Title of Rule: Revision to the Medical Assistance Rule concerning Nursing Facility Reimbursement, Section 8.400
Rule Number: MSB 19-02-14-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

STATEMENT OF BASIS AND PURPOSE

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

   The rule change revises the methodology to calculate the Medicaid Management Information System (MMIS) per diem reimbursement rate and the methodology to calculate one of the five nursing facility supplemental payments

   The rule change is needed to address a growing inequality in nursing home reimbursment. Due to how the MMIS per diem reimbursement rate is currently calculated, a large number of nursing homes are reimbursed above their Core Component per diem rate (per diem cost) requiring the Department to recover overpayments the following year. Conversely, a large number of nursing homes are reimbursed well below their Core Component per diem rate, leading to a delay in total payment for the nursing home of up to two years.

   The change in methodology means the MMIS per diem reimbursement rate will be the same percentage of the Core Component per diem rate for all nursing homes. In addition, the amount not reimbursed through the MMIS will now be reimbursed as a supplemental payment in the same year.

   The rule change also revises language throughout to improve clarity/understanding of the nursing home reimbursement methodology and to remove outdated language.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   Sections 25.5-6-202 & 25.5-6-203, C.R.S.

Initial Review	**04/12/19**	Final Adoption	**05/10/19**
Proposed Effective Date	**06/30/19**	Emergency Adoption	

DOCUMENT #02

Title of Rule: Revision to the Medical Assistance Rule concerning Nursing Facility Reimbursement, Section 8.400
Rule Number: MSB 19-02-14-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

REGULATORY ANALYSIS

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

   Class 1 nursing homes will bear the costs and receive the benefits of the proposed rule.

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 change will affect nursing homes by creating greater uniformity in MMIS reimbursement. All nursing homes will now be reimbursed the same percentage of their Core Component per diem rate (per diem cost) in the MMIS. Nursing homes will no longer receive a MMIS rate greater than their Core Component per diem rate, not will they receive a rate considerably less.

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

   There is no change to the statutory limitations on General Fund growth or any changes to the provider fees, so there is no anticipated impact on overall reimbursement to Class 1 nursing homes. There are no additional costs to the Department or to any other agency.

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

   Inaction will result in continued inequality in reimbursement across Class 1 nursing homes. The current MMIS reimbursement rate is not calculated based on a nursing homes Core Component per diem rate (per diem cost) but is instead calculated based on the prior year MMIS per diem reimbursement rate. The disconnect means certain nursing homes are reimbursed more than their Core Component per diem rate and some nursing homes are reimbursed considerably less than their Core Component per diem rate through the MMIS. The benefits of the proposed rule will mean greater uniformity in the calculation of the MMIS rate for all nursing homes.

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

There are no other methods that are less costly or intrusive that still achieve the purpose of the proposed rule.

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

   No alternative methods were seriously considered by the Department to achieve the desired goal of the proposed rule.

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 ~~10 CCR 2505-10 section~~ Section 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 valuation system as determined by the Department.~~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.

DRAFT

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 DONs, 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~~nursing facility provider” 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. Swing bed facilities are not included as C~~c~~lass I ~~facilities~~nursing facility providers.

14. “Core Component~~s~~ per diem rate” means the per diem rate for direct and indirect health care services costs, administrative and general services costs, and fair rental allowance for capital-related assets ~~prospective per diem rate components~~for Class 1 nursing facility providers.

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 ~~10 CCR 2505-10 section~~ Section 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.

DRAFT

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. “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.

24~~3~~. “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.

25. “MMIS per diem reimbursement rate” means the per diem rate used for Medicaid Management Information Systems (MMIS) claims based reimbursement.

~~24~~26. “Normalization ratio” means the statewide average case-mix index divided by the facility’s cost report period case-mix index.

~~25~~27. “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~~28. “Nursing facility provider” means a facility provider that meets the state nursing facility licensing standards established pursuant to C.R.S. §~~section~~ 25-1.5-103, and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

~~27~~29. “Nursing salary ratios” means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse’s aides.

