THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligiblity Rule Concerning Expansion of Parent Eligiblity (HB 1293)
Rule Number:	MSB 09-11-04-A
Division / Contact / Phone:	Client and Community Relations / Corinne Lamberson / 6587

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-11-04-A, Revision to the Medical Assistance Eligiblity Rule Concerning Expansion of Parent Eligiblity (HB 1293)
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.4.G, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current existing text from §8.100.4.G through §8.100.4.G.11 with new text provided from §8.100.4.G through §8.100.4.G.10.

This change is effective 06/30/2010

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligiblity Rule Concerning Expansion of Parent Eligiblity (HB 1293)
Rule Number:	MSB 09-11-04-A
Division / Contact / Phone:	Client and Community Relations / Corinne Lamberson / 6587

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule is to expand Medical Assistance eligibility to parents up to 100% of the Federal Poverty Level (FPL). The proposed rule will expand Medical Assistance through the current 1931 Medical Assistance category. As a result, this will eliminate the Parents Plus program.

   The 1931 Medicaid category of assistance will be expanded from 28% FPL to 100% FPL and will cover parents with a Medicaid eligible child in the home. Parents with a CHP+ eligible child in the home will no longer receive medical coverage through Parents Plus and will not be eligible for coverage through the expanded 1931 category. Parents with a CHP+ eligible child were covered incorrectly without the required waiver approval from the Centers for Medicare and Medicaid Services. This population is expected to receive medical coverage through the Adults without Medicaid Dependent Children population which is slated for a 2012 implementation.

   The proposed rule will increase medical coverage for Colorado's low income parents and ensure access to preventative health care services. The Department must implement the proposed rule to comply with the Colorado Health Care Affordability Act (HB 09-1293).

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25.5-4-402.3.

Initial Review		Final Adoption	**05/14/2010**
Proposed Effective Date	**06/30/2010**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligiblity Rule Concerning Expansion of Parent Eligiblity (HB 1293)
Rule Number:	MSB 09-11-04-A
Division / Contact / Phone:	Client and Community Relations / Corinne Lamberson / 6587

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rule will affect low income parents who may be eligible for 1931 Medicaid up to 100% FPL.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The qualitative impact of the proposed rule impacts parents with very low income. The rule allows additional low income parents to become eligible for 1931 Medicaid, thus reducing the number of uninsured and underinsured persons in Colorado.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The legislation that provided the authority for the proposed rule has identified the hospital provider fee as the sole funding source for the eligibility of additional parents. House Bill 09-1293 projects between Fiscal Year 2014-2015 there will be 43,900 individuals enrolled in the Medical Assistance expansion up to 100% FPL at a total cost of $153,145,589. Of this, $76,572,795 is revenue collected from the hospital provider fee and $76,572,794 is matching federal funds.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The Department must implement the proposed rule pursuant the Colorado Health Care Affordability Act (HB 09-1293).

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   N/A

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   None

8.100.4.G. Family and Children's Covered Groups

1. For Family and Children's Medical Assistance, any person who is determined to be eligible for Medical Assistance at any time during a calendar month shall be eligible for benefits during the entire month.

2. Families whose total income does not exceed 100% of the federal poverty level~~is less than the State standard of assistance referenced in the AFDC/1931 Need Standard chart.~~ Parents or caretaker relatives eligible for this~~e~~ category shall have a dependent child in the household receiving Medical Assistance. This population is referenced as 1931 Medical Assistance.

3. Medical assistance shall be furnished to any person who is residing in a participating Medicaid facility and who would be eligible for section 1931 Medical assistance if that person resided outside a facility.

4. Persons who would be eligible for 1931 Medical Assistance except for the inclusion in the assistance unit of a relative not included as financially responsible whose income makes the unit ineligible. This procedure is referenced as the 113 rule.

5. A child born to a woman receiving Medical Assistance at the time of the child's birth is continuously eligible for one year as long as the child remains a member of the mother's household. This provision also applies in instances when the woman received Medical Assistance to cover the child's birth through retroactive Medical Assistance. To receive Medical Assistance under this category, the family need not file an application nor provide a social security number or proof of application for a social security number for the newborn. Anyone can report the birth of the baby verbally or in writing. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time. Once reported, a newborn meeting the above criteria shall be added to the Medical Assistance case according to timelines defined by the Department. Please review the Department User Reference Guide for timeframes. This population is referenced as Eligible Needy Newborn.

6. Children up to age six whose income does not exceed their proportionate share of 133% of the federal poverty level or whose total family income does not exceed 133% of the federal poverty level. This population is referenced as Expanded Child.

7. Children up to age 19 whose income does not exceed their proportionate share of 100% of the federal poverty level or whose total family income does not exceed 100% of the federal poverty level. This population is referenced as Ribicoff.

~~8. Effective July 01, 2006 and thereafter, adult parents or caretaker relatives who have a child receiving Medical Assistance or the Children's Basic Health Plan and are above the income limits for 1931 Medical Assistance and whose income does not exceed their proportionate share of 60% of the federal poverty level or whose total family income does not exceed 60% of the federal poverty level. Eligible individuals may not qualify for Medical Assistance in this category if the legislative appropriation is expended. This population is referenced as Parents Plus.~~

~~9~~8. Medical assistance shall be provided to a woman:

   a. whose pregnancy is medically verified in writing by a medical professional (a certified medical assistant or higher level position supervised by a registered nurse or doctor) confirming the pregnancy and the estimated date of delivery, if pregnancy is not observable ; and

   b. whose income does not exceed her proportionate share of 133% of the federal poverty level or whose total family income does not exceed 133% of federal poverty level.

   c. For a period beginning with the date of application for medical assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has

been approved, Medical Assistance coverage must be provided regardless of changes in the woman's financial circumstances. This population is referenced as Expanded Pregnant.

~~10~~9. A pregnant legal immigrant who has been a legal immigrant for less than five years is eligible for medical care if she meets the eligibility requirements for expectant mothers listed in 8.100.4.G.9. This population is referenced as Legal Immigrant Prenatal.

~~11~~10. If an individual is found ineligible because their income exceeds their proportionate share of the federal poverty level, a recalculation shall be performed to look at the Medical Assistance required household as a whole. The household's total income, after the allowable Medical Assistance deductions, shall be compared to the maximum federal poverty level. If the individual is then eligible under this process, they shall be eligible under the same category for which they originally were determined ineligible. This procedure is referenced as the Boatwright rule.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Nursing Facility Benefits, Submission of Cost Reporting Information, Nursing Facility Reimbursement
Rule Number:	MSB 09-12-21-A
Division / Contact / Phone:	LTB / Diane Taylor / 2336

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-12-21-A, Revision to the Medical Assistance Rule Concerning Nursing Facility Benefits, Submission of Cost Reporting Information, Nursing Facility Reimbursement
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.440, 8.442, 8.443, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace existing text from §8.440 "NURSING FACILITY BENEFITS" through §8.440.1.B.6.a with the new text provided.

