RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 1187]

Nursing Facility Services; Payment Methodology for Movable Property and Exceptional Payments

The Department of Public Welfare (Department) by this order adopts amendments to Chapter 1187 (relating to nursing facility services), to read as set forth in Annex A. These amendments are adopted under sections 201 and 443.1 of the Public Welfare Code (act) (62 P. S. §§ 201 and 443.1) and sections 1396a and 1396r of the Social Security Act (42 U.S.C.A. §§ 1396a and 1396r).

Omission of Proposed Rulemaking

The Department is omitting notice of proposed rulemaking in accordance with section 204(1)(iv) and (3) of the act of July 31, 1968 (P. L. 769, No. 240) (CDL) (45 P. S. § 1204(1)(iv) and (3)) and 1 Pa. Code § 7.4(1)(iv) and (3) because:

- The Department finds that publication of these amendments as proposed rulemaking is contrary to the public interest. The primary purpose of these amendments is to change the case-mix payment methodology to remove perceived disincentives for nursing facilities to purchase unusual or expensive movable property items necessary to serve their Medical Assistance (MA) residents. These amendments permit additional grant payments to those MA nursing facilities that provide nursing facility services to MA residents who require certain extraordinary and expensive medical equipment to receive care and treatment in accordance with their individual care plans. These amendments also revise the case-mix payment methodology relating to movable property in a way that is anticipated to result in overall increases in case-mix per diem rates, and therefore provide additional reimbursement to the vast majority of MA nursing facilities. Adopting these amendments by final rulemaking will enable the Department to make the additional grants and reimbursement available as quickly as possible, and thereby better ensure that MA nursing facility residents receive the necessary care and services required by law.

- These amendments relate to reimbursement for nursing facility services under the MA Program, which is a Commonwealth grant or benefit.

Purpose of Amendments

These amendments revise the Department's case-mix regulations to incorporate and expand existing exceptional payment policies to permit the Department to pay additional reimbursement to nursing facilities for nursing facility services provided to certain MA residents who require medically necessary exceptional durable medical equipment (DME). These amendments also revise the Department's case-mix regulations to change the payment methodology as it relates to the costs of movable property that is used by nursing facilities to provide services to their residents. In addition, these amendments revise the Department's case-mix regulations to clarify existing payment policies and methodology.

Background

A. *Medicaid and the MA Program*

In 1965, Congress authorized the Medicaid Program by adding Title XIX to the Social Security Act. See 42 U.S.C.A. §§ 1396—1396r Medicaid is a grant-in-aid program in which the Federal government provides financial assistance to participating states to aid them in furnishing various health care services to poor and needy persons. State participation in the Medicaid Program is voluntary. If a state chooses to participate in the Medicaid Program, however, it must comply with Title XIX and implementing Federal regulations.

Under Title XIX, a participating state must designate a single state agency responsible for the administration of the state's Medicaid Program. The single state agency must prepare a state plan for MA (State Plan) and submit it to the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)) of the United States Department of Health and Human Services for approval. See 42 U.S.C.A. § 1396. Among other things, a State Plan must provide coverage of certain medical services, including nursing facility services, and at the state's option may provide coverage of other services. Upon approval by CMS, the state becomes eligible for Federal financial participation in the costs of the medical care and services specified in its State Plan. See 42 U.S.C.A. § 1396(a).

The Commonwealth participates in the Title XIX Medicaid Program. The Department is the designated single State agency responsible for administration of the Commonwealth's Medicaid Program, which is known as the MA Program. The MA Program provides coverage of a wide array of medical services, including nursing facility services, to this Commonwealth's poor and needy citizens.

B. *MA Nursing Facility Services*

1. *Conditions of Participation*

To lawfully provide nursing facility services in this Commonwealth, a person or entity must first obtain a license to do so from the Department of Health (DOH). See section 806(a) of the Health Care Facilities Act (35 P. S. § 448.806(a)). The person or entity is not required to participate in the MA Program to obtain a license. See section 808 of the Health Care Facilities Act (35 P. S. § 448.808) and 28 Pa. Code Chapter 201 (relating to applicability, definitions, ownership and general operation of long-term care nursing facilities). Rather, a licensee of a nursing facility chooses to seek enrollment and to participate in the MA Program as a provider of MA nursing facility services. Thus, participation by nursing facility providers in the MA Program is voluntary.

Federal law, 42 U.S.C.A. § 1396a(a)(27), requires that a nursing facility that wishes to participate in the MA Program must sign an enrollment form called a "Provider Agreement" to enroll as a provider. The provider agreement does not create a contractual relationship between the Department and the provider. Rather, because the MA Program is a grant program, the obligations and duties of both the provider and the Department are derived from and governed by law and regulation. The provider agreement merely signifies the provider's voluntary enrollment in the MA Program.

A nursing facility that is not enrolled in the MA Program may not receive reimbursement from the De-

partment for any nursing facility services that the facility may provide to MA-eligible residents. See section 443.1(3) of the act (62 P. S. § 443.1(3)) and § 1187.101(c) (relating to general payment policy).

As a condition of enrollment and continued participation in the MA Program, a nursing facility shall comply with the requirements for participation imposed by Federal and state statutes and regulations, including the Nursing Home Reform Law, 42 U.S.C.A. § 1396r, and implementing Federal regulations. See § 1187.21(3) (relating to nursing facility participation requirements). These requirements impose various duties on MA participating nursing facilities such as:

- The duty to provide services and activities that permit each resident to attain or maintain his highest practicable physical, mental and psychosocial well-being. See 42 U.S.C.A. § 1396r(b)(2) and (4)(A)(i) and (ii) and (d)(1)(A); and 42 CFR 483.25 and 483.75 (relating to quality of care; and administration).
- The duty to accommodate resident needs and preferences. See 42 U.S.C.A. § 1396r(c)(1)(v)(I); 42 CFR 483.15(e)(1) (relating to quality of life).
- The duties to promote, maintain and enhance the quality of life of each resident. See 42 U.S.C.A. § 1396r(b)(1)(A).
- The duty to properly equip the nursing facility and the rooms and otherwise provide a suitable environment. See 42 U.S.C.A. § 1396r(c)(4)(B)(ii); 42 CFR 483.15(h) and 483.70(d)(2)(iv) (relating to physical environment).
- The duty to provide equal access to quality care. See 42 U.S.C.A. § 1396r(c)(4)(B)(ii).
- The duty to ensure that residents do not experience any avoidable diminution of the ability to ambulate and transfer. See 42 CFR 483.25(a)(1)(ii).
- The duty to ensure that residents do not experience any avoidable diminution of the ability to use speech, language, or other functional communications systems. See 42 CFR 483.25(a)(1)(v).
- The duty to provide appropriate treatment and services to maintain or improve a resident's abilities in activities of daily living, including ambulation and communication. See 42 CFR 483.25(a)(2).
- The duty to prevent avoidable decreases in a resident's social interactions. See 42 CFR 483.25(f)(2).
- The duty to provide nursing facility services to a resident in accordance with that resident's written plan of care. See 42 U.S.C.A. § 1396r(b)(2) and (b)(4)(A)(i) and (ii).
- The duty to provide nursing facility services in accordance with instructions of the physician who is responsible for supervising the health care being provided to a resident. See 42 U.S.C.A. § 1396r(b)(6)(A).

A nursing facility that fails to comply with applicable program requirements, including the aforementioned duties, is subject to the imposition of various remedies by both CMS and the Department, including termination of the facility's participation in the MA Program.

2. *Items and Services Covered by the MA Case-mix Per Diem Rate*

Under Federal law, the Department may specify the items and services included in its MA case-mix per diem rate. See 42 U.S.C.A. § 1396r(c)(1)(B)(iii) and (4)(B)(ii). See also 42 U.S.C.A. § 1396r(f)(7). The Department has specified that the MA rate covers payment for routine services and items. See § 1187.51(c) (relating to scope). Routine services and items include, among other things: "services required to meet certification standards, . . . the use of equipment and facilities, . . . [r]eusable items furnished to residents, such as . . . wheelchairs . . . and other durable medical equipment[,] . . . [and] special medical services of a rehabilitative, restorative or maintenance nature, designed to restore or maintain the resident's physical and social capabilities." See § 1187.51(c)(1), (5) and (10).

The Department has also included provisions in the Commonwealth's Title XIX State Plan that authorize the Department, under certain limited circumstances, to make exceptional payments to nursing facilities. During the period January 1, 1996, through October 31, 1999, the State Plan restricted exceptional payments to nursing facilities providing services to "high technology dependent residents, such as ventilator dependent and head and/or spinal cord injured individuals." Under these State Plan provisions, the only additional costs that could be paid through the exceptional payments were costs for the rental of equipment and the supplies necessary to care for high technology-dependent residents. Before the Department would enter into an exceptional payment agreement, the Department had to be satisfied that the nursing facility's per diem rate did not cover the additional exceptional costs related to the care of the high technology-dependent resident and that the resident could not otherwise obtain appropriate care.

3. *Payment in Full for Covered Services and Items*

An MA nursing facility must accept payment at the MA case-mix per diem rate as payment in full for the covered services and items specified by the Department. See sections 444.1 and 1406(a) of the act (62 P. S. §§ 444.1 and 1406(a)); and § 1101.63(a) (relating to payment in full). An MA nursing facility may not seek or accept any other payment to provide a covered item or service to an MA resident, even though the cost of the particular item or service required to meet the resident's individual needs exceeds the facility's MA payment rate. In those instances in which the Department has entered into an exceptional payment agreement with an MA nursing facility, the facility must accept the MA per diem rate and any additional payments made under the exceptional payment agreement as payment in full for covered services and items provided to the resident specified in the agreement.

C. *Overview of the Existing Case-Mix Rate Calculation*

The MA Program pays for nursing facility services provided to eligible recipients by enrolled nursing facility providers based upon prospective per diem rates calculated in accordance with the Department's case-mix payment methodology. See §§ 1187.1(c), 1187.2 (definition of "per diem rate"), 1187.96(e) and 1187.101. A nursing facility's prospective per diem rate is comprised of one "capital" rate component and three "net operating" rate components. See § 1187.96(e) (relating to price and rate setting computions). The capital component is based upon the nursing facility's fair rental value (FRV). The three net operating components are based upon peer group prices. See § 1187.96(a)—(e).

As specified in the Department's regulations, the Department computes "peer group prices" annually, using the nursing facility information system (NIS) database. See §§ 1187.2, 1187.52(a) and 1187.91 (relating to policy; definitions; and database). Generally, for any given fiscal year, the NIS database compiles costs from the three

most recent audited cost reports for each MA nursing facility on file as of March 31.[1] See § 1187.91. Applying a complex formula to these compiled costs, the Department calculates the peer group price for the three net operating cost centers for each of the 14 nursing facility peer groups. See §§ 1187.91 and 1187.94—1187.96. The resulting peer group prices are then used by the Department to set the net operating rate components for each nursing facility. See § 1187.96(a)—(c) (relating to price and rate setting computions).

The net operating cost components of the nursing facility's prospective payment rate are limited by or based upon the facility's peer group prices. The Department adjusts the resident care component of each nursing facility's prospective rate every quarter of the rate-setting year to reflect the resource usage of the facility's MA residents. The nursing facility's prospective rate, as adjusted each quarter, remains in effect during the rate-setting period. See §§ 1187.95 and 1187.96. When combined with the capital rate component, these net operating components comprise the nursing facility's case-mix per diem rate.

Under the case-mix regulations, the Department uses capital costs in computing the capital component of nursing facilities' per diem rates by means of an FRV methodology. Instead of recognizing depreciation and interest costs, however, the FRV methodology establishes an imputed rental cost for equipment, housing and shelter that the nursing facility uses to render services to its residents. A nursing facility's FRV is based upon the appraised depreciated replacement value of the facility's fixed and movable property as determined by the most recent appraisal of the facility conducted by the Department or its contractor.

For purposes of the case-mix system, the DME is considered movable property. See §§ 1187.2 (definitions of "movable property" and "appraisal of nursing facilities") and 1187.96(d)(1). The DME includes: bedrails, ice bags, canes, crutches, walkers, wheelchairs, traction equipment and hospital beds. See § 1187.51(c)(5). Because DME is a type of movable property, an MA nursing facility's capital rate component is computed by, among other things, including the appraised depreciated replacement value of that equipment in the total appraised value of the facility, which is then used to derive the facility's overall FRV. See § 1187.96(d)(1) and (2).

D. *Purpose of the New Case-Mix Payment Policies*

Nursing facilities have repeatedly objected to the Department's decision to include movable property in the FRV methodology and to the way in which the Department determines the value of that equipment in computing the overall FRV. Consumers have also expressed concerns about the way in which the Department recognizes movable property costs. Consumers have contended that the reimbursement methodology creates disincentives to nursing facilities obtaining equipment that is expensive or unusual, or both, in that the methodology does not pay, only partially pays or does not promptly pay equipment costs.

While the Department believes that its case-mix payment methodology provides fair and adequate reimbursement for nursing facility services, the Department recognizes that, in some situations, a nursing facility's obligation to provide appropriate and necessary services to an MA resident requires that the facility obtain certain DME that is unusual, expensive and otherwise extraordinary. Under current Department regulations, the DME is considered a routine service or item that is covered under the nursing facility's MA per diem rate. Therefore, the nursing facility must accept payment at the MA case-mix per diem rate as payment in full for covered services and items provided to the MA resident, including any medically necessary DME. See § 1101.63(a) (relating to payment in full).

Notwithstanding the nursing facility's obligation to accept payment at the MA per diem rate as payment in full, the Department also recognizes that, because case-mix per diem rates are based upon average costs, adjusted in part by the average acuity of MA residents, some facilities may be reluctant to obtain DME that, although medically necessary, is also unusual and expensive. The reluctance may translate into either delay in the provision of medically necessary DME or, in extreme cases, the outright failure to provide the equipment. In either situation, the likely outcomes are that the resident's needs are not being met and that the nursing facility provider is out of compliance with both State and Federal requirements. These outcomes are unacceptable.

To prevent these unacceptable outcomes and to further encourage nursing facilities to meet their legal obligations to provide necessary care and services, including equipment to improve the resident's ability to self-ambulate and otherwise maximize his independence, the Department is promulgating the amendments set forth in Annex A. The primary purpose of these amendments is to change the case-mix payment methodology to remove perceived disincentives for nursing facilities to purchase unusual or expensive movable property items necessary to serve their MA residents. These changes are part of the Department's continuing efforts to assure that MA nursing facility residents receive care and services allowing them to attain and maintain their highest practicable physical, mental and psychosocial well being in accordance with applicable law, including the Nursing Home Reform Law and Title II of the Americans with Disabilities Act (42 U.S.C.A. §§ 12131—12134).

E. *Public Process*

Prior to the publication of these amendments, the Department published an advance notice at 29 Pa.B. 5657 (October 30, 1999), announcing its intent to amend its State Plan and nursing facility payment policies to expand its exceptional payment provisions. The Department subsequently published a notice at 29 Pa.B. 5957 (November 20, 1999), announcing that it had drafted provisions to incorporate this policy change into its nursing facility payment methods and standards and that the proposed revisions were available for public review and comment. The Department also discussed and solicited comments on the proposed changes at meetings of the Medical Assistance Advisory Committee (MAAC) on October 27, 1999, December 9, 1999, January 27, 2000, and March 23, 2000; the Long Term Care Subcommittee meetings of the MAAC on October 13, 1999, December 15, 1999, February 9, 2000, and April 12, 2000; the Consumer Subcommittee meetings of the MAAC on October 27, 1999, and March 22, 2000; and the Fee for Service Subcommittee meeting of the MAAC on October 28, 1999. The meetings were open to the public.

The Department received a total of 94 written comments on its draft policy changes from consumers, con-

[1] Although the Department audits nursing facilities' allowable costs for each fiscal period, unlike the process used by the prior, retrospective payment system, the Department does not reconcile each facility's prospective payments based upon the facility's final audited costs for the rate-setting period. Rather, the Department uses the audit to set the nursing facility's future payment rates. See § 1187.108(a) (relating to gross adjustments to nursing facility payments). Moreover, in some situations, the Department may use data from less than three audit reports or from unaudited cost.

sumer representatives, industry representatives and other interested parties. In November 2000, the Department released a second draft of its revised case-mix regulations to the members of the MAAC, and the Long Term Care and Consumer Subcommittees of the MAAC. A summary of the significant changes between the November 1999 and the November 2000 draft follows:

"Eligible facility"—In the November 1999 draft, the Department limited the availability of exceptional DME grants to "eligible facilities." The definition of "eligible facility" excluded special rehabilitation and hospital-based nursing facilities. The Department received comments objecting to the exclusion of these types of nursing facilities from receiving exceptional payments. Upon consideration of these comments, the Department eliminated the definition of "eligible facility" from the draft regulatory language. The effect of the elimination of this definition is that all MA nursing facility providers may receive an exceptional DME grant, subject to the conditions and limitations set forth in §§ 1187.151—1187.158.

