COLORADO
Department of Health Care
Policy & Financing
1570 Grant Street
Denver, CO 80203

Nov. 1, 2022

The Honorable Julie McCluskie, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative McCluskie:

Enclosed please find the Department of Health Care Policy & Financing's Nursing Facility Reimbursement Recommendations Report to the Joint Budget Committee. Required by HB 22-1247, the Department must make recommendations to the Joint Budget Committee, the Health and Human Services Committee of the Senate and the Public and Behavioral Health and Human Services Committee of the House concerning suggested actions for permanently changing Medicaid nursing facility provider reimbursement policy in Colorado to prioritize quality, sustainability, and sound fiscal stewardship to avoid further one-time cash infusions.

This report includes recommendations that bridge the gap between costs and payments. These recommendations address a mixture of short-term challenges (such as labor shortages and associated costs), medium-term challenges (such as increasing access to behavioral health and rural sustainability), as well as long-term challenges (such as transformative changes to nursing facility infrastructure). The report also provides high level information about how Colorado Medicaid reimbursement currently works, a review of how recent changes in consumer choices, the labor market, and COVID-19 have created challenges for nursing facilities, and recommendations on how the state may navigate these challenges.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

cc: Senator Chris Hansen, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Noah Strayer, Budget Analyst, Office of State Planning and Budgeting
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Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Nov. 1, 2022

The Honorable Rhonda Fields, Chair
Senate Health and Human Services Committee
200 E Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

Enclosed please find the Department of Health Care Policy & Financing's Nursing Facility Reimbursement Recommendations Report to the Joint Budget Committee. Required by HB 22-1247, the Department must make recommendations to the Joint Budget Committee, the Health and Human Services Committee of the Senate and the Public and Behavioral Health and Human Services Committee of the House concerning suggested actions for permanently changing Medicaid nursing facility provider reimbursement policy in Colorado to prioritize quality, sustainability, and sound fiscal stewardship to avoid further one-time cash infusions.

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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

cc: Senator Joann Ginal, Vice Chair, Health and Human Services Committee
Senator Janet Buckner, Health and Human Services Committee
Senator Sonya Jaquez Lewis, Health and Human Services Committee
Senator Barbara Kirkmeyer, Health and Human Services Committee
Senator Cleave Simpson, Health and Human Services Committee
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COLORADO
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Nov. 1, 2022

The Honorable Dafna Michaelson Jenet, Chair
House Public & Behavioral Health & Human Services Committee
200 E Colfax Avenue
Denver, CO 80203

Dear Representative Michaelson Jenet:

Enclosed please find the Department of Health Care Policy & Financing's Nursing Facility Reimbursement Recommendations Report to the Joint Budget Committee. Required by HB 22-1247, the Department must make recommendations to the Joint Budget Committee, the Health and Human Services Committee of the Senate and the Public and Behavioral Health and Human Services Committee of the House concerning suggested actions for permanently changing Medicaid nursing facility provider reimbursement policy in Colorado to prioritize quality, sustainability, and sound fiscal stewardship to avoid further one-time cash infusions.

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If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

cc: Representative Emily Sirota, Vice Chair, House Public & Behavioral Health & Human Services Committee
Representative Judy Amabile, House Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, House Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, House Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, House Public & Behavioral Health & Human Services Committee
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Nursing Facility Reimbursement Recommendations Report

Nov. 1, 2022

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Executive Summary

House Bill (H.B.) 22-1247 directed the Department of Health Care Policy & Financing (the Department) to meet with nursing facility stakeholders and suggest permanent changes to nursing facility reimbursement that "prioritize quality, sustainability and sound financial stewardship." The Department is pleased to share the following findings:

- Nursing facility costs outpaced the statutory limit on rate growth in recent years;
- The primary causes of this cost increase are labor shortages and wage growth;
- Facilities with disproportionately high Medicaid member utilization are more likely to be facing financial hardship;
- As more people are served in their homes, the nursing facility population increasingly comprises high-need or complex need populations including behavioral health, mental health, or cognitive need populations; and
- Continual analysis around performance-based payments is needed to further incentivize top performing facilities.

Following stakeholder feedback sessions, the Department reviewed financial statements, cost report data, wage records, occupancy data, acuity measures, federal initiatives, academic reports, and other state funding models. The following recommendations are based on that review process:

1. The rate of nursing facility reimbursement growth should be increased in SFY 2023-24;
2. Any short-term increase in funding should include targeted funding to high Medicaid utilizers;
3. Colorado should require greater transparency in ownership and financial practices;
4. Nursing facility admissions from the Department of Corrections (DOC) should be incentivized;
5. The Department should continue to work with stakeholders, sister agencies, and federal partners to allow nursing facilities to diversify service delivery options, including identifying and removing regulatory and licensing barriers;
6. Funding for existing performance-based payments should be recalculated to a higher percentage of total reimbursement;
7. Funding for existing behavioral health and complex needs payments should be recalculated to a higher percentage of total reimbursement;
8. By removing duplicate reimbursement created by the inclusion of Medicare costs in Medicaid rate setting, the Department can create a more equitable reimbursement model;

9. The Department should increase payments to rural nursing facilities to make the reimbursement mechanism equitable between all Colorado Medicaid facilities;
10. Provider fee revenues and payments should be maximized when the Taxpayer Bill of Rights (TABOR) limitations allow;
11. Across-the-board rate increases should be removed from statute to align with all other Medicaid provider rate increases that are appropriated through the General Assembly;
12. The Department should continue work on developing rate adjustments for facilities that focus on innovation or single room occupancy;
13. Existing value-based payment programs should be further incentivized; and
14. A payment withholding program should be implemented to offer reimbursement based on outcomes.

The conclusion from the work outlined above is that immediate stabilization must be achieved for any medium-term and long-term transformational efforts to be successful. As such, the Department has outlined these recommendations into sections that clearly show short-term pathways toward improving stability, medium-term pathways to increase efficiency, and long-term pathways to evolve the reimbursement structure. However, before going into detail concerning the recommendations outlined herein, introduction and background sections have been included to summarize how the state of Colorado has arrived at the situation as it stands today and how the reimbursement structure currently works, respectively.

Introduction

Colorado's nursing facility reimbursement methodology is uniquely outlined in statute and, in most years, has required an annual 3.0% reimbursement rate increase.[1] For over a decade, this methodology has largely financially benefited the nursing facility industry, guaranteeing a year-over-year increase, while other providers' rate increases depend on an annual appropriation from the General Assembly. However, the COVID-19 pandemic increased labor costs as well as the complexity of the resident population, resulting in costs that have outpaced the statutory reimbursement increase. To support the health, safety, and welfare of Colorado's nursing facility residents and the solvency of Colorado nursing facilities, the state has infused a total of $71 million to nursing facilities through six separate one-time payments over the last two years.

The most recent one-time payment was authorized in H.B. 22-1247, which was signed into law on April 25, 2022. The bill provided $27 million in enhanced payments to nursing facilities targeting staffing costs, supporting facilities with high Medicaid utilization, those that serve a high percentage of individuals with complex needs, and increasing nursing facility capacity to accept individuals from hospitals who require a step-down level of care. Additionally, the bill required the Department to meet with community stakeholders to draft a report concerning "suggested changes for permanently changing Medicaid nursing facility provider reimbursement to prioritize quality, sustainability, and sound fiscal stewardship to avoid further one-time cash infusions."

This report includes recommendations that, if implemented, will result in improved financial stability for Colorado nursing facilities, while also creating the fiscal and policy infrastructure to generate long-term transformational change. These recommendations address a mixture of short-term challenges (such as labor shortages and associated costs), medium-term challenges (such as increasing access to behavioral health care and rural sustainability), as well as long-term challenges (such as transitioning to smaller more individualized models of care aimed at serving Coloradans with the most complex needs). The report also provides foundational information about how Colorado Medicaid reimbursement currently works, a review of how recent changes in consumer choices, the labor market, and COVID-19 have created challenges for nursing facilities, and recommendations for how the state may approach navigating these challenges.

In developing the recommendations for this report, the Department:

- Passed and implemented regulation requiring quarterly financial reporting from all Medicaid nursing facilities in the state and their associated ownership entities;

[1] H.B. 20-1362 limited SFY 2019-20 and SFY 20-21 reimbursement rate increases to 2.0%. See Table 2 in Appendix A - Data Tables.

- Reviewed nursing facility cost report data collected between 2014 and 2021 to analyze changes in expenses related to labor, food, and other costs;
- Reviewed Medicaid and Medicare utilization;
- Studied solutions recently proposed and implemented in other states as well as goals and proposed actions being evaluated at the federal level;
- Conducted broad stakeholder outreach collecting potential solutions to recent challenges;
- Convened a small group of external stakeholders to evaluate the feasibility of the proposed solutions; and
- Evaluated factors that impact nursing facility sustainability, such as occupancy, Medicaid volume, payer source mix, and geographic location.

