Title of Rule:	Changes to Provider Reimbursement Rates for the Old Age Pension Health and Medical Care Program
Rule Number:	MSB 09-01-15-A
Division / Contact / Phone:	State Programs & Federal Financing Div / Cindy Arcuri/ X 3996

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-01-15-A, Changes to Provider Reimbursement Rates for the Old Age Pension Health and Medical Care Program
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) 8.941.1 and 8.941.9, 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)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text from *§8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM* through the end of §8.941.1.G. with the new text attached. Also, please replace current text from *§8.941.9 REIMBURSEMENT TO PROVIDERS* through the end of the section with new text attached. This change is effective 04/10/2009.

*to be completed by MSB Board Coordinator

Title of Rule:	Changes to Provider Reimbursement Rates for the Old Age Pension Health and Medical Care Program
Rule Number:	MSB 09-01-15-A
Division / Contact / Phone:	State Programs & Federal Financing Div / Cindy Arcuri/ X 3996

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).

   Effective January 9, 2009, an emergency rule was adopted that allowed increases for specific provider rates in order for the Old Age Pension Health and Medical Care Program to reimburse providers closer to the program's statutory spending limits. However, in order to meet projected State budget reduction targets, in accordance with Section 8.941.9, the Executive Director of the Department lowered reimbursement rates for this program back to their former levels, effective February 1, 2009. Current budget strategies accommodate the restoration of reimbursement rates to the higher levels approved on January 9, 2009. This proposed rule increases reimbursement rates to those higher levels effective April 15, 2009.

   This current proposed rule also adds in clarifying language under Section 8.941.1(E) relating to the authority of the Executive Director of the Department to increase reimbursement rates to providers within constitutional and statutory limits. The language added is identical to the language added under the emergency rule adopted by the Medical Services Board at its January 9, 2009 Board meeting. The language is added here again in MSB 09-01-15-A since the emergency rule adopted in January, MSB 08-11-21-B, will not be in effect permanently.

   The proposed rule also deletes language under 8.941.1(B) that limits inpatient hospital benefits for Old Age Pension Health and Medical Care Program recipients who receive inpatient hospital services from providers of the Colorado Indigent Care Program. This restriction is no longer necessary for budgetary purposes.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal regulation and/or

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

   Explain:

   Under state regulations, the emergency rule passed in January 2009 expires in April. It is imperatively necessary to pass this current rule at this time in order for the program to continue operating under proper regulatory authority.

3. Federal authority for the Rule, if any:

Initial Review		Final Adoption	**05/08/2009**
Proposed Effective Date	**04/10/2009**	Emergency Adoption	**04/10/2009**

DOCUMENT #01

Not applicable. This is a state-only program.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-2-1-1. C.R.S. (2008); Colorado Constitution, Article XXIV

Title of Rule:	Changes to Provider Reimbursement Rates for the Old Age Pension Health and Medical Care Program
Rule Number:	MSB 09-01-15-A
Division / Contact / Phone:	State Programs & Federal Financing Div / Cindy Arcuri/ X 3996

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 persons affected by this proposed rules are the recipients and providers of medical care for the Old Age Pension Health and Medical Care Program. Changes to reimbursement rates and benefits directly impact providers and may indirectly affect client access to care.

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 rule will adjust payment rates based on the Medicaid reimbursement as follows:

Service Type	Rates Effective 01/09/09 - 01/31/09	Rates Effective 02/0/09 - 04/14/09	Proposed Rates Effective 04/15/09
Pharmacy	75%	70%	75%
Inpatient Hospital	10%	10%	10%
Outpatient Services	65%	60%	65%
Practioner/Physician	65%	60%	65%
Emergency Dental	65%	60%	65%
Laboratory and X-Ray	65%	60%	65%
Medical Supply	65%	60%	65%
Hospice and Home Health	65%	60%	65%
Emergency Transportation	65%	60%	65%

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

   The Department is implementing these rate changes in order to better manage the Old Age Pension Health and Medical Care Program's expenditures within statutory and constitutional spending authority limits The provision under Section 8.941.1 allowing the Executive Director to increase reimbursement rates without advance approval from the Medical Services Board was approved in January 2009, under a previous emergency rule, MSB # 08-11-21-B and is made permanent in this current rule, 09-01-05-A. There are no administrative costs associated with changing authorized reimbursement rates for Old Age Pension Health and Medical Care Program providers within the State's Medicaid Management Information System.

Unexpended moneys from this program revert to the Supplemental Old Age Pension Health and Medical Care Fund. The Department estimates that even with this increase in provider reimbursement rates, the balance of this reserve fund will sufficiently cover State budgetary needs, should the General Assembly appropriate funds from this Supplemental Old Age Pension Health and Medical Care Fund to the General Fund.

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

   Inaction on Section 8.941.9 would result in needlessly low reimbursement rates to providers, which in turn could negatively affect participation in the program and potentially limit client access to health care services. Inaction would also result in noncompliance with the intent of the Long Bill appropriations for FY 2008-09. Inaction in section 9.941.1 (B.) might also unnecessarily restrict client access to inpatient hospital services.

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

   At this time, the most efficient means to financially manage the program is to modify reimbursement rates.

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

   The Department has modeled numerous rate change and expenditures scenarios. This proposal does not eliminate benefits for recipients and provides an equitable benefit to health care providers.

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

In accordance with the Constitution of Colorado, Title XXIV, Section 7, and the Colorado Social Services Act, an Old Age Pension Health Care Program is established to provide necessary medical care for the Old Age Pension recipients who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. The State Department is designated as the single State agency to administer the program.

The Old Age Pension Health Care Supplemental Program is authorized by Colorado Revised Statues, Section 26-2-117, C.R.S. The funding for this program cannot be accessed until all funds in the Old Age Pension Health Care Program are exhausted.

A. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program provide optional benefits to clients who qualify for (State only) OAP-A and (State only) OAP-B pensions who do not qualify for Federal Financial Participation in the Colorado Medicaid Program. These cases are coded with Supplemental Income Status Code (SISC) C.

B. Under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program, only the following State funded benefits are provided: physician and practitioner services, inpatient hospital, outpatient services, lab and x-ray, emergency transportation, emergency dental, pharmacy, home health services and supplies, and Medicare cost sharing. ~~As of January 1, 2004 the inpatient hospital benefit is suspended until October 15, 2004.~~

~~Effective October 15, 2004, the inpatient hospital benefit is restored at those hospitals which participate under the Colorado Indigent Care Program. Services to the clients covered under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program are limited to those inpatient services available under the Colorado Indigent Care Program.~~

Effective January 1, 2006, Medicare Part D prescription drugs provided pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (defined at 42 U.S.C. Sections 1395w-102 and 141 and 42 C.F.R. Section 423, et seq.) shall not be a benefit for those individuals who are eligible for both Medicare and the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program. The pharmacy drug benefit under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program shall follow Medicaid regulations, as specified under 8.830.

For the benefits listed above, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program shall only be used to provide clients with health care services determined to be medically necessary by the health care provider.

C. All other medical benefits not listed in paragraph B are excluded under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program. Inpatient care in an institution for tuberculosis or mental diseases, skilled and intermediate nursing facility services, and home and community based services are also excluded.

D. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program eligibility shall not be retroactive. Eligibility shall begin with the date of application or date eligibility is established, whichever is later.

E. The Executive Director of the Department of Health Care Policy and Financing, under the direction of the State Medical Services Board, shall manage the Old Age Pension Health and Medical Care

fund and the supplemental Old Age Pension Health and Medical Care fund to assure that utilization controls and other mechanisms are in place in order to hold expenditures within the constitutional and statutory limits.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will exceed the available funds, he/she shall take action to reduce expenditures as needed by reducing, suspending, or eliminating payments for covered benefits.

The Executive Director shall consider reducing, suspending or eliminating benefits, individually or in any combination, based upon the shortest duration of time and considering the least impact on the client. The Executive Director shall report to the Board whenever such action is required, specifying the dollar impact, length of time for the reduction, and the number of clients and providers affected. In addition, the Executive Director shall report to the Board on the feasibility of other cost reduction options.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will be less than the available funds, he/she may take action to increase expenditures up to constitutional and statutory limits by modifying the reimbursement methodology for covered benefits. In addition, the Executive Director shall report to the Board whenever such action is taken.

F. Counties shall provide information to Old Age Pension Health Care Program clients regarding the disposal of excess resources in order to qualify for the Medicaid program. Such information shall include advisements concerning the prohibition of transfer of assets without fair consideration.

G. If Medicare pays for a medical service that is a non-benefit for this group, the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program.

8.941.9 REIMBURSEMENT TO PROVIDERS

As of July 1, 2007, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program will reimburse inpatient hospital services at 10% of the appropriate Medicaid reimbursement. [Eff 07/30/2007]

As of ~~January 9, 2009~~April 15, 2009, providers of physician and practitioner services; outpatient services (including outpatient hospitals, federal qualified health centers, rural health centers and dialysis centers); emergency dental services, independent laboratory and x-ray services; medical supply services; hospice and home health services; and emergency transportation services will be reimbursed at 65% of the appropriate Medicaid reimbursement. As of ~~January 9, 2009~~April 15, 2009, pharmacy claims are reimbursed at 75% of the appropriate Medicaid reimbursement.

In accordance with 8.941.1(E), the Executive Director may alter the reimbursement for any service with the condition that expenditures remain within the constitutional and statutory limits. [Eff 07/30/2007]

Title of Rule:	Revisions to the Medical Assistance Rules for Nursing Facility Benefits, Nursing Facility Cost Reporting and Nursing Facility Classifications
Rule Number:	MSB 09-03-12-B
Division / Contact / Phone:	LTB/NF / Diane Taylor / 2336

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-03-12-B, Revisions to the Medical Assistance Rules for Nursing Facility Benefits, Nursing Facility Cost Reporting and Nursing Facility Classifications
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.440, 8..441, 8.443, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text from §8.440 NURSING FACILITY BENEFITS through the end of §8.441.6.C with the new text attached.

Please replace current text from §8.443 NURSING FACILITY REIMBURSEMENT through the end of §8.443.17.G with the new text attached from §8.443 NURSING FACILITY REIMBURSEMENT through the end of §8.443.19.G.

This change is effective 04/10/2009.

*to be completed by MSB Board Coordinator

Title of Rule:	Revisions to the Medical Assistance Rules for Nursing Facility Benefits, Nursing Facility Cost Reporting and Nursing Facility Classifications
Rule Number:	MSB 09-03-12-B
Division / Contact / Phone:	LTB/NF / Diane Taylor / 2336

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-03-12-B, Revisions to the Medical Assistance Rules for Nursing Facility Benefits, Nursing Facility Cost Reporting and Nursing Facility Classifications
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.440, 8..441, 8.443, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text from §8.440 NURSING FACILITY BENEFITS through the end of §8.441.6.C with the new text attached.

Please replace current text from §8.443 NURSING FACILITY REIMBURSEMENT through the end of §8.443.17.G with the new text attached from §8.443 NURSING FACILITY REIMBURSEMENT through the end of §8.443.19.G.

This change is effective 04/10/2009.

*to be completed by MSB Board Coordinator

Title of Rule:	Revisions to the Medical Assistance Rules for Nursing Facility Benefits, Nursing Facility Cost Reporting and Nursing Facility Classifications
Rule Number:	MSB 09-03-12-B
Division / Contact / Phone:	LTB/NF / Diane Taylor / 2336

STATEMENT OF BASIS AND PURPOSE

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

   To implement HB 08-1114 that changes the nursing facility (NF) reimbursement from a cost-based system to a hybrid system. It mandates administrative costs are set to a price and health care costs are reimbursed on actual, allowable costs to a maximum. The statutory change provides for additional payments to facilities who serve residents with major mental illness or developmental disability and/or cognitive loss, dementia or acquired traumatic brain injury. It provides for additional payments to facilities that develop, implement and sustain a Quality Improvement program to enhance the lives and care of NF residents. A NF provider fee provides funding for all rate add-ons and to fund the base rate to the extent the base rate exceeds the statutory limit on annual growth in the general fund share of NF per diem payments.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal regulation and/or

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

   Explain:

   To implement HB 08-1114 that increases reimbursement to ensure the health and safety of nursing facility residents.

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. (2008);
   25.5-6-201 - 25.5-6-204, C.R.S. (2008)

Initial Review		Final Adoption	**05/08/2009**
Proposed Effective Date	**04/10/2009**	Emergency Adoption	**04/11/2009**

DOCUMENT #02

Title of Rule:	Revisions to the Medical Assistance Rules for Nursing Facility Benefits, Nursing Facility Cost Reporting and Nursing Facility Classifications
Rule Number:	MSB 09-03-12-B
Division / Contact / Phone:	LTB/NF / Diane Taylor / 2336

REGULATORY ANALYSIS

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

   All class I nursing facilities will be affected by this rule. These facilities, including those not certified for Medicaid residents, will bear the cost of a provider fee, with some exceptions, that will be charged and collected on a non-Medicare day basis. Medicaid certified facilities receive back a portion of the fee through per diem payments and enjoy the benefits of additional payments for which they qualify. Facilities that are non-Medicaid certified bear the cost of the fee without benefits of the enhanced programs. Medicaid certified facilities will benefit from payments for enhanced programs of quality improvement. Providers who serve Medicaid residents with moderate to severe cognitive loss/dementia/acquired brain injury and who serve residents with major mental illness or developmental disabilities will receive additional payments.

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 additional payments for quality improvement incentivize providers to implement and sustain programs that enhance quality of life and quality of care for Medicaid beneficiaries. The additional payments for facilities serving Medicaid residents with moderate to severe cognitive loss/dementia/acquired brain injury and who serve residents with major mental illness or developmental disabilities helps to cover the additional costs of handling this group of residents whose needs are not adequately addressed in the case mix adjusted payment system.

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

   The general fund share of the aggregate statewide average of the nursing facility per diem payment for the capital, health care and administrative and general components is limited to an annual growth of 3 percent. This is a savings of approximately 1.5% based on trending nursing facility payments. The add-on payments for quality, cognitive loss/dementia/acquired brain injury, major mental illness and developmental disabilities and per diem payments of more than 3% are paid by the nursing facility provider fee.

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

This rule will reduce the general fund share of nursing facility payments and enhance the payments and benefits of Medicaid certified facilities and beneficiaries. The Department will be in statutory violation without the implementation of this rule. Inaction also increases the general fund share of nursing facility per diem payments to current trending models of 4.5% annually from the 3% growth limitation of this rule.

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

   None

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

   This proposed rule was developed over 18 months in conjunction with the two long term care associations and its members, a provider unaffiliated with these associations, the Ombudsman, the Department and the Department's contract auditor. The rule changes the reimbursement system from a cost-based system to a hybrid system where administrative costs are reimbursed on a price and health care costs are reimbursed on actual, allowable costs. Various methodologies were considered, but the proposed system was best for both the providers, beneficiaries and the Department.

8.440 NURSING FACILITY BENEFITS

Special definitions relating to nursing facility reimbursement:

1. "Acquisition Cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

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

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

4. "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the "Boechk Commercial Underwriter's Valuation System for Nursing Homes."

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

5. "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility providers in the state.