~~28~~30. “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~~31. “Occupancy-imputed days” means the use of a predetermined number for patient days rather than actual patient days in computing per diem cost.

~~30~~32. “Per diem cost” means the daily cost of care and services per patient for a nursing facility provider.

33. “Per diem fee” means the dollar amount of provider fee that the Department shall charge a nursing facility provider per non-Medicare day.

DRAFT

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

~~32~~34. "Provider fee" means a licensing fee, assessment, or other mandatory payment as specified under 42 C.F.R. § ~~section~~ 433.55.

~~33~~35. "Raw food" means the food products and substances, including but not limited to nutritional supplements, that are consumed by residents.

~~34~~36. "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~~37. "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~~38. "Statewide average per diem rate" means the average ~~daily dollar amount of the per patient payments to~~ per diem rate for all Medicaid-participating nursing 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.~~

~~39~~39. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under 42 C.F.R § 483.12 Freedom from abuse, neglect, and exploitation, 42 C.F.R. § 483.24 Quality of life, or 42 C.F.R. § 483.25, Quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm~~related to participation requirements under 42 CFR section 483.13, resident behavior and facility practices, 42 CFR section 483.15, quality of life, or 42 CFR section 483.25, quality of care, that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F)" per State Operations Manual, chapter 7~~.

~~40~~40. "Supplemental ~~Medicaid~~ Payment" means a lump sum payment that is made in addition to a nursing facility provider's MMIS per diem reimbursement rate. A supplemental Medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

DRAFT

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~~.~~ Effective July 1 of each year, a MMIS per diem reimbursement rate ~~For~~ for C~~c~~lass I nursing facility providers~~ies, a payment rate for each participating nursing facility~~ shall be ~~determined~~established for reimbursement of billed claims.

1. The MMIS per diem reimbursement rate shall equal the July 1 Core Component per diem rate multiplied by a percent factor. The percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by the statutory limit pursuant to C.R.S 25.5-6-202(9)(b)(II).

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

3. In the event that MMIS per diem reimbursement rate is greater than the Core Component per diem rate, the Department shall reduce the rate to no greater than the Core Component per diem rate.

The Core Component per diem rate shall be determined using~~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 ~~for the purpose of~~ cost auditing purposes.

The ~~nursing facility prospective~~ Core Component per diem rate ~~includes the following components~~shall be the sum of the following per diem rates:

1. Health ~~Care~~care per diem rate described in Section 8.443.7.D,~~.~~
2. Administrative and ~~General~~general per diem rate described in Section 8.443.8.E, and~~.~~
3. Fair ~~Rental~~ rental ~~Allowance~~ allowance per diem rate described in Section 8.443.9.B~~for Capital-Related Assets~~.

DRAFT

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

In addition to the ~~above~~ MMIS ~~per diem~~ claims reimbursement ~~for core components~~, a Class 1 nursing facility provider may be reimbursed supplemental payments. Supplemental payments are funded using available provider fee dollars collected as described in Section 8.443.17. Supplemental payments shall be funded in the subsequent order based upon the statutory hierarchy pursuant to C.R.S § 25.5-6-203(2)(b)~~prospective supplemental payment shall be made for:~~.

1. Medicaid utilization supplemental payment described in Section 8.443.10.C,

2. Acuity Adjusted Core Component supplemental payment described in Section 8.443.11.B,

3. Pay-For-Performance supplemental payment described in Section 8.443.12,

4. Cognitive Performance Scale supplemental payment described in Section 8.443.10.A,

5. Preadmission Screening and Resident Review II Resident supplemental payment described in Section 8.443.10.B,

6. Preadmission Screening and Resident Review II Facility supplemental payment described in Section 8.443.10.B, and

7. Core Component supplemental payment described in Section 8.443.11.A.~~1.~~

~~Residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury.~~

~~2. 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.~~

~~3. Care and services rendered to Medicaid residents to recognize the costs of the provider fee. Only Medicaid's portion of the provider fee will be included in the supplemental payment. The provider fee supplemental payment shall not be equal to the amount of the fee charged and collected but shall be an amount equal to a calculated per diem fee charged multiplied by the number of Medicaid resident days for the facility. Costs associated with the provider fee are not an allowable cost on the MED-13.~~

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

DRAFT

8.443.10 COGNITIVE PERFORMANCE SCALE, PREADMISSION SCREENING AND RESIDENT REVIEW II, AND MEDICAID UTILIZATION SUPPLEMENTAL PAYMENTS ~~FOR FACILITIES WITH COGNITIVE IMPAIRED AND PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I NURSING FACILITIES~~

8.443.10.A COGNITIVE PERFORMANCE SCALE SUPPLEMENTAL PAYMENT

~~In addition to the reimbursement components paid pursuant to 10 CCR 2505-10 section 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~~The ~~state department~~ Department shall pay a supplemental payment to nursing facility providers who have residents ~~who~~ with ~~have~~ moderate~~ly~~ 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 a supplemental payment~~ based upon the resident's score on the Cognitive Performance Scale (CPS) ~~used in the RUG-III Classification system and reported on the MDS form. Resident CPS scores range from zero (intact) to six (very severe impairment)~~.

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

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

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

The CPS per diem rate multiplier (x) shall equal an amount such that the total statewide CPS supplemental payment divided by total statewide CPS Medicaid days equal one percent of the statewide average MMIS per diem reimbursement rate.

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

a. Medicaid residents with a CPS score of 4, 5, or 6 are determined using the RUG-III classification system and reported on the MDS form.

b. The determination of Medicaid residents with a CPS score of 4, 5, or 6 shall be made using the April MDS roster. ~~Annually the Department will identify those~~

DRAFT

~~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.~~

4. CPS Medicaid patient days shall equal the count of Medicaid residents with a CPS score of 4, 5, 6, or equivalent, multiplied by the days in the year.

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

~~5. These 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 supplemental payment 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 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. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.10.B PREADMISSION SCREENING AND RESIDENT REVIEW II SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers ~~For those residents who have~~ who have residents with severe mental health conditions or developmental disabilities 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 be paid a supplemental payment~~.

DRAFT

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

2. On May 1st each year, the Department will identify those MedicaidMedicaid residents meeting the PASRR II criteria days for each nursing facilityshall equal the count of PASRR II residents on May 1, multiplied by the days in the year.

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 supplemental PASRR II per diem rate payment will be calculated asshall equal two percent- of the statewide MMIS per diem reimbursement rate as described Section 8.443.1.B.average per diem rate for the combined rate components paid pursuant to 10 CCR 2505-10 sections 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 supplemental PASRR II payment 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 to 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.

64. The Department shall pay an additional PASSRR II supplemental payment to facilities that offer specialized behavioral services to residents who have severe behavioral health needs. These services shall include enhanced staffing, training, and programs designed to increase the resident's skills for successful community reintegrationAn additional supplemental 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.

75. The additional PASRR II supplemental payment for nursing facility providers that have an approved specialized behavioral services program shall be calculated using the methodology described in Section 8.443.10.B.1 through Section 8.443.10.B.3.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 supplemental PASRR II payment will be calculated as two percent of the statewide average per diem rate for the combined rate components paid pursuant to 10 CCR 2505-10 sections 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),~~

6. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.10.C MEDICAID UTILIZATION SUPPLEMENTAL PAYMENT

The ~~In addition to the per diem core rate components paid pursuant to 10 CCR 2505-10 sections 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 d~~Department shall pay a supplemental payment to nursing facility providers ~~an additional supplemental 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. Annually, the Department shall calculate the payment by multiplying the percentage of Medicaid patient days by the provider fee as described in Section 8.443.17~~Each July 1st the Department will calculate the funding obligation required to pay for supplemental payments related to CPS (10 CCR 2505-10 section 8.443-10A), PASRR II (10 CCR 2505-10 section 8.443.10B), Pay for Performance (10 CCR 2505-10 section 8.443.12) and any annual increase greater than the statutory limitation in the growth of the general fund share of the aggregate statewide average per diem rate described in 10 CCR 2505-10 section 8.443.11~~.

