THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Medical Assistance Rule Concerning Colorado Indigent Care Program, Section 8.907
Rule Number:	MSB 12-02-09-A
Division / Contact / Phone:	Financial & Administrative Services / Karen Talley / 303-866-3170

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 12-02-09-A, Medical Assistance Rule Concerning Colorado Indigent Care Program, Section 8.907
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) 8.907, Client Copayment, 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*

At §8.907.A in the table following the first unnumbered paragraph in the second column from the left please insert the words “Ambulatory Surgery” to the current table heading so that it now reads “Inpatient Hospital Ambulatory Surgery Copayment.” In the third column please insert the new words provided “Inpatient & Emergency Room – “ to the current table heading so that it now reads “ Inpatient & Emergency Room – Physician Copayment.” In the fifth column please remove the word “and” from the current text and insert the new wording “ & Emergency Transportation” so that it reads “Hospital Emergency Room Specialty Outpatient Clinic & Emergency Transportation Copayment.” And in the sixth and final column please remove the word “Lab” and insert the new wording “Laboratory Radiology, Imaging” to the remaining current text so that it reads “Prescription and Laboratory, Radiology, Imaging Copayment.” All other text should remain as is.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Please replace all current text from §8.907.A.1 through the end of §8.907.A.9 with the new text provided that includes §8.907.A.1 through the end of §8.907.A.10.

These changes are effective 6/30/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Medical Assistance Rule Concerning Colorado Indigent Care Program, Section 8.907
Rule Number:	MSB 12-02-09-A
Division / Contact / Phone:	Financial & Administrative Services / Karen Talley / 303-866-3170

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 current rule states that clients are responsible for paying a portion of their medical bills. The client's portion is called the "client copayment". CICP providers must charge each CICP client a copayment for services rendered. For CICP, there are different copayments for different service charges. This rule change will update current CICP rules pertaining to CICP copayments to ensure that CICP providers continue to provide accessible services to CICP clients that are costly to the provider and to ensure CICP providers receive reasonable revenue for those services provided. The proposed rule change will also ensure that copayments for services allowed under the CICP are consistent among all particpating CICP providers.

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. (2011);
   25.5-3-101, et seq.

Initial Review	**04/13/2012**	Final Adoption	**05/11/2012**
Proposed Effective Date	**06/30/2012**	Emergency Adoption	

DOCUMENT # 02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Medical Assistance Rule Concerning Colorado Indigent Care Program, Section 8.907
Rule Number:	MSB 12-02-09-A
Division / Contact / Phone:	Financial & Administrative Services / Karen Talley / 303-866-3170

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 classes of persons who will be affected by the proposed rule change include CICP providers (hospitals and clinics) and CICP clients. The proposed rule change is to ensure that CICP providers continue to provide accessible services to CICP clients that are costly to CICP providers and ensure CICP providers receive reasonable revenue for providing those services. The alignment of CICP copayments will ensure that copayments are consistent among all of our CICP providers and will alleviate clients from paying more for the same service if received from another CICP provider.

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

   Available funding to all CICP providers is limited by the available appropriation. There should not be any increase or decrease in the number of providers or medically indigent clients participating in the program. Continued access to costly services for CICP clients is the only measurable impact of the proposed rule change.

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 will not be any additional costs to the Department or any other agency as a result of the implementation and enforcement of the proposed rule change.

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

   There will not be any probable cost to the rule change, as funding for CICP providers is limited by the available appropriation. The benefits of proposed rule changes is to align CICP copayments, which will make it administratively consistent from provider to provider and will allow CICP clients to manage the cost of the health care services more efficiently. In addition, clients will have continued access to costly services for CICP clients, that otherwise could be unavailable if providers cannot not receive adequate revenue for those services.

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

The proposed rule change will not create any additional cost to the Department and there is not a less intrusive method for achieving the desired outcome without the proposed rule change.

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.

   After receiving feedback from CICP providers and other stakeholders, the Department determined there was not an alternative method for achieving the desired outcome to continue to make accessible services to CICP clients that are costly to providers to discount. Without the changes to the copayment rules, some CICP providers may not continue to offer costly services to clients or as an alternative, clients may be required to pay the full cost of these services.

8.907 CLIENT COPAYMENT

A. Client Copayments - General Policies

A client is responsible for paying a portion of his/her medical bills. The client's portion is called the "client copayment". Qualified health care providers are responsible for charging the client a copayment. The maximum allowable client copayments by service are shown below in the Client Copayment Table. Qualified health care providers may require clients to pay their copayment prior to receiving care (except for emergency care).