Background

To better understand how nursing facility reimbursement has progressed over the last decade, the Department reviewed wage and cost data from state fiscal year (SFY) 2013-14 through SFY 2020-21. This review confirmed that nursing facilities are experiencing cost pressure at a time when their revenues are in decline. The methodology for nursing facility reimbursement is outlined in statute and requires a 3.0% rate cap in most years. Despite the year-over-year reimbursement rate increases, Medicaid reimbursement has not kept pace with costs experienced by nursing facilities since SFY 2019-20. Costs have increased primarily due to increases in labor-related health care costs and other associated operational costs due to the COVID-19 pandemic. Supplemental payments, conversely, have decreased during this period due to decreases in the length of stay and overall number of individuals receiving care in SFY 2022-23.

Reimbursement Methodology

Established at C.R.S. 25.5-6-202, nursing facility reimbursement is based on an annually readjusted per diem rate for allowable costs related to providing daily services to Medicaid residents. The per diem rate includes costs for health care services, administrative and general services, and fair rental value for capital-related assets. The sum of these three components constitutes the core components rate.

Reimbursement for the core components rate is made primarily through the Medicaid reimbursement rate for claims billed and adjudicated through the Medicaid Management Information System (MMIS). Every nursing facility is reimbursed the same portion of their core components rate through this mechanism. The remaining portion of the core components rate is included in the calculation of a nursing facility's monthly supplemental payment.

The Medicaid claims reimbursement rate increases annually using the established General Fund growth cap. In most years, the General Fund growth cap is statutorily set at up to 3.0%. For most of the last decade, increases in the Medicaid claims reimbursement rate have generally coincided with increases in the core components rate. Prior to SFY 2019-20, nursing facilities' Medicaid claims reimbursement rates were on average 92% of the core components rate.[2]

Starting in SFY 2019-20, annual growth in the average facility's core components rate began increasing at a greater amount compared to the annual increase in the Medicaid claims reimbursement rate. For the first time in over a decade, the prescriptive reimbursement methodology no longer benefited most nursing facilities, and, in fact, created financial challenges

[2] See Table 2 in Appendix A - Data Tables.

for many; most notably for those facilities with a high census of Medicaid members. See Figure 1 below.

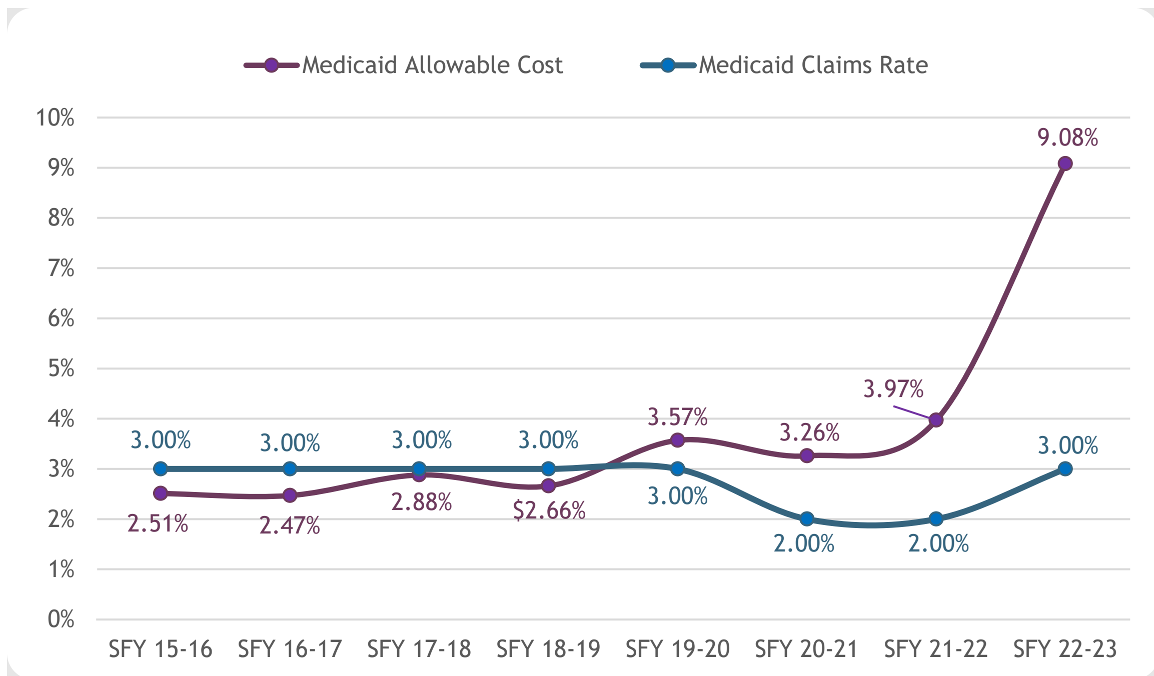

Figure 1. Comparison of Medicaid allowable cost versus Medicaid reimbursement rate

Nursing Facility rates have historically been priced at approximately 92.5% of the statutory definition of cost with the remainder factored into the supplemental payments calculation.[3] The recent increase in costs has produced a shortfall against this benchmark.

[3] The Department notes that Medicaid claims reimbursement rates set to 100% of Medicaid allowable cost should not be the goal as the calculation of cost includes items that are already reimbursed by other health care payers (i.e., Medicare expenses), additional funding for a portion of difference is distributed through monthly supplemental payments, and 100% of costs is not the standard across other long-term services and supports providers.

Labor Related Health Care Costs

From SFY 2018-19 to SFY 2022-23, core components rates have increased approximately 21%. This increase is due primarily to labor-related health care costs as the dependency on temporary staffing has increased. Labor shortages continue to affect nursing facilities, and result in staffing hours for temporary staff tripling since cost report year end (CRYE) 2017. This causes an increase in labor cost as hourly rates for temporary staff far exceed rates for permanent staff.

In CRYE 2021, rates for permanent certified nursing assistants (CNAs) were on average $18 per hour compared to $52 per hour for temporary CNAs.[4] The average hourly rates for temporary CNAs are almost three times that of permanent CNAs. This increased cost is compounded by an increasing dependency on the usage of temporary workforce. Figure 2 shows how much the staffing hours have increased for temporary registered nurses (RNs), licensed practical nurses (LPNs), directors of nursing (DONs), and CNAs for the period cost report year CRYE 2017 through CRYE 2021.[5]

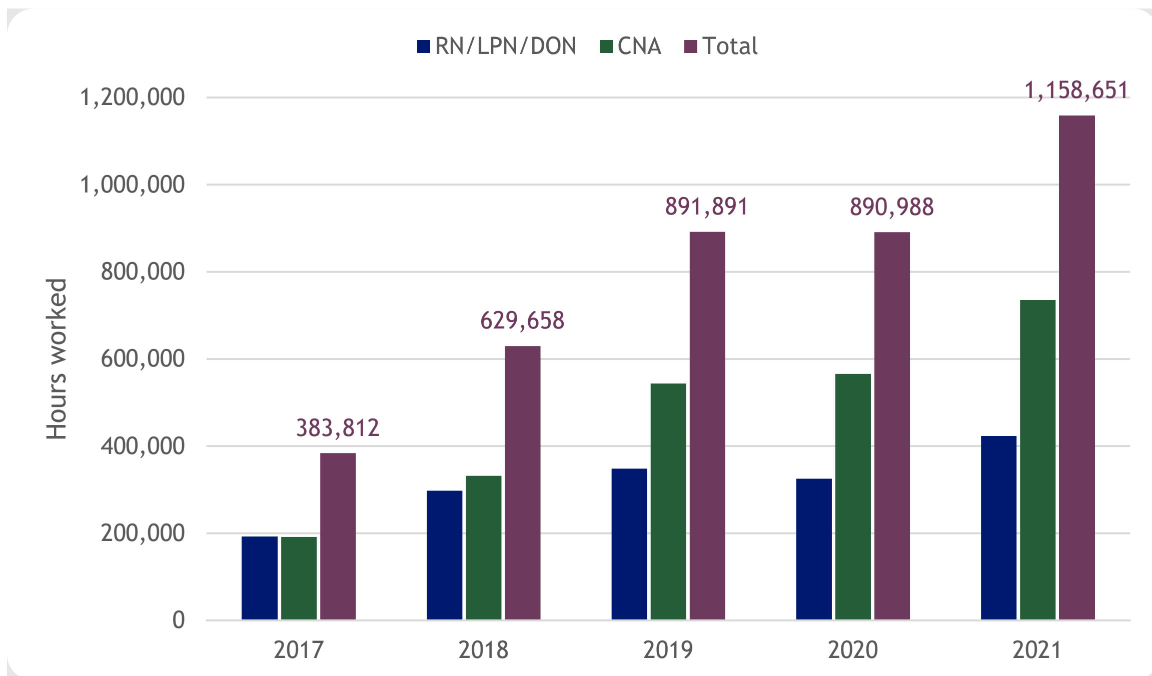

Figure 2. Temporary staffing hours by cost report year

[4] See Table 3 in Appendix A - Data Tables.
[5] From the Medicaid cost report.

