

Title of Rule: Revision to the Medical Assistance Provider Fee Financing Nursing Facility Rule  
Concerning Rate Effective Date, Section 8.443.13  
Rule Number: MSB 16-03-08-A  
Division / Contact / Phone: Special Finance / Matt Haynes / 6305

## STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

8.443.13 Addresses Rate Effective Dates for Class I skilled nursing facilities. The rules were incomplete in regard to the Schedule of Core Components Reimbursement Rates, and these revisions provide the detail needed concerning those rates.

8.443.13 also prescribes the establishment of the July 1 Medicaid Management Information system (MMIS) rate based on an as-filed cost report without adjustments. MMIS rates are currently set by comparing the allowable growth to an interim rate calculated from the as-filed cost report, and setting the rate to the lower of the two. The rate is then reconciled to the rate calculated from the final audited cost report in the subsequent year in the form of a supplemental payment. The as-filed cost report often has errors, and adjustments must be made during the audit process. These errors and adjustments can result in an interim rate that is below the allowable growth for a provider and a final audited rate that is greater. This results in the provider's MMIS rate being set at the interim level below their allowable growth. The allowable growth for the provider for the next year is from the MMIS rate set by the as-filed cost report although the final audited rate was higher. The provider never catches up in terms of their MMIS rate.

Additionally, utilizing as-filed cost reports to set reimbursement rates has led to significant delays in finalizing and implementing the provider fee model.

The Department is recommending a change to this process so that MMIS rates are set by the allowable growth only. The change implements a standard increase to the MMIS rates for all providers with a reconciliation to the audited rate in the subsequent year. These changes obviate the risks to provider reimbursement rates and eliminate a source of delay, while also making the rate setting and true-up processes simpler and easier to understand. Providers will be able to anticipate their year over year change in MMIS rates when budgeting for their homes. There is no General Fund impact as a result of this change as the statewide growth remains the same.

2. An emergency rule-making is imperatively necessary

- to comply with state or federal law or federal regulation and/or
- for the preservation of public health, safety and welfare.

Initial Review	<b>04/08/2016</b>	Final Adoption	<b>05/13/2016</b>
Proposed Effective Date	<b>06/30/2016</b>	Emergency Adoption	

**DOCUMENT #02**

Title of Rule: Revision to the Medical Assistance Provider Fee Financing Nursing Facility Rule  
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Explain:

3. Federal authority for the Rule, if any:

42 CFR Section 433.68

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2015);  
25.5-6-202  
25.5-6-203

Initial Review	<b>04/08/2016</b>	Final Adoption	<b>05/13/2016</b>
Proposed Effective Date	<b>06/30/2016</b>	Emergency Adoption	

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## REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Class I Nursing Facilities

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

There is no change to the statutory limitations on general fund growth or any changes to the provider fees, so there is no anticipated significant impact on overall reimbursement to the class of providers. The rule will simplify the MMIS rate setting; making it easier for the providers to understand what change in MMIS rates to expect year over year. This change also simplifies the rate reconciliation process. The calculation of interim rates is often a cause of delay in completing the calculations of the provider fees and supplemental payments, and these changes will eliminate those delays.

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

There are no additional costs to the Department or any anticipated significant effect on state revenues.

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

Inaction will result in the continued use of an as-filed unaudited cost report to set MMIS reimbursement that can have negative impacts to providers who have errors in their as-filed cost reports. Inaction will also result in the continued complexity in the rate setting and rate reconciliation process, and will cause there to still be risk for significant delay in finalization and implementation of the provider fees and supplemental payments.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no other methods for achieving the purpose of the proposed rule.

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6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

The only method for achieving the purpose of the proposed rule is to make a change to the rule.

1 **8.443.13 RATE EFFECTIVE DATE**

2 8.443.13.A. ~~For cost reports filed by all facilities except the State-administered Class IV~~  
 3 ~~facilities, the rate shall be effective on the first day of the eleventh (11th) month~~  
 4 ~~following the end of the nursing facility's cost reporting period.~~

5 For cost reports filed by all facilities except the State administered Class II and IV  
 6 facilities, a July 1<sup>st</sup> and subsequent Schedule of Core Components  
 7 Reimbursement Rates shall be established by the Department based on the last  
 8 day of the cost reporting fiscal year end. The July 1<sup>st</sup> Schedule of Core  
 9 Components Reimbursement Rate shall be based on the cost reporting period  
 10 ending no later than the previous April 30<sup>th</sup>.

11 Additional Schedule of Core Components Reimbursement Rates shall be  
 12 established as follows:

- 13 1. Rate effective on the first day of the 11<sup>th</sup> month following the end of the facility's  
 14 cost reporting period.
- 15 2. Rate effective on the first day of the 6<sup>th</sup> month following the rate effective date  
 16 stated in 8.443.13.A.1.
- 17 3. If the 11 month or 6 month rate stated in 8.443.13.A.1 and 8.443.13.A.2 coincide  
 18 with July 1<sup>st</sup>, only two rates will be established.
- 19 4. If the 6 month rate stated in 8.443.13.A.2 is after the July 1<sup>st</sup> rate set by the  
 20 subsequent cost report, only two rates will be established.