6. a. "Base value" means:

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

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

b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

c. An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

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

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

9. "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not

limited to registered nurses, licensed practical nurses, certified nurse aides and restorative nurses.

10. "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.

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

12. "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of Medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's Medicaid residents as further specified in this section.

13. "Class I facility" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia.

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

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

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

17. "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each resource utilization group as of a specific point in time.

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

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

20. "Index" means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.

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

22. "Median per diem cost" means the daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.

23. "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the Medicare and Medicaid programs.

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

25. "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.

26. "Nursing facility provider" means a facility provider that meets the state nursing home licensing standards established pursuant to section 25-1.5-103 (1) (a), C.R.S., and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

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

28. "Nursing weights" means numeric scores assigned to each category of the resource utilization groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.

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

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

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

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

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

34. Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

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

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

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

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

8.440.1 SERVICES AND ITEMS INCLUDED IN THE PER DIEM PAYMENT

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

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

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

2. Dietary services;

3. Activities program;

4. Room/bed maintenance services;

5. Routine personal hygiene items and services; and

6. Laboratory services.

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

   b. Copies are available for inspection and available at cost at the following address: Director, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-~~1714~~1818; or may be examined at any State Publications Depository Library.

8.440.1.C. Each nursing facility shall furnish, within the per diem rate, equipment necessary to the operation of the facility and provide for necessary medical, nursing, respiratory and rehabilitation care. Such equipment includes, but is not limited to, the following:

1. Adaptive equipment for activities of daily living;

2. Air mattresses, other special mattresses, sheepskins and other devices for preventing/treating decubitus ulcers;

3. Apnea monitors and necessary supplies and equipment;

4. Atomizers;

5. Autoclaves and sterilizers;

6. Bath equipment, i.e., raised and/or padded toilet seats, trapeze benches, tub/shower stools or benches;

7. Bedrails, footboards, trapeze bars, traction and fracture frames, bedside stands;

8. Bed linens;

9. Beds, including hospital beds;

10. Blood glucose monitors;

11. Commode chairs;

12. Deodorizers;

13. Emesis basins;

14. Flameproof curtains;

15. Flashlights;

16. Foot pumps;

17. Gerry chairs, cushioned chairs;

18. Ice bags or equivalent;

19. Intermittent positive pressure breathing equipment, including Sodium Chloride or sterile water required for operation;

20. Irrigating solutions, i.e., Acetic Acid, Potassium Permanganate, Sodium Chloride, and sterile water;

21. Lifts, i.e., hydraulic, tub, slings;

22. Lymphedema pumps and compressors;

23. Medically necessary manual or power wheelchairs for intermittent and full-time use, including cushions and pads as required for the prevention or treatment of skin breakdown, if purchased by the nursing facilities.

    a. Wheelchairs, if required, shall meet the specific needs of the resident and shall be ordered by a physician. The Primary Care Physician shall concur that the wheelchair being prescribed for the resident is medically necessary.

    b. All costs associated with the purchase of the wheelchair shall be charged to the health care line of the nursing facility. Wheelchair expenses shall be ~~capitalized~~ reported in the appropriate health care line of the Med-13~~and depreciated over a fourteen month period.~~

    c. The wheelchair shall be sent with the resident in the event the resident is transferred to another facility or returns home. The transferring facility shall expense the remainder of the chair in the fiscal year during which the transfer occurs.

24. Medicine cups;

25. Oxygen masks, regulators, humidifiers, hoses, nasal catheters, as needed, for the administration of oxygen;

26. Percussors and respirators;

27. Positioning pillows;

28. Reading lights;

29. Scissors, forceps, and nail files;

30. Sitz baths;

31. Sphygmomanometers, stethoscopes, and other examination equipment;

32. Splints;

33. Stryker pads;

34. Suction apparatus and gavage tubing;

35. Supplies and equipment necessary for delivery of special dietary needs;

36. Surgical stockings for routine use;

37. Ventilators and related equipment and supplies;

38. Walkers, crutches, canes and medically necessary accessories for ambulatory devices;

39. Weighing scales.

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

1. Bandaids, gauze pads, dressings and bandages;

2. Bedside utensils, bedpans, basins;

3. Catheters and related supplies, irrigating trays and accessories;

4. Charting supplies;

5. Colostomy and ileostomy bags, supplies, and dressings, ostomy supplies;

6. Disposable sterile nursing supplies including, but not limited to, cotton, face masks, gloves, tape, finger cots;

7. Drinking tubes/straws, water pitchers/glasses;

8. Fleece pads;

9. Foot soaks;

10. Hypodermic syringes and needles, including syringes and needles for insulin administration, intravenous supplies and equipment and related equipment;

11. Minor medical surgical supplies;

12. Miscellaneous applicators;

13. Nebulizers, recreational/therapeutic equipment and supplies to conduct on-going activities program;

14. Safety pins;

15. Thermometers;

16. Tongue depressors;

17. Tracheostomy care kits, cleaning supplies;

18. Urinals, urinary bags, and tubes and supplies.

8.440.1.E. Routine personal hygiene items/services shall be provided by the nursing facility within the per diem rate. These items include, but are not limited to, hair hygiene services (i.e., simple trims, such as trimming bangs or cutting of some hair that may need minor cutting in the back) hair hygiene supplies (i.e., shampoo, hair conditioner, comb, brush); bath soap, disinfecting soaps or specialized cleaning agents when indicated to treat special skin problems or to fight infection; razors, shaving cream; toothbrush, toothpaste, mouthwash, denture adhesive, denture cleanser, dental floss; moisturizing lotion; tissues, cotton balls, cotton swabs; deodorant) incontinence care and supplies (i.e., pads, cloth and disposable diapers, pants, liners, sanitary napkins and related supplies) towels, washcloths; and hospital gowns; bathing; shaving; nail hygiene services (i.e., routine trimming, cleaning and filing, not polishing).

8.440.1.F. Various over-the-counter (OTC) drugs and supplies as required to meet the residents' assessed needs shall be furnished by the facility, within the per diem rate, at no charge to the resident. OTC drugs/supplies including but not limited to:

1. Artificial tears;

2. Aspirin, acetaminophen, ibuprofen, and other non-prescription analgesics available now or in the future;

3. Cough and cold supplies, i.e., cold tablets, decongestants, cough syrup/tablets;

4. Douches;

5. Evacuant suppositories, laxatives, stool softeners, enemas;

6. First aid supplies, i.e., alcohol, hydrogen peroxide, merthiolate and other antiseptics/germicides, Betadine, Phisohex, chlorhexidene gluconate, providone/iodine solution and wash, epsom salt;

7. Lubricants, rubbing compounds and ointments, i.e., petroleum jelly, bag balm, other body lotions for treatment of dry skin or skin breakdowns, bacitracin ointment and other ointments used in treatment of wounds;

8. Vitamins (multi and single) and mineral supplements.

8.440.1.G. The following services and provisions shall be provided by the facility within the per diem rate:

1. Food and dietary services, including special diets, supplements and nutrients ordered by the physician, in accordance with the needs of the residents and appropriate licensing requirements;

2. Room for accommodation of the resident in accordance with licensing requirements, including storage for personal belongings, bedside equipment, suitable bed, clean and comfortable mattress, pillows and an adequate supply of clean linen;

3. Maintenance of clean, comfortable and sanitary environment through provision of heat, light, ventilation and sanitation to meet health and aesthetic needs of the resident, in accordance with the physicians' orders and licensing regulations;

4. Basic personal laundry, excluding dry-cleaning, mending, hand washing, or other specialties.

5. Consultant services when the facility employs or contracts with consultants in an effort to meet regulations.

6. Specialized rehabilitative services, including, but not limited to, physical therapy, speech-language pathology, occupational therapy and mental health rehabilitative services for mental illness and mental retardation, when required in the resident's comprehensive plan of care. Specialized rehabilitative services shall be provided under the written order of a physician by qualified personnel. The facility shall provide the required services or obtain the required services from a provider of specialized rehabilitative services.

7. Ongoing activities program directed by a qualified professional, to meet the interests and the physical, mental and psychosocial well-being of each resident. The nursing facility can charge for entertainment and social events that are outside the scope of the required activities program.

8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT

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

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

2. Flowers and plants;

3. Gifts purchased on behalf of a resident;

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

5. ~~Other il~~tems or services requested by the resident, including but not limited to, over the counter drugs/related items not prescribed by a physician, not included in the nursing care plan and not ordinarily furnished for effective patient care. In these instances, it is required that: ~~and not included as either a benefit of Medicaid, within the per diem rate, or as allowable under the Post Eligibility Treatment of Income (PETI), 10 C.C.R. 2505-10, Section 8.110;~~

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

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

~~6. Over the counter drugs/related items not prescribed by a physician, not included in the nursing care plan and not ordinarily furnished for effective patient care.~~

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

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

~~7~~6. Personal clothing and dry cleaning;

~~8~~7. Personal comfort items, including smoking materials, notions, novelties and confections/candies;

~~9~~8. Personal reading material, subscriptions;

~~10~~9. Private room;

~~11~~10. Social events and entertainment offered off premises and outside the scope of the regular facility activities program;

~~12~~11. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. If the resident refuses the prepared food the facility shall offer substitutes. Residents may be charged only for specially prepared food if they are informed that there will be a charge, and the charge may be only the difference in price between the requested item and the covered item pursuant to 42 C.F.R. 483.35.

~~13~~12. Telephone, television/radio for personal use, if not equally available to all residents.

13. Provider fee.

14. Prescription drugs, with certain specific exemptions.

15. Ambulance transport, including emergent and non-emergent.

16. Oxygen

17. Physician fees

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

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

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

2. The physician orders a private room.

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

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

8.441 NURSING FACILITY COST REPORTING

8.441.1 SUBMISSION OF THE MED-13 AND MINIMUM DATA SET (MDS)

8.441.1.A. For purposes of completing MED I3, each nursing facility shall:

1. Establish a 12-month period that is designated to the Department as the facility's fiscal year. The fiscal year shall remain the same as designated to the Department with two exceptions:

a. Providers seeking to coordinate their fiscal year with the fiscal year they have established with the Internal Revenue Service.

b. Subchapter "S" corporations required by law to have a fiscal year end of December 31.

2. Provide adequate cost data that:

a. Is based on their financial and statistical records. All financial and statistical records of the facility shall be maintained in accordance with generally accepted accounting principles as approved by the American Institute of Certified Public Accountants.

b. Is verifiable by reference to adequate supporting documentation by qualified auditors during the normal course of their audit;

c. Is based on the accrual basis of accounting.

i) Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected and expenses are reported in the period in which they are incurred, regardless of when they are paid.

ii) Where a governmental institution operates on a cash basis of accounting, cost data based on such accounting shall be acceptable, subject to appropriate treatment of capital expenditures.

d. Includes the Medicare cost report that was most recently filed with the Medicare fiscal intermediary. If the facility cannot file a current Medicare cost report for reasons beyond its control, the facility shall submit other reliable Medicare cost information that the Department has approved.

~~3~~3~~.~~ ~~In order to provide the required cost data and not impair comparability~~, Maintain ~~f~~financial and statistical records ~~shall be maintained~~ in a manner consistent from one reporting period to another ~~.~~in order to provide the required cost data and not impair comparability.

4. ~~Nursing facilities shall r~~Retain all records required to support information supplied on the MED-13 for a period of at least five (5) years from the date of submission.

8.441.1.B. Nursing facilities shall submit all Minimum Data Set (MDS) resident assessments and tracking documents to the Centers for Medicare and Medicaid Services (CMS) MDS database for Colorado maintained at the Colorado Department of Public Health and Environment (CDPHE). All assessment data submitted shall conform to federal and state specifications and meet minimum editing and validation requirements.

8.441.1.C. Failure to maintain adequate accounting and/or statistical records shall be cause for termination or suspension of the facility's provider agreement.

8.441.2 COMPLETION OF THE MED-13 --GENERAL INSTRUCTIONS

8.441.2.A. The MED-13 consists of the certification page and ~~Schedules A, B, C, D, E, and F~~and all schedules. All information called for in the schedules must be furnished unless:

1. It is not applicable to the nursing facility operation; or

2. The books and records do not provide the information and it is not available by other reasonable means.

8.441.2.B. The financial information included shall be based on that appearing in the facility's audited financial statement. Adjustments to convert to the accrual basis of accounting shall be required if the records are maintained on other accounting bases.

8.441.2.C. Nursing facilities that are a part of a larger health facility extending short term, intensive or other health care not generally considered nursing facility care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. In certain instances, such cost apportionment schedules may be required by the Department if deemed necessary for a fair presentation of expense attributable to nursing facility patients.

8.441.2.D. The instructions regarding the MED-13 ~~do not cover each line on any page but~~ are designed to cover those items that may require additional explanation or to provide an example.

8.441.3 COMPLETION OF THE MED-13 CERTIFICATION PAGE

8.441.3.A. Type of control indicates ownership or auspices under which the nursing facility is conducted.

8.441.3.B. Accounting basis:

1. Accrual Recording revenue when earned and expenses when incurred.

2. Modified Cash Recording revenue when received and expenses when incurred.

3. Cash Recording revenue when received and expenses when paid after giving effect to adjustments for pre payments, etc. and depreciation.

4. Nursing facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis.

8.441.3.C. Statistical Data

1. The statistical data shall be accurate. A resident day is that period of service rendered to resident between the census taking hours on two (2) successive days, the day of discharge being counted only when the resident was admitted that same day.

2. The total resident days ~~(entered in schedule M, line 4)~~ for the period shall be accurate and not an estimate of days of care provided. Resident days shall include days for residents having special duty nurses.

3. The accumulation method format set forth in Form NH 1 ("Monthly Census Summary -- Nursing Home Patients") shall be used. Such monthly record shall be kept concerning all patients, both Medicaid residents and non-Medicaid residents, by the nursing facility. Sample copies of the required format may be obtained from the Department.

8.441.3.D. The certification statement on the MED-13 shall be read and signed by the licensed owner or corporate officer and the preparer of the MED-13.

8.441.3.E. The Department may require a nursing facility to provide the opinion of a certified public accountant if, in the Department's opinion, adjustments made to prior reports indicate disregard of the certification and reporting instructions. The CPA shall certify that the report is in compliance with the Department's regulations and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

8.441.4 COMPLETION OF REVENUES SCHEDULE ~~A – REVENUES~~

8.441.4.A. Revenues shall be listed as recorded in the general books and records and are affected by the accounting basis and procedures used. Expense recoveries credited to expense accounts

shall not be reclassified in order to be reflected as revenues for purposes of ~~completion of~~ completing the revenue schedule~~Schedule A~~.

8.441.4.B. Revenue from patients shall be classified sufficiently in the accounting records to allow preparation of this schedule.

1. “Routine services” or “daily services” are those services that include room, board, nursing services and such services as supervision, feeding, incontinency for which the associated costs are in nursing service.

2. "Routine services~~” or~~” or “daily services" shall represent only the established charge for daily care, excluding additional charged, if any, for other services.

~~8.441.4.C. Revenue from residents or others resulting from charges made for room reservations shall be used in reduction of related expenses.~~

8.441.4.~~D~~C. Revenue from ancillary services provided to residents, such as pharmacy, medical supplies and occupational therapy supplies shall be applied in reduction of the related expense. The resulting expense, after adjustment, shall not be a negative figure. A revenue classification "Miscellaneous" or "Sundry" requires an analysis and determination of the amounts included therein, which represent expense recoveries or income to be applied in reduction of a related expense.