Please replace existing text from §8.440.1.D through §8.440.1.D.1 with the new text provided.

Please replace existing text from §8.440.2 "SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT" through §8.440.2.C.3 with the new text provided (§8.440.2.C. 1 through 3 is new text.)

Please replace existing text from §8.442.2 "DELAYS OR CORRECTIONS IN MINIMUM (MDS) SUBMITTAL" through §8.442.2.A.1.d with the new text provided.

Please replace existing text from §8.442.3 "PROPOSED ADJUSTMENTS" through 8.442.5.B with the new text provided.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Please replace the existing text from §8.443.1.B.3 through §8.443.1.B.3.4 with the new text provided.

Please replace the existing text from §8.443.1.E through §8.443.3.A. with the new text provided.

Please replace the existing text from §8.443.7 'HEALTH CARE REIMBURSEMENT RATE CALCULATION" through§8.443.7.A.1 to the end of the second paragraph

Please replace the existing text from §8.443.7.A.5. through §8.443.7.A.18 with the new text provided than now ends at 8.443.7.A.16

Please replace the existing text from §8.443.7.C "CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH" through 8.443.8.A.19 with the new text provided (now ends at 8.443.8.A.18)

Please replace the existing text from 8.443.8.D through 8.443.8.D.11 with the new text provided (now ends at 8.443.8.D.13)

Please replace the existing text from 8.443.10 "~~RATE ADD-ON PER DIEM~~SUPPLEMENTAL PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES" through 8.443.11 end of first unnumbered paragraph with the new text provided.

Please replace the existing text from 8.443.11.5 through 8.443.12 to the end of the first unnumbered paragraph with the new text provided.

Please replace the existing text from 8.443.12.4 through 8.443.6 to the end of the unnumbered paragraph with the new text provided

Please replace the existing text from 8.443.17.4 through 8.443.17.4(vi) with the new text provided

These changes are effective 06/30/2010

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Nursing Facility Benefits, Submission of Cost Reporting Information, Nursing Facility Reimbursement
Rule Number:	MSB 09-12-21-A
Division / Contact / Phone:	LTB / Diane Taylor / 2336

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   To implement SB 09-263 that revises the nursing facility reimbursement methodology to reinstate the eight per cent (8%) per year growth limitation on allowable health care services costs and changes the per diem add-on payments for quality performance measures, cognitive loss/dementia or acquired brain injury, PASRR Level II residents and the provider fee offset to a supplemental payment paid monthly to nursing facility providers. Additionally, supplemental payments will be made from the provider fee collected from nursing facility providers for the state share of the base rate components of direct and indirect health care services costs, administrative and general services costs and capital services costs exceeding the statutory limitation on annual growth in the general fund

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   SPA 09-013 approved by CMS effective 7/1/09

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25.5-6-201 - 25.5-6-203

Initial Review		Final Adoption	**05/14/2010**
Proposed Effective Date	**06/30/2010**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Nursing Facility Benefits, Submission of Cost Reporting Information, Nursing Facility Reimbursement
Rule Number:	MSB 09-12-21-A
Division / Contact / Phone:	LTB / Diane Taylor / 2336

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   All class I nursing facilities will be affected by this rule. Class I nursing facilities with health care costs that exceed the annual growth limit of eight percent (8%) will be affected by this rule to the extent actual health care costs are not reimbursed. With a statutory General Fund 0% growth limitation, growth of actual base rate costs of class I nursing facilities will be shifted to reimbursement from a provider fee charged and collected on all class I nursing facility non-Medicare days with some exceptions. Medicaid-certified facilities receive back a portion of the provider fee through supplemental payments reimbursing the base rate that exceeds the General Fund growth limitation in addition to an enhanced program for quality improvement and additional reimbursement for facilities that serve residents with moderate to severe cognitive loss/dementia/acquired brain injury and who serve residents with major mental illness and/or developmental disabilities. Facilities that are not Medicaid-certified bear the cost of the provider fee without benefits of the enhanced program and additional reimbursements.

   2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The quantitative impact of the health care services costs growth limitation is estimated to reduce overall class I nursing facility reimbursement by approximately $7 Million. The shift from funding base components with General Fund to funding with a provider fee is estimated to be approximately $12 Million. These changes are not expected to affect the quality of care to class I nursing facility residents.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The effect on state revenues is to reduce General Fund expenditures by approximately $15 Million - $12 Million shifting base components to provider fee reimbursement and $3 Million as the state's share of the health care growth limitation.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

This rule will reduce the General Fund share of nursing facility payments. The Department will be in statutory violation without the implementation of this rule. Inaction also increases the General Fund share of nursing facility per diem payments to current trending models of 4.5% annually from the 0% growth limitation of this rule.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   None

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department worked with both long term care associations and the Department's JBC analyst to reduce General Fund payments in the least restrictive way possible. Various ways to implement General Fund savings were considered, but the proposed system was agreed by all parties to be best for the providers, beneficiaries and the Department.

8.440 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. "Actual cost" or "cost" means the audited cost of providing services.

3. "Administration and General Services Costs" means costs as defined at 8.443.8.

4. "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."

   The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by the state board.

5. "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

6. a. "Base value" means:

   i) The appraised value of a capital-related asset for the fiscal year 1986-87 and every fourth year thereafter.

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

   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.

~~7~~7. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

~~8~~8. "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

~~9~~9. "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 DONs, registered nurses, licensed practical nurses, certified nurse aides and restorative nurses.

1~~0~~0. "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.

1~~1~~1. "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.

1~~2~~2. "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.

1~~3~~3. "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. Swing bed facilities are not included as class I facilities.

1~~4~~4. "Core Components" means the health care, administrative and general and fair rental allowance for capital-related assets prospective per diem rate components.

1~~5~~5. "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.

~~16~~16. "Direct or indirect health care services costs" means the costs incurred for patient support services as defined at 8.443.7

~~17~~17. "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.

~~18~~18. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

~~19~~19. "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.

~~20~~20. "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.

~~21~~21. "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.

~~22~~22. "Median per diem cost" means the 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.

~~23~~23. "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 Medicare and Medicaid programs.

~~24~~24. "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.

~~25~~25. "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.

~~26~~26. "Nursing facility provider" means a facility provider that meets the state nursing ~~home~~ facility 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.

~~27~~27. "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse's aides.

~~28~~28. "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.

~~29~~29. "Occupancy-imputed days" means the use of a predetermined number for patient days rather than actual patients days in computing per diem cost.

~~30~~30. "Per diem cost" means the daily cost of care and services per patient for a nursing facility provider.

~~31~~31. "Per diem rate" means the daily dollar amount of reimbursement that the state department shall pay a nursing facility provider per patient.

