Title of Rule: Medicaid Nursing Facilities Demonstration of Need with Technical Changes Revision to the Medical Assistance Program Requirements for Nursing Facilities, Section 8.400
Rule Number: MSB 21-08-04-A
Division / Contact / Phone: Office of Community Living / Nancy Schwalm / 303-866-4188

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 Colorado General Assembly passed House Bill 21-1227, authorizing the Department to develop a "demonstration of need" to provide a consistent way that Medicaid beds can be approved for new Nursing Facilities that were not Medicaid-certified prior to June 30, 2021. This bill includes technical changes related to the nursing facility statute that will allow private pay or Medicare-only nursing facilities to add up to five Medicaid beds without becoming fully Medicaid certified. A rule change is needed to develop clear and consistent criteria for the Department to use when considering new Nursing Facility Medicaid bed approval. The demonstration of need will establish a process that considers demographic need, innovative practices, and quality of the provider. The technical changes in the rule revision will serve to reduce transfer trauma for nursing facility residents. The Department's goal is to ensure that Colorado's growing older adult population will have access to new, outstanding nursing facilities statewide, as well as provide enough Medicaid beds in response to the steady increase in older adult Medicaid enrollment.

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:

   The Social Security Act mandates standards that must be met by providers participating in Medicare and Medicaid programs. These standards are found in 42 Code of Federal Regulations, Part 483, subpart B, "Requirements for States and Long-Term Care Facilities" and in State Operations Manual, Chapter 2 – The Certification Process.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021); Colorado Revised Statutes added 25.5-6-209 (2021), amended 25.5-6-201 and 25.5-6-202 (2021)

Initial Review	**02/11/22**	Final Adoption	**03/11/22**
Proposed Effective Date	**04/30/22**	Emergency Adoption	

DOCUMENT #09

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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.

   New nursing facilities seeking Medicaid certification after June 30, 2021, will be affected by the proposed rule and will need to follow the rule revision application criteria. Private pay or Medicare-only nursing facilities seeking to add up to 5 Medicaid certified beds as part of the allowable technical changes will also be affected by the proposed rule. Eligible and enrolled individuals with Medicaid benefits and their families will be affected by the increased opportunity for more choices and options of nursing facilities that offer Medicaid beds. The proposed rule does not increase costs.

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 quantitative impact of this bill has the potential to serve thousands of older adults over the next decade and beyond. Colorado's State Demographer forecasts that Colorado's aging population is growing, with the 65-and older population expected to increase by 37 percent over the next 10 years, with the highest percentage of growth in those over age 75. Medicaid enrollment of older adults has been growing steadily, with an increase of 51 percent over the last decade. The Federal Health and Human Services Office for Planning and Evaluation indicates that "more than one-half of adults will use some paid long-term services and supports, such as nursing home care." The rule revision will increase the number of Medicaid certified beds available throughout the state as we ready our services for population growth.

   The qualitative impact of the rule change offers Colorado's older adults increased access to new, innovative models of nursing facilities. Residents residing in private pay or Medicare facilities will not experience the trauma of having to move to a different facility once they enroll in Medicaid, with the rule revision allowing for up to five Medicaid beds in non-Medicaid certified nursing facilities.

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

   There are no further costs to the Department or anticipated effect on state revenues from this proposed rule. The potential increase of service utilization is unknown. New nursing facilities must follow appropriate licensing, certification, and enrollment procedures through the Colorado Department of Public Health and Environment and the Department. This may increase an agency's administrative costs if an applicant is not a current provider.

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

   The benefits of this rule include increased options to Medicaid-certified nursing facilities throughout the State, innovation requirements for new nursing facilities being built, reduction in transfer trauma for nursing facility residents who change from private pay or Medicare to Medicaid, and an increased choice of providers for Members and their families. There are no benefits for inaction, but the probable costs of inaction include service limitations for older adults enrolling in Medicaid and needing nursing facility care, continued transfer trauma for nursing facility residents residing in private pay and Medicare-only facilities who are required to move when they enroll in Medicaid benefits, and the lack of a consistent and thoughtful approach in allowing new nursing facilities to be built in Colorado. There are zero to minimal additional costs from this proposed rule. All potential benefits outweigh inaction as increasing access to care and services is invaluable.

