

CHAPTER 383

HEALTH CARE POLICY AND FINANCING

HOUSE BILL 08-1114

BY REPRESENTATIVE(S) White, Butcher, Kerr J., Liston, Marostica, McFadyen, Stafford, Frangas, Solano, Borodkin, Jahn, and Labuda;
also SENATOR(S) Isgar, Brophy, Kester, McElhany, Mitchell S., Shaffer, Taylor, Tochtrop, Boyd, Groff, and Williams.

AN ACT

CONCERNING THE REIMBURSEMENT OF NURSING FACILITIES UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", AND, IN CONNECTION THEREWITH, AMENDING THE REIMBURSEMENT SYSTEM FOR CLASS I NURSING FACILITIES AND AUTHORIZING THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO CHARGE AND COLLECT A QUALITY ASSURANCE FEE FROM CERTAIN CLASS I NURSING FACILITIES, AND MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds that certain components of the current Colorado medicaid system of reimbursement for class I nursing facility providers threaten the receipt of adequate health care and other services for the state's medicaid recipients who reside in class I nursing facilities.

(2) The general assembly further finds that it agrees with the conclusion of the report completed by the committee of providers, recipient advocates, department of health care policy and financing program administrators, and contract auditors convened under Senate Bill 06-131 and House Bill 07-1183 that it is in the best interest of the state and its medicaid recipients who reside in class I nursing facilities to enact, in part, a new medicaid reimbursement system for the state's class I nursing facilities.

(3) The general assembly further finds that in order to ensure adequate funding with respect to the system of medicaid reimbursement for class I nursing facility providers that the department of health care policy and financing should charge and collect a quality assurance fee from the providers not otherwise exempt to promote continuity and quality of care for the state's medicaid recipients who reside in class I nursing facilities.

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

SECTION 2. 25.5-6-201, Colorado Revised Statutes, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

25.5-6-201. Special definitions relating to nursing facility reimbursement.
AS USED IN THIS PART 2, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(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 IN THE FOLLOWING CATEGORIES:

(a) ADVERTISING, RECRUITMENT, AND PUBLIC RELATIONS, TO THE EXTENT THAT SUCH COSTS ARE NECESSARY, REASONABLE, AND PATIENT-RELATED;

(b) TRAVEL AND TRAINING OF FACILITY STAFF, UNLESS THE TRAVEL INCLUDES RESIDENTS OF THE FACILITY OR THE TRAINING IS FOR THE FACILITY STAFF DESCRIBED IN PARAGRAPH (a) OF SUBSECTION (15) OF THIS SECTION; AND

(c) ALL OTHER COSTS THAT ARE NOT DIRECT OR INDIRECT HEALTH CARE SERVICES, RAW FOOD COSTS, OR CAPITAL-RELATED ASSETS.

(4) "APPRAISED VALUE" MEANS THE DETERMINATION BY A QUALIFIED APPRAISER WHO IS A MEMBER OF AN INSTITUTE OF REAL ESTATE APPRAISERS, OR ITS EQUIVALENT, OF THE DEPRECIATED COST OF REPLACEMENT OF A CAPITAL-RELATED ASSET TO ITS CURRENT OWNER. THE DEPRECIATED REPLACEMENT APPRAISAL SHALL BE BASED ON THE "BOECHK COMMERCIAL UNDERWRITER'S VALUATION SYSTEM FOR NURSING HOMES". THE DEPRECIATED COST OF REPLACEMENT APPRAISAL SHALL BE REDETERMINED EVERY FOUR YEARS BY NEW APPRAISALS OF THE NURSING FACILITIES. THE NEW APPRAISALS SHALL BE BASED UPON RULES PROMULGATED BY THE STATE BOARD.

(5) "ARRAY OF FACILITY PROVIDERS" MEANS A LISTING IN ORDER FROM LOWEST PER DIEM COST FACILITY TO HIGHEST FOR THAT CATEGORY OF COSTS OR RATES, AS MAY BE APPLICABLE, OF ALL MEDICAID-PARTICIPATING NURSING FACILITY PROVIDERS IN THE STATE.

(6) (a) "BASE VALUE" MEANS:

(I) FOR THE FISCAL YEAR 1986-87 AND EVERY FOURTH YEAR THEREAFTER, THE APPRAISED VALUE OF A CAPITAL-RELATED ASSET;

(II) FOR EACH YEAR IN WHICH AN APPRAISAL IS NOT DONE PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (a), THE MOST RECENT APPRAISAL TOGETHER WITH FIFTY PERCENT OF ANY INCREASE OR DECREASE EACH YEAR SINCE THE LAST APPRAISAL, AS REFLECTED IN THE INDEX.

(b) FOR THE FISCAL YEAR 1985-86, THE BASE VALUE SHALL NOT EXCEED TWENTY-FIVE THOUSAND DOLLARS PER LICENSED BED AT ANY PARTICIPATING FACILITY, AND, FOR EACH SUCCEEDING FISCAL YEAR, THE BASE VALUE SHALL NOT EXCEED THE PREVIOUS YEAR'S LIMITATION ADJUSTED BY ANY INCREASE OR DECREASE IN THE INDEX.

(c) AN IMPROVEMENT TO A CAPITAL-RELATED ASSET, WHICH IS AN ADDITION TO THAT ASSET, AS DEFINED BY RULES ADOPTED BY THE STATE BOARD, SHALL INCREASE THE BASE VALUE BY THE ACQUISITION COST OF THE IMPROVEMENT.

(7) "CAPITAL-RELATED ASSET" MEANS THE LAND, BUILDINGS, AND FIXED EQUIPMENT OF A PARTICIPATING FACILITY.

(8) "CASE-MIX" MEANS A RELATIVE SCORE OR WEIGHT ASSIGNED FOR A GIVEN GROUP OF RESIDENTS BASED UPON THEIR LEVELS OF RESOURCES, CONSUMPTION, AND NEEDS.

(9) "CASE-MIX ADJUSTED DIRECT HEALTH CARE SERVICES COSTS" MEANS THOSE COSTS COMPRISING THE COMPENSATION, SALARIES, BONUSES, WORKERS' COMPENSATION, EMPLOYER-CONTRIBUTED TAXES, AND OTHER EMPLOYMENT BENEFITS ATTRIBUTABLE TO A NURSING FACILITY PROVIDER'S DIRECT CARE NURSING STAFF WHETHER EMPLOYED DIRECTLY OR AS CONTRACT EMPLOYEES, INCLUDING BUT NOT LIMITED TO REGISTERED NURSES, LICENSED PRACTICAL NURSES, AND NURSES' AIDES.

(10) "CASE-MIX INDEX" MEANS A NUMERIC SCORE ASSIGNED TO EACH NURSING FACILITY RESIDENT BASED UPON A RESIDENT'S PHYSICAL AND MENTAL CONDITION THAT REFLECTS THE AMOUNT OF RELATIVE RESOURCES REQUIRED TO PROVIDE CARE TO THAT RESIDENT.

(11) "CASE-MIX NEUTRAL" MEANS THE DIRECT HEALTH CARE COSTS OF ALL FACILITIES ADJUSTED TO A COMMON CASE-MIX.