~~32~~32. "Provider fee" means a licensing fee, assessment, or other mandatory payment as specified under 42 CFR 433.55.

~~33~~33. "Raw food" means the food products and substances, including but not limited to nutritional supplements, that are consumed by residents.

~~34~~ 34. "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.

~~35~~35. "Resource utilization group" (RUG) means the system for grouping a nursing facility's residents according to their clinical and functional status identified from data supplied by the facility's minimum data set as published by the United States Department of Health and Human Services.

~~36~~36. "Statewide average per diem rate" means the average daily dollar amount of the per patient payments to all Medicaid-participating facility providers in the state.

~~37~~27. "Medicare patient day" means all days paid for by Medicare. For instance, a Medicare patient day includes those days where Medicare pays a Managed Care Organization for the resident's care.

~~38~~38. "Per diem fee" means the daily dollar amount of provider fee that the state department shall charge a nursing facility provider per non-Medicare day.

39. "Substandard Quality of Care means one or more deficiencies related to participation requirements under 42 CFR 483.13, resident behavior and facility practices, 42 CFR 483.15, quality of life, or 42 CFR 483.25, quality of care, that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F)" per State Operations Manual, chapter 7.

40. "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.

8.440.1 SERVICES AND ITEMS INCLUDED IN THE PER DIEM PAYMENT

8.440.1.A. Payment to ~~skilled~~ nursing facilities, swing-bed facilities and intermediate ~~nursing~~ care facilities for the mentally retarded shall be an all inclusive per diem rate, except as provided for within this rule. This rate covers the necessary services to the resident, including room and board, as well as nursing and ordinary supplies and equipment related to the day-to-day care of the resident and the operation of the facility.

8.440.1.B. The following general service areas shall be provided within the per diem rate:

1. Nursing services, therapies, aide services and medically related social services;

2. Dietary services;

3. Activities program;

4. Room/bed maintenance services;

5. Routine personal hygiene items and services; and

6. Laboratory services.

   a. Waivered laboratory services provided by nursing facilities enrolled in the Medicaid program are subject to the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as set forth in 42 C.F.R. 493, October 1, 1994 edition. No amendments or later editions are incorporated. Facilities that collect specimens, including drawing blood specimens, but do not perform testing of specimens, are not subject to CLIA requirements. A facility shall obtain a Certificate of Waiver from the Centers for Medicare and Medicaid or its designated agency if the facility only performs waivered tests as defined by CLIA.~~.~~

8.440.1.D. All supplies, including disposables, necessary for effective resident care shall be provided by the nursing facility within the per diem rate. Such supplies include, but are not limited to, the following:

1. ~~Bandaids~~Band-Aids, gauze pads, dressings and bandages;

8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT

8.440.2.A. The following general categories and examples of items and services are not included in the facility's per diem rate. Items 1 – ~~12~~ 11 may be charged to the resident's personal needs funds if requested, in writing by a resident and/or the resident's family:

1. Cosmetic and grooming items and services in excess of those for which payment is allowed under the per diem rate, i.e., beauty permanents, hair relaxing, hair coloring, hair styling, hair curling, shaving lotion and cosmetics such as lipstick, perfume, eye shadow, rouge/blush, haircuts, beyond simple trimming, normally performed by licensed barbers or beauticians;

~~2. Flowers and plants;~~

~~3~~2. Gifts purchased on behalf of a resident;

~~4~~3. Non-covered special care services, i.e., a private duty nurse not employed by the nursing facility, prescribed by the resident's physician;

~~5~~4. Items or services requested by the resident, including but not limited to, over the counter drugs/related items not prescribed by a physician, not included in the nursing care plan and not ordinarily furnished for effective patient care. In these instances, it is required that:

a. The resident has made an informed decision supported by a statement in the Personal Needs Funds file that he/she/family is willing to use personal funds.

b. The balance in the Personal Needs Funds in the resident's ledger is sufficient to cover the charge.

~~6~~5. Personal clothing and dry cleaning;

~~7~~6. Personal comfort items, including smoking materials, notions, novelties and confections/candies;

~~8~~7. Personal reading material, subscriptions;

~~9~~8. Private room;

~~10~~9. Social events and entertainment offered off premises and outside the scope of the regular facility activities program;

~~11~~10. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. If the resident refuses the prepared food the facility shall offer substitutes. Residents may be charged only for specially prepared food if they are informed that there will be a charge, and the charge may be only the difference in price between the requested item and the covered item pursuant to 42 C.F.R. 483.35.

~~12~~11. Telephone, television/radio for personal use, if not equally available to all residents.

~~13~~12. Provider fee.

~~14~~13. Prescription drugs, with certain specific exemptions.

~~15~~14. Ambulance and medical transport, including emergent and non-emergent.

~~16~~15. Oxygen

~~17~~16. Physician fees

~~18~~17. Non-nursing costs, including but not limited to direct and indirect outpatient therapy, assisted living, independent living, adult day care and meals-on-wheels.

8.440.2.B. The Department's approval shall be required in order for a resident or his/her relatives to be billed for the following:

1. The physician orders that a full-time R.N. or L.P.N. is needed. The R.N. or L.P.N. is not employed by the nursing facility and has duties limited to the care of a particular resident, or two such residents in the same room.

2. The physician orders a private room.

3. The attending physician shall indicate the medical necessity on the resident's chart for either service above and shall submit to the Department a completed copy of Form 10013 (Physician's Request for Additional Benefits).

4. Upon approval of the Form 10013, payment for such services may be received from the resident's personal needs fund, relatives or others.

8.440.2.C The following items are allowable costs for class II and class IV facilities only:

1. Eye/Hearing examinations

2. Eyeglasses and repairs

3. Hearing aids and batteries

8.442.2 DELAYS OR CORRECTIONS IN MINIMUM DATA SET (MDS) SUBMITTAL

8.442.2.A. A nursing facility shall be notified each quarter of its residents' case mix index values, and shall be granted not less than 14 calendar days in which to make any corrections to the resident MDS assessments. After the period of time for correcting resident assessments has passed each quarter, the final nursing facility resident assessment data shall be used by the Department, or its designee, to calculate that quarter's resident case mix acuity adjustment for each facility.

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

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

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

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

~~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.~~

8.442.3 PROPOSED ADJUSTMENTS

8.442.~~4~~ 3.A. Following completion of a field audit, desk review or rate calculation, the Department or its contract auditor shall notify the affected nursing facility in writing of any proposed adjustment(s) to the costs reported on the facility's MED-13 form and the basis of the proposed adjustment(s).

8.442. ~~4~~3.B~~.A~~. The facility shall have 35 calendar days from the date the notification was mailed to submit additional documents or other supporting information to the Department or its contract auditor in response to the proposed adjustment(s).

8.442.~~4~~3.C~~.B.~~ The Department may grant an additional period, not to exceed 30 calendar days, for the facility to submit such documents and information, when necessary and appropriate, given the facility's particular circumstances.