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.

   None were proposed or rejected.

8.430 MEDICAID CERTIFICATION OF NEW NURSING FACILITIES OR ADDITIONAL BEDS

8.430.1 DEFINITIONS

Action means denial or approval of the application or request for additional information regarding an application.

Existing Colorado Nursing Facility means any licensed nursing facility ~~continuously licensed in Colorado for a period of at least 30 days prior to the date of application and which meets state and federal requirements.~~currently Medicaid certified by the Colorado Department of Health Care Policy and Finance and licensed by the Colorado Department of Public Health and Environment.

Licensed Bed Capacity means the licensed bed capacity of a nursing facility on file with Colorado Department of Public Health and Environment (CDPHE).

New ~~Nursing~~ nursing ~~Facility~~facility means ~~any nursing~~ a facility not licensed and Medicaid certified as a Colorado nursing facility as of the date of application of June 30, 2021.~~or any nursing facility, which for a period of 30 or more days subsequent to the date of application, has not been licensed as a Colorado nursing facility.~~

Financially solvent means the ability of a company to meet its long-term financial obligations, as verified by an approved and qualified third-party auditor.

Case-Mix means the system determined by the State Department for grouping a nursing facility's residents according to their clinical and functional status as identified from data supplied by the facility's minimum data set (MDS) as published by the United States Department of Health and Human Services.

Special Focus Facility means a nursing facility~~ies~~ that ~~have~~has a history of serious quality issues or ~~are~~is included in the Centers for Medicare & Medicaid Services (CMS) program to stimulate improvements in the nursing facility's ~~ir~~ quality of care.

8.430.2 APPLICABILITY

8.430.2.A. 10 CCR 2505-10, S~~s~~ection 8.430 applies to all nursing facilities except:

1. A nursing facility that is currently Colorado Medicaid certified and experiences a change of ownership or a facility that is placed~~ment~~ into receivership under the United States Bankruptcy Code and/or pursuant to C.R.S. § 25-3-108. ~~if the ownership change or receivership action involves no increase to its previously approved Medicaid bed total.~~

2. A nursing facility exclusively serving the developmentally disabled (intermediate care facility for individuals with intellectual disabilities (ICF/IID) and home and community-based services for the developmentally disabled group homes).

3. A replacement facility for existing residents in a facility owned/operated by the applicant. Approval for the ~~beds~~ replacement facility shall only be granted if the conditions in subparagraphs a. through e, are met:

a. The applicant clearly documents that the old structure was substantially inadequate to efficiently and effectively ~~promote~~ provide quality of care for the residents.

b. The replacement facility is located no more than five miles from the original facility, or fifteen (15) miles if the original facility is in a rural community.

c. ~~The number of beds in the replacement facility is limited to the original number of Medicaid-certified beds being replaced.~~

i) If the facility is the only Medicaid certified facility in the county, the replacement facility shall have no distance limitation, but must be in the same county

d. Residents living in the original facility at the time it is closed are given the right of first refusal for beds in the replacement facility.

e. The replacement facility has ~~masurable~~measurable innovative practices and design features exceeding that of the current facility. Examples of measurable innovative practices may include but are not limited to:

i) Improvements in technology

ii) Access to private rooms.

iii) Access to outdoor common areas.

iv) Improvements to noise control features.

v) Lighting modifications that support safety and independence.

vi) General features that promote safety and independence.

vii) Air quality/airflow measures that serve to prevent infections.

8.430.3 NEW NURSING FACILITY CERTIFICATION

8.430.3.A. Procedures and Criteria for Medicaid Certification of a New Nursing Facility

1. The burden of demonstrating the need for a new Medicaid facility shall be entirely on the applicant.

2. The applicant for Medicaid certification of a new nursing facility shall:

a. File a letter of intent to apply for certification with the Department in January or July of the year in which the application will be filed. The letter of intent shall specify:

i) The person or corporation who will submit the application.

ii) The proposed service area.

iii) The number of beds in the new facility for which Medicaid approval will be requested.

b. No later than five months from the date of filing the letter of intent, the applicant shall submit a complete application. The application shall include:

i) The name, address and phone number of the person or corporation requesting approval for the new nursing facility.

ii) The total number of proposed beds and the number of beds requested for Medicaid certification.

iii) A description of the service area and justification that the service area can be reasonably served by the new nursing facility.

iv) If construction of the additional beds or the new nursing facility has not been completed by the date the application is filed, the following documentation shall also be provided:

1) Official written documentation showing ownership of the proposed new nursing facility.