Client Copayment Table

CICP Rating	Inpatient Hospital, Ambulatory Surgery Copayment	Inpatient & Emergency Room - Physician Copayment	Outpatient Clinic Copayment	Hospital Emergency Room, ~~and~~ Specialty Outpatient Clinic & Emergency Transportation Copayment	Prescription and ~~Lab~~ Laboratory, Radiology, Imaging Copayment
N	$15	$7	$7	$15	$5
A	$65	$35	$15	$25	$10
B	$105	$55	$15	$25	$10
C	$155	$80	$20	$30	$15
D	$220	$110	$20	$30	$15
E	$300	$150	$25	$35	$20
F	$390	$195	$25	$35	$20
G	$535	$270	$35	$45	$30
H	$600	$300	$35	$45	$30
I	$630	$315	$40	$50	$35
.	.	.	.	.	.
Z	$0	$0	$0	$0	$0

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related client copayments.

1. ~~1.~~ Hospital inpatient facility charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay ~~longer than~~ of 24 hours or longer . The client is responsible for the corresponding Hospital Inpatient Copayment.

2. Ambulatory Surgery charges are for all operative procedures received by a client who is admitted to and discharged from the hospital setting on the same day. The client is responsible for the corresponding Inpatient Hospital Copayment for the non-physician (facility) services and the corresponding Physician Copayment for the physician services.

3. The Inpatient and Emergency Room Physician charges are for services provided to a client by a physician in the hospital setting, including inpatient and emergency room care. The client is responsible for the corresponding Physician Copayment.

4. Outpatient Clinic charges are for all non-physician (facility) and physician services received by a client while receiving care in the outpatient clinic setting, but does not include charges from outpatient services provided in the hospital setting (i.e. emergency room care, ambulatory surgery,radiology). Outpatient charges include primary and preventive medical care. The client is responsible for the corresponding Outpatient Clinic Copayment.

5.4.25. Hospital Emergency Room, outpatient charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care). The client is responsible for the corresponding Hospital Emergency Room Copayment.

6.5. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a client while receiving care in the specialty outpatient clinic setting, but do not include charges from outpatient services provided in the hospital setting (i.e., emergency room care, ambulatory surgery). Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. The client is responsible for the corresponding Specialty Outpatient Clinic Copayment. A qualified health care provider must receive written approval from the Department to charge the Specialty Outpatient Clinic Copayment.

7.6. Emergency Transportation charges are for transportation provided by an ambulance. The client is responsible for the corresponding Emergency Transportation Copayment.

7. Laboratory Service charges are for all laboratory tests received by a client not associated with an inpatient facility or hospital outpatient charge during the same periodperiod, . TThe client is responsible for the corresponding Laboratory Services Copayment.

8. Radiology and Imaging Service charges are for all radiology and imaging services received by a client while receiving care in the outpatient clinic setting, but does not include charges from outpatient or inpatient services provided in the hospital setting. The client is responsible for the corresponding Radiology and Imaging Copayment.

9. Prescription charges are for prescription drugs received by a client at a qualified health care provider's pharmacy as an outpatient service. The client is responsible for the corresponding Prescription Copayment. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.

10. Clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in an Outpatient setting are responsible for the Hospital Inpatient Facility copayment in addition to the Outpatient Specialty Clinic copayment.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	8.443.17.A.4.e Nursing Facility Provider Fees – Reporting non-Medicare days and Estimating total non-Medicare days for new facilities
Rule Number:	MSB 12-03-01-A
Division / Contact / Phone:	Financial and Administrative Services Office / Matt Haynes / 6305

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 12-03-01-A, 8.443.17.A.4.e Nursing Facility Provider Fees – Reporting non-Medicare days and Estimating total non-Medicare days for new facilities
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) 8.443.17.A.4.e, 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 the current text at §8.443.17.A.4.e with the new text provided for this paragraph. Text in this filing from §8.443.17.A through the end of §8.443.17.A.4.d is for clarification purposes only and should not be changed. No other text in this section should be changed.

This change is effective 06/30/2102.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	8.443.17.A.4.e Nursing Facility Provider Fees – Reporting non-Medicare days and Estimating total non-Medicare days for new facilities
Rule Number:	MSB 12-03-01-A
Division / Contact / Phone:	Financial and Administrative Services Office / Matt Haynes / 6305

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).

   8.443.17.A.4.e addresses the reporting of non-Medicare days. The current program policy is to collect these days annually. In rule, the current instruction is to collect the data monthly. Part of the proposed changes to this section is to align the rule with current program practice. Additionally, this section of rule is currently silent concerning the determination of non-Medicare days for new providers. The current practice, exactly as it is with Medicaid caseload, is to annualize partial data and estimate in the case of no data. The proposed changes to this section align the rules with current practice in an area where the rules are currently silent.

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. (2011);
   25.5-6-203, C.R.S. (2011)

Initial Review	**04/13/2012**	Final Adoption	**05/11/2012**
Proposed Effective Date	**06/30/2012**	Emergency Adoption	

DOCUMENT # 03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	8.443.17.A.4.e Nursing Facility Provider Fees – Reporting non-Medicare days and Estimating total non-Medicare days for new facilities
Rule Number:	MSB 12-03-01-A
Division / Contact / Phone:	Financial and Administrative Services Office / Matt Haynes / 6305

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.