8.442.3.D. The Department's contract auditor shall complete the field audit, desk review or rate calculation within 30 days of the expiration of the 35 day provider response period. The contract auditor shall also complete and deliver the resulting rate letter to the Department by the 30th day following the expiration of the 35 day provider response period.

~~**8.442.5 OUT OF STATE FINANCIAL RECORD REVIEW**~~

~~8.442.5.A. Nursing facilities owned by organizations maintaining financial records outside the State of Colorado may elect to pay $300 for auditing financial records at the home office in lieu of making such records available at the Colorado facility.~~

~~8.442.5.B. The fee shall be payable to the Department upon submission of the MED-13 form along with a letter stating the home office location.~~

8.443 NURSING FACILITY REIMBURSEMENT

8.443.1.B. 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.

The Health Care, Administrative and General and Fair Rental Allowance for Capital-Related Assets components are referred to as "core components" .

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

~~4~~1. ~~An additional per diem rate to nursing facility providers who have r~~Residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury.

~~5~~2. ~~An additional per diem rate for those r~~Residents who have severe mental health conditions that are classified at Level II by the Medicaid program's Preadmission Screening and Resident Review (PASRR) assessment tool.

~~6~~3. ~~An additional per diem rate for c~~Care and services rendered to Medicaid residents to recognize ~~per diem~~the costs of the provider fee. Only Medicaid's portion of the provider fee will be included in the ~~rate add-on~~supplemental payment. The provider fee ~~add-on~~supplemental payment shall not be equal to the amount of the fee charged and collected but shall be an amount equal to ~~the~~ a calculated per diem fee charged multiplied by the number of Medicaid resident days for the facility. Costs associated with the provider fee are not an allowable cost on the MED-13.

~~7~~-4. ~~Beginning July 1, 2009, an additional per diem amount for~~Facilities that have implemented a program meeting specified performance criteria beginning July 1, 2009.

8.443.1.E. For swing-bed facilities, the annual payment rate shall be determined as the state-wide average class I nursing facilities payment rate at January 1 of each year.

8.443.1.~~E~~F. 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), and

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

3. Meets the requirements of the Department's regulations.

8.443.2 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 ~~sixteen or more~~ 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.

   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.

8.443.3 IMPUTED OCCUPANCY FOR CLASS II AND PRIVATELY OWNED CLASS IV FACILITIES

8.443.3.A. The Department or its designee shall determine the ~~what are audited allowable costs per patient day~~audited allowable costs per patient day.~~.~~

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

8.443.7.A 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), the provider must keep contemporaneous time records or perform time studies 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. Time studies used must meet the following criteria:

5. Non-prescription drugs ordered by a physician ~~which~~ that are included in the per diem rate.

6. Consultant fees for nursing, medical records, registered dieticians, 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.

7. Purchases, rental, depreciation, interest and repair expenses of health care equipment and medical supplies used for health care services such as nursing care, medical records, social services, therapies and activities. ~~No equipment shall be considered health care unless it is listed below:~~

   ~~Tub purchased or leased because of medical necessity~~

   ~~Mattress purchased or leased because of medical necessity~~

   ~~Beds purchased or leased because of medical necessity~~

~~Bed Rails~~

~~Wheelchairs and related accessories~~

~~Patient Lift~~

~~Patient Lift Chair Recliner~~

~~Charting System~~

~~Med-Cart~~

~~Exercise equipment~~

~~Scale~~

~~Thermometer~~

~~Trapeze~~

~~Oximeter~~

~~Apnea Monitors~~

~~Canes, Crutches and Walkers~~

~~Infusion, Suction and Lymphedema Pumps~~

~~TENS Units~~

~~Vaporizers, Room Type~~

~~Computers and related software used in health care departments~~

~~Equipment ordered by a physician due to medical necessity~~

~~Purchased oxygen concentrators per 8.441.5K~~

~~8. Medical Supplies. Office supplies are not considered a health care expense.~~

~~9. Depreciation and interest for major health care equipment purchases. No equipment shall be considered health care unless it is listed in (7) above;~~

~~10~~8. Purchase or rental of motor vehicles and related expenses, including salary and benefits associated with the van driver(s), for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. An example of the dual purpose vehicle is one used for both resident transport and maintenance activities.

~~11~~9. Copier lease expense, computers and software used in the departments classified as health care, as documented by appropriate logs or other auditable documentation.

~~12~~10. Salaries, fees, or other expenses related to health care duties performed by a facility owner or manager who has a medical or nursing credential. Note that costs associated with the Nursing Home Administrator are an administrative and general cost.

~~13.~~11. Related Party Management Fees and Home Office Costs

Related party management fees and home office costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the related party which are listed in this section, may be included in the health care cost center equal to the actual costs incurred by the related party. To be included in the health care cost center, the provider must show a direct relationship between the health care costs incurred and the facility receiving the services. Allocations, time studies or estimates will not be allowed. For example, home office or management company nurses must keep contemporaneous time logs in 15 minute increments supporting the number of hours worked at each facility. In addition, documentation supporting the nurse's cost must be maintained. Only salaries, payroll taxes and employee benefits associated with health care personnel will be considered as allowable in the health care cost center. No overhead expenses will be included. Even if a related party exception is granted in accordance with CCR 8.441.5.I.4, no mark-up or profit will be allowed in the health care cost center, only supported actual costs.

Non-Related Party Management Fees

Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.

~~14.~~12. Professional liability insurance, whether self-insurance or purchased, loss settlements, claims paid and insurance deductibles.

~~15~~13. Medical director fees.

~~16~~14. Therapies and services provided by an individual qualified to provide these services under Federal Medicare/Medicaid regulations including:

Utilization review

Dental care, when required by federal law

Audiology

Psychology and mental health services

Physical therapy

Recreational therapy

Occupational therapy

Speech therapy

~~17~~15. Nursing licenses and permits, disposal costs associated with infectious material (medical or hazardous waste), background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

~~18~~16. 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.

8.443.7.C. CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

For the fiscal year beginning 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.

8.443.7.~~C~~ D. 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. This payment shall not exceed the health care limit described at 8.443.7B. 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 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 direct 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.

   b. The statewide health care maximum allowable reimbursement rate (calculated at 8.443.7B) 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 indirect health care maximum allowable reimbursement shall be determined as follows:

   a. The percentage of the indirect health care per diem cost to total health care cost shall be determined by dividing the indirect 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 in direct 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 the case mix reimbursement rate component.

5. The indirect 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.

8.443.7.~~D~~ E DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV FACILITIES

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

2. For non-state administered class IV facilities, one hundred twenty-five percent (125%) of the median 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 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~~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 2nd.

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.

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.

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

8.443.8 REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

8.443.8.A. 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 in 8.443.7.A.1.