2) Location of the proposed new nursing facility including documentation of ownership, lease or option to buy the land.

3) Documentation from a financial institution regarding financing support for the new nursing facility.

4) Complete, written documentation that preliminary architectural plans for the proposed new nursing facility have been submitted to CDPHE.

5) Expected completion date of the new nursing facility.

v) A statement regarding any previous contracts with or enrollment in any state's Medicaid program. The statement shall assure that the applicant has never been found guilty of fraud or been decertified from participation in the Medicaid program in Colorado or any other state.

3. A completed application shall be made available on the Department's ~~Internet~~ website for public review and comment. In addition, the applicant shall submit a local public newspaper notice published within the service area defined in the application ~~provide newspaper notice~~ at the applicant's expense. ~~,~~The applicant must provide a copy of the newspaper notice after ~~that~~ the application has been posted for public review~~submitted~~. A public hearing on the application may be conducted.

4. As a condition of approval, the new provider may be required to execute an appropriate performance agreement, as specified by the Department.

5. Approval or denial of an application for Medicaid certification of a new nursing facility shall be based on all the following information from the applicant:

a. Planned resident capacity and payer mix.

b. Planned ~~differentiation~~ measurable innovative practices of the proposed new facility from existing nursing facilities in the same service area (e.g., new models of care, special programs, or targeted populations).

c. ~~The applicant's marketing plan, including planned communications and presentations to discharge personnel and placement agencies.~~

~~d.~~ Demographic analysis of the applicant's designated service area, including review of State demography data and a market analysis of other available long-term care services, e.g., assisted living, home health, home and community-based services, etc., and the extent to which such alternative services are utilized.

e. Projections of net patient revenue and operating costs.

f. Audited financial statements for the most recently closed fiscal year for the entity seeking Medicaid certification.

g. A statement from an actuary, certified public accountant, or financial firm indicating the applicant will be able to remain financially solvent for a time period of no less than thirty-six (36) months post project. ~~.Additional financial, market or programmatic information requested by the Department within two months after the application date;~~

h. Historical information concerning the quality of care and survey compliance in other nursing facilities owned or managed by the applicant or a related entity or individual.

~~i)~~ Facilities facing enhanced oversight or designated as a Special Focus Facility or Special Focus Facility candidate will not be considered for Medicaid certification.

~~i~~j.. A statement assuring cooperation with de-institutionalization and community placement efforts.

k.~~j~~. Documentation of whether the proposed new facility provides needed beds to an underserved geographical area, as described in Section 8.430.3.A.5.j.i., or to an underserved special population, as described in Section 8.430.3.A.5.j.ii.

i) To qualify as an underserved geographical area of the state, the application must demonstrate, with appropriate documentation, that:

1) The ~~N~~nnew ~~N~~nnursing F~~f~~acility is located in the service area defined by the application. The service area must be no smaller than one (1) full county. The service area shall be no more than two contiguous counties in the state.

2) The service area shall have a nursing facility bed to population ratio of less than 40 beds per 1,000 persons over the age of 75 years.

a) The population projections shall be based upon statistics issued by the State Department of Local Affairs.

b) The applicable statistics for applications involving beds for which construction is complete at the time of application shall be the population statistics for the period including the date on which the application is filed.

c) The applicable statistics for applications involving beds for which construction is not complete at the time of application shall be the population projections for the expected date of completion of the beds set forth in the application.

d) The service area ratio will exempt Colorado Veterans Community Living Centers and include only beds generally available to the public.

3) The occupancy of existing nursing facilities in the proposed service area exceeds ninety percent (90%) for the six (6) months preceding the filing date of the application, as demonstrated by the nursing facility quarterly census statistics maintained by CDPHE.

ii) An application for a ~~n~~New n~~n~~ursing ~~F~~facility to serve an underserved special population shall contain the following information and documentation:

1) A description of the special populations to be served and why they cannot be served in the community.

