3. Medicaid case load for each facility will be determined using Medicaid paid claims data for the calendar year ending prior to the July 1st rate setting. Providers with less than a full year of paid claims data will have their case load annualized.

4. Preliminary state share: Effective July 1, 2009 and each succeeding year the Department shall calculate a preliminary state share commitment towards the class I Medicaid nursing facility reimbursement system. The preliminary state share shall be calculated using the same methodology used to calculate the legislative appropriation base year amount. The Medicaid per diem rates used in this calculation are the preliminary rates that would be effective July 1st prior to any rate reduction provided for within this section of the plan.

5. For the fiscal year beginning July 1, 2009 and each succeeding year the final state share of Medicaid per diem rates will be limited to the legislative appropriation amount from the base year increased by the statutory limitation over the prior SFY. These determinations will 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. For the fiscal year beginning July 1, 2009 and each succeeding year, if the provider fee is insufficient to fully fund the supplemental Medicaid payments for pay for performance, CPS, PASRR II and the provider fee offset, the state department may suspend or reduce the supplemental Medicaid payments.

7. Provider fee revenue will first be used to pay the provider fee offset payment, then pay for performance, then PASRR II and CPS, then the state share of the base rate exceeding the statutory limitation on annual growth in the general fund. Any difference between the amount of provider fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share above.

SFY 2009-10	$53,616,414
SFY 2010-11	$72,699,123
SFY 2011-12	$84,511,966

8. Notwithstanding any other provision of law or any federal law that temporarily increases the federal matching participation rate for any fiscal year, payments to nursing facility providers from the general fund share of the aggregate statewide average of the per diem rate shall be calculated based on a fifty-percent federal match.

4. The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions. Applications and supporting documentation as received will be considered complete. No post receipt or additional information will be accepted for that application. Facilities will be selected for onsite verification of performance measures representations based on risk.

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

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

Nursing Facility Rate Reduction

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

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

RATE EFFECTIVE DATE

For cost reports filed by all facilities except the State-administered class IV facilities, the rate shall be effective on the first day of the eleventh (11th) month following the end of the nursing facility's cost reporting period.

For 12-month cost reports filed by the State-administered class IV facilities, the rate shall be effective on the first day covered by the cost report.

The permanent rate shall be established, issued and shall pay Medicaid claims billed on and after the later of the following dates:

1. The beginning of the provider's new rate period, as set forth under Rate Effective Date.

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

2. Calculating uncompensated Medicaid costs for Interim Payments made to nursing facilities with financial reporting periods corresponding to the State fiscal year of July 1 through June 30.
   a. Adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the as-filed Colorado "Med-13" cost report, Schedule C, column 9, line 63.
   b. Total resident days for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are as reported on the as-filed Colorado "Med-13" cost report, Schedule M, line D.4.
   c. The average per-diem cost for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) are computed by dividing the adjusted costs for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) by the total resident days for the fiscal year reporting period that includes the first six months of the Payment calendar year (January through June).
   d. Adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the as-filed Colorado "Med-13" cost report, Schedule C, column 9, line 63.
   e. Total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) are as reported on the as-filed Colorado "Med-13" cost report, Schedule M, line D.4.
   f. The average per-diem cost for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) is

computed by dividing the adjusted costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) by the total resident days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December).

g. Total Medicaid patient days for the first six months of the calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS).
h. Medicaid costs for the first six months of the Payment calendar year (January through June) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the first six months of the calendar year (January through June) by total Medicaid patient days for the first six months of the Payment calendar year (January through June) and adding in the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report.
i. Total Medicaid patient days for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).
j. Medicaid costs for the last six months of the Payment calendar year (July through December) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the last six months of the calendar year (July through December) by total Medicaid patient days for the last six months of the Payment calendar year (July through December).
k. Medicaid costs for the Payment calendar year (January through December) are computed by adding Medicaid costs for the first six months of the Payment calendar year (January through June) plus Medicaid costs for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) and adding in the portion of the Nursing Facility Provider Fee that is attributable to Medicaid, where that portion is calculated by multiplying the ratio of total Medicaid patient days to total resident days by the Nursing Facility Provider Fee for the corresponding reporting period of the Colorado "Med-13" cost report.
l. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES" for the first six months of the Payment calendar year (January through June).
m. Medicaid patient payments for the first six months of the Payment calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS).

n. Total Medicaid payments for the first six months of the Payment calendar year (January through June) are the sum of Medicaid reimbursements for the State fiscal year reporting period that includes the first six months of the Payment calendar year (January through June) and Medicaid patient payments for the first six months of the Payment calendar year (January through June).
o. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES" for the last six months of the Payment calendar year (July through December).
p. Medicaid patient payments for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).
q. Total Medicaid payments for the last six months of the Payment calendar year (July through December) are the sum of Medicaid reimbursements for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December) and Medicaid patient payments for the last six months of the Payment calendar year (July through December).
r. Total Medicaid payments for the Payment calendar year (January through December) are computed by adding total Medicaid payments for the first six months of the Payment calendar year (January through June) plus total Medicaid payments for the last six months of the Payment calendar year (July through December).
s. Uncompensated Medicaid costs for the Payment calendar year (January through December) are the difference between total Medicaid costs for the Payment calendar year (January through December) and total Medicaid payments for the Payment calendar year (January through December).
t. Nursing facilities with uncompensated costs less than or equal to $0 will not receive the Payment nor be required to certify their uncompensated costs.