(12) "CASE-MIX REIMBURSEMENT" MEANS A PAYMENT SYSTEM THAT REIMBURSES EACH FACILITY ACCORDING TO THE RESOURCE CONSUMPTION IN TREATING ITS CASE-MIX OF MEDICAID RESIDENTS, WHICH CASE-MIX MAY INCLUDE SUCH FACTORS AS THE AGE, HEALTH STATUS, RESOURCE UTILIZATION, AND DIAGNOSES OF THE FACILITY'S MEDICAID RESIDENTS AS FURTHER SPECIFIED IN THIS SECTION.

(13) "CLASS I FACILITY" MEANS A PRIVATE FOR-PROFIT OR NOT-FOR-PROFIT NURSING FACILITY PROVIDER OR A FACILITY PROVIDER OPERATED BY THE STATE OF COLORADO, A COUNTY, A CITY AND COUNTY, OR SPECIAL DISTRICT THAT PROVIDES GENERAL SKILLED NURSING FACILITY CARE TO RESIDENTS WHO REQUIRE TWENTY-FOUR-HOUR NURSING CARE AND SERVICES DUE TO THEIR AGES, INFIRMITY, OR HEALTH CARE CONDITIONS, INCLUDING RESIDENTS WHO ARE BEHAVIORALLY CHALLENGED BY VIRTUE OF SEVERE MENTAL ILLNESS OR DEMENTIA.

(14) "DIRECT HEALTH CARE SERVICES COSTS" MEANS THOSE COSTS SUBJECT TO CASE-MIX ADJUSTED DIRECT HEALTH CARE SERVICES COSTS.

(15) "DIRECT OR INDIRECT HEALTH CARE SERVICES COSTS" MEANS THE COSTS

INCURRED FOR PATIENT SUPPORT SERVICES, INCLUDING THE FOLLOWING:

(a) SALARIES, PAYROLL TAXES, WORKERS' COMPENSATION PAYMENTS, TRAINING, AND OTHER EMPLOYEE BENEFITS FOR REGISTERED NURSES, LICENSED PRACTICAL NURSES, AIDES, MEDICAL RECORDS LIBRARIANS, SOCIAL WORKERS, AND ACTIVITY PERSONNEL;

(b) NONPRESCRIPTION DRUGS ORDERED BY A PHYSICIAN;

(c) CONSULTANT FEES FOR NURSING, MEDICAL RECORDS, PATIENT ACTIVITIES, SOCIAL WORKERS, PHARMACIES, PHYSICIANS, AND THERAPIES;

(d) PURCHASES, RENTALS, AND COSTS INCURRED TO OPERATE, MAINTAIN, OR REPAIR HEALTH CARE EQUIPMENT;

(e) SUPPLIES FOR NURSES, MEDICAL RECORDS PERSONNEL, SOCIAL WORKERS, ACTIVITY PERSONNEL, AND THERAPY PERSONNEL;

(f) MEDICAL DIRECTOR FEES;

(g) THERAPIES AND OTHER MEDICALLY RELATED SERVICES, INCLUDING THE FOLLOWING:

(I) UTILIZATION REVIEW;

(II) DENTAL CARE, WHEN REQUIRED BY FEDERAL LAW;

(III) AUDIOLOGY;

(IV) PSYCHOLOGY;

(V) PHYSICAL THERAPY;

(VI) RECREATIONAL THERAPY;

(VII) OCCUPATIONAL THERAPY; AND

(VIII) SPEECH THERAPY;

(h) OTHER PATIENT SUPPORT SERVICES DETERMINED AND DEFINED BY THE STATE BOARD PURSUANT TO RULE;

(i) RAW FOOD COSTS THAT DO NOT INCLUDE THE COSTS OF EQUIPMENT, STAFF, OR OTHER COSTS ASSOCIATED WITH MEAL PREPARATION;

(j) MALPRACTICE INSURANCE;

(k) DEPRECIATION AND INTEREST FOR MAJOR HEALTH CARE EQUIPMENT, SUCH AS EQUIPMENT PURCHASED FOR THE SOLE PURPOSE OF PROVIDING CARE TO FACILITY RESIDENTS; AND

(1) PHOTOCOPYING RELATED TO HEALTH CARE PURPOSES SUCH AS MEDICAL RECORDS OF PATIENTS.

(16) "FACILITY POPULATION DISTRIBUTION" MEANS THE NUMBER OF COLORADO NURSING FACILITY RESIDENTS WHO ARE CLASSIFIED INTO EACH RESOURCE UTILIZATION GROUP AS OF A SPECIFIC POINT IN TIME.

(17) "FAIR RENTAL ALLOWANCE" MEANS THE PRODUCT OBTAINED BY MULTIPLYING THE BASE VALUE OF A CAPITAL-RELATED ASSET BY THE RENTAL RATE.

(18) "IMPROVEMENT" MEANS THE ADDITION TO A CAPITAL-RELATED ASSET OF LAND, BUILDINGS, OR FIXED EQUIPMENT.

(19) "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.

(20) "INDEX MAXIMIZATION" MEANS CLASSIFYING A RESIDENT WHO COULD BE ASSIGNED TO MORE THAN ONE CATEGORY TO THE CATEGORY WITH THE HIGHEST CASE-MIX INDEX.

(21) "MEDIAN PER DIEM COST" MEANS THE AVERAGE 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.

(22) "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 FEDERAL MEDICARE AND MEDICAID PROGRAMS.

(23) "NORMALIZATION RATIO" MEANS THE STATEWIDE AVERAGE CASE-MIX INDEX DIVIDED BY THE FACILITY'S COST REPORT PERIOD CASE-MIX INDEX.

(24) "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.

(25) "NURSING FACILITY PROVIDER" MEANS A FACILITY PROVIDER THAT MEETS THE STATE NURSING HOME LICENSING STANDARDS ESTABLISHED PURSUANT TO SECTION 25-1.5-103 (1) (a), C.R.S., AND IS MAINTAINED PRIMARILY FOR THE CARE AND TREATMENT OF INPATIENTS UNDER THE DIRECTION OF A PHYSICIAN.

(26) "NURSING SALARY RATIOS" MEANS THE RELATIVE DIFFERENCE IN HOURLY WAGES OF REGISTERED NURSES, LICENSED PRACTICAL NURSES, AND NURSE'S AIDES.

(27) "NURSING WEIGHTS" MEANS NUMERIC SCORES ASSIGNED TO EACH CATEGORY OF THE RESOURCE UTILIZATION GROUPS THAT MEASURE THE RELATIVE AMOUNT OF

RESOURCES REQUIRED TO PROVIDE NURSING CARE TO A NURSING FACILITY PROVIDER'S RESIDENTS.

(28) "OCCUPANCY-IMPUTED DAYS" MEANS THE USE OF A PREDETERMINED NUMBER FOR PATIENT DAYS RATHER THAN ACTUAL PATIENTS DAYS IN COMPUTING PER DIEM COST.

(29) "PER DIEM COST" MEANS THE DAILY COST OF CARE AND SERVICES PER PATIENT FOR A NURSING FACILITY PROVIDER.

(30) "PER DIEM RATE" MEANS THE DAILY DOLLAR AMOUNT OF REIMBURSEMENT THAT THE STATE DEPARTMENT SHALL PAY A NURSING FACILITY PROVIDER PER PATIENT.