~~8.441.4.E. Prescription drugs, with certain specific exemptions, are not provided to Medicaid residents by the nursing facility.~~

8.441.4.~~F~~D. Medical supplies, with certain specific exceptions, shall be provided to Medicaid residents without separate additional charges to the resident or relatives. The costs of these supplies or services shall be included in audited costs.

8.441.4.~~G~~E. Those specific medical supplies or services for which a separate additional charge is allowed are to be accounted for ~~on Schedule C~~ as "Items Purchased for Resale" and the cost thereof shown ~~on Schedule A o~~on the appropriate line for elimination ~~of Schedule C~~.

8.441.4.~~H~~F. Revenues related to services rendered which are not an obligation of the state shall be offset against allowable costs if the associated expense can not be determined. If the associated expense can be determined, related expense should be removed as non-allowable (i.e., if barber and beauty shop revenue is $1,000 and the related expense is $900, enter $900; however, if expenses cannot be determined, enter $1,000).~~entered in "Column 4" to the extent of the related expense (i.e., if beauty and barber shop revenue is $I,000 and the related expense is $900, enter $900; however, if expenses cannot be determined, enter $I,000).~~

8.441.4.~~I~~G. Revenues not related to patient care ("Other Revenue Centers") shall be applied in reduction of the related expense. ~~Enter on Schedule A in "Column 4"~~Remove the cost, if known, (such as employee meals or telephone expense) or the gross revenue if cost cannot be determined.

8.441.4.~~J.~~H Revenue from residents, or others, resultant from charges made for room reservations, shall be classified sufficiently in the accounting records, and such amount shall be entered on ~~Schedule A~~the Revenue Schedule and identified as room reservation charges. This revenue shall also be offset ~~in Column 7, Schedule C, Line 48~~against allowable expenses.

8.441.4.~~K~~I. An ~~i~~investment or interest income adjustment shall be necessary only if interest expense is incurred, and only to the extent of such interest expense.

8.441.4.~~L~~J. Laundry revenue shall be applied to laundry expense.

8.441.4.~~M~~K. Open lines are provided for entry of sundry sources of revenue not directly related to patients, such as pay telephone commissions, contributions and grants received. These items need not be applied as a reduction of expense.

8.441.4.~~N~~L. Accounts receivable charged off or provision for uncollectible accounts shall be reported on ~~Schedule A~~the Revenue Schedule as a deduction from gross revenue. However, if a nursing home accounts for such revenue deductions as an administrative expense, the amounts shall be entered ~~on Schedule B~~ as "Other expenses not related to patient care."

~~8.441.4.O. The amounts entered on Schedule A, "Column 4" shall be transferred to Schedule C, Column 7. The totals of these columns on both schedules shall agree.~~

8.441.5 COMPLETION OF ~~SCHEDULE B~~ NON-REIMBURSABLE EXPENSES AND EXPENSE LIMITATIONS AND ADDITIONS SCHEDULE

8.441.5.A. The following expenses shall be excluded or limited from operating expenses because they are not normally incurred in providing patient care:

1. Fees paid directors and non-working officers' salaries shall not be allowed as reimbursable costs.

2. Loan acquisition fees and standby fees shall not be considered part of the current expense of patient care but shall be amortized over the life of the related loan.

8.441.5.B. COMPENSATION OF OWNERS AND OWNER-RELATED EMPLOYEES

1. For purposes of Section 8.441.5.B, the following definitions shall apply:

a. Compensation means the total benefit received by the owner for the services he/she renders to the facility. Such compensation shall only include:

i) Salary amounts paid for managerial, administration, professional and other services;

ii) Amounts paid by the facility for the personal benefits of the owner;

iii) The costs of assets and services which the owner receives from the facility; and

iv) Deferred compensation.

b. Necessary Services means those services needed for the efficient operation and sound management of the facility such that, had the owners or owner-related individuals not rendered the services, the facility would have had to employ another individual to perform the services.

c. Owner means an individual with a five percent (5%) or more ownership interest in the facility.

d. Owner-Related Individual means an individual who is a member of an owner's immediate family which includes a spouse, natural or adoptive parent, natural or adopted child, step-parent, step-child, sibling or step-sibling, in-laws, grandparents and grandchildren.

e. Ownership Interest means the entitlement to a legal or equitable interest in any property of the facility whether such interest is in the form of capital, stock or profits of the facility.

2. Compensation for services of owners and owner related employees shall be adequately documented to be necessary and such employees shall adequately documented to be qualified to provide these services. Adequate documentation shall include but not be limited to:

    a. Date and time of services;

    b. Position description;

    c. Individual's educational qualifications, professional title and work experience;

    d. Type and extent of ownership interest;

    e. Relationship to and name of owner (if an owner related individual).

3. The methods set forth below shall determine the allowable costs of salaries paid to owner and owner related employees. For each method, if an owner or owner-related employee is compensated for services to the facility, any compensation paid to another individual in the same position shall be excluded from the allowable costs for that cost reporting period.

    a. Owner and Owner-Related Administrators: The maximum allowable cost of salaries paid to owner and owner-related administrators shall be equal to the median of salaries paid to all non owner and non owner related administrators in facilities of comparable size. The median shall be computed by the Department from a survey of all Colorado Medicaid participating facilities conducted each January, and shall be applied to salaries for that calendar year. Categories of facilities, based on licensed bed capacity, for purposes of determining comparability shall be as follows: 1 74; 74 99; 100 149; 150 200 and more than 200.

    b. Owner and Owner-Related ~~/~~Assistant Administrator: The maximum allowable cost for such services shall be 75% of the maximum allowable salary of an owner or owner related~~/~~ assistant administrator of a comparable facility. No costs shall be allowable for owner or owner related assistant administrators in facilities with licensed bed capacities less than 150.

    c. Owner and Owner-Related Physicians Performing Administrative Services: Salaries shall be an allowable cost up to the maximum established for owner and owner-related administrators in a comparable facility.

    d. Owner and Owner-Related ~~/~~Nursing Directors: Salaries shall be an allowable cost up to a maximum of 65% of the maximum allowable salary of an owner or owner-related administrator of a comparable facility.

4. Fringe benefits for owner and owner-related employees shall be allowable costs up to a maximum established by the Department each March for that calendar year. This maximum shall be equal to the fringe benefit percentage of private employees in Colorado as determined by the survey conducted by the State Department of Personnel, minus that portion of the computation that includes holidays, vacation and sick leave days.

5. Exceptions to the application of the median as the maximum allowable salary for owner and owner-related employees shall be approved by the Department only where the nursing home can demonstrate that it has unique characteristics or the employee in question has special qualifications and experience which would make application of the median for that size facility unreasonable. Requests for exceptions shall be submitted to the ~~contract~~ Department~~auditor~~ in writing no later than 90 days prior to the end of the facility's fiscal year.

8.441.5.C. LEGAL FEES, EXPENSES AND COSTS

1. Legal fees, expenses and costs incurred by nursing facilities shall be allowable, in the period incurred, if said costs are reasonable, necessary and patient-related. ~~Such costs shall be reimbursed only to the extent they affect the rates for those periods.~~ These legal fees, expenses and costs shall be documented in the provider's files, and shall be clearly identifiable, including identification by case number and title, if possible. Failure to clearly identify these costs shall result in disallowance.

2. The following categories shall not be deemed reasonable, necessary and patient-related:

   a. Legal fees, expenses and costs incurred in connection with the appeal of a Medicaid classification or reimbursement rate, rate adjustment, personal needs audit, or payment for any financial claim by or against the State of Colorado, or its agencies by a provider, in the event the State of Colorado or any of its agencies prevails in such a proceeding. In the event that each party prevails on one or more issues in litigation, allowable legal fees, expenses and costs in such cases shall be apportioned by percentage, for reimbursement purposes, by the administrative law judge rendering the final agency decision. In the event of the stipulated settlement of any such appeal, the parties shall, by agreement, determine the allowability for the provider's legal fees, expenses and costs. If a settlement agreement is silent concerning legal fees, expenses or costs, they shall not be allowable.

   b. Legal fees, expenses and costs incurred in connection with a proceeding by the Department or the CDPHE to deny, suspend, revoke or fail to renew or terminate the license or provider contract of a long-term care facility, or to refuse to certify, decertify or refuse to recertify a long-term care facility as a provider under Medicaid and the Departments prevail in such a proceeding. Legal fees, expenses and costs incurred in connection with a proceeding by the United States Department of Health and Human Services to refuse to certify, decertify, or refuse to recertify a long-term care facility and the Department prevails in such a proceeding. For the purposes of this paragraph, the word "prevail" shall mean a result, whether by settlement, administrative final agency action or judicial judgment, which results in a change of the terms of a previously granted provider license, certification, or contract, including involuntary change of ownership or probation.

   c. Legal fees, expenses and costs incurred in connection with a civil or criminal judicial proceeding against the provider by the State of Colorado and any of its agencies as the result of the provider's participation in the Medicaid program, resulting from fraud or other misconduct by the provider, and the State or its agencies prevail in such proceeding. For the purposes of this paragraph, the word "prevail" shall mean any result but dismissal or acquittal of a criminal action or dismissal, directed judgment, or judgment for the provider in a civil action.

   d. Legal fees, expenses and costs incurred in connection with an investigation by federal, state, or local governments and their agencies that might lead to a civil or criminal proceeding against the provider as a result of alleged fraud or other misconduct by the provider in the course of the provider's participation in the Medicaid program shall not be allowable where the provider makes any payment of funds to any federal, state, or local governments and their agencies as a result of the alleged fraud or misconduct which was the subject of the investigation.

   e. Legal fees, expenses and costs incurred for lobbying Congress, the Legislature of Colorado, or the State Boards of Medical Services, Health or Human Services.

   f. Legal fees, expenses and costs incurred by the seller in the normal course of the sale of a nursing home.

g. Nonrefundable retainers paid to Counsel.

h. Legal fees, expenses and costs associated with a change of ownership incurred for any reason after a change of ownership has occurred.

i. Legal fees, expenses, or costs as a result of an attorney entering an appearance in person or in writing by counsel for the provider during the Informal Reconsideration. Legal fees, expenses and costs that are advisory in nature before and during the Informal Reconsideration process will be allowable.

8.441.5.D. DEPRECIATION

1. For purposes of this section concerning depreciation, the following definitions shall apply:

   "MAI Appraiser" means the designation "Member, Appraisal Institute" awarded by the American Institute of Real Estate Appraisers.

   "Straight Line Method of Depreciation" means the method of depreciation where the amount to be depreciated is first determined by subtracting the estimated salvage value of the asset from its cost or fair market value in the case of donated assets. The amount to be depreciated is then distributed equally over the estimated useful life of the asset.

2. Except as specified in this manual, Medicare rules and regulations as delineated in the Medicare and Medicaid Guide, 1981, published by Commerce Clearing House, paragraph 4501 4897P, shall be utilized in the treatment of depreciation costs for purposes of reimbursement under Medicaid. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

3. Depreciation on assets used to provide covered services to Medicaid recipients may be included as an allowable patient cost. Only the straight-line method of computing depreciation may be utilized for purposes of Medicaid reimbursement. Depreciation costs shall be identifiable as such, and shall be recorded in the provider's accounting records in accordance with "generally accepted accounting principles."

4. Depreciable items must be capitalized and written off over the estimated useful life of the item using the straight-line method of depreciation. With respect to expenditures during every facility fiscal year which begins on or after July 1, 1998, the following items must be depreciated:

   a. Assets that, at the time of acquisition, had an estimated useful life of (2) two years or more; and a historical cost of $5,000 or more.

   b. Betterments or improvements that extend the original estimated useful life of an asset by (2) two years or more, or increase the productivity of an asset significantly; and cost $5,000 or more.

   c. For the purpose of applying the $5,000 threshold in paragraphs A and B above, the costs of assets, betterments, and/or improvements shall be combined if the costs:

      i) Are incurred within the same fiscal year of the nursing facility; and

ii) Are of the same type or relate to the same project. For example, costs related to renovations or improvements to a facility's kitchen~~, done in three phases costing $3,000 each,~~ must be combined.

d. Major repairs are repairs which:

i) Occur infrequently, involve significant amounts of money, and increase the economic usefulness of the asset in the future, because of either increased efficiency, greater productivity, or longer life; or

ii) Restore the original estimated useful life of an asset where without such repairs, the useful life of the asset would be reduced or immediately ended; these repairs occur infrequently and have a significant cost in relation to the asset being repaired.

e. If the composite method of depreciation is used, the time period over which the major repair must be depreciated is not necessarily the remaining life of the composite asset. For example, a major repair to a roof of a facility that has a remaining useful life of thirty (30) years would not have to be depreciated over thirty (30) years if the normal life of the roof is only fifteen (l5) to twenty (20) years; the shorter period could be used.

f. The following are examples of major repairs and are not intended as a complete list: replacement or partial replacement of a roof, flooring, boiler, or electrical wiring.

8.441.5.E. EXPENSED ITEMS

1. Items which are to be entirely expensed in the year of purchase, rather than depreciated, are as follows:

a. All repair and maintenance costs, except major repairs.

b. Assets that, at the time of acquisition, had an estimated useful life of less than two (2) years; or cost less than $5,000.

c. Betterments or improvements that do not extend the useful life of an asset by two (2) years or more, or do not increase the productivity of an asset significantly; or cost less than $5,000.

d. For the purpose of applying the $5,000 threshold in paragraphs “b” and “c” above, assets, betterments, and/or improvements that are purchased separately shall be combined if they meet the criteria described in section 8.441.5.D.

8.441.5.F. HISTORICAL COSTS

1. Historical costs shall be established in accordance with the Medicare and Medicaid Guide, l98l, published by Commerce Clearing House, paragraphs 4501-4897P, except that any appraisals required or recommended shall be performed by an MAI Appraiser rather than an "appraisal expert" as defined in the Guide. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-~~1714~~1818. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. When the Internal Revenue Service requires a facility to change its allocation of costs of land, buildings or equipment for purposes of tax reporting, a copy of the IRA notice shall be submitted to the Department in order for the changes to be reflected in the cost report.

3. In regards to a determination of a bona fide sale, an initial presumption that the sale was not bona fide may be offset by a valuation report of an MAI appraiser of the reproduction cost depreciated to date on a straight-line basis. Cost determined in this manner shall be accepted for future depreciation purposes.