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Impact on Supplemental Payments

Nursing facilities are also reimbursed through supplemental payments for services that result in better care and higher quality of life for residents, care rendered to Medicaid residents with behavioral and complex needs, and the portion of the core components rate not included with the Medicaid claims reimbursement rate.

Pursuant to C.R.S. 25.5-6-203, nursing facility supplemental payments are funded using provider fees and matching federal funds. When provider fees are insufficient to fully fund supplemental payments, supplemental payments are reduced following an established funding hierarchy.[6] Provider fees have been insufficient to fully fund supplemental payments every year over the last decade as a result of a statutory limitation on any increases to the provider fee.

From SFY 2014-15 to SFY 2019-20, 88% of total calculated supplemental payments were paid to nursing facilities due to the funding limitations. Since then, total calculated supplemental payments have increased due to increases in Medicaid cost. Conversely, available provider fees have decreased due to a decrease in non-Medicare patient days.[7] The consequence of this is only 51% of total calculated supplemental payments were funded in SFY 2022-23, leaving 49% of the total calculated supplemental payment unfunded. Figure 3 shows the percent of total calculated supplemental payments that were actually paid to nursing facilities and the percent that went unexpended.

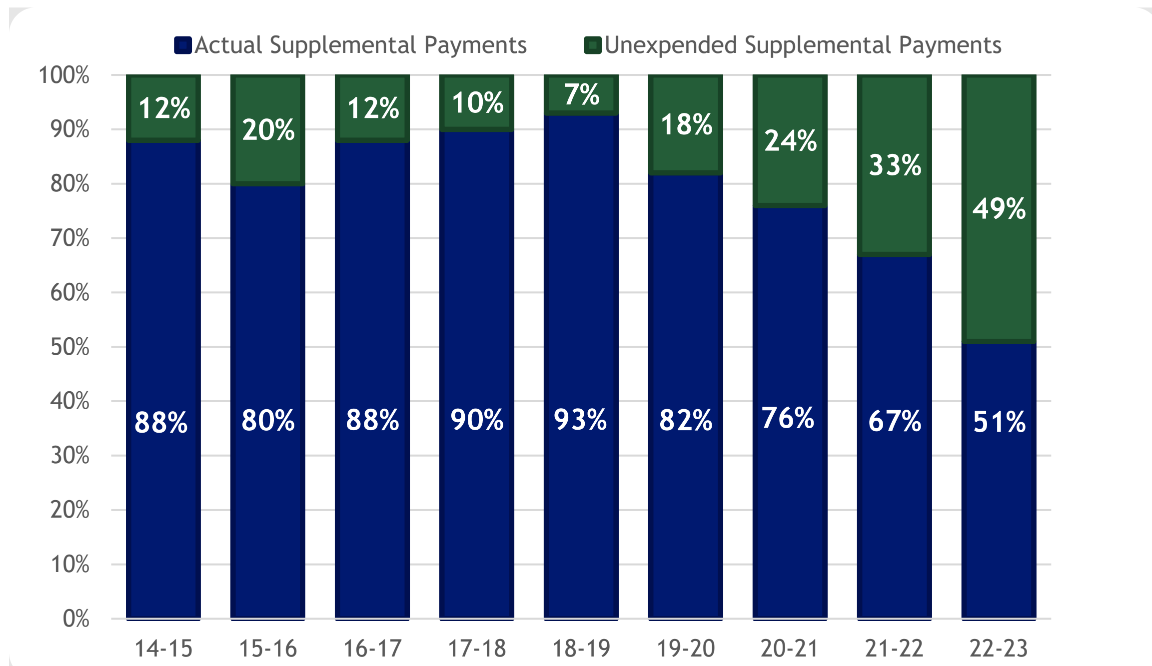

Figure 3. Percent of total calculated supplemental payments paid to nursing facilities by state fiscal year

[6] See Table 4 in Appendix A - Data Tables.
[7] Provider fees are calculated using non-Medicare patient days and not total nursing facility patient days. Non-Medicare patient days equal total patient days minus Medicare patient days.

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Summary

Costs have increased for nursing facilities over the last few years due to labor shortages and the COVID-19 pandemic. However, reimbursement is statutorily limited and unable to keep up with increases in cost. There have been six infusions of funds appropriated by the General Assembly, including three COVID-19 relief supplemental payments, the H.B. 22-2147 supplemental payments that occurred in April 2022, and two appropriations related to state and local minimum wage adjustments (H.B. 19-1210 and H.B. 22-1333). These payments did not address the underlying issues afflicting nursing facilities.

H.B. 22-1247 directed the Department to prioritize "quality, sustainability, and sound fiscal stewardship to avoid further one-time cash infusions." The Department believes there should be a focus on stabilizing nursing facility solvency while pursuing meaningful changes to prioritize quality and flexibilities to allow for innovation. For this reason, the Department recommends that any revision to reimbursement pursued by the General Assembly must address solvency and stability while nursing facilities recover from the impacts of COVID-19. However, any revisions should also ensure that future nursing facility reimbursement achieves a more proactive focus on quality, infection control, and person-centered outcomes.

Recommendations

Changes in the Medicaid reimbursement methodology should be utilized to improve nursing facility stability, quality, and health outcomes, and should occur in a phased approach over time as financial consistency and workforce availability improves. Recommendations are organized into short-term, medium-term, and long-term recommendations.

Short-Term Recommendations (Improve Stability)

The short-term need that emerged from the Department's analysis - and confirmed by stakeholders - is funding to address challenges related to financial stability and staffing costs. The fiscal instability and staffing challenges experienced by nursing facilities present a potential health and safety risk that must be addressed to ensure success with the medium- and long-term recommendations in this report.

Starting in 2008, the reimbursement methodology for Medicaid nursing facility rates was set in Colorado state statute, allowing for an annual 3.0% growth rate. This largely benefited nursing facility providers up until SFY 2019-20, when the rate of wage growth created a financial shortfall that cannot be addressed without statute change. The Department recommends a larger rate increase in FY 2023-24 than the annual 3.0% growth rate and correcting the challenges associated with the statutorily defined and inflexible reimbursement rate growth provision by reverting this

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decision to annual budget requests. This is the standard by which every other Medicaid provider adheres.

The existing rate setting methodology provides multiple options for distributing additional funds appropriated for the purposes of improving stability and the ability to retain staff. In the short-term, the Department recommends pursuing the following coordinated actions:

1. **Increase the annual statewide average growth rate for a limited period**

   This first recommendation would allow for a fast and simple solution to distribute funding and would be an across-the-board increase to nursing facilities effective July 1, 2023. The Department's analysis indicates that increases in labor costs have outpaced rate growth and recommends a rate adjustment to factor in this trend. Further discussion is provided in Appendix B - Short Term Recommendations.

   Additionally, any rate adjustment should require that a substantial portion be directed toward workforce development and wages. Federal partners have signaled that potential regulation surrounding safe and consistent staffing levels may be imminent. To ensure access to sufficient staffing, nursing facilities need to train and retain their workforce.

2. **Supplemental funding for high Medicaid utilizing nursing facilities**

   This second recommendation would allow the Department to target reimbursement based on a facility's financial need. Specifically, the Department's analysis of nursing facility financial data reveals high Medicaid utilization as a common factor amongst struggling facilities. This is related to the inability to offset low Medicaid claims reimbursement rates with higher Medicare, managed care, or private pay options. The existing reimbursement methodology can be amended to provide additional support for facilities that provide greater access to Medicaid members. Further discussion is provided in Appendix B - Short Term Recommendations.

Furthermore, the Department identified short-term recommendations with no fiscal impact:

3. **Require greater transparency in ownership and business practices**

   Nursing facility ownership practices have been identified as an additional factor related to resident health and safety as well as an impairment to informed consumer choice. Ownership by limited liability corporations (LLCs), trusts, and investment firms often masks the relationship between all parties involved with the day-to-day operations of a nursing facility. This impairs the ability of the Department and consumers to clearly identify facilities owned by entities associated with unsafe practices or concerning fiscal situations.

The Department has begun analysis on financial statements for Medicaid nursing facilities and associated management companies; however, further requirements should be established to identify more transparency in ownership and service delivery practices for nursing facilities. This issue has been raised as a concern by the Congressional Select Subcommittee on the Coronavirus Crisis and the National Academies of Sciences, Engineering, and Medicine in 2022.[8,9] As a part of any bill targeting nursing facility stability and funding, the legislature can empower the Department - and its sister agencies - with a greater ability to collect and publish ownership records so that consumers can make informed choices. This should include at a minimum:

a. Allowing the Department to collect financial transparency documents in perpetuity.
b. Allowing the scope of this collection to include details on transactions, identification of dividends, and corporate or management company fee collection.
c. Disclosure of shared ownership interest in any business transaction conducted by a nursing facility that receives state funding.