2) Justification for the service area to be served.

3) A determination of whether there are existing excess beds in the proposed service area and, if so, why the existing excess beds cannot be used by or converted for use by the special populations.

a) The determination of existing excess beds shall include a population ratio analysis and occupancy analysis as set forth in Section 8.430.3.A.5.j.i., and shall be calculated by utilizing the formulas, methods and statistics set forth therein.

b) The justification of why existing excess beds cannot be used for or converted for use by the special populations(s) must be clearly demonstrated and supported by relevant and competent evidence.

4) Applications based on an underserved special population~~s~~ must document the ~~that one or more of the following~~ special population~~s~~ of clients who have been certified for a hospital level of care in accordance with Section 8.470 is ~~is~~ underserved in the proposed service area. Health Care Policy and Finance will verify the need using utilization records, hospital backlogs, and historical admission denials.

:

~~a) Clients with AIDS.~~

~~b) Clients with mental, intellectual or developmental disabilities, as defined by the Preadmission Screening and Annual Resident Review (PASRR) process described at Section 8.401.18.~~

~~c) Clients with a traumatic head injury.~~

~~d) Clients who have been certified for a hospital level of care in accordance with Section 8.470.~~

5) The following requirements may also apply to approval of ~~N~~n~~n~~ew ~~N~~n~~n~~ursing ~~F~~facilities for special populations:

a) The Statewide URC shall certify long-term care prior authorization requests for Medicaid clients who are verified as meeting the special populations definitions provided in Section 8.430.3.A.5.j.ii.4.

b) In the case of applications for approval of ~~N~~n~~n~~new ~~N~~n~~n~~ursing ~~F~~f~~f~~acilities for individuals with intellectual or developmental disabilities, all restrictions concerning Medicaid reimbursement described at Section 8.401.41 et seq., Guidelines for Institutions for Mental Diseases (IMD's), shall apply.

6) A bed approved for a specific underserved special population shall not be used for any other population, even if a Medicaid client occupying this type of bed is discharged or experiences a change in physical condition which requires transfer to a general skilled nursing unit bed.

a) The Department may authorize an additional number of beds for individuals transitioning in/out of the specific special need or to support solvency of the special population program.

b) The Department's approval or denial determination will be communicated through Operational Memos.

8.430.4 COMPLETION OF APPROVED ~~BEDS~~NURSING FACILITY

8.430.4.A. Construction of approved ~~beds~~ nursing facilities shall adhere strictly to the specifications provided in the application. A new application shall be submitted and shall be subject to the criteria for approval in effect at the time of the new application when any of the following changes apply to the new facility with approved Medicaid beds ~~for a new facility~~:

1. Persons or corporations which ~~has~~ have ownership.

2. The site upon which the new facility ~~beds were built or~~ will be constructed.

3. Proposed service area.

4. Condition under which approval of facility ~~beds~~ is requested with reference to underserved geographical or underserved population criteria in accordance with Section 8.430.3.A.5.j.

8.430.4.B. The applicant shall complete the project within ~~30~~ sixty (60)- months of the date of the Department's approval of the application. The Department may authorize one (1) extension of up to thirty (30) months if the applicant can show a good effort towards completion of the project.

8.430.4.C. No extension beyond the ~~30~~ ninety (90)- ~~-~~month period shall be considered unless completion of the project is delayed for reasons beyond the applicant's control.

1. The following shall be considered reasons beyond the applicant's control:

a. Natural disasters.

b. Hazardous soil or water conditions documented by local authorities and unknown to applicant at time of acquisition of the property.

c. Fires or explosions at the construction site serious enough to substantially delay the project.

d. Public health emergency.

2. The following shall not be considered beyond the applicant's control:

a. Lack of financing or changes in need for financing.

b. Delays due to litigation.

c. Construction delays (examples of construction delays which would not be granted an extension: weather, management-labor problems, subcontractor missed deadlines, permit or zoning variance problems).