"Reasonableness determinations"—In the November 1999 draft, the Department specified that the issuance of an exceptional DME grant would be conditioned upon, among other things, the Department's determination that "it [was] reasonable for the MA Program to pay for the exceptional DME." The Department further specified that one circumstance in which it would be unreasonable for the MA Program to pay was when the Department determined that "[t]he expense of the Exceptional DME [was] clearly disproportionate to the therapeutic or rehabilitative benefits that are expected to be derived from the use of the equipment." The Department received comments objecting to the provisions requiring "reasonableness determinations," and in particular, to the above-quoted provision which the commentators characterized as imposing an inappropriate "cost/benefit" analysis in the exceptional payment decision-making process. Upon consideration of these comments, the Department eliminated the provisions relating to "reasonableness determinations" from the draft regulatory revisions. The Department notes, however, that the amendments in Annex A specify that the Department must determine that the exceptional DME is medically necessary before the Department will issue an exceptional DME grant to a nursing facility. In making medical necessity determinations, the Department will continue to consider whether the resident's needs can be met with less costly, medically appropriate alternatives, or with equipment and services that are already available to the resident.

"Prior authorization"—In the November 1999 draft, the Department specified that "[t]he facility's request must be submitted to and approved by the Department before the facility purchases or rents the DME for which the facility is requesting [an Exceptional DME] grant." The Department received comments objecting to this "prior authorization" provision. Upon consideration of these comments, the Department eliminated the requirement that the nursing facility request and receive the Department's approval before purchasing or renting the exceptional DME. The amendments set forth in Annex A allow a nursing facility to request an exceptional DME grant up to 30 days after it purchases or rents the equipment.

"Scope of the draft changes"—The November 1999 draft incorporated and expanded the Department's existing exceptional payment policies into the case-mix regulations. While the comments that the Department received were generally very supportive of the Department's proposal to make these changes, the comments also suggested that the changes did not go far enough. A number of commentators requested, for example, that the Department expand the list of exceptional DME to include standard motorized wheelchairs. Other commentators noted that the changes did not address overall concerns with the adequacy of FRV methodology. Upon consideration of these comments, the Department was not convinced that standard motorized wheelchairs should be considered exceptional DME. The Department did determine, however, that other changes could also serve to encourage nursing facilities to purchase movable property items necessary to serve their MA residents, and that the Department would revise the underlying case-mix payment methodology for movable property to further promote that objective. The Department included these additional revisions in the draft regulatory provisions. The amendments set forth in Annex A both revise the basic case-mix payment methodology for movable property and add Chapter 1187, Subchapter K (relating to exceptional payment for nursing facility services) setting forth the exceptional DME payment policies.

"Notice of rule change"—When it first announced its intent to change its exceptional payment policies, the Department also stated that it intended to make the changes by publishing a notice of rule change (NORC). See 29 Pa.B. 5957. The Department received comments objecting to the use of a NORC. After consideration of these comments, the Department announced that it would adopt the changes by promulgating final-form regulations. The Department has received no comments objecting to the publication of final-form regulations or to the omission of proposed rulemaking. For the reasons set forth in this Preamble, the Department is proceeding with the adoption of the regulations in Annex A by final-form rulemaking, notice of proposed rulemaking omitted.

Following distribution of the November 2000 draft, the Department received an additional 80 comments on the draft changes to its reimbursement methodology. The Department has considered all comments received in drafting the amendments set forth in Annex A. An overview of the changes being made by the amendments as well as a detailed explanation of each revision follows.

F. *Overview of the New Case-Mix Payment Policies*

1. *Movable Property Payment Methodology*

Currently the Department pays MA nursing facility providers on a per diem rate basis for nursing facility services provided to MA residents. These per diem rates include a capital component that is based upon the FRV of the nursing facilities' allowable fixed and movable property. The nursing facilities' FRV is subject to the capital component payment limitation contained in § 1187.113 (relating to capital component payment limitation) commonly known as "the moratorium."

The amendments to Chapter 1187 set forth in Annex A remove allowable movable property costs from the FRV calculation. Under the revised payment methodology, movable property is divided into two classes based on acquisition cost: minor movable property (items with an acquisition cost of less than $500) and major movable property (items with an acquisition cost of $500 or more). Allowable minor movable property costs are included in the appropriate cost center of the net operating portion of the nursing facilities' per diem rates. Allowable major movable property costs are included in a new movable property component in the capital portion of the nursing facilities' per diem rates. In addition, allowable movable property costs are no longer subject to the capital compo-

nent payment limitation contained in § 1187.113. Nursing facilities' movable property capital rate components are based upon their most recent audited cost report in the NIS database for cost reporting periods beginning on or after January 1, 2001.

The amendments also include provisions that allow for a transition during the period until the new movable property payment becomes fully effective. See, §§ 1187.51(e), 1187.91(1)(iv)(D) and (2)(ii)(A) and 1187.96(d)(2). The transition period begins on January 1, 2001, and at that time the revised rules for preparing cost reports and determining allowable costs become effective. The transition period does not end on any particular date. Rather, it ends individually for each nursing facility. The end of a nursing facility's transition period for the net operating component occurs when, for purposes of setting annual peer group prices and quarterly per diem rates, the facility no longer has any audited cost reports in the NIS database for a cost reporting period beginning before January 1, 2001.

During the transition period, the Department will determine peer group prices and net operating per diem rate components using information set forth on the audited cost reports in the NIS database. Initially, this means that the peer group prices and rates will be based upon the audited costs as set forth in the audited cost reports prepared under Chapter 1181 (relating to nursing facility care), for cost reporting periods ending on or before December 31, 1995, and under Chapter 1187, for cost reporting periods that began on or after January 1, 1996, but before January 1, 2001. The Department will continue to compute the 3-year average per diem rate based upon the three most recent audited cost reports. In making this computation, the Department will use the audited costs set forth in earlier audited cost reports used without any modification or adjustment except as follows: Effective with July 1, 2001, price and rate setting, the Department will reverse audit adjustments disallowing or reclassifying minor movable property or linen costs that reduce audited allowable net operating costs in the NIS database for fiscal periods beginning prior to January 1, 2001. See § 1187.91(1)(iv)(D).

Thus, for example, if a nursing facility has one audited cost report in the NIS database for a cost reporting period beginning on January 1, 2001, and the facility's other two audited cost reports are for periods beginning on January 1, 1999 and 2000, the costs and adjustments set forth in those two audited cost reports will not be adjusted or modified so as to reflect the changes in the amendments in Annex A pertaining to the allowability or nonallowability of costs. As a result, although under the amendments "depreciation on transportation equipment" is no longer an allowable net operating cost, the Department will not adjust the nursing facility's audited costs for the periods in the earlier reports to eliminate the facility's audited allowable depreciation on transportation equipment. In like manner, the Department will not adjust or modify the nursing facility's audited costs for these earlier periods to include previously nonallowable costs, such as the rental cost of major movable property. To the extent that the nursing facility reported costs relating to linens and minor movable property as net operating costs on the cost reports for these earlier periods, the Department will reverse audit adjustments that disallowed or reclassified the reported costs for linens or minor movable property for these earlier periods.

During the public process, the Department received recommendations to fully implement the new movable property payment methodology in setting capital component rates effective July 1, 2001, and therefore eliminate the need for transition provisions. The Department finds this proposal impracticable, as it would require that the nursing facilities submit amended cost reports, and that the Department audit those cost reports. Therefore, pending implementation of the revised methodology, the Department will continue to include movable property costs in computing nursing facilities' fair rental. During the transition period, the Department will continue to include movable property in the FRV determination in computing a nursing facility's capital component rate until the facility has an audited cost report in the database for a fiscal period beginning on or after January 1, 2001. In determining the facility's FRV, however, the Department will no longer apply the moratorium limitation in § 1187.113 to movable property costs for rates effective on or after July 1, 2001. Once the nursing facility has an audited cost report in the database for a fiscal period beginning on or after January 1, 2001, the Department will calculate the facility's movable property component of its capital rate in accordance with § 1187.96(d)(2)(ii).

The Department also received a comment during the public process recommending that it use costs reported on the most recently "filed" cost reports for rate-setting purposes during the transition. The Department notes that, in its initial discussions with the associations representing the nursing facility industry, the associations recommended only that the Department reverse audit disallowances involving certain net operating costs of minor movable property in transitioning from the existing to the new payment methodology. The Department accepted this recommendation, and as described above, included provisions in the amendments in Annex A that authorize these revisions to the audited costs. In addition, the Department also determined to eliminate the application of the moratorium regulations to movable property costs, among other things. The Department believes that these measures provide for an adequate and fair transition. The issue of using audited versus reported costs was resolved by the Department as part of its promulgation of Chapter 1187.

2. *Exceptional Payment Provisions*

Prior to November 1, 1999, the Department's approved State Plan authorized the Department to make exceptional payments to cover the costs associated with the rental of equipment and supplies necessary to provide services to "high technology-dependent residents." In promulgating these amendments to Chapter 1187, the Department is expanding these exceptional payment policies in its regulations. With the amendments set forth in Subchapter K (which take effect retroactive to November 1, 1999), the Department regulations now allow additional payments for nursing facility services that involve the provision of exceptional DME. The additional payments are not limited to cases involving MA residents who are ventilator-dependent or who have suffered head or spinal cord injuries, but are available, subject to the conditions in Subchapter K, in all cases in which exceptional DME is medically necessary. The additional payments are not limited to the cost of rent and supplies, but are based upon the reasonable and prudent costs incurred by the nursing facility to purchase or rent the exceptional DME and to obtain related services and items necessary for the effective use of that equipment, including accessories and supplies, and resident and staff training.

Although the exceptional payments authorized under these amendments are based upon the costs incurred by a

nursing facility to obtain the necessary DME and related services and supplies, the Department notes that the exceptional payments constitute additional reimbursement to the MA nursing facility for nursing facility services provided to a particular resident. They are not intended as a direct payment for the DME or other related services or supplies. Because the Department considers the exceptional payments as payment for nursing facility services, the Department will only authorize the payments to enrolled nursing facility providers.

The Department also notes that the exceptional payments authorized under Subchapter K are not intended to cover situations when a nursing facility incurs a higher cost of providing services to a resident because of costs associated with something other than the use of exceptional DME. Example, exceptional payments are not available to cover situations in which an MA resident may require a higher-than-usual number of nursing hours. The risk that these costs may be necessary is a risk that a nursing facility voluntarily assumes when it elects to participate (or to continue to participate) in the MA Program. See § 1101.63. Moreover, these situations are adequately addressed by the existing case-mix regulations, including the case-mix index (CMI) computations and adjustments.

Although the amendments permit an eligible nursing facility to receive additional reimbursement, no nursing facility has an obligation to request or an automatic right to obtain the reimbursement. Rather, a nursing facility makes the choice to request an exceptional DME grant and may obtain additional grant payments only if it complies with Subchapter K. Among other things, Subchapter K requires that: (i) the facility must submit a proper written request for an exceptional DME grant; (ii) the identified resident must be MA-eligible; (iii) the DME must be exceptional; and (iv) the DME must be medically necessary.

The submission of a request for a grant does not stay or otherwise affect a nursing facility's obligation to provide proper nursing facility services, including exceptional or other DME. Indeed, the amendments expressly permit the nursing facility to immediately obtain all medically necessary DME and to request an exceptional DME grant afterwards.

3. *Enforcement Activities*

A nursing facility that is enrolled in the MA Program has numerous obligations under Federal law, including the obligation to provide its MA residents with any DME that is medically necessary. Failure to provide medically necessary DME is a violation of state and Federal law and constitutes a "deficiency" for purposes of §§ 1187.121 and 1187.122 (relating to applicability; and requirements).

By promulgating these amendments, the Department is changing the case-mix payment methodology relating to movable property costs. The Department anticipates that these changes will result in increases in the case-mix per diem rates of the vast majority of MA nursing facilities. The Department is also providing MA nursing facilities with the option to obtain additional payments when they serve MA residents who need exceptional DME. All of these changes are intended to eliminate purported disincentives to providing unusual or expensive equipment in serving MA residents. In addition, however, to ensure that nursing facilities are providing legally sufficient nursing facility services to their MA residents, the Department, in cooperation with the DOH and the Department of Aging (PDA), is increasing its focus upon instances of reported noncompliance. This increase in focus is being effectuated by various means.

First, the Department has established a hotline for use by residents and their representatives. The number of that hotline is (877) 299-2918. When the Department receives a complaint that the nursing facility services being provided to a resident do not include medically necessary DME, the Department will respond by contacting the nursing facility and requesting information, or by sending a Utilization Management Review (UMR) team or requesting the DOH to send out a survey team to determine whether the facility should be cited for a deficiency.

Second, the Department is taking proactive measures to identify persons who may require exceptional DME, to determine whether these persons are receiving services and items necessary to meet their individual needs. Initially, the Department will review services being provided to paraplegic and quadriplegic residents. Thereafter, the Department intends to focus on other subsets of the MA population.

Third, the Department has met and will continue to meet with Ombudsman and Options staff to inform them of the availability of exceptional DME grants, the Department's interest in identifying residents who may benefit from additional or different DME, including exceptional DME, and how the Options staff and Ombudsman may report to the Department or DOH when they believe that a resident's needs are not being adequately met.

When, as a result of these activities or otherwise, the Department determines that a nursing facility has failed to provide necessary standard or exceptional DME, the Department will impose remedies. These remedies may include termination of the nursing facility's participation in the MA Program, fines, and the recovery of payments.

G. *Explanation of Specific Changes to Chapter 1187*

§ 1187.2. Definitions

Appraisal. As originally promulgated, § 1187.2 sets forth a definition of "appraisal of nursing facilities." The Department has revised that definition to use the terms "fixed property," "movable property" and "depreciated replacement cost." The requirement that an appraisal be made "by qualified personnel of an independent appraisal firm under contract with the Department" was moved from § 1187.57(b).

Depreciated replacement cost. The term "depreciated replacement cost" replaces "replacement costs." As originally promulgated, Chapter 1187 included "replacement costs" as a defined term. Among other things, that definition specified that the amount required to replace the entire nursing facility was to be reduced by "an allowance for accrued depreciation," that is, although the word "depreciation" did not appear in the defined term, the concept was incorporated in the definition. See § 1187.2. Thus, the new term more fully describes the underlying concept. In addition, the revised term replaces two undefined terms that were synonymous with "replacement cost": "depreciated replacement cost" and "depreciated replacement value," which appeared in §§ 1187.57(b) and 1187.96(d) and were synonyms for the previous defined term. Finally, the original definition has been amended so that it now applies only to a nursing facility's fixed property, while a new, alternative definition sets forth the meaning of "depreciated replacement cost" in the context of "movable property."

DME—Durable medical equipment. The amendments add a new term to those in § 1187.2: "durable medical equipment or DME." The definition of "DME" has four significant features:

1. *Movable property.* For an item to come within the definition of "DME," it must meet the definition of "movable property." The latter is a residual definition, it encompasses any tangible item used in the course of providing nursing facility services that does not qualify as fixed property or a supply. Thus, for example, a whirlpool bath that is affixed to the building would be an item of fixed property and, consequently, would not qualify as an item of DME.

2. *Connection to the Federal definition.* The definition of "DME" is based in part upon the first three parts of the Federal definition as set forth at 42 CFR 414.202 (relating to definitions): "Durable medical equipment means equipment . . . that (1) [c]an withstand repeated use; (2) [i]s primarily and customarily used to serve a medical purpose; (3) [g]enerally is not useful to an individual in the absence of an illness or injury[.]" However, because the Department's definition is applicable only for DME used in a nursing facility, the Department has not included the fourth specification of the Federal definition, that the DME must be "appropriate for use in the home." To the contrary, because circumstances in a nursing facility can be very different from circumstances in a person's home, that part of the Federal definition is inapplicable.

3. *Standard DME.* The definition of "DME" recognizes two classes of DME: "exceptional DME" and "standard DME." The latter is a residual class, that is any item of DME that does not qualify as "exceptional DME" must be "standard DME." There is no third class.

4. *Exceptional DME.* All DME necessary to provide nursing facility services to residents is an item or service covered by the MA case-mix per diem rate and the allowable costs of DME are used to compute nursing facility case-mix per diem rates. The purpose of defining "exceptional DME" is to specify those types of DME that, when needed in the course of providing nursing facility services to an MA resident, give rise to the opportunity of the nursing facility to request an exceptional DME grant. An exceptional DME grant authorizes a nursing facility to receive payment in addition to its MA case-mix per diem rate payment. By authorizing exceptional DME grants, the Department is able to recognize the extraordinary costs associated with small subsets of the nursing facility population whose medical needs are so extensive and complex that they cannot be adequately served without highly customized or specialized DME. For an item of DME to qualify as "exceptional DME" it must satisfy two conditions: Its acquisition cost (determined in accordance with § 1187.61) must meet or exceed the minimum acquisition cost threshold set by the Department in its annual notice pertaining to exceptional DME, and it must be either "specially adapted DME" (as that term is defined in § 1187.2), or it must be a type of DME identified in the annual notice.

a. *Minimum acquisition cost.* The Department's per diem rates pay for nursing facility services provided to residents having various and varied needs for DME, including types of DME that are used with a fairly low frequency (such as, ventilators). However, even when these types of DME are used infrequently, their cost is reflected in the overall rate. For this reason, the Department has determined that a minimum acquisition cost is an appropriate threshold for defining what items of DME should be considered "exceptional." During the public process, the Department received a comment recommending that equipment that costs more than $2,000 or $3,000 should be considered "exceptional DME." In considering what an appropriate threshold would be, the Department notes that CMS recently increased its capitalization threshold to $5,000. See CMS Pub. 15-1 § 108.1. Because the Department found this threshold to be reasonable and consistent with the current inventory of movable property in nursing facilities, the current minimum acquisition cost as set forth at 31 Pa.B 1422 (March 10, 2001) is $5,000. By setting the specific amount of this threshold in the annual notice, however, the Department has retained the ability to make simple and expeditious adjustments in this amount, as DME acquisition costs fluctuate over time.

b. *The annual list of exceptional DME.* To put nursing facilities on notice as to what types of DME can qualify as "exceptional DME," and to simplify the process of handling exceptional DME grant applications, the Department believes that a list of that DME is useful and desirable. To provide full public disclosure and information, the Department will publish an annual list of types of DME whereby, if the acquisition cost of an item on the list meets the minimum acquisition cost threshold, that item is deemed to be an item of exceptional DME. The Department intends to review recommended additions to the list on an annual basis, and intends to publish this annual list by means of a public notice set forth in July of each year in the *Pennsylvania Bulletin*. Persons who wish to have an item considered by the Department should submit a written request to the Department. All requests received on or before December 31 will be considered in developing the list effective the following July. Any requests received after December 31 will be considered during the next annual review cycle. To provide interested persons with clear instructions regarding the submittal of these requests, the Department has removed the words "at least" from the draft definition of "exceptional DME." Consequently, all recommended changes to the list will be considered together, and not on an ad hoc basis. Moreover, because changes to the list will be considered through this process, the submittal of a request to add an unlisted type of DME to the annual list is intended to be an administrative remedy that must be exhausted before other relief may be sought.

