as approved by the American Institute of Certified Public Accountants.
 - b. Is verifiable by reference to adequate supporting documentation by qualified auditors during the normal course of their audit.
 - c. Is based on the accrual basis of accounting.

Nursing facilities shall submit all Minimum Data Set (MDS) resident assessments and tracking documents to the Centers for Medicare and Medicaid Services (CMS) MDS database for Colorado maintained at the Colorado Department of Public Health and Environment (CDPHE). All assessment data submitted shall conform to federal and state specifications and meet minimum editing and validation requirements.

Failure to maintain adequate accounting and/or statistical records shall be cause for termination or suspension of the facility's provider agreement.

LEGAL FEES, EXPENSES AND COSTS

1. Legal fees, expenses and costs incurred by nursing facilities shall be allowable, in the period incurred, if said costs are reasonable, necessary and patient-related. Such costs shall be reimbursed only to the extent they

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affect the rates for those periods. These legal fees, expenses and costs shall be documented in the provider's files, and shall be clearly identifiable, including identification by case number and title, if possible. Failure to clearly identify these costs shall result in disallowance.

2. The following categories shall not be deemed reasonable, necessary and patient-related:
 - a. Legal fees, expenses and costs incurred in connection with the appeal of a Medicaid classification or reimbursement rate, rate adjustment, personal needs audit, or payment for any financial claim by or against the State of Colorado, or its agencies by a provider, in the event the State of Colorado or any of its agencies prevails in such a proceeding. In the event that each party prevails on one or more issues in litigation, allowable legal fees, expenses and costs in such cases shall be apportioned by percentage, for reimbursement purposes, by the administrative law judge rendering the final agency decision. In the event of the stipulated settlement of any such appeal, the parties shall, by agreement, determine the allowability for the provider's legal fees, expenses and costs. If a settlement agreement is silent concerning legal fees, expenses or costs, they shall not be allowable.
 - b. Legal fees, expenses and costs incurred in connection with a proceeding by the Department or the CDPHE to deny, suspend, revoke or fail to renew or terminate the license or provider contract of a long-term care facility, or to refuse to certify, decertify or refuse to recertify a long-term care facility as a provider under Medicaid and the Departments prevail in such a proceeding. Legal fees, expenses and costs incurred in connection with a proceeding by the United States Department of Health and Human Services to refuse to certify, decertify, or refuse to recertify a long-term care facility and the Department prevails in such a proceeding. For the purposes of this paragraph, the word "prevail" shall mean a result, whether by settlement, administrative final agency action or judicial judgment, which results in a change of the terms of a previously granted provider license, certification, or contract, including involuntary change of ownership or probation.
 - c. Legal fees, expenses and costs incurred in connection with a civil or criminal judicial proceeding against the provider by the State of Colorado and any of its agencies as the result of the provider's participation in the Medicaid program, resulting from fraud or other misconduct by the provider, and the State or its agencies prevail in such proceeding. For the purposes of this paragraph, the

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word "prevail" shall mean any result but dismissal or acquittal of a criminal action or dismissal, directed judgment, or judgment for the provider in a civil action.

- d. Legal fees, expenses and costs incurred in connection with an investigation by federal, state, or local governments and their agencies that might lead to a civil or criminal proceeding against the provider as a result of alleged fraud or other misconduct by the provider in the course of the provider's participation in the Medicaid program shall not be allowable where the provider makes any payment of funds to any federal, state, or local governments and their agencies as a result of the alleged fraud or misconduct which was the subject of the investigation.
- e. Legal fees, expenses and costs incurred for lobbying Congress, the Legislature of Colorado, or the State Boards of Medical Services, Health or Human Services.
- f. Legal fees, expenses and costs incurred by the seller in the sale of a nursing home.
- g. Nonrefundable retainers paid to Counsel.
- h. Legal fees, expenses and costs incurred for any reason after a change of ownership has occurred.
- i. Legal fees, expenses, or costs as a result of an attorney entering an appearance in person or in writing by counsel for the provider during the Informal Reconsideration. Legal fees, expenses and costs that are advisory in nature before and during the Informal Reconsideration process will be allowable.

DEPRECIATION

- 1. For purposes of this section concerning depreciation, the following definitions shall apply:

"MAI Appraiser" means the designation "Member, Appraisal Institute" awarded by the American Institute of Real Estate Appraisers.

"Straight Line Method of Depreciation" means the method of depreciation where the amount to be depreciated is first determined by subtracting the estimated salvage value of the asset from its cost or fair market value in the case of donated assets. The amount to be depreciated is then distributed equally over the estimated useful life of the asset.

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2. Depreciation on assets used to provide covered services to Medicaid recipients may be included as an allowable patient cost. Only the straight-line method of computing depreciation may be utilized for purposes of Medicaid reimbursement. Depreciation costs shall be identifiable as such, and shall be recorded in the provider's accounting records in accordance with "generally accepted accounting principles."
3. Depreciable items must be capitalized and written off over the estimated useful life of the item using the straight-line method of depreciation. With respect to expenditures during every facility fiscal year which begins on or after July 1, 1998, the following items must be depreciated:
 - a. Assets that, at the time of acquisition, had an estimated useful life of (2) two years or more; and a historical cost of \$5,000 or more.
 - b. Betterments or improvements that extend the original estimated useful life of an asset by (2) two years or more, or increase the productivity of an asset significantly; and cost \$5,000 or more.
 - c. For the purpose of applying the \$5,000 threshold in paragraphs A and B above, the costs of assets, betterments, and/or improvements shall be combined if the costs:
 - i) Are incurred within the same fiscal year of the nursing facility.
 - ii) Are of the same type or relate to the same project. For example, renovations or improvements to a facility's kitchen, done in three phases costing \$3,000 each, must be combined.
 - d. Major repairs are repairs which:
 - i) Occur infrequently, involve significant amounts of money, and increase the economic usefulness of the asset in the future, because of either increased efficiency, greater productivity, or longer life; or
 - ii) Restore the original estimated useful life of an asset where without such repairs, the useful life of the asset would be reduced or immediately ended; these repairs occur infrequently and have a significant cost in relation to the asset being repaired.
 - e. If the composite method of depreciation is used, the time period over which the major repair must be depreciated is not necessarily the remaining life of the composite asset. For example, a major

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repair to a roof of a facility that has a remaining useful life of thirty (30) years would not have to be depreciated over thirty (30) years if the normal life of the roof is only fifteen (15) to twenty (20) years; the shorter period could be used.

- f. The following are examples of major repairs and are not intended as a complete list: replacement or partial replacement of a roof, flooring, boiler, or electrical wiring.

EXPENSED ITEMS

1. Items which are to be entirely expensed in the year of purchase, rather than depreciated, are as follows:
 - a. All repair and maintenance costs, except major repairs.
 - b. Assets that, at the time of acquisition, had an estimated useful life of less than two (2) years; or cost less than \$5,000.
 - c. Betterments or improvements that do not extend the useful life of an asset by two (2) years or more, or do not increase the productivity of an asset significantly; or cost less than \$5,000.
 - d. For the purpose of applying the \$5,000 threshold in paragraphs "b" and "c" above, assets, betterments, and/or improvements that are purchased separately shall be combined if they meet the criteria described in section 8.441.5.D.

HISTORICAL COSTS

1. Historical costs shall be established in accordance with the Medicare and Medicaid Guide, 1981, published by Commerce Clearing House, paragraphs 4501 - 4897P, except that any appraisals required or recommended shall be performed by an MAI Appraiser rather than an "appraisal expert" as defined in the Guide. No amendments or later editions are incorporated.
2. When the Internal Revenue Service requires a facility to change its allocation of costs of land, buildings or equipment for purposes of tax reporting, a copy of the IRS notice shall be submitted to the Department in order for the changes to be reflected in the cost report.
3. In regards to a determination of a bona fide sale, an initial presumption that the sale was not bona fide may be offset by a valuation report of an MAI appraiser of the reproduction cost depreciated to date on a straight-line basis. Cost determined in this manner shall be accepted for future depreciation purposes.

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4. An initial presumption that a sale was not bona fide shall be made when any of the following factors exist:
- a. The seller and purchaser are persons for whom a loss from the sale or exchange of property is not allowed under the Internal Revenue Services Code between:
 - i) Members of a family. The term "family" means a brother or sister (whole or half-blood relationship), spouse, ancestor, or lineal descendant, including in-laws and in-laws of ancestors of lineal descendants.
 - ii) An individual and a corporation if the individual owns (directly or indirectly) more than 50% in value of the outstanding stock.
 - iii) Two corporations if more than 50% in value of the outstanding stock in both is owned, directly or indirectly, by the same individual, but only if either one of the corporations was a personal holding company or a foreign personal holding company for the taxable year preceding the date of the sale or exchange.
 - iv) A grantor and a fiduciary of any trust.
 - v) A fiduciary of one trust and a fiduciary of another trust, if the same person is grantor of both trusts.
 - vi) A fiduciary of a trust and any beneficiary of such trust.
 - vii) A fiduciary of a trust and a beneficiary of another trust, if the same person is a grantor of both trusts.
 - viii) A fiduciary of a trust and a corporation more than 50% in value of the outstanding stock of which is directly or indirectly owned by or for the trust or a grantor of the trust. This would, for example, have the effect of denying a loss in a transaction between a corporation, more than 50% of the stock of which was owned by a father, and a trust established for his children. Under the constructive ownership rules (below), the children are treated as owning the stock owned by the father.
 - ix) A person and an exempt charitable or education organization controlled by the person or, if the person is an individual, by the individual or his family.