   Class I Nursing Facilities

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 proposed changes provide clarity as to the process for reporting non-Medicare days and clarity as to the process for new providers. The determination of non-Medicare days affects the calculation of the fees owed for the provider fee program.

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 additional costs to the Department or effects on State revenue.

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

   The proposed rule will provide clarity and consistency to the process for reporting non-Medicare days and for determining non-Medicare days for new providers. Inaction results in rules that are conflicting with current program policy and practice, and could pose a risk of appeal.

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

   The purpose can only be achieved through rule.

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 purpose can only be achieved through rule changes.

8.443.17 PROVIDER FEES

8.443.17.A The state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal 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 assisted living residences as defined in Section 25-27-102 (1.3), C.R.S., or that provide 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 a percentage of 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 or revenues received by a nursing facility that are not related to services provided to nursing facility residents (for example, outpatient revenue).

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 the statutory limited growth in the general fund pursuant to 8.443.11

(vii) Acuity or case-mix of residents pursuant to 8.443.7.D

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 total patient days or more;

(ii) nursing facilities with less than 55,000 total patient days.

The state department will lower the amount of the provider fee charged to nursing facility providers with 55,000 total patient days or more to meet the requirements of 42 CFR 433.68 (e). In addition, the 55,000 total patient day threshold can be modified 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~~monthly~~ its total number of days of care provided to non-Medicare residents to the Department of Health Care Policy & Financing. The non-Medicare patient days reported will be from the calendar year prior to the July 1 rate setting process. Providers with less than a full year of non-Medicare patient days data will have their non-Medicare days annualized. New providers with no non-Medicare patient days data will have their non-Medicare days estimated by the Department. The non-Medicare patient days will be used for the provider fee calculation.~~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.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Nursing Facility Funding Specification - Medicaid Caseload, Section 8.443.11
Rule Number:	MSB 12-03-01-B
Division / Contact / Phone:	Financial and Administrative Services Office / Matt Haynes / 6305

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 12-03-01-B, Revision to the Medical Assistance Rule Concerning Nursing Facility Funding Specification - Medicaid Caseload, Section 8.443.11
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) 8.443.11.3, 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 the current text at §8.443.11.3 with the new text provide in this filing. No other text should be changed. Text provided in this filing from §8.443.11 through the end of §8.443.11.7with the exclusion of paragraph 3. is for clarification only and should not be changed.

This change is effective 06/30/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Nursing Facility Funding Specification - Medicaid Caseload, Section 8.443.11
Rule Number:	MSB 12-03-01-B
Division / Contact / Phone:	Financial and Administrative Services Office / Matt Haynes / 6305

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).

   8.443.11.3 addresses the determination of Medicaid caseload that is used in calculated portions of the supplemental payment. The rule currently addresses the process for new providers with partial data, but is silent concerning new providers that have come into existence after the calendar year preceding the July 1 rate setting but before the July 1 rate setting begins. The current policy of the program is to estimate these days, and the proposed changes add that to rule.

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. (2011);
   25.5-6-202, C.R.S. (2011)

Initial Review	**04/13/2012**	Final Adoption	**05/11/2012**
Proposed Effective Date	**07/01/2012**	Emergency Adoption	

DOCUMENT # 04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Nursing Facility Funding Specification - Medicaid Caseload, Section 8.443.11
Rule Number:	MSB 12-03-01-B
Division / Contact / Phone:	Financial and Administrative Services Office / Matt Haynes / 6305

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.

   Class I Nursing Facilities

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 proposed changes provide clarity as to the process for new providers. The determination of Medicaid caseload affects the calculation of the supplemental payments from the provider fee program.

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 additional costs to the Department or effects on state revenues

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

   The proposed rule will provide clarity and consistency to the process for determining Medicaid caseload for new providers.

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

   There are no other methods for achieving the purpose of the proposed rule.

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 only method to formalize the current program policy was to have it established in rule.

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 by statute. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation. In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers 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 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.

1. Non-state and federal payment percent: Annually the Department will determine the percent of nursing facility per diem rates 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. Providers with no paid claims data for the calendar year ending prior to the July 1st rate setting will have their Medicaid caseload estimated by the Department.

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 rule.

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 the

statutory growth limitation over the prior SFY. These determinations will be made during the July 1st rate setting process each year. If the preliminary state share (less the amount applicable to provider fees) is greater than the indexed legislative base year amount, proportional reductions will be made to the preliminary nursing facility rates to reduce the state share to the indexed legislative appropriation base year amount.

6. Provider fee revenue will first be used to pay the provider fee offset payment, then the payment for acuity or case-mix of residents, then the Pay-for-Performance program, then payments for residents who have moderately to severe mental health conditions, cognitive dementia or acquired brain injury, and then the supplemental Medicaid payments for the amount by which the average statewide per diem rate exceeds the general fund share established under Section 25.5-6-202(9)(b)(II), C.R.S.. 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%: