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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 23-0015

This file contains the following documents in the order listed:

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

Financial Management Group

October 30, 2023

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

Re: Colorado 23-0015

Dear Adela Flores-Brennan:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 23-0015. Effective for dates of services on or after July 26, 2023, this amendment adjusts the rate calculation for nursing facility (NF) services to align with the federal rate methodology, and, grants authority to annually adjust the Pre-Admission Screening and Resident Review (PASRR) Program and Cognitive Performance Scale (CPS) payment rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 23-0015 is approved effective July 26, 2023. The CMS-179 and the amended plan pages are attached.

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

Sincerely,

[redacted]

Rory Howe
Director

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0015

2. STATE: CO

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2023

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 7,783,025
b. FFY 2024 $ 31,967,862

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D -- Nursing Facility Benefits -- Pages 15-15a, 23a, 34-39

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D -- Nursing Facility Benefits -- Pages 15-15a, 23a, 34-39 (TNs 20-0025, 19-0003, 09-013, 20-0017)

9. SUBJECT OF AMENDMENT
Adjusts the supplement Medicaid payment rates a qualifying nursing facility receives by revising the Resource Utilization Group (RUG) method to be in line with the federal methodology. It also grants authority to annually adjust the PASRR level II and CPD payment rates. Finally, it adds an additional supplemental payment to certain nursing facilities to ensure access to care.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED

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

Attn: Alex Lyons

FOR CMS USE ONLY

16. DATE RECEIVED: May 17, 2023

17. DATE APPROVED
October 30, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL: Rory Howe

21. TITLE OF APPROVING OFFICIAL: Director, Financial Management Group

22. REMARKS

Instructions on Back

1. Medicare statutes.

2. Medicare regulations.

3. Medicaid and Medicare guidelines.

4. Generally accepted accounting principles.

Effective July 1 of each year, a MMIS per diem reimbursement rate for Class 1 nursing facility providers shall be established for reimbursement of billed claims.

1. The MMIS per diem reimbursement rate shall equal a nursing facility provider's Core Component per diem rate multiplied by a percent factor. The percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by 3.00%.

    a. For State Fiscal Year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement or the SFY 2019-20 Core Component per diem rate.

2. For SFY 2020-21 and SFY 2021-22, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous ear statewide average MMIS per diem reimbursement rate of patient payment increased by 2.00%.

3. For SFY 2023-24, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by 10.00%.

4. A nursing facility provider shall be notified, in writing or by electronic notification, at least ten business day before any change to their Core Component per diem rate, MMIS per diem reimbursement rate or percent factor.

The Core Component per diem rate shall be determined using information on the MED-13, the Minimum Data Set (MDS) resident assessment information and information obtained by the Department or its designee retained for cost auditing purposes.

The Core Component per diem rate includes the following components:

1. Health Care,
2. Administrative and General, and
3. Fair Rental Allowance for Capital-Related Assets.

In addition to the MMIS per diem reimbursement rate, a Class 1 nursing facility provider may be reimbursed the following supplemental Medicaid payments.

1. Medicaid Utilization Supplemental Medicaid Payment,
2. Acuity Adjusted Core Component Supplemental Medicaid Payment,
3. Pay-for-Performance Supplemental Medicaid Payment,
4. Cognitive Performance Scale Supplemental Medicaid Payment,
5. Preadmission Screening & Resident Review II Resident Supplemental Medicaid Payment,
6. Preadmission Screening & Resident Review II Facility Supplemental Medicaid Payment, and
7. Core Component Supplemental Medicaid Payment.

For class II 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,

CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND MEDICAID CASE MIX INDEX (CMI):

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider .

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

Effective July 1, 2023, resident reimbursement classification and case mix index shall be established utilizing the Patient Driven Payment Model (PDPM) nursing component classification methodology and associated weights, as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

For State fiscal year 2023-2024 only, facilities negatively impacted by the transition to the PDPM nursing component classification case mix index will instead use the resource utilization groups RUG-III, Version 5.20 34 Grouper classification case mix index scores.

The Department confirms cost neutrality in this transition due to the usage of a cost based UPL and the cap on statewide average per diem rate growth established in Attachment 4.19-A, page 15.

