METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING FACILITY CARE

B. New providers after the receivership period.

1. In those cases where a new operator takes control and ownership of a nursing facility from the receiver, the new operator is to receive an initial rate paid to the prior owner. The rate of the prior owner is to remain in effect until the new provider submits a cost report which establishes a rate effective date on the first day of the third calendar month following the last month covered by the cost report, unless the new operator utilizes the retrospective option described below.

2. The new operator may elect to have a retrospective rate set for the initial three (3) months of operation. To exercise this option the new operator must file a cost report for the first three (3) months of operation. The first day of operation is defined to mean the first day of licensure of the new operator. The last day of the initial three (3) months of operation will be the last day of the month in which the 90th day occurs. The cost report must be filed within 90 days of the end of the initial three (3) months of operation.

3. The retrospective rate established from this three (3) month cost report shall be in effect from the first date of licensure of the new owner until the last day of the month in which the 90th day occurs. This same rate shall be a prospectively paid rate to the new operator beginning with the first day of the month after the three (3) month cost reporting period.

4. The initial rate paid to the new operator shall be the prior owner's rate. However, the retrospective rate established by the three (3) month cost report shall replace the initial rate paid to the operator.

   This retrospective rate may be higher or lower than the initial rate established and paid to the new operator in which case the under or over payment shall be either paid to or collected from the new operator. This retrospectively established rate shall not exceed the maximum reasonable cost rates as established pursuant to the method Section II A of the State Plan entitled Maximum Reasonable Allowable Cost.

5. The three (3) month cost report shall also establish the prospective rate for the period beginning on the first day of the third calendar month covered by the cost report.

6. Should the first cost report filed for the period immediately following the three (3) month cost report described above demonstrate a reduction in per diem costs of more than five (5) percent which is caused by a reduction in per diem costs and not an increase in census, the following special provision shall apply:

   The provider's prospective per diem rate driven by the three (3) month cost report shall be retroactively reduced to the per diem rate as determined by the actual costs of the provider. The Department shall recover the difference between the provider's actual costs and the prospective rate paid to the provider. This recovery shall not apply to the three (3) month retrospective rate as established by the initial three (3) month cost report.

IX. Hospital Swing Beds - When a hospital offers swing bed services, payment will be made at the average rate per client day paid to Class I nursing facilities for services furnished during the previous calendar year. Payment for nursing facility services may not exceed the rates charged for the same services to private residents or residents with other sources of income.

Oxygen provided to swing bed patients will be paid at the same rate currently paid for residents in nursing care facilities in addition to payments made for routine services.

Recipients shall be required to contribute all patient income minus the personal needs amount to the cost of their skilled or intermediate nursing care. Collection as well as determination of the patient income amount shall be in accordance with the CDSS Staff Manual, Volume 8, Section entitled "Patient Income and Possessions".

X. Long Term Care Hospital Patients Program - This program provides extra reimbursement to nursing homes for costly, heavy care patients admitted directly from the hospital. The program is limited to patients whose hospitalization is being paid by Medicaid. In addition, the PRO must make a finding that the patient would continue to need hospital level of care.

Rate-setting under the Long Term Care Hospital Patients Program is prospective and is based on an itemization of patient costs submitted by the nursing home before the patient's admission to the facility. These costs must be based on a plan of care approved by the PRO that adequately addresses each of the patient's care needs.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING FACILITY CARE

The cost figure is approved by the CDSS prior to the patient's admission to the facility. An extra five percent (5%) is added to the approved cost figure in setting the per diem rate for the patient. This reimbursement rate is subject to revision after the patient's admission to the nursing home based on the PRO's periodic assessment of the patient's current care needs. The ceiling for payment under this Program is the lower of :

A. Ninety percent (90%) of the Medicaid payment to the discharging hospital, or

B. Ninety percent (90%) of the average Medicaid hospital rate in the State.

X. IMPLEMENTATION OF A PASS-THROUGH PAYMENT SYSTEM FOR THE COSTS ASSOCIATED WITH THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA '87).

A. Pursuant to Senate Bill 90-18, the Department shall make pass-through payments to nursing facilities providers to cover the costs associated with the provisions of the Federal law P.L. 101-203 The Omnibus Budget Reconciliation Act of 1987 (OBRA '87).