<u>Provider Cost Report Fiscal Year End</u>	<u>Effective Date of Rate</u>	<u>Acuity Adjusted 11 Month Rate Effective Date</u>	<u>Acuity Adjusted 6 Month Rate Effective Date</u>
<u>01/31/Year 1</u>	<u>07/01/Year 1</u>	<u>12/01/Year 1</u>	<u>06/01/Year 2</u>
<u>02/28/Year 1</u>	<u>07/01/Year 1</u>	<u>01/01/Year 2</u>	<u>07/01/Year 2 (N/A)</u>
<u>03/31/Year 1</u>	<u>07/01/Year 1</u>	<u>02/01/Year 2</u>	<u>08/01/Year 2 (N/A)</u>
<u>04/30/Year 1</u>	<u>07/01/Year 1</u>	<u>03/01/Year 2</u>	<u>09/01/Year 2 (N/A)</u>
<u>05/31/Year 1</u>	<u>07/01/Year 2</u>	<u>04/01/Year 2</u>	<u>10/01/Year 2</u>
<u>06/30/Year 1</u>	<u>07/01/Year 2</u>	<u>05/01/Year 2</u>	<u>11/01/Year 2</u>
<u>07/31/Year 1</u>	<u>07/01/Year 2</u>	<u>06/01/Year 2</u>	<u>12/01/Year 2</u>
<u>08/31/Year 1</u>	<u>07/01/Year 2</u>	<u>07/01/Year 2 (N/A)</u>	<u>01/01/Year 3</u>
<u>09/30/Year 1</u>	<u>07/01/Year 2</u>	<u>08/01/Year 2</u>	<u>02/01/Year 3</u>
<u>10/31/Year 1</u>	<u>07/01/Year 2</u>	<u>09/01/Year 2</u>	<u>03/01/Year 3</u>
<u>11/30/Year 1</u>	<u>07/01/Year 2</u>	<u>10/01/Year 2</u>	<u>04/01/Year 3</u>
<u>12/31/Year 1</u>	<u>07/01/Year 2</u>	<u>11/01/Year 2</u>	<u>05/01/Year 3</u>

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22 8.443.13.B. For 12-month cost reports filed by the State-administered Class IV facilities, the  
 23 rate shall be effective on the first day covered by the cost report.

- 1 8.443.13.C. ~~The permanent rate shall be established, issued and shall pay Medicaid claims~~  
2 ~~billed on and after the later of the following dates:~~
- 3 ~~1. The beginning of the provider's new rate period, as set forth in 10 CCR 2505-10~~  
4 ~~section 8.443.13.A, or~~
- 5 ~~2. One hundred (100) days after the date the MED-13 is filed by the provider.~~
- 6 ~~\_\_\_\_\_ A July 1 Medicaid Management Information System (MMIS) rate shall be~~  
7 ~~established and issued. The July 1 MMIS rate shall and pay Medicaid claims~~  
8 ~~with dates of services on and after, July 1 of each year. The rate shall be equal to~~  
9 ~~the July 1 MMIS rate established in the previous year, prior to statutory~~  
10 ~~adjustments, plus the applicable allowable growth. The July 1 MMIS rate shall~~  
11 ~~not exceed limitations defined in C.R.S. 25.5-6-202(9)(b)(I) and may be subject~~  
12 ~~to statutory adjustments.~~
- 13 8.443.13.D. ~~In the event a permanent rate cannot be established, issued and paid as set forth~~  
14 ~~at 10 CCR 2505-10 section 8.443.13.A:~~
- 15 ~~1. The Department shall establish and issue a temporary rate calculated on the~~  
16 ~~provider's filed cost report without adjustments.~~
- 17 ~~2. All temporary rates shall, at the time the permanent rate is established, issued~~  
18 ~~and paid, be subject to adjustment and recovery of any over or under payments.~~
- 19 ~~\_\_\_\_\_ The July 1<sup>st</sup> MMIS rate established at 8.443.13.C will be reconciled to the~~  
20 ~~Schedule of Core Components Reimbursement Rate(s) established in~~  
21 ~~8.443.13.A based on the adjusted MED-13. The reconciled amount will be~~  
22 ~~included in the supplemental payment calculation for the state fiscal year~~  
23 ~~following the calculation of the final Schedule of Core Components~~  
24 ~~Reimbursement Rate and will be subject to available funding.~~
- 25 8.443.13.E. ~~Any delay in completion of the audit of the MED-13 that occurs within 90 days~~  
26 ~~from the filing of the MED-13, and that is attributable to the provider, shall~~  
27 ~~operate, on a time equivalent basis, to extend the time in which the Department~~  
28 ~~shall establish the Schedule of Core Components Reimbursement Rates, issue~~  
29 ~~and pay a temporary rate under the provisions set forth in 8.443.13.A above.~~
- 30 8.443.13.F ~~Delay in completion of the audit that is attributable to the provider shall include,~~  
31 ~~but not be limited to, the following:~~
- 32 1. ~~Failure of the provider to meet with the contract auditor at reasonable times~~  
33 ~~requested by the auditor;~~
- 34 2. ~~Failure of the provider to supply the contract auditor with information reasonably~~  
35 ~~needed to complete the audit, including the Medicare cost report that the provider~~  
36 ~~most recently filed with the Medicare fiscal intermediary or other Medicare~~  
37 ~~information approved by the Department.~~

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3. The time period that elapses during completion of the procedures described in 10 CCR 2505-10 section 8.442.1, whichever is relevant and later in a particular case.

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