SUPPLEMENTAL MEDICAID PAYMENTS FOR CLASS 1 NURSING FACILITY PROVIDERS

Cognitive Performance Scale Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to Class 1 nursing facility providers who have residents with moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury based upon the resident's score on the Cognitive Performance Scale (CPS).

*(Medicaid CPS Resident Count * Days in Prior Calendar Year) * (2.00% * Statewide Average Core Component Per Diem Rate)*

1. Annually, the Department shall calculate the payment by multiplying a CPS per diem rate by CPS Medicaid days.

2. The CPS per diem rate shall be calculated based on the number of standard deviations a nursing facility provider's CPS percentage is above the statewide average CPS percentage. The CPS per diem rate shall be determined in accordance with the following table:

Standard Deviation Above Statewide Average	CPS Per Diem
Greater Than or Equal to Statewide Average + 1 Standard Deviation	1x
Greater Than or Equal to Statewide Average + 2 Standard Deviation	2x
Greater Than or Equal to Statewide Average + 3 Standard Deviation	3x

The CPS per diem rate multiplier (x) shall equal an amount such that the total statewide CPS supplemental Medicaid payment divided by total statewide CPS Medicaid days equal

2.00% of the statewide average Core Component per diem rate as of July 1 of the state fiscal year.

3. The CPS percentage shall be the sum of Medicaid residents with a CPS score of 4, 5, or 6 divided by the sum of Medicaid residents.

4. CPS Medicaid patient days shall be the count of Medicaid residents with a CPS score of 4, 5, 6, or equivalent multiplied by the days in the calendar year ending prior to the state fiscal year.

5. A CPS score of 4, 5, or 6 shall be determined based on a Medicaid resident's score on the CPS as reported on the MDS assessment.

6. A Medicaid resident shall be included if they have an active MDS assessment on a nursing facility provider's most recent April roster.

    a. Effective April 1, 2020 and ending June 30, 2020, a one-time revision will be exercised for State Fiscal year 2020-2021 to pull MDS data that is most recent and unaffected by Coronavirus Disease 2019 (COVID-19) emergency procedures.

7. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthly to Class 1 nursing facility providers. For state administered Class 1 nursing facility providers the amount shall be divided by four and reimbursed quarterly.

Preadmission Screening and Resident Review II Resident Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to Class 1 nursing facility providers who serve residents with severe mental health conditions that are classified at Level II by the Medicaid program's Preadmission Screening and Resident Review (PASRR) tool.

*(Medicaid PASRR II Resident Count * Days in Prior Calendar Year) * (4.00% * Statewide Average Core Component Per Diem Rate)*

1. Annually, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.

2. The PASRR II per diem rate shall equal 4.00% of the statewide average Core Component per diem rate as of July 1 of the state fiscal year.

3. Medicaid PASRR II days shall be the count of Medicaid PASRR II residents multiplied by the days in the calendar year ending prior to the state fiscal year.

4. A Medicaid PASRR II resident shall be determined based on the most recently completed MDS assessment occurring during the previous 365 days ending May 1 of the prior state fiscal year.

    a. Effective April 1, 2020 and ending June 30, 2020, a one-time revision will be exercised for State Fiscal Year 2020-2021 to pull data from the previous 365 calendar days ending March 1, 2020 to account for COVID-19 delays for MDS submissions.

5. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthly to Class 1 nursing facility providers. For state administered Class 1 nursing facility providers the amount shall be divided by four and reimbursed quarterly.

Preadmission Screening and Resident Review II Facility Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to Class 1 nursing facility providers that offer specialized behavioral services to residents who have severe behavioral health needs. These services shall include enhanced staffing, training, and programs designed to increase the resident's skills for successful community reintegration.

If specialized behavioral services nursing facility provider then:
*(Medicaid PASRR II Resident Count * Days in Prior Calendar Year) **
*(4.00% * Statewide Average Core Component Per Diem Rate)*

1. Annually, the Department shall determine those nursing facility providers with a specialized behavioral services program. A nursing facility provider has a specialized behavioral services program if they can demonstrate annually that they provide additional staff training/credentialing, therapeutic groups and work programs, life skills training, community reintegration efforts, and a Memorandum of Understanding with local mental health providers in March of the prior state fiscal year.

2. For those nursing facility providers with a specialized behavioral services program, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.

3. The PASRR II per diem rate shall equal 4.00% of the statewide average Core Component per diem rate as of July 1 of the state fiscal year.