During the course of the public process, the Department received comments recommending that the Department identify standard motorized wheelchairs as "exceptional DME." The Department has not included the wheelchairs in either the definition of "exceptional DME" or in its public notice (31 Pa.B. 1422) designating the particular equipment it considers "exceptional." The Department disagrees that power wheelchairs should be labeled "exceptional." To the contrary, it is the Department's position that the equipment should be part of the standard array of DME routinely available in nursing facilities. To address concerns that the expense of that equipment makes its acquisition cost-prohibitive for nursing facilities, the Department notes that the amendments in addition to permitting exceptional grant payments under certain circumstances, substantially revise the case-mix payment methodology relating to movable property costs to eliminate purported disincentives for nursing facilities to provide equipment, like standard motorized wheelchairs, that may be somewhat more costly than other equipment routinely found in nursing facilities.

Fair rental value. The original definition of "FRV" has been amended to reflect changes in the regulations. The

Department has modified the draft revised definition so that it also pertains to movable property because, in some instances, the Department will use the FRV of that movable property. See § 1187.96(d)(2)(i).

Fixed property. The Department has amended the original definition by eliminating the various examples of "land improvements" and "detached buildings" and by making other changes intended to clarify the original definition. However, no change in the scope of the definition is intended. During the public process the Department received a comment recommending that the Department retain the examples in the definition of "fixed property." While the Department does not accept this recommendation, the Department notes that the examples of fixed equipment included in the original definition continue to be examples of fixed equipment under the revised regulation.

Initial appraisal. As originally promulgated, Chapter 1187 provides that each enrolled nursing facility "will be appraised at its depreciated replacement cost." See § 1187.57(b). Thus, for each nursing facility, there must be a first or original (that is, initial) appraisal. By adding the term "initial appraisal" to § 1187.2, the Department is codifying the current colloquialism and establishing a basis for making clear reference to refer to all of the appraisals. The term stands in contrast to the terms "updated appraisal," "reappraisal" and "limited appraisal."

Interest. As originally promulgated, § 1187.2 set forth a definition of "interest—capital indebtedness" and "interest—administrative." The amendments merge both concepts under the general term "interest" and rename the terms, "capital interest" and "other interest." In addition, the definition of "capital interest" has been changed to replace the term "capital purposes" with the more specific "fixed property, major movable property or minor movable property." Likewise, the definition of "other interest" has been changed so that "the acquisition of supplies" is expressly included within the meaning of "day-to-day operational activities." These changes do not alter the former meanings of these terms, but are intended to clarify possible ambiguities in the original version.

Limited appraisal. As originally promulgated, a limited appraisal could be conducted as a result of additions or deletions to capital, regardless of whether the capital was fixed or movable property. Under the amendments, limited appraisals are no longer necessary for additions or deletions involving movable property. The Department has committed to performing annual inventories in appraising movable property in instances where a capital rate component is computed using the FRV of movable property. Therefore, limited appraisals are used only to account for changes involving fixed property. The definition has been further modified to make clear that, for a limited appraisal to be conducted, it first must be requested by the nursing facility. If no request is made, the Department has no obligation to direct the independent appraisal firm under contract with the Department to conduct any appraisal. The Department also amended the definition to expressly set forth the function and effect of a limited appraisal, it "results in the modification of the depreciated replacement cost set forth in an initial appraisal, a reappraisal or an updated appraisal." A modification is solely prospective in nature: a limited appraisal cannot serve as a basis for revising a nursing facility's capital rate component for a rate year in effect on or before the date that the limited appraisal is conducted.

Movable property. As originally promulgated, Chapter 1187 set forth a definition of "movable property" in § 1187.2, then used the term "movable equipment" in §§ 1187.2, 1187.96(d)(1) and 1187.112. Although these terms were synonymous, the amendments eliminate the latter, to eliminate possible ambiguities. In reworking the definition of movable property, the Department makes reference to tangible items. That term excludes "intangible items" such as annuities, stocks, shares, patents, copyrights, trade or service marks, choses in action, notes, bonds, insurance policies, goodwill, contract rights, options, legal rights, receivables and other evidences of debt, documents, and cash. No change in the scope of "movable property" or "fixed property" is intended by the inclusion of "tangible items" and the exclusion of "intangible items" from the revised definitions. In addition to these changes, the definition of "movable property" has been rewritten to reflect the revisions being made to the case-mix payment system. "Movable property" is a residual term: any tangible item that does not qualify as either fixed property or a supply is deemed to be an item of movable property.

During the public process, the Department received a comment recommending that language regarding transportation costs should be added to the movable property definition. While the Department does not accept this recommendation, the Department notes that transportation equipment used in a nursing facility in the course of providing nursing facility services to residents is "movable property" as defined in § 1187.2.

Major and minor movable property. The definition of "movable property" divides that class of tangible items into two subclasses: "major" and "minor" movable property. Taken together, these classes are exclusive. There is no third classification; any item of movable property must fall into one or the other subclass. The factor that determines this classification is the "acquisition cost" of the item. The rules for establishing an item's acquisition cost are set forth in § 1187.61.

Movable property appraisal. An appraisal conducted to determine the depreciated replacement cost of some or all of the movable property of a nursing facility. So long as necessary, the Department will conduct these appraisals on an annual basis. During the public process, the Department received a comment questioning the need for this definition. The definition is needed because movable property appraisals will be used during the transition period, and in some instances, for new nursing facilities.

Real estate tax cost. As originally promulgated, Chapter 1187 made repeated reference to "real estate taxes or reasonable payment made in lieu of real estate taxes." See §§ 1187.51(e)(4)(ii), 1187.57(a), 1187.71(a)(4)(iii), 1187.91(2)(ii), 1187.96(d)(3) and 1187.97(1)(ii). To simplify references to this category of cost, the Department has added the definition of "real estate tax cost" to § 1187.2. In setting forth that definition, the Department does not intend that it result in any change in the treatment of these costs.

Reappraisal. As originally promulgated, Chapter 1187 did not require annual appraisals. Instead, it merely required that nursing facilities be "reappraised" every 5 years after the implementation of the case-mix payment system. See § 1187.57(b)(2). In practice, however, the Department contracted with an independent appraisal firm to provide the Department with updated appraisals on an annual basis. In addition, during 1998, the Department required that the firm inspect all enrolled nursing facilities and provide the Department with new appraisals. The latter are referred to as "reappraisals." The Department has revised this term to reflect that meaning.

Related services and items. As set forth in Subchapter K, which is promulgated by these amendments, the Department will under certain conditions make payments under "exceptional DME grants." Those payments are intended to pay the nursing facility for the necessary, reasonable and prudent costs incurred in acquiring and using exceptional DME when that equipment is needed by an MA resident. In various situations, the cost of using that equipment will also entail substantial additional costs. As set forth in § 1187.154(a)(1), an exceptional DME grant authorizes payment of the necessary, reasonable and prudent costs of the exceptional DME and of "related services and items." The purpose of the definition of that term is to specify what is encompassed by that term.

Specially adapted DME. Generally, an item of DME qualifies as "exceptional DME" if its acquisition cost meets or exceeds the minimum acquisition cost threshold and if it is of a particular type set forth on the Department's annual list. However, even if DME does not fall into any of the types listed in the notice, it still can qualify as "exceptional" if its acquisition cost meets or exceeds the minimum acquisition cost threshold and it is "specially adapted." The Department has made allowance for "specially adapted DME" to provide nursing facilities with the opportunity of receiving additional payments in those situations when a particular resident requires an expensive and unique item of DME and when there is no reasonable expectation that, when that resident has ceased to use the item, it might then be used by some other actual or potential resident of the facility, or would be usable by another person only if substantial modifications were made to it. An example of a device is a motorized wheelchair equipped with a palate drive device that is fabricated to meet the particular needs of a specific quadriplegic resident. The definition of "specially adapted DME" has three significant features, of which "contemporaneous use" is by far the most important:

1. *Unique construction.* An item of DME is "uniquely constructed" if it is originally fabricated or assembled to suit the particular physical or medical circumstances of the intended user. For example, if a motorized wheelchair is ordered for a particular resident, that item of DME would typically be assembled from various off-the-shelf components, and the choice of those components depends upon the physical circumstances of the intended user. Under these circumstances, the fabrication of the wheelchair might (depending on circumstances) qualify as "unique construction." Even if it did, however, that circumstance would not be sufficient to cause the wheelchair to be an item of specially adapted DME.

2. *Substantial adaptation or modification.* An item of DME is "substantially adapted or modified" if, in its original or earlier configuration, it was not suitable for use by the current intended user but, as a result of subsequent modifications, has become suitable. These modifications must be substantial. For example, merely switching a joystick from the left to the right side of a chair and altering the height and depth of the seat would not, by itself, constitute "substantial adaptation." On the other hand, if the joystick on an existing wheelchair were replaced with a palate drive control system that could not only drive the wheelchair but also control features such as "tilt in space" adjustments, the change would constitute a substantial adaptation. The mere fact that an item of DME has undergone a "substantial adaptation" does not, in itself, cause the item to be specially adapted DME. For instance, if the palate drive controls were removed from the wheelchair and replaced with a joystick control, this change might well cause the wheelchair to be suitable for contemporaneous use by numerous other persons, in which case it would not qualify as "specially adapted DME."

3. *Contemporaneous use by another resident.* By defining "specially adapted DME" to be DME that is unsuitable for contemporaneous use by another resident, the Department intends to exclude from this classification all DME that could be used by another actual or potential resident, either without any adaptation or modification or without any substantial adaptation or modification. If an item of DME is susceptible to that use, that item cannot qualify as an item of specially adapted DME, regardless of whether it was "uniquely constructed" or "substantially adapted or modified" to suit the needs of a particular resident.

The allowance for specially adapted DME is intended to address those rare situations where an expensive item of DME is so uniquely configured to the needs of a particular resident that, once that resident has ceased to use the item, it could not be used by any other resident, or could not be used by another resident unless substantial adaptations or modifications were made to it. In these situations, a nursing facility may be extremely reluctant to expend a substantial sum to obtain the item, since any further use would be impracticable. It is only in these situations that the Department intends that exceptional DME grants be given to permit additional payment to the nursing facility.

The "contemporaneous use" criterion is not intended to be applied to the particular residents of the nursing facility. Thus, for instance, in reviewing an application for an exceptional DME grant, the Department does not intend to review the medical or other records of the nursing facility's other residents before making a determination. Instead, the "contemporaneous use" criterion is intended to apply to the expected range of nursing facility residents, who come in a wide variety of sizes, shapes, conditions and capabilities. For these persons, the Department expects nursing facilities to obtain and use DME that satisfies the needs of persons within these ranges. Thus, for instance, the Department expects that nursing facilities will obtain and make available a variety of manual and motorized wheelchairs for the use of existing or potential residents, and a wheelchair does not become "specially adapted" merely because it is constructed to accommodate a person who is taller than average, shorter than average, heavier than average, or lighter than average, or because that person requires a differently-positioned control device.

An example of an item of DME that is not suitable for contemporaneous use is a motorized wheelchair that uses a palate drive fabricated to suit the needs of a particular quadriplegic resident. Another example of a wheelchair that is not suitable for contemporaneous use would be a wheelchair designed to the requirements of a resident with severe skeletal deformities related to a disease process, such as cerebral palsy or multiple sclerosis. An example of a wheelchair that is suitable for contemporaneous use is a wheelchair with larger-than-normal components, intended to accommodate a larger-than-average resident. Mere changes in size and strength are insufficient to cause a wheelchair to be "specially adapted." Rather, the wheelchair must have some additional, medically necessary feature that prevents the foreseeable contemporaneous use by some other person without substantial adaptation or modification of the item.

During the public process, the Department received a comment recommending that the Department clarify the definition of "specially adapted" to provide that, in cases when a resident needs a wheelchair that must be fitted for specifications by a professional or which consists of numerous component parts, the wheelchair would be both "exceptional" and "specially adapted." Because the Department does not believe that the definition needs to be clarified, the Department has not revised the definition as recommended in the comment. Under the definition of specially adapted equipment set forth in Annex A, a wheelchair is exceptional if it is both specially adapted and its cost equals or exceeds the minimum acquisition cost specified by the Department. The mere fact that a wheelchair is fitted to a resident under the instructions of a professional does not, in itself, cause the wheelchair to qualify as "specially adapted DME." Although a wheelchair may not be exceptional or specially adapted, the Department notes that a wheelchair is standard DME that is covered by the case-mix per diem rate.

Supply. Supplies are a class of tangible item. Examples of supplies include: resident care personal hygiene items such as soap, toothpaste, toothbrushes and shampoo; resident activity items such as games and craft materials; medical supplies, including wound dressings, disposable tubing and syringes, incontinence care supplies, including catheters and disposable diapers; dietary supplies such as foodstuffs and disposable table ware and implements; laundry supplies such as detergents and bleaches; housekeeping and maintenance supplies, such as cleaners, toilet paper, paper towels, and light bulbs; and administrative supplies, such as forms, paper, pens, pencils, and ink or toner for printers and copiers. Any tangible item that is identified on the AHA Guidelines as having an original estimated useful life of 1 year or greater is not a "supply" even though a nursing facility intends to use, or only uses, the item for less than 12 months.

In response to a comment received during the public process, the Department deleted the terms "relatively small in size" and "inexpensive," which were contained in the November 2000 draft, from the definition of "supply" in Annex A. The Department agrees that the life of an item is the key factor in determining whether an item is a supply or movable property. The Department will use American Hospital Association Uniform Chart of Accounts and Definitions for Hospitals (AHA Guidelines) to determine the item's expected useful life in deciding whether an item is a supply or movable property. Thus, for example, an item that is identified in AHA Guidelines as having as estimated useful life of 1 year or more is not a supply within the meaning of this definition.

Transportation equipment. Under the amendments, transportation equipment is a form of movable property. (Depending on its acquisition cost, an item of transportation equipment will be either major or minor movable property.) Because, under the amendments, this equipment is treated in the same manner as all other movable property, the definition of "transportation equipment" has been removed from Chapter 1187.

Updated appraisal. As originally promulgated, Chapter 1187 only required that nursing facilities be reappraised once every 5 years. See § 1187.57(b)(2). Nonetheless, for each year in which an "initial appraisal" or "reappraisal" was not performed, the Department contracted with its independent appraisal firm to update the previous appraisals to account for reported changes in the value of land, changes in the cost of factors affecting the replacement of the entire nursing facility, and expected depreciation. These appraisals are known as "updated appraisals." The Department has included this term in § 1187.2 to formally establish it as a term of art.

§ 1187.22. Ongoing Responsibilities of Nursing Facilities

The Department's focus on movable property has two distinct aspects. First, the Department has revised the manner in which per diem rates are computed and in which nursing facilities are otherwise reimbursed. Second, the Department will increase its scrutiny of nursing facility conduct involving the provision of DME to residents. To make that oversight more efficient and effective, the Department has added two new paragraphs to § 1187.22, which sets forth additional conditions of participation for MA nursing facility providers.

Under paragraph (16), a nursing facility must maintain a separate written record identifying all requests for, and all physician orders for exceptional DME or DME as is designated by the Department. This new requirement is intended to give the Department flexibility in monitoring the provision of various types of standard DME, like standard motorized wheelchairs, while, at the same time avoiding the situation when the nursing facility is required to maintain a record of all types of DME.

During the public process, the Department received a comment expressing concern that residents may be vulnerable to coercion and influence by the nursing facility to "refuse" DME that is costly to the facility. The comment suggested that the Department require nursing facilities to obtain an informed, written waiver from the resident, and to provide to the resident a written notice of their right to receive the DME and contact information for the PDA Ombudsman and DOH Division of Long-Term Care.

The Department is also concerned about situations when a nursing facility applies for an exceptional DME grant and the Department determines that, although the item is medically necessary, it does not qualify as exceptional DME. Unless the resident refuses the DME, the nursing facility must provide the equipment to the resident. Because these situations have the potential for substantial abuse to the detriment of residents, the Department has added paragraph (17), which requires the nursing facility to notify the Department of any these refusal. The purpose of this requirement is to give the Department notice that a purported refusal has been made, thus allowing the Department to investigate the matter on a timely basis. In these situations, the Department intends to have one or more persons contact the resident in person. If the Department finds that a nursing facility has improperly pressured the resident to refuse an item of DME, the Department will treat that conduct as a significant instance of noncompliance with State and Federal law and regulation.