2. Any portion of other staff costs directly attributable to administration.

3. Advertising and public relations.

4. Recruitment costs and staff want ads for all personnel.

5. Office supplies.

6. Telephone costs.

7. Purchased services: accounting fees, legal fees; computer services. A computer service refers to any costs associated with the information technology system such as repair, maintenance and upgrades.

~~8. Computers and related software used in administrative departments.~~

~~9~~8. Management fees and home office costs, except as described in 8.443.7.A.13.

~~10~~9. Licenses and permits (except health care licenses and permits) and training for administrative personnel, dues for professional associations and organizations.

~~11~~10. All business related travel of facility staff and consultants, except that required for transporting residents to activities or for medical purposes.

~~12~~11. Insurance, including insurance on vehicles used for resident transport, is an administrative cost. The only exception is professional liability insurance, which is a health care cost.

~~13~~12. Facility membership fees and dues in trade groups or professional organizations.

~~14~~13. Miscellaneous general and administrative costs.

~~15~~14. 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.

~~16~~15. Purchases (including depreciation and interest), rentals, repairs, betterments and improvements of equipment utilized in ~~administration~~administrative departments~~.~~, including but not limited to the following:

Resident room furniture and décor, excluding beds and mattresses

Office furniture and décor

Dining room and common area furniture and décor

Lighting fixtures

Artwork

Computers and related software used in administrative departments

~~17~~16. Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below.

~~18~~17. 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.

~~19~~18. Background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

8.443.8.D Determination of the Administrative and General Maximum Allowable Rate (Limit) for Class II and IV Facilities.

The determination of the reasonable cost of services shall be made every 12 months. 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 median actual costs of all class II facilities.

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

3. ~~The determination of the reasonable cost of services shall be made every 12 months.~~ Determination of the rates 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 May 2.

~~4. Determination of the rates 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.~~

~~5~~4. 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.

~~6~~5. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

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

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

~~7~~6. 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.

~~8~~7. 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.

~~9~~8. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.8.E. 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. Determination of the class I rates beginning on July 1 each year shall utilize the most current MED-13 cost report submitted, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

~~1~~2. 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~~3. 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~~4. In computing per diem cost, each nursing facility provider shall annually submit cost reports to the Department.

~~4~~5. Actual days of care shall be counted rather than occupancy-imputed days of care.

~~5~~6. 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~~7. 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~~8. 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 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~~9. 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~~10. 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~~11. 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.

12. For fiscal years commencing on and after July 1, 2009, through the fiscal year commencing July 1, 2014, if a reallocation of management costs between administrative and general costs and the health care costs causes a nursing facility provider's administrative and general costs to exceed the reasonable price established by the state department, the state department may pay the nursing facility provider the higher per diem payment for administrative and general services.

~~11~~13. The reasonable price will be phased in over three years in accordance with the following schedule:

8.443.10 ~~RATE ADD-ON PER DIEM~~SUPPLEMENTAL PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES

8.443.10.A In addition to the reimbursement components paid pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets), the state department shall pay ~~an additional per diem~~a supplemental payment~~ rate~~ 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 pay a ~~an additional per diem rate~~supplemental 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).

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

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

3. Those facilities with a CPS percentage greater than the mean plus one, two or three standard deviations will receive an add-on rate for their Medicaid residents with a CPS score of 4, 5, or 6 in accordance with the following table:

   Mean plus one standard deviation $1.00

   Mean plus two standard deviations $2.00

   Mean plus three or more standard deviations $3.00

4. If the expected average ~~rate add-on~~payment for those residents receiving ~~an add-on~~a supplemental payment is less than one percent of the average nursing facility rate (prior to ~~rate add-ons~~supplemental payments), the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid ~~add-on~~supplemental payment equal to one percent of the average nursing facility rate prior to ~~add-on~~supplemental payments.

5. These calculations will be performed annually to coincide with the July 1st rate setting process. Each facility's aggregate CPS add-on will be calculated by taking the add-on rate times Medicaid days with a CPS score of 4, 5 or 6.

6. The CPS ~~add-on to each provider's per diem rate~~supplemental payment will be calculated by dividing the facility aggregate CPS amount determined above by the facility's expected Medicaid case load (Medicaid patient days). Medicaid case load for each facility will be determined using Medicaid paid claims data for the calendar year ending prior the July 1st rate setting. Providers with less than a full year of paid claims data will have their case load annualized.

8.443.10.B For those residents who have severe mental health conditions or developmental disabilities that are classified at Level II by the Medicaid program's preadmission screening and resident

review assessment tool (PASRR II), the nursing facility provider shall ~~have an amount added to its per diem rate~~be paid a supplemental payment.

1. On May 1st each year, 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 add-on 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 per diem PASRR II rate.

3. The ~~per diem~~supplemental PASRR II ~~rate~~ payment will be calculated as two percent of the statewide average per diem rate for the combined rate components paid pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets),

4. The ~~per diem~~supplemental PASRR II ~~rate add-on~~payment for each facility will be calculated by dividing the aggregate PASRR II payment by expected Medicaid case load (Medicaid patient days). Medicaid case load for each facility will be determined using Medicaid paid claims data for the calendar year ending ~~prior~~ prior to the July 1st rate setting. Providers with less than a full year of paid claims data will have their case load annualized.

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

6. An additional supplemental 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, drumming and medication. 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.

7. Facilities that offer specialized behavioral services must meet the specified criteria described above and have the program approved by the Department. The additional payment for facilities that have an approved specialized behavioral services program will be calculated as follows:

   On May 1st each year, the Department will identify those Medicaid residents meeting the PASRR II criteria for the nursing facility with an approved specialized behavioral program.

   The Department will determine the number of PASRR II days eligible for the PASRR II specialized behavioral program add-on by taking the number of PASRR II residents in the facility on May 1st times 365 days. The Department will then calculate the aggregate PASRR II payment for the facility by taking the number of PASRR II eligible days times the per diem PASRR II rate.

   The ~~per diem~~supplemental PASRR II ~~rate~~ payment will be calculated as two percent of the statewide average per diem rate for the combined rate components paid pursuant to

8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets),

8.443.10.C In addition to the per diem core rate components paid pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets) the state department shall pay a nursing facility provider an additional ~~per diem~~supplemental amount for care and services rendered to Medicaid residents to offset payment of the provider fee. This amount shall not be equal to the amount of the fee charged and collected but shall be an amount equal to the per diem fee charged multiplied by the number of Medicaid resident days for the facility.

1. Each July 1st the Department will ~~estimate~~ calculate the funding obligation required to pay for ~~add-on~~supplemental payments related to CPS (8.443-10A), PASRR II (8.443.10B), Pay for Performance (8.443.12) and any annual increase greater than ~~three percent~~the statutory limitation in the growth of the general fund share of the aggregate statewide average per diem rate described in 8.443.11.