2. The percentage of Medicaid patient days shall be Medicaid patient days divided by total patient days.

~~2~~3. Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.~~Once the funding obligation is determined, that amount will be divided by twelve to determine the supplemental payment amount that will be paid monthly to each facility as a pass through payment.~~

DRAFT

~~Example Facility's Provider Fee Medicaid Supplemental Payment~~

~~7/1/xx provider fee per diem required to cover funding obligation~~	~~$7.30~~
~~TIMES: Expected non-Medicare resident 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 resident days during the state fiscal year~~	~~20,000~~
~~EQUALS: per diem amount per resident~~	~~$6.21.~~
~~TIMES: Medicaid resident days~~	~~16,000~~
~~Total annual supplemental payment~~	~~$99,360~~
~~DIVIDE BY: Twelve Months for monthly supplemental payment~~	~~$8,280~~

4. Total patient days shall be reported by a nursing facility provider to the Department for the calendar year ending prior to July 1. The Department shall annualize or estimate total patient days for nursing facility providers reporting less than a full year.

5. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

DRAFT

8.443.11 ~~FUNDING SPECIFICATIONS~~CORE COMPONENT AND ADJUSTED CORE COMPONENT SUPPLEMENTAL PAYMENTS

8.443.11.A CORE COMPONENT SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers for the difference between the Core Component per diem rate and the MMIS per diem reimbursement rate.

1. Annually, the Department shall calculate the payment by taking the difference between the MMIS per diem reimbursement rate and the Core Component per diem rate, both described in Section 8.443.1.B, multiplied by applicable Medicaid patient days.

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

3. Applicable Medicaid patient days shall equal Medicaid patient days divided by the days in the year, multiplied by the days the Core Component per diem rate was effective.

4. Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.

5. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

~~The general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to 10 CCR 2505-10 sections 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets) shall be limited by statute. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation. In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers exceeding the statutory limitation on annual growth in the general fund share of the aggregate statewide average of the per diem rate net of patient payment, proportional decreases will be made to the rates so that anticipated payments will equal the statutory growth limitation in the general fund share of the per diem rate. The percentage will be determined in accordance with the following fraction: Legislative appropriations / The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for all class I Nursing Facilities.~~

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

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

~~3. Medicaid case load for each facility will be determined using Medicaid paid claims data for the calendar year ending prior to the July 1st rate setting. Providers with less than a full year of paid claims data will have their case load annualized. Providers with no paid claims data for the calendar year ending prior to the July 1st rate setting will have their Medicaid caseload estimated by the Department.~~

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

~~5. For SFY 2009 and each succeeding year the final state share of Medicaid per diem rates will be limited to the legislative appropriation amount from the base year increased by the statutory growth limitation over the prior SFY. These determinations will be made during the July 1st rate setting process each year. If the preliminary state share (less the amount applicable to provider fees) is greater than the indexed legislative base year amount, proportional reductions will be made to the preliminary nursing facility rates to reduce the state share to the indexed legislative appropriation base year amount.~~

~~6. Provider fee revenue will first be used to pay the provider fee offset payment, then the payment for acuity or case-mix of residents, then the Pay-for-Performance program, then payments for residents who have moderately to severe mental health conditions, cognitive dementia or acquired brain injury, and then the supplemental Medicaid payments for the amount by which the average statewide per diem rate exceeds the general fund share established under C.R.S. section 25.5-6-202(9)(b)(II). Any difference between the amount of provider fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share above.~~

~~7. The following calculation illustrates the above and, for illustration purposes, assumes the statutory limit on general fund is 3%:~~

DRAFT

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 Prior Year General Fund Legislative Appropriations		55,000,000	
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

8.443.11.B ACUITY ADJUSTED CORE COMPONENT SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers for the difference between the Core Component per diem rate and the adjusted Core Component per diem rate for the prior year.