4. An initial presumption that a sale was not bona fide shall be made when any of the following factors exist:

    a. The seller and purchaser are persons for whom a loss from the sale or exchange of property is not allowed under the Internal Revenue Services Code between:

        i) Members of a family;

        ii) An individual and a corporation if the individual owns (directly or indirectly) more than 50% in value of the outstanding stock;

        iii) Two corporations if more than 50% in value of the outstanding stock in both is owned, directly or indirectly, by the same individual, but only if either one of the corporations was a personal holding company or a foreign personal holding company for the taxable year preceding the date of the sale or exchange;

        iv) A grantor and a fiduciary of any trust;

        v) A fiduciary of one trust and a fiduciary of another trust, if the same person is grantor of both trusts;

        vi) A fiduciary of a trust and any beneficiary of such trust;

        vii) A fiduciary of a trust and a beneficiary of another trust, if the same person is a grantor of both trusts;

        viii) A fiduciary of a trust and a corporation more than 50% in value of the outstanding stock of which is directly or indirectly owned by or for the trust or a grantor of the trust. This would, for example, have the effect of denying a loss in a transaction between a corporation, more than 50% of the stock of which was owned by a father, and a trust established for his children. Under the constructive ownership rules (below), the children are treated as owning the stock owned by the father; and

        ix) A person and an exempt charitable or education organization controlled by the person or, if the person is an individual, by the individual or his family.

    b. The term "family" means a brother or sister (whole or half-blood relationship, spouse, ancestor, or lineal descendant, including in laws and in laws of ancestors of lineal descendants.

    c. In determining stock ownership;

    d. The transaction was effected without significant investment on the part of the purchaser; i.e., cash or property was not transferred from the purchaser to the

seller and the sales price was met by assumption of existing debt and promises to pay additional amounts or issuance of life annuities to the seller.

e. The sales price could be considered excessive when compared with other sales or costs of constructing, furnishing, and equipping other facilities of comparable size and quality during the preceding twelve months.

8.441.5.G. INTEREST

1. For purposes of this section concerning interest, the following definitions shall apply:

   a. Interest means the cost incurred for the use of borrowed funds.

   b. Interest on current indebtedness means the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expense.

   c. Interest on capital indebtedness means the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

   d. Necessary means that the interest:

      i) Is incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments shall not be considered necessary;

      ii) Is incurred on a loan made for a purpose reasonably related to patient care; and

      iii) Is reduced by investment income except where such income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or provider's qualified pension fund shall not used to reduce interest expense.

   e. Proper means that interest:

      i) Is incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and

      ii) Is paid to a lender not related through control or ownership or personal relationship to the borrowing organization. However, interest shall be allowable if paid on loans from the provider's donor restricted funds, the funded depreciation account or provider's qualified pension funds.

2. To be allowable, the interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors affects the bargaining process that usually accompanies the making of a loan and could be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans shall be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed and that the interest rate is reasonable.

3. Interest on loans to providers by partners, stockholders or related organizations are allowable as costs at a rate not in excess of the prime rate.

4. Where the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, the interest shall be an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

5. Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.

6. Allowable interest expense on current indebtedness of a provider shall be adjusted to reflect the extent to which working capital needs which are attributable to covered services for beneficiaries have been met by payment to the provider designed to reimburse currently as services are furnished to beneficiaries.

8.441.5.H. MANAGEMENT SERVICES

1. The following requirements apply to all management companies:

   a. Management company costs shall be considered administrative costs ~~unless all management company personnel charged to health care are professionally qualified in the health care field as required by these regulations.~~except as described at 8.443.7.A.13.

   b. Management company costs allocated to facilities shall be based on actual services provided to the facility. The allocation shall be documented.

   c. If the compensation to on-site management staff is separately reported on the cost report, that compensation shall not also be included in the allowable management costs for the facility. This rule shall apply regardless of whether owners or owner-related organizations are involved in the administration or management services.

2. In addition to the requirements of 8.441.5.H.1, the following requirements shall apply to owner-related management companies:

   a. "Owner-related management company" means an individual or organization that is related to, owned or controlled by the owner(s) of the nursing facility, as described in 8.441.5.B.

   b. Management services provided to the nursing facility by an owner-related management company are subject to the related party rules at 8.441.5.B.

   c. When management services are provided to a nursing facility by an owner-related management company, the nursing facility shall compile and present for inspection supporting documentation of actual costs incurred in providing the management company services. This shall include, at a minimum, the following:

      i) Documentation supporting the reasonableness of salaries paid to owners and owner-related employees of the management company, as specified in 8.441.5.B;

      ii) Allocation schedules;

iii) Medicare Home Office cost reports;

iv) All tax records and filings of the management company;

v) All management company records to support financial statements.

d. Documentation supporting the reasonableness of salaries and other compensation paid to owners and employees of an owner-related management company shall be available for inspection and shall include, but not be limited to, the following:

i) Salary survey(s) for the geographic location demonstrating that the salaries and other compensation are comparable to market for their respective position and size of entity;

1) If the provider does not provide a salary survey, the auditor shall use the latest survey of the Healthcare Financial Management Association (HFMA).

2) Salary surveys are to be of a sufficiently large sample, including non-related nursing facility management companies, to lend support to the salaries. Surveys including a small number of facilities (less than ten), facilities related through common ownership or control or facilities of incomparable size shall be considered unacceptable.

ii) A position description for the person listing the duties performed;

iii) Date and time of services provided by each owner-related individual;

iv) Job applications, resumes, professional title, educational qualifications, and other documentation of work experience and qualifications; and

v) The type and extent of ownership interest for each owner or owner-related individual employed by or performing services for the management company.

e. Limitations shall be based on the median salaries included in the survey(s) referenced in 8.441.5.H.2.d. If the owner or owner-related party receives compensation from two or more entities, the total compensation received from those entities shall be evaluated for reasonableness. In the absence of reasonable documentation that the owners and/or owner-related parties are working employees, the compensation claimed for these persons shall be disallowed as a cost not related to patient care.

f. Compensation to owners of related party companies, regardless of organizational structure, must be paid within seventy-five (75) days of the end of the fiscal year. Payment of the compensation shall be evidenced by documentation submitted to the IRS. Failure to provide adequate documentation ~~at~~ during the field audit ~~visit~~ process shall result in disallowance of unsupported or unpaid amounts. Disallowed compensation shall not be allowed in any future period.

8.441.5.I. ITEMS FURNISHED BY RELATED ORGANIZATIONS OR COMMON OWNERSHIP

1. Costs applicable to services, facilities and supplies furnished by organizations related to the nursing facility by common ownership or control are allowable costs of the nursing facility at the cost to the related organization or the open market price, whichever is less.

2. The following definitions are applicable for the purposes of this regulation:

    a. Common ownership means that an individual or individuals directly or indirectly possess a significant (5% or more) ownership interest, as defined in 8.441.5.B, in the nursing facility and the institution or organization serving the nursing facility.

    b. Control means that an individual or an organization has common ownership with or is related to another organization or institution, or has the power, directly or indirectly, to influence significantly or to direct the actions or policies of another organization or an institution.

    c. Related to the nursing facility means:

        i) The nursing facility, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities or supplies; or

        ii) An owner-related individual, as defined in 8.441.5.B, is employed by the nursing facility at the time that the nursing facility is obtaining services, facilities or supplies from an organization whose owner is related to the nursing facility employee; or

        iii) An owner-related individual, as defined in 8.441.5.B, is employed by an organization which is providing services, facilities or supplies to a nursing facility whose owner is related to the supplier's employee.

3. Related providers or organizations shall be identified by the nursing facility on Schedule F of the MED-l3.

4. The charge by the related provider or organizations for the services, facilities or supplies shall be considered an allowable cost when the nursing facility demonstrates all of the following by clear and convincing evidence:

    a. The supplying organization is a bona fide separate organization; and

    b. A substantial part of the supplier's business activity of the type carried on with a nursing facility is transacted with others than the nursing facility and organizations related to the supplier by common ownership or control; and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; and

    c. The services, facilities or supplies are those which commonly are obtained by institutions, such as the nursing facility, from other organizations and are not basic elements of patient care ordinarily furnished directly to the patients by such institutions; and

    d. The charge to the nursing facility is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities or supplies.

8.441.5.J. NON-SALARIED STAFF

1. Members of religious orders serving under an agreement with their administrative offices shall be allowed comparable salaries paid persons performing comparable services.

2. If maintenance is provided such persons by the nursing facility, i.e., room board, clothing, the amount of these benefits shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

8.441.5.K. OXYGEN

1. Only purchased oxygen concentrator ~~costs~~costs, whether expensed or capitalized, shall be allowable costs on the MED-13. Such costs include, but are not limited to, all supplies, equipment and servicing ~~expenses~~expenses related to the maintenance of the purchased concentrators.

~~2. Oxygen concentrators purchased by nursing facilities shall be capitalized over the useful life of the asset. All supplies and service costs are allowable.~~

~~3. The nursing facilities shall have document the costs incurred with the oxygen concentrators. These costs shall be segregated by costs associated with Medicaid residents and non-Medicaid residents.~~

~~4~~2. Oxygen concentrators of any size leased ~~provided~~ by medical supply companies to Medicaid nursing facility residents shall not be allowable costs and shall not be included in the MED-13.

8.441.5.L LIMITATION ON MEDICARE PART A AND PART B COSTS [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]~~1231145~~

1. Only those Medicare costs that are reasonable, necessary and patient-related shall be included in calculating the allowable Medicaid reimbursement for class I nursing facilities.~~1231146~~

2. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for a class I facility shall be: The level of Part A costs allowed in the facility's latest Medicare cost report submitted by the facility to the Department prior to July 1, 1997.

3. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for newly certified Medicaid nursing facilities shall be: The level of Part A costs allowed in the facility's first full year Medicaid cost report submitted by the facility to the Department.~~1231148~~

4. Part B direct costs for Medicare shall be excluded from the allowable Medicaid reimbursement for class I nursing facilities.

~~8.441.5.L. FAIR RENTAL ALLOWANCE FOR CAPITAL RELATED ASSETS~~

~~1. For purposes of this section concerning fair rental allowance, the following definitions shall apply:~~

~~Appraised Value means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent, the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the most recent edition of the Boeckh™ Commercial Building Valuation System for Windows™ available on December 31st of the year preceding the year in which the appraisals are to be performed. This material is incorporated by reference into these rules. Information about obtaining or examining the applicable edition is available from the Custodian of Records, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. The incorporated material may also be examined at any State Publications Depository Library.~~

~~Base Value means the value of the capital related assets as determined by the most current appraisal report completed by the Department or its designee and any additional information considered relevant by the Department. For each year in which an appraisal is not done, base value means the most recent appraisal value increased or decreased by fifty percent (50%) of the change in the Index. Under no circumstances shall the base value exceed $25,000 per bed plus the percentage rate of change~~

~~Capital-Related Asset means the land, buildings and fixed equipment of a participating facility.~~

~~Fair Rental Allowance means the product obtained by multiplying the base value of a capital-related asset by the rental rate.~~

~~Fair Rental Allowance Per Diem Rate means the fair rental allowance described above, divided by the greater of the audited patient days on the provider's annual cost report or ninety percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.~~

~~Fiscal Year means the State fiscal year from July 1 through June 30.~~

~~Fixed equipment means building equipment as defined under the Medicare principle of reimbursement as specified in the Medicare provider reimbursement manual, part 1, section 104.3. Specifically, building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:~~

~~a. Affixed to the building and not subject to transfer; and~~

~~b. A fairly long life but shorter than the life of the building to which it is affixed.~~

~~Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, a publication of R.S.Means Company, Inc. that is updated annually (section M.450, "Nursing Home"), hereafter referred to as the Means Index. This material is incorporated by reference into these rules. Information about obtaining or examining the applicable edition is available from the Custodian of Records, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. The incorporated material may also be examined at any State Publications Depository Library.~~

~~Rental Rate means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.~~

~~2. In the case of facilities for which an appraisal was completed pursuant to RFP GB 347 (October 21, 1985) and no major physical plant expansions or additions were completed prior to the Department's reappraisal of the property, the following data shall remain unchanged through following appraisals:~~

~~a. Average story height.~~

~~b. Gross floor area.~~

~~c. Total perimeter.~~

~~d. Construction classification.~~

~~e. Construction quality.~~

f. Year built

3. In the case of those facilities that have completed a major physical plant expansion, addition or deletion, the initial appraisal measurements and data specified in paragraph 2 above shall be modified only to the extent of the relevant appraisal data specific to the new expansion, addition or deletion.

4. The appraisal shall take into consideration the economic impact the addition, deletion or use modification may have had on the overall value of the entire facility.

5. The variables from the Boeckh program that are to be calculated/determined by the Department or its designee, and which will be incorporated into the Request for Proposal (RFP) which defines the scope of the appraisals, include:

a. Record information: State identification number of the nursing facility as provided by the Department.

b. Property owner: Name of nursing facility.

c. Street, address, city.

d. Zip code.

e. Land value.

f. Section number: Assign lowest to oldest section and have basements immediately follow the section they are beneath.

g. Occupancy: Primarily nursing facility or basement.

h. Construction classification.

i. Number of stories.

j. Gross floor area: The determination of the exterior dimensions of all interior areas including stairwells of each floor. In addition, interior square footage measurements shall be reported for (a) non-nursing facility areas; (b) shared service area by type of service; and (c) revenue-generating areas so that these non-nursing facility portions of the facility can be omitted from the total square footage or allocated based on their nursing facility related use.

k. Construction quality.

l. Year nursing facility was built.

m. Building effective age.

n. Building condition.

o. Exterior wall material.

p. Total perimeter: Common walls between sections shall be excluded from both sections.

q. Average story height.

r. Roof material.

s. Roof pitch.

t. Heating System.

u. Cooling system.

v. Plumbing fixtures (Basements only).

w. Passenger Elevators: Actual number.

x. Freight elevators: Actual number.

y. Sprinkler system: Percent of gross area served.

z. Manual Fire Alarm System: Percent of gross area served.

aa. Automatic fire detection: Percent of gross area served.

bb. Floor finish.

cc. Ceiling finish.

dd. Total partition walls (Basement only).

ee. Partition wall structure.

ff. Partition wall finish.

gg. Miscellaneous additional items: All components not included in the preceding list and also not automatically calculated by the Boeckh Program shall be included here. The appraiser shall use professional judgment when valuing such items. Items shall be entered at depreciated value.

hh. Site improvements: Items shall be included at depreciated value, except landscaping, to be determined by the appraiser based upon professional judgment. Depreciation for site improvements will, in many instances, be different from the depreciation for the structure. A list of site improvements and corresponding values shall be retained with the appraiser's work papers.

ii. User adjustment factor: Used in those cases where facilities are appraised in total and only partly used as a nursing facility, i.e., hospital and nursing facility combined or a residential and nursing facility combined.

jj. The Department's use of the depreciation tables specified in the preceding subsection is based on the understanding that the Boeckh program will publish a depreciation table that establishes depreciation using one-year effective age increments ("a progressive table"). If the Boeckh program ceases publishing a progressive table, the Department shall evaluate and implement a new depreciation table or method to be used for the appraisals.

6. The fair rental allowance shall only be adjusted due to the following:

a. The base value of a facility shall be increased in subsequent cost reports due to improvements.

b. At the start of a new state fiscal year by a new rental rate amount or additional indices.