2. Once the funding obligation is determined, that amount will be divided by ~~total patient days~~twelve to determine the ~~per diem~~ supplemental payment amount that will be ~~added~~ paid monthly to each facility~~'s per diem rate~~ as a pass through payment.

   The following example illustrates how the state department will calculate the per diem amount to be added to each facility's Medicaid per diem rate to offset the provider fee:

   Example Facility's Provider Fee Medicaid ~~Per Diem Rate Add-On~~Supplemental Payment

7/1/xx provider fee per diem required to cover funding obligation	$7.30
TIMES: Expected non-Medicare ~~patient~~ resident days during the state fiscal year	17,000
EQUALS: 7/1/xx FY actual facility provider fees which will be paid	$124,100
DIVIDED BY: Expected total ~~patient~~ resident days during the state fiscal year	20,000
EQUALS: ~~7/1/xx FY~~ per diem amount per resident ~~to add to each facility's~~	$6.21.
TIMES: Medicaid ~~per diem~~resident ~~payment~~days	~~$6.21~~16,000
Total annual supplemental payment	$99,360
DIVIDE BY: Twelve Months for monthly	$8,280

supplemental payment	

8.443.11 FUNDING SPECIFICATIONS

The general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets) shall be limited ~~to~~by statute. ~~an annual increase of three percent~~. 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 an annual three percent increase in the~~ exceeding the statutory limitation on annual growth in the general fund share of the aggregate statewide average of the per diem rate net of patient payment, proportional decreases will be made to the rates so that anticipated payments will equal ~~a three percent increase~~the statutory growth limitation in the general fund share of the per diem rate. 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.

5. For SFY 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 ~~three percent~~the statutory growth limitation over the prior SFY. These determinations ~~we~~ 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. Provider fee revenue will first be used to pay the provider fee offset payment, then the state's share of the per diem rate over the general fund cap, then the Pay-for-Performance program and then payments for severe mental health conditions, cognitive dementia and acquired brain injury. ~~state share of CPS, PASRR II, provider fee and pay for performance rate add-ons~~. 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.

7. The following calculation illustrates the above and, for illustration purposes, assumes the statutory limit on general fund is 3%:

   2505_10_20090830_8-443-11inline.jpg

8.443.12 PAY-FOR-PERFORMANCE COMPONENT

Starting July 1, 2009, the Department shall ~~pay~~make a ~~an additional per diem rate~~a supplemental 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~~ 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.

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 matrix.

6. The per diem rate add-on will be calculated according to the following table:

   0 – ~~20~~ 45 points = No add-on

   ~~21 – 45 points = $1.00 per day add-on~~

   46 – 60 points = $~~2~~1.00 per day add-on

   61 – 79 points = $~~3~~2.00 per day add-on

   80 – 100 points = $~~4~~3.00 per day add-on

   If the expected average ~~rate add-on~~payment for those facilities receiving ~~an add-on~~a supplemental payment is less than ~~five-tenths~~twenty-five hundredths of one percent of the statewide average per diem base rate ~~(prior to rate add-ons)~~, the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid add-on payment equal to ~~five-tenths~~twenty-five hundredths of one percent of the average nursing facility base rate ~~prior to add-on payments~~.

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

8.443.17 PROVIDER FEES

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 pursuant to 8.443.17.B.1

        (ii) CPS pursuant to 8.443.10.A

        (iii) PASRR pursuant to 8.443.10.B

        (iv) Pay for Performance pursuant to 8.443.12

        (v) Provider Fee Offset Payment pursuant to 8.443.10.C

        (vi) Excess of ~~3%~~the statutory limited growth in the general fund pursuant to 8.443.11

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Amending Hospital Supplemental Payments, § 8.300.8 B and 8.903.C
Rule Number:	MSB 10-03-08-A
Division / Contact / Phone:	State Programs and Federal Financing / Cindy Arcuri / X3996

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 10-03-08-A, Revision to the Medical Assistance Rule Concerning Amending Hospital Supplemental Payments, Sections 8.300.8 B and 8.903.C
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.300.8.B and 8.903.C, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current existing text from §8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment through 8.300.8.B.2 1st unnumbered paragraph with new text provided from §8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment through 8.300.8.B.2 (unnumbered paragraph has been deleted.)

Please replace current existing text from §8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS through 8.903.C.16 with new text provided from §8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS through §8.903.C.9.

Effective 06/30/2010

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Amending Hospital Supplemental Payments, § 8.300.8 B and 8.903.C
Rule Number:	MSB 10-03-08-A
Division / Contact / Phone:	State Programs and Federal Financing / Cindy Arcuri / X3996

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This proposed rule modifies and/or deletes sections of current rule that are to be replaced upon implementation of the Colorado Health Care Affordability Act of 2009 (Act) , C.R.S. 25.5-4-402.3. The Act authorizes the Department to assess a hospital provider fee to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program (CICP) and expand Medicaid and Child Health Plan Plus (CHP+) health coverage. This new proposed fee-based reimbursement methodology replaces the current methodology for making supplemental Medicaid and disproportionate share hospital payments to hospitals.

   The rule deletes portions of 8.300.8B and 8.903.C related to payments to hospitals that will no longer be made under the new proposed fee-based reimbursement methodology. The "Pediatric Major Teaching Hospital Payment" will continue to be made, and a portion thereof will be funded with the proposed hospital provider fee. Existing rule pertaining to payments to clinics that serve low-income uninsured populations remain unchanged because the hospital provider fee reimbursement methodology applies only to payments for hospital-based services.

   Implementation of the Act is subject to federal approval of State Plan Amendments by the Centers for Medicare and Medicaid Services (CMS), retroactive to July 1, 2009.

   Concomitant approval of proposed State rule MSB 10-03-08-B, instituting the new proposed hospital provider fee collection and disbursement financing mechanism, is necessary. If this proposed rule MSB 10-03-08-A is promulgated without concurrent acceptance of proposed MSB 10-03-08-B, no State regulatory authority will exist to make supplemental Medicaid and disproportionate share hospital payments to hospitals beyond April 9, 2010.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

☐ for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

   42 CFR 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25.5-4-402.3

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Amending Hospital Supplemental Payments, § 8.300.8 B and 8.903.C
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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Colorado hospitals will benefit from increased Medicaid and Colorado Indigent Care Program (CICP) reimbursements made possible through provider fee funding under proposed rule MSB 10-03-08-B. Low-income uninsured persons will benefit from expanded Medicaid and Child Health Plan Plus (CHP+) eligibility. This rule, MSB 10-03-08-A, is a companion rule to MSB 10-03-08-B, and deletes portions of current rule that will no longer be applicable upon approval of MSB 10-03-08-B.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The provider fee proposed under the companion rule MSB 10-03-08-B will generate an additional $189.4 million in federal funds to increase reimbursements to hospitals. Hospitals will have a net impact of $86 million.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no administrative costs associated with deleting portions of this rule that will no longer be applicable upon approval of the companion rule MSB 10-03-08-B.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   In the long run, in addition to increased payments to Colorado hospitals, the provider fee mechanism of the companion rule MSB 10-03-08-B will offer health insurance coverage to an additional 100,000 low-income Coloradans through Medicaid and Child Health Plan Plus (CHP+) expansions. The changes proposed in MSB 10-03-08-A are to delete portions of current rule that will no longer be applicable under MSB 10-03-08-B.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Deleting portions of current rule is the most efficient method to ensure that rules will not conflict with State Plan Amendments and Colorado statute implementing the provider fee mechanism proposed under the companion rule, MSB 10-03-08-B.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

The Department has worked for over a year with stakeholders, consultants and the Centers for Medicare and Medicaid Services (CMS) to achieve an acceptable provider fee structure. The Hospital Provider Fee Oversight and Advisory Board, created under the Colorado Health Care Affordability Act of 2009, recommends the adoption of this proposed rule and its companion rule, MSB 10-03-08-B.