1. Annually, the Department shall calculate the payment by taking the difference between the prior year Core Component per diem rate and the prior year adjusted Core Component per diem rate, multiplied by applicable Medicaid patient days.

2. Applicable Medicaid patient days shall equal Medicaid patient days divided by the days in the prior year, multiplied by the days an adjusted Core Component per diem rate was effective.

3. Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.

4. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

DRAFT

8.443.12 PAY-FOR-PERFORMANCE ~~COMPONENT~~SUPPLEMENTAL PAYMENT

~~Starting July 1, 2009, t~~The Department shall ~~make~~ pay a supplemental payment ~~based upon performance~~ to those nursing facility providers that provide services ~~that~~ resulting 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. Annually, the Department shall calculate the payment by multiplying a Pay-for-Performance (P4P) per diem rate by Medicaid patient days.

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

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

3. The P4P points will be based on a completed and verified/audited application including ~~The 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 application includes the following:

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

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

~~2~~4. The prerequisites for participating in the program are as follows:

a. No facility with substandard deficiencies on a regular annual, complaint, or any other CDPHE survey will be considered for pay for performance. Substandard quality of care means one or more deficiencies related to participation requirements under 42 C.F.R. § 483.12 Freedom from Abuse, Neglect, and Exploitation, 42 C.F.R. § 483.24 Quality of Life quality of life, or 42 C.F.R. § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm

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

DRAFT

summary report must be made ~~publically~~publicly available along with the facility's State's survey results.

~~3~~5. To apply the facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The facility must maintain documentation supporting its representations for each performance measure the facility represents it meets or exceeds the specified criteria. The required documentation for each performance measure is identified on the application and must be submitted with 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~~6. The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions. 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 payment for those facilities receiving a supplemental payment is less than twenty-five hundredths of one percent of the statewide average per diem base rate, the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid add-on payment equal to twenty-five hundredths of one percent of the average nursing facility base rate.~~

7. Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.

~~7~~8. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.~~These calculations will be performed annually to coincide with the July 1st rate setting process.~~

DRAFT

8.443.13 RATE EFFECTIVE DATE

8.443.13.A~~.~~ For cost reports filed by ~~all facilities~~ Class 1 nursing facility providers, ~~except the State administered Class II and IV facilities,~~ a July 1 Core Component per diem rate and subsequent adjusted ~~Schedule of~~ Core Component~~s~~ ~~Reimbursement~~ per diem ~~Rates~~ rates shall be established by the Department based on the last day of the cost reporting fiscal year end~~. The July 1st Schedule of Core Components Reimbursement Rate shall be based on the cost reporting period ending no later than the previous April 30th~~.

~~Additional Schedule of~~ Core Component~~s~~ ~~Reimbursement~~ per diem ~~Rates~~ rates shall be established as follows:

1. On July 1 in accordance with the table below.

2. ~~Rate effective o~~On the first day of the ~~11th~~ 23rd month following the end of the facility's cost reporting period.

~~2~~3. ~~Rate effective o~~On the first day of the 6th month following the 23rd month rate effective date ~~stated in 8.443.13.A.1~~.

~~3~~4. If the ~~11~~ 23-month or ~~6~~ 6-month rate ~~stated in 8.443.13.A.1 and 8.443.13.A.2~~ coincide with July 1, ~~only two rates will be established.~~ only a July 1 and a January 1 rate shall be established

~~4~~5. If the ~~6 month~~6-month rate ~~stated in 8.443.13.A.2~~ is after the July 1 rate set by the subsequent cost report, ~~only two rates will be established~~ only a July 1 and 23-month rate shall be established.