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- b. The transaction was effected without significant investment on the part of the purchaser; i.e., cash or property was not transferred from the purchaser to the seller and the sales price was met by assumption of existing debt and promises to pay additional amounts or issuance of life annuities to the seller.
- c. The sales price could be considered excessive when compared with other sales or costs of constructing, furnishing, and equipping other facilities of comparable size and quality during the preceding twelve months.

INTEREST

- 1. To be allowable, the interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower.
- 2. Interest on loans to providers by partners, stockholders or related organizations are allowable as costs at a rate not in excess of the prime rate.
- 3. Allowable interest expense on current indebtedness of a provider shall be adjusted to reflect the extent to which working capital needs which are attributable to covered services for beneficiaries have been met by payment to the provider designed to reimburse currently as services are furnished to beneficiaries.

MANAGEMENT SERVICES

- 1. The following requirements apply to all management companies:
 - a. Management company costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge of health care personnel from the management company or home office may be included in the health care cost center equal to the actual salaries and benefits of those health care personnel.
 - b. Management company costs allocated to facilities shall be based on actual services provided to the facility. The allocation shall be documented.
 - c. If the compensation to on-site management staff is separately reported on the cost report that compensation shall not also be included in the allowable management costs for the facility.

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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 capitalized over 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:

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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.

**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.

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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:

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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.

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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 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.

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2. Administrative and General.
3. Fair Rental Allowance for Capital-Related Assets.

For state-operated 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 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 developmentally disabled individuals whose medical and psychosocial needs are best served by receiving care in a community setting.
 - a. 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.
 - b. 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.

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- c. Class II facilities shall be certified in accordance with 42 C.F.R. 442, Subpart C, 42 C.F.R. 483 and shall be licensed by the CDPHE. Class II facilities shall provide care and a program of services consistent with licensure and certification requirements.
3. Class IV facilities are those facilities whose program of care is designed to treat developmentally disabled individuals 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 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 necessarily be limited to, care, treatment, training and education for each individual.
 - b. Class IV facilities shall be certified in accordance with 42 C.F.R. 442, Subpart C, 42 C.F.R. 483 and shall be licensed by the CDPHE as a class IV facility. Class IV facilities shall provide care and a program of services consistent with licensure and certification requirements.
 - c. State-administered, tax-supported facilities are not subject to the maximum reimbursement provisions and do not earn an incentive allowance.
 - d. 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 AND PRIVATELY OWNED CLASS IV 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

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that imputed occupancy shall not be applied in calculating the facility's health care services and food costs.

3. The licensed bed capacity shall remain in effect until the Department is advised that the licensed bed capacity has changed through the filing of a subsequent cost report.
4. The imputed patient day calculation shall remain in effect until a new rate from a subsequent cost report is calculated. Should the subsequent cost report indicate an occupancy rate of less than 85 percent of licensed bed day capacity, the resulting rate shall be imputed in accordance with the provisions of this section.

Nursing facilities located in rural communities with a census of less than 85 percent shall not be subject to imputed occupancy. A nursing facility in a rural community shall be defined as a nursing facility in:

1. A county of less than fifteen thousand population.
2. A municipality of less than fifteen thousand population which is located ten miles or more from a municipality of over fifteen thousand population.
3. The unincorporated part of a county ten miles or more from a municipality of fifteen thousand population or more.

Any nursing facility that has a reduction in census, causing it to be less than 85 percent, resulting from the relocation of mentally ill or developmentally disabled residents to alternative facilities pursuant to the provisions of the Omnibus Reconciliation Act of 1987 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. The imputed occupancy calculation shall be applied when required at the end of this period.

Imputed occupancy shall be applied to a new nursing facility as follows:

1. A new nursing facility means a facility not in the Colorado Medicaid program within thirty days prior to the start date of the Medicaid provider agreement.
2. For the first cost report submitted by a new facility, the facility shall be entitled to the higher of the imputed rate or the monthly weighted average rate computed by the Department.

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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 1, and June 30.

For class II and privately-owned class IV intermediate care facilities for the mentally retarded, 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.

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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 1 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 report period to the midpoint of the provider's rate period.

ADMINISTRATIVE COST INCENTIVE ALLOWANCE FOR CLASS II AND PRIVATELY OWNED CLASS IV 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 and privately owned class IV 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.

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HEALTH CARE REIMBURSEMENT RATE CALCULATION

Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

If an employee has dual health care and administrative duties (i.e. Admissions and Marketing), contemporaneous time records must be kept or time studies performed to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.
3. Non-prescription drugs ordered by a physician which are included in the per diem rate.
4. Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.
5. Purchases, rental, and repair expenses of health care equipment and supplies used for health care services such as nursing care, medical records, social services, and activities.

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6. **Food Costs.** Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM REIMBURSEMENT RATES (LIMIT)

For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for direct and indirect health care services and raw food, the state department shall establish an annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. The health care limit will be calculated as follows:

1. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before December 31 of the preceding year.
2. The MED-13 cost report shall be deemed filed if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before December 31.
3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of the limit, the Department may:
 - a. Exclude part, or all, of a provider's MED-13.
 - 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 percentage change in the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. measured from the midpoint of the reporting period to the midpoint of the payment-setting period.
4. The health care limit 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.
5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the median costs of direct and indirect health care services and raw food as determined by an array of all class I facility providers: except

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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.

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**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

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system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's Medicaid residents on a quarterly basis.

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:
 - a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.
 - b. The facility's Medicaid resident acuity case mix index shall be a two quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.
 - c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.
 - d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.
 - e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.
 - f. The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.
2. The annual facility specific health care maximum reimbursement rate shall be determined as follows:
 - a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

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- b. The statewide health care maximum allowable reimbursement rate shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.
 - c. The facility specific maximum reimbursement rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.
 3. The annual facility specific other health care maximum allowable reimbursement shall be determined as follows:
 - a. The percentage of the other health care per diem cost to total health care cost shall be determined by dividing the other health care per diem cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.
 - b. The facility specific other health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.
 4. The case mix reimbursement rate component shall be determined as follows:
 - a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.
 - b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall be the case mix reimbursement rate component.
 5. The other health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

**DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM
ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV FACILITIES**

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1. For class II facilities, one hundred twenty-five percent (125%) of the weighted actual costs of all class II facilities;
2. For non-state administered class IV facilities, one hundred twenty-five percent (125%) of the weighted average actual costs of all class IV facilities.
3. State-administered class IV facilities shall not be subject to the health care limit. The Med-13s of the state-administered class IV facilities shall be included in the health care limit calculation for other class IV facilities.
4. The determination of the reasonable cost of services shall be made every 12 months.
5. 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.
6. 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 May 2.
7. 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.
8. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.
9. 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.

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10. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

Administration Costs means the following categories of reasonable, necessary and patient-related costs:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, hall monitors, security guards, janitorial and plant staff and food service staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records or perform a time study in order to properly allocate their salaries between cost centers. Time studies used must meet the criteria described under Health Care Reimbursement Rate Calculation.
2. Any portion of other staff costs directly attributable to administration.
3. Advertising.
4. Recruitment costs and staff want ads for all personnel.
5. Public relations.
6. Office supplies.
7. Telephone costs.
8. Purchased services: accounting fees, legal fees; computer services. Computer services refer to any costs associated with the information technology system such as repair, maintenance and upgrades.
9. Computers and related software used in administrative departments.
10. Payroll taxes.
11. Licenses and permits (except health care licenses and permits), non resident transportation, training for administrative personnel, dues for professional associations and organizations.
12. All travel of facility staff, except that required for transporting residents to activities or for medical purposes.

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13. Insurance, including insurance on vehicles used for resident transport, is an administrative cost. The only exception is professional liability insurance that is a health care cost.
14. Facility membership fees in trade groups or professional organizations.
15. Miscellaneous general and administrative costs.
16. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.
17. Purchases, rentals, repairs, betterments and improvements of equipment utilized in administration.
18. Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below.
19. All other reasonable, necessary and patient-related costs which are not specifically set forth in the description of "health care services" above, and which are not property, room and board, food or capital-related assets.
20. Background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.
21. Management fees and home office costs except as described under Health Care Reimbursement Rate Calculation.

Property costs include:

1. Depreciation costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).
2. Rental costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).
3. Property taxes.
4. Property insurance.
5. Interest on loans associated with property costs covered in this section.

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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. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.
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.