~~c. The base value of a facility can be decreased by a change in either the physical (structural) condition and/or use modification of the facility.~~

~~d. The provider has constructed and occupied a new physical plant and is no longer using the old structure for providing care to nursing facility residents. Base value shall be a new appraisal conducted by the Department or its designee at the time the new physical plant is ready for occupancy.~~

~~i) The provider shall continue to be reimbursed at the old fair rental allowance rate until the first scheduled MED-13 after the move sets a new rate.~~

~~ii) A new appraisal shall be performed to coincide with the filing of the next scheduled cost report following the move.~~

~~8.441.5.M. The amounts entered on Schedule B shall be transferred to Schedule C, Column 8. The totals of these columns on both schedules shall agree.~~

8.441.6 COMPLETION OF ~~SCHEDULE C –~~ OPERATING EXPENSES SCHEDULE

8.441.6.A. All expenses should be reported on ~~Schedule C~~the operating expenses schedule. All adjustments to eliminate expenses or to apply expense recoveries shall be made on ~~Schedule C~~the operating expenses schedule.

8.441.6.B. Expense centers in ~~Schedule C~~operating expenses shall be used for distribution of expenses by object or natural classifications within the department or function. The expenses shall be classified sufficiently within the accounting records to allow preparation of ~~Schedule C~~operating expenses schedule.

8.441.6.C. Total expenses reported on the operating expenses schedule~~Column 6 of Schedule C~~ shall agree with the total expenses in the general ledger.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.1.A. Where no specific Medicaid authority exists, the sources listed below shall be considered in reaching a rate determination:

1. Medicare statutes.

2. Medicare regulations.

3. Medicaid and Medicare guidelines.

4. Generally accepted accounting principles.

8.443.1.B. For class I nursing facilities, ~~A~~a payment rate for each participating nursing facility shall be determined on the basis of information on the MED-13, the Minimum Data Set (MDS) resident assessment information and information obtained by the Department or its designee retained for the purpose of cost auditing.

The nursing facility prospective per diem rate includes the following components:

1. Health Care.

2. Administrative and General.

3. Fair Rental Allowance for Capital-Related Assets.

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

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

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

6. An additional per diem rate for care and services rendered to Medicaid residents to recognize per diem costs of the provider fee. Only Medicaid's portion of the provider fee will be included in the rate add-on. The provider fee add-on shall not be equal to the amount of the fee charged and collected but shall be an amount equal to the per diem fee charged multiplied by the number of Medicaid resident days for the facility.

7. Beginning July 1, 2009, an additional per diem amount for meeting specified performance criteria.

8.443.1.C For class II and privately-owned class IV intermediate care facilities for the mentally retarded, 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.

2. Administrative and General.

3. Fair Rental Allowance for Capital-Related Assets.

8.443.1.D For state-operated class IV intermediate care facilities for the mentally retarded, 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 retrospective per diem rate includes the following components:

1. Health Care.

2. Administrative and General, which includes capital.1230977

8.443.1.~~C~~E. No nursing facility care shall receive reimbursement unless and until the nursing facility:

1. Has a license from the Colorado Department of Public Health and Environment (CDPHE), and

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

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

8.443.2 NURSING FACILITY CLASSIFICATIONS

1. Class I facilities are those facilities licensed and certified to provide general skilled nursing facility care.

2. Class II facilities are those facilities whose program of care is designed to treat developmentally disabled individuals whose medical and psychosocial needs are best served by receiving care in a community setting.

   a. Class II facilities shall provide care and services designed to maximize each resident's capacity for independent living and shall seek out and utilize other community programs and resources to the maximum extent possible according to the needs and abilities of each individual resident.

   b. Class II facilities serve sixteen or more persons whose medical and psychosocial needs require services in an institutional setting and are expected to provide such services in an environment which approximates a home-like living arrangement to the maximum extent possible within the constraints and limitations inherent in an institutional setting.

   c. Class II facilities shall be certified in accordance with 42 C.F.R. 442, Subpart C, 42 C.F.R. 483 and shall be licensed by the CDPHE. Class II facilities shall provide care and a program of services consistent with licensure and certification requirements.

3. Class IV facilities are those facilities whose program of care is designed to treat developmentally disabled individuals who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program.

   a. Class IV facilities shall offer full-time, 24-hour interdisciplinary and professional treatment by staff employed at such facility. Staff must be sufficient to implement and carry out a comprehensive program to include, but not necessarily be limited to, care, treatment, training and education for each individual.

   b. Class IV facilities shall be certified in accordance with 42 C.F.R. 442, Subpart C, 42 C.F.R. 483 and shall be licensed by the CDPHE as a Class IV facility. Class IV facilities shall provide care and a program of services consistent with licensure and certification requirements.

c. State-administered, tax-supported facilities are not subject to the maximum reimbursement provisions and do not earn an incentive allowance.

d. Private, non-profit or proprietary facilities that are not tax-supported or state-administered are subject to the maximum reimbursement provisions and may earn an incentive allowance.

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

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

1. The Department shall utilize the total audited patient days on the MED-13 unless the audited patient days on the MED-13 constitute an occupancy rate of less than 85 percent of licensed bed day capacity when computing the audited allowable cost per patient day for all rates.

2. In such cases, the patient days shall be imputed to an 85 percent rate of licensed bed day capacity for the nursing facility and the per diem cost along with the resulting per diem rate shall be adjusted accordingly except that imputed occupancy shall not be applied in calculating the facility's health care services and food costs.

3. The licensed bed capacity shall remain in effect until the Department is advised that the licensed bed capacity has changed through the filing of a subsequent cost report.

4. The imputed patient day calculation shall remain in effect until a new rate from a subsequent cost report is calculated. Should the subsequent cost report indicate an occupancy rate of less than 85 percent of licensed bed day capacity, the resulting rate shall be imputed in accordance with the provisions of this section.

8.443.3.B. Nursing facilities located in rural communities with a census of less than 85 percent shall not be subject to imputed occupancy. A nursing facility in a rural community shall be defined as a nursing facility in:

1. A county ~~of~~ with a population of less than fifteen thousand ~~population~~; or

2. A municipality with a population of less than fifteen thousand ~~population~~ which is located ten miles or more from a municipality with a population of over fifteen thousand ~~population~~; or

3. The unincorporated part of a county ten miles or more from a municipality w~~o~~ith a population of fifteen thousand ~~population~~ or more.

8.443.3.C. Any nursing facility that has a reduction in census, causing it to be less than 85 percent, resulting from the relocation of mentally ill or developmentally disabled residents to alternative facilities pursuant to the provisions of the Omnibus Reconciliation Act of 1987 shall:

1. Be entitled to the higher of the imputed occupancy rate or the ~~monthly weighted average~~median rate computed by the Department for two cost reporting periods.

2. The imputed occupancy calculation shall be applied when required at the end of this period.

8.443.3.D. Imputed occupancy shall be applied to a new nursing facility as follows:

1. A new nursing facility means a facility not in the Colorado Medicaid program within thirty days prior to the start date of the Medicaid provider agreement.

2. For the first cost report submitted by a new facility, the facility shall be entitled to the higher of the imputed rate or the ~~monthly weighted average~~median rate computed by the Department.

3. For the second cost report submitted by a new facility, imputed occupancy shall be applied but the rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in the ~~monthly weighted average~~median computation.

4. For the third cost report and cost reports thereafter, imputed occupancy shall be applied without exception.

8.443.3.E. Nursing facilities undergoing a state-ordered change in case mix or patient census that significantly reduces the level of occupancy in the facility shall:

1. Be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department for two cost reporting periods.

2. At the end of this period, the imputed occupancy calculation shall be applied when required.

8.443.4 INFLATION ADJUSTMENT

~~8.443.4.A. At the beginning of each facility's new rate period, the inflation adjustment shall be applied to all costs except interest and costs covered by fair rental allowance.~~

~~1. The inflation adjustment shall equal the annual percentage change in the National Bureau of Labor Statistics Consumer Price Index (U.S. city average, all urban consumers), from the preceding year, times actual costs (less interest expense and costs covered by the fair rental allowance) or times reasonable cost for that class facility, whichever is less.~~

~~2. The annual percentage change in the National Bureau of Labor Statistics Consumer Price Index shall be rounded at least to the fifth decimal point.~~

~~3. The price indexes listing in the latest available publication prior to the July 1 limitation setting shall be used to determine inflation indexes. The inflation indexes shall be revised and~~

8.443.4.A. For class I nursing facilities, the per diem amount paid for direct and indirect health care services and administrative and general services costs shall include an allowance for inflation in the costs for each category using a nationally recognized service that includes the federal government's forecasts for the prospective Medicare reimbursement rates recommended to the United States Congress. Amounts contained in cost reports used to determine the per diem amount paid for each category shall be adjusted by the percentage change in this allowance measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.~~1231015~~

1. The percentage change shall be rounded at least to the fifth decimal point.

2. The index used for this allowance will be the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. The latest available publication prior to July 1 rate setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1, and June 30.

8.443.4.B For class II and privately-owned class IV intermediate care facilities for the mentally retarded, at the beginning of each facility's new rate period, the inflation adjustment shall be applied to all costs except interest and costs covered by fair rental allowance.

1. The inflation adjustment shall equal the annual percentage change in the National Bureau of Labor Statistics Consumer Price Index (U.S. city average, all urban consumers), from the preceding year, times actual costs (less interest expense and costs covered by the fair rental allowance) or times reasonable cost for that class facility, whichever is less.

2. The annual percentage change in the National Bureau of Labor Statistics Consumer Price Index shall be rounded at least to the fifth decimal point.

3. The price indexes listing in the latest available publication prior to the July 1 limitation setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1 and June 30.

4. The provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period.

~~published every July 1 to be used for rate effective dates between July 1 and June 30.~~

8.443.5 ADMINISTRATIVE COST INCENTIVE ALLOWANCE FOR CLASS II AND PROVIATELY OWNED CLASS IV FACILITIES

8.443.5.A. If the nursing facility's combined audited administration, property, and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) cost per patient day is less than the maximum reasonable cost for administration, property and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) costs for the class, the provider will earn an incentive allowance.

8.443.5.B. The incentive allowance for class II and privately owned class IV facilities shall be calculated at ~~12.5~~ 25 percent of the difference between the facility's audited inflation adjusted cost and the maximum reasonable cost for that class.~~,~~ The incentive allowance will not ~~not to~~ exceed 12 percent of the ~~maximum~~ reasonable cost. ~~for Class I facilities.~~

~~8.443.5.C. The incentive allowance for Class II and privately owned Class IV facilities shall be calculated at 25 percent of the difference between the facility's audited cost and the maximum reasonable cost for that class.~~

8.443.5.~~D~~C. No incentive allowance shall be paid on health care services, raw food, fair rental value allowance and leasehold costs.

8.443.6 CASE MIX ADJUSTMENTS

8.443.6.A. The resource utilization group–III (RUG-III) 34 category, index maximizer model, version 5.12b, as published by the Centers for Medicare and Medicaid Services (CMS), shall be used to adjust costs reported in the health care cost center in the determination of limits and in the rate calculation. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-~~1714~~1818. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library. The Department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

8.443.6.B. The Department shall distribute facility listings identifying current assessments for residents in the nursing facility on the 1st day of the first month of each quarter as reflected in the Department's MDS assessment database.

1. The listings shall identify resident social security numbers, names, assessment reference date, the calculated RUG-III category and the payor source as reflected on the prior full assessment and/or current claims data.

2. Resident listings shall be reviewed by the nursing facility for completeness and accuracy.

3. If data reported on the resident listings is in error or if there is missing data, facilities shall have until the last day of the second month of each quarter to correct data submissions, or until a later date if approved by the Department pursuant to 10 C.C.R. 2505-10, Section 8.442.2.

    a. Errors or missing data on the resident listings due to untimely submissions to the CMS database maintained by the CDPHE shall be corrected by the nursing facility transmitting the appropriate assessments or tracking documents to CDPHE.

    b. Errors in key field items shall be corrected by following the CMS key field specifications through the CDPHE

    c. Errors on the current payor source shall be noted on the resident listings prior to signing and returning to the Department.

4. Each nursing facility shall sign and return its resident listing to the Department no later than 15 calendar days after it was mailed by the Department.

5. Residents shall be assigned a RUG-III group calculated on their most current non-delinquent assessment available on the 1st day of the first month of each quarter as amended during the correction period.

    a. The RUG-III group shall be translated to the appropriate case mix index or weight.

    b. Two average case mix indices for each Medicaid nursing facility shall be determined from the individual case mix weights for the applicable quarter:

        i) The facility average case mix index shall be a simple average, carried to four decimal places, of all resident case mix indices.

        ii) The Medicaid average case mix index shall be a simple average, carried to four decimal places, of all residents where Medicaid is the per diem payor source anytime during the 30 days prior to their current assessment.

    c. Any incomplete assessments and current assessment in the database older than 122 days shall be included in the calculation of the averages using the case mix index established in these rules.

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

8.443.7.A Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed

and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

If an employee has dual health care and administrative duties (i.e. Admissions and Marketing), the provider must keep contemporaneous time records or perform time studies~~must be kept or time studies performed~~ to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation. Time studies used must meet the following criteria:

a. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

b. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

c. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

d. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

e. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

f. The ~~cost~~time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.

Health Information Managers (Medical Records Librarians): Must work directly with the maintenance and organization of medical records.

Social Workers: Includes social workers, life enhancement specialists and admissions personnel.

Central or Medical Supply personnel: Includes duties associated with stocking and ordering medical and/or central supplies.

Activity personnel: Personnel classified as 'activities' must have a direct relationship (i.e., providing entertainment, games, and social opportunities) to residents. For instance, security guards and hall monitors do not qualify as activities personnel. Costs associated with security guards and hall monitors are classified as administrative and general.

3. If the provider's chart of accounts directly identifies payroll taxes and benefits associated with health care versus administrative and general cost centers, the amounts directly

identified will be appropriately allowed as either health care or administrative and general. If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be allocated to the cost centers (health care and administrative and general) based on total employee wages reported in those cost centers. The reporting method for payroll taxes and benefits by cost center is required to be consistent from year to year. When a provider wishes to change its reporting method because it believes the change will result in more appropriate and a more accurate allocation, the provider must make a written request to the Department for approval of the change ninety (90) days prior to the end of that cost reporting period. The Department has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the Department approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods. The approval will be for a minimum three year period. The provider can not change methods until the three year period has expired.

4. Personnel licensed to perform patient care duties shall be reported in the administrative and general cost center if the duties performed by these personnel are administrative in nature.~~1231071~~

5. Non-prescription drugs ordered by a physician which are included in the per diem rate.~~1231072~~

6. Consultant fees for nursing, medical records, registered dieticians, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.~~1231073~~

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

   Tub purchased or leased because of medical necessity

   Mattress purchased or leased because of medical necessity

   Beds purchased or leased because of medical necessity

   Bed Rails

   Wheelchairs and related accessories

   Patient Lift

   Patient Lift Chair Recliner

   Charting System

   Med-Cart

   Exercise equipment

   Scale

   Thermometer

Trapeze

Oximeter

Apnea Monitors

Canes, Crutches and Walkers

Infusion, Suction and Lymphedema Pumps

TENS Units

Vaporizers, Room Type

Computers and related software used in health care departments

Equipment ordered by a physician due to medical necessity

Purchased oxygen concentrators per 8.441.5K

8. Medical Supplies. Office supplies are not considered a health care expense.~~1231074~~

9. Depreciation and interest for major health care equipment purchases. No equipment shall be considered health care unless it is listed in (7) above;~~1231075~~

10. Purchase or rental of motor vehicles and related expenses, including salary and benefits associated with the van driver(s), for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. An example of the dual purpose vehicle is one used for both resident transport and maintenance activities.~~1231076~~

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

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

13. Related Party Management Fees and Home Office Costs

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

Non-Related Party Management Fees

Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.~~1231078~~

14. Professional liability insurance, whether self-insurance or purchased, loss settlements, claims paid and insurance deductibles.~~1231079~~

15. Medical director fees.~~1231080~~

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

Utilization review

Dental care, when required by federal law

Audiology

Psychology and mental health services

Physical therapy

Recreational therapy

Occupational therapy

Speech therapy

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

18. Food Costs. Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

8.443.7.B CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM REIMBURSEMENT RATES (LIMIT)

For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for direct and indirect health care services and raw food, the state department shall establish an annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. The health care limit will be calculated as follows:

1. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before December 31 of the preceding year.~~1231061~~

2. The MED-13 cost report shall be deemed filed if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before December 31.~~1231062~~

3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of the limit, the Department may:~~1231063~~

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

b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. measured from the midpoint of the reporting period to the midpoint of the payment-setting period.

