Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-13-038

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

DEC 05 2013

Barbara Prehmus
Colorado Department of Health Care
Policy and Financing
1570 Grant Street
Denver, Co 80203-1818

Re: Colorado 13-038

Dear Ms. Prehmus:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 13-038. Effective for services on or after July 1, 2013, this amendment modifies the methods and standards for nursing facility payments.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 13-038 is approved effective July 1, 2013. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

Cindy Mann
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**	1. TRANSMITTAL NUMBER: **13-038**	2. STATE: **COLORADO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2013**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN   AMENDMENT TO BE CONSIDERED AS A NEW PLAN   **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION **CFR 42 Section 447.272**	7. FEDERAL BUDGET IMPACT a. **FFY 2012-13 $(1,216,964)** b. **FFY 2013-14 $(5,006,584)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **4.19D Pages 15a, 34-39c, 45, 46**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* **4.19D 15a, 34-39a, 45, 46**

10. SUBJECT OF AMENDMENT

Revisions to Rates, Supplemental Payments, and Reporting of Days for Nursing Facility Providers

11. GOVERNOR'S REVIEW *(Check One)*

GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED

Governor's letter dated 01 September 2011

12. SIGNATURE OF STATE AGENCY OFFICIAL	16. RETURN TO **Colorado Department of Health Care Policy and Financing** **1570 Grant Street** **Denver, CO 80203-1818** Attn: **Barbara Prehmus**
13. TYPED NAME **John Bartholomew**	
14. TITLE **Director, Finance Office**	
15. DATE SUBMITTED	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED DEC 05 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JUL 01 2013	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME	22. TITLE Deputy Director, Policy & Financial Mgt. CMCS

23. REMARKS

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

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

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

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

For class II and privately-owned class IV intermediate care facilities for individuals with intellectual disabilities, a payment rate for each participating facility shall be determined on the basis of the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

The facility's prospective per diem rate includes the following components:

1. Health Care.

percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

SUPPLEMENTAL MEDICAID PAYMENT FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS 1 NURSING FACILITIES

Cognitive Performance Scale (CPS) Supplemental Payment

In addition to the reimbursement components paid under Health Care Services and Administrative and General Costs and Fair Rental Allowance for Capital-Related Assets, the state department shall make a supplemental Medicaid payment to nursing facility providers who have residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. To reimburse the nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury, the state department shall calculate the payment based upon the resident's score on the Cognitive Performance Scale (CPS) used in the RUG-III Classification system and reported on the MDS form. Resident CPS scores range from zero (intact) to six (very severe impairment). The Department will compute the payment annually as of July 1, 2009, and each July 1 thereafter, and it shall be not less than one percent of the statewide average per diem base rate.

1. Annually the Department will identify those Medicaid residents with a CPS score of 4, 5, or 6 for each nursing facility. They will then calculate the percent of Medicaid residents with a CPS score of 4, 5, or 6 as a percentage of all Medicaid residents for the facility. This amount is the facility's CPS percentage. Annual Medicaid days for all Medicaid residents with CPS scores of 4, 5 or 6 are summed. These total days are multiplied by one percent of the statewide average nursing per diem base rate to determine the total payment required. That total required payment is then tiered to pay out based on one, two or three standard deviations from the mean.

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

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

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

   Mean plus one standard deviation $1.00
   Mean plus two standard deviations $2.00

Mean plus three standard deviations $3.00

5. If the expected average supplemental payment for those residents receiving this payment is more or less than one percent of the average nursing facility base rate, the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid supplemental payment equal to one percent of the average nursing facility base rate.

6. These calculations will be performed annually to coincide with the July 1st rate setting process. Each facility's annual CPS supplemental payment will be calculated by taking the payment of $1, $2, or $3 multiplied by the number of Medicaid days for residents with a CPS score of 4, 5 or 6. The total annual payment is divided into twelve monthly supplemental payments.

7. If it is determined by the state department that the case-mix reimbursement includes a factor for nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury, the state department may eliminate the supplemental Medicaid payment to those providers who serve residents with severe cognitive dementia or acquired brain injury.

PASRR II Resident and Facility Supplemental Payments

A supplemental Medicaid payment shall be made to nursing facility providers who serve residents who have severe mental health conditions that are classified at Level II by the Medicaid program's preadmission screening and resident review assessment tool (PASRR). The Department shall compute this payment annually as of July 1, 2009, and each July 1 thereafter.

1. Annually the Department will identify those Medicaid residents meeting the PASRR II criteria for each nursing facility.

2. The Department will determine the number of PASRR II days eligible for the PASRR II supplemental payment by taking the number of PASRR II residents in each facility on May 1st times 365 days. The Department will then calculate the aggregate PASRR II payment for each facility by taking the number of PASRR II eligible days times the PASRR II rate. That aggregate payment shall be divided by twelve for a monthly supplemental payment.

3. The per diem PASRR II rate will be calculated as two percent of the statewide average base rate.

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

An additional payment will be made to facilities that offer specialized behavioral services to residents who have severe mental health conditions that are classified at a PASRR Level II. Specialized services include, but are not limited to, enhanced staffing in social services and activities, specialized training for staff on behavior management, creating resident specific written guidelines with positive reinforcement, crisis intervention and psychotropic medication training. Specialized programs also include daily therapeutic groups such as anger management, conflict resolution, effective communication skills, hygiene, art therapy, goal setting, problem solving, Alcoholics Anonymous and Narcotics Anonymous, in addition to stress management/relaxation groups such as Yoga, Tai Chi and drumming. Therapeutic work programming, community safety training, and life skills training that include budgeting and learning how to navigate public transportation and shopping, for example, are also required to increase the resident's skills for successful community reintegration.

Provider Fee Offset Supplemental Payment

In addition to the reimbursement rate components paid pursuant to Health Care Services and Administrative and General Costs and Fair Rental Allowance for Capital-Related Assets the state department shall pay a nursing facility provider a supplemental Medicaid payment for care and services rendered to Medicaid residents to offset payment of the provider fee. The Department shall compute this payment annually, as of July 1, 2009, and each July 1 thereafter.

1. Except for changes in the number of patient days, each July 1st the Department will estimate the funding obligation required to pay for the supplemental Medicaid payments related to Pay for Performance, CPS, PASRR II and will fund the base rate components of administrative and general, health care and capital to the extent the base rate exceeds the statutory limit on annual growth in the general fund share of the aggregate statewide average per diem rate described below.

2. The amount will be divided into twelve (12) supplemental monthly payments.

The following example illustrates how the state department will calculate the provider offset amount to be paid monthly to each facility:

Example Facility's Provider Fee Medicaid Supplemental Payment

7/1/xx provider fee per diem	$7.30
TIMES: Expected non-Medicare patient days during the state fiscal year	17,000
EQUALS: 7/1/xx FY actual facility provider fees that will be paid	$124,100

MULTIPLIED BY: Percent of Medicaid days (15,000) to total patient days (20,000) during the state fiscal year	75%
EQUALS: Annual supplemental payment to offset the provider fee	$ 93,075
DIVIDED BY: Twelve (12) monthly supplemental payments	$ 7,756

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

The general fund share of the aggregate statewide average of the per diem base rate net of patient payment shall be limited to the statutory increase. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation on the annual increase. In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers being greater than the statutory increase in the general fund share of the aggregate statewide average of the per diem base rate net of patient payment, the amount of the average statewide per diem rate that exceeds the general fund share shall be paid as a supplemental Medicaid payment using the provider fee. If the provider fee is insufficient to fully fund the supplemental Medicaid payment, the supplemental Medicaid payment shall be reduced to all providers proportionately. The percentage will be determined in accordance with the following fraction: Legislative appropriations / The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for all Class I Nursing Facilities.

1. Non-state and federal payment percent: Annually the Department will determine the percent of nursing facility per diem rates and supplemental payments paid by non-state and non-federal fund sources. This determination will be based on an analysis of Medicaid nursing facility class I paid claims. A sample period of claims may be used to perform this analysis. The analysis will be prepared prior to the annual July 1st rate setting.

2. Legislative appropriation base year amount: The base year will be the state fiscal year (SFY) ending June 30, 2008. The legislative appropriation for the base year will be determined by multiplying each nursing facility's time weighted average Medicaid per diem rate during the base year by their expected Medicaid case load (Medicaid patient days) for the base year. This amount will be reduced by the non-state and non-federal payment percentage, and then the residual will be split between state and federal sources using the time weighted Federal Medical Assistance Percentage (FMAP) during the base year.

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

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. 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.

Starting July 1, 2009, the Department shall a make a supplemental Medicaid payment based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents (pay for performance). The payment will be based on a nursing facility's performance in the domains of quality of life, quality of care and facility management.

1. The nursing facilities pay for performance application includes specific performance measures in each of the domains: quality of life, quality of care and facility management. The application includes the following:

   a. The number of points associated with each performance measure;

   b. The criteria the facility must meet or exceed to qualify for the points associated with each performance measure.