B. Definitions:

Pass-through Payment: A pass-through payment to a nursing facility is a payment which covers the costs associated with the requirements of OBRA '87. The payments "pass-through" the usual rate-setting process by being paid outside of the usual prospective nature of the rate-setting system. The pass through payment is an "up front" interim payment to providers to cover the initial year OBRA '87 costs which, under the Colorado prospective rate-setting system, is generally not recovered by providers. The pass-through payment is only an estimate of the providers soon to be experienced costs. The actual costs of the provider are to be audited. The pass-through payment is retroactively adjusted to cover the actual costs incurred by the provider. These paymets are issued to cover the OBRA 87 costs for the period incurred for the July 1, 1989 to June 30, 1990 period.

Add-on Payment: Add-on payment is an increase to the provier's usual Medicaid rate. The add-on covers OBRA 87 costs. Like the pass-through payment, the add-on is an interim payment to providers to cover initial year OBRA 87 costs which, under the prospective rate-setting system, is generally not recovered by providers. The add-on payment is based on an estimate of the OBRA 87 costs to be incurred by provides. The add-on pyament is adjusted to actual allowable OBRA 87 costs through an audit reconciliation process. The add-on payments begin October 1, 1990.

Eligible Nursing Facilities: All Class I and V nursing facilities are to receive pass-through payments. The nursing facilities in these classes comply with the Nursing Home Reform provisions of Section 1989 of the Social Security Act (as amended by OBRA '87).

97-004
06/25/97
10/01/97
96-002

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING FACILITY CARE

C. OBRA '87 costs incurred from July 1, 1989 through June 30, 1990.

1. Class I and V nursing facilities are to complete the Schedule G which becomes part of the next regularly scheduled "Financial and Statistical Report for Nursing Homes" (MED-13) to be filed by the provider. The Schedule G form shall include provider's best estimate of the OBRA '87 costs and patient days incurred for the period of July 1, 1989 through June 30, 1990.

2 a. The Department is to review the information on the Schedule G for completeness and reasonableness. The Department shall pay to the eligible nursing facilities a lump sum payment for one-hundred percent of the costs indicated on the Schedule G which are determined by the Department to be reasonable. The lump sum payment shall be based on the estimated reasonable costs, divided by the total estimated patient days of the July 1, 1989 to June 30, 1990 period.

b. The review of the reasonableness of the provider's estimate of a pass-through payment shall be undertaken to assure the payments are based on the minimum costs a nursing home can reasonably be expected to incur and shall cover only those costs which represent new cost levels not previously incurred by the provider and which represent costs over and above the previously incurred level of costs by the provider. Those costs which would be incurred on a one-time-only basis and paid for by a pass-through shall not be used in setting future prospective payments. The Department's review may rely on pass-through cost estimates submitted by other providers. Should a provider's estimate be unreasonably high when compared to these other estimates, the Department may reduce the payment to an amount which appears more reasonable. In the case of such adjustments to the Schedule G estimate, the provider may appeal such findings.

The Department's test for reasonableness of a pass-through estimate from a provider is as follows:

(1) Any pass-through payment request of less than $30,000.00 shall be deemed reasonable.

(2) Any pass-through payment request of more than $30,000.00 dollars shall be deemed reasonable if the amount of training costs per aide did not exceed $885.00 per aide. This figure is based on the cost per aide received from providers for pass-through payment. The $885.00 per aide is approximately 140% of the average costs per aide presented by all other providers.

(3) Any provider whose requests exceeded this amount shall be given an opportunity to provide a rationale for the higher costs. If the Department finds there to be a reasonable basis for the higher estimate, the payment may be increased.

TN No. 97-004
Approval Date 06/25/97
Effective Date 10/01/97
Supersedes TN No. 96-002

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING FACILITY CARE

3 a. All pass-through payments shall be subject to audit and adjusted to actual costs. These costs, which are ongoing costs, shall be included on the Annual Costs Reports of the nursing facilities and used to set the future prospective of the nursing facilities.

b. The audit shall also examine any previous rate payments which may have included the same costs covered by the pass-through payments. In such cases, the past rate payments are to be adjusted to remove the costs covered by the pass-through payment.

These pass-through payments cover costs in the July 1989 to June 1990 period. The pass-through payments were made at the end of this period in June and July 1990. During the July 1989 to June 1990 period, providers submitted cost reports which covered parts of the July 1989 to June 1990 period and which included OBRA '87 costs covered by the pass-through payments. These cost reports may have carried rate payments for the July 1989 to June 1990 period. In which case the provider was already receiving a Medicaid rate payment for part of the July 1989 to June 1990 period for the OBRA '87 costs. Under these circumstances, the pass-through payments which were based on an entire year's costs may be duplicative of the rate payments described here. In these cases, the previous rate payment shall be adjusted to take into account the duplicative payment.