4. Incentivize admissions from the Department of Corrections

The Department was additionally tasked with identifying "practices regarding care and services to compassionate release of individuals from the Department of Corrections." The Department has engaged with providers, the Department of Corrections, and the Centers for Medicare and Medicaid Services (CMS) regarding revisions to payment policies and believes existing authority will allow the creation of better incentives for this population plus those individuals who have completed their sentences. Work is underway to identify interested providers and appropriate reimbursement. This program may be launched by the end of SFY 2022-23.

5. Resolve licensing barriers to allow diversified funding options

Nursing facility providers have deep and valuable expertise in serving people 65 and older and people with disabilities. As more Coloradans choose to receive their long-term care in the community, nursing facility providers should consider developing business models that expand their long-term care delivery capabilities in order to diversify their revenue stream while partnering with other health care providers to share operational functions and costs where appropriate, thereby reducing their administrative and overhead costs. The

[8] https://coronavirus.house.gov/news/press-releases/chairman-clyburn-s-opening-statement-hearing-examining-long-term-care-america
[9] https://www.nationalacademies.org/our-work/the-quality-of-care-in-nursing-homes

Department met with stakeholders regarding challenges and opportunities related to diversified service lines and revenue streams beyond nursing facility care. The Department recommends nursing facility organizations consider diversification of their business lines in areas including, but not limited to, the following:

1. Assisted living services, including serving more complex individuals;
2. Home and Community-Based Services (HCBS) provision, including services in the community and adult day services;
3. Child care licensing and provision for the nursing facility workforce;
4. Establishing partnerships with rural hospitals; and
5. Utilization of excess space and/or land.

While providers expressed interest in the provision of other services, licensing barriers currently impede the ability to move forward without construction remodeling. In the short-term, the Department will work with sister agencies and CMS to investigate potential regulatory solutions where they may exist and make further recommendations when solutions can be identified.

Medium-Term Recommendations (Increase Efficiency and Equality)

Additionally, the Department reviewed existing reimbursement policy to identify opportunities that improve the efficiency of current reimbursement. There was a particular focus on improving the quality of life and care provided to residents with behavioral health or complex needs. The Department identified opportunities to address duplicative and inequitable payments. The recommendations in this section do not impact aggregate reimbursement, but instead offer insight as to the possible redirection of existing funding.

6. Increase Pay for Performance Supplemental Payments

The Pay for Performance supplemental payment reimburses nursing facilities for services that result in better care and higher quality of life for residents. It is a nationally recognized payment model continuing to push standards over the last decade. However, such payments made to nursing facilities have remained relatively flat despite increasing costs.

The Pay for Performance supplemental payment calculation methodology has not changed since its implementation in SFY 2008-09. Pay for Performance supplemental payments have experienced negligible increases while total supplemental payments increased almost 30%.[10]

[10] See in Appendix A - Data Tables.

This has limited the payment's efficacy over the last decade. Nursing facilities have cited that the workload is not worth the additional reimbursement, resulting in limited or nonparticipation. Increasing the Pay for Performance supplemental payment can increase reimbursement commensurate with the work required, potentially increasing participation and the performance scores of currently participating nursing facilities.

7. **Increase behavioral health and complex needs payments**

The Department's data suggests that as more people 65 and older receive services within their home and the community, the acuity of nursing facility populations is increasing, most notably in the areas of behavioral health and cognitive and complex needs. The Department recommends that its reimbursement strategy should adjust to this trend, recognizing the additional staff and supports (and therefore cost) necessary to care for these higher acuity residents.

The Preadmission Screening and Resident Review (PASRR) II supplemental payment and the Cognitive Performance Scale (CPS) supplemental payment reimburse nursing facilities for care to residents with behavioral health and complex needs. Both payments currently deliver limited reimbursement to nursing facilities that provide care to these residents. The SFY 2022-23 average CPS supplemental payment per CPS resident equaled $916 per year and the average PASRR II supplemental payment per PASRR II resident totaled approximately $1,800 per year. Any nursing facility that is part of an approved specialized behavioral services (SBS) program receives an additional payment equal to the PASRR II supplemental payment, thereby doubling the PASRR II supplemental payment.[11]

Currently, 77% of Medicaid nursing facilities qualify for the PASRR supplemental payment and only 13% quality for the CPS supplemental payment. The financial incentive for nursing facilities is not sufficient for these payments, limiting the number of facilities that have sufficient resources to care for residents with behavioral health and complex needs, causing a backlog of patients at hospitals. There is also concern that few nursing facilities will accept residents with behavioral health and complex needs if a nursing facility that serves this population closes. Increasing the PASRR II and CPS supplemental payments can increase reimbursement more proportionate to cost, potentially increasing nursing facility participation and reducing the current limited concentration of nursing facilities providing care to residents with behavioral health and complex needs.

[11] See Table 7 in Appendix A - Data Tables.

8. Remove Medicare costs from Medicaid reimbursement

Medicare Part A costs are an allowable cost included in nursing facility Medicaid reimbursement. C.R.S. 25.5-6-202(9)(c)(II) states nursing facilities “may include the level of Medicare Part A ancillary costs that was included and allowed in the facility’s last Medicaid cost report filed prior to July 1, 1997.” Allowing these costs to be reported on the Medicaid cost report creates two issues. First, nursing facilities are reimbursed for the same costs by both Medicare and Medicaid. Secondly, this creates an inequitable effect on Medicaid reimbursement for nursing facility care between rural and urban facilities as well as between old and new facilities.

Cost reports from 1996 were used to establish a cap on Medicare expenses for Medicaid cost reports. This cap is unique to each nursing facility. Current Medicare utilization does not typically reflect levels experienced in 1996. Some nursing facility caps result in 100% of their Medicare Part A costs included in Medicaid reimbursement. Conversely, some nursing facility caps are low, resulting in a limited portion of their Medicare Part A costs included in Medicaid reimbursement. In addition, there is uneven distribution of Medicare utilization across nursing facilities. The result is nursing facilities with greater Medicare caps and utilization receive increased Medicaid reimbursement, which is offset with decreased Medicaid reimbursement for nursing facilities with smaller Medicare caps and utilization. No other state has been identified that allows for Medicare costs to be reported on Medicaid cost reports.

The Department recommends removing Medicare Part A costs from Medicaid reimbursement to remove that inequity. Aggregate nursing facility Medicaid reimbursement would not change with the removal of Medicare Part A costs. Instead, Medicaid reimbursement would rebalance across the state. Nursing facilities with high Medicare costs would experience a decrease in Medicaid reimbursement and nursing facilities with low Medicare costs would experience an increase in Medicaid reimbursement. This change would not impact federal payments, would remove the potential for reimbursement from both Medicaid and Medicare for the same Medicare costs, and reinvest savings into facilities that serve Medicaid populations.

9. Increase supplemental payments to rural nursing facilities

Nursing facility supplemental payments and provider fees inequitably reimburse urban fee-paying nursing facilities compared to rural fee-paying nursing facilities on a per day basis. Since SFY 2018-19, average supplemental payments for urban fee-paying nursing facilities have been more than rural fee-paying nursing facilities. Rural nursing facilities do not have

the same resources to receive the quality and behavioral health supplemental payments that urban nursing facilities receive. While urban fee-paying nursing facilities receive greater supplemental payments, they also pay on average slightly less in provider fees because some urban fee-paying nursing facilities are assessed a discounted per diem fee.

Thus, there exists an inequity, as urban fee-paying nursing facilities receive on average $1.80 in supplemental payments for every $1.00 in provider fees while rural fee-paying nursing facilities receive on average $1.65 in supplemental payments for every $1.00 in provider fees. The difference equates to $750,000 annually, approximately 10% less in net reimbursement for rural fee-paying nursing facilities. Any further increase in supplemental payments or provider fees will only increase this difference. To address this inequity, the Department recommends that revisions be made to the Medicaid utilization supplemental payment so that rural fee-paying nursing facility supplemental payments are commensurate with urban fee-paying nursing facility supplemental payments on a per day basis.

10. Maximize provider fees when TABOR limitations allow

Implementing any of the listed recommendations in this section will not change aggregate nursing facility reimbursement. Instead, the recommendations will transfer a greater portion of reimbursement to outcome-based and behavioral health and complex needs supplemental payments, while also reducing identified reimbursement inequalities. Provider fees for supplemental payments are limited in statute. Any change that increases supplemental payments to some nursing facilities, decreases supplemental payments to others.

Federal regulations allow for the provider fee to equal 6% or less of net patient revenues (NPR) for all fee-paying nursing facilities. There are currently 37 state Medicaid programs that charge a provider fee on nursing facilities to fund a portion of their state share of Medicaid spending. Sixteen of those state Medicaid programs charge a provider fee equal to or greater than 5.5% of NPR.[12] To help address the separation between provider fee funds and supplemental payment reimbursement previously discussed, statute can be revised to allow nursing facility provider fees to be charged up to the allowable federal NPR limit, which will allow the Department to increase total supplemental payments up to the federal upper payment limit if fees are sufficient to do so.