The Department also received a comment recommending that the Department require nursing facilities to issue a notice whenever a request by a resident or resident's representative for DME is denied by the facility. The comment suggested that a requirement would be consistent with notice requirements of MA participating Managed Care Organizations (MCO) when they refuse to authorize services. While the Department agrees that monitoring is necessary to insure that the amendments achieve their intended purpose, the Department is not convinced that the functions performed by nursing facilities are analogous to those performed by MCOs, and therefore, it has not amended the regulations as suggested in the comment. The Department believes that

nursing facility providers perform functions similar to other direct care providers, like physicians, hospitals, or other inpatient or outpatient providers. The Department does not require the providers to issue written notices when, in the course of providing treatment, they decline to provide a service or item requested by an MA recipient.

§ 1187.51. Scope.

§ 1187.51(c)(5).

As originally drafted, the amendments treated all costs of exceptional DME as nonallowable costs. Consistent with that treatment, the Department proposed to modify § 1187.51(c)(5) to provide that the case-mix per diem rate is only computed using costs associated with "standard DME." However, after reviewing the comments, the Department has changed the treatment of exceptional DME costs and has decided to retain the original language.

During the public process, the Department was asked several questions regarding recognition and treatment of costs associated with DME approved or disapproved through the exceptional DME grant process. In response to these questions, the Department notes that, under § 1187.51(c)(5), which is unaffected by the amendments the costs incurred for both standard and exceptional DME may be reported on a nursing facility's cost report and, to the extent otherwise allowable, will be used to set a facility's prospective per diem rate. Costs related to DME which is not medically necessary or which is furnished for the convenience of a nursing facility or a resident are not allowable.

§ 1187.51(e).

A fundamental change effectuated by the amendments is to shift the costs of minor movable property from the capital cost component to the three net operating cost components. That change raises the question of how to determine the appropriate net operating cost center to which a particular cost should be assigned. The changes in § 1187.51(e) are intended to resolve that question. In addition, the Department has modified the introductory part of subsection (e) to include the words "for purposes of cost reporting." This modification is intended to establish the timetable for the transition period, and to ensure that the amendments are not misunderstood. In particular, this revision makes clear that, during the transition period, the changes in Subchapter E (relating to allowable program costs and policies) will only have an effect upon the cost reporting requirements, and not upon the Department's price setting or rate setting decisions. Regardless of which cost center is appropriate, therefore, the revised rules only apply to those cost reporting periods that begin on or after January 1, 2001, except as specified in § 1187.91(1)(iv)(D).

§ 1187.51(e)(1)

As originally promulgated, § 1187.51(e)(1) identified 14 categories of costs that, for purposes of the Case-mix Payment System, may be both "resident care costs" and "allowable costs." The amendments add a 15th category: "supplies and minor movable property . . . used in a nursing facility in the course of providing a service or engaging in an activity identified in subsection (e)(1)." For example, if game and craft items are used in the course of providing resident activities services, the cost of those items is properly included as an allowable resident care cost.

§ 1187.51(e)(2)

As originally promulgated, § 1187.51(e)(2) identified four categories of costs that, for purposes of the case-mix payment system, may be both "other resident related costs" and "allowable costs." The amendments add a fifth category: "supplies and minor movable property . . . used in a nursing facility in the course of providing a service or engaging in an activity identified in subsection (e)(2)." For example, laundry soaps and bleaches, floor cleaners, toilet paper, paper towels and light bulbs are properly included as allowable other resident related costs. In addition, changes to § 1187.51(e)(2)(i) also set forth the Department's determination that the costs of supplies and minor movable property associated with "food, food preparation, food service, and kitchen and dining supplies" are and should be treated as "other resident related costs," while § 1187.51(e)(2)(ii) sets forth the Department's determination that linen costs be treated in like manner.

§ 1187.51(e)(3).

As originally promulgated, § 1187.51(e)(3) identified 20 categories of costs that, for purposes of the case-mix payment system, may be both "administrative costs" and "allowable costs." The amendments delete two of these categories and add one new one. The two deleted categories are "transportation equipment depreciation" and "transportation equipment interest." Under the revised Chapter 1187, all transportation equipment directly used by the nursing facility is "movable property," and the costs of this equipment are treated in the same manner as the costs of all other movable property. Thus, if an item of transportation equipment costs $500 or more, it is an item of major movable property. Otherwise, it is an item of minor movable property. In the latter instance, the cost of that item is an allowable cost within the administrative cost center. The new category encompasses "supplies and minor movable property . . . used in a nursing facility in connection with an activity identified in subsection (e)(3)." Thus, for example, the acquisition cost of office supplies is properly included as an allowable administrative cost.

§ 1187.51(e)(4).

As originally promulgated, § 1187.51(e)(4) provided that "FRV" was an allowable cost. That provision pertained to the FRV of all items, including fixed and movable property. The amendments change this provision. While the FRV of fixed property remains an allowable cost, for purposes of price and rate setting the FRV of movable property is only an allowable cost until an audited cost report for a cost report period beginning on or after January 1, 2001, has been submitted to the NIS database for the nursing facility. Once that condition is met, the draft amendments provided that the allowable cost would be "the audited acquisition cost of the major movable property" for the most recent audited cost report. The Department has clarified that provision to make reference to the audited "acquisition" cost. In addition, the Department revised the "real estate tax cost" provision so that it uses the defined term. See § 1187.96(d)(3).

§ 1187.56. Selected Administrative Cost Policies.

§ 1187.56(1)(ii)(D).

As originally promulgated, § 1187.56(1)(ii)(D) provided that "[h]ome office allocations, including administratively allowable depreciation and interest costs relating to transportation equipment, shall be reported in the general administration line of the cost report." The Department has removed the references to transportation equipment to be consistent with the revisions to other provisions of the regulations that remove specific references to transportation equipment. In making this change, the Department does not intend to alter the

treatment of home office costs or home office allocations. Thus, home office costs and allocations continue to include both direct and indirect allowable home office costs, including depreciation and interest relating to home office fixed and movable property. All home office costs continue to be recognized as general and administrative costs.

§ 1187.56(2) and (3).

The amendments have changed the term "interest—administrative" to "other interest" and modified the associated definition. The changes in paragraphs (2) and (3) reflect the new terminology. In addition, they clarify that this cost is allowable only if "necessary and proper." Additionally, the provision formerly in § 1187.56(2)(vii), which pertained to "interest expense on funds borrowed for transportation equipment purchases," has been eliminated because, under the amendments, that interest is capital interest and, as such, is no longer an allowable cost.

§ 1187.56(4).

The provision formerly § 1187.56(4) has been removed in its entirety. That provision provided that certain costs associated with the acquisition and ownership of transportation equipment (namely interest and depreciation) were allowable costs to be included in a nursing facility's "administrative cost center." Under the amendments, transportation equipment is an undifferentiated type of movable property. Thus, under the amendments, the acquisition cost of this movable property is an allowable capital cost if the acquisition cost is $500 or more; or an allowable administrative cost if the acquisition cost is less than $500.

§ 1187.56(7).

As originally promulgated, § 1187.56(7) provided that "[r]ental expense for plant, property and equipment is not recognized as a separate allowable cost. It is included in the FRV." Because, under the amendments, the rental cost of movable property is an allowable cost, the original provision is no longer completely correct. Therefore, it has been deleted and, in its place, § 1187.59(a) has been amended to provide that rental expense for fixed property is not an allowable cost.

§ 1187.57. Selected Capital Cost Policies.

Former § 1187.57(a).

Under Chapter 1187 as originally promulgated, a nursing facility's capital rate component was comprised of two parts: an "FRV" element that pertained to all fixed and movable property, and a "real estate tax cost" element. Former subsection (a) summarized this arrangement. However, as a result of the amendments, the capital rate component is now comprised of three parts: the fixed property component; the movable property component; and the real estate tax cost component. Thus, former subsection (a) has been removed, and the introductory part of § 1187.57 now summarizes the composition of the capital cost component.

Former § 1187.57(b)(1)—(4).

As originally promulgated, paragraphs (1)—(4) set forth various provisions pertaining to the appraisal of nursing facilities. Those provisions have been incorporated in modified form into the new version in revised subparagraphs (ii), (v), (vii) and (viii). Changes in wording reflect the updated terminology, clarifications and changes in the overall system.

Former § 1187.57(b)(5).

As originally promulgated, paragraph (5) stated: "The original cost of a nursing facility will not be a factor in the determination of the appraised depreciated replacement cost." In the amended version, this provision has been omitted as unnecessary: The definition of "depreciated replacement cost" is clear that the appraisal considers "the amount required to replace" fixed or movable property, not the amount required to obtain it in the first place.

Former § 1187.57(c) and (d).

In the draft version of the amendments disseminated to the public, the Department erroneously indicated that it intended to remove these subsections. The Department has no such intention. However, those provisions have been modified to conform to the revised system and terminology. Thus, the substance of former § 1187.57(c) is in §§ 1187.57(1)(x) and (2)(i)(D), while the substance of former § 1187.57(d) is in § 1187.57(1)(viii).

§ 1187.57(1)

This paragraph specifies that the new "fixed property component" of a nursing facility's capital rate is based upon the depreciated replacement cost of the facility's fixed property and the associated financial yield rate. In addition, it provides detail on how and when the underlying appraisals will be performed and used. In particular:

Under Chapter 1187 as originally promulgated, the Department was not required to obtain an annual appraisal for each nursing facility but, rather, was only required to reappraise the facility once every 5 years. The revised version specifies that the Department will not only make an annual determination of the depreciated replacement cost of each nursing facility's fixed property but, in addition, specifies that when an initial appraisal or reappraisal has not been done within the preceding 12-month period, the Department will use an "updated appraisal."

The revisions expressly recognize the various types of appraisals currently used by the Department, that is, "initial appraisals," "limited appraisals," "updated appraisals" and "reappraisals." In addition, the revisions set forth the Department's prior and current practice regarding the use of these appraisals, including the requirement that, for the results of a limited appraisal to be included in the Department's determination of a nursing facility's capital rate for a rate year, the facility must request the limited appraisal by January 31 of the preceding rate year.

§ 1187.57(2)

One of the principal changes made by these amendments is the removal of movable property from the FRV system of determining capital costs. In effectuating that change, the audited acquisition costs of minor movable property are treated as net operating costs, and are included in the computation of peer group prices. The audited acquisition costs of major movable property, however, are treated as capital costs. To implement this change, the Department needs audited cost reports that set forth the audited costs of major movable property. The information is only available starting with cost reporting periods beginning on January 1, 2001. For this reason, paragraph (2) is divided into two subparagraphs. Until the required audited costs are in the database, the Department will continue to use the FRV system to include movable property costs in the capital rate component. Once the audited costs are in the database, the Department will begin using the audited acquisition costs for movable property.

§ 1187.57(3)

As originally promulgated, § 1187.57(a) provided that a nursing facility's capital rate component would be computed using, among other things, "the nursing facility's real estate taxes or reasonable payment made in lieu of real estate taxes." Paragraph (3) sets forth the same thought using the revised terminology.

§ 1187.5. Costs of related parties.

The wording of this section has been revised to clarify that it applies to movable property and supplies furnished by a related party. No change in the substance of this provision is intended. Thus, for instance, home office costs and management service costs involving a related party continue to be administrative costs. See §§ 1187.51(e)(3) and 1187.56.

§ 1187.59. Nonallowable costs.

§ 1187.59(a)(24).

As originally promulgated, § 1187.59(a)(24) stated that the Department would not recognize as an allowable cost "[d]epreciation and interest on indebtedness for capital plant facilities not included in the FRV payment." The amendments substitute the following list: "Depreciation on fixed or movable property, capital interest, amortization—capital costs and rental expense for fixed property." As revised, this provision encompasses not only those costs originally declared to be nonallowable, but also relocates the rules pertaining to rental expense (as it applies to fixed property) and "amortization—capital costs." See §§ 1187.51(e)(4) and 1187.71(a)(4)(v) (although nursing facility's must report amortization—capital costs, these costs are not included in the listing of allowable costs and, consequently, under § 1187.51(e), are nonallowable).

§ 1187.60. Prudent buyer concept.

The Department revised the wording of this section to conform it to the revised terminology pertaining to movable property and supplies. No change is intended to the substance of this section.

§ 1187.61. Movable Property Cost Policies.

In general.

§ 1187.61 is a new section. The purpose of this section is to set forth the rules on how the allowable acquisition cost of an item of movable property shall be determined, and to specify offsets against those costs. For the cost of movable property to be allowable under this provision, the cost to acquire the movable property must be incurred by the nursing facility, that is, the facility must purchase or rent the movable property. Thus, for example, a nursing facility may use DME (such as, a wheelchair) that is owned by a resident in rendering services to the resident in accordance with his care plan. In these instances, the nursing facility has not incurred an acquisition cost.

In addition, for the cost of movable property to be allowable, the Department has added language to this provision that requires that the nursing facility must place the movable property in service during the cost reporting period in which the facility reports the cost. This requirement is intended to protect against the situation when a nursing facility contracts to purchase or rent movable property, with delivery and payment to be made later. Especially when the nursing facility would retain the ability to cancel the order, this situation would permit abusive cost reporting practices.

§ 1187.61(a).

Subsection (a) makes clear that the related party and prudent buyer rules in §§ 1187.58 and 1187.60 are applicable and shall limit the actual acquisition cost of movable property.

§ 1187.61(b)(1).

Paragraph (1) provides that "acquisition cost is determined on a per-unit basis." Thus, for instance, if a nursing facility pays $600 for three identical television sets, the acquisition cost is $200 per set, even if purchased under a "buy 2, get 1 free" arrangement. On the other hand, if the nursing facility purchases three nonidentical television sets that are individually priced at $100, $200 and $300, the acquisition cost of each is the individual amount paid.

§ 1187.61(b)(2).

Chapter 1187 specifies that nursing facility cost reports shall be prepared using the accrual basis of accounting. See §§ 1187.71(d) and 1187.73(b). Consistent with this requirement, when a nursing facility contracts to purchase an item of movable property, the full purchase price of the item generally is capitalized, including that portion of the purchase price that has not yet been paid as of the close of the cost reporting year. Thus, for instance, if the nursing facility purchases a motor vehicle on a 4-year installment sales contract, the full acquisition cost of that item is recognized in a single cost reporting period. Also, capital interest is a nonallowable cost. See § 1187.59(a)(24). Therefore, in computing the acquisition cost of an item purchased under an installment sales agreement, all interest costs must be excluded. Moreover, if the nursing facility has contracted to purchase an item, but has not received the item and has not paid the full purchase price, then under § 1187.61(a), there is no allowable acquisition cost for that period. Thus, for instance, if the motor vehicle is contracted for in one cost reporting period, but not received and put into service until the subsequent cost reporting period, the cost is only considered to have accrued as of the second cost reporting.

§ 1187.61(b)(3).

Under Chapter 1187 as originally promulgated, the rental cost of fixed and movable property was a nonallowable cost. Under the amendments, the rental cost of fixed property continues to be a nonallowable cost. However, when an item of movable property is acquired by renting or leasing it, the acquisition cost of that item is an allowable cost: If the total acquisition cost is $500 or more, that cost is an allowable capital cost; if it is less than $500, it is an allowable net operating cost. Assume, for instance, that an item is rented for a 24-month period, at $100 per month, when the first month of the rental period is the last month of the cost reporting period, with the result that, for the initial cost reporting period, the nursing facility only paid $100 in rent. For that cost reporting period, the nursing facility would report $100 in rental acquisition costs. However, although the rent for that period was less than $500, the total rent for the item is $2,400. Therefore (and assuming that the imputed purchase price also is $500 or more), the acquisition cost of this item should be reported as a capital cost, rather than a net operating cost.

With regard to the specifics of § 1187.61(b)(3):

- *"Renting" versus "Leasing."* As used in the amendments, the words "rent" and "lease" are considered synonyms. They pertain to any situation when the

owner or rightful possessor of an item of property (the lessor) grants to another person (the lessee) the right to possess, use and enjoy that item for a specified period of time, in exchange for payment of a stipulated consideration, that is, rent. If a nursing facility enters into a contract whereby it leases an item for a period of time and, at the end of that time, obtains title to it (or has the option of purchasing it), that item is considered to be leased or rented except that, at the end of the period, if an additional payment is required to obtain title to the item, that payment is treated as the purchase price of the item, for purposes of computing its acquisition cost.

- *Annual acquisition costs.* If a nursing facility purchases an item of movable property, the entire acquisition cost of that item is reported in the cost reporting period during which the item was first placed into service. By contrast, if the nursing facility leases that item, the acquisition cost of that item is reported on an annual basis, for each cost reporting period in which the item is leased.

- *Computation of the acquisition cost.* The annual acquisition cost of a rented or leased item of movable property is limited by the "imputed purchase price" of that item. For purposes of making this comparison, the latter is annualized on a straight-line basis over its useful life. If the item is only in use for a portion of a cost reporting period, both the rent and the imputed purchase price are pro rated for that portion. For example, for an item with a purchase price of $3,600 and an expected useful life of 3 years, the annualized purchase price is $1,200 per year. If the monthly lease payment is $150 (that is, an annual cost of $1,800), the "acquisition cost" of this item would be limited to $1,200 per year ($100 × 12 months), assuming that no other lower amount would qualify as the "imputed purchase price."