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6. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

Class I Administrative and General Per Diem Reimbursement Rate

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the Department shall establish an annually readjusted schedule to pay each facility a reasonable price for the costs.

1. The reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers.
2. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one or more licensed beds, the reasonable price shall be one hundred five percent of the median per diem cost for all class I facilities.
3. In computing per diem cost, each nursing facility provider shall annually submit cost reports to the Department.
4. Actual days of care shall be counted rather than occupancy-imputed days of care.
5. The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation.
6. Amounts contained in cost reports used to establish this median 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.
 - a. The percentage change shall be rounded at least to the fifth decimal point.
 - b. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.
7. The reasonable price determined at July 1, 2008 will be adjusted annually at July 1st for three subsequent 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

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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.

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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.

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FAIR RENTAL ALLOWANCE FOR CAPITAL-RELATED ASSETS

1. For purposes of this section concerning fair rental allowance, the following definitions shall apply:

Appraised Value means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent, the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the most recent edition of the Boeckh™ Commercial Building Valuation System available on December 31st of the year preceding the year in which the appraisals are to be performed.

Base Value means the value of the capital related assets as determined by the most current appraisal report completed by the Department or its designee and any additional information considered relevant by the Department. For each year in which an appraisal is not done, base value means the most recent appraisal value increased or decreased by fifty percent (50%) of the change in the Index. Under no circumstances shall the base value exceed \$25,000 per bed plus the percentage rate of change referred to as the per bed limit.

Capital-Related Asset means the land, buildings and fixed equipment of a participating facility.

Fair Rental Allowance means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

Fair Rental Allowance Per Diem Rate means the fair rental allowance described above, divided by the greater of the audited patient days on the provider's annual cost report or ninety percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

Fiscal Year means the State fiscal year from July 1 through June 30.

Fixed equipment means building equipment as defined under the Medicare principle of reimbursement as specified in the Medicare provider reimbursement manual, part 1, section 104.3. Specifically, building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:

- a. Affixed to the building and not subject to transfer; and
- b. A fairly long life but shorter than the life of the building to which it is affixed.

Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, a publication of R.S.Means Company.

Inc. that is updated annually (section M.450, "Nursing Home"), hereafter referred to as the Means Index.

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

FAIR RENTAL ALLOWANCE PER DIEM REIMBURSEMENT RATES

In addition to the reimbursement components paid under Health Care Services and Administrative and General Costs, a per diem rate constituting a fair rental allowance for capital-related assets shall be paid to each nursing facility provider as a rental rate based upon the nursing facility's appraised value.

1. For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for capital-related assets, the state department shall establish an annual per bed limit.
2. The annual per bed limit established July 1, 1985 is \$25,000 per bed plus the percentage rate of change in the Means Index.
3. The Means Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, a publication of R.S.Means Company, Inc. that is updated annually (section M.450, "Nursing Home").
4. The per bed limit shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.
5. The fair rental allowance will be calculated for each facility using the lesser of the Base Value plus non-appraisal year modifications to the physical structure due to improvements or a change in the condition and/or use of the facility subsequent to the appraisal increased or decreased by fifty percent (50%) of the change in the Means Index or the annual per bed limit.
6. In computing the fair rental allowance per diem rate, the fair rental allowance is multiplied by the rental rate to obtain the annual allowable fair rental payment.
7. The rental rate is the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.
8. The resulting fair rental payment amount is divided by the greater of the audited patient days based on the provider's annual cost report or ninety

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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

Cognitive Performance Scale (CPS) Supplemental Payment

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

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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.

PASRR II Resident and Facility Supplemental Payments

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.

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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.

Provider Fee Offset Supplemental Payment

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. The 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	\$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

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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

Excess of Statutory Limitation on Growth in the General Fund Supplemental Payment

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.

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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 be 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. 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.

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Starting July 1, 2009, the Department shall 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.

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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.

Supplemental Payment for Acuity or Case-Mix of Residents

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 for acuity or case-mix of residents.

1. Annually the state department will calculate the difference between each nursing facility's prior fiscal year audited July 1 per diem cost and the per diem cost revised for changes in acuity or case-mix of residents.
2. Medicaid caseload for each facility will be determined using the paid claims data for the calendar year ending prior to the July 1 rate setting.
3. The state department will calculate the number of calendar days that the per diem cost revised for changes in acuity or case-mix were in effect.
4. Medicaid days are divided by 365 to get the total number of Medicaid days per calendar day.
5. Medicaid days per calendar day are multiplied by the number of calendar days to determine the Medicaid days applied to the per diem cost revised for changes in acuity or case-mix.

The Medicaid days applied to the per diem cost revised for changes in acuity or case-mix are multiplied by the difference between each nursing facility's prior fiscal year audited July 1 per diem cost and the per diem cost revised for changes in acuity or case-mix of residents to determine the supplemental payment for acuity or case-mix of residents.

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Effective December 1, 2010, nursing facilities that provided care to Program of All Inclusive Care for the Elderly (PACE) residents in SFY 2009 will receive a one-time supplemental Medicaid payment for nursing facility services provided to Medicaid clients, such that the total of all payments will not exceed the Upper Payment Limit for nursing facility services. Each qualifying nursing facility's lump sum payment is calculated as the difference between the nursing facility's Interim and Final SFY 2009 per diem rate, multiplied by their individual PACE resident days that occurred during SFY 2009. This payment will be distributed to providers in the third quarter of SFY 2011.

Supplemental Provisions:

1. 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.
2. Provider fee revenue will first be used to pay the provider fee offset payment, then acuity, 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.

SFY 2009-10	\$53,616,414
SFY 2010-11	\$72,699,123
SFY 2011-12	\$84,511,966
SFY 2012-13	\$84,166,164
SFY 2013-14	\$88,514,898

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 forty-five-hundredths percent (1.45%).

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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 (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.

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2. One hundred (100) days after the date the MED-13 is filed by the provider.

In the event a permanent rate cannot be established, issued and paid as set forth under Rate Effective Date:

1. The Department shall establish and issue a temporary rate calculated on the provider's filed cost report without adjustments.
2. All temporary rates shall, at the time the permanent rate is established, issued and paid, be subject to adjustment and recovery of any over or under payments.

Any delay in completion of the audit of the MED-13 that occurs within 90 days from the filing of the MED-13, and that is attributable to the provider, shall operate, on a time equivalent basis, to extend the time in which the Department shall establish, issue and pay a temporary rate under the provisions set forth above.

RATES FOR NEW FACILITIES

A new nursing facility means a facility:

1. That has not previously been certified for participation in Title XIX; or
2. That has not participated in Title XIX for a period in excess of 30 days prior to the effective date of the current Title XIX certification; or
3. That has changed from one class designation to another.

Nursing facilities that have undergone a transfer of ownership are not new nursing facilities provided the previous owner had participated in Title XIX in the last 30 days prior to ownership change.

A new nursing facility shall receive a per diem rate equal to the most recent average weighted rate for the appropriate nursing facilities class at the time the new facility begins business as a Medicaid provider.

1. This per diem rate shall remain in effect until a new rate is established based on the first cost report submitted as specified below.
2. The average weighted rate shall be calculated by the Department on the 30th of each month and shall not be revised when new rates are established which would retroactively affect the calculation.
3. The average weighted rate paid a new facility shall be adjusted on July 1 each year by the average weighted rate in effect on July 1.

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New nursing facilities shall submit MED-13s 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 and Privately Owned class IV 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 report 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.

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- b. The receiver shall submit a cost report for the time beginning when the receiver is appointed until the time the receiver is no longer operationally in control of the nursing facility operation.
 - i) This cost report shall set a rate payable to the receiver for the date the receiver took operational control of the facility.
 - ii) This retrospective rate may set a rate higher or lower than the initial rate established and paid to the receiver in which case the under or over payment shall be either paid to or collected from the receiver.
 - iii) The retrospectively set rate shall not exceed the established maximum allowable rates for that period.
- 2. New providers after the receivership period
 - a. The new operator shall receive the rate paid to the prior owner until the new provider submits a cost report unless the new operator chooses the retrospective option described below where a new operator takes control and ownership of a nursing facility from the receiver.
 - b. The new operator may elect to have a retrospective rate set for the initial three months of operation.
 - i) In order to exercise this option, the new operator shall file a cost report for the first three months of operation.
 - ii) The first day of operation shall mean the first day of licensure of the new operator. The last day of the initial three months of operation shall be the last day of the month in which the 90th day occurs.
 - iii) The cost report shall be filed within 90 days of the end of the initial three months of operation.
 - c. The retrospective rate established from the three month cost report shall be in effect from the first date of licensure of the new owner until the last day of the month in which the 90th day occurs. This rate shall be a prospectively paid rate to the new operator beginning with the first day of the month after the three month cost reporting period.
 - d. The initial rate paid to the new operator shall be the prior owner's rate.
 - i) The retrospective rate established by the three month cost report shall replace the initial rate paid to the operator.