4. Audits of the estimated pass-through payments which find an overpayment has occurred may be appealed. Providers who have been overpaid and appealed must begin to repay the funds while the appeal is pending. Repayment cannot exceed 25% of the provider's claim payment.

5. Audits of the estimated pass-through payments which find an underpayment has occurred shall cause the total underpayment to be paid.

6. The maximum reimbursement rate shall not apply to the pass-through payments and subsequent audit adjustments, nor shall the costs associated with the pass-through payments be in the maximum reimbursement rate array of costs for State Fiscal Year 1991.

7. a. The above describes a payment methodology which includes all OBRA '87 costs incurred by nursing facilities for Aide Training, Certification and Continuing Education. The costs associated with Aide Training and Certification will be billed to HCFA as State Administrative expenses Continuing Education will be billed as Medical Assistance. Therefore, the portion of the pass-through payment which covers Aide Training and

TN No. 97-004
Approval Date 06/25/97
Effective Date 10/01/97
Supersedes TN No. 96-002

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING FACILITY CARE

Certification is not considered a part of this State Plan per the instructions found in HCFA State Medicaid manuals 16 and 66. However, the portion which covers Continuing Education is considered a part of this State Plan.

b. The ongoing costs associated with Aide Training and certification shall be used to establish prospective rates for the nursing facilities. The Department shall structure its cost reporting and audit requirements to separately identify these costs and their impact on the prospective rates paid to facilities. The State shall bill these cost to HCFA as a state administered expenses.

D. OBRA'87 costs incurred from July 1,, 1990 through June 30, 1991.

1. Effective October 1, 1990 through June 30, 1991, all Class I and V nursing facilities are to receive a rate add-on of $1.20 per day to the usual Medicaid rate received by these nursing facilities. This $1.20 per patient day add-on payment is based on the Department's estimate that this payment should be sufficient to cover the minimum costs all nursing facilities can reasonably be expected to incur and which represents new cost levels not previously incurred by the provider for similar cost activity.

2. All Class I and V nursing facilities receiving the $1.20 per patient day add-on payment are to complete a special Schedule G form with the provider's next regularly scheduled cost report which covers this period. The purpose of the Schedule G form is to provide a list of the actual OBRA 87 costs these nursing facilities have actually incurred.

3. The costs listed on the special Schedule G form are to include those costs directly required by OBRA 87. These costs are to include only minimum costs nursing facilities need to incur in order to implement the OBRA'87 nursing facility requirements. These costs are to represent new cost levels not previously incurred by the provider for similar costs activities. Those costs incurred on a one time only basis and paid for by the add-on or previous pass-through payment shall not be used in setting future prospective payments.

4. All add-on payments shall be subject to audit and adjustment to actual OBRA'87 costs which meet the conditions specified in paragraph 3 above.

97-004
06/25/97
10/01/97
96-002

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING FACILITY CARE

The audit shall also examine any previous or ongoing rate payments which may have included the same type of costs claimed by the provider on the special Schedule G form.

5. The total allowable Schedule G costs shall be developed into a per diem cost and compared to the $1.20 per diem add-on payment previously paid by the State. If the actual allowable per diem cost is greater than the $1.20 per diem add-on payment, the provider will be found to be under paid. In which case, the add-on payment shall be increased to cover the total amount of the under payment.

6. If the actual allowable per diem costs i less than the $1.20 per diem payment, the provider has been over paid. These findings may be appealed. However, the providers who have been over paid and appeals must begin to repay the over payment while the appeal is pending. Repayment cannot exceed 25% of the provider's claim payment.

7. The maximum reimbursement rate shall not apply to the add-on payments and subsequent reconciliation payment. Nor shall the costs associated with the add-on payments be in the maximum reimbursement array of costs of State Fiscal Year 1992. However, OBRA'87 costs, which are included in prospectively set rates and not covered by the add-on payments, are included in the maximum reimbursement array of costs for State Fiscal Year 1992.

8. a. The above describes a payment methodology which includes all OBRA'87 costs incurred by nursing facilities for AIDE Training, Certification and Continuing Education. The costs associated with Aide Training and Certification will be billed to HCFA as State Administrative expense. Continuing Education will be billed as Medical Assistance. Therefore, the portion of the add-on payment which covers Aide Training and Certification is not considered a part of this State Plan per the instructions found in HCFA State Medicaid manuals 16 and 66. However, the portion which covers Continuing Education is considered a part of this State Plan.

   b. The ongoing costs associated with aide training and competency certification shall be used to establish prospective rates for the nursing facilities. The Department shall structure its cost reporting and auditing requirements to separately identify these costs and their impact on the prospective rates paid to facilities. The State shall bill these costs to HCFA as state administrative expense.