~~Provider~~ Cost Report Fiscal Year End	July 1 Rate Effective Date ~~Effective Date of Rate~~	23 ~~Acuity Adjusted~~ ~~11~~ Month Rate Effective Date	~~Acuity Adjusted~~ 6 Month Rate Effective Date
01/31/Year 1	07/01/Year ~~1~~2	12/01/Year ~~1~~2	06/01/Year ~~2~~3
02/28/Year 1	07/01/Year ~~1~~2	01/01/Year ~~2~~3	~~07/01/Year 2~~ (N/A)
03/31/Year 1	07/01/Year ~~1~~2	02/01/Year ~~2~~3	~~08/01/Year 2~~ (N/A)
04/30/Year 1	07/01/Year ~~1~~2	03/01/Year ~~2~~3	~~09/01/Year 2~~ (N/A)
05/31/Year 1	07/01/Year ~~2~~3	04/01/Year ~~2~~3	10/01/Year ~~2~~3
06/30/Year 1	07/01/Year ~~2~~3	05/01/Year ~~2~~3	11/01/Year ~~2~~3
07/31/Year 1	07/01/Year ~~2~~3	06/01/Year ~~2~~3	12/01/Year ~~2~~3
08/31/Year 1	07/01/Year ~~2~~3	~~07/01/Year 2~~ (N/A)	01/01/Year ~~3~~4
09/30/Year 1	07/01/Year ~~2~~3	08/01/Year ~~2~~3	02/01/Year ~~3~~4
10/31/Year 1	07/01/Year ~~2~~3	09/01/Year ~~2~~3	03/01/Year ~~3~~4
11/30/Year 1	07/01/Year ~~2~~3	10/01/Year ~~2~~3	04/01/Year ~~3~~4
12/31/Year 1	07/01/Year ~~2~~3	11/01/Year ~~2~~3	05/01/Year ~~3~~4

8.443.13.B~~.~~ For 12-month cost reports filed by the State-administered Class IV ~~facilities~~nursing facilty providers, the rate shall be effective on the first day covered by the cost report.

DRAFT

~~8.443.13.C. A July 1 Medicaid Management Information System (MMIS) rate shall be established and issued. The July 1 MMIS rate shall pay Medicaid claims with dates of services on and after, July 1 of each year. The rate shall be equal to the July 1 MMIS rate established in the previous year, prior to statutory adjustments, plus the applicable allowable growth. The July 1 MMIS rate shall not exceed limitations defined in C.R.S. 25.5-6-202(9)(b)(I) and may be subject to statutory adjustments.~~

~~8.443.13.D. The July 1 MMIS rate established at 8.443.13.C will be reconciled to the Schedule of Core Components Reimbursement Rate(s) established in 8.443.13.A based on the adjusted MED-13. The reconciled amount will be included in the supplemental payment calculation for the state fiscal year following the calculation of the final Schedule of Core Components Reimbursement Rate and will be subject to available funding.~~

8.443.13.~~E~~C~~.~~ Any delay in completion of the audit of the MED-13 that is attributable to the provider, shall operate, on a time equivalent basis, to extend the time in which the Department shall establish the Schedule of Core Components Reimbursement Rates, under the provisions set forth in Section 8.443.13.A above.

8.443.13.~~F~~D 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 CCR 2505-10 s~~Section 8.442.1~~, whichever is relevant and later in a particular case~~.

DRAFT

8.443.17 CLASS I NURSING FACILITY PROVIDER FEES

8.443.17.A The ~~state d~~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~~ A C~~c~~lass I nursing facility provider that is licensed in this State shall pay a fee assessed by the ~~state d~~Department.

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

   a. A nursing facility provider operated as a continuing care retirement community (CCRC) 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 C.R.S. § ~~section~~ 25-27-102(1.3), or that provide assisted living services on-site, twenty-four hours per day, seven days per week;

   b. A ~~skilled~~ nursing facility provider owned and operated by the state;

   c. A nursing facility provider that is a distinct part of a facility that is licensed as a general acute care hospital; and

   d. A nursing facility provider 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~~3. Annually, ~~T~~the ~~state d~~Department shall calculate the provider fee by multiplying a per diem fee by non-Medicare patient days ~~to collect from each nursing facility during the July 1 rate-setting process~~.