4. The health care limit and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the median costs of direct and indirect health care services and raw food as determined by an array of all class I facility providers; except that, for state veteran nursing homes, the health care limit will be one hundred thirty percent (130%) of the median cost.

a. In determining the median cost, the cost of direct health care shall be case-mix neutral.~~1231092~~

b. Actual days of care shall be counted, not occupancy-imputed days of care, for purposes of calculating the health care limit.

c. Amounts contained in cost reports used to determine the health care limit shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

i). The percentage change shall be rounded at least to the fifth decimal point.

ii). The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

6. Annually, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

7. The health care limit for health care reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

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

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. This payment shall not exceed the health care limit described at 8.443.7B. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall

determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's Medicaid residents on a quarterly basis

~~8.443.7.A. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:~~

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:

~~1~~a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.

~~2~~b. The facility's Medicaid resident acuity case mix index shall be a two quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.

~~3~~c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.

~~4~~d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.

~~5~~e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.

~~6.~~f The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.

~~8.443.7.B.~~2 The annual facility specific direct health care maximum reimbursement rate shall be determined as follows:

~~1~~a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

~~2.~~b The statewide health care maximum allowable reimbursement rate (calculated at 8.443.7B) shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.

~~3~~c. The facility specific maximum reimbursement ~~rate for~~rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity

ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.

~~8.443.7.C~~3. The annual facility specific ~~other~~ indirect health care maximum allowable reimbursement shall be determined as follows:

~~1~~a. The percentage of the ~~other~~ indirect health care per diem cost to total health care cost shall be determined by dividing the ~~other~~ indirect health care per diem cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

~~2~~b. The facility specific ~~other~~ in direct health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.

~~8.443.7.D~~4. The case mix reimbursement rate component shall be determined as follows:

~~1~~a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.

~~2~~b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall the case mix reimbursement rate component.

~~8.443.7.E~~5. The ~~other~~ indirect health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

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

1. For class II facilities, one hundred twenty-five percent (125%) of the median actual costs of all class II facilities;~~1231094~~

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

3. State-administered class IV facilities shall not be subject to the health care limit. The Med-13s of the state-administered class IV facilities shall be included in the health care limit calculation for other class IV facilities.

4. The determination of the reasonable cost of services shall be made every 12 months.

5. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed in accordance with these regulations, by each facility on or before December 31 of the preceding year.

6. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2nd.

~~1231062~~7. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

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

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

8. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.

9. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

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

8.443.8 REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

8.443.8.A Administration Costs means the following categories of reasonable, necessary and patient-related costs:

~~12310971~~1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, hall monitors, security guards, janitorial and plant staff and food service staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records or perform a time study in order to properly allocate their salaries between cost centers. Time studies used must meet the criteria described in 8.443.7.A.1.

~~12310982~~. Any portion of other staff costs directly attributable to administration.

~~12310993~~. Advertising and public relations.

~~12311004~~. Recruitment costs and staff want ads for all personnel.

5. Office supplies.

6. Telephone costs.

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

8. Computers and related software used in administrative departments.

~~123~~9. Management fees and home office costs, except as described in 8.443.7.A.13.

~~1231106~~10. Licenses and permits (except health care licenses and permits) and training for administrative personnel, dues for professional associations and organizations.~~1231107~~

11. All business related travel of facility staff and consultants, except that required for transporting residents to activities or for medical purposes.~~1231108~~

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

~~1231109~~

13. Facility membership fees and dues in trade groups or professional organizations.~~1231110~~

14. Miscellaneous general and administrative costs.~~1231111~~

15. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.~~1231112~~

16. Purchases, rentals, repairs, betterments and improvements of equipment utilized in administration.~~1231113~~

17. Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below.~~1231114~~

18. All other reasonable, necessary and patient-related costs which are not specifically set forth in the description of "health care services" above, and which are not property, room and board, food or capital-related assets.

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

8.443.8.B Property costs include:

1. Depreciation costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).~~1231117~~

2. Rental costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).~~1231118~~

3. Property taxes.

~~1231119~~

4. Property insurance.

5. Mortgage insurance.~~1231120~~

6. Interest on loans associated with property costs covered in this section.~~1231121~~

7. Repairs, betterments and improvements to property not covered by the fair rental allowance.~~1231122~~

8. Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by the regulations regarding expensing of items.~~1231123~~

8.443.8.C Room and board includes:

1. Dietary, other than raw food, and salaries related to dietary personnel including tray help, except registered dieticians which are health care.~~1231125~~

2. Laundry and linen.~~1231126~~

3. Housekeeping.~~1231127~~

4. Plant operation and maintenance (except removal of infectious material or medical waste which is health care).~~1231128~~

5. Repairs, betterments and improvements to equipment related to room and board services.~~1231129~~

8.443.8.D The maximum allowable reimbursement of administration, property and room and board costs, excluding raw food, land, buildings and fixed equipment, shall not exceed:

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

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

3. The determination of the reasonable cost of services shall be made every 12 months.

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

5. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May2.

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

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

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

7. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.

8.443.8.E Class I Administrative and General Per Diem Reimbursement Rate

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the Department shall establish an annually readjusted schedule to pay each facility a reasonable price for the costs.

In computing per diem cost, each nursing facility provider shall annually submit cost reports to the Department.

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

The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation.

a. The percentage change shall be rounded at least to the fifth decimal point.

b. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

7. The reasonable price determined at July 1, 2008 will be adjusted annually at July 1st for three subsequent years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8. For each succeeding fourth year, the Department shall re-determine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

9. The reasonable price established by the median per diem costs determined each succeeding fourth year will be adjusted annually at July 1st for the three intervening years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

10. For fiscal years commencing on and after July 1, 2008, through the fiscal year commencing July 1, 2014, the state department shall compare a nursing facility provider's administrative and general per diem rate to the nursing facility provider's administrative and general services per diem rate as of June 30, 2008, and the state department shall pay the nursing facility provider the higher per diem amount for each of the fiscal years.

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

July 1, 2008 – 50% reasonable price

50% cost-based rate

July 1, 2009 – 50% reasonable price

50% cost-based rate

July 1, 2010 75% reasonable price

25% cost-based rate

July 1, 2011100% reasonable price

The phase in will allow a percentage of the reasonable price established in accordance with these rules (reasonable price) and a percentage of the July 1, 2008 administrative and general rate in accordance with the rules in effect prior to implementation of these rules (cost-based rate). The cost-based rate determined at July 1, 2008 will be adjusted annually at July 1st for two subsequent years. The cost-based rate shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. 1231015The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8.443.8.F For the purpose of reimbursing class II and privately-owned class IV intermediate care facilities for the mentally retarded a per diem rate for the cost of administrative and general services, the Department shall establish an annually readjusted schedule to reimburse each facility, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health care services costs and a fair rental allowance for capital-related assets.

1. In computing per diem cost, each intermediate care facility for the mentally retarded provider shall annually submit cost reports to the Department.

2. The per diem reimbursement rate will be total allowable costs for administrative and general and health care services (actual or the limit per 8.443.7D) divided by the higher of actual resident days or occupancy imputed days per 8.443.3.

3. An inflation adjustment per 8.443.4B will be applied to the per diem administrative and general and health care reimbursement rates.

4. An incentive allowance for administrative and general costs may be included per 8.443.5.

5. Each facility will be paid a per diem for capital-related assets per 8.443.9.A.

8.443.9 FAIR RENTAL ALLOWANCE FOR CAPITAL-RELATED ASSETS

8.443.9.A. FAIR RENTAL ALLOWANCE: DEFINITIONS AND SPECIFICATIONS

1. For purposes of this section concerning fair rental allowance, the following definitions shall apply:~~1230863~~

   a. Appraised Value means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent, the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the most recent edition of the Boeckh™ Commercial Building Valuation System available on December 31st of the year preceding the year in which the appraisals are to be performed. This material is incorporated by reference into these rules. Information about obtaining or examining the applicable edition is available from the Custodian of Records, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. The incorporated material may also be examined at any State Publications Depository Library.

   b. Base Value means the value of the capital related assets as determined by the most current appraisal report completed by the Department or its designee and any additional information considered relevant by the Department. For each year in which an appraisal is not done, base value means the most recent appraisal value increased or decreased by fifty percent (50%) of the change in the Index. Under no circumstances shall the base value exceed $25,000 per bed plus the percentage rate of change referred to as the per bed limit.

   c. Capital-Related Asset means the land, buildings and fixed equipment of a participating facility.

   d. Fair Rental Allowance means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

   e. Fair Rental Allowance Per Diem Rate means the fair rental allowance described above, divided by the greater of the audited patient days on the provider's annual cost report or ninety percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

   f. Fiscal Year means the State fiscal year from July 1 through June 30.

g. Fixed equipment means building equipment as defined under the Medicare principle of reimbursement as specified in the Medicare provider reimbursement manual, part 1, section 104.3. Specifically, building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:

i) Affixed to the building and not subject to transfer; and

ii) A fairly long life but shorter than the life of the building to which it is affixed.

h. Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, a publication of R.S.Means Company, Inc. that is updated annually (section M.450, "Nursing Home"), hereafter referred to as the Means Index. This material is incorporated by reference into these rules. Information about obtaining or examining the applicable edition is available from the Custodian of Records, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. The incorporated material may also be examined at any State Publications Depository Library.1230873

i. Rental Rate means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.~~1230874~~

2. In the case of facilities for which an appraisal was completed pursuant to RFP GB 347 (October 21, 1985) and no major physical plant expansions or additions were completed prior to the Department's reappraisal of the property, the following data shall remain unchanged through following appraisals:

a. Average story height.

b. Gross floor area.

c. Total perimeter.

d. Construction classification.

e. Construction quality.

f. Year built.

3. In the case of those facilities that have completed a major physical plant expansion, addition or deletion, the initial appraisal measurements and data specified in paragraph 2 above shall be modified only to the extent of the relevant appraisal data specific to the new expansion, addition or deletion.

4. The appraisal shall take into consideration the economic impact the addition, deletion or use modification may have had on the overall value of the entire facility.

5. The variables from the Boeckh program that are to be calculated/determined by the Department or its designee, and which will be incorporated into the Request for Proposal (RFP) which defines the scope of the appraisals, include:

a. Record information: State identification number of the nursing facility as provided by the Department.

b. Property owner: Name of nursing facility.

c. Street, address, city.

d. Zip code.

e. Land value.

f. Section number: Assign lowest to oldest section and have basements immediately follow the section they are beneath.

g. Occupancy: Primarily nursing facility or basement.

h. Construction classification.

i. Number of stories.

j. Gross floor area: The determination of the exterior dimensions of all interior areas including stairwells of each floor. In addition, interior square footage measurements shall be reported for (a) non-nursing facility areas; (b) shared service area by type of service; and (c) revenue-generating areas so that these non-nursing facility portions of the facility can be omitted from the total square footage or allocated based on their nursing facility related use.

k. Construction quality.

l. Year nursing facility was built.

m. Building effective age.

n. Building condition.

o. Exterior wall material.

p. Total perimeter: Common walls between sections shall be excluded from both sections.

q. Average story height.

r. Roof material.

s. Roof pitch.

t. Heating System.

u. Cooling system.

v. Plumbing fixtures (Basements only).

w. Passenger Elevators: Actual number.

x. Freight elevators: Actual number.

y. Sprinkler system: Percent of gross area served.

z. Manual Fire Alarm System: Percent of gross area served.

aa. Automatic fire detection: Percent of gross area served.

bb. Floor finish.

cc. Ceiling finish.

dd. Total partition walls (Basement only).

ee. Partition wall structure.

ff. Partition wall finish.

gg. Miscellaneous additional items: All components not included in the preceding list and also not automatically calculated by the Boeckh Program shall be included here. The appraiser shall use professional judgment when valuing such items. Items shall be entered at depreciated value.

hh. Site improvements: Items shall be included at depreciated value, except landscaping, to be determined by the appraiser based upon professional judgment. Depreciation for site improvements, in many instances, is different from the depreciation for the structure. A list of site improvements and corresponding values shall be retained with the appraiser's work papers.

ii. User adjustment factor: Used in those cases where facilities are appraised in total and only partly used as a nursing facility, i.e., hospital and nursing facility combined or a residential and nursing facility combined.

6. The fair rental allowance shall only be adjusted due to the following:

a. The base value of a facility shall be increased in subsequent cost reports due to improvements. Construction-in-progress will not be considered an improvement until the project is complete and the asset is placed into service.

b. At the start of a new state fiscal year by a new rental rate amount or additional indices.

c. The base value of a facility can be decreased by a change in either the physical (structural) condition and/or use modification of the facility.

d. The provider has constructed and occupied a new physical plant and is no longer using the old structure for providing care to nursing facility residents. Base value shall be a new appraisal conducted by the Department or its designee at the time the new physical plant is ready for occupancy.

i) The provider shall continue to be reimbursed at the old fair rental allowance rate until the first scheduled MED-13 after the move sets a new rate.

ii) A new appraisal shall be performed to coincide with the filing of the next scheduled cost report following the move.

8.443.9.B FAIR RENTAL ALLOWANCE PER DIEM REIMBURSEMENT RATES

In addition to the reimbursement components paid pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs), a per diem rate constituting a fair rental allowance for capital-related assets shall be paid to each nursing facility provider as a rental rate based upon the nursing facility's appraised value.

1. For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for capital-related assets, the state department shall establish an annual per bed limit.

2. The annual per bed limit established July 1, 1985 is $25,000 per bed plus the percentage rate of change in the Means Index.

3. The Means Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, a publication of R.S.Means Company, Inc. that is updated annually (section M.450, "Nursing Home").

4. The per bed limit shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

5. The fair rental allowance will be calculated for each facility using the lesser of the Base Value plus non-appraisal year modifications to the physical structure due to improvements or a change in the condition and/or use of the facility subsequent to the appraisal increased or decreased by fifty percent (50%) of the change in the Means Index or the annual per bed limit.

6. In computing the fair rental allowance per diem rate, the fair rental allowance is multiplied by the rental rate to obtain the annual allowable fair rental payment.