(31) "PROVIDER FEE" MEANS A LICENSING FEE, ASSESSMENT, OR OTHER MANDATORY PAYMENT THAT IS RELATED TO HEALTH CARE ITEMS OR SERVICES AS SPECIFIED UNDER 42 CFR 433.55.

(32) "RAW FOOD" MEANS THE PRODUCTS AND SUBSTANCES, INCLUDING BUT NOT LIMITED TO NUTRITIONAL SUPPLEMENTS, THAT ARE CONSUMED BY RESIDENTS.

(33) "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.

(34) "RESOURCE UTILIZATION GROUPS" MEANS THE SYSTEM FOR GROUPING A NURSING FACILITY'S RESIDENTS ACCORDING TO THEIR CLINICAL AND FUNCTIONAL STATUSES AS IDENTIFIED FROM DATA SUPPLIED BY THE FACILITY'S MINIMUM DATA SET AS PUBLISHED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(35) "STATEWIDE AVERAGE PERDIEM RATE" MEANS THE AVERAGE DAILY DOLLAR AMOUNT OF THE PER PATIENT PAYMENTS TO ALL MEDICAID-PARTICIPATING FACILITY PROVIDERS IN THE STATE.

SECTION 3. 25.5-6-202, Colorado Revised Statutes, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

25.5-6-202. Providers - nursing facility provider reimbursement - repeal.

(1)(a) SUBJECT TO AVAILABLE APPROPRIATIONS, FOR THE PURPOSE OF REIMBURSING A MEDICAID-CERTIFIED CLASS I NURSING FACILITY PROVIDER A PER DIEM RATE FOR THE COST OF DIRECT AND INDIRECT HEALTH CARE SERVICES AND RAW FOOD, THE STATE DEPARTMENT SHALL ESTABLISH AN ANNUALLY READJUSTED SCHEDULE TO PAY EACH NURSING FACILITY PROVIDER THE ACTUAL AMOUNT OF THE COSTS. THE PAYMENT SHALL NOT EXCEED ONE HUNDRED TWENTY-FIVE PERCENT OF THE MEDIAN COST OF DIRECT AND INDIRECT HEALTH CARE SERVICES AND RAW FOOD AS DETERMINED BY AN ARRAY OF ALL FACILITY PROVIDERS; EXCEPT THAT, FOR STATE VETERAN NURSING HOMES, THE PAYMENT SHALL NOT EXCEED ONE HUNDRED THIRTY PERCENT OF THE MEDIAN COST.

(b) IN COMPUTING PER DIEM COST, EACH NURSING FACILITY PROVIDER SHALL ANNUALLY SUBMIT COST REPORTS, AND ACTUAL DAYS OF CARE SHALL BE COUNTED, NOT OCCUPANCY-IMPUTED DAYS OF CARE. IN ADDITION, IN DETERMINING THE MEDIAN COST, THE COST OF DIRECT HEALTH CARE SHALL BE CASE-MIX NEUTRAL. THE COST REPORTS USED BY THE STATE DEPARTMENT TO ESTABLISH THE PER DIEM COST SHALL BE THOSE FILED WITH THE STATE DEPARTMENT DURING THE PERIOD ENDING DECEMBER 31 OF THE PRIOR YEAR FOLLOWING IMPLEMENTATION OF THIS SUBSECTION (1) AND FOR EACH SUCCEEDING YEAR. THE STATE DEPARTMENT SHALL REDETERMINE THE MEDIAN PER DIEM COST BASED UPON THE MOST RECENT COST REPORTS FILED DURING THE PERIOD ENDING DECEMBER 31 OF THE PRIOR YEAR.

(2) THE STATE DEPARTMENT SHALL FURTHER ADJUST AND, SUBJECT TO AVAILABLE APPROPRIATIONS, PAY THE PER DIEM RATE TO THE NURSING FACILITY PROVIDER FOR THE COST OF DIRECT HEALTH CARE SERVICES BASED UPON THE ACUITY OR CASE-MIX OF THE NURSING FACILITY PROVIDER RESIDENTS IN ORDER TO PROVIDE FOR THE RESOURCE UTILIZATION OF ITS RESIDENTS. THE STATE DEPARTMENT SHALL DETERMINE THIS ADJUSTMENT IN ACCORDANCE WITH EACH RESIDENT'S STATUS AS IDENTIFIED AND REPORTED BY THE NURSING FACILITY PROVIDER ON ITS FEDERAL MEDICARE AND MEDICAID MINIMUM DATA SET ASSESSMENT. THE STATE DEPARTMENT SHALL ESTABLISH A CASE-MIX INDEX FOR EACH NURSING FACILITY PROVIDER ACCORDING TO THE RESOURCE UTILIZATION GROUPS SYSTEM, USING ONLY NURSING WEIGHTS. THE STATE DEPARTMENT SHALL CALCULATE NURSING WEIGHTS BASED UPON STANDARD NURSING TIME STUDIES AND WEIGHTED BY FACILITY POPULATION DISTRIBUTION AND COLORADO-SPECIFIC NURSING SALARY RATIOS. THE STATE DEPARTMENT SHALL DETERMINE AN AVERAGE CASE-MIX INDEX FOR EACH NURSING FACILITY PROVIDER'S MEDICAID RESIDENTS ON A QUARTERLY BASIS.

(3) (a) SUBJECT TO AVAILABLE APPROPRIATIONS, FOR THE PURPOSE OF REIMBURSING A MEDICAID-CERTIFIED CLASS I NURSING FACILITY PROVIDER A PER DIEM RATE FOR THE COST OF ITS ADMINISTRATIVE AND GENERAL SERVICES, THE STATE DEPARTMENT SHALL ESTABLISH AN ANNUALLY READJUSTED SCHEDULE TO PAY EACH NURSING FACILITY PROVIDER A REASONABLE PRICE FOR THE COSTS, WHICH REASONABLE PRICE SHALL BE A PERCENTAGE OF THE MEDIAN PER DIEM COST OF ADMINISTRATIVE AND GENERAL SERVICES AS DETERMINED BY AN ARRAY OF ALL NURSING FACILITY PROVIDERS. FOR FACILITIES OF SIXTY LICENSED BEDS OR FEWER, THE REASONABLE PRICE SHALL BE ONE HUNDRED TEN PERCENT OF THE MEDIAN PER DIEM COST FOR ALL CLASS I FACILITIES. FOR FACILITIES OF SIXTY-ONE LICENSED BEDS AND MORE, THE REASONABLE PRICE SHALL BE ONE HUNDRED FIVE PERCENT OF THE MEDIAN PER DIEM COST FOR ALL CLASS I FACILITIES.

(b) IN COMPUTING PER DIEM COST, EACH NURSING FACILITY PROVIDER SHALL ANNUALLY SUBMIT COST REPORTS TO THE STATE DEPARTMENT, AND ACTUAL DAYS OF CARE SHALL BE COUNTED, NOT OCCUPANCY-IMPUTED DAYS OF CARE. THE COST REPORTS USED TO ESTABLISH THIS MEDIAN PER DIEM COST SHALL BE THOSE FILED DURING THE PERIOD ENDING DECEMBER 31 OF THE PRIOR YEAR FOLLOWING IMPLEMENTATION OF THIS SUBSECTION (3), AND, FOR EACH SUCCEEDING FOURTH YEAR, THE STATE DEPARTMENT SHALL REDETERMINE THE MEDIAN PER DIEM COST BASED UPON THE MOST RECENT COST REPORTS FILED DURING THE PERIOD ENDING DECEMBER 31 OF THE PRIOR YEAR.

(4) IN ADDITION TO THE REIMBURSEMENT COMPONENTS PAID PURSUANT TO SUBSECTIONS (1) TO (3) OF THIS SECTION, A PER DIEM RATE CONSTITUTING A FAIR RENTAL ALLOWANCE FOR CAPITAL-RELATED ASSETS SHALL BE PAID TO EACH NURSING FACILITY PROVIDER AS A RENTAL RATE BASED UPON THE NURSING FACILITY'S APPRAISED VALUE.

(5) IN ADDITION TO THE REIMBURSEMENT RATE COMPONENTS PAID PURSUANT TO SUBSECTIONS (1) TO (4) OF THIS SECTION, THE STATE DEPARTMENT SHALL PAY AN ADDITIONAL PER DIEM RATE BASED UPON PERFORMANCE TO THOSE NURSING FACILITY PROVIDERS THAT PROVIDE SERVICES THAT RESULT IN BETTER CARE AND HIGHER QUALITY OF LIFE FOR THEIR RESIDENTS. THIS AMOUNT SHALL BE DETERMINED BY THE STATE DEPARTMENT BASED UPON PERFORMANCE MEASURES ESTABLISHED IN RULES ADOPTED BY THE STATE BOARD IN THE DOMAINS OF QUALITY OF LIFE, QUALITY OF CARE, AND FACILITY MANAGEMENT. THE PAYMENT SHALL BE COMPUTED ANNUALLY AND SHALL NOT BE LESS THAN FIVE-TENTHS OF ONE PERCENT OF THE STATEWIDE AVERAGE PER DIEM RATE FOR THE COMBINED RATE COMPONENTS DETERMINED PURSUANT TO SUBSECTIONS (1) TO (4) OF THIS SECTION.

(6) (a) IN ADDITION TO THE REIMBURSEMENT RATE COMPONENTS PURSUANT TO SUBSECTIONS (1) TO (5) OF THIS SECTION, THE STATE DEPARTMENT SHALL PAY AN ADDITIONAL PER DIEM RATE TO NURSING FACILITY PROVIDERS WHO HAVE RESIDENTS WHO HAVE MODERATELY TO VERY SEVERE MENTAL HEALTH CONDITIONS, COGNITIVE DEMENTIA, OR ACQUIRED BRAIN INJURY.

(b) FOR THOSE RESIDENTS WHO HAVE SEVERE MENTAL HEALTH CONDITIONS THAT ARE CLASSIFIED AT A LEVEL II BY THE MEDICAID PROGRAM'S PREADMISSION SCREENING AND RESIDENT REVIEW ASSESSMENT TOOL, THE NURSING FACILITY PROVIDER SHALL HAVE AN AMOUNT ADDED TO ITS PER DIEM RATE AS DETERMINED BY THE STATE DEPARTMENT. THE STATE DEPARTMENT SHALL COMPUTE THIS PAYMENT ANNUALLY, AND IT SHALL BE NOT LESS THAN TWO PERCENT OF THE STATEWIDE AVERAGE PER DIEM RATE FOR THE COMBINED RATE COMPONENTS DETERMINED PURSUANT TO SUBSECTIONS (1) TO (4) OF THIS SECTION.

(c) TO REIMBURSE THE NURSING FACILITY PROVIDERS WHO SERVE RESIDENTS WITH SEVERE COGNITIVE DEMENTIA OR ACQUIRED BRAIN INJURY, THE STATE DEPARTMENT SHALL PAY AN ADDITIONAL PER DIEM RATE BASED UPON THE RESIDENT'S COGNITIVE ASSESSMENT ESTABLISHED IN RULES ADOPTED BY THE STATE BOARD. THE STATE DEPARTMENT SHALL COMPUTE THIS PAYMENT ANNUALLY, AND IT SHALL BE NOT LESS THAN ONE PERCENT OF THE STATEWIDE AVERAGE PER DIEM RATE FOR THE COMBINED RATE COMPONENTS DETERMINED UNDER SUBSECTIONS (1) TO (4) OF THIS SECTION.

(7) IN ADDITION TO THE PER DIEM RATE COMPONENTS PAID PURSUANT TO SUBSECTIONS (1) TO (6) OF THIS SECTION, THE STATE DEPARTMENT SHALL PAY A NURSING FACILITY PROVIDER AN ADDITIONAL PER DIEM AMOUNT FOR CARE AND SERVICES RENDERED TO MEDICAID RESIDENTS TO OFFSET PAYMENT OF THE PROVIDER FEE ASSESSED UNDER THE PROVISIONS OF SECTION 25.5-6-203. THIS AMOUNT SHALL NOT BE EQUAL TO THE AMOUNT OF THE FEE CHARGED AND COLLECTED BUT SHALL BE AN AMOUNT EQUAL TO THE PER DIEM FEE CHARGED IN ACCORDANCE WITH SECTION 25.5-6-203 MULTIPLIED BY THE NUMBER OF MEDICAID RESIDENT DAYS FOR THE FACILITY.

(8) (a) FOR FISCAL YEARS COMMENCING ON AND AFTER JULY 1, 2008, THROUGH THE FISCAL YEAR COMMENCING JULY 1, 2014, THE STATE DEPARTMENT SHALL COMPARE A NURSING FACILITY PROVIDER'S ADMINISTRATIVE AND GENERAL SERVICES PER DIEM RATE AS DETERMINED UNDER SUBSECTION (3) OF THIS SECTION TO THE NURSING FACILITY PROVIDER'S ADMINISTRATIVE AND GENERAL SERVICES PER DIEM RATE AS OF JUNE 30, 2008, AND THE STATE DEPARTMENT SHALL PAY THE NURSING FACILITY PROVIDER THE HIGHER PER DIEM AMOUNT FOR EACH OF THE FISCAL YEARS.

(b) THIS SUBSECTION (8) IS REPEALED, EFFECTIVE JULY 1, 2015.

(9) (a) THE PER DIEM AMOUNT PAID FOR DIRECT AND INDIRECT HEALTH CARE SERVICES AND ADMINISTRATIVE AND GENERAL SERVICES COSTS SHALL INCLUDE AN ALLOWANCE FOR INFLATION IN THE COSTS FOR EACH CATEGORY USING A NATIONALLY RECOGNIZED SERVICE THAT INCLUDES THE FEDERAL GOVERNMENT'S FORECASTS FOR THE PROSPECTIVE MEDICARE REIMBURSEMENT RATES RECOMMENDED TO THE UNITED STATES CONGRESS. AMOUNTS CONTAINED IN COST REPORTS USED TO DETERMINE THE PER DIEM AMOUNT PAID FOR EACH CATEGORY SHALL BE ADJUSTED BY THE PERCENTAGE CHANGE IN THIS ALLOWANCE MEASURED FROM THE MIDPOINT OF THE REPORTING PERIOD OF EACH COST REPORT TO THE MIDPOINT OF THE PAYMENT-SETTING PERIOD.