4. The per diem fee shall equal the previous year per diem fee increased by an inflation factor.

   a. The inflation factor shall be based on a national skilled nursing facility market basket index. The inflation factor is the inflation index at the midpoint of the current year divided by the inflation index at the midpoint of the previous year.

DRAFT

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 10 CCR 2505-10 section 8.443.17.B.1

(ii) CPS pursuant to 10 CCR 2505-10 section 8.443.10.A

(iii) PASRR pursuant to 10 CCR 2505-10 section 8.443.10.B

(iv) Pay for Performance pursuant to 10 CCR 2505-10 section 8.443.12

(v) Provider Fee Offset Payment pursuant to 10 CCR 2505-10 section 8.443.10.C

(vi) Excess of the statutory limited growth in the general fund pursuant to 10 CCR 2505-10 section 8.443.11

(vii) Acuity or case-mix of residents pursuant to 10 CCR 2505-10 section 8.443.7.D

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

c. The aggregate dollar amount of provider fee funds necessary will be divided by non-Medicare patient days for all class I nursing facilities to obtain a per day provider fee assessment amount for each of the two following categories:

(i) nursing facilities with 55,000 total patient days or more;

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

b. The state dDepartment will shall lower the amount of the provider per diem fee for charged to nursing facility providers with 55,000 total patient days or more to meet the requirements of 42 C.F.R. § section 433.68(e). In addition, tThe 55,000 total patient day threshold can may be modified to meet the requirements of 42 C.F.R. § section 433.68(e).

5. 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. Non-Medicare patient days shall be reported by a nursing facility provider to the Department for the calendar year ending prior to July 1.Each nursing facility will report annually its total number of days of care provided to non-Medicare residents to the Department of Health Care Policy & Financing. The non-Medicare patient days reported will be from the calendar year prior to the July 1 rate setting process. Providers with less than a full year of non-Medicare patient days data will have their non-Medicare days annualized. New providers with no non-Medicare patient days data will have their non-

DRAFT

~~Medicare days estimated by the Department. The non-Medicare patient days will be used for the provider fee calculation.~~

a~~f~~. A nursing facility~~'s~~ provider's non-Medicare patient days ~~will~~ shall be estimated ~~in order~~ to determine the provider~~'s~~ fee ~~payment~~ if and only if one of the following conditions exist:

i) A new nursing facility provider,

ii) A nursing facility provider that will close during the rate year, or

iii) A nursing facility provider that has had a change of certification or licensure.

The nursing facility provider ~~will~~ shall have ~~their~~ non-Medicare patient days estimated for each model year until the nursing facility provider has twelve ~~12~~ months of data for the calendar year preceding the calendar year ending prior to July 1~~rate year~~.

If a nursing facility~~'s~~ provider's non-Medicare patient days are estimated, the Department shall compare estimated non-Medicare patient days to actual non-Medicare patient days in the subsequent year. ~~and the~~If a nursing facility~~'s~~ provider's actual non-Medicare days differ by more than five percent ~~5%~~from estimated non-Medicare patient days ~~from the prior year estimated non-Medicare patient days used to determine the provider's fee payment~~, the ~~state d~~Department ~~will~~ shall multiply the difference by the prior year per diem fee and add it in the current year provider fee~~review the facility's provider fee calculation, and an adjustment to the facility's annual provider fee payment will be made in the subsequent year~~.

~~g~~6. These calculations will be performed annually to coincide with the July 1st rate setting process.~~Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed the state department.~~

~~h~~7. The ~~state d~~Department shall assess the provider fee ~~on a monthly basis~~monthly.

~~i~~8. The fee assessed pursuant to this section is due at most thirty~~30~~ days after the end of the month for which the fee was assessed.

DRAFT