The Department estimates that an additional $20 million in provider fees can be collected, resulting in a supplemental payment increase of $40 million (a $20 million increase in net reimbursement). Increased supplemental payments can be used to either fund the medium-

[12] From the Kaiser Family Foundation (KFF).

term recommendations listed above or to reimburse a portion of total calculated supplemental payments not currently reimbursed to nursing facilities due to the limited provider fees. Further analysis is available in Appendix D - Maximize Provider Fee.

The Department has identified this as a medium-term recommendation due to limitations imposed by TABOR. Nursing facility provider fees are TABOR non-exempt and count as TABOR revenue to the state and additional nursing facility fees collected will increase TABOR revenue. When the state is above the TABOR revenue limit, as it is currently, additional nursing facility fees would increase taxpayer TABOR refunds paid from the General Fund. Unless the nursing facility provider fee gains a TABOR exemption, this action would yield no net benefit to the state's spending power when TABOR revenue limits are exceeded.

The Department recommends legislative action to increase nursing facility provider fees to the federal limit when TABOR limitations allow.

11. Remove fixed across-the-board annual rate increases

Nursing facility rates established by statute have created a fixed rate of growth regardless of economic indicators or budget availability. While this has created comfort and stability for providers in years of slow economic growth, it simultaneously created instability in years of cost and wage growth. Furthermore, the fixed reimbursement rate growth has created a situation in which the state has had limited options in responding to the COVID-19 pandemic and the subsequent post-pandemic financial impacts.

In 2021, rapidly increasing wages contributed to nursing facility financial woes requiring state legislation via H.B. 22-1247 to provide enhanced financial support. In 2022, Colorado had funding readily available to incentivize vaccine boosters for nursing facility residents and staff members; however, the statutorily mandated formula for reimbursement prevented this plan from occurring in the most financially efficient way.

Colorado can drive innovation through revisions to nursing facility reimbursement. Nursing facility Medicaid rate changes can be based on current economic indicators and budget availability, as is the case for every other Medicaid provider. Alternatively, the state can better direct this funding toward recommendations and innovations that provide better health outcomes, behavioral and mental health supports, promote dignity amongst residents, and ensure facilities are best equipped to combat infection-related illnesses ranging from future pandemics to seasonal flus.

After stability, efficiency, and equality measures are implemented, the Department recommends the state transition to a payment system that no longer provides across the board increases. Future payment increases should be tied to or diverted toward:

a. Facilities that provide better health outcomes,
b. Facility and care model redesigns,
c. Stable and consistent staffing practices, and
d. Serving individuals with behavioral health and complex needs.

Long-Term Recommendations (Evolve Reimbursement Structure)

To effect permanent change, Colorado must modify the structure and incentives associated with how facilities are reimbursed. Medicaid is the dominant payer of nursing facility care and therefore has the greatest leverage in promoting outcomes. While the Department asserts that the limited nature of statewide funds cannot simultaneously provide stability while promoting innovation, more changes to the reimbursement structure should be taken in the next three to five years.

12. Establish a method to fund private room nursing facilities

Stakeholders identified funding for private rooms as perhaps the single most effective action the state could take toward modernizing nursing facility models of care. Private room facilities inherently have better infection control outcomes, better serve individuals with behavioral health needs or severe mental illness, promote dignity and person-centered care standards, and make Medicaid facilities more marketable to individuals with non-Medicaid pay sources. Additionally, such a change would allow Medicaid members greater access to the standard of care already established in most non-Medicaid and private nursing facilities throughout the state. In response to COVID-19 outcomes, CMS has signaled that reducing room occupancy is a federal goal and has asked all states to review options to provide for private room rates in Medicaid facilities.

This option would likely carry a substantial cost when viewed from a per patient per day standpoint because facilities would have to reduce the number of licensed beds to achieve this goal. There are facilities - particularly in rural settings - that are currently operating at sub 50% capacity. For these facilities, the cost of remodels or renovations would be significant, but revenue would not be sacrificed as the demand for additional services does not exist.

The Department spoke with nursing facilities that have mixed private/semi-private rooms and found that the typical premium for a private room results in an increase of 15-25% in per

diem costs. This suggests that incentivizing this change is in reach and would not double the per person cost. This increase in costs is due to smaller facilities having less overhead, staffing, and food needs.

The Department believes that implementing a private room incentive would drive change amongst providers committed to health outcomes and best practices. Currently there are six Medicaid providers in the state that operate with 100% private rooms. This would serve to limit the costs imposed on the Medicaid system in the early years following implementation, but it could become significant should a large volume of providers modernize their facilities. The Department believes this should be the standard of care in the future, but additional funding analysis must be conducted to fully understand the budgetary impact.

Evidence shows that smaller, innovative, and non-traditional nursing facilities had fewer deaths and infections resulting from COVID-19.[13] The Department reviewed options for incentivizing innovative facilities (such as the Greenhouse model).[14] In evaluating these concepts, the Department found significant overlap between private room facilities and smaller or innovative facilities. Four of the six existing private room facilities would be considered smaller and innovative. Additionally, a facility under construction in La Junta would meet all three definitions. There are currently no facilities that would be characterized as smaller or innovative that do not offer 100% private rooms.

All recommendations for funding private room facilities can also target smaller or innovative facilities, but it is the view of the Department that these are in large part the same, with the private room definition capturing the largest number.

13. Further incentivize existing value-based purchasing programs

The Department would further recommend that additional emphasis on quality- or outcome-based supplemental payments be made as soon as possible. A phased approach of increasing existing value-based payments to double (short-term) and then triple (long-term) current funding levels will provide better balance to outcome- versus cost-based reimbursement goals.

Additional consideration should be made to facilities that house disproportionately high Medicaid populations. One observation shows that as Medicaid utilization rates increase, facilities tend to destabilize financially. This is believed to be related to Medicaid rates lagging Medicare and/or private rates. Providers are unable to shift costs to non-Medicaid

[13] https://www.jamda.com/article/S1525-8610%2821%2900120-1/fulltext
[14] https://thegreenhouseproject.org/

providers when Medicaid utilizations exceed a certain threshold. However, these providers serve a crucial role in the care continuum. They often provide essential access to care in areas of the state that have the greatest dependency on Medicaid. Colorado can recognize this inability to shift costs and provide additional compensation to facilities serving disproportionally high numbers of Medicaid residents.

14. Implement a payment withholding program

Following an expiration of funding increases targeting financial stability, Colorado must transition to a reimbursement system focused on transforming nursing facility models of care to meet the needs and consumer choices of today. This means facilities need to be smaller, offer private environments, and be able to offer services that are more tailored to a public that is increasingly capable of receiving services in their home and community.

Funding based on outcomes is required to move into this model of care. As noted throughout this report, Colorado has an existing value-based payment, but it makes up a small percentage of the overall funding strategy. This lack of emphasis on outcomes must be rebalanced to drive change. This can be achieved through additional supplemental payments or by redirecting current rate increases to outcome-based payments until a better balance of outcome-based payments is achieved.

This is not an unfamiliar concept. The CMS currently withholds 2% of all Medicare payments to fund federal initiatives that drive patient safety and quality outcomes. These funds are then redistributed based on quality goals. Colorado's reimbursement methodology should take steps to further emphasize health, safety, and quality outcomes as the financial health of nursing facilities improves. Withholding payment similar to Medicare could be utilized to further fund or redistribute funding to facilities that meet the performance goals of the state of Colorado.

H.B. 22-1247 Compliance and Payment Evaluation

H.B. 22-1247 directed the Department to issue three payments to nursing facilities beyond those already authorized in SFY 2021-22. The three payments are below.

1. **Workforce Enhanced Payment** – payment to support hiring new employees and increase workforce retention.
2. **Medicaid Enhanced Payment** – payment to support nursing facilities with a disproportionate share of Medicaid and high-needs populations.
3. **Hospital Discharge Payment** – payment to incentivize nursing facilities to accept new admissions from hospitals.

Both the Workforce Enhanced Payment and Medicaid Enhanced Payment were paid to nursing facilities in April 2022. The Workforce Enhanced Payment totaled $17,588,000. The payment was calculated based on a nursing facility's percent of statewide aggregate Medicaid days. The average payment made to all Medicaid enrolled nursing facilities was approximately $95,000. The Medicaid Enhanced Payment totaled $7,000,000. The payment was calculated based on a nursing facility having a Medicaid resident count greater than 90% of their total resident count and a PASRR II Medicaid resident count greater than the statewide average PASRR II resident count plus one standard deviation. Each of the 17 nursing facilities that were eligible for this payment received $411,765.

The Hospital Discharge Payment will total $2,413,000. The payment will be made by the end of SFY 2021-22 and will be calculated based on the number of Medicaid members discharged from a hospital that a nursing facility admitted during the period May 2022 through June 2022.Table 1 presents the Workforce Enhanced Payments and Medicaid Enhanced Payments by nursing facility.