(b) THE GENERAL FUND SHARE OF THE AGGREGATE STATEWIDE AVERAGE OF THE PER DIEM RATE NET OF PATIENT PAYMENT PURSUANT TO SUBSECTIONS (1) TO (4) OF THIS SECTION SHALL BE LIMITED TO AN ANNUAL INCREASE OF THREE PERCENT. THE STATE'S SHARE OF THE REIMBURSEMENT RATE COMPONENTS PURSUANT TO SUBSECTIONS (1) TO (4) OF THIS SECTION MAY BE FUNDED THROUGH THE PROVIDER FEE ASSESSED PURSUANT TO THE PROVISIONS OF SECTION 25.5-6-203 AND ANY ASSOCIATED FEDERAL FUNDS. ANY PROVIDER FEE USED AS THE STATE'S SHARE AND ALL FEDERAL FUNDS SHALL BE EXCLUDED FROM THE CALCULATION OF THE GENERAL FUND LIMITATION ON THE ANNUAL INCREASE.

(c) (I) THE GENERAL ASSEMBLY FINDS THAT THE HISTORICAL GROWTH IN NURSING FACILITY PROVIDER RATES HAS SIGNIFICANTLY EXCEEDED THE RATE OF INFLATION. THESE INCREASES HAVE BEEN CAUSED IN PART BY THE INCLUSION OF MEDICARE COSTS IN MEDICAID COST REPORTS. THE STATE OF COLORADO HAS AN INTEREST IN LIMITING THESE EXCEPTIONAL INCREASES IN MEDICAID NURSING FACILITY PROVIDER RATES BY REMOVING MEDICARE PART B DIRECT COSTS FROM THE MEDICAID NURSING FACILITY PROVIDER RATES AND BY IMPOSING A CEILING ON THE MEDICARE PART A ANCILLARY COSTS THAT ARE INCLUDED IN CALCULATING MEDICAID NURSING FACILITY RATES.

(II) FOR ALL RATES EFFECTIVE ON OR AFTER JULY 1, 1997, FOR EACH CLASS I NURSING FACILITY PROVIDER, ONLY SUCH COSTS AS ARE REASONABLE, NECESSARY, AND PATIENT-RELATED MAY BE REPORTED FOR REIMBURSEMENT PURPOSES. NURSING FACILITY PROVIDERS 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. ANY SUBSEQUENT INCREASE IN THIS AMOUNT SHALL BE LIMITED TO EITHER THE INCREASE IN THE FACILITY'S ALLOWABLE MEDICARE PART A ANCILLARY COSTS OR THE PERCENTAGE INCREASE IN THE COST OF MEDICAL CARE REPORTED IN THE UNITED STATES DEPARTMENT OF LABOR BUREAU OF LABOR STATISTICS CONSUMER PRICE INDEX FOR THE SAME TIME

PERIOD, WHICHEVER IS LOWER. PART B DIRECT COSTS FOR MEDICARE SHALL BE EXCLUDED FROM THE ALLOWABLE REIMBURSEMENT FOR FACILITIES.

(III) THE SPECIFIC METHODOLOGY FOR CALCULATING THE LIMITATIONS AND COST-REPORTING REQUIREMENTS DESCRIBED IN THIS PARAGRAPH (c) SHALL BE ESTABLISHED BY RULES PROMULGATED BY THE STATE BOARD.

(d) THE REIMBURSEMENT RATE COMPONENTS PURSUANT TO SUBSECTIONS (5) TO (7) OF THIS SECTION SHALL BE FUNDED ENTIRELY THROUGH THE PROVIDER FEE ASSESSED PURSUANT TO THE PROVISIONS OF SECTION 25.5-6-203 AND ANY ASSOCIATED FEDERAL FUNDS. NO GENERAL FUND MONEYS SHALL BE USED TO PAY FOR THE REIMBURSEMENT RATE COMPONENTS ESTABLISHED PURSUANT TO SUBSECTIONS (5) TO (7) OF THIS SECTION.

(10) THE STATE BOARD SHALL PROMULGATE RULES PURSUANT TO THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, C.R.S., TO IMPLEMENT THIS SECTION, INCLUDING ESTABLISHING UNIFORM ACCOUNTING, REPORTING, AND PAYMENT PROCEDURES CONSISTENT WITH THIS SECTION, TO DETERMINE A NURSING FACILITY PROVIDER'S COSTS AND PAYMENTS TO THE PROVIDER.

(11) THE PROVISIONS OF THIS SECTION SHALL NOT TAKE EFFECT UNLESS AND UNTIL THE FEDERAL GOVERNMENT APPROVES A WAIVER AUTHORIZING THE PROVIDER FEES SPECIFIED IN SECTION 25.5-6-203. TO ESTABLISH THE REIMBURSEMENT RATE FOR CLASS I NURSING FACILITIES UNTIL THE WAIVER IS GRANTED, THE STATE DEPARTMENT SHALL APPLY THE LAWS AND PROCEDURES USED IMMEDIATELY PRIOR TO JULY 1, 2008.

SECTION 4. 25.5-6-203, Colorado Revised Statutes, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

25.5-6-203. Nursing facilities - provider fee - federal waiver - fund created - rules. (1) (a) BEGINNING WITH THE FISCAL YEAR COMMENCING JULY 1, 2008, AND EACH FISCAL YEAR THEREAFTER, THE STATE DEPARTMENT SHALL CHARGE AND COLLECT PROVIDER FEES ON HEALTH CARE ITEMS OR SERVICES PROVIDED BY NURSING FACILITY PROVIDERS FOR THE PURPOSE OF OBTAINING FEDERAL FINANCIAL PARTICIPATION UNDER THE STATE'S MEDICAL ASSISTANCE PROGRAM AS DESCRIBED IN ARTICLES 4 TO 6 OF THIS TITLE. THE PROVIDER FEES SHALL BE USED TO SUSTAIN OR INCREASE REIMBURSEMENT FOR PROVIDING MEDICAL CARE UNDER THE STATE'S MEDICAL ASSISTANCE PROGRAM FOR NURSING FACILITY PROVIDERS.

(b) THE PROVIDER FEES SHALL BE CHARGED ON A NONMEDICARE-RESIDENT DAY BASIS AND SHALL BE BASED UPON THE AGGREGATE GROSS OR NET REVENUE, AS PRESCRIBED BY THE STATE DEPARTMENT, OF ALL NURSING FACILITY PROVIDERS SUBJECT TO THE PROVIDER FEE. THE STATE DEPARTMENT MAY EXEMPT REVENUE CATEGORIES FROM THE GROSS OR NET REVENUE CALCULATION AND THE COLLECTION OF THE PROVIDER FEE FROM NURSING FACILITY PROVIDERS, AS AUTHORIZED BY FEDERAL LAW.