2. The prerequisites for participating in the program are as follows:

   a. No facility with substandard deficiencies on a regular annual, complaint, or any other Colorado Department of Public Health and Environment survey will be considered for pay for performance. Per State Operations Manual, this is generally no H level deficiencies or above. No F's or higher in 221 - 226, 240 – 258, 309 - 312, 314, 315, 317 – 334.

   b. The facility must perform a resident/family satisfaction survey. The survey must (a) be developed, recognized, and standardized by an entity external to the facility; and, (b) be administered on an annual basis with results tabulated by an agency external to the facility. The facility must report their response rate, and a summary report must be made publically available along with the facility's State's survey results.

3. To apply the facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The facility must maintain documentation supporting its representations for each performance measure the facility represents it meets or exceeds the specified criteria. The required documentation for each performance measure is identified on the matrix and must be submitted with its application. In addition, the facility must include a written narrative for each sub- category to be considered that describes the process used to achieve and sustain each measure.

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

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

Supplemental Payment for Acuity or Case-Mix of Residents

In addition to the reimbursement components paid under Health Care Services and Administrative and General Costs and Fair Rental Allowance for Capital-Related Assets, the state department shall make a supplemental Medicaid payment to nursing facility providers for acuity or case-mix of residents.

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

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

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.

Supplemental Provisions:

1. For the fiscal year beginning July 1, 2009 and each succeeding year, if the provider fee is insufficient to fully fund the supplemental Medicaid payments for pay for performance, CPS, PASRR II and the provider fee offset, the state department may suspend or reduce the supplemental Medicaid payments.

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

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

Nursing Facility Rate Reduction

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

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

Effective for the State Fiscal Year beginning July 1, 2012, the aggregate state-wide nursing facility per diem rate will be reduced by one and forty-five-hundredths percent (1.45%).

Effective for the State Fiscal Year beginning July 1, 2013, and for each State Fiscal Year thereafter, each nursing facility's calculated MMIS per diem reimbursement rate will be reduced 1.5%.

RATE EFFECTIVE DATE

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

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

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

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

financial participation under the state's medical assistance program. The provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

1. Each class I nursing facility that is licensed in this State shall pay a fee assessed by the state department.

2. The following nursing facility providers are excluded from the provider fee:

   a. A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services, and skilled nursing care on a single, contiguous campus. Assisted living services include an assisted living residence as defined in section 25-27-102, C.R.S., or that provides assisted living services on-site, twenty-four hours per day, seven days per week
   b. A skilled nursing facility owned and operated by the state;
   c. A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and
   d. A facility that has forty-five or fewer licensed beds.

3. To determine the amount of the fee to assess pursuant to this section, the state department shall establish a rate per non-Medicare patient day that is equivalent to accrual basis gross revenue (net of contractual allowances) for services provided to patients of all class I nursing facilities licensed in this State. The percentage used to establish the rate must not exceed that allowed by federal law. For the purposes of this section, total annual accrual basis gross revenue does not include charitable contributions received by a nursing facility.

4. The state department shall calculate the fee to collect from each nursing facility during the July 1 rate-setting process.

   a. Each July 1, the state department will determine the aggregate dollar amount of provider fee funds necessary to pay for the following:
      (i) State department's administrative cost
      (ii) Provider Fee Offset Payment
      (iii) Changes in acuity or case-mix of residents
      (iv) Pay for Performance
      (v) CPS
      (vi) PASRR Resident and Facility
      (viii) Excess of statutory limitation on growth in the general fund

   b. This calculation will be based on the most current information available at the time of the July 1 rate-setting process.

c. The aggregate dollar amount of provider fee funds necessary will be divided by non-Medicare patient days for all class I nursing facilities to obtain a per day provider fee assessment amount for each of the two following categories:
   (i) Nursing facilities with 55,000 non-Medicare patient days or more;
   (ii) Nursing facilities with less than 55,000 non-Medicare patient days.

   The state department will lower the amount of the provider fee charged to nursing facility providers with 55,000 non-Medicare patient days or more to meet the requirements of 42 CFR 433.68 (e).

d. Each facility's annual provider fee amount will be determined by taking the per day provider fee calculated above times the facility's reported annual non-Medicare patient days.

e. Each nursing facility will report annually its total number of days of care provided to non-Medicare residents to the state department. Non-Medicare patient days reported in the year prior to the July 1 rate-setting process will be used as the facility's annual non-Medicare patient days for the provider fee calculation. New Facilities, facilities that will close during the rate year, and facilities with a change in certification or licensure will have their non-Medicare days estimated in order to determine the provider's fee payment.

f. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed the state department.

g. The state department shall assess the provider fee on a monthly basis.

h. The fee assessed pursuant to this section is due 30 days after the end of the month for which the fee was assessed.

All provider fees collected pursuant to this section by the state department shall be transmitted to the state treasurer, who shall credit the same to the Medicaid nursing facility cash fund, which fund is hereby created and referred to in this section as the 'fund'.