§ 1187.61(b)(4).

The case-mix payment system is a prospective payment system that uses annual per diem rates (adjusted quarterly) to compensate nursing facilities for providing nursing facility services. In setting these rates, the system looks at the reasonable allowable costs incurred in the past. However, there is no correlation between the rates in effect for a given rate year and the costs by the nursing facility during that same 12-month period. Rather, the rates are set using audited costs of previous periods (adjusted for inflation and the nursing facilities "case-mix") as a basis for determining what a reasonable rate would be for the period in question. Consistent with that methodology, the amendments provide for the inclusion of the imputed "cost" of an item acquired as a gift or donation. The assumption is that, if the nursing facility had not acquired the item at no cost, it would have had to have purchased the same or similar item and, thus, would have incurred an allowable cost, and the cost would be included in the NIS database. Thus, for the NIS database to reflect the imputed cost of the donated item, the amendments provide that the nursing facility receiving the item shall report the appraised depreciated replacement cost of the item. Assuming that the item is related to the provision of nursing facility services, that cost is an allowable cost. The amendments also place the burden on the nursing facility of obtaining the necessary appraisal. This arrangement is wholly appropriate, since the nursing facility is in the position of knowing when these items are donated and, further, bears the consequences that arise from failure to obtain that appraisal.

§ 1187.61(b)(5).

In a trade-in situation, an old item is used to pay some or the entire purchase price of the new item. Thus, for instance, if a nursing facility "trades-in" an old lawnmower as part of the purchase of a new lawnmower, the acquisition cost of the new lawnmower is the amount the facility is paying (that is, the amount of money (exclusive of interest) being paid) plus the trade-in value of the old lawnmower. The trade-in value of the old lawnmower is determined by depreciating its acquisition cost on a straight-line basis over its useful life as determined by the specified "Uniform Chart." The draft version of this provision was modified to eliminate possibly ambiguous or confusing phrasings.

§ 1187.61(c).

The purpose of the offsets is to prevent nursing facilities from "gaming" the case-mix payment system by, for instance, acquiring items of movable property solely to increase their reported costs, then selling or otherwise conveying the movable property to another person. The Department finds these rules appropriate, as nursing facilities do not typically resell items of movable property to other entities but, instead, are themselves the end-users of the items. Moreover, these rules encourage nursing facilities to fully consume items of major movable property.

During the public process, the Department was asked why the term "pay" was used in the draft of this section, while "liquidate" was used in § 1187.52. The Department has revised the wording of § 1187.61(c) to eliminate the perceived inconsistencies.

During the public process, the Department received a recommendation that the Department amend its regulations to specify how a nursing facility's status as a debtor in bankruptcy might affect that facility's allowable costs, including short-term liabilities that are not liquidated within 1 year. The Department has already provided nursing facilities with guidance on this issue: When a nursing facility has not liquidated its short-term liabilities, the facility may, under 1 Pa.Code § 35.18 (relating to petitions for issuance, amendment, waiver or deletion of regulations), submit a petition to the Secretary of the Department seeking a waiver of the application of the regulations to those costs. The Department finds that this response adequately addresses the commentator's concern.

§ 1187.61(d).

Under the amendments, the acquisition cost of movable property is an allowable cost and, if a nursing facility trades-in, conveys, transfers or removes an item from service, an offset is taken. Under these circumstances, it would be inconsistent for losses on those transactions to be considered an allowable cost. Consequently, they are expressly declared to be nonallowable.

§ 1187.61(e).

The purpose of this provision is to ensure that, when an item of movable property is rented or leased by the nursing facility, the nursing facility obtains adequate documentation of the terms and conditions of the transaction. Failure to secure the documentation at the time of the transaction results in the acquisition costs being deemed nonallowable. When an item of movable property is rented, and if the rental agreement also covers maintenance, services or supplies, only that portion of the rent that relates to the item of movable property is considered in determining the annual acquisition cost that may be

reported as an allowable minor or major movable property cost. Maintenance, services or supplies covered by the rental agreement would be reported in the appropriate net operating cost center.

§ 1187.71. Cost Reporting.

§ 1187.71(a).

This section identifies those costs that a nursing facility includes in its annual cost report. Included costs are not necessarily "allowable costs." See, § 1187.71(a)(4), which requires that facilities report depreciation, interest on capital indebtedness, the cost of renting the nursing facility, and "amortization—capital costs." The principal changes made in this subsection are: (1) the inclusion of a provision for minor movable property in each of the three net operating cost centers; and (2) the inclusion of supplies in each of those cost centers. Aside from those changes: (a) because the "resident care costs" now includes a minor movable property provision, the DME provision was removed as superfluous; (b) in the "other resident related costs", the dietary provision was amended so that all kitchen, food service and dining supplies are expressly encompassed within this category; and the "laundry" provision was amended so that the linen costs are expressly encompassed within that category; (c) in the "administrative costs," because costs associated with transportation equipment are now treated as costs of movable property, and equipment rental is a form of acquisition cost, the separate provisions for those costs have been eliminated as obsolete and duplicative. Also, although the draft version of the amendments proposed to eliminate "officers' life insurance" as a reportable cost, that proposal was in error and has been reversed. The changes to the "capital costs" reflect the changes in terminology and the need to have the costs of "major movable property" reported separately.

§ 1187.71(c).

Subsection (c) was modified so that it uses the same terminology as other sections, while retaining the same meaning as the original version.

§ 1187.71(f).

The terminology of subsection (f) was modified to clarify that the financial records that enrolled nursing facilities must maintain include lease agreements and rental agreements involving either fixed or movable property. In addition, because "supplies" is now a defined term, "requisitions for supplies" has been removed to avoid possible confusion.

§ 1187.80. Failure to file a cost report.

§ 1187.80. In general.

A function of § 1187.80 is to establish an incentive for nursing facilities to file timely and acceptable cost reports. Because, under the amendments, a nursing facility's movable property component of the capital rate will be computed using information from a single audited cost report, the revised system may motivate some facilities to attempt to "game" the system by withholding cost reports. For instance, a nursing facility that purchased voluminous quantities of major movable property in 1 year, and little or none in the following year, might consider withholding the cost report for the latter year, in hopes that the costs from the first year would be used in 2 separate rate years. Because of this concern, the Department originally proposed that late or nonfilers would receive $0 for their capital component. During the public process, the Department received a comment questioning the severity of this proposed change. Upon consideration of this comment, the Department concluded that a less severe incentive should suffice. Therefore, in addition to changes intended to more clearly state the rule, it has changed the proposed regulation as noted in this Preamble.

§ 1187.80(b).

As originally drafted, if a nursing facility failed to file a timely cost report, the amendments would have reduced the facility's net operating components by 5%, but would have reduced the facility's capital rate component to $0. However, in response to comments, the Department revisited the capital portion of this provision. Because the Department is concerned with attempts to manipulate the movable property costs, the Department revised this provision so that, for cost reporting periods beginning on or after January 1, 2001, the failure to file a timely cost report will cause the movable property component of the capital rate to default to $0.

In subsection (b), the meaning of the introductory language has been clarified. As noted in this Preamble, nursing facility payments are computed using a prospective comprehensive per diem rate. Thus, regardless of the particular mix of items and services used to provide care to a particular MA resident, the payment for that resident is computed using the entire rate. Consequently, although Chapter 1187 speaks at various places of "rates" for the various cost centers, those "rates" are not "payment rates" but, rather, are more accurately and properly understood to be components of the comprehensive per diem rate. In like manner, it is inaccurate to speak of "payment to the nursing facility for net operating costs for cost reporting periods involved." Therefore, the phrasing of this subsection has been amended to eliminate possible ambiguities and to more accurately describe the functioning of the case-mix payment system.

§ 1187.91. Database.

§ 1187.91(1)(iv)(D).

The Department has included various provisions in the amendments that provide for a transition from the existing movable property payment methodology to the new methodology set forth in the amendments. The Department has added this new subsection to implement one aspect of the transition. Specifically, the new subsection authorizes the Department to disregard audit adjustments that disallow or reclassify costs for linens and minor movable property reported as net operating costs on cost reports for fiscal periods beginning prior to January 1, 2001. This new subsection only applies to price and rate-setting effective on or after July 1, 2001; it does not authorize modification of audit adjustments for any other price and rate-setting period. Moreover, this new subsection only authorizes the disregard of adjustments that reduce costs already reported. It does not permit modification of audit reports to include costs that were not previously reported on cost reports or to increase costs beyond those reported on cost reports. The new subsection specifies that the Department will not adjust the audited statistics when revising the nursing facility audited Resident Care, Other Resident Care and Administrative allowable costs as a result of the application of this section. However, the new subsection does specifically authorize the Department to recalculate the maximum allowable administrative cost, and to disallow administrative costs in excess of the 12% limitation as specified in § 1187.56(1)(i).

§ 1187.91(2).

As originally promulgated, Chapter 1187 provided that the capital rate would consist of two components. One component involves what is now called "real estate tax costs." Although changes in wording have been made in § 1187.91, no change in meaning is intended with regard to the "real estate tax cost" component. Rather, the revised version reflects the Department's interpretation of the original wording. However, the amendments do alter the other originally promulgated part which dealt with FRV.

As originally promulgated, the FRV component of the capital rate pertained to all fixed and movable property. The amendments remove "movable equipment" from that formulation: The acquisition costs of "minor movable property" are included in net operating cost centers, while the acquisition costs of "major movable property" are used to compute a new component of the capital rate component. To implement this change, the Department is issuing revised MA-11 cost reporting forms and schedules. These will first be used for the cost reporting periods that begin on January 1, 2001. Cost reports for earlier periods will use old versions of the MA-11 and will not set forth the required information. As explained elsewhere, the Department finds it impracticable to have the nursing facilities revise the cost reports for these periods, and it is impracticable for the Department to reaudit those cost reports. Therefore, there will be a transition period during which the new cost report will be submitted and audited, but during which the movable property component will be computed using the FRV system. However, as soon as a new MA-11 has been audited and the verified costs have been submitted and input into the NIS database, the Department will begin using the contents of that audited cost report (and its successors) in the next rate setting.

§ 1187.96—Price and rate setting.

As originally promulgated, Chapter 1187 provided that each nursing facility's capital rate had two parts, the "FRV" (which encompassed both fixed and movable property) and the "real estate tax cost." The amendments revise the system so that a nursing facility's capital rate now has three components: (1) The fixed property component still uses the FRV system; (2) a new component is established for movable property; and (3) the real estate tax cost component remains unchanged.

§ 1187.96(d)

The 90% adjustment. To encourage nursing facility efficiency and economy associated with nursing facility occupancy levels, the Department makes minimum occupancy adjustments. Thus, if a nursing facility's overall occupancy level is below 90% of total available bed days, the Department makes an adjustment to the total facility resident days as though the nursing facility were at 90% occupancy. See § 1187.23(a). This adjustment is made to the administrative and capital cost components. *Id.*; § 1187.96(c) and (d). However, it is not applied to a newly constructed nursing facility until that facility has been enrolled in the MA Program for one full annual price setting period. See § 1187.97(1)(iv). The amendments retain the 90% adjustment.

§ 1187.96(d)(1).

As originally promulgated, § 1187.96(d)(1) provided that the determination of the "FRV" included all fixed and movable property of the nursing facility. As amended, this paragraph provides that only the FRV of the fixed property will be used for purposes of computing the capital rate. Although the wording has been modified, the process for determining that amount remains unchanged.

§ 1187.96(d)(2).

Immediate conversion to the revised system is impracticable and, consequently, there must be a transition period. During the transition period, the movable property component will be computed in accordance with § 1187.96(d)(2)(i), which reproduces the result of Chapter 1187 as originally promulgated. Afterwards, it will be computed in accordance with subparagraph (ii), which sets forth the new method.

§ 1187.97. Rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities.

§ 1187.97(1)(ii).

This section defines "new nursing facility" as a "newly constructed, licensed and certified nursing facility; or an existing nursing facility that has never participated in the MA Program or an existing nursing facility that has not participated in the MA Program during the past 2 years." As originally promulgated, § 1187.97(1)(ii) specified how the capital rate component for a new nursing facility would be calculated. Because, under the amendments, the capital rate component now consists of three parts, rather than two, this paragraph has been amended to reflect that change.

In addition, a distinction is made between nursing facilities that are certified for participation in the MA Program prior to January 1, 2001, and those that are certified for participation on or after that date. As set forth in subparagraph (ii), the earlier "new nursing facilities" will transition from the original to the revised case-mix system in the same manner as all other nursing facilities. However, because the Department has no movable property appraisals for the later "new nursing facilities," the transition for these facilities will be based upon the acquisition cost of their new movable property, plus the depreciated replacement cost of any other movable property, amortized over 3 years. Except when the new nursing facility lacks a depreciation schedule for its used movable property, the latter method will eliminate the use of appraisals as a basis for the costs used to set the movable property component of the new nursing facilities' capital rate components.

The Department has modified the treatment of real estate taxes in setting per diem rates for new nursing facilities. The purpose of this change is to ensure that, until audited costs are available in the NIS database, the new nursing facility's capital rate component is computed using current real estate tax costs.

§ 1187.97(2)(iii).

Under Chapter 1187 as originally promulgated, the acquisition cost of fixed and movable property had no effect upon the rates, because the allowable costs for those items were determined using the FRV system. The amendments, however, modify that system so that the acquisition costs of movable property are an allowable cost. The purpose of this subparagraph (iii) is to clarify that, when a nursing facility changes owners, that transaction has no effect upon the reported or allowable movable property costs.

§ 1187.112.

To conform this section to the revised terminology, the term "movable equipment" is being replaced with "movable property."

§ 1187.113.

Under Chapter 1187 as originally promulgated, § 1187.113 imposed a limitation on the computation of the capital component of a nursing facility's per diem rate. That limitation, known as the "bed moratorium" (§ 1187.96(d)(1)), applied to both fixed and movable property. However, in addition to moving minor movable property costs to the net operating cost centers, the amendments also eliminate the application of the moratorium to major movable property costs. Thus, under the amended Chapter 1187, the allowable acquisition costs of movable property will be included in the computation of the nursing facilities per diem rate. The moratorium continues to be applicable to fixed property.

Subchapter K: Exceptional payment for nursing facility services.

As originally promulgated in Chapter 1187 when a nursing facility provided nursing facility services to an MA eligible resident, payment made by the Department at the per diem rate constituted payment in full for those services, including the use of any and all DME. See §§ 1187.51 and 1101.63. "Durable medical equipment" or "DME" is a form of movable property. See § 1187.2. However, under provisions of the State Medicaid plan, the Department also is authorized to make additional payments, if requested by a nursing facility and if the resident in question requires certain high-technology DME. By promulgating Subchapter K, the Department is establishing this option as a part of its regulations.

As set forth in Subchapter K, when certain requirements are met, the Department will make "exceptional payments" to enrolled nursing facilities. Those payments are made in addition to any payments made under a nursing facility's per diem rate, and are made only to nursing facilities. They are not made to residents, DME vendors, physicians, or other persons and entities.

To receive an exceptional payment, a nursing facility must request and the Department must approve an "exceptional DME grant." Whether a nursing facility submits a request is optional.

When it initially disseminated its draft regulations, the Department intended to continue its current practice of requiring grant agreements whenever it approved a nursing facility's exceptional grant request. The Department has determined that this practice is unnecessary. Because the requirements relating to exceptional DME grants are now included in the Department's regulations, the Department will no longer use grant agreements for grants issued on or after July 1, 2001. The Department has deleted all references to grant agreements from Subchapter K. Due to the optional, exceptional and individual nature of these grants, however, the Department will specify the particular terms of each grant in writing, and nursing facilities will be required to certify to the Department, on a form designated by the Department, that they have read and understand the terms of the grant, as a condition of receiving the grant.

Although there is a direct correlation between the amount of an exceptional payment and the necessary, reasonable and prudent cost of the associated DME, the payment is not made for the purpose of reimbursing the nursing facility for its costs of obtaining the exceptional DME. Under the prospective payment system set forth in Chapter 1187, the Department pays for nursing facility services provided to MA residents. See § 1187.51. Consistent with this approach, an exceptional payment constitutes additional payment for nursing facility services provided to the resident identified in the exceptional DME grant.

During the public process, the Department received a comment recommending that the Department require nursing facilities to notify residents of the availability of exceptional DME upon admission to a nursing facility and to assess residents as to their need for the equipment as part of the annual resident assessment. The Department has not included these requirements in Subchapter K because nursing facilities are already required to notify residents of services and items that are covered by Medicare and Medicaid payments and to periodically perform assessments of their residents' needs and to develop comprehensive care plans based upon those assessments. See 42 CFR 483.10(b)(5) and (6) and 483.20 (relating to resident rights; and resident assessment).

§ 1187.151. Definitions.

In general.

The definitions in § 1187.151 pertain to the provisions in Subchapter K. A "resident" as defined therein is not only a resident of a nursing facility, but rather, is an MA eligible resident of a nursing facility enrolled in the MA Program as a provider of nursing facility services, and is identified in a request for an exceptional DME grant as needing exceptional DME.

Exceptional DME grant. An exceptional DME grant is not money or other consideration. Rather, it is a conditional authorization given by the Department. That authorization sets forth the Department's permission for a particular nursing facility to submit invoices to the Department for additional payments, above and beyond any payments made at the facility's case-mix per diem rate, for nursing facility services provided to an identified MA resident. In the absence of a grant, a nursing facility may not present the Department with an invoice or other demand for any payment.