Table 1. H.B. 22-1247 Enhanced Payments

Nursing facility	Workforce Enhanced Payment	Medicaid Enhanced Payment	Total Payment
Allison Care Center	$90,046	$0	$90,046
Amberwood Court Rehabilitation	$136,318	$0	$136,318
Arbor View	$130,502	$0	$130,502
Ardent Health and Rehabilitation Center	$94,841	$0	$94,841
Arvada Care and Rehabilitation Center	$54,171	$0	$54,171
Autumn Heights Health Care Center	$164,036	$411,765	$575,801
Avamere Transitional Care - Brighton	$59,659	$0	$59,659
Avamere Transitional Care - Malley	$124,494	$0	$124,494
Bear Creek Center	$147,663	$0	$147,663
Belmont Lodge Health Care Center	$124,082	$0	$124,082

COLORADO
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Nursing facility	Workforce Enhanced Payment	Medicaid Enhanced Payment	Total Payment
Bent County Healthcare Center	$63,725	$0	$63,725
Berkley Manor Care Center	$98,830	$0	$98,830
Berthoud Care and Rehabilitation	$78,743	$0	$78,743
Beth Israel at Shalom Park	$180,099	$0	$180,099
Bethany Nursing and Rehab Center	$210,803	$0	$210,803
Boulder Canyon Health and Rehabilitation	$147,000	$0	$147,000
Briarwood Health Care Center	$115,705	$0	$115,705
Broadview Health & Rehabilitation Center	$139,423	$411,765	$551,188
Brookshire House Rehabilitation and Care Community	$113,304	$0	$113,304
Brookside Inn	$140,223	$0	$140,223
Broomfield Skilled Nursing and Rehabilitation Center	$171,524	$0	$171,524
Bruce McCandless State Veterans Nursing facility	$26,598	$0	$26,598
Cambridge Care Center	$127,844	$411,765	$539,609
Canon Lodge Care Center	$33,964	$0	$33,964
Casey's Pond Senior Living Community	$52,559	$0	$52,559
Castle Peak Senior Life and Rehabilitation	$43,698	$0	$43,698
Castle Rock Care Center	$76,271	$0	$76,271
Cedars Healthcare Center	$123,981	$0	$123,981
Centre Avenue Health and Rehabilitation Facility	$18,159	$0	$18,159
Cherrelyn Healthcare Center	$165,905	$0	$165,905
Cherry Creek Nursing Center	$232,007	$411,765	$643,772
Cheyenne Manor	$31,803	$0	$31,803
Cheyenne Mountain Center	$202,324	$0	$202,324
Christopher House Rehabilitation and Care Community	$103,189	$411,765	$514,954
Clear Creek Care Center	$80,761	$0	$80,761
Colonial Health and Rehabilitation Center	$108,366	$0	$108,366
State Veterans Nursing facility - Fitzsimons	$22,297	$0	$22,297
State Veterans Nursing facility - Rifle	$11,250	$0	$11,250
State Veterans Nursing facility - Home lake	$12,589	$0	$12,589
Colorow Health Care	$67,135	$0	$67,135
Columbine Manor Care Center	$79,549	$0	$79,549
Columbine West Health and Rehabilitation Facility	$81,764	$0	$81,764
Cottonwood Inn Rehabilitation & Extended Care Center	$41,643	$0	$41,643
Covenant Living of Colorado	$30,913	$0	$30,913
Creekside Village Health and Rehabilitation Center	$126,578	$411,765	$538,343
Crestmoor Health and Rehabilitation Center	$134,783	$411,765	$546,548
Cripple Creek Care Center	$68,227	$0	$68,227
Crowley County Nursing Center	$35,374	$0	$35,374

Nursing facility	Workforce Enhanced Payment	Medicaid Enhanced Payment	Total Payment
Denver North Care Center	$146,487	$411,765	$558,252
Desert Willow Health and Rehabilitation Center	$106,073	$0	$106,073
Devonshire Acres	$75,918	$0	$75,918
E. Dene Moore Care Center	$58,853	$0	$58,853
Eagle Ridge at Grand Valley	$82,917	$0	$82,917
Eben Ezer Lutheran Care Center	$118,684	$0	$118,684
Elevation Health and Rehabilitation Center	$106,855	$411,765	$518,620
Elk Ridge Health and Rehabilitation Center	$63,851	$0	$63,851
Elms Haven Center	$263,003	$0	$263,003
Englewood Post Acute and Rehabilitation	$74,945	$0	$74,945
Evergreen Nursing facility	$51,812	$0	$51,812
Fairacres Manor	$152,858	$0	$152,858
Falcon Heights Health and Rehabilitation Center	$107,924	$0	$107,924
Forest Ridge Senior Living	$110,629	$0	$110,629
Forest Street Compassionate Care Center	$74,014	$0	$74,014
Fountain View Health and Rehabilitation Center	$87,270	$411,765	$499,035
Fowler Health Care	$45,041	$0	$45,041
Frasier Meadows Health Care Center	$10,712	$0	$10,712
Garden Terrace Alzheimer's Center of Excellence	$119,771	$0	$119,771
Glenwood Springs Health Care	$71,004	$0	$71,004
Golden Peaks Center	$53,610	$0	$53,610
Good Samaritan Society - Fort Collins Village	$54,231	$0	$54,231
Good Samaritan Society - Loveland Village	$83,382	$0	$83,382
Good Samaritan Society - Simla	$39,225	$0	$39,225
Grace Manor Care Center	$25,270	$0	$25,270
Gunnison Valley Health Senior Care Center	$60,023	$0	$60,023
Hallmark Nursing Center	$125,420	$0	$125,420
Harmony Pointe Nursing Center	$171,381	$0	$171,381
Health Center at Franklin Park	$62,614	$0	$62,614
Heritage Park Care Center	$53,377	$0	$53,377
Highline Rehabilitation and Care Community	$173,799	$0	$173,799
Hildebrand Care Center	$101,201	$0	$101,201
Hillcrest Care Center	$26,871	$0	$26,871
Holly Heights Care Center	$114,063	$0	$114,063
Holly Nursing Care Center	$42,450	$0	$42,450
Horizons Care Center	$38,437	$0	$38,437
Irondale Post Acute	$127,570	$0	$127,570
Julia Temple Healthcare Center	$174,336	$0	$174,336

Nursing facility	Workforce Enhanced Payment	Medicaid Enhanced Payment	Total Payment
Junction Creek Health and Rehabilitation Center	$104,180	$0	$104,180
Juniper Village - The Spearly Center	$207,626	$0	$207,626
Kiowa Hills Health and Rehabilitation Center	$75,345	$0	$75,345
La Villa Grande Care Center	$71,882	$0	$71,882
Lakewood Villa	$71,822	$0	$71,822
Lamar Estates	$27,259	$0	$27,259
Larchwood Inns	$94,334	$0	$94,334
Lemay Avenue Health and Rehabilitation Facility	$94,513	$0	$94,513
Life Care Center of Aurora	$100,657	$0	$100,657
Life Care Center of Colorado Springs	$85,353	$0	$85,353
Life Care Center of Evergreen	$79,447	$0	$79,447
Life Care Center of Greeley	$70,073	$0	$70,073
Life Care Center of Littleton	$87,807	$0	$87,807
Life Care Center of Longmont	$136,055	$0	$136,055
Life Care Center of Pueblo	$119,085	$0	$119,085
Life Care Center of Westminster	$120,589	$0	$120,589
Lincoln Community Hospital Nursing facility	$20,284	$0	$20,284
Linden Place Health and Rehabilitation Center	$121,879	$0	$121,879
Little Sisters of the Poor Mullen facility	$69,428	$0	$69,428
Littleton Care and Rehabilitation Center	$34,591	$0	$34,591
Lowry Hills Care and Rehabilitation	$112,445	$0	$112,445
Manorcare Health Services - Boulder	$74,676	$0	$74,676
Manorcare Health Services - Denver	$123,885	$0	$123,885
Mantey Heights Rehabilitation and Care Center	$71,022	$0	$71,022
Mapleton Care Center	$89,139	$0	$89,139
Medallion Post Acute Rehabilitation	$52,822	$0	$52,822
Mesa Manor Center	$60,722	$0	$60,722
Mesa Vista of Boulder	$260,937	$411,765	$672,702
Monte Vista Estates	$54,912	$0	$54,912
Mount St. Francis Nursing Center	$167,744	$0	$167,744
Mountain Vista Health Center	$127,946	$0	$127,946
Namaste Alzheimer Center	$106,826	$0	$106,826
North Shore Health and Rehabilitation Facility	$93,032	$0	$93,032
North Star Rehabilitation and Care Community	$115,538	$0	$115,538
Orchard Park Health Care Center	$150,672	$0	$150,672
Orchard Valley Health and Rehabilitation Center	$93,122	$0	$93,122
Paonia Care and Rehabilitation Center	$53,777	$0	$53,777
Park Forest Care Center	$145,907	$411,765	$557,672