(c) IN ACCORDANCE WITH THE REDISTRIBUTIVE METHOD SET FORTH IN 42 CFR 433.68 (e) (1) AND (e) (2), THE STATE DEPARTMENT SHALL SEEK A WAIVER FROM THE BROAD-BASED PROVIDER FEES REQUIREMENT OR THE UNIFORM PROVIDER FEES

REQUIREMENT, OR BOTH, TO EXCLUDE NURSING FACILITY PROVIDERS FROM THE PROVIDER FEE. THE STATE DEPARTMENT SHALL EXEMPT THE FOLLOWING NURSING FACILITY PROVIDERS TO OBTAIN FEDERAL APPROVAL AND MINIMIZE THE FINANCIAL IMPACT ON NURSING FACILITY PROVIDERS:

(I) A FACILITY OPERATED AS A CONTINUING CARE RETIREMENT COMMUNITY THAT PROVIDES A CONTINUUM OF SERVICES BY ONE OPERATIONAL ENTITY PROVIDING INDEPENDENT LIVING SERVICES, ASSISTED LIVING SERVICES RESIDENCES, AS DEFINED IN SECTION 25-27-102 (1.3), C.R.S., OR THAT PROVIDE ASSISTED LIVING SERVICES ON-SITE, TWENTY-FOUR HOURS PER DAY, SEVEN DAYS PER WEEK, AND SKILLED NURSING CARE ON A SINGLE, CONTIGUOUS CAMPUS;

(II) A SKILLED NURSING FACILITY OWNED AND OPERATED BY THE STATE;

(III) A NURSING FACILITY THAT IS A DISTINCT PART OF A FACILITY THAT IS LICENSED AS A GENERAL ACUTE CARE HOSPITAL; AND

(IV) A FACILITY THAT HAS FORTY-FIVE OR FEWER LICENSED BEDS.

(d) THE STATE DEPARTMENT MAY LOWER THE AMOUNT OF THE PROVIDER FEE CHARGED TO CERTAIN NURSING FACILITY PROVIDERS TO MEET THE REQUIREMENTS OF 42 CFR 433.68 (e) AND TO OBTAIN FEDERAL APPROVAL.

(e) THE IMPOSITION AND COLLECTION OF A PROVIDER FEE SHALL BE PROHIBITED WITHOUT THE FEDERAL GOVERNMENT'S APPROVAL OF A STATE MEDICAID PLAN AMENDMENT AUTHORIZING FEDERAL FINANCIAL PARTICIPATION FOR THE PROVIDER FEES. THE STATE DEPARTMENT MAY ALTER THE METHOD PRESCRIBED IN THIS SECTION TO THE EXTENT NECESSARY TO MEET THE FEDERAL REQUIREMENTS AND TO OBTAIN FEDERAL APPROVAL.

(f) IF THE PROVIDER FEE REQUIRED BY THIS SUBSECTION (1) IS NOT APPROVED BY THE FEDERAL GOVERNMENT, NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, THE STATE DEPARTMENT SHALL NOT IMPLEMENT THE ASSESSMENT OR COLLECTION OF THE PROVIDER FEE FROM NURSING FACILITY PROVIDERS.

(g) THE STATE DEPARTMENT SHALL ASSESS THE PROVIDER FEE ON A MONTHLY BASIS AND SHALL COLLECT THE FEE FROM NURSING FACILITY PROVIDERS BY NO LATER THAN THE END OF THE NEXT SUCCEEDING CALENDAR MONTH. THE STATE DEPARTMENT SHALL REQUIRE EACH NURSING FACILITY PROVIDER TO REPORT MONTHLY ITS TOTAL NUMBER OF DAYS OF CARE PROVIDED TO NONMEDICARE RESIDENTS.

(h) THE STATE DEPARTMENT SHALL NOT ASSESS OR COLLECT THE PROVIDER FEE UNTIL STATE MEDICAID PLAN AMENDMENTS ADOPTING THE MEDICAID REIMBURSEMENT SYSTEM FOR THE STATE'S CLASS I NURSING FACILITY PROVIDERS, PURSUANT TO SECTION 25.5-6-202, INCLUDING THE WAIVER WITH RESPECT TO THE PROVIDER FEES PURSUANT TO THIS SECTION, HAVE BEEN APPROVED BY THE FEDERAL GOVERNMENT.

(i) THE STATE BOARD SHALL PROMULGATE ANY RULES PURSUANT TO THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, C.R.S., NECESSARY FOR

THE ADMINISTRATION AND IMPLEMENTATION OF THIS SECTION.

(2)(a) ALL PROVIDER FEES COLLECTED PURSUANT TO THIS SECTION BY THE STATE DEPARTMENT SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE MEDICAID NURSING FACILITY CASH FUND, WHICH FUND IS HEREBY CREATED AND REFERRED TO IN THIS SECTION AS THE "FUND".

(b) (I) ALL MONEYS IN THE FUND SHALL BE SUBJECT TO FEDERAL MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE PURPOSE OF PAYING THE ADMINISTRATIVE COSTS OF IMPLEMENTING SECTION 25.5-6-202 AND THIS SECTION AND TO PAY A PORTION OF THE PER DIEM RATES ESTABLISHED PURSUANT TO SECTION 25.5-6-202 (1) TO (4).

(II) FOLLOWING THE PAYMENT OF THE AMOUNTS DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (b), THE MONEYS REMAINING IN THE FUND SHALL BE SUBJECT TO FEDERAL MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE PURPOSE OF PAYING THE RATES ESTABLISHED UNDER SECTION 25.5-6-202 (5) TO (7).

(III) ANY MONEYS IN THE FUND NOT EXPENDED FOR THESE PURPOSES MAY BE INVESTED BY THE STATE TREASURER AS PROVIDED BY LAW. ALL INTEREST AND INCOME DERIVED FROM THE INVESTMENT AND DEPOSIT OF MONEYS IN THE FUND SHALL BE CREDITED TO THE FUND. ANY UNEXPENDED AND UNENCUMBERED MONEYS REMAINING IN THE FUND AT THE END OF ANY FISCAL YEAR SHALL REMAIN IN THE FUND AND SHALL NOT BE CREDITED OR TRANSFERRED TO THE GENERAL FUND OR ANY OTHER FUND BUT MAY BE APPROPRIATED BY THE GENERAL ASSEMBLY TO PAY NURSING FACILITY PROVIDERS IN FUTURE FISCAL YEARS.

SECTION 5. 25.5-6-204 (1) (a), (2), (3), (4), and (5), Colorado Revised Statutes, are amended to read:

25.5-6-204. Providers - reimbursement - intermediate care facility for the mentally retarded - reimbursement - maximum allowable - repeal. (1) (a) For the purpose of making payments to ~~private, nonprofit, or proprietary nursing facility providers~~ and intermediate care facilities for the mentally retarded, the state department shall establish a price schedule to be readjusted every twelve months, that shall reimburse, subject to available appropriations, each ~~such~~ provider, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted ~~nursing~~ DIRECT HEALTH CARE SERVICES costs as defined in section ~~25.5-6-202 (1)~~ 25.5-6-201 (9), and a fair rental allowance for capital-related assets as defined in section ~~25.5-6-203 (4)~~ 25.5-6-201 (7). The state board shall adopt rules, including uniform accounting or reporting procedures, in order to determine ~~such~~ THE actual or reasonable cost of services and case-mix adjusted ~~nursing~~ DIRECT HEALTH CARE SERVICES costs and the reimbursement therefor. The provisions of this paragraph (a) shall not apply to state-operated intermediate care facilities for the mentally retarded.

(2) (a) In addition to ~~such~~ THE actual or reasonable costs and the reimbursement therefor, the state department shall, subject to available appropriations, include an allowance equal to the change in the national bureau of labor statistics consumer price index from the preceding year ~~which is~~ to compensate for fluctuating costs.