7. The rental rate is the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

8. The resulting fair rental payment amount is divided by the greater of the audited patient days based on the provider's annual cost report or ninety percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

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

8.443.10.A In addition to the reimbursement components paid pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets), the state department shall pay an additional per diem rate to nursing facility providers who have residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. To reimburse the nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury, the state department shall pay an additional per diem rate based upon the resident's score on the Cognitive Performance Scale (CPS) used in the RUG-III Classification system and reported on the MDS form. Resident CPS scores range from zero (intact) to six (very severe impairment).

1. Annually the Department will identify those Medicaid residents with a CPS score of 4, 5, or 6 for each nursing facility. They will then calculate the percent of Medicaid residents with a CPS score of 4, 5, or 6 as a percentage of all Medicaid residents for the facility. This amount is the facility's CPS percentage. The MDS for residents on the April roster will be the source data used in these calculations.

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

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

Mean plus one standard deviation $1.00

Mean plus two standard deviations $2.00

Mean plus three or more standard deviations $3.00

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

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

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

8.443.10.B For those residents who have severe mental health conditions that are classified at Level II by the Medicaid program's preadmission screening and resident review assessment tool (PASRR II), the nursing facility provider shall have an amount added to its per diem rate.

1. On May 1st each year, the Department will identify those Medicaid residents meeting the PASRR II criteria for each nursing facility.

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

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

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

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

6. An additional payment will be made to facilities that offer specialized behavioral services to residents who have severe mental health conditions that are classified at a PASRR Level II. Specialized services include, but are not limited to, enhanced staffing in social services and activities, specialized training for staff on behavior management, creating resident specific written guidelines with positive reinforcement, crisis intervention and psychotropic medication training. Specialized programs also include daily therapeutic groups such as anger management, conflict resolution, effective communication skills, hygiene, art therapy, goal setting, problem solving Alcoholics Anonymous and Narcotics

Anonymous, in addition to stress management/relaxation groups such as Yoga, Tai Chi, drumming and medication. Therapeutic work programming, community safety training, and life skills training that include budgeting and learning how to navigate public transportation and shopping, for example, are also required to increase the resident's skills for successful community reintegration.

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

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

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

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

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

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

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

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

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

   7/1/xx provider fee per diem required to cover funding obligation $7.30

   TIMES: Expected non-Medicare patient days during the state fiscal year 17,000

   EQUALS: 7/1/xx FY actual facility provider fees which will be paid $124,100

   DIVIDED BY: Expected total patient days during the state fiscal year 20,000

   EQUALS: 7/1/xx FY per diem amount to add to each facility's

Medicaid per diem payment $6.21

8.443.11 FUNDING SPECIFICATIONS

The general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets) shall be limited to an annual increase of three percent. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation on the annual increase. In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers being greater than an annual three percent increase in the general fund share of the aggregate statewide average of the per diem rate net of patient payment, proportional decreases will be made to the rates so that anticipated payments will equal a three percent increase 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.

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 three percent over the prior SFY. These determinations we 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. Provider fee revenue will first be used to pay the state share of CPS, PASRR II, provider fee and pay for performance rate add-ons. Any difference between the amount of provider

fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share above.

7. The following calculation illustrates the above:

Actual Prior Year General Fund Legislative Appropriations		55,000,000	Rate Components paid pursuant to 8.443.7 Health Care Services (HC) and 8.443.8 Administrative and General Costs (A&G) and 8.443.9 Fair Rental Allowance for Capital-Related Assets (FRV)
Actual Medicaid Days		324,000	
Average of the Per Diem Rate Net of Patient Payment		169.75	
Three Percent Increase		103.00%	
Current Year Limit on Legislative Appropriations		174.85	
Times Estimated Medicaid Days		325,644	
Current Year Limit on Legislative Appropriations		56,937,446	(Legislative Appropriation)
3% Limit in GF Growth Funded by Increase in Provider Fees		1,000,000	Provider fee revenue will first be used to pay the state share of CPS, PASRR II, provider fee and pay for performance rate add-ons. Any difference between the amount of the provider fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share. In this example, the General Fund (GF) anticipated increase is $1,067,867 more than the 3% limit and the provider fees expected to be available equal $1,000,000. After considering the $1,000,000, the provider fee is at the limit (currently 5.5% of revenue).
Expenditure Limit	(d)	57,937,446	
Estimated Current Fiscal Year Expenditures	(e)	58,608,313	(The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load)
Estimated Impact of General Fund Cap	(e) - (d)	670,867	
3% Cap Adjustment Factor	(d) / (e)	0.98855338	

The following calculation is an example of how the 3% cap adjustment factor will be applied:

Facility	Estimated Medicaid Days (a)	Estimated Per Diem Rate for Rate Components: FRV, A&G, HC (b)	Total Projected Payments (c) = (a) * (b)	3% Cap Adjustment Factor (f) = (d) / (e)	Facility Medicaid Rate for Components: FRV, A&G, HC (g) = (c) * (f)	Legislative Appropriations (a) * (g)
Facility #1	7,021	187.70	1,317,842	0.98855338	185.55	1,302,757
Facility #2	49,933	201.57	10,064,745	0.98855338	199.26	9,949,538
Facility #3	24,958	195.40	4,876,668	0.98855338	193.16	4,820,847
Facility #4	45,512	183.54	8,353,272	0.98855338	181.44	8,257,656
Facility #5	25,315	163.66	4,142,926	0.98855338	161.78	4,095,504
Facility #6	17,513	195.42	3,422,303	0.98855338	193.18	3,383,129
Facility #7	24,529	173.85	4,264,244	0.98855338	171.86	4,215,433
Facility #8	51,164	159.80	8,175,751	0.98855338	157.97	8,082,167
Facility #9	53,070	165.99	8,808,824	0.98855338	164.09	8,707,993
Facility #10	26,629	194.59	5,181,737	0.98855338	192.36	5,122,424
	325,644		58,608,313			57,937,446

8.443.12 PAY-FOR-PERFORMANCE COMPONENT

Starting July 1, 2009, the Department shall pay an additional per diem rate 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 ~~matrix~~ application for the additional quality performance payment includes specific performance measures in each of the domains, quality of life, quality of care and facility management. The ~~matrix~~application includes the following:

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

   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~~application and must be submitted with ~~its~~ the 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 matrix.

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

0 – 20 points = No add-on

21 – 45 points = $1.00 per day add-on

46 – 60 points = $2.00 per day add-on

61 – 79 points = $3.00 per day add-on

80 – 100 points = $4.00 per day add-on

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

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

~~8.443.8 DETERMINATION OF REASONABLE COST OF SERVICES~~

8.443.8.A. The determination of the reasonable cost of services shall be made every 12 months, and is subject to the limitations described in sections 8.443.9, 8.443.10 8.443.11, 8.443.12 and 10 C.C.R. 2505-10, Section 8.441.5.L.

8.443.8.B. Determination of the rates beginning on July 1 each year shall utilize the Medicaid population in each nursing facility Class on May 1 and the most current MED-13 cost report submitted, in accordance with these regulations, by each facility on or before May 2.

8.443.8.C. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May2.

8.443.8.D. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the Class, the Department may:

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

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

8.443.8.E. State-administered Class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered Class IV facilities shall be included in the maximum rate calculation for other Class IV facilities.

8.443.8.F. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

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

8.443.9 MAXIMUM ALLOWABLE REIMBURSEMENT FOR HEALTH CARE SERVICES AND FOOD COSTS

8.443.9.A. Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, nurse aides, medical records librarians, social workers, and activity personnel. These personnel shall be appropriately licensed and/or certified, as applicable, although nurse aides may work in any facility for up to four months before becoming certified;

2. Non-prescription drugs ordered by a physician which are included in the per diem rate;

3. Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting;

4. Purchases, rental, and repair expenses of health care equipment and supplies used for health care services such as nursing care, medical records, social services, activity and recreational therapy;

5. Depreciation and interest for major health care equipment purchases;

6. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.

7. Photocopying expenses related to health care services (e.g., residents' medical records), as documented by appropriate logs;

8. Salaries, fees, or other expenses related to work performed by a facility owner or manager who has a medical or nursing credential;

9. Malpractice insurance for the health care personnel listed above;

10. Medical director fees;

11. Therapies and services provided by an individual qualified provide these services under Federal Medicare/Medicaid regulations including:

a. Utilization review;

b. Dental care, when required by federal law;

c. Audiology;

d. Psychology and mental health services;

e. Physical therapy;

f. Recreational therapy; and

g. Occupational therapy.

8.443.9.B. Food Costs means the cost of raw food, and shall not include the costs of real or personal property, staff, preparation or other items related to the food program.

8.443.9.C. The maximum allowable reimbursement of providing health care services and food costs shall not exceed:

1. For Class I facilities, one hundred twenty-five percent (125%) of the weighted average actual costs of all Class I facilities.

a. The ceiling on weighted average actual costs shall be based upon the normalized case mix adjusted nursing cost for each facility.

b. Actual patient days for both urban and rural facilities shall be used for purposes of calculating the maximum reimbursement rates.

2. For Class II facilities, one hundred twenty-five percent (125%) of the weighted actual costs of all Class II facilities;

3. For Class IV facilities, one hundred twenty-five percent (125%) of the weighted average actual costs of all Class IV facilities.

8.443.10 MAXIMUM ALLOWABLE REIMBURSEMENT FOR ADMINISTRATION COSTS

8.443.10.A. Administration Costs means the following categories of reasonable, necessary and patient-related costs:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, janitorial and plant staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records in order to properly allocate their salaries between cost centers;

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

3. Advertising;

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

5. Public relations;

6. Office supplies;

7. Telephone costs;

8. Purchased services: management and home office fees for administrative services; accounting fees, legal fees; computer services;

9. Payroll taxes;

10. Licenses, liability insurance, non medical transportation, training for administrative personnel, dues for professional associations and organizations;

11. All travel of facility staff, except that required for transporting residents to activities or for medical purposes;

12. All insurance except for malpractice insurance for health care personnel. Insurance on vans, whether owned or leased, is an administrative cost;

13. Facility membership fees in trade groups or professional organizations;

14. Miscellaneous general and administrative costs;

15. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs;

16. Purchases, rentals, repairs, betterments and improvements of equipment utilized in administration;

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

18. All other reasonable, necessary and patient-related costs which are not specifically set forth in the description of "health care services" above, and which are not property, room and board, food or capital-related assets.

8.443.10.B. Property costs include:

1. Depreciation costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care);

2. Rental costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care);

3. Property taxes;

4. Property insurance;

5. Interest on loans associated with property costs covered in this section;

6. Repairs, betterments and improvements to property not covered by the fair rental allowance;

7. Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by the regulations regarding expensing of items.

8.443.10.C. Room and board includes:

1. Dietary other than raw food;

2. Laundry and linen;

3. Housekeeping;

4. Plant operation and maintenance; and

5. Repairs, betterments and improvements to equipment related to room and board services.

8.443.10.D. The maximum allowable reimbursement of administration, property and room and board costs, excluding raw food, land, buildings and fixed equipment, shall not exceed:

1. For Class I facilities, one hundred twenty percent (120%) of the weighted average actual costs of all Class I facilities. The ceiling on weighted average actual costs shall be calculated as set forth in the regulation regarding such calculation.

2. For Class II facilities, one hundred twenty percent (120%) of the weighted average actual costs of all Class II facilities.

3. For Class IV facilities, one hundred twenty percent (120%) of the weighted average actual costs of all Class IV facilities.

8.443.11 LIMITATIONS ON GROWTH OF ALLOWABLE COSTS [Eff. 10/30/07]

8.443.11.A. For Class I facilities, any increase in allowable (i.e.; reimbursed) costs shall not exceed:

1. Six percent (6%) per year for administrative costs, and

2. Eight percent (8%) per year for health care services costs.

3. These limitations shall apply to:

a. The costs used in annually calculating the weighted average cost ceilings for all Class I nursing facilities, and

b. The costs allowed when calculating an individual rate change for a Class I facility.

~~c. Any cost increases allowed by the Department for each facility between July 1 and the following June 30 of each year. The base to which the six percent (6%) administrative cost limitation is applied shall be the individual facility audited costs used to set the July 1, 1997 rate for the facility. The base to which the eight percent (8%) health care services cost limitation is applied shall be the individual facility audited costs used to set the rates effective on July 1, 2005.~~

~~d. For fiscal year 2007 - 2008, a grant program is established to assist class I eligible facilities whose total overall reimbursement rate was increased to meet at least eighty five percent (85%) of the statewide average total overall reimbursement rate, but not more than110% of that facility's overall reimbursement rate had the fiscal year 2006 – 2007 rule not been in effect. Each eligible facility's rate will be increased by its percentage of annualized patient days times the estimated decrease in its rate compared to the sum of all eligible providers' decrease in the eligible provider's rate between July 1, 2006 and June 30, 2007.~~

~~e. After application of the limitations of maximum reimbursement rate and growth on allowable costs, the allowable costs for the facility may be increased through the payment of a fluctuating cost allowance and/or administrative cost incentive allowance.~~

~~8.443.12 LIMITATION ON MEDICARE PART A AND PART B COSTS [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]~~

~~8.443.12.A. Only those Medicare costs that are reasonable, necessary and patient related shall be included in calculating the allowable Medicaid reimbursement for class I nursing facilities.~~

~~8.443.12.B. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for a class I facility shall be:~~

~~The level of Part A costs allowed in the facility's latest Medicare cost report submitted by the facility to the Department prior to July 1, 1997.~~

~~8.443.12.C. Part B direct costs for Medicare shall be excluded from the allowable Medicaid reimbursement for class I nursing facilities.~~

8.443.13 RATE EFFECTIVE DATE [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.443.13.A. 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.

8.443.13.B. 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.

8.443.13.C. 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 in 8.443.13.A, or

2. One hundred (100) days after the date the MED-13 is filed by the provider.

8.443.13.D. In the event a permanent rate cannot be established, issued and paid as set forth at 8.443.13.A:

1. The Department shall establish and issue a temporary rate calculated on the provider's filed cost report without adjustments.

2. All temporary rates shall, at the time the permanent rate is established, issued and paid, be subject to adjustment and recovery of any over or under payments.

8.443.13.E. Any delay in completion of the audit of the MED-13 that occurs within 90 days from the filing of the MED-13, and that is attributable to the provider, shall operate, on a time equivalent basis, to extend the time in which the Department shall establish, issue and pay a temporary rate under the provisions set forth above.

8.443.13.F. Delay in completion of the audit that is attributable to the provider shall include, but not be limited to, the following:

1. Failure of the provider to meet with the contract auditor at reasonable times requested by the auditor;

2. Failure of the provider to supply the contract auditor with information reasonably needed to complete the audit, including the Medicare cost report that the provider most recently filed with the Medicare fiscal intermediary or other Medicare information approved by the Department.

3. The time period that elapses during completion of the procedures described in 10 C.C.R. 2505-10, Sections 8.442.1, whichever is relevant and later in a particular case.

8.443.14 RATES FOR NEW FACILITIES

8.443.14.A. A new nursing facility means a facility:

1. That has not previously been certified for participation in Title XIX; or

2. That has not participated in Title XIX for a period in excess of 30 days prior to the effective date of the current Title XIX certification; or

3. That has changed from one class designation to another.

8.443.14.B. Nursing facilities that have undergone a transfer of ownership are not new nursing facilities provided the previous owner had participated in Title XIX in the last 30 days prior to ownership change.