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- ii) The retrospective rate may be higher or lower than the initial rate established and paid to the new operator in which case the under or over payment shall be either paid to or collected from the new operator.
- iii) The retrospectively established rate shall not exceed the maximum reasonable cost rates for that period.
- c. The three month cost report shall establish the prospective rate for the period established by the regulations at Section 8.443.13.
- f. The provider shall file the first cost report after the three month cost report. If the first cost report filed for the period immediately following the three month cost report demonstrates a reduction in per diem costs more than five percent which is caused by a reduction in per diem costs and not an increase in census, the following special provision shall apply:
 - i) The provider's prospective per diem rate driven by the three month cost report shall be retroactively reduced to the per diem rate as determined by the actual costs of the provider.
 - ii) The Department shall recover the difference between the provider's actual costs and the prospective rate paid to the provider. This recovery shall not apply to the three month retrospective rate as established by the initial three month cost report.

These special provisions do not apply when the receiver is appointed at the request of any other party such as the previous operator, landlord or other interested party.

PAYMENT FOR OUT OF STATE NURSING FACILITY CARE

Payments for out-of-state nursing facility care shall be made to providers when:

1. The nursing facility services are needed because of a medical emergency.
2. The nursing facility services are needed because the resident's health would be endangered if he/she were required to travel to Colorado and the attending physician has certified to such in the resident's medical records.
3. The Department determines, on the notification from the client's primary care physician, the needed medical services or necessary supplementary resources, are not available in Colorado but are available in another state:
 - a. The Department's State Utilization Review Contractor may review the appropriateness of care plan and documentation that the resident will demonstrate significant improvement.

The out-of-state nursing facility shall:

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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 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 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

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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 services, and skilled nursing care on a single, contiguous campus. Assisted living services include an assisted living residence as defined in section 25-27-102, C.R.S., or that provides assisted living services on-site, twenty-four hours per day, seven days per week
 - 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) Changes in acuity or case-mix of residents
 - (iv) Pay for Performance
 - (v) CPS
 - (vi) PASRR Resident and Facility
 - (viii) Excess of statutory limitation on growth in the general fund
 - b. This calculation will be based on the most current information available at the time of the July 1 rate-setting process.

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- 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 annually 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. New Facilities, facilities that will close during the rate year, and facilities with a change in certification or licensure will have their non-Medicare days estimated in order to determine the provider's fee payment.
- f. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed the state department.
- g. The state department shall assess the provider fee on a monthly basis.
- h. 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'.

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1. All monies in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the administrative cost of implementing section 25.5-6-202 and this section and to pay a portion of the per diem rates established pursuant to section 25.5-6-202 (1) to (4).
2. Following payment of the amounts described above, the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the rates established under section 25.5-6-202 (5) to (7).
3. Any monies in the fund not expended for these purposes may be invested by the state treasurer as provided by law.
 - a. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.
 - b. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or any other fund but may be appropriated by the general assembly to pay nursing facility providers in future fiscal years.

The state department shall establish administrative penalties for the late payment by a nursing facility of a fee assessed pursuant to this section.

The state department may recoup any payments made to nursing facilities providing services pursuant to the Medicaid program up to the amount of the fees owed as determined pursuant to this section and any administrative penalties owed if a nursing facility fails to remit the fees and administrative penalties owed within 30 days after the date they are due. Before recoupment of payments pursuant to this section, the state department may allow a nursing facility that fails to remit fees and administrative penalties owed an opportunity to negotiate a repayment plan with the state department. The terms of the repayment plan may be established at the discretion of the state department.

HOSPITAL BACK UP LEVEL OF CARE

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

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Contractor (SURC) must make a finding that the patient would continue to need hospital level of care.

Rate-setting under the Hospital Level Nursing Facility Clients Program is prospective and is based on an itemization of patient costs submitted by the nursing facility before the patient's admission to the facility. These costs must be based on a plan of care approved by the URC that adequately addresses each of the patient's care needs. The rate is approved by the Department prior to the client's admission to the facility. This reimbursement rate is subject to revision after the client's admission to the nursing facility based on the SURC's periodic assessment of the client's current care needs. The ceiling for payment under this program shall not exceed ninety percent (90%) of the Medicaid payment to the discharging hospital.

HOSPITAL SWING BEDS

When a hospital offers swing bed services, payment will be made at the average rate per client day paid to class I nursing facilities for services furnished during the previous calendar year. Payment for nursing facility services may not exceed the rates charged for the same services to private residents or residents with other sources of income.

Oxygen provided to swing bed patients is being paid at the same rate currently paid for residents in nursing care facilities in addition to payments made for routine services.

Recipients shall be required to contribute all patient income minus the personal needs amount to the cost of their skilled or intermediate nursing care. Collection as well as determination of the patient income amount shall be in accordance with the 10 C.C.R. 2505-10, §8.482 entitled "Resident Income and Possession".

RECOVERIES

In the event that an audit or other competent evidence reveals that a provider is indebted to the Medicaid program, the State shall recover this amount either through a repayment agreement by offsetting against current and future claims of the provider, through litigation, or by any other appropriate legal resource. Recovered amounts shall be reported to the Federal government through the HCFA 64.

APPEALS AND HEARING

The State provides an appeals or exception procedure that allows an individual nursing facility to submit additional evidence during and subsequent to the field audit of the nursing facility's annual cost report. Following completion of the rate audit process and the Department's issuance of a "rate letter" (stating the nursing facility's rate), the nursing facility is entitled to prompt administrative review through (1) informal reconsideration by the Department, and (2) a de novo hearing before an administrative law judge. Any issue relevant to the Department's

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calculation of the nursing facility's reimbursement rate may be considered during administrative review. However, the only evidence which may be admitted and considered is the evidence submitted by the nursing facility during the audit process prior to the issuance of the rate letter being appealed.

PUBLIC NURSING FACILITIES ADJUSTMENT

Effective October 25, 2001, expenditures for Medicaid services made by publicly owned nursing facilities shall be reflected in computation of an adjustment to quarterly expenditure reports. Application of this adjustment shall result in federal reimbursement, at the applicable matching rate, of total Medicaid expenditures that are up to but which do not exceed the allowable percentage of the Medicare Upper Payment Limit for nursing facility services established under federal regulations.

To complete this calculation, medicaid recipients within the publish nursing facilities shall be categorized into the forty-four (44) resource utilization groups ("RUGs") established by the Centers for Medicare & Medicaid Services for purpose of determining Medicare reimbursement. Once the RUGs categorization of Medicaid recipients is complete, a weighted average Medicare rate (which reflects the applicable rural wage index adjustment for the Prospective Payment System ("PPS")) will be calculated for each public facility. The weighted average Medicare rate will then be adjusted to remove ancillary services that are not included in the applicable Colorado Medicaid reimbursement rate for each public facility.

The weighted average per diem Medicare rate and the applicable per diem rate of Medicaid reimbursement shall then be compared. The difference between the Medicare reimbursement rate and the Medicaid reimbursement rate will be multiplied by Medicaid utilization for each public facility to determine the amount of public expenditures reflected in the quarterly payment adjustment.

IMPLEMENTATION OF A PASS-THROUGH PAYMENT SYSTEM FOR THE COSTS ASSOCIATED WITH THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA '87)

Pursuant to Senate Bill 90-18, the Department shall make pass-through payments to nursing facility providers to cover the costs associated with provisions of P.L. 101-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87)

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METHODS AND STANDARDS FOR ESTABLISHING PROSPECTIVE PAYMENT RATES
- NURSING FACILITY CARE

7. Public Nursing Facilities Adjustment

- A. Effective October 25, 2001, expenditures for Medicaid services made by publicly owned nursing facilities shall be reflected in computation of an adjustment to quarterly expenditure reports. Application of this adjustment shall result in federal reimbursement, at the applicable matching rate, of total Medicaid expenditures that are up to but which do not exceed the allowable percentage of the Medicare Upper Payment Limit for nursing facility services established under federal regulations.

To complete this calculation, Medicaid recipients within the public nursing facilities shall be categorized into the forty-four (44) resource utilization groups ("RUGs") established by the Centers for Medicare & Medicaid Services for the purpose of determining Medicare reimbursement. Once the RUGs categorization of Medicaid recipients is complete, a weighted average Medicare rate (which reflects the applicable rural wage index adjustment for the Prospective Payment System ("PPS")) will be calculated for each public facility. The weighted average Medicare rate will then be adjusted to remove ancillary services that are not included in the applicable Colorado Medicaid reimbursement rate for each public facility.

The weighted average per diem Medicare rate and the applicable per diem rate of Medicaid reimbursement shall then be compared. The difference between the Medicare reimbursement rate and the Medicaid reimbursement rate will be multiplied by Medicaid utilization for each public facility to determine the amount of public expenditures reflected in the quarterly payment adjustment.

- B. Effective July 1, 2008, public nursing facilities will receive supplemental Medicaid payments to provide reimbursement to public providers for uncompensated care related to nursing facility services for Medicaid clients, such that total payments will not exceed the Medicare Upper Payment Limit for nursing facility services by provider class (state-owned and non-state owned Government nursing facilities). The nursing facilities Medicare Upper Payment Limit will be equal to a reasonable estimate of the amount that would be paid for nursing facility services using Medicare cost principles.

Public nursing facilities will certify their uncompensated costs for providing nursing facility services for Medicaid clients based on the Department's demonstration of the uncompensated Medicaid costs calculations performed for each provider. The Public Nursing Facility Supplemental Payment (Payment) will be distributed to providers based

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on each provider's uncompensated Medicaid care costs relative to the sum of uncompensated Medicaid care costs for all providers in the class, multiplied by the available Medicare Upper Payment Limit for the class. No public facility shall receive aggregate Medicaid payments that exceed the uncompensated costs it certifies for providing nursing facility services to Medicaid clients.

Interim Payments for the Payment calendar year (January through December) will be made by December 31 of the following calendar year using as-filed cost reports to calculate uncompensated costs. Uncompensated costs will be calculated for Final Payments using audited cost reports. Final Payments will serve to adjust the Interim Payment such that the sum of the Interim and Final Payments to each provider shall equal the Payment amount calculated based on uncompensated costs calculated through audited cost reports. Final Payments will be made by June 30 of the calendar year following the year of the Interim Payment. In the event that data entry errors are detected after the Final Payment has been made, or other unforeseen payment calculation errors are detected after the Final Payment has been made, reconciliations and adjustments to impacted provider payments will be made retroactively. Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed to each provider for purposes of authorizing certification. Each provider shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Payment.

Uncompensated costs for nursing facilities with State fiscal year reporting periods (i.e. July 1 through June 30) must be calculated and approximated for the calendar year Payment using cost reports from two adjacent years following the methodology in 7.B.2 and 7.B.4.

1. Calculating uncompensated Medicaid costs for Interim Payments made to nursing facilities with financial reporting periods of January 1 through December 31.
 - a. Adjusted costs are as reported on the as-filed Colorado "Med-13" cost report, Schedule C, column 9, line 63.
 - b. Total resident days are as reported on the as-filed Colorado "Med-13" cost report, Schedule M, line D.4.
 - c. The average per-diem cost is calculated by dividing adjusted costs by total resident days.
 - d. Total Medicaid patient days are as recorded in the Colorado Medicaid Management Information System (MMIS) for the calendar year that corresponds to the reporting period of the Colorado "Med-13" cost report

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- b. Medicaid costs are calculated by multiplying the average per-diem cost by total Medicaid patient days.
 - c. Total Medicaid costs are the sum of Medicaid costs and the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report.
 - d. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the calendar year that corresponds to the reporting period of the Colorado "Med-13" cost report.
 - e. Medicaid patient payments are as recorded in the Medicaid Management Information System (MMIS) for the calendar year that corresponds to the reporting period of the Colorado "Med-13" cost report.
 - f. Total Medicaid payments are the sum of Medicaid reimbursements and Medicaid patient payments.
 - g. Uncompensated Medicaid costs are the difference between total Medicaid costs and total Medicaid payments.
 - h. Nursing facilities with uncompensated costs less than or equal to \$0 will not receive the Payment nor be required to certify their uncompensated costs.
2. Calculating uncompensated Medicaid costs for Interim Payments made to nursing facilities with financial reporting periods corresponding to the State fiscal year of July 1 through June 30.
- a. Adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the as-filed Colorado "Med-13" cost report, Schedule C, column 9, line 63.
 - b. Total resident days for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the as-filed Colorado "Med-13" cost report, Schedule M, line D.4.
 - c. The average per-diem cost for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are computed by dividing the adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) by the total resident days for the fiscal year reporting period that includes the first six months of the Payment calendar year (January through June).
 - d. Adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the as-filed Colorado "Med-13" cost report, Schedule C, column 9, line 63.
 - e. Total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the as-filed Colorado "Med-13" cost report, Schedule M, line D.4.
 - f. The average per-diem cost for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) is

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- computed by dividing the adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) by the total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December).
- g. Total Medicaid patient days for the first six months of the calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS).
 - h. Medicaid costs for the first six months of the Payment calendar year (January through June) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the first six months of the calendar year (January through June) by total Medicaid patient days for the first six months of the Payment calendar year (January through June) and adding in the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report.
 - i. Total Medicaid patient days for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).
 - j. Medicaid costs for the last six months of the Payment calendar year (July through December) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the last six months of the calendar year (July through December) by total Medicaid patient days for the last six months of the Payment calendar year (July through December).
 - k. Medicaid costs for the Payment calendar year (January through December) are computed by adding Medicaid costs for the first six months of the Payment calendar year (January through June) plus Medicaid costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) and adding in the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report.
 - l. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the first six months of the Payment calendar year (January through June).
 - m. Medicaid patient payments for the first six months of the Payment calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS).

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- n. Total Medicaid payments for the first six months of the Payment calendar year (January through June) are the sum of Medicaid reimbursements for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) and Medicaid patient payments for the first six months of the Payment calendar year (January through June).
 - o. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the last six months of the Payment calendar year (July through December).
 - p. Medicaid patient payments for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).
 - q. Total Medicaid payments for the last six months of the Payment calendar year (July through December) are the sum of Medicaid reimbursements for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) and Medicaid patient payments for the last six months of the Payment calendar year (July through December).
 - r. Total Medicaid payments for the Payment calendar year (January through December) are computed by adding total Medicaid payments for the first six months of the Payment calendar year (January through June) plus total Medicaid payments for the last six months of the Payment calendar year (July through December).
 - s. Uncompensated Medicaid costs for the Payment calendar year (January through December) are the difference between total Medicaid costs for the Payment calendar year (January through December) and total Medicaid payments for the Payment calendar year (January through December).
 - t. Nursing facilities with uncompensated costs less than or equal to \$0 will not receive the Payment nor be required to certify their uncompensated costs.
3. Calculating uncompensated Medicaid costs for Final Payments made to nursing facilities with financial reporting periods of January 1 through December 31.
- a. Adjusted costs are as reported on the audited Colorado "Med-13" cost report, Schedule C, column 11, line 63.
 - b. Total resident days are as reported on the audited Colorado "Med-13" cost report, Schedule of Adjustments, "Adjusted Balance" column.
 - c. The average per-diem cost is calculated by dividing adjusted costs by total resident days.

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- d. Total Medicaid patient days are as recorded in the Colorado Medicaid Management Information System (MMIS) for the calendar year that corresponds to the reporting period of the Colorado audited "Med-13" cost report.
 - e. Medicaid costs are calculated by multiplying the average per-diem cost by total Medicaid patient days.
 - f. Total Medicaid costs are the sum of Medicaid costs and the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report.
 - g. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" for the calendar year that corresponds to the reporting period of the Colorado "Med-13" cost report.
 - h. Medicaid patient payments are as recorded in the Medicaid Management Information System (MMIS) for the calendar year that corresponds to the reporting period of the audited Colorado "Med-13" cost report.
 - i. Total Medicaid payments are the sum of Medicaid reimbursements and Medicaid patient payments.
 - j. Uncompensated Medicaid costs are the difference between total Medicaid costs and total Medicaid payments.
 - k. Nursing facilities with uncompensated costs less than or equal to \$0 will not receive the Payment nor be required to certify their uncompensated costs.
4. Calculating uncompensated Medicaid costs for Final Payments made to nursing facilities with financial reporting periods corresponding to the State fiscal year of July 1 through June 30.

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- a. Adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the audited Colorado "Med-13" cost report, Schedule C, column 11, line 63.
- b. Total resident days for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the audited Colorado "Med-13" cost report, Schedule of Adjustments, "Adjusted Balance" column.
- c. The average per-diem cost for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are computed by dividing the adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) by the total resident days for the fiscal year reporting period that includes the first six months of the Payment calendar year (January through June).
- d. Adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the audited Colorado "Med-13" cost report, Schedule C, column 11, line 63.
- e. Total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the audited Colorado "Med-13" cost report, Schedule of Adjustments, "Adjusted Balance" column.
- f. The average per-diem cost for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) is computed by dividing the adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) by the total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December).
- g. Total Medicaid patient days for the first six months of the calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS).
- i. Medicaid costs for the first six months of the Payment calendar year (January through June) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the first six months of the calendar year (January through June) by total Medicaid patient days for the first six months of the Payment calendar year (January through June)) and adding in the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report.

TN No. 11-042
Supersedes TN No. 08-018

Approval Date DEC 20 2011
Effective Date 7/1/2011

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- h. Total Medicaid patient days for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).
- i. Medicaid costs for the last six months of the Payment calendar year (July through December) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the last six months of the calendar year (July through December) by total Medicaid patient days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December).
- j. Medicaid costs for the Payment calendar year (January through December) are computed by adding Medicaid costs for the first six months of the Payment calendar year (January through June) plus Medicaid costs for the last six months of the Payment calendar year (July through December).
- k. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES" for the first six months of the Payment calendar year (January through June).
- l. Medicaid patient payments for the first six months of the Payment calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS).
- m. Total Medicaid payments for the first six months of the Payment calendar year (January through June) are the sum of Medicaid reimbursements for the first six months of the Payment calendar year (January through June) and Medicaid patient payments for the first six months of the Payment calendar year (January through June).
- n. Medicaid reimbursements for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS). Medicaid reimbursements shall include any supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES" for the last six months of the Payment calendar year (July through December).
- o. Medicaid patient payments for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).

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- p. Total Medicaid payments for the last six months of the Payment calendar year (July through December) are the sum of Medicaid reimbursements for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) and Medicaid patient payments for the last six months of the Payment calendar year (July through December).
- q. Total Medicaid payments for the Payment calendar year (January through December) are computed by adding total Medicaid payments for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) plus total Medicaid payments for the last six months of the Payment calendar year (July through December).
- r. Uncompensated Medicaid costs for the Payment calendar year (January through December) are the difference between total Medicaid costs for the Payment calendar year (January through December) and total Medicaid payments for the Payment calendar year (January through December).
- s. Nursing facilities with uncompensated costs less than or equal to \$0 will not receive the Payment nor be required to certify their uncompensated costs.

TN No. 11-042
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**FACILITY EVACUATION PAYMENTS AND MEDICAID ADMINISTRATIVE
PROCESSES**

Medicare and Medicaid nursing facilities must take measures to adhere to all applicable federal and state processes and/or rules when affected by natural disasters and critical incidents. If situations imposed by the disaster or critical incident impedes the ability of the facility to adhere to applicable federal and/or state rules and processes, the facility will report the rule or process that cannot be followed due to the disaster to Colorado Department of Health Care and Policy and Financing (the state agency). The facility may request modification or waiver of the process and/or rule from the state agency and the request will be modified or waived at the state agency's discretion. This is applied when facilities:

- (a) Due to the disaster or critical incident, must evacuate residents from Medicare and/or Medicaid participating facilities into non-participating facilities and/or other locations, including but not limited to shelters, state licensed private nursing facilities, hospitals, community, or other;
- (b) Due to the disaster or critical incident, cannot follow federal and/or state processes and/or rules, including but not limited to, Pre-Admission Screening and Resident Review (PASRR), Institution for Mental Disease (IMD) restrictions, and/or Minimum Data Set (MDS) rules and processes;
- (c) Due to the disaster or critical incident, cannot comply with licensure and certification requirements;
- (d) Due to the disaster or critical incident, nursing facilities receive home and community based (HCBS waiver) or home health clients in order to preserve their health, safety, and welfare;
- (e) Due to the disaster or critical incident, the evacuated facility is evacuated beyond the 30-day MDS/Prospective Payment System (PPS) "emergency transfer" limit and continues to retain staff (or share staff with the receiving facility), have operational expenses, and requests payment in order to preserve client access to this Medicaid service; and
- (f) Due to the disaster or critical incident, the affected facilities (evacuated or receiving) cannot adhere to any other federal and/or state process and/or rules.

TN No. 13-054

Supersedes TN No. NEW

Approval Date MAY 21 2014

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

Evacuation Payment Methodology

The Department will use the methodology detailed in Colorado SPA 4.19-D, TN 09-013, entitled "Nursing Facility Benefits", which establishes a prospective reimbursement system for nursing facilities. To address how the methodology is applied during a disaster and resulting nursing facility evacuation, the process allows the evacuated resident to "transfer" to a receiving facility, a mutual payment agreement between the facilities to form, and a "pass-through" payment to occur.

Here is the process:

1. When a resident is transferred to a second facility with an anticipated return to the originating facility, the originating facility may bill for the services using the originating facility's provider number. The originating facility will be responsible for payment to the second facility for the services the second facility provides. This occurs when the transfer is for no more than 30 days.
 - a. A mutual agreement between the facilities is formed which addresses how to disburse reimbursement differentials, disparities, patient payment issues, shared staff, etc.
 - b. The evacuated facility will bill under its provider number and "pass through" payment to the receiving facility, and
 - c. The evacuated facility will record the census.
2. The evacuating facility should determine by day 15 whether or not residents will be able to return to the facility within 30 days. (If the residents are able to return to the originating facility, the MDS cycle will continue as though the residents were never transferred.) The intermediary will process these claims using the originating facility's provider number as if the resident had not been transferred.

TN No. 13-054

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3. If the originating facility determines that the resident will not return to their facility within the previously mentioned time frame of 30 days, the originating facility will discharge the resident as appropriate. The receiving facility will then admit the resident and complete an admission MDS (and/or a 5-day MDS) as per the OBRA/ PPS requirements. The MDS cycle will begin as of the admission date.
 - a. Prior to day 30 or on day 30, the receiving facility should discharge or admit the evacuated residents, which terminates the pass through payment process.
 - b. The evacuated facility may not bill for day 30, if the resident is admitted into the receiving facility on day 30.
 - c. If the receiving facility admits residents on day 30, it must initiate a new PAR.
4. Until the return or not date is determined, the OBRA/PPS MDSs are to continue to be done as per their respective schedules.
5. If the transfer period with the pass through payment must occur beyond the thirty days, both facilities must notify the Department that transfer cannot occur and provide supporting evidence explaining why the transfer cannot occur.
6. The Department will make a determination of whether it should grant an extended transfer period.
7. If the Department grants the extended transfer period, the "pass-through" payment system will continue until discharge or a permanent placement is possible.

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METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES - OTHER
TYPES OF CARE

16. Psychiatric Residential Treatment Facilities

METHODOLOGY

The Psychiatric Residential Treatment Facility (PRTF) reimbursement rate is an all-inclusive per diem rate based on a prospective payment model for the 24-hour treatment of Medicaid clients residing within a PRTF.

The sources used to develop the all-inclusive per diem rate include:

- a. Historical cost reports and utilization data from numerous PRTFs within Colorado
- b. Various nurse compensation benchmarking data sources including: Pay Scale, Allied Physicians, Economic Research Institute, and the Health Resources and Services Administration of the U.S. Department of Health and Human Services
- c. State of Colorado Medicaid Fee-For-Service (FFS) reimbursement rates for mental health services comparable to mental health services provided within a PRTF
- d. Subject matter expertise with broad managed care experience
- e. Subject matter expertise with developing mental health payment models, and
- f. Historical Medicaid cost and utilization claims data.

The PRTF per diem rate is determined to reimburse for the following three categories:

1. Child maintenance services including 24-hour care, room and board, and administrative services.

Costs for child maintenance services are determined using PRTF submitted facility, personnel, food, and occupancy expenses, janitorial, maintenance, rent, property taxes, etc.

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METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

16. Psychiatric Residential Treatment Facilities

2. Medical services including behavioral health therapies, medication management, psychiatrist care and supervision, case management, and rehabilitative type therapies.

Costs for medical services are determined using 660 expected minutes of care per week divided as follows:

- a. Individual Therapy (120 minutes/week),
- b. Group Therapy (240 minutes/week),
- c. Family Therapy (90 minutes/week),
- d. Treatment Team Care (60 minutes/week),
- e. Psychiatrist Care, including treatment team care, medication management, and post-intervention debriefs (90 minutes/week, services), and
- f. Occupational Therapy (60 minutes/week).

3. Registered Nurse (RN) staffing on-site 24 hours per day, 7 days per week.

Costs for RN staffing are determined using three full-time equivalent (FTE) salaries with benefits, training and ongoing education, and an additional amount to accommodate coverage during vacation time.

PROVIDER REIMBURSEMENT

The per diem rate is all-inclusive, covering all costs associated with daily care, administrative services, and room and board. No services are to be billed by the PRTF in addition to the PRTF per diem rate on the same date of service for a Medicaid client.

Payments are made to providers as they are billed with Medicaid Management Information System (MMIS) on a weekly, bi-weekly, or monthly basis.

Services shall be provided in an out-of-state setting if medically necessary and no suitable treatment option is found in Colorado. Out-of-state providers must enroll as a Colorado Medicaid Provider pursuant to 10 C.C.R. 2505-10, Section 8.013.1, and shall meet the requirements pursuant to 10 C.C.R. 2505-10, Section 8.765.5.N.1.d and Section 8.765.5.N.1.e prior to receiving payment. Payment for services provided in an out-of-state setting shall be individually negotiated by the Department. Payment is not to exceed 100% of billed charges.

TN No. 15-0032
Supersedes TN No. 06-017

Approval Date **SEP 09 2015**
Effective Date July 1, 2015

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METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

16. Psychiatric Residential Treatment Facilities

UPPER PAYMENT LIMIT (UPL) CALCULATION

The Department conducts an analysis of the prevailing private-pay and commercial-insurance rates for PRTF-like services for the purposes of setting the Upper Payment Limit (UPL) for PRTF services according to 42 CFR 447.325.

PAYMENT RATES

The PRTF rate is set according to the methodology outlined in this document and is adjusted according to Colorado General Assembly appropriation.

PRTF services shall be reimbursed at the lower of the following:

1. Submitted charges, or
2. Fee schedule for PRTF services as determined by the Department of Health Care Policy and Financing.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. The reimbursement rates were set as of July 1, 2015 and are effective for services provided on or after that date. Effective July 1, 2015, the all-inclusive per diem reimbursement rate is \$390.70.

TN No. 15-0032
Supersedes TN No. 06-017

Approval Date **SEP 09 2015**
Effective Date July 1, 2015

ATTACHMENT A

OBRA'87 Topic: Requirements Relating to Provision of Services

Summary Impact on: Nursing Facility

<u>OBRA'87 Requirement</u>	<u>State Requirement</u>	<u>Fiscal Impact</u>
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Quality of Life

- Promote the maintenance/enhancement of patient quality of life.

Previous State regulations did require social work and activity programming to meet needs of residents. State regulations also required same qualification at these regulations.

The interpretative guidelines seem to indicate a higher level of effort that required in the past. The State assumes NFs will need to increase their social work and/or activity staff personnel by approximately 25 percent of an FTE. Average costs per activity/social worker personnel is assumed to be \$10.48 per hour. Assuming a full time person works 2,080 hours, a quarter person is 520 hours. There are 183 NFs = \$997,276 x 65 percent Medicaid patients x 75 percent of the year (10/1/90 - 6/30/91) = \$486,172.

The State has a special program of providing mental health services to nursing facility residents which is not reimbursed through the nursing home rate structure and not a part of Section 4.19D. Further information on this special program is in Attachment D.

OBRA'87 Topic: 95-007
Date Approved: 8/2/96
Effective Date: 10/1/95
OBRA'87 Transmittal: 90-010

ATTACHMENT A

OBRA'87 Topic: Requirements Relating to Provision of Services

Summary Impact on: Nursing Facility

OBRA'87 Requirement

State Requirement

Fiscal Impact

Quality of Life

NF must:

- Maintain quality assessment and assurance committee - composed of nursing director, physician, and three other staff members; committee must meet quarterly to identify quality assurance activities and implement plans to correct deficiencies.

Previous State requirement.

Since NFs required to meet this requirement no increase due to OBRA'87.

Sec. 1919(b) (1)

Transmittal 92-007
Effective Date 8/2/96
Fiscal Year 10/1/95
Transmittal 90-010

ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Provision of Services

Primary Impact on: Nursing Facility

<u>OBRA '87 Requirement</u>	<u>State Requirement</u>	<u>Fiscal Impact</u>
<u>Plan of Care</u> Services must be provided according to a plan of care. Plan to be developed by: <ul style="list-style-type: none">• attending physician• RN• Resident or representative Plan must describe patients medical, nursing and psychosocial needs, and how needs will be met. Plan must be reviewed/revised periodically following resident assessment. [Sec. 1919(b)(2)]	Previous State requirement.	No new cost increase due to OBRA '87. The State has previously required comprehensive plans of care, developed by the attending physician, RN, resident or representative. OBRA '87 does introduce the new MDS form which will be the principle plan of care document. Pre-existing level of effort and cost experience will be used to meet the preparation requirements of the MDS. The State also estimates additional nursing time will be needed in the preparation than previously experience. This new level of effort is provided for in the fiscal impact found on page 3.

95-007
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12/1/95
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ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Provision of Services

Primary Impact on: Nursing Facility

<u>OBRA '87 Requirement</u>	<u>State Requirement</u>	<u>Fiscal Impact</u>
Resident assessment must be conducted by RN no later than 4 days following admission.	Not previous State requirement, however, a general assessment of resident's conditions were required.	The resident assessment requirements of OBRA 87 are more extensive than State requirements. Please see Detailed Analysis, Attachment B.
Assessment must:		
• describe resident capabilities and significant impairments in performing ADLs	Same	The PASARR assessments were conducted by agencies independent of the NFs, therefore, NFs incurred no, or very little, cost for this review.
• be based on uniform minimum data set prescribed by HHS	Same	
• identify medical problems of Medicare-eligible residents	Same	
• use State-specified instrument for Medicaid-eligible residents	Previous State requirement	
• be performed at least once every 12 months, or after significant change in condition	Not previous State requirement, however, a general assessment of resident's conditions were required.	
• be coordinated with PAS to avoid duplication	Not previous State requirement.	
Pre-admission screening (PAS) - MR/MI residents must not be admitted to NF without State MR/MI authority concurrence.		

[Sec. 1919(b)(3)]

ORIGINAL NO. 95-007
 Date Approved 8/2/96
 Date 10/1/95
 Transmittal 90-010

ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Provision of Services

Primary Impact on: Nursing Facility

OBRA '87 Requirement

State Requirement

Fiscal Impact

Required Training of Nurse Aides

Within first 4 months of employment, nurse aide must:

- complete a state-approved training and competency evaluation program
- be determined competent

Nurse aides employed as of July 1, 1989, must complete training and competency evaluation by January 1, 1990.

Training required for aides who have not performed nursing-related services for a 24-month period.

NF to provide regular in-service education.

NF must query state nurse aide registry to determine competency prior to employing aides.

[Sec 1919(b)(5)(B)]

No previous State requirement.

Significant fiscal impact (See detailed worksheet, Attachment C)

Portion of aide training expenses covered under Section 4.19D of the State Plan which is considered to be medical assistance.

Continuing education total: \$558,196 (see Attachment C for calculations and estimates).

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95-007
 8/2/96
 10/1/95
 Transmittal 90-010

ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Residents' Rights

Primary Impact on: Nursing Facility

OBRA '87 Requirement

State Requirement

Fiscal Impact

Equal Access to Quality Care

NF must maintain identical policies and practices regarding transfer, discharge and covered Medicaid services for all individuals regardless of payment source.

This requirement must be detailed in the Medicaid State plan.

Not a previous State requirement.

While not a previous State requirement, the State does not believe this will incur a significant impact beyond the level of effort currently incurred by NFs or if there is a fiscal impact, it is confined to documenting a transfer or a discharge has been completed in accordance with the new standards. The State believes these document requirements will be satisfied when the NF completes the resident assessment on residents upon transfer or discharge the resident assessment task has been found to cost more and has been included in the "add-on" payment calculation.

Based upon State surveyor knowledge of provision of care in Colorado, NFs equal access to quality of care has been provided to non-Medicaid residents.

ORIGINAL NO. 95-007
Date Approved 8/2/96
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Encodes Transmittal 90-010

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ATTACHMENT A

OBRA '87 Topic: Requirements Relating to Residents' Rights

Primary Impact on: Nursing Facility

<u>OBRA '87 Requirement</u>	<u>State Requirement</u>	<u>Fiscal Impact</u>
<u>Protection of Resident Funds</u>	Previous State requirement.	There will be a slight fiscal impact to the bookkeeping operation due to the \$50.00 rule. Amount of fiscal impact should be less than \$50,000 per year.
NF may not require residents to deposit personal funds with the facility.	Generally speaking, State requirements covered these OBRA '87 requirements in most areas. However, the requirement that all amounts of \$50.00 or more be deposited in an interest bearing account and credit the interest to the individual's account may require additional bookkeeping, as most homes currently place all personal needs money into one personal needs account. Generally speaking, no provisions are made to keep accounts with less than \$50.00 segregated from the other personal needs accounts.	\$50,000 X 65% Medicaid residents = \$32,500.
NF must, if it accepts the written authorization to manage and account for personal funds:		As stated, the State has had very extensive regulations governing the administration of personal needs funds. The only difference in the OBRA '87 regulations is the \$50.00 interest bearing provision. The State does not foresee NFs having extra staff or incurring additional time to meet this requirement. However, the State does foresee a small new level of effort for the state activities to meet the requirement. Staff would involve changing existing accounting procedures. Some NFs may expend small amounts of money in this training, reformatting activities. While it is very difficult to estimate a cost for this item, it seems reasonable to assume no more than 15 hours per NF at a cost of \$20 per professional accounting time would be sufficient for this task.
<ul style="list-style-type: none"> • Deposit all amounts \$50 and over in an interest-bearing account separate from the facility's operating account. • Credit interest to the separate account. Maintain other personal funds in a non-interest bearing account or petty cash fund. 		
<ul style="list-style-type: none"> • Keep separate accounting for each resident's personal funds and make the written records accessible to residents. 		
<ul style="list-style-type: none"> • Upon death of resident, promptly convey personal funds and final accounting to administrator of resident's estate. 		