4 Medicaid PASRR II days shall equal the count of PASRR II residents on May 1, multiplied by the days in the calendar year ending prior to the state fiscal year.

5. A Medicaid PASRR II resident shall be determined based on the most recently completed MDS assessment occurring during the previous 365 days ending May 1 of the prior state fiscal year.

    a. Effective April 1, 2020 and ending June 30, 2020, a one-time revision will be exercised for State Fiscal Year 2020-2021 to pull data from the previous 365 calendar days ending March 1, 2020 to account for COVID-19 delays for MDS submissions.

6. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthly via ACH transaction or check to Class 1 nursing facility providers. For state administered Class 1 nursing facility providers the amount shall be divided by four and reimbursed quarterly.

Medicaid Utilization Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to Class 1 nursing facility providers for care and services rendered to Medicaid residents.

1. Annually, the Department shall calculate the percentage of Medicaid patient days to total patient days.

2. The percentage of Medicaid patient days shall then be multiplied by the Provider Fee.

3. Percentage of Medicaid patient days shall be Medicaid patient days divided by total patient days.

4. Medicaid patient days shall be from the MMIS for the calendar year prior the state fiscal year. Total patient days shall be from the nursing facility provider for the calendar year ending prior to the state fiscal year.

5. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthly to Class 1 nursing facility providers. For state administered Class 1 nursing facility providers the amount shall be divided by four and reimbursed quarterly.

Core Component Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to Class 1 nursing facility providers for the difference between their MMIS per diem reimbursement rate and Core Component per diem rate.

1. Annually, the Department shall calculate the difference between the MMIS per diem reimbursement rate and the Core Component per diem rate. The difference shall then be multiplied by applicable Medicaid patient days.

2. Applicable Medicaid patient days shall be Medicaid patient days divided by days in the calendar year ending prior to the state fiscal year, multiplied by the days the Core Component per diem rate was effective.

3. Medicaid patient days shall be from the MMIS for the calendar year ending prior to the state fiscal year the Core Component per diem rate was effective.

4. For SFY 2019-20, the Department shall include the difference between the SFY 2018-19 MMIS per diem reimbursement rate and the SFY 2018-19 Core Component per diem rate, multiplied by applicable Medicaid patient days.

5. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthly to Class 1 nursing facility providers. For state administered Class 1 nursing facility providers the amount shall be divided by four and reimbursed quarterly.

Pay-For-Performance Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to Class 1 nursing facility providers that provide services resulting in better care and higher quality of life for their residents.

1. Annually, the Department shall calculate the payment by multiplying a Pay-for-Performance (P4P) per diem rate by Medicaid patient days.

2. The P4P per diem rate shall be calculated according to the following table:

P4P Points	Per Diem Rate
0 – 20 points	No add on
21 – 45 points	$1.00
46 – 60 points	$2.00
61 – 79 points	$3.00
80 – 100 points	$4.00

3. The P4P points shall be based on a completed and verified/audited application including 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.

4. 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. Substandard quality of care means one or more deficiencies related to participation requirements under Freedom from Abuse, Neglect, and Exploitation, Quality of Life quality of life, or quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

   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 publicly available along with the facility's State's survey results.

5. 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.

6. 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

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

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

9. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthlyto Class 1 nursing facility providers. For state administered Class 1 nursing facility providers the amount shall be divided by four and reimbursed quarterly.

Acuity Adjusted Core Component Supplemental Medicaid Payment

The Department shall make a supplemental Medicaid payment to Class 1 nursing facility providers for changes in resident acuity or case-mix.

1. Annually, the Department shall calculate the difference between the prior year Core Component per diem rate and the prior year Core Component per diem rate adjusted for changes in resident acuity or case-mix. The difference shall then be multiplied by applicable Medicaid patient days.

2. Applicable Medicaid patient days shall be Medicaid patient days divided by days in the calendar year ending prior to the state fiscal year, multiplied by the days the acuity adjusted Core Component per diem rate was effective.

3. Medicaid patient days shall be from the MMIS for the calendar year ending prior to the state fiscal year the acuity adjusted Core Component rate was effective.

4. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthlyto Class 1 nursing facility providers. For state administered Class 1 nursing facility providers the amount shall be divided by four and reimbursed quarterly.