8.443.14.C. A new nursing facility shall receive a per diem rate equal to the most recent average weighted rate for the appropriate nursing facilities class at the time the new facility begins business as a Medicaid provider.

1. This per diem rate shall remain in effect until a new rate is established based on the first cost report submitted as specified below.

2. The average weighted rate shall be calculated by the Department on the 30th of each month and shall not be revised when new rates are established which would retroactively affect the calculation.

3. The average weighted rate paid a new facility shall be adjusted on July 1 each year by the average weighted rate in effect on July 1.

8.443.14.D. New nursing facilities shall submit MED-13s during their initial year of operation as follows: *[Eff 01/30/2007]*

1. The first cost report shall be for a period covering the first day of operation through the facility's fiscal year end. *[Eff 01/30/2007]*

a. If the first cost report for the period covers a period of 90 days or more, imputed occupancy shall be applied as described in 10 C.C.R. 2505-10, Section 8.443.3.A. *[Eff 01/30/2007]*

b. If the first cost report for the period covers a period of 90 days or more, the first cost report shall set the base for limitations on growth of allowable costs as described in 10 C.C.R. 2505-10, Section 8.443.11.A. *[Eff 01/30/2007]*

2. If the first cost report for the period specified above covers a period of 89 days or less, the facility's first cost report shall not be submitted until the next fiscal year end. *[Eff 01/30/2007]*

3. The next cost report shall be submitted for the twelve month period following the period of the first cost report. *[Eff 01/30/2007]*

4. A new nursing facility shall advise the Department of the date its fiscal year will end and of the reporting option selected. *[Eff 01/30/2007]*

8.443.14.E. Imputed occupancy shall be applied to the first cost report submitted by a new class II or privately owned class IV facility. The facility shall be entitled to the higher of the imputed rate or the monthly weighted average rate computed by the Department. *[Eff 01/30/2007]*

8.443.14.F. Imputed occupancy shall be applied to the second cost report submitted by a new class II or privately owned class IV facility. The rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in ~~the monthly weighted average~~median computation. *[Eff 01/30/2007]*

8.443.15 CHANGE OF OWNERSHIP OR WITHDRAWAL FROM MEDICAID

8.443.15.A. A licensed nursing facility owner(s) that intends to change the ownership of a Medicaid nursing facility, or that intends to terminate its participation in the Medicaid program, shall notify the Department in writing at least 45 calendar days in advance of the proposed change or termination.

1. The advance written notice shall include a specific date for the proposed change or termination and shall be delivered to the Department.

2. The exact date of the change of ownership or termination of Medicaid participation shall be subject to approval by the Department, after consultation with the parties to the proposed transaction and the CDPHE.

8.443.15.B. In the case of a change of ownership that does not require a new license from the CDPHE, the existing Medicaid provider agreement shall continue in effect, together with all associated rights and responsibilities.

8.443.15.C. In the case of a change of ownership which does require a new license from the CDPHE, the transferring owner's Medicaid provider agreement shall be assigned to the successor owner, unless the successor owner refuses in writing to accept assignment of that provider agreement.

1. The assignment of an existing Medicaid provider agreement shall be accomplished by the successor owner's signature of an appropriate acceptance document, as specified by the Department.

2. The assignment of the Medicaid provider agreement shall not be effective prior to the effective date of the successor owner's nursing facility license from the CDPHE.

3. In the event that a successor owner refuses to accept assignment of the transferring owner's Medicaid provider agreement, the successor owner shall indicate such refusal in a written communication to the Department.

4. Until a successor owner has signed a written acceptance of assignment, the Department shall assume that the successor owner intends to refuse such assignment, and the Department shall act accordingly to protect its interests and those of the facility's residents.

8.443.15.D. An assigned Medicaid provider agreement shall be subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including but not limited to the following:

1. Any existing plan of correction;

2. Any expiration date for a Class II provider agreement;

3. Compliance with applicable health and safety requirements;

4. Compliance with the ownership and financial interest disclosure requirements, and any other requirements described elsewhere in this staff manual;

5. Compliance with the civil rights requirements cited in the provider agreement; and

6. At the discretion of the Department, payment of any debts or other obligations, whether known, fixed, definite, liquidated, or not, owed to the Department by the transferring owner. Such liability may also apply, at the discretion of the Department, to any debts or obligations that arose under any earlier, assigned provider agreement(s), but shall not apply to any debt or obligation that was assigned prior to August 1, 2003.

7. The assignment of liability described in the preceding paragraph 6 shall not prejudice the Department's right to pursue any remedy against a previous facility owner or owners for repayment of the assigned debts or obligations.

8.443.15.E. In the event that a successor owner refuses to accept assignment of the transferring owner's Medicaid provider agreement:

1. The transferring owner's Medicaid provider agreement shall terminate on the date approved by the Department for the change of ownership.

2. Prior to the termination of the transferring owner's Medicaid provider agreement, the Department shall have the discretion to withhold reimbursement to the transferring owner for whatever period of time is necessary to recover overpayments or other debts owed to the Department by the transferring owner.

3. The successor owner shall file a new application for a Medicaid provider agreement with the Department or its designated agent. The Department shall not approve the new agreement until the successor owner complies with all requirements for such approval. The Department may delay the effective date of the successor owner's Medicaid provider agreement until the expiration of the withholding period described in the preceding paragraph 2, or until the Department has approved alternative payment arrangements or security for the transferring owner's debts.

4. The Department may require a new facility survey as part of the successor owner's application for a new Medicaid provider agreement even if a new facility survey is not required by the federal Medicare program (e.g., where the successor owner has accepted assignment of an existing Medicare provider agreement).

5. No Medicaid reimbursement shall be paid to the successor owner until the application for a Medicaid provider agreement has been approved, regardless of the effective date of the successor owner's license from the CDPHE.

6. Where appropriate in connection with a proposed change of ownership, the Department shall have the discretion to notify facility residents and/or their guardians that Medicaid reimbursement for facility care may be temporarily or permanently discontinued.

8.443.15.F. A licensed nursing facility owner that transfers ownership or terminates its Medicaid participation shall submit a final MED-13 covering the period from the ending date of the last previous report through the date of the transfer or termination.

1. The initial rate for the successor owner shall be the rate which would have been paid to the previous owner based on the audited final cost report.

2. If the previous owner's final cost report is for a period of less than 89 days, that report shall be disregarded and the previous owner's last cost report for a twelve (12) month period shall be used to set a rate for the successor owner.

~~8.443.15.G. The successor owner shall submit one (1) cost report during the initial year of operation as follows:~~

~~1. Providers shall submit their first cost report for a period covering their first date of operation through the fiscal year end;~~

~~2. If the cost report for the period specified above covers a period of 89 calendar days or less, the provider's first cost report shall not be submitted until after the next facility fiscal year;~~

~~3. The next cost report shall be submitted for the twelve (12) month period following the period of the first cost report.~~

8.443.16 STATE-OPERATED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (CLASS IV)

8.443.16.A State-operated intermediate care facilities for the mentally retarded (class IV) shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services. Actual costs will be determined on the basis of information on the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

1. These costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period.

2. Reimbursement to state-operated intermediate care facilities for the mentally retarded shall be adjusted retrospectively at the close of each twelve-month period.

3. The retrospective per diem rate will be calculated as total allowable costs divided by total resident days.

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 3% growth in the general fund pursuant to 8.443.11

    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 monthly its total number of days of care provided to non-Medicare residents to the Department of Health Care Policy & Financing. 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.

f. If a facility's actual non-Medicare patient days differ by more than 5% from the prior year reported non-Medicare patient days used to determine the provider's fee payment, the facility can request the state department, in writing, to review the facility's provider fee calculation. If the state department determines that the facility's actual non-Medicare patient days differ by more than 5% from the facility's non-Medicare patient days used to determine the facility's provider fee, an adjustment to the facility's annual provider fee payment will be made. The facility's annual provider fee will be based on actual non-Medicare patient days rather than reported days in the prior year.

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

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

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

8.443.17.B 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'.

1. All monies in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the administrative cost of implementing section 25.5-6-202 and this section and to pay a portion of the per diem rates established pursuant to section 25.5-6-202 (1) to (4).

2. Following payment of the amounts described above, the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the rates established under section 25.5-6-202 (5) to (7).

3. Any monies in the fund not expended for these purposes may be invested by the state treasurer as provided by law.

a. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.

b. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or any other fund but may be appropriated by the general assembly to pay nursing facility providers in future fiscal years.

8.443.17.C The state department shall establish administrative penalties for the late payment by a nursing facility of a fee assessed pursuant to this section.

1. The state department may recoup any payments made to nursing facilities providing services pursuant to the Medicaid program up to the amount of the fees owed as determined pursuant to this section and any administrative penalties owed if a nursing facility fails to remit the fees and administrative penalties owed within 30 days after the date they are due. Before recoupment of payments pursuant to this section, the state department may allow a nursing facility that fails to remit fees and administrative penalties owed an opportunity to negotiate a repayment plan with the state department. The terms of the repayment plan may be established at the discretion of the state department.

8.443.17.D The state department will prepare an annual reconciliation of provider fees received and payments made. Any shortfall or ~~excel~~ excessin the provider fee cash fund will be used to increase or reduce provider fees in the following year. Except that in the event the state department determines there is not enough provider fee available, the state department may reduce payments to facilities proportionately to the amount of provider fee available. The state department can, at it's discretion, establish a provider fee fund minimum balance or cash reserve.

8.443.~~16~~ 18 RATES FOR RECEIVERSHIP

8.443.~~16~~18.A. The following rate provisions apply for a facility where a receiver has been appointed by the Court, pursuant to Section 25-3-108, C.R.S., at the request of the CDPHE:

1. During the Receivership

   a. During the term of the receivership, the facility shall be reimbursed the rate payable to the previous operator.

      i) The Department may increase the rate if it finds that the patient-related, necessary and reasonable costs of the facility operation are not covered by the rate payable to the previous operator.

      ii) The Department's analysis of necessary, patient related and reasonable costs incurred by the receiver shall not include any previous unpaid expenses of the prior owner or the mortgage costs of the facility.

   b. The receiver shall submit a cost report for the time beginning when the receiver is appointed until the time the receiver is no longer operationally in control of the nursing facility operation.

      i) This cost report shall set a rate payable to the receiver for the date the receiver took operational control of the facility.

      ii) This retrospective rate may set a rate higher or lower than the initial rate established and paid to the receiver in which case the under or over payment shall be either paid to or collected from the receiver.

      iii) The retrospectively set rate shall not exceed the established maximum allowable rates for that period.

2. New providers after the receivership period

   a. The new operator shall receive the rate paid to the prior owner until the new provider submits a cost report unless the new operator chooses the retrospective option

described below where a new operator takes control and ownership of a nursing facility from the receiver.

b. The new operator may elect to have a retrospective rate set for the initial three months of operation.

i) In order to exercise this option, the new operator shall file a cost report for the first three months of operation.

ii) The first day of operation shall mean the first day of licensure of the new operator. The last day of the initial three months of operation shall be the last day of the month in which the 90th day occurs.

iii) The cost report shall be filed within 90 days of the end of the initial three months of operation.

c. The retrospective rate established from the three month cost report shall be in effect from the first date of licensure of the new owner until the last day of the month in which the 90th day occurs. This rate shall be a prospectively paid rate to the new operator beginning with the first day of the month after the three month cost reporting period.

d. The initial rate paid to the new operator shall be the prior owner's rate.

i) The retrospective rate established by the three month cost report shall replace the initial rate paid to the operator.

ii) The retrospective rate may be higher or lower than the initial rate established and paid to the new operator in which case the under or over payment shall be either paid to or collected from the new operator.

iii) The retrospectively established rate shall not exceed the maximum reasonable cost rates for that period.

e. The three month cost report shall establish the prospective rate for the period established by the regulations at Section 8.443.13.

f. The provider shall file the first cost report after the three month cost report. If the first cost report filed for the period immediately following the three month cost report demonstrates a reduction in per diem costs more than five percent which is caused by a reduction in per diem costs and not an increase in census, the following special provision shall apply:

i) The provider's prospective per diem rate driven by the three month cost report shall be retroactively reduced to the per diem rate as determined by the actual costs of the provider.

ii) The Department shall recover the difference between the provider's actual costs and the prospective rate paid to the provider. This recovery shall not apply to the three month retrospective rate as established by the initial three month cost report.

8.443.~~16~~18.B. These special provisions do not apply when the receiver is appointed at the request of any other party such as the previous operator, landlord or other interested party.

8.443.~~17~~ 19 PAYMENT FOR OUT OF STATE NURSING FACILITY CARE

8.443.~~17~~19.A. Payments for out-of-state nursing facility care shall be made to providers when:

1. The nursing facility services are needed because of a medical emergency.

2. The nursing facility services are needed because the resident's health would be endangered if he/she were required to travel to Colorado and the attending physician has certified to such in the resident's medical records.

3. The Department determines, on the notification from the client's primary care physician, the needed medical services or necessary supplementary resources, are not available in Colorado but are available in another state;

    a. The Department's State Utilization Review Contractor may review the appropriateness of care plan and documentation that the resident will demonstrate significant improvement.

8.443.~~17~~19.B. Where the resident needs rehabilitation services, the resident shall meet all of the following criteria:

1. The resident's medical condition, as documented by the physician, shall be stable to the extent that the resident's primary need is no longer for acute medical care but for intensive, multi-disciplinary rehabilitation care.

2. The resident's disability shall be within 12 months of admission.

8.443.~~17~~19.C. The out-of-state nursing facility shall send the following to the Department monthly:

1. Problem list and rehabilitation goals;

    a. Treatment plan relative to each rehabilitation goal;

    b. Time frame for goal achievement; and

2. Statement of expected discharge status (e.g., timing and the resident's condition on discharge).

8.443.~~17~~19.D. Those residents without need for rehabilitation services shall be expected to meet Colorado nursing facility admission requirements as described in 10 C.C.R. 2505-10, Sections 8.402.01-8.402.10 and can be admitted if:

1. It is general practice for residents in a particular locality to use nursing facility services in another state; or

2. The resident of an out-of-state nursing facility has been determined to be eligible for Colorado Medicaid due to his inability to indicate his/her intended state of residence.

8.443.~~17~~19.E. The out-of-state nursing facility shall:

1. Enroll as a provider in the Colorado Medicaid Program;

2. Submit a copy of the re-certification survey yearly upon completion done by the survey and certification and/or licensure agency in their state;

3. Submit a copy of the following documentation with the claims:

    a. The current Medicaid provider agreement with the state where it is located;

b. The provider number in the state where it is located; and

c. Their Medicaid rate, at the time services were rendered, in the state where it is located.

8.443.1~~7~~9.F. Payment shall not exceed 100 percent of audited Medicaid costs as determined by the Department or its designee. Audited costs shall be based on Medicaid costs in the state where the facility is located.

8.443.1~~7~~19.G. If the facility is not a Medicaid participant in the state where it is located, it shall submit to the Department an audited Medicare cost report. The payment shall not exceed 100 percent of audited Medicare costs.