Nursing facility	Workforce Enhanced Payment	Medicaid Enhanced Payment	Total Payment
Parkmoor Village Healthcare Center	$113,316	$0	$113,316
Parkview Care Center	$100,627	$0	$100,627
Pelican Pointe Health and Rehabilitation Center	$93,546	$0	$93,546
Pikes Peak Center	$223,128	$0	$223,128
Pine Ridge Extended Care Center	$56,160	$0	$56,160
Pioneer Health Care Center	$136,073	$0	$136,073
Poudre Canyon Health and Rehabilitation Center	$99,660	$0	$99,660
Progressive Care Center	$70,383	$0	$70,383
Pueblo Care and Rehabilitation Center	$123,694	$0	$123,694
Regent Park Nursing and Rehabilitation	$51,520	$0	$51,520
Rehabilitation and Nursing Center of the Rockies	$88,548	$0	$88,548
Ridgeview Post Acute	$137,458	$411,765	$549,223
Rio Grande Inn	$69,828	$0	$69,828
River Valley Inn Nursing Facility	$71,948	$0	$71,948
Riverbend Health and Rehabilitation Center	$122,637	$0	$122,637
Riverdale Rehabilitation & Care Community of Brighton	$155,545	$411,765	$567,310
Rock Canyon Respiratory and Rehabilitation Center	$125,026	$0	$125,026
Rowan Community	$103,338	$0	$103,338
San Luis Care Center	$60,525	$0	$60,525
Sandrock Ridge Care and Rehabilitation	$67,165	$0	$67,165
Sedgwick County Memorial Nursing facility	$25,802	$0	$25,802
Sharmar Village Care Center	$37,810	$0	$37,810
Sierra Rehabilitation and Care Community	$160,035	$411,765	$571,800
Skyline Ridge Nursing and Rehabilitation Center	$94,316	$0	$94,316
South Platte Health and Rehabilitation Center	$89,431	$0	$89,431
South Valley Post Acute Rehabilitation	$151,222	$411,765	$562,987
Southeast Colorado Hospital LTC Center	$75,996	$0	$75,996
Spanish Peaks Veterans Community Living Center	$18,233	$0	$18,233
Springs Village Care Center	$118,404	$0	$118,404
St. Paul Health Center	$118,816	$0	$118,816
Sterling Health and Rehabilitation Center	$70,180	$0	$70,180
Summit Rehabilitation and Care Community	$105,446	$0	$105,446
Sundance Skilled Nursing and Rehabilitation	$90,602	$0	$90,602
Sunny Vista Living Center	$110,205	$0	$110,205
The Gardens	$58,614	$0	$58,614
The Green House Homes at Mirasol	$90,894	$0	$90,894
The Katherine and Charles Hover Green Houses	$16,946	$0	$16,946
The Pavilion at Villa Pueblo	$89,509	$0	$89,509

Nursing facility	Workforce Enhanced Payment	Medicaid Enhanced Payment	Total Payment
The Peaks Care Center	$59,336	$0	$59,336
The Rehabilitation Center at Sandalwood	$72,401	$0	$72,401
The Suites at Clermont Park Care Center	$30,847	$0	$30,847
The Suites at Someren Glen Care Center	$70,067	$0	$70,067
The Suites Parker	$137,506	$0	$137,506
The Valley Inn	$85,419	$0	$85,419
The Villas at Sunny Acres	$128,716	$0	$128,716
Trinidad Inn Nursing Facility	$128,991	$0	$128,991
University Heights Rehabilitation and Care	$148,708	$0	$148,708
University Park Care Center	$189,121	$0	$189,121
Uptown Health Care Center	$151,992	$411,765	$563,757
Valley Manor Care Center	$51,938	$0	$51,938
Valley View Health Care Center	$95,635	$0	$95,635
Valley View Villa	$45,501	$0	$45,501
Villa Manor Care Center	$94,907	$0	$94,907
Vista Grande Inn	$94,692	$0	$94,692
Walbridge Memorial Convalescent Wing	$37,105	$0	$37,105
Walsh Healthcare Center	$31,964	$0	$31,964
Washington County Nursing Facility	$54,732	$0	$54,732
Western Hills Health Care Center	$115,460	$0	$115,460
Westlake Care Community	$54,320	$0	$54,320
Westlake Lodge Health and Rehabilitation Center	$72,366	$0	$72,366
Wheatridge Manor Care Center	$77,399	$0	$77,399
Willow Tree Care Center	$38,353	$0	$38,353

Appendices

Appendix A - Data Tables

Table 2. Statewide average core components rate, statewide average Medicaid claims reimbursement rate, and rate difference by state fiscal year

SFY	Core Components		Medicaid Claims Reimbursement		$ Rate Difference	% Rate Difference
	Rate	% Change	Rate	% Change		
14-15	$ 220.23	2.3.0%	$ 201.66	3.0%	$ 18.57	-
15-16	$ 225.76	2.5%	$ 208.19	3.0%	$ 17.57	9.20%
16-17	$ 231.34	2.5%	$ 214.43	3.0%	$ 16.91	7.89%
17-18	$ 238.00	2.9%	$ 220.87	3.0%	$ 17.13	7.76%
18-19	$ 244.33	2.7%	$ 227.49	3.0%	$ 16.84	7.40%
19-20	$ 253.05	3.6%	$ 234.31	3.0%	$ 18.74	8.00%
20-21	$ 261.28	3.3.0%	$ 239.00	2.0%	$ 22.28	9.32%
21-22	$ 271.66	4.0%	$ 243.79	2.0%	$ 27.87	11.43.0%
22-23	$ 296.32	9.1%	$ 251.07	3.0%	$ 46.32	18.45%

Table 3. Average hourly rates for nursing facility workers by cost report year

CRYE	DON/ RN	LPN	Temp DON/RN /LPN	CNA	Temp CNA	Total	Total (non-Temp)
2017	$ 33.79	$ 26.79	$ 72.29	$ 15.53	$ 32.28	$ 21.85	$ 21.31
2018	$ 35.45	$ 28.03	$ 70.81	$ 16.72	$ 34.92	$ 23.60	$ 22.72
2019	$ 38.19	$ 28.19	$ 77.68	$ 16.84	$ 37.95	$ 24.59	$ 23.31
2020	$ 40.12	$ 29.11	$ 78.70	$ 17.78	$ 41.62	$ 25.85	$ 24.50
2021	$ 41.35	$ 30.07	$ 94.04	$ 18.60	$ 52.20	$ 28.13	$ 25.48

Table 4. Supplemental payment funding hierarchy

Funding Level	Supplemental Payment
1st	Medicaid Utilization
2nd	Acuity Adjustment
3rd	P4P
4th	CPS
5th	PASRR II Resident
6th	PASRR II Facility
7th	Core Components

Table 5. Total calculated supplemental payments, actual supplemental payments, and amount supplemental payments were reduced by state fiscal year

SFY	Total Supplemental Payments	Actual Supplemental Payments	% of Total	Reduced Supplemental Payments	% of Total
14-15	$ 104,005,569	$ 91,824,551	88%	$ 12,181,018	12%
15-16	$ 125,861,968	$ 100,432,231	80%	$ 25,429,737	20%
16-17	$ 117,196,873	$ 103,118,257	88%	$ 14,078,616	12%
17-18	$ 119,095,377	$ 107,663,088	90%	$ 11,432,289	10%
18-19	$ 120,952,170	$ 111,930,376	93%	$ 9,021,794	7%
19-20	$ 140,310,052	$ 115,643,035	82%	$ 24,667,017	18%
20-21	$ 154,930,032	$ 118,128,881	76%	$ 36,801,151	24%
21-22	$ 168,164,347	$ 112,312,116	67%	$ 55,852,231	33%
22-23	$ 208,455,120	$ 106,364,089	51%	$ 102,091,031	49%

Table 6. P4P supplemental payments and total supplemental payments by state fiscal year

SFY	P4P Payment	Total Payment	% of Total Payment
13-14	$ 6,616,631	$ 92,042,022	7.19%
14-15	$ 6,750,242	$ 91,824,551	7.35%
15-16	$ 6,880,724	$ 100,432,231	6.85%
16-17	$ 5,682,521	$ 103,118,257	5.51%
17-18	$ 6,635,279	$ 107,663,088	6.16%
18-19	$ 7,805,535	$ 111,930,376	6.97%
19-20	$ 8,997,343	$ 115,643,035	7.78%
20-21	$ 9,048,881	$ 118,128,881	7.66%
21-22[15]	$ 9,469,711	$ 112,312,116	8.43%
22-23	$ 6,936,907	$ 106,364,089	6.52%

Table 7. Per resident payment for PASRR and CPS supplemental payments for SFY 2022-23

Row	Description	CPS Payment	PASRR II Patient Payment	PASRR II Facility Payment[16]
Row A	Nursing Facilities Receiving Payment	28	173	57
Row B	Residents Included in Payment	852	1,971	1,073
Row C	Total Payment	$ 780,501	$ 3,611,473	$ 1,966,060
Row D	Per Resident Payment	$ 916	$ 1,832	$ 1,832

[15] The 2021 P4P application was significantly adjusted to accommodate nursing facilities during the height of the COVID-19 pandemic. The application became mostly narrative based and focused on how nursing facilities were paying attention to the quality measures considering the adjustments that had to be made with COVID-19.
[16] For nursing facilities with an approved SBS application.