3. Calculating uncompensated Medicaid costs for Final Payments made to nursing facilities with financial reporting periods of January 1 through December 31.

   a. Adjusted costs are as reported on the audited Colorado "Med-13" cost report, Schedule C, column 11, line 63.
   b. Total resident days are as reported on the audited Colorado "Med-13" cost report, Schedule of Adjustments, "Adjusted Balance" column.
   c. The average per-diem cost is calculated by dividing adjusted costs by total resident days.

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

4. Calculating uncompensated Medicaid costs for Final Payments made to nursing facilities with financial reporting periods corresponding to the State fiscal year of July 1 through June 30.

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

h. Total Medicaid patient days for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).

i. Medicaid costs for the last six months of the Payment calendar year (July through December) are computed by multiplying the average per-diem cost for the State fiscal year reporting period that includes the last six months of the calendar year (July through December) by total Medicaid patient days for the State fiscal year reporting period that includes the last six months of the Payment calendar year (July through December).

j. Medicaid costs for the Payment calendar year (January through December) are computed by adding Medicaid costs for the first six months of the Payment calendar year (January through June) plus Medicaid costs for the last six months of the Payment calendar year (July through December).

k. Medicaid reimbursements are the sum of payments as recorded in the Medicaid Management Information System (MMIS) and Medicaid supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES" for the first six months of the Payment calendar year (January through June).

l. Medicaid patient payments for the first six months of the Payment calendar year (January through June) are as recorded in the Medicaid Management Information System (MMIS).

m. Total Medicaid payments for the first six months of the Payment calendar year (January through June) are the sum of Medicaid reimbursements for the first six months of the Payment calendar year (January through June) and Medicaid patient payments for the first six months of the Payment calendar year (January through June).

n. Medicaid reimbursements for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS). Medicaid reimbursements shall include any supplemental payments paid in accordance under this Attachment 4.19D Section called "SUPPLEMENTAL MEDICAID PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES" for the last six months of the Payment calendar year (July through December).

o. Medicaid patient payments for the last six months of the Payment calendar year (July through December) are as recorded in the Medicaid Management Information System (MMIS).

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

OS Notification

State/Title/Plan Number: **Colorado 11-042**

Type of Action: **SPA Approval**

Required Date for State Notification: December 22, 2011

Fiscal Impact:

FFY 2011	**$ 2,834,269**
FFY 2012	**$11,337,074**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective July 1, 2011, this nursing facility (NF) amendment provides for a 1.4 percent reduction to the aggregate state-wide NF per diem rate. It addition, the amendment revises the hierarchy of existing supplement payments and increases the payment pool amount available for SFY 2012 from SFY 2011.

The net FFP impact of this SPA is an overall increase in NF provider reimbursement as a result of the supplemental payment program. While SFY 2012 per diem rates are being reduced by 1.4 percent, Colorado experienced 2.5 percent reduction to their rates last year (SFY 2011). The average rate for SFY 2011 was $175.58, while the average rate for SFY 2012 is $183.24. The State has found no evidence that access to care was inhibited in prior years when rate reductions were of a greater magnitude than the decreases applied to most services this SFY. Additionally, in the last several years, the State has been able to increase reimbursement to NF providers, as is the case with 11-042, through the supplemental payment program. NF providers and stakeholders were supportive of the overall reimbursement methodology given that, in the aggregate, total reimbursement was greater than the previous fiscal year, and that reimbursement would have declined without the proposed changes.

To date, the State has not seen a decrease in providers willing to care for Medicaid clients,

nor client's complaints regarding access to care. The State plans on modifying the plan in the future to implement the Accountable Care Collaboration (ACC) initiative. The State intends to implement numerous strategies to increase access to care, if this were to become an issue. They provided an extensive list of these strategies.

The source of non-Federal share for per diem payments is General Fund. The source of non-Federal share for supplemental payments is derived from a CMS permissible provider tax. Public notice/process requirements were met. The UPL was reviewed and deemed to be acceptable with adequate room to accommodate the proposed payments. Tribal consultation requirements were met. Responses to the funding questions were adequate.

Other Considerations: This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

CMS Contact: Christine Storey, (303) 844-7044
National Institutional Reimbursement Team