This amount shall be determined every twelve months when the statewide average cost is determined by adjusting for inflation. The ~~nursing facility~~ provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period. This allowance is applied to all costs, including case-mix adjusted ~~nursing~~ DIRECT HEALTH CARE SERVICES costs as ~~that term is defined in section 25.5-6-202 (1)~~ 25.5-6-201 (9), less interest, up to the reasonable cost established and will be allowed to proprietary, nonprofit, and tax-supported homes; except that ~~such~~ THE allowance shall not be applied to the costs of state-operated intermediate facilities for the mentally retarded.

(b) (I) The state board shall adopt rules to:

(A) Determine and pay to privately owned intermediate care facilities for the mentally retarded a reasonable share of the amount by which the reasonable costs of the categories of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only. ~~Such~~ THE reasonable share shall be defined as twenty-five percent of ~~such~~ THE amount in ~~such~~ THE categories for each facility, not to exceed twelve percent of the reasonable cost.

(B) ~~For fiscal year 2003-04, and for each fiscal year thereafter, determine and pay to nursing facility providers a reasonable share of the amount by which the reasonable costs of the categories of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only of each facility provider. Such reasonable share shall be defined as twelve and one-half percent of such amount in such categories for each facility, not to exceed twelve percent of the reasonable cost. As used in this sub-subparagraph (B), "nursing facility provider" means a facility provider that meets the state nursing home licensing standards in section 25-1.5-103 (1)(a), C.R.S., is maintained primarily for the care and treatment of inpatients under the direction of a physician, and meets the requirements in 42 U.S.C. sec. 1396d for certification as a qualified provider of nursing facility services.~~

(II) ~~This paragraph (b) shall take effect January 1, 1995.~~

(c) ~~The department may research and develop a nonmonetary incentive program for nursing facility providers. Such program shall recognize those nursing facility providers who achieve the highest quality-of-care standards within their facilities.~~

(d) ~~(f) Beginning July 1, 2003, subject to available appropriations, there is hereby established a resident-centered quality improvement program, which shall be known as ResQUIP, for the purpose of encouraging improvement in the quality of life in nursing facilities by resident participation in life-enriching activities that promote enhanced communication, better understanding of resident needs and self-determination, and building positive relationships and a sense of community in a nonthreatening environment that provides an encouraging and accepting atmosphere.~~

(H) ~~The state department may issue incentive grants under the program, subject to available appropriations, to nursing facility providers that meet the criteria established by the state board by rule. A nursing facility provider may also apply~~

for an incentive payment:

~~(III) Applicants for program incentive grants shall clearly define a resident-centered program proposal pursuant to rules established by the state department. Such application shall include a request for a specific grant amount. Proposals and requests for a specific grant amount may include direct and indirect costs including enhanced education and training for staff, human resource expenditures, and other activities that may encourage improvement in the quality of life of residents in nursing facilities.~~

~~(IV) Rules issued by the state board regarding the incentive grant program shall include requirements in applications by providers for participation by residents or family members.~~

~~(V) The state department and the ResQUIP team of each nursing care facility that receives an incentive grant shall conduct an evaluation of the proposal to demonstrate program and financial accountability, on at least an annual basis, to ensure that the grants are spent only on the implementation of the proposal. The composition of each ResQUIP team shall be established by rule of the state board. Any payments that are not spent on the proposal shall be returned to the state department.~~

~~(VI) Beginning July 1, 2004, and each July 1 thereafter, the state department shall report annually to the members of the health and human services committees of the house of representatives and the senate, or any successor committees, on consumer satisfaction surveys and other facility information. For each nursing facility, this report shall contain information on the survey results, the number of complaints, and the number of occurrences that are reported to the department of public health and environment pursuant to section 25-1-124, C.R.S.~~

~~(e) There is hereby established within the state department a nursing facility patient program improvement fund. The state department shall pay out of such fund, subject to rules adopted by the state board and subject to appropriations made for that purpose by the general assembly, moneys to any qualified nursing facility submitting a proposal which would provide medicaid services to a more difficult patient case mix or which would improve quality of care and quality of life within the qualifying facility.~~

~~(3) For the purpose of making payments for providers' services, the rules established by the state board shall provide that, in the determination of reasonable compensation, the criteria provided under Title XVIII of the social security act shall be taken into consideration. The state has authority to implement prospective rate reimbursement for providers where appropriate; except that the state department is authorized to pass payments through to nursing facility providers in advance of providers' implementation of the automated minimum data-set system, in accordance with the federal "Omnibus Budget Reconciliation Act of 1987". The state department shall not arbitrarily discriminate between physicians and optometrists who provide similar services, goods, and prosthetic devices in the field of vision care within the scope of their respective practices, as defined by state law.~~

~~(4) (a) For the purposes of this section, "reasonable costs" means the maximum~~

allowable reimbursement based on the following categories of costs:

~~(f) Actual health care services and food costs; and~~

~~(H) Actual administration, property, and room and board costs, excluding capital-related assets and excluding food costs.~~

~~(b) Case-mix adjusted nursing costs shall be subject to the maximum allowable reimbursement limitation on health care costs as set forth in sub-subparagraph (A) of subparagraph (H) of paragraph (c) of this subsection (4). In determining the maximum allowable reimbursement limitation, case-mix adjusted nursing costs shall be normalized, as defined in section 25.5-6-202 (8), for each nursing facility provider based upon the average of the provider's quarterly case-mix indices for residents during the provider's most recently reported cost reporting period.~~

~~(c) Effective July 1, 1995, the maximum allowable reimbursement shall not exceed the following amounts in the following categories:~~

~~(I) **Administrative costs.** (A) Class I facilities: One hundred twenty percent of the weighted average actual costs of all class I facilities;~~

~~(B) Class II facilities: One hundred twenty percent of the weighted average actual costs of all class II facilities;~~

~~(C) Class IV facilities: One hundred twenty percent of the weighted average actual costs of all class IV facilities;~~

~~(H) **Health care – food and case-mix adjusted nursing costs.** (A) Class I facilities: One hundred twenty-five percent of the weighted average actual costs of all class I facilities adjusted for facility case-mix weight;~~

~~(B) Class II facilities: One hundred twenty-five percent of the weighted average actual costs of all class II facilities;~~

~~(C) Privately owned class IV facilities: One hundred twenty-five percent of the weighted average actual costs of all class IV facilities.~~

~~(d) For the purpose of calculating both the individual nursing facility provider's rates and the maximum allowable reimbursement rates identified in subparagraphs (I) and (H) of paragraph (c) of this subsection (4), only administrative costs as defined in section 25.5-6-201 (2) shall be imputed to the eighty-fifth percentile for urban facilities with occupancy rates below eighty-five percent.~~

~~(e) Food costs shall not include the costs of real or personal property, staff, preparation, or other items related to the food program. The dollar amount per patient day shall be established every twelve months in accordance with rules established by the state board.~~

~~(f) (I) The general assembly finds that the historical growth in nursing facility rates has significantly exceeded the rate of inflation. These increases have been caused in part by the inclusion of medicare costs in medicaid cost reports. The state~~

~~of Colorado has an interest in limiting these exceptional increases in medicaid nursing facility rates by imposing growth ceilings on nursing facility rates, instituting a case-mix reimbursement system, removing medicare part B direct costs from the medicaid nursing facility rates, and imposing a ceiling on the medicare part A ancillary costs that are included in calculating medicaid nursing facility rates.~~

(H) Notwithstanding any other provision in this article and articles 4 and 5 of this title, the following limitations shall apply to rates for reimbursement of nursing facilities:

(A) For all rates effective on or after July 1, 1997, for each class I and class V facility, any increase in administrative costs shall not exceed six percent per year; and

(B) For all rates effective on or after July 1, 1997, for each class I and class V facility, only such costs as are reasonable, necessary, and patient-related may be reported for reimbursement purposes. Nursing facilities may include whatever level of medicare part A ancillary costs was included and allowed in the facility's latest medicaid cost report filed prior to July 1, 1997. Any subsequent increase in this amount shall be limited to either the increase in the facility's allowable medicare part A ancillary costs or the percentage increase in the cost of medical care reported in the United States department of labor bureau of labor statistics consumer price index for the same time period, whichever is lower. Part B direct costs for medicare shall be excluded from the allowable reimbursement for facilities.