§ 1187.152. Additional reimbursement of nursing facility services related to exceptional DME.

§ 1187.152(a).

For an item of DME to qualify as "exceptional DME," the acquisition cost of that item must meet or exceed the minimum acquisition cost threshold in the Department's annual notice. Because, at the present time, that threshold is $5,000, any item of exceptional DME is and must be an item of major movable property. See § 1187.2 (definition of "movable property"). Although the Department is using the annual list to specify the amount of the threshold to permit ready adjustment of it, the Department expects that the adjustments will track changes in the cost of DME and, consequently, that "exceptional DME" will always qualify as "major movable property." As set forth in § 1187.52(e)(4)(ii)(B), the acquisition costs of major movable property are (subject to various conditions) allowable costs. Thus, because all items of exceptional DME are movable property, the cost of exceptional DME is (generally) an allowable cost. Like other allowable nursing facility costs, the cost of an item of exceptional DME is limited by the requirement that it be necessary, reasonable and prudent. See § 1187.152(a).

When DME and related services and items are approved by a grant, subsection (a) specifies the mechanism for conclusively determining the amount of exceptional DME costs that is "necessary, reasonable and prudent": It is the amount of the costs "identified in the nursing facility's grant." Consequently, "[a]ny costs incurred in

excess of the costs identified in the grant are not allowable costs. . . " For cost reporting and auditing purposes, this provision is conclusive. However, when the DME or related services and items are not approved by a grant, these provisions do not apply.

§ 1187.152(b).

Subsection (b) provides that, if a nursing facility provides nursing facility services to an MA eligible resident, and if those services involve the use of "exceptional DME," the nursing facility may seek additional reimbursement by requesting a grant from the Department. This phrasing is intended to indicate that the nursing facility is not required to make a request. If no request is made, the nursing facility still may receive payment through the submission of invoices, based upon its per diem rate. However, in the absence of a grant request, the Department will not issue a grant and, consequently, there will be no authorization of an additional payment.

During the public process, the Department received comments suggesting that, in addition to permitting nursing facilities to apply for exceptional DME grants, the Department should also permit requests to be submitted by residents and their outside physicians, and that residents should have the right to request independent assessments to determine their need for DME. These suggestions were prompted by the concern that, because the decision to request a grant lies in the hands of the nursing facility, facilities may decline to make requests unless they are reasonably confident that the requests will be granted. While the Department agrees that the resident, the resident's family and the resident's physician should be active participants in developing the resident's care plan, the Department is not willing to reduce or limit the obligation that a nursing facility provider has to make all medically necessary DME available to its residents, as part of its responsibility to provide care and services, including DME, under the residents' individual plans of care. For this reason, the Department has not accepted the suggestion to allow persons other than nursing facilities to submit exceptional DME grant requests. Nonetheless, to address the concern that nursing facilities may not make exceptional DME requests in order to avoid their obligation to provide necessary care to their residents, the Department has amended § 1187.22 to provide that the nursing facility must maintain a separate written record identifying all requests or physicians' orders received by the facility for exceptional DME, and for other DME the Department may specify. The purpose of this amendment is to provide the Department with a means of effectively and efficiently determining whether the requests are incorrectly ignored or rejected.

In addition, the Department and the DOH monitor nursing facilities to ensure that they provide services in compliance with law. If a resident or the resident's family, representative or physician believe that the nursing facility is not allowing them to participate in the care planning process or that the facility is not meeting the residents needs, the Department urges the resident, or the resident's family member, representative or physician to contact the local Area Agency on Aging (AAA) ombudsman, the DOH complaint hotline at (800) 254-5164, or the Department's DME hotline at (877) 299-2918. In addition, the resident or resident representative may consider consulting his attorney or the local legal services organization. The telephone number of the local AAA and legal services organizations are listed in the blue pages of the telephone book.

§ 1187.152(c).

Subsection (c) sets forth the conditions that must be met for the Department to issue a grant to a nursing facility. Among other things, this subsection specifies that the grant is not effective until the nursing facility certifies to the Department that it has read and understands the terms of the grant.

§ 1187.152(c)(1).

The Department has developed forms for use in applying for a grant. In addition, the Department will be developing and publishing guidelines for the preparation and submittal of grant requests. This paragraph requires that the nursing facility comply with all instructions in effect at the time the request is made.

§ 1187.152(c)(2).

The definition of "DME—durable medical equipment" specifies that DME is movable property that, among other things, "is primarily and customarily used to serve a medical purpose" and "generally is not useful to an individual in the absence of illness or injury." Thus, DME is movable property that serves a medical purpose. Consistent with this purpose, the Department will not authorize exceptional payments for exceptional DME unless that DME is medically necessary.

In its original draft version of the amendments, the Department proposed to set forth a definition of "medical necessity." However, after receiving comments during the public process suggesting that the Department use the definition already in § 1101.21, the Department revised its draft to incorporate that definition. The Department also received comments during the public process that, for purposes of the exceptional DME provisions, the Department should modify that definition in § 1101.21. The Department, however, finds that consistency is desirable and, consequently, has not revised the definition in this context.

In addition, during the public process, the Department received a comment suggesting that, in determining whether an item of DME is medically necessary, the Department should consider alternative, less-expensive items, and should consider the resident's independent ability to operate both the proposed and the alternative items. The Department does, and will continue to, consider these factors in determining whether an item of DME is medically necessary.

§ 1187.152(c)(3).

"Durable medical equipment" and "exceptional DME" are defined in § 1187.2 and the Department's annual notice. Thus, an item of DME is "exceptional DME" if it meets the definitions and conditions set forth therein.

§ 1187.152(c)(4).

Paragraph (4) permits the Department to refuse a grant if the Department finds that the requesting nursing facility's physical plant, equipment, staff, program and policies are not sufficient to insure the safe, appropriate and effective use of the exceptional DME. As an example, if the circumstances of a nursing facility are such that a ventilator cannot be used in conformity with these requirements, the grant may be refused. In this case, the nursing facility should make alternative arrangements for the resident in question. Typically, those arrangements would involve the transfer of the resident to a different nursing facility that does have the requisite capacity.

§ 1187.152(c)(5).

As originally drafted, this provision required that the nursing facility execute a grant agreement as a condition of receiving a grant. For reasons specified, the Department has determined that grant agreements are no longer necessary, and has eliminated references to grant agreements from the amendments. The Department has included new language in this section that requires a nursing facility to certify to the Department that it has read and understands the terms of its grant as a condition of issuance of the grant.

§ 1187.153. Exceptional DME grants—process.

§ 1187.153(a).

Section 1187.152(c)(1) provides that the Department will issue a grant if, among other things, "[t]he nursing facility's request for a grant complies with all applicable Department instructions." Section 1187.153(a)(1) sets forth the fundamental parameters of those instructions. Thus, all those requests must be "in writing," "on forms designated by the Department," "completed in accordance with all applicable instructions," "be accompanied by all necessary supporting documentation specified in the Department's instructions" and "submitted . . . no later than 30 days from the date on which the nursing facility purchases or rents the DME."

The draft version of paragraph (2) has been revised to eliminate possibly ambiguous provisions. As revised, paragraph (2) requires that a notice be provided to a resident's "authorized representative" whenever that person has been designated. In addition, regardless whether an "authorized representative" has been designated or not, notice must also be provided to the resident. The purpose of this notice is two-fold. First, it informs the resident or authorized representative, or both, of the nursing facility's request. Second, it informs those persons that the nursing facility believes that the identified DME is medically necessary. The nursing facility must provide this notice to the resident at the same time the facility submits its request to the Department.

As used in this paragraph, the term "authorized representative" means a person who is not an employee of the nursing facility and is responsible for making decisions on behalf of the resident. The person shall be so designated by the resident or a court, and documentation shall be available on the resident's clinical record to this effect. An employee of the nursing facility will be permitted to be a responsible person only if appointed by the resident's legal guardian or by a court. If an incompetent resident has no authorized representative, the nursing facility should immediately make arrangements for a person to serve in that capacity.

§ 1187.153(b).

Subsection (b) describes the notice that the Department will give of its decision to approve or deny a request for a grant. The Department will send notices to the nursing facility that filed the request and to the resident and the resident's authorized representative.

During the public process, the Department received comments recommending that the regulations should require the Department to respond to a nursing facility's request for an exceptional DME grant within a specific time frame, or provide that a request for an exceptional DME grant would be deemed approved if the Department does not act on it within 21 days. While the Department has not revised the regulation as suggested, the Department will endeavor to respond to each request within 21 days. If, however, the Department does not act within that time frame, the request is not automatically approved. The Department notes that the exceptional payment policies give nursing facility providers the option to request and obtain additional payment under certain circumstances. The policies are not intended to, and do not, alter a nursing facility's obligation to provide care and services to its residents in accordance with all applicable State and Federal requirements. Among other things, a nursing facility must ensure that its residents receive necessary services and items as specified in their care plans, including DME, regardless of whether the facility has submitted a request for, or received an exceptional DME grant. The Department also notes that it has amended the regulations to allow nursing facilities to submit requests for exceptional DME grants within 30 days after purchasing or renting the DME.

§ 1187.154. Exceptional DME grants—general conditions and limitations.

§ 1187.154(a).

Subsection (a) states the scope and effect of an exceptional DME grant. A grant is not a payment. Rather, it is a conditional authorization given to a nursing facility to receive a limited and specified amount as an exceptional payment subject to certain specified terms. To receive such a payment, the nursing facility must comply with the Department's billing requirements in § 1101.68.

§ 1187.154(a)(2).

Paragraph (2) states that a grant does not "limit costs that are, or must be, incurred by a nursing facility to provide services to any of its residents" including the resident identified in a grant or an application for a grant. By electing to enroll in the MA Program as a provider of nursing facility services, the nursing facility has voluntarily assumed the responsibility to provide services "in accordance with applicable law and regulations." Some of the applicable laws and regulations are identified in this preamble. However, nursing facilities are deemed to have notice of the laws and regulations and, therefore, must comply with all laws and regulations, whether identified herein or not.

§ 1187.153(c)(1).

An item of exceptional DME is, by definition, an item of movable property having an acquisition cost that meets or exceeds the minimum acquisition cost threshold. Because that threshold presently is $5,000, any item of exceptional DME is, by definition, classified as an item of major movable property. As originally promulgated, Chapter 1187 included all items in the FRV system used to compute the capital rate. Under the amendments, however, major movable property has been removed from the FRV system and, instead, the acquisition cost of major movable property is now an allowable cost. As set forth in § 1187.152(a), for purposes of determining the necessary, reasonable and prudent cost of an item of DME that is subject to a grant, that cost is limited to and deemed to be the amount specified in the grant. Paragraph (1) specifies how these costs shall be reported by the nursing facility.

During the public process, the Department was asked whether a nursing facility whose request for an exceptional DME grant is approved, but for an amount less than the cost incurred by the facility, may report the difference on its cost report. The Department has revised § 1187.154 to specify that the amount of the exceptional payments authorized by a grant is based upon the necessary, reasonable and prudent cost of the exceptional

DME and the related services and items identified in the grant. In identifying its allowable costs on its cost report, therefore, the nursing facility must adjust those reported costs to the necessary, reasonable and prudent cost amounts identified in the nursing facility's grant. See § 1187.154(a) and (c).

Another comment questioned whether the Department will take the position that a nursing facility that reports costs on its cost report related to equipment for which an exceptional DME grant has been denied, has committed program fraud or abuse. The Department will evaluate each situation and determine on a case-by-case basis whether there is reason to believe that fraud or abuse has occurred based on the specific circumstances.

§ 1187.154(c)(2).

Section 1187.60(c) identifies types of income that reduce allowable costs. The Department has amended that subsection to provide that payments received by a nursing facility under an exceptional DME grant shall offset costs. Paragraph (2) specifies how those offsets are to be made by the nursing facilities on their cost reports. Because the acquisition cost of exceptional DME must be reported as a major movable property cost, that portion of an associated payment that pertains to the DME must be used as an offset to the nursing facility's major movable property costs. Likewise, a payment associated with "related services and items" must be used as an offset against costs in the cost center where the costs of those services and items were reported. If a nursing facility receives a payment under an exceptional DME grant that was approved after the period in which the acquisition costs were reported and that payment was unable to be accrued, the facility may not revise or amend the earlier costs but, instead, the payment shall offset costs in the more-recent period. Thus, for instance, if a nursing facility purchases a specially adapted wheelchair at the end of cost reporting period No. 1, it would report that cost on the cost report for that period. If, however, that period ends before the request for a grant is made, the payment made by the Department might not be received by the nursing facility until the cost report has already been submitted. In this situation, the nursing facility would not amend its cost report. Rather, it would report the payment as an offset to major movable property costs on the cost report for the subsequent cost reporting period.

§ 1187.154(d).

Federal and State laws require that a provider participating in the MA Program must accept as payment in full the amounts paid by the Department. This subsection explains the meaning of this requirement in the context of a payment made under an exceptional DME grant.

§ 1187.154(f).

As originally drafted, this subsection included the following additional text: "If a nursing facility timely appeals an adverse Department determination relating to its grant, the Department's determination is not final until the Department issues a final adjudication on the nursing facility's appeal. The Department's adjudication of any such dispute shall be final, except as it may be reviewed by an appellate court pursuant to the Administrative Agency Law (2 Pa.C.S. § 101 et seq.). Any dispute which is not timely presented to the Bureau of Hearings and Appeals for adjudication shall be deemed waived and released and may not thereafter be the subject of any claim, proceeding or cause of action against the Commonwealth of Pennsylvania, the Department or its officials and employees." These sentences were redundant and unnecessary, as they merely repeated the content and effect of provisions in § 1187.141 (relating to nursing facility's right to appeal and to a hearing), which is made applicable to Subchapter K by § 1187.158(a)(4).

§ 1187.154(i).

Compliance with the conditions and limitations in subsection (i) is a condition of receiving a grant. A nursing facility is not required to request an exceptional DME grant. Therefore, if a nursing facility concludes that some or all of these conditions and limitations are unacceptable, the facility can avoid their effect by declining to request a grant and, in that instance, these provisions do not apply. However, if the nursing facility requests and receives a grant, these provisions are applicable. Under the revised amendments, costs associated with exceptional DME are (generally, and subject to various limitations) allowable costs. When the Department makes additional payments to a nursing facility pursuant to an exceptional DME grant, the amounts of those payments will be treated as an offset to the allowable costs in accordance with § 1187.154(c). Further, because it is a condition of participation that a nursing facility provider must accept case-mix per diem rate payments and any additional payment under a grant as payment in full, the facility will have been fully paid for the nursing facility services it provided to the MA resident named in the grant. Therefore, if a nursing facility were to purchase a wheelchair that met the definition of "specially adapted DME," and the facility requested and received a grant, and if the resident was thereafter discharged into the community and the Department directed that title to the wheelchair be transferred to the resident, the facility would be required under this subsection to transfer title without receiving further compensation for the transferred item. In that case the offset provisions contained in § 1187.61(c)(1) (relating to movable property cost policies) would not apply.

§ 1187.155. Exceptional DME grants—payment conditions and limitations.

§ 1187.155(a).

An exceptional DME grant constitutes authorization given by the Department for a nursing facility to submit invoices to the Department for payment related to the provision of nursing facility services related to the use of exceptional DME. There are two types of grants. One type authorizes the nursing facility to bill for and receive a single lump sum payment. The other type authorizes multiple payments to be billed for and received on a periodic basis. These are referred to as "monthly payments." In rare cases, however, the Department may vary the period, to account for differing payment schedules.

§ 1187.155 Draft subsection (b).

As originally drafted, costs of exceptional DME identified in a grant agreement would have been nonallowable costs and, to ensure that all costs associated with those items would be excluded, the Department proposed that the cost of maintenance, repairs and supplies not included in "related services and items" would also be encompassed by the grants. However, as explained in this Preamble, the Department has decided that exceptional DME costs will (subject to various limitations) be treated as allowable costs. Consequently, there no longer is a need to make special provision to include the cost of maintenance, repairs and supplies within the scope of the exceptional DME grant. Therefore, the Department has removed draft subsection (b) in its entirety. This change

will simplify the administration of the exceptional DME grant process, as well as the recordkeeping duties of the nursing facilities.

Revised subsection (b) (former subsection (c)).

As originally proposed, this subsection specified that the maximum allowable exceptional payment authorized by a grant was limited to the lowest of four criteria: (1) the nursing facility's actual acquisition cost; (2) the applicable MA outpatient fee schedule amount, if any; (3) 80% of the amount that would be approved by Medicare if the DME were a Medicare Part B covered service or item; and (4) the maximum approved amount specified in the nursing facility's grant agreement. Because grant agreements will no longer be used, the latter criterion has been deleted and the amount specified in a grant will be determined by applying the first three criteria.