97-004
06/25/97
10/01/97
96-002

State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING FACILITY CARE

STANDARDS

I. Basis for Determining Allowable Costs

The State of Colorado has determined that establishment of the maximum reasonable cost based on the 90%-ile for health care and raw food costs, and 85 percentile for administration, room and board and property costs, and a fair rental allowance payment for capital related assets set forth above for all classes of facilities except the State-administered ICF/MR's, is reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. The State of Colorado has determined that establishment of a retrospective rate setting methodology for the State-administered ICF/MR's (as specified in Section II of the Methods part of the manual) is reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. In the determination of rates for long-term care facility services, the State of Colorado references, in order of importance:

A. Federal and State Medicaid statutes and regulations.

B. Medicare statutes and regulations.

C. Medicaid and Medicare guidelines.

D. Generally accepted accounting principles (GAAP).

E. Specific standards not based upon the above include:

- Fair rental allowance for capital related asset costs. (Not applicable to the State-operated ICF/MR's.)

- Depreciation - only straight-line depreciation may be used. (Straight-line depreciation only applies to assets not covered by fair rental allowance.)

- Owner and owner-related employees - allowable salaries and fringe benefits are limited based on annual surveys.

- Return on equity - not allowable.

No. 97-004
06/25/97
10/01/97
96-002

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING HOME CARE

- Interest - interest on loans to providers for the provision of patient care by partners, stockholders or related organizations is an allowable cost at a rate not to exceed the prime lending.

- Legal fees - limited to those costs which the State has determined to be reasonable, necessary and cost related. However, legal fees, expenses and costs incurred in connection with an investigation by federal, state or local governments and their agencies that might lead to a civil or criminal proceeding against the provider as a result of alleged fraud or other misconduct by the provider in the course of the provider's participation in the Medicaid program shall not be allowable where the provider makes any payment of funds to any federal, state or local governments and their agencies as a result of the alleged fraud or misconduct which was the subject of the investigation. All Medicaid rate appeals must go through a mandatory reconsideration process before a formal appeal is filed. Only those legal fees and costs that are advisory in nature are allowable during the informal reconsideration. Legal fees and costs in a formal appeal are allowable only to the extent that the provider is successful in the appeal.

- Management fees - administrative services provided by management company are limited to the maximum allowed owner-administrator's salary minus the amount being paid to the actual administrator. Other services provided by management companies are reimbursed based on actual audited cost.

- Elimination of the Imputed Occupancy is in effect as of October 1, 1991 and reinstated effective October 1, 1992.

97-004
06/25/97
10/01/92
96-002

State of Colorado
METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATE - NURSING HOME CARE

VIII. Billing and payment of oxygen supplies and services for nursing facility Medicaid residents.

A. Oxygen Concentrators Purchased by Nursing Facilities.

1. Effective with service dates after March 1, 1991, nursing home facilities are permitted to report on their yearly Financial and Statistical (MED-13 Cost Report) the costs associated with oxygen concentrators purchased by the nursing facilities after March 1, 1991. All supplies and servicing costs associated with purchased concentrators are allowable.

The nursing homes are to record, for verification by the contract auditor, the costs incurred with the concentrators purchased after March 1, 1991. These costs are to be segregated by expenses associated with Medicaid residents and non-Medicaid residents.

2. For those cost reporting periods of the various nursing facilities covering the period of March 1, 1991, through February 29, 1992, the following cost settlement process will occur.

a. The contract auditor shall make a comparison between the oxygen concentrator Medicaid revenues received by the nursing facility and the oxygen concentrator costs incurred by the nursing home provider for periods consistent with the cost reporting periods of the provider.

b. In cases where the audit of this cost report finds oxygen concentrator revenues exceed oxygen concentrator costs for Medicaid residents, the provider shall be found to be overpaid and collection of the overpayment shall occur.

c. In cases where the audit of the cost report finds concentrator revenues are less than oxygen concentrator costs for Medicaid residents, the provider shall be found to be underpaid and shall receive an additional payment from Medicaid for the amount of the underpayment.

d. The costs of the oxygen concentrators shall be included in the next rates set by the above mentioned cost reports.

e. Allowable costs of oxygen concentrators shall be defined as follows: All concentrators purchased by nursing facilities shall be capitalized over the useful life of the asset. All supplies and service costs are allowable.

97-004
06/25/97
10/01/97
96-002