8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

1. Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a ~~Low Income~~ CICP Disproportionate Share Hospital Payment defined in 10 CCR 2505-10 section 8.~~903~~2000.

2. Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive an ~~Low Income Shortfall~~ Uninsured Disproportionate Share Hospital ~~p~~Payment defined in 10-CCR 2505-10 section 8.2000.

~~The total available funds for the Low Income Shortfall payment equals the percentage of Self Pay Days plus Other Paid Days of those providers who qualify for the Low income Shortfall payment compared to all other Medicaid Inpatient Hospital providers multiplied by the General Fund appropriated by the General Assembly to Safety-Net Provider Payments. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital-specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low-Income Shortfall payment for the specific provider.~~

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Contract Requirements for Qualified Health Care Providers

1. A contract will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by 26-15-106 (5)(a)(I), C.R.S.

2. A contract will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver metropolitan area and complex care that is not contracted for in the remaining areas of the state, as required by (5)(a)(II), C.R.S.

3. Contracts may be executed with general providers throughout Colorado that can meet the following minimum criteria:

   a. Licensed or certified as a general hospital, community health clinic, or maternity hospital (birth center) by the Department of Public Health and Environment.

   b. Hospital providers shall assure that emergency care is available to all clients throughout the contract year.

   c. Hospital providers shall have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

   d. If the general provider is located within the City and County of Denver, the general provider must offer discounted specialty health care services to a specific population, of which more than 50% must reside outside the City and County of Denver (does not apply to University Hospital or Denver Health).

B. Determination of Client Eligibility to Receive Discounted Health Care Services Under Available CICP Funds

1. Using the information submitted in connection with an application to receive discounted health care services under available CICP funds, the provider shall determine whether the applicant meets all requirements to receive discounted health care services under available CICP funds. If the applicant is eligible to receive discounted health care services under available CICP funds, the qualified health care provider shall determine an appropriate rating and copayment for the client, using the current federal poverty levels published in The Federal Register (referred to as the ability-to-pay scale) and copayment table, under section 8.907 in these regulations.

2. The qualified health care provider should determine if the applicant is eligible to receive discounted services under available CICP funds at the time of application, unless required documentation is not available. The qualified health care provider shall determine whether the applicant is eligible to receive discounted health care services

within 15 days from the date that the applicant submits a signed application and such other information, written or otherwise, as is necessary to process the application.

3. The qualified health care provider shall provide the applicant and/or representative a written notice of the provider's determination as to the applicant's eligibility to receive discounted services under available CICP funds. If eligibility to receive discounted health care services is granted by the qualified health care provider, the notice shall include the date when eligibility began. If eligibility to receive discounted health care services is denied, the notice shall include a brief, understandable explanation of the reason(s) for the denial. Every notice of the qualified health care provider's decision, whether an approval or a denial, shall include an explanation of the applicant's appeal rights found at Section 8.908 in these regulations.

C. Distribution of Available Funds to Providers

1. Distribution of available funds to qualified hospitals is found in 10 CCR 2505-10 section 8.2000.

~~health care providers (providers) is limited by the annual legislative appropriation and funds will be proportionately allocated to providers based on the anticipated utilization of services. Payments made under this section to state-owned and local-owned hospital providers will consist of Certification of Public Expenditure (see 8.903.C.3) and federal funds, as determined by the federal financial participation (FFP) amount. Payments made under this section to private-owned hospital providers will consist of General Fund and federal funds, as determined by the FFP amount.~~

~~Hospital providers who participate in the Colorado Indigent Care Program and whose percent of Medicaid-eligible inpatient days relative to total inpatient days is equal to 1% or greater, qualify to receive a Low-Income payment and a High-Volume payment. In addition, local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and those state-owned hospital providers whose percent of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association, qualify for a Bad Debt payment if funding exists.~~

~~To receive a Low-Income payment, hospital providers must have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.~~

2. Distribution of available funds for indigent care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate medically indigent charges. Available medically indigent charges are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 of each fiscal year. Medically indigent costs are inflated forward to the budget year using the United States Department of Labor Bureau of Labor Statistics Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year. ~~The basis for this calculation will be data published by the Colorado Indigent Care Program in its most recent available~~

~~annual report available before rate setting by the Department for each upcoming State fiscal year.~~

~~3. Annually, state-owned and local-owned hospital providers shall submit a letter to the Department which states the cost not directly compensated by General Fund or Federal Funds for Medicaid inpatient hospital services and medically indigent services associated with the distribution of available funds. (Referred to as Certification of Public Expenditures.)~~

~~4.~~ Providers will be notified of the distribution amounts for each State fiscal year no later than thirty (30) days prior to July 1 of each State fiscal year. The Department will notify the provider, without prior notice, of any changes in the distribution amounts applicable to the provider for a current State fiscal year that occur after July 1 of that State fiscal year.

~~5~~3. Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department concerning the use of CICP funding.

~~6~~4. Providers shall deduct the full patient liability amount from total charges, which is the amount due from the client as identified in the CICP Copayment Table, as defined under Section 8.907 in these regulations. The summary information submitted to the Department concerning the use of CICP funding by the provider shall include the full patient liability amount even if the provider receives the full payment at a later date or through several smaller installments or no payment from the client.

~~7~~5. Beyond the distribution of available funds made by the CICP, allowable client copayments, and other third-party sources, a provider shall not seek payment from a client for the provider's CICP discounted health care services to the client.

~~8. High-Volume Payment. This payment is an allocation of the available Medicare Upper Payment Limit and is available only to hospital providers. As required by federal regulations, there would be three allotments of the upper payment limit: state-owned, local-owned, and private-owned hospital providers.~~

~~The amount of available funds under the Medicare Upper Payment Limit is distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for qualified hospital providers. This calculation would be separate for state-owned, local-owned, and private-owned hospital providers, since the three groups are limited to unique pools of funds.~~

~~The available funds under the Medicare Upper Payment Limit are multiplied by the hospital provider specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for qualified hospital providers to calculate the High-Volume payment for the specific hospital provider. The available funds under the Medicare Upper Payment Limit by hospital provider category are:~~

~~a. Private-Owned Hospital Providers. The General Fund and FFP available and allocated by the Department under the Medicare Inpatient Upper Payment Limit for private-owned hospital providers.~~

~~b. Local-Owned Hospital Providers. The Certification of Public Expenditure and FFP available under the Medicare Inpatient Upper Payment Limit for local-owned hospital providers.~~

c. State-Owned Hospital Providers. The Certification of Public Expenditure and FFP available under the Medicare Inpatient Upper Payment Limit for state-owned hospital providers.

No payment (consisting of Federal Funds and General Fund or Certification of Public Expenditure) to a Local-Owned Hospital or State-Owned Hospital Provider will exceed 100% of uncompensated Medicaid inpatient hospital costs. Any amount of the calculated High-Volume payment that exceeds the calculated uncompensated Medicaid inpatient hospital costs will be added to the Low-Income payment calculation for that hospital provider. Uncompensated Medicaid inpatient hospital costs will be the maximum of the calculation of billed charges from inpatient claims paid in the most recently available State fiscal year multiplied by the cost-to-charge ratio available as of March 1 of each fiscal year minus the Medicaid reimbursement paid amount from inpatient claims paid in the same period, or the uncompensated Medicaid inpatient hospital costs from the prior State fiscal year, as reported under 8.903(C)(3) in these regulations, such that both figures will be inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

9. Low-Income payment. This payment is an allocation of the available Disproportionate Share Hospital Allotment imposed by the federal Centers for Medicare and Medicaid Services and is only available to hospital providers. The Disproportionate Share Hospital Allotment (or Cap) would be distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for hospital providers. This calculation is separate for public-owned (state-owned and local-owned) and private-owned hospital providers, since the two hospital provider categories have unique pools of General Fund appropriated each fiscal year.

As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment (consisting of Federal Funds and General Fund or Certification of Public Expenditure) to a hospital provider will exceed 100% of Medically Indigent costs. No hospital provider will receive a payment greater than hospital provider specific inflated medically indigent care costs or the uncompensated medically indigent costs as required under 8.903(C)(3). If the calculation generates a hospital provider specific payment beyond either of these amounts, the federal funds will remain under the Disproportionate Share Hospital Allotment.

The available Disproportionate Share Hospital Allotment is multiplied by the hospital provider specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for hospital providers to calculate the Low-Income payment for the specific hospital provider category.

a. Private-Owned Hospital Providers. The available Disproportionate Share Hospital Allotment for private-owned hospital providers equals the General Fund and FFP available and allocated by the Department under the Disproportionate Share Hospital Allotment for private-owned hospital providers.

b. Public-Owned Hospital Providers. The available federal funds Disproportionate Share Hospital Allotment for public-owned (state-owned and local-owned) hospital providers equals the Disproportionate Share Hospital Allotment minus other federal funds designated as a Disproportionate Share Hospital payment under another payment and the amount of the federal funds distributed to the private-owned hospital providers.

10. Weighted Costs, High-Volume Payment and Low-Income Payment.

~~The hospital provider specific medically indigent costs are increased by the percent of Medicaid-eligible inpatient (fee-for-service and managed care) days relative to total inpatient days and percent of medically indigent days relative to total inpatient days to measure the relative Medicaid and low-income care to total care provided. For state-owned hospital providers, these percentages are not allowed to exceed one standard deviation above the mean for each weight.~~

~~The hospital provider specific medically indigent costs are further increased by the Disproportionate Share Hospital Factor, if the hospital provider qualifies, to account for disproportionately high volumes of Medicaid. To qualify for the Disproportionate Share Hospital Factor, the hospital provider's percent of Medicaid-eligible inpatient days relative to total inpatient days must equal or exceed one standard deviation above the mean. If the hospital provider does qualify, then the Disproportionate Share Hospital Factor would equal the hospital provider's specific percent of Medicaid-eligible inpatient days relative to total inpatient days. For local-owned hospital providers with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and private-owned hospital providers, the Disproportionate Share Hospital Factor is doubled. For local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the mean. If the hospital provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.~~

~~The hospital provider specific medically indigent costs are further increased by the Medically Indigent Factor, if they qualify, to account for disproportionately high volumes of low-income care provided. To qualify for the Medically Indigent Factor, the hospital provider's percent of medically indigent days relative to total inpatient days must exceed the mean. If the hospital provider does qualify, then the Medically Indigent Factor equals the hospital provider specific percent of medically indigent days relative to total inpatient days. For local-owned hospital providers with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and private-owned hospital providers, this factor is doubled. For local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers, the Medically Indigent Factor is not allowed to exceed one standard deviation above the mean. If the hospital provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.~~

~~11. Bad Debt Payment. A Bad Debt payment is made only if federal funds remain available under the Disproportionate Share Hospital Allotment (or Cap) following the distribution of the Low-Income payment and the Low-Income Shortfall payment. This payment is available to local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers whose percent of Medicaid-eligible inpatient days relative to total inpatient days equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association if funding exists.~~

~~The amount of available federal funds remaining under the Disproportionate Share Hospital Allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt costs for all hospital providers that qualified to receive the Bad Debt payment. Available Bad Debt charges are converted to Bad Debt costs using the most recent hospital provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.~~

~~Available funds under the Disproportionate Share Hospital Allotment are multiplied by the hospital provider specific Bad Debt costs divided by the sum of all Bad Debt costs for all hospital providers that qualified to receive the Bad Debt payment to calculate the Bad Debt payment for the specific hospital provider.~~

6~~12~~. Pediatric Major Teaching Hospital Payment. Hospital providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria: [Eff. 7/1/2007]

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s; [Eff. 7/1/2007]

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed; [Eff. 7/1/2007]

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations. [Eff. 7/1/2007]

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and [Eff. 7/1/2007]

e. Participates in the Colorado Indigent Care Program [Eff. 7/1/2007]

~~The payment will be made prior to the High-Volume payment and will equal the Major Teaching Hospital Rate multiplied by the available Medicare Upper Payment Limit for the hospital providers that qualified to receive the Pediatric Major Teaching Payment.~~ The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly. [Eff. 7/1/2007]

~~13. To calculate the distribution of available funds to hospital providers, hospital providers shall annually submit data relating to the number of Medicaid-eligible inpatient days and total inpatient days in a form specified by the Department by April 30 of each year. [Eff. 7/1/2007]~~

7~~14~~. Colorado Health Care Services Payment. This payment is repealed effective September 1, 2009.

8~~15~~. Rural Hospital Payment. This payment is repealed effective September 1, 2009.

9~~16~~. Public Hospital Payment. This payment is repealed effective September 1, 2009.