Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-03-02-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 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).

   House Bill (H.B.) 23-1228 increases nursing home reimbursement starting in state fiscal year (SFY) 2023-24. The proposed rule increases the SFY 2023-24 statewide average nursing home per-diem reimbursement rate by 10%, compared to a limited 2% or 3% increase in previous years. The proposed rule also increases the Cognitive Performance Scale (CPS) and Preadmission Screening and Resident Review (PASRR) II supplemental payment starting in SFY 2023-24, reimbursement for providing care to residents with cognitive and/or behavioral disabilities.

   The propose rule also makes necessary changes to the case mix adjustment applied to nursing home per diem reimbursement rates due to the current Resource Utilization Group (RUG) tool no longer utilized by the Center for Medicare & Medicaid Services (CMS) after October 1, 2023.

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: H.B. 23-1228 increases SFY 2023-24 (July 1, 2023 through June 30, 2024) nursing home reimbursement. Emergency rule-making is necessary to comply with state law allowing for the change to nursing home reimbursement to be effective July 1, 2023. The proposed rule was not presented at a previous MSB meeting as H.B. 23-1228 was sent to the Governor for signature May 17, 2023.

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

   25.5-4-402.4(4)(b), (g), C.R.S.

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-03-02-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 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.

   Nursing homes will benefit from the proposed rule. The statewide average nursing home per-diem reimbursement rate will increase by 10% in SFY 2023-24, compared to previous years where the increase was limited to 2% or 3%. Nursing homes providing care to more residents with mental health conditions, cognitive dementia, and/or developmental disabilities will benefit as their CPS and PSRR supplemental payments will increase starting in SFY 2023-24.

   Nursing homes providing care to less residents with mental health conditions, cognitive dementia, and/or developmental disabilities will bear the costs as other nursing home supplemental payments will be reduced to offset the CPS/PASRR supplemental payment increase. There are limited provider fee funds and an increase in one supplemental payment means a decrease to the other supplemental payments. The state and federal governments will bear the costs of the proposed rule by funding the increase to per-diem reimbursement rates to nursing homes.

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 10% increase in reimbursement rates equates to a $43 million reimbursement increase to nursing homes starting in SFY 2023-24. CPS and PASRR supplemental payments will increase by $5.75 million with a corresponding $5.75 million decrease to other supplemental payments.

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

   The state funding obligation is approximately $21.5 million per SFY. Additional costs include an increased administrative burden on Department staff for the implementation of these changes.

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

   The benefit of the proposed rule includes additional reimbursement to nursing homes. The cost of the proposed rule is the additional administrative burden on

Department staff to implement these changes. The cost of the proposed rule also includes an increased state funding obligation.

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 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 (a) of this paragraph (1).

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 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 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~~37. "Statewide average per diem rate" means the average per diem rate for all Medicaid-participating nursing facility providers in the state.

~~39~~38. "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~~39. "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 PROVIDER REIMBURSEMENT

8.443.1.B CLASS 1 NURSING FACILITY PROVIDER REIMBURSEMENT

i. ~~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.

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

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

~~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 the sum of the following per diem rates:

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

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

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

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

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

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

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

8.443.6 CASE MIX ADJUSTMENTS

8.443.6.A. ~~The resource utilization group–III (RUG-III) 34 category, index maximizer model, version 5.12b, as published by the Centers for Medicare and Medicaid Services (CMS), the resource utilization group–III (RUG-III) 34 category, index maximizer model, version 5.12b is hereby incorporated by reference. The incorporation of RUG-III 34 category, index maximizer model, version 5.12b excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.~~A resident's case mix index shall be determined using a case mix classification system. The case mix classification system shall be maintained through public postings on the Department's website. The ~~Department may update the~~ case mix classification system~~methodology~~ may be updated to reflect advances in resident assessment or classification subject to federal requirements.

8.443.6.B. A resident's case mix index shall be determined on a Quarterly basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.443.10 COGNITIVE PERFORMANCE SCALE, PREADMISSION SCREENING AND RESIDENT REVIEW II, AND MEDICAID UTILIZATION SUPPLEMENTAL PAYMENTS

8.443.10.A COGNITIVE PERFORMANCE SCALE SUPPLEMENTAL PAYMENT

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

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~~ two percent of the statewide average ~~MMIS~~ July 1 Core Component 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 Department utilized case mix ~~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.

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.

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 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).

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

2. Medicaid PASRR II days shall equal the count of PASRR II residents on May 1, multiplied by the days in the year.

3. The PASRR II per diem rate shall equal ~~two~~ four percent of the statewide July 1~~MMIS~~ Core Component per diem ~~reimbursement~~ rate ~~as described Section 8.443.1.B~~.

4. The Department shall pay an additional PA~~S~~SRR 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 reintegration.

5. 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.

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