During the public process, the Department received a comment suggesting that the Department must ensure that the maximum allowable payment authorized by the subsection is sufficient to meet the resident's need. The Department believes that the comment misapprehends the nature of the payment system. The exceptional payment authorized under a grant is in addition to the payment that the nursing facility receives to provide care and services to its MA residents. It is the rate as a whole, and not any component or the additional payment authorized by a grant that should be considered in determining the adequacy of reimbursement. Moreover, by electing to participate in the MA Program, a nursing facility assumes the responsibility to provide appropriate nursing facility services to its MA residents. Included in this is the responsibility to make all medically necessary DME available to its residents. Further, by enrolling in the MA Program, the facility agrees to accept payment made at the case-mix per diem rate as payment in full for covered services and items, including DME. If a nursing facility receives an exceptional payment, that payment is made to the facility (not the resident), as additional payment for services provided to that resident. However, the nursing facility's obligation to provide the services exists regardless whether the facility requests or receives an exceptional DME grant.

Subsection (c) (former subsection (d)).

§ 1187.155(c)(1).

Exceptional payments made under a grant will be subject to the conditions and limitations in Chapter 1101, including § 1101.64 (relating to third-party medical resources). The purpose of exceptional DME grants is to provide nursing facilities with additional payments in situations when they provide nursing facility services to certain residents who require certain unusual and expensive DME. In situations when a third-party payer has already paid for that DME, no grant is necessary. As explained in this Preamble, the issuance of a grant constitutes authorization from the Department to the nursing facility to submit invoices for payments pertaining to nursing facility services involving the use of exceptional DME. The submittal of these invoices is governed by § 1101.68.

Because exceptional DME grants are only issued infrequently and in extraordinary circumstances, the Department has determined that each grant should be treated individually, and that the terms and conditions should vary in accordance with the particular needs and circumstances of the MA eligible resident, the capabilities of the nursing facility, and the changing technology of DME. Consequently, the Department has determined that the use of individual written grants is appropriate. Each grant will specify: (i) the resident who needs the exceptional DME; (ii) the exceptional DME and related services and items needed by the resident; (iii) whether the nursing facility is authorized to request a lump-sum payment or periodic payment under the grant; (iv) the amount of additional payments and, if periodic payments are authorized, payment intervals at which the additional payment amounts may be requested; and (v) the effective date of the grant. Section 1187.154(c)(2) ensures that the imposition of those terms is specifically contemplated by the Department's regulations.

§ 1187.156. Exceptional DME notification and reporting requirements.

Section 1187.156 sets forth previously proposed provisions pertaining to the various notices and status reports be given to the Department. Until the Department provides different guidance, all reports and notices shall be sent to the Bureau of Long Term Care Programs, attention Division of LTC Provider Services, P. O. Box 8025, Attn: Exceptional Payment Section, Harrisburg, PA 17105.

§ 1187.157. Termination or suspension of exceptional DME grants and recovery of exceptional payments.

§ 1187.157(a).

Section 1187.157 was originally proposed as § 1187.156. As originally drafted, this section spoke of the "revocation" of an exceptional DME grant. That term suggested that a grant would only come to an end as a result of some affirmative act by the Department. That suggestion was incorrect. Generally, a grant ends as a result of some extrinsic event or condition. Therefore, the Department has modified the section to speak of "termination."

As set forth in subparagraph (5)(i), when a grant is terminated, the nursing facility no longer has authorization to obtain payments for services provided "after the termination date." Thus, for example, if a grant is terminated because the nursing facility is advised by the resident's attending physician that the exceptional DME is no longer medically necessary (§ 1187.157(a)(1)(iv)), the termination date is the date specified by the physician and, while the facility can receive exceptional payments for services provided up through that date, it no longer has authorization to receive payments for services provided thereafter. This limitation is in keeping with the principle that exceptional DME grant payments are intended as payment for nursing facility services.

In addition, the Department has modified this subsection to allow for the suspension of payments under a grant. In all or most instances, these new provisions will only apply when the grant in question authorizes periodic or monthly payments. The Department has included these provisions as an intermediate measure, to be used when termination appears unnecessary but when an interruption of payments also seems appropriate.

During the public process, the Department received a comment suggesting that it was not clear whether, in situations when the Department discontinues payment because the need for the exceptional DME no longer exists, the Department would issue advance notices. The Department agrees that advance notice should be given in some instances and has accordingly revised § 1187.157(a)(2).

§ 1187.157(b).

Subsection (b) makes explicit the Department's right to recover payments made for services provided during a

period of suspension or after the termination date of a grant. In addition, it provides that, if a nursing facility that has received payments pursuant to an exceptional DME grant has violated Subchapter K or the terms of its grant (such as, by submitting a request for payment in excess of the amount authorized, or for costs incurred for services and items not identified in the grant), the Department can recover some or all of the exceptional payments made under that grant in addition to or instead of terminating the nursing facility's grant. Under the latter option, the nursing facility would still be bound by the terms of this subchapter and its grant, even though the payments have been recovered.

§ 1187.157(c).

Subsection (c) makes clear that the rights and remedies available to the Department under § 1187.156 do not supersede or replace any rights, remedies or sanctions that are otherwise available to the Department under other laws and regulations.

During the public process, the Department was asked whether the exceptional DME grant process would have to be started over again if the Department revokes a grant due to a resident being temporarily discharged or transferred to a hospital or other health care provider. Another comment noted that some chronic conditions require repeated admissions to a hospital and that it was not prudent to subject residents and nursing facilities to repeated applications for exceptional DME for this reason. The Department agrees that, on occasion, suspension of a grant may be preferable to termination of the grant. Consequently, it has revised the regulations to permit suspensions in certain circumstances.

§ 1187.158. Appeals.

Section 1187.158 is new. The section sets forth provisions originally addressed in draft § 1187.152(d) and (e).

§ 1187.158(a).

With one exception, the changes in Subchapter K involve changes in the manner that nursing facilities are reimbursed for nursing facility services provided to certain MA residents. Thus, with one exception, the nursing facility is the only party who can be aggrieved by the denial of a request for a DME grant, or by the termination or suspension of a grant. Consequently, in the original version of Subchapter K, the Department proposed that, with one exception, only the nursing facility would have the right to appeal the decision of the Department made under this subchapter.

The one exception involves determinations of medical necessity. As discussed in this Preamble, regardless of whether a particular item of DME qualifies as "exceptional DME," if the circumstances of a resident cause that item to be medically necessary, the nursing facility has a positive duty under State and Federal law to use that DME in providing the resident with nursing facility services. However, if an item of DME is not medically necessary, the nursing facility is not required to use it, although it may elect to do so. Moreover, if the DME is not medically necessary and is not part of the routine items and services provided by the nursing facility, but the resident nonetheless wants it, the facility is entitled to charge the resident for that item.

As set forth in § 1187.152(c)(2), one criterion that must be met for a grant request to be approved is that the associated DME is "medically necessary." When a nursing facility submits a request for an exceptional DME grant it must, among other things, provide documentation and representation in support of the proposition that the identified DME is medically necessary. In considering the request, the Department reviews this information. If the Department concludes that the DME is not medically necessary, this is a ground for denying the request. Id. Thus, in the event that a request is denied for lack of medical necessity, not only has the Department determined that no exceptional payment will be made to the nursing facility but, in addition, the Department has determined that the facility has no legal obligation to use that DME in providing services to the resident. Only in this way does a Departmental decision adversely affect the resident. As originally drafted, the resident would only have been allowed to appeal a Departmental decision if it were based, in whole or in part, upon a finding of no medical necessity. Consistent with this position, when a request was denied for lack of medical necessity, the Department originally proposed that nursing facilities would not be able to appeal that determination.

Commentators, and in particular those representing consumers' interests, were critical of the manner in which the Department described the limited appeal rights of the residents. In part, this criticism seems to reflect the idea that, by issuing a grant, the Department is purchasing the DME for the resident. That conception is mistaken. When the Department approves a grant, it gives its authorization for the nursing facility to bill for and receive an additional payment for nursing facility services. Nonetheless, the Department does recognize that residents or their authorized representatives, or both, may find this rule and the contemplated limitation on appeals to be confusing. In addition, the Department recognizes that, on a regular basis, nursing facilities commence appeals in the names of their residents. To simplify the process, the Department has revised the regulations so that residents (acting directly or through their authorized representatives) and nursing facilities can appeal all types of decisions relating to exceptional DME grants.

The Department's original position was based upon its determination that, except in situations involving medical necessity, residents lacked standing because they were not aggrieved. Although the Department has modified its regulations to permit residents to maintain appeals in other instances, this change is not based upon a change in the Department's conclusion that the residents are not aggrieved.

§ 1187.158(b)

As originally drafted, subsection (b)(1) was located in § 1187.153 and provided as follows: "If, within the time limits set by subsection (d), the resident or the nursing facility fails to timely appeal the Department's decision to deny a grant as provided in subsection (d), the Department's decision is final. Any dispute regarding or arising from the Department's decision which is not timely presented by the resident or the nursing facility to the Department for adjudication shall be deemed waived and released and may not thereafter be the subject of any appeal, claim, proceeding or cause of action against the Commonwealth, the Department or its officials and employees. If the resident or the nursing facility timely appeals the Department's decision to deny a grant, the Department's denial is not final until the Department issues a final adjudication on the appeal. The Department's adjudication of an appeal shall be final, except as it may be reviewed by an appellate court pursuant to the Administrative Agency Law (2 Pa.C.S. § 101 et seq.)." That provision was deleted as redundant. In

§ 1187.158(a)(5), all appeals must be filed with the Bureau of Hearings and Appeals (BHA) within 30 days of the date of the Department's written notice and, as set forth in § 1187.158(a)(3), if a nursing facility appeals the denial, termination or suspension of a grant, § 1187.141(b), (d) and (e) apply. Those provisions already establish that, if a nursing facility fails to timely appeal an adverse decision of the Department, the Department's decision is final, and that any dispute regarding or arising out of that decision that has not been timely presented to BHA is deemed waived and released and may not thereafter be the subject of any appeal, action or proceeding. Those provisions further establish that, if a timely appeal is filed, the Department's denial is not final until the Department issues a final adjudication of that appeal. The final decisions are, of course, reviewable by an appellate court under the Administrative Agency Law.

Section 1187.158(b)(2)(i) and (ii) indicates some of the implications when the Department denies a grant request. Subparagraphs (iii) and (iv) indicate some of the effects of a termination or suspension of a grant. In all cases, these provisions are intended to ensure that nursing facilities and residents have clear notice of the conduct required and expected by the Department in these circumstances.

During the public process, the Department received a comment objecting to the requirement that, as a condition of receiving an exceptional DME grant, a nursing facility bring disputes relating to the grant initially and exclusively to the BHA. The commentator suggested that this provision eliminates providers' right to appeal to the Board of Claims. The Department does not agree that the regulation eliminates any provider rights. A payment made to a nursing facility for nursing facility services to MA recipients—regardless whether the payment is made pursuant to per diem rates or an exceptional DME grant—is "assistance" for purposes of section 402 of the act (62 P. S. § 402), and, as such, is a "grant." See 62 Pa.C.S. § 102(f) (relating to application of part) and 25 Pa.B. 4477, (October 14, 1995). The Board of Claims does not have jurisdiction over disputes involving grants, nor does it have jurisdiction over disputes involving MA provider agreements. See 62 Pa.C.S. § 106(f) and (e) (relating to public access to procurement information). Further, an MA provider's relationship with the Department is not contractual in nature. Rather, the obligations and duties of both the provider and the Department are derived from and governed by law and regulation, not any contract. The exceptional payment policies in Annex A do not create a contractual relationship or contractual rights or impose contractual obligations. The policies allow a nursing facility the option to request additional payments for services provided to MA residents when those services require the use of exceptional DME, and authorize the Department to issue a grant to the nursing facility when certain regulatory conditions are met. The policies also set forth the applicable terms and conditions for the grants. In addition, the Department notes that the regulatory language to which the commentator objects is a continuation of longstanding policy and practice. The provision is based upon analogous terms that have been included in all of the Department's exceptional payment grant agreements with nursing facilities since 1988.

The Department received a comment suggesting that appeals brought before the BHA should be expedited and decisions rendered within 30 days of filing. Except in situations when the Department determines that an item of DME is not medically necessary, the Department notes that the dispute underlying an appeal from the denial or termination of an exceptional DME grant is whether the Department's payments will be limited to those made under the per diem rates or, in addition, will include payments made under a grant. The dispute involves a question of reimbursement, which does not affect the nursing facility's obligation to provide necessary care to the resident. Nonetheless, if a nursing facility or resident desire an expedited hearing, they may ask BHA to expedite their appeals. BHA considers these requests on a case-by-case basis. The Department also notes that, regardless of whether an appeal is filed, nursing facilities are responsible to provide necessary care and services to residents.

The Department received a comment suggesting that the draft appeal provisions appeared to produce decisions that would be forever binding, regardless of a possible change in medical condition. The Department believes that the commentator's concern relates to language that appeared in the prior drafts of the regulation, which stated: "If, within the time limits set by subsection (d), the resident or the nursing facility fails to timely appeal the Department's decision to deny a grant as provided in subsection (d), the Department's decision is final. Any dispute regarding or arising from the Department's decision which is not timely presented by the resident or the nursing facility to the Department for adjudication shall be deemed waived and released and may not thereafter be the subject of any appeal, claim, proceeding or cause of action against the Commonwealth, the Department or its officials and employees. If the resident or the nursing facility timely appeals the Department's decision to deny a grant, the Department's denial is not final until the Department issues a final adjudication on the appeal. The Department's adjudication of any such appeal shall be final, except as it may be reviewed by an appellate court under the Administrative Agency Law." The Department has deleted this language from the amendments because the Department has determined that it merely restates what the existing law, including § 1187.141(b), (d) and (e), already provide. The Department has, however, included a new paragraph, § 1187.158(b)(1), to make clear that the denial or termination of a grant does not prohibit a nursing facility from submitting a new request for an exceptional DME grant for the same resident who was the subject of a prior denied request or terminated grant if the facility reasonably believes that there has been a change in the resident's condition since the denial or termination.

The Department received a comment noting that, if the Department denies an exceptional DME grant on the grounds that the identified DME is not medically necessary, the draft amendments would permit the nursing facility to provide DME and charge the resident. So long as the resident requests that the DME be provided, and so long as the nursing facility complies with applicable State and Federal requirements, the nursing facility may do so. The commentator's concern was that, in that situation, the resident's entire personal needs account could be depleted to cover the expense of costly DME. The commentator recommended that if exceptional DME is in use during an appeal process, the nursing facility should assume the cost until an appropriate alternative can be secured. The Department notes that, if as a result of the appeal, the DME is found to be medically necessary, then regardless whether it is exceptional or not, the nursing facility is required to provide it and refund any amount paid by the resident. If, on the other hand, the DME is

found to be not medically necessary, the nursing facility is entitled to retain the money, since the resident requested that the DME be provided.

The Department received a comment recommending that, instead of requiring a nursing facility to issue a refund to the resident "immediately" in the event an appeal is sustained, the regulation should be revised to permit the nursing facility 60 days from the date the appeal is sustained to issue the refund. The commentator suggested that a revision would be consistent with the regulation governing refunds of resident personal funds. The Department accepts the recommendation and has revised the regulation to allow nursing facilities 60 days to refund payments made by residents.

Fiscal Impact

A. *Public Sector*

1. *Commonwealth*

Currently, the Department pays MA nursing facility providers on a per diem rate basis for services provided to MA residents. These nursing facility per diem rates include a capital component that provides a fair rental payment for use of the facilities' allowable movable property. In addition to the per diem payment rates, the Department also makes exceptional payments to nursing facilities in certain limited circumstances. Prior to November 1, 1999, exceptional payments were limited to the rental of equipment and supplies necessary to care for the high technology-dependent residents, such as ventilator dependent or head or spinal cord, or both, injured individuals.

The amendments revise the Department's case-mix regulations to incorporate and expand existing exceptional payment policies to permit the Department to make additional payments to nursing facilities for nursing facility services provided to certain MA residents who require medically necessary exceptional DME. As a result of these amendments, exceptional payments will no longer be limited to the rental of equipment and supplies, but will be based upon the costs to purchase and rent exceptional DME and certain services and items necessary to the effective use of those exceptional items, including staff and resident training.

These amendments also revise the Department's case-mix regulations to change the payment methodology as it relates to the costs of movable property that is used by nursing facilities to provide services to their residents by: (i) removing movable property from the FRV calculation; (ii) recognizing minor movable property costs as net operating costs; (iii) using actual audited major movable property acquisition costs to compute the capital component of nursing facilities' case-mix per diem rates; and, (iv) eliminating the application of the moratorium in determining allowable movable property costs.

The amendments will increase Departmental expenditures by $26.633 million ($12.147 million in State funds) for Fiscal Year 2001-2002.

2. *Political Subdivisions*

There will be a fiscal impact on individual political subdivisions to the extent that county nursing facilities receive additional exceptional payments and increased case-mix per diem rates as a result of the amendments in Annex A.

B. *Private Sector*

1. *General Public*

Although the amendments provide for enhanced payments to nursing facilities for certain medically necessary exceptional DME and otherwise revise the case-mix payment methodology in a way that is likely to result in an increase in payment rates for the majority of MA nursing facility providers, there will be no fiscal impact on the general public as a result of the amendments in Annex A. The additional and increased payment rates authorized by these amendments will help to better ensure that MA nursing facility providers provide services in conformity with law and that MA residents of those providers receive necessary care and services in conformity with their care plans.

2. *Private Nursing Facilities*

There will be a fiscal impact on individual private nursing facilities to the extent that those facilities receive additional exceptional payments and increased case-mix per diem rates as a result of the amendments.