(H) The specific methodology for calculating the limitations and cost reporting requirements described in this paragraph (f) shall be established by rules promulgated by the state board.

~~(g) The state department is authorized to utilize a case-mix system for reimbursing some or all of Colorado's class I and class V medicaid nursing facilities. A case-mix reimbursement system reimburses each facility according to the resource consumption in treating its case mix of medicaid residents, which may include such factors as the age, health status, resource utilization, and diagnoses of the facility's medicaid residents.~~

(h) Effective July 1, 2000, a case-mix reimbursement component, as defined in section 25.5-6-202 (3), for nursing costs shall be paid to class I and class V nursing facility providers and implemented as follows:

(i) The state department shall determine each resident's clinical and functional status as identified and reported by each nursing facility provider using the federal medicare and medicaid program minimum data set assessment.

(H) For the purpose of determining each provider's case-mix index, the state department shall use the resource utilization groups classification system, nursing weights only. In classifying residents, an index maximization approach shall be used. Nursing weights shall be calculated based upon standard nursing time studies and weighted by Colorado specific nursing salary ratios and facility population distribution as defined in section 25.5-6-202 (9) and (4).

~~(III) An average case-mix index shall be determined for each nursing facility provider's medicaid recipients on a quarterly basis.~~

~~(IV) The state board shall promulgate such rules as are necessary to implement the case-mix reimbursement system pursuant to this paragraph (h).~~

~~(5) (a) (i) Interested members of the joint budget committee of the general assembly, the state department, the state ombudsman and interested long-term care ombudsmen, and nursing facility providers shall develop a methodology for determining when and under what circumstances a limitation on the increase in health care services costs for class I and class V facilities shall be implemented. The methodology may take into consideration factors including but not limited to nursing facility caseload, the implementation of refinancing mechanisms, federal mandates, inflation, and other economic factors.~~

~~(H) The members of the group specified in subparagraph (i) of this paragraph (a) shall report to the joint budget committee of the general assembly by November 15, 2002, with recommendations for a methodology for determining when and under what circumstances there shall be implementation of a limitation on the increase in health care services costs for class I and class V facilities. The general assembly shall enact legislation by July 1, 2003, implementing a methodology for determining when and under what circumstances a limitation on the increase in health care services costs shall be implemented, which legislation shall include a repeal of paragraph (b) of this subsection (5).~~

~~(b) In the event the general assembly fails to enact legislation by July 1, 2003, specifying when and under what conditions a limitation on the increase in nursing facility health care costs shall be imposed, then for rates effective on and after July 1, 2005, in addition to the limitations specified in subparagraph (H) of paragraph (f) of subsection (4) of this section, for each class I and class V facility, any increase in health care services costs shall not exceed eight percent per year; except that, for the fiscal year beginning July 1, 2006, the eight-percent limitation shall not apply to a class I facility with an average annual medicaid resident census that exceeds sixty-four percent of the number of actual residents for that same period. The calculation of the eight percent per year limitation for rates effective on or after July 1, 2005, shall be based on the facility's cost reports, as specified by rule of the state board, in the preceding year.~~

SECTION 6. Repeal. 25.5-6-207, Colorado Revised Statutes, is repealed.

SECTION 7. Appropriation -- adjustment to the 2008 long bill. (1) In addition to any other general fund appropriation, there is hereby appropriated, to the department of health care policy and financing, for allocation to the executive director's office, for the fiscal year beginning July 1, 2008, the sum of one hundred nineteen thousand nine hundred sixty-eight dollars (\$119,968) and 1.0 FTE, or so much thereof as may be necessary, for the implementation of this act. In addition to said appropriation, the general assembly anticipates that the department of health care policy and financing will receive one hundred nineteen thousand nine hundred sixty-eight dollars (\$119,968) federal funds in the fiscal year beginning July 1, 2008, for the implementation of this act. Although the federal funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions

used relative to these funds in developing state appropriation amounts.

(2) For the implementation of this act, the general fund appropriation to the controlled maintenance trust fund made in section 23 of the annual general appropriation act, for the fiscal year beginning July 1, 2008, shall be decreased by one hundred nineteen thousand nine hundred sixty-eight dollars (\$119,968).

SECTION 8. Appropriation -- adjustment to the 2008 long bill. (1) For the implementation of this act, appropriations made in the annual general appropriation act to the department of health care policy and financing, for the fiscal year beginning July 1, 2008, shall be adjusted as follows:

(a) The cash fund appropriation to the executive director's office is increased by the sum of one hundred twenty-seven thousand four hundred sixty-one dollars (\$127,461) and 1.3 FTE, or so much thereof as may be necessary, for the implementation of this act. Said sum, shall be from the Medicaid nursing facility cash fund created in section 25.5-6-203 (2) (a), Colorado Revised Statutes. In addition to said appropriation, the general assembly anticipates that the department of health care policy and financing will receive one hundred twenty-seven thousand four hundred sixty-one dollars (\$127,461) federal funds for the implementation of this act. Although the federal funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions used relative to these funds in developing state appropriation amounts.

(b) The cash fund appropriation for the medical services premiums division is increased by five million nine hundred twenty-seven thousand one hundred sixty dollars (\$5,927,160), or so much thereof as may be necessary, for the implementation of this act. Said sum, shall be from the Medicaid nursing facility cash fund created in section 25.5-6-203 (2) (a), Colorado Revised Statutes. In addition to said appropriation, the general assembly anticipates that the department of health care policy and financing will receive five million nine hundred twenty-seven thousand one hundred sixty dollars (\$5,927,160) federal funds for the implementation of this act. Although the federal funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions used relative to these funds in developing state appropriation amounts.

SECTION 9. Effective date. (1) Except as provided in subsection (2) and (3) of this section, this act shall take effect July 1, 2008.

(2) Section 7 of this act shall take effect on April 1, 2009, but only if on or before March 31, 2009, the executive director of the department of health care policy and financing has not submitted written notice to the revisor of statutes that the federal government has approved the waiver establishing the provider fees created in section 25.5-6-203, Colorado Revised Statutes.

(3) Section 8 of this act shall take effect on April 1, 2009, but only if, by March 31, 2009, the executive director of the department of health care policy and financing has submitted written notice to the revisor of statutes that the federal government has approved the waiver establishing the provider fee created in section 25.5-6-203, Colorado Revised Statutes.

SECTION 10. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: June 2, 2008