Appendix B - Short-Term Recommendations

Increasing the General Fund growth cap to 5.86% in SFY 2023-24 can uniformly increase nursing facility reimbursement starting July 1, 2023, helping to address the identified sustainability issues. A 5.86% General Fund growth cap would increase nursing facility reimbursement by approximately $19.2 million, compared to a 3.0% General Fund growth cap in SFY 2023-24.

A 5.86% General Fund growth cap will increase the General Fund's share of core components rates by $9.6 million. Table 8 provides the comparison in General Fund obligation with a 3.0% and 5.86% General Fund growth cap in SFY 2023-24.

Table 8. General Fund Obligation with 3.0% and 5.86% General Fund Growth Cap

Row	Description	3.0% Growth Cap	5.86% Growth Cap	Difference	Calculation
Row A	Medicaid Days	3,236,921	3,236,921	-	
Row B	SFY 23 iC Rate w/o Patient Payment	$ 208.64	$ 208.64	$ -	
Row C	Growth Cap	3.0%	5.86%	2.86%	
Row D	SFY 24 iC Rate w/o Patient Payment	$ 214.90	$ 220.86	$ 5.96	Row B * (100% + Row C)
Row E	Medicaid Claims Reimbursement w/o Patient Payment	$ 695,614,288	$ 714,908,145	$ 19,293,857	Row A * Row D
Row F	General Fund Obligation	$ 347,807,144	$ 357,454,082	$ 9,646,938	Row E * 50% FMAP

A high Medicaid utilizer supplemental payment can increase reimbursement to those nursing facilities most struggling. A nursing facility's payment can equal their Medicaid days multiplied by a per diem payment. The per diem payment can be tiered based on a nursing facility's percent of Medicaid days to total days. The payment can increase nursing facility reimbursement by approximately $20 million in SFY 2023-24. A new supplemental payment will increase the General Fund's share of nursing facility Medicaid reimbursement by approximately $10 million. Table 9 provides the General Fund obligation increase with a high Medicaid utilizer supplemental payment.

Table 9. General Fund Obligation Increase with a High Medicaid Utilizer Supplemental Payment

Row	Description	100%-85% Utilization	84.99%-75% Utilization	<74.99% Utilization	Total
Row A	Medicaid Days	1,565,711	846,392	824,818	3,236,921
Row B	Per Diem Payment	$ 10.00	$ 5.00	$ -	
Row C	Payment	$ 15,657,110	$ 4,231,960	$ -	$ 19,889,070
Row D	General Fund Obligation	$ 7,828,555	$ 2,115,980	$ -	$ 9,944,525

Appendix C - State Initiatives to Address Labor

In 2021 H.B. 21-1333 was enacted to authorize payments to Medicaid nursing facilities that institute a $15 per hour minimum wage. This legislation built upon worker passthrough payments established by H.B. 19-1210. Using supplemental payments to target wage supports is a valid way to address growing costs caused by volatility in the labor market. The Department identified several states that have adopted similar strategies including Michigan, North Carolina, Florida, and Illinois.

The CMS touted the Illinois plan for incorporating retention strategies as well as safety standards at the same time. Illinois will annually reward facilities that implement tiered wage rates for CNAs who honor experience, tenure, and training. The aim is to retain long-term CNA staff who may or may not be working towards RN certifications. Additionally, Illinois has established minimum staffing benchmarks to earn a secondary payment with the aim of rewarding facilities that maintain safe and consistent staffing levels. Similar plans can be implemented in Colorado and the CMS has indicated support for Medicaid programs targeting staffing supports.

Consistent staffing is considered a best practice as familiarity with the residents promotes better health outcomes. Additionally, empowering facilities to retain staff long-term can help to erode the dependency on staffing agencies that has emerged in recent years.

The Department also notes that two bills from 2022 target the CNA shortage. H.B. 22-1298 waives fees for license/recertification. S.B. 22-226 includes a re-engagement initiative for the Colorado Department of Public Health & Environment (CDPHE) to connect with health care workers who have left the field. S.B. 22-226 also created the In-Demand Short-Term Health Care Credentials Program which covers tuition, fees, and course materials through the community college systems in Colorado. While still too early to assess the impact to Medicaid costs, any initiative that increases the supply of CNAs is expected to reduce costs incurred from the dependency on staffing agencies.

Appendix D - Maximize Provider Fee

Current statute limits nursing facility provider fees below the allowable 6% federal NPR limit and are insufficient to fully fund supplemental payments. SFY 2022-23 nursing facility provider fees are at 4.26% of the NPR, equal $53 million, and fund $106 million in supplemental payments. The nursing facility provider fees fund only 51% of total calculated supplemental payments that could be made.

If the statute were revised to allow nursing facility fees to be collected up to the federal 6% NPR limit, with supplemental payments up to the federal upper payment limit, in SFY 2022-23, the Department estimates an additional $22 million fees could be collected, resulting in an additional $44 million in supplemental payments, and a net reimbursement increase of $22 million. As noted above, as a TABOR non-exempt enterprise, increases in provider fees would require revenue offsets under current TABOR projections.

See Table 10 for a comparison of estimated SFY 2022-23 nursing facility fees, supplemental payments, and net reimbursement under the current statutorily limited nursing facility provider fee compared to fees up to the federal limit.

Table 10. Estimated SFY 2022-23 nursing facility fees, supplemental payments, and net reimbursement with current statutorily limited fees and federally limited fees

Description	Current Statute Limited Fees	Federally Limited Fees	Difference
Total Provider Fee	$ 53,383,208	$ 75,231,346	$ 21,848,138
Supplemental Payment	$ 106,364,089	$ 150,462,692	$ 43,696,276
Net Reimbursement	$ 53,383,208	$ 72,352,991	$ 18,722,303

Appendix E - Incentivize Single Occupancy Rooms

H.B. 22-1247 also directed the Department to review options for incentivizing single occupancy rooms. Through stakeholder feedback, this option was identified as having the greatest potential to improve infection control outcomes as well as supporting placements for individuals with behavioral or mental health needs. In addition, positive impacts on resident dignity and privacy are likely.

Medicaid access to single occupancy rooms is currently limited to six facilities in the state. Often those facilities have greater demand for Medicare and private pay placements due to consumer demand for private rooms. This further erodes Medicaid placements as these facilities are less dependent on Medicaid funding.

In reviewing the current reimbursement strategy set forth in statute, there is no accommodation or incentive made to facilities that run single occupancy business models. Providers indicated that while some costs (nursing hours, food, and medical supplies) would be eliminated by reducing census counts in this model, fixed price components of the rate calculation limit their ability to convert. This is due to the fixed costs related to operating a building (rent, property tax, nursing facility administrators, utilities etc.). Providers further elaborated that converting to single occupancy rooms limits the cost efficiency from a price per day standpoint as the resulting impact on rates would be high due to the aforementioned fixed costs.

The Department observes that in recent years multiple facilities have already made the change to single occupancy rooms and new builds in the state have chosen this path regardless of the Medicaid funding component. Furthermore, many facilities are currently operating at low capacity, sometimes even 50% or less. In these scenarios a conversion to single occupancy rooms, while costly up front, would not change ongoing costs as the utilization is already reduced. This is particularly true in rural areas of the state; however, this does not mean that these facilities are currently solvent.

Stakeholders did indicate that this would be feasible and highly impactful but would also be costly from a price per day standpoint. Options for implementation may include:

1. Tiered administrative rate components for 100% single occupancy rooms and/or, regulatory options assigning greater weight toward rental valuations for single occupancy room facilities. These options would be least impactful and would simply redirect a greater share of the fixed nursing facility reimbursement toward facilities that have converted to single occupancy room models.

2. A higher second statewide average rate for facilities that offer 100% single occupancy rooms. This option would be highly impactful and would initially have a lower cost due to the

limited number of facilities that currently offer 100% private rooms but could rapidly increase costs in the future should more facilities convert.

3. Supplemental payments issued directly to facilities that have 100% single occupancy rooms. The impact of these supplemental payments would be dependent on funding levels, but additional funding could be controlled in the future.
4. Implementing a separate statewide average rate for facilities that provide private rooms to all residents, with few exceptions (e.g., couples). Currently, the limited number of qualified facilities would limit first year costs associated with this change; however, should facilities convert in mass, the budget impact could grow rapidly.

This standard should be the guiding factor in transforming the nursing facilities models of care into a safe and dignified health care option for Coloradans 65 and older. Stakeholders identified that this may be the single most effective option in providing better health care. Private rooms mitigate infection, provide privacy and dignity to individuals who require support with toileting, bathing, or a range of medical procedures. Facilities would be better equipped to support individuals with behavioral needs and would likely be more marketable to individuals with non-Medicaid payer sources. As a result, this type of transformation would additionally provide greater equity in health care as populations associated with Medicaid coverage would have greater access to the standard of care that currently exists in non-Medicaid and private pay nursing facilities.