Paperwork Requirements

These amendments have increased the paperwork requirements for the Commonwealth and for those nursing facilities requesting exceptional payment for DME in accordance with conditions in these amendments. The nursing facilities are required to submit a request for exceptional payment, which includes documentation to support their request, and obtain the Department's written response to that request. In addition, nursing facilities are required to maintain a separate written log identifying requests for exceptional DME and provide notification to the Department if an MA eligible resident refuses medically necessary DME.

Effective Date

The following amendments are effective November 1, 1999: Subchapter K, the definitions of "DME—durable medical equipment," "related services and items" and "specially adapted DME" as contained in § 1187.2 and § 1187.59(c)(5). The remaining amendments take effect July 1, 2001, and, except to the limited extent specified in § 1187.91(iv)(D), apply to cost reports for fiscal periods starting on or after January 1, 2001.

Sunset Date

There is no sunset date for these final-omitted regulations.

Public Comment Period

Although these final-omitted regulations are being adopted without being published as proposed, interested persons are invited to submit their written comments within 30 days from the date of this publication for consideration by the Department as to whether the regulations should be revised. The comments should be sent to the Department of Public Welfare, Office of Medical Assistance Programs, Attn: Regulations Coordinator, Room 515 Health and Welfare Building, Harrisburg, PA 17105.

Persons with a disability may use the AT&T Relay Service by calling (800) 654-5984 (TDD users) or (800) 654-5988 (Voice users). Person who require another alternative, please contact the Office of Legal Counsel at (717) 782-2209.

Regulatory Review

Under section 5.1(c) of the Regulatory Review Act (71 P. S. § 745.5a(c)), on December 12, 2001, the Department

submitted a copy of these final-omitted regulations to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Health and Welfare and the Senate Committee on Public Health and Welfare. On the same date, the regulations were submitted to the Office of the Attorney General for review and approval under the Commonwealth Attorneys Act (71 P. S. §§ 732-101—732-506).

Under section 5.1(d) of the Regulatory Review Act, these regulations were deemed approved by the Committees on December 2, 2002. Under section 5.1(e) of the Regulatory Review Act, on January 1, 2002, IRRC met and approved by IRRC.

Findings

The Department finds that:

(1) Notice of proposed rulemaking is contrary to public interest under section 204(3) of the CDL and the regulations thereunder, 1 Pa. Code § 7.4(3).

(2) Notice of proposed rulemaking is omitted because these amendments relate to a Commonwealth grant or benefit in accordance with section 204(1)(iv) of the CDL and 1 Pa. Code § 7.4(1)(iv).

(3) The adoption of the amendments in the manner provided in this order is necessary and appropriate for the administration and enforcement of section 443.1(2) and (3) of the act.

Order

The Department, acting under the authority of the act, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 1187, are amended by amending §§ 1187.2, 1187.22, 1187.51, 1187.56—1187.60, 1187.71, 1187.80, 1187.91, 1187.96, 1187.97, 1187.112 and 1187.113; and by adding §§ 1187.61 and 1187.151—1187.158 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Secretary of the Department shall submit this order and Annex A to the Attorney General and General Counsel for approval as to the legality and form as required by law.

(c) The Secretary of the Department shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) This order shall take effect upon publication and apply retroactively November 1, 1999; for Subchapter K, the definitions of "DME—durable medical equipment", "related services and items" and "specially adapted DME" as contained in § 1187.2 and § 1187.59(c)(5). The remaining amendments take effect July 1, 2001, and, except to the limited extent specified in § 1187.91(iv)(D), apply to cost reports for fiscal periods starting on or after January 1, 2001.

FEATHER O. HOUSTOUN,
Secretary

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission, relating to this document, see 32 Pa.B. 477 (January 26, 2002).)

Fiscal Note: 14-473. (1) General Fund; (2) Implement Year 2001-02 is $12,147,000; (3) 1st Succeeding Year 2002-03 is $12,317,000; 2nd Succeeding Year 2003-04 is $18,454,000; 3rd Succeeding Year 2004-05 is $28,771,000; 4th Succeeding Year 2005-06 is $29,641,000; 5th Succeeding Year 2006-07 is $29,641,000; (4) 2000-01 Program—$722,565,000; 1999-00 Program—$693,625,000; 1998-99 Program—$721,631,000; (7) Long-Term Care; (8) recommends adoption. Funds have been included in the Long-Term Care appropriation of these costs.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1187. NURSING FACILITY SERVICES

Subchapter A. GENERAL PROVISIONS

§ 1187.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

Appraisal—A determination of the depreciated replacement cost of fixed or movable property, made by qualified personnel of an independent appraisal firm under contract with the Department.

* * * * *

DME—Durable medical equipment—

(i) Movable property that:

(A) Can withstand repeated use.

(B) Is primarily and customarily used to serve a medical purpose.

(C) Generally is not useful to an individual in the absence of illness or injury.

(ii) Any item of DME is an item of movable property. There are two classes of DME:

(A) *Exceptional DME*. DME that has a minimum acquisition cost that is equal to or greater than an amount specified by the Department by notice in the *Pennsylvania Bulletin* and is either specially adapted DME or other DME that is designated as exceptional DME by the Department by notice in the *Pennsylvania Bulletin*.

(B) *Standard DME*. Any DME, other than exceptional DME, that is used to furnish care and services to a nursing facility's residents.

* * * * *

Depreciated replacement cost—

(i) As used in conjunction with fixed property, depreciated replacement cost is the amount required to replace the fixed property with new and modern fixed property using the most current technology, code requirements/standards and construction materials that will duplicate the production capacity and utility of the existing fixed property at current market prices for labor and materials, less an allowance for accrued depreciation.

(ii) As used in conjunction with movable property, depreciated replacement cost is the amount required to replace the movable property with new and modern movable property, less an allowance for accrued depreciation.

* * * * *

FRV—Fair rental value—The imputed rent for the fixed or movable property used at a nursing facility to provide nursing facility services to its MA residents.

* * * * *

Fixed property—Land, land improvements, buildings including detached buildings and their structural components, building improvements, and fixed equipment lo-

cated at the site of the licensed nursing facility that is used by the nursing facility in the course of providing nursing facility services to residents. Included within this term are heating, ventilating, and air-conditioning systems and any equipment that is either affixed to a building or structural component or connected to a utility by direct hook-up.

* * * * *

Initial appraisal—An appraisal of the fixed property of a new nursing facility, made for the purpose of computing the fixed property component of that nursing facility's initial capital rate. An initial appraisal will be based, in part, upon an onsite inspection of the new nursing facility's fixed property conducted by qualified personnel of an independent appraisal firm under contract with the Department.

Interest—

(i) *Capital interest.* The direct actual cost incurred for funds borrowed to obtain fixed property, major movable property, or minor movable property.

(ii) *Other interest.* The direct actual cost incurred for funds borrowed on a short-term basis to finance the day-to-day operational activities of the nursing facility, including the acquisition of supplies.

* * * * *

Limited appraisal—An appraisal requested by a nursing facility and conducted to determine the effect of changes in the fixed property of a nursing facility, where the cost of the changes to the nursing facility was more than $200,000 or 10% of the most recent appraised depreciated replacement cost of the nursing facility's fixed property, whichever is lower. A limited appraisal results in the modification of the depreciated replacement cost set forth in an initial appraisal, a reappraisal or an updated appraisal.

* * * * *

Movable property—A tangible item that is used in a nursing facility in the course of providing nursing facility services to residents and that is not fixed property or a supply. There are two classes of movable property:

(i) *Major movable property.* Any movable property that has an acquisition cost of $500 or more.

(ii) *Minor movable property.* Any movable property that has an acquisition cost of less than $500.

Movable property appraisal—An appraisal of some or all of the movable property of a nursing facility. Depending upon circumstances, this appraisal may pertain to all movable property or only to major movable property. Movable property appraisals are conducted by qualified personnel of an independent appraisal firm under contract with the Department.

* * * * *

Real estate tax cost—The cost of real estate taxes assessed against a nursing facility for a 12-month period, except that, if the nursing facility is contractually or otherwise required to make a payment in lieu of real estate taxes, that nursing facility's "cost of real estate taxes" is deemed to be the amount it is required to pay for a 12-month period.

Reappraisal—An appraisal of the fixed property of a nursing facility, made for the purpose of computing the fixed property component of that nursing facility's capital rate. A reappraisal will be based, in part, upon an onsite inspection of the nursing facility's fixed property conducted by qualified personnel of an independent appraisal firm under contract with the Department.

* * * * *

Related services and items—Services and items necessary for the effective use of exceptional DME. The term is limited to:

(i) Delivery, set up and pick up of the equipment.

(ii) Service, maintenance and repairs of the equipment to the extent covered by an agreement to rent the equipment.

(iii) Extended warranties.

(iv) Accessories and supplies necessary for the effective use of the equipment.

(v) Periodic assessments and evaluations of the resident.

(vi) Training of appropriate nursing facility staff and the resident in the use of the equipment.

Reorganized nursing facility—An MA participating nursing facility that changes ownership as a result of the reorganization of related parties or a transfer of ownership between related parties.

Resident assessment—A comprehensive, standardized evaluation of each resident's physical, mental, psychosocial and functional status conducted within 14 days of admission to a nursing facility, promptly after a significant change in a resident's status and on an annual basis.

* * * * *

Specially adapted DME—DME that is uniquely constructed or substantially adapted or modified in accordance with the written orders of a physician for the particular use of one resident, making its contemporaneous use by another resident unsuitable.

Supply—

(i) A tangible item that is used in a nursing facility in the course of providing nursing facility services to residents and is normally consumed either in a single use or within a single 12-month period.

(ii) Examples of supplies include:

(A) Resident care personal hygiene items such as soap, toothpaste, toothbrushes and shampoo.

(B) Resident activity supplies such as game and craft items.

(C) Medical supplies such as surgical and wound dressings, disposable tubing and syringes, and supplies for incontinence care such as catheters and disposable diapers.

(D) Dietary supplies such as disposable tableware and implements and foodstuffs.

(E) Laundry supplies such as soaps and bleaches

(F) Housekeeping and maintenance supplies such as cleaners, toilet paper, paper towels and light bulbs.

(G) Administrative supplies such as forms, paper, pens and pencils, copier and computer supplies.

* * * * *

Total facility CMI—The arithmetic mean CMI of all residents regardless of the residents' sources of funding.

UMR—Utilization Management Review—An audit conducted by the Department's medical and other profes-

sional personnel to monitor the accuracy and appropriateness of payments to nursing facilities and to determine the necessity for continued stay of residents.

Updated appraisal—An appraisal of a nursing facility's fixed property that is based upon the depreciated replacement cost set forth in the nursing facility's initial appraisal or most recent reappraisal and brought forward to a new date. An updated appraisal does not involve an additional onsite inspection of the nursing facility's fixed property. The depreciated replacement costs set forth in an updated appraisal are determined through the application of factors to allow for appreciation and depreciation estimated to have taken place between the two appraisal dates.

* * * * *

§ 1187.22. Ongoing responsibilities of nursing facilities.

In addition to meeting the ongoing responsibilities established in Chapter 1101 (relating to general provisions), a nursing facility shall, as a condition of participation:

(1) Assure that every individual applying for admission to the facility is prescreened by the Department as required by section 1919 of the Social Security Act (42 U.S.C.A. § 1396r(e)(7)) and 42 CFR Part 483, Subpart C (relating to preadmission screening and annual review of mentally ill and mentally retarded individuals).

(2) Assure that every individual who receives MA, who is eligible for MA or who is applying for MA, is reviewed and assessed by the Department or an independent assessor and found to need nursing facility services prior to admission to the nursing facility, or in the case of a resident, before authorization for MA payment.

(3) Assure immediate access to a resident by the following individuals:

(i) The resident's physician.

(ii) A representative of the Secretary of the United States Department of Health and Human Services.

(iii) A representative of the Commonwealth who is involved in the administration of the MA Program.

(iv) An ombudsman authorized by the Department of Aging, including those employed by a local area agency on aging.

(v) A representative of Pennsylvania Protection and Advocacy, the agency designated under Subchapter III of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. §§ 6041—6043) and the Protection and Advisory for Mentally Ill Individuals Act of 1986 (42 U.S.C.A. §§ 10801—10851).

(4) Assure that it is necessary for each resident to remain in the nursing facility.

(5) Assure that each resident's assessment data are complete and accurate in accordance with Federal regulations and the *Health Care Financing Administration Resident Assessment Instrument Manual.*

(6) Assure that the resident assessment data and the resident verification report are valid for the picture date and are submitted within the time limits specified in § 1187.33(a)(5)(relating to resident data reporting requirements).

(7) Assure that each invoice for nursing facility services provided to each MA resident is accurate.

(8) Have in operation a system for managing residents' funds that, at a minimum, fully complies with the requirements established by Federal law and Federal and State regulations in accordance with § 1187.78 (relating to accountability requirements related to resident personal fund management).

(9) Cooperate with reviews and audits conducted by the Department and furnish the residents' clinical and fiscal records to the Department upon request.

(10) Provide written responses to the Department for UMR reports requiring corrective action.

(11) Take corrective action within acceptable time frames as described in UMR reports.

(12) File an acceptable cost report with the Department within the time limit specified in § 1187.73 or § 1187.75 (relating to annual reporting; and final reporting).

(13) In addition to meeting the reporting requirements of § 1101.43 (relating to enrollment and ownership reporting requirements), notify the Department in writing within 30 days of a change in the name or address of corporate officers.

(14) Submit a written request for MA nursing facility participation to the Department if the nursing facility changes ownership and the new owner wishes the nursing facility to participate in the MA Program. The agreement in effect at the time of the ownership change will be assigned to the new owner subject to applicable statutes and regulations and the terms and conditions under which it was originally issued.

(15) Assure that individual resident information collected in accordance with this chapter is kept confidential and released only for purposes directly connected to the administration of the MA Program.

(16) Maintain a separate written record in accordance with instructions by the Department, identifying the requests or physician's orders received by the facility for exceptional DME or other DME as specified by the Department.

(17) Notify the Department in writing within 15 days if an MA eligible resident refuses DME that the Department has determined is medically necessary.

Subchapter E. ALLOWABLE PROGRAM COSTS AND POLICIES

§ 1187.51. Scope.

(a) This subchapter sets forth principles for determining the allowable costs of nursing facilities.

(b) The *Medicare Provider Reimbursement Manual* (HCFA Pub. 15-1) and the Federal regulations at 42 CFR Part 489 (relating to provider and supplier agreements) appropriate to the reimbursement for nursing facility services under the Medicare Program are a supplement to this chapter. If a cost is included in this subchapter as allowable, the HCFA Pub. 15-1 and applicable Federal regulations may be used as a source for more detailed information on that cost. The HCFA Pub. 15-1 and applicable Federal regulations will not be used for a cost that is nonallowable either by a statement to that effect in this chapter or because the cost is not addressed in this chapter or in the MA-11. The HCFA Pub. 15-1 or applicable Federal regulations will not be used to alter the treatment of a cost provided for in this subchapter or the MA-11.

(c) The Department's payment rate for nursing facility services to eligible residents in participating nursing

facilities includes allowable costs for routine services. Routine services may include the following:

(1) Regular room, dietary and nursing services, social services and other services required to meet certification standards, medical and surgical supplies and the use of equipment and facilities.

(2) General nursing services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.

(3) Items furnished routinely and uniformly to residents, such as resident gowns, water pitchers, basins and bedpans.

(4) Items furnished, distributed to residents or used individually by residents in small quantities such as alcohol, applicators, cotton balls, bandaids, antacids, aspirin (and other nonlegend drugs ordinarily kept on hand), suppositories and tongue depressors.

(5) Reusable items furnished to residents, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.

(6) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician.

(7) Basic laundry services.

(8) Nonemergency transportation.

(9) Beauty and barber services.

(10) Other special medical services of a rehabilitative, restorative or maintenance nature, designed to restore or maintain the resident's physical and social capacities.

(d) Nursing facilities will receive payment for allowable costs in four general cost centers:

(1) Resident care costs.

(2) Other resident related costs.

(3) Administrative costs.

(4) Capital costs.

(e) Within the limits of this subchapter, allowable costs for purposes of cost reporting include those costs necessary to provide nursing facility services. These may include costs related to the following:

(1) *Resident care costs.*

(i) Nursing.

(ii) Director of nursing.

(iii) Related clerical staff.

(iv) Practitioners.

(v) Medical director.

(vi) Utilization and medical review.

(vii) Social services.

(viii) Resident activities.

(ix) Volunteer services.

(x) Over-the-counter drugs.

(xi) Medical supplies.

(xii) Physical, occupational and speech therapy.

(xiii) Oxygen.

(xiv) Beauty and barber.

(xv) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in the course of providing a service or engaging in an activity identified in this paragraph.

(2) *Other resident related costs.*

(i) Dietary, including food, food preparation, food service, and kitchen and dining supplies.

(ii) Laundry and linens.

(iii) Housekeeping.

(iv) Plant operation and maintenance, including the repair, maintenance and service of movable property.

(v) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in the course of providing a service or engaging in an activity identified in this paragraph.

(3) *Administrative costs.*

(i) Administrator.

(ii) Office personnel.

(iii) Management fees.

(iv) Home office costs.

(v) Professional services.

(vi) Determination of eligibility.

(vii) Advertising.

(viii) Travel/entertainment.

(ix) Telephone.

(x) Insurance.

(xi) Interest other than that disallowed under § 1187.59(a)(24) (relating to nonallowable costs).

(xii) Legal fees.

(xiii) Amortization—administrative costs.

(