2. Form No. 95-007
 Approved 8/2/96
 Issue Date 10/1/95
 Transmittal 90-010

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Total Attachment A Costs in Period July 1990 to June 1991

Quality of Life	\$ 486,172
Resident Assessments	795,000
24 Hour Nursing	183,660
Aides Training	2,025,242
Specified Rights	260,000
Resident Funds	32,500
TOTAL	\$3,782,574

Patient days October 1, 1990 - June 30, 1991 = 2,790,688

Add-on Rate = \$1.35

Total Attachment A Costs Which is Medical Assistance

Quality of Life	\$ 486,172
Resident Assessments	795,600
24 Hour Nursing	183,660
Aides Training	558,196
Specified Rights	260,000
Resident Funds	32,500
TOTAL	\$2,316,128

Patient days October 1, 1990 - June 31, 1991 = 2,790,688

Medical Assistance costs per day = .83 cents per day

_____ 95-007
 _____ 8/2/95
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 _____ 90-010
 Services Transmittal

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ATTACHMENT B

Detailed Analysis on Resident Assessment

Assumption #1

Effective October 1, 1990, OBRA 87 requires all residents be assessed each quarter.

Assumption #2

Nursing facilities assess residents under current practice and regulations. Much of the costs have been incurred by nursing facilities. However, the Department estimates that each assessment will require an additional 1.5 hours of nursing time to complete the assessment.

Assumption #3

There are currently 10,000 Medicaid residents. This 10,000 person enrollment is generally steady throughout the year. During any year, it is reasonable to expect nursing facilities to complete 10,000 Medicaid assessments, including admissions, transfers, quarterly reviews, etc.

Assumption #4

The average hourly costs of an RN with fringe benefits is 17.68.

Calculation

10,000 Medicaid residents
X 4 Assessments per year
10,000 Assessments
X 1.5 hours per assessment
60,000 hours
X 17.68 costs per hour
\$1,060,800
X 75% Nine months of assessments in the July 1990 to June 1991 year
\$ 795,600

Transmittal No. 95-007
Date Approved 8/2/96
Effective Date 10/1/96
Fiscal Year Transmittal 90-010

1.

ATTACHMENT C

Attended worksheet for required training of nurses aides.

Federal law and instruction allows aide training expenses associated with continuing education of nurse aides to be claimed by the states as medical assistance and as such is covered by State Plan TN 90-10. The training and certification of new aides is considered to be Medicaid administration. These figures provide detail on these two categories of costs. The costs in State Fiscal Year 1990 have already been "passed-through" to the nursing facilities in June 1990, the actual amount paid is presented in this report. The costs in State Fiscal Year 1991 are an estimate of the portion of the rate add-on the providers have received in State Fiscal Year 1991 beginning with dates of service after October 1, 1990.

Assumption #1:

The most recent figures from the Colorado Department of Regulatory Agencies (which administers the aide training certification responsibility in Colorado) show there are 7,000 nursing home aides.

Assumption #2:

There is a 50% turnover in aides per year. Each newly hired aide would need to receive 75 hours of training. Since some new aides recently received 75 hours of aide training, they would not be subject to the continuing education requirements until they are at least in their second quarter of employment. We assume that only 65% of total 3,000 aides would need continuing education a year due to the 50% turnover rate.

Assumption #3:

Aides in nursing facilities would need to complete their continuing education during the period when they are not working in the nursing facilities. Such overtime activity would cause many aides to be paid time and one-half. According to Department statistics, time and one-half would be approximately \$6.48 in the July 1989 to June 1990 period and \$7.01 in the July 1990 to June 1991 period.

Assumption #4:

Nursing facilities began the continuing education process in January 1990 as originally required by HCFA.

TRANSMITTAL NO. 95-007
 Approved 8/2/96
 Effective Date 10/1/95
 HCFA Transmittal 90-010

ATTACHMENT C

I. Aide training, certification and continuing education costs for the July 1, 1989 to June 30, 1990 period.

Total Medicaid "pass-through" expenditures to date: \$2,419,299

These pass-through payments were based on the requests submitted by providers during this period. The Department is in the process of auditing these requests to actual costs. When the providers submitted their requests, a break down between aide training and continuing education costs was not established. The audits will provide this break down. The Department estimates the following amounts were expended in the following categories:

Aide Training and certification:	2,148,421.00	(i.e., Medicaid administration)
Continuing Education:	<u>270,878.00</u>	(i.e., Medicaid assistance)
Total:	2,419,299.00	

The basis for the Department's estimates for continuing education are as follows:

1. Salary Costs

7,000	Total aides
X 65%	Aides needing continuing education
4,550	Aides needing 24 hours continuing education a year

4,550 aides X 12 hours training* X \$6.84/hour = \$373,646

2. Training Time

150 classes (with 10 aides per class) X 2. hours X \$13/hour = \$43,272

3. Total

	373,646
+	<u>43,272</u>
	416,736
X	<u>65% Medicaid residents</u>
	\$270,878

*Twelve hours of training time is specified here instead of 24 hours because the continuing education would have only been provided from January 1, 1990 through June 30, 1990

II. Aide training certification and continuing education costs for the July 1, 1990 to June 30, 1991 period.

The State is providing a rate "add-on" payment of \$1.20 beginning with dates of service beginning October 1, 1990. This rate "add-on" payment covers many new cost categories besides aide training. The Department provides a breakdown of the aide training expenses as follows:

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DATE	<u>8/2/96</u>
ISSUE DATE	<u>10/1/95</u>
	<u>90-010</u>

ATTACHMENT C

Aide Training and Certification

1. Initial Training Total: 1,467,046 (i.e., Medicaid administration)

3,500 new aides X 75 hours X \$4.21/hour = \$1,105,125

Training the Trainer

Two RNs per nursing facility X 183 homes X 445 per RN = \$162,870

Supplies and Materials

3,500 new aides X \$25/aide = \$87,500

Training Time

1,000 classes X 75 hours X \$12.00/training hour = \$901,500

TOTAL:

\$1,105,125

162,870

87,500

901,500

\$2,256,995

X 65% Medicaid share of residents

\$1,467,046

2. Continuing Education Total: \$558,196 (i.e., Medical assistance)

Salary Costs

7,000 total aides

X 65% Aides will need continuing education

4,550 aides needing 24 hours continuing education a year

4,550 aides X 24 hours training X \$7.01/hour = \$765,492

Training Costs

150 classes (with 30 aides per class) X 24 hours X \$12.00/hour = \$93,282

TOTAL:

\$765,492

+93,282

\$858,764

X 65% Medicaid share of residents

\$558,196

1.20 ?
.1 ?

3. Total amount of the \$1.20 rate add-on associated with aide training:

\$1,467,046 Training and certification

+ 558,196 Continuing education

\$2,025,242

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Amount of the 17 cents in revenue established to be Medicaid Administration and Medical Assistance.
 The 17 cents is expected to be paid during the October 1, 1990 to June 30, 1991 period.

Estimate 7/1/88 - 6/30/90	Total Aide Training and Certification costs:	2,419,299.00
	Aide Training and Certification	2,148,921.00 = Medicaid Administration
	Continuing Education	270,868.00 = Medical Assistance

The 17 cents in revenue for the 10/1/90 to 6/30/91 period is based on the OBRA'87 costs described above.

The portion of the 17 cent which relates to Medicaid Administration is 15.1 cents (2,148,421.00 ÷ 89%. 89% of 17 cents is 15.1 cents).

The portion of the 17 cents which relates to Medical Assistance is 1.9 cents (270,878 ÷ 11%. 11% of 17 cents is 1.9 cents).

ATTACHMENT D

Costs of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for benefits.

The rate add-on analysis provided in Attachments A, B and C indicates an expectation that nursing facilities will need to increase their staffing levels to meet the OBRA '87 requirements. Specifically all nursing facilities are expected to increase their social work staff on average by 25 percent of a Full Time Employee. Facilities are also expected to increase their nursing staff to complete the MOS/resident assessment and related requirements.

An additional program to promote care and treatment of the psychosocial needs of the Medicaid residents in Colorado nursing facilities includes a mental health initiative which was expected to cost \$2.8 million for the period of July 1, 1990, through June 30, 1991. This program is based on the results of the PASARR examination of the residents in Colorado facilities exhibiting evidence of mental illness. Over 2,300 PASARR reviews were completed in the last year. The PASARR exam, in addition to indicating the need for nursing facility placement, also identified the mental health needs of the residents. These exams indicated that 800 residents were in need of various forms of mental health treatments to meet their psychosocial needs.

On the basis of the needs identified in the PASARR process, a special mental health treatment program provided by the mental health professionals in the employ of local mental health clinics will be delivered to these residents. This program will provide therapies, treatments and in-house training to nursing facility staff to meet the psychosocial needs of these residents.

This program will be reimbursed by Medicaid through the rehabilitation option. Medicaid payments will go directly to the mental health clinics who will be directly treating the nursing facility residents. Since this payment methodology is not included in the rate add-on it is not included in State Plan TN 90-10. However, this \$2.8 million initiative which is in direct response to the OBRA '87 reforms should, when combined with the provision of State Plan TN 90-10 which includes a interim rate add on payment of \$1.37 (see page 4 of CDSS 2/21/91 letter) as well as retrospective adjustment to actual cost, meet the psychosocial needs of nursing facility residents.

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