8.430.4.D. Applicants who complete the project within the ~~30~~sixty (60)- ~~-~~month period or any extension period ~~shall be~~are eligible for a Medicaid provider agreement provided the facility is inspected on-site and found by CDPHE to be in compliance with standards for licensure as a nursing facility and certification for Medicaid participation and so long as the applicant meets all other conditions of participation.

8.430.4.E. When two or more applications for the same service area or special population are received in the same application period the following conditions apply:

1. ~~Upon request, each applicant shall submit the estimated per diem costs to be incurred by the provider/developer over the first five (5) years of the project. The applicant shall provide assurances that the per diem costs shall be sufficient to meet all quality of care standards during this period. The application with the lowest per diem costs shall be chosen for enrollment in the Medicaid program.~~

2. ~~The rate to be paid for the new beds shall be based on the estimated per diem costs for all costs not including registered nurses, licensed practical nurses and nurses' aides for the five year period or the actual audited Medicaid rate during the period, whichever is lower. Should the estimated per diem costs for registered nurses, licensed practical~~

~~nurses and nurses' aides be higher than the estimate, these costs shall be subject to the actual audited Medicaid rate-setting procedures. The rate to be paid to an existing provider is the per diem rate approved by the Department for that facility.~~

1. The Department will select the applicant that demonstrates the more measurable innovative practices, including but not limited to:

a. Improvements in technology;

b. Access to private rooms;

c. Access to outdoor common areas;

d. Improvements to noise control features;

e. Lighting modifications that support safety and independence;

f. General features that promote safety and independence; and

g. Air quality/airflow measures that serve to prevent infections.

~~**8.430.5 NOTIFICATION OF INCREASED OR DECREASED MEDICAID BEDS**~~

~~8.430.5.A. Beginning June 1, 2004, any existing Colorado nursing facility shall notify the Department when it increases or decreases the number of certified Medicaid beds, i.e., when it converts some or all of its licensed non-Medicaid beds to or from general skilled Medicaid nursing facility beds~~

~~8.430.5.B. The notification shall contain the following:~~

~~1. The prior number of Medicaid beds, the number of additional or decreased Medicaid beds and the date effective.~~

~~2. The nursing facility's total licensed bed capacity, consisting of Medicaid-certified beds and licensed non-Medicaid beds. A copy of the current facility license shall be attached.~~

8.430.6 LIMITED MEDICAID CERTIFICATION

8.430.6.A. Beginning June 30, 2021, non-Medicaid certified facilities may reserve up to five beds for the purpose of minimizing transfer trauma, coordinating transfers, and accommodating long term residents of the facility that have outlived their third-party coverage or ability to privately pay for room and board.

1. Facilities will not be considered Medicaid certified and not subject to the criteria in 8.430.3 New Medicaid Certification.

2. Facilities seeking to add up to the allowable five (5) beds shall submit a Provider Enrollment and letter requesting the beds to the Department.

3. Facilities seeking more than the allowable five (5) beds must meet the application process in Section 8.430.

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 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 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 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 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 Class I nursing facility providers.

14. "Core Component 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 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 Section 8.443.7.

17. "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each Case-Mix~~resource utilization~~ group as of a specific point in time. The current system in use is the resource utilization group (RUG).

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. "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. "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.

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

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.

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

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

30. "Nursing weights" means numeric scores assigned to each category of the Case-Mix ~~resource utilization~~ groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents. The current system in use is the resource utilization group (RUG).

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

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.

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

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

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.

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.

38. "Statewide average per diem rate" means the average per diem rate for all Medicaid-participating nursing facility providers in the state.

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.

40. "Supplemental 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.

8.443 NURSING FACILITY REIMBURSEMENT

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:

   a. [Expired 05/15/2016 per House Bill 16-1257].

   b. 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 must~~shall~~ be based on a nationally-recognized valuation system determined by the ~~state d~~Department ~~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.

   c. 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.

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

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

   f. 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.

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

h. 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.

i. [Expired 05/15/2016 per House Bill 16-1257]

j. Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, which shall be the most recent publication of R.S.Means Company, Inc. that is updated quarterly (section M.450, “Nursing Home”), hereafter referred to as the Means Index.

k. 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 nationally-recognized valuation system determined by the ~~state~~ D~~d~~epartment~~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 nationally-recognized valuation system determined by the ~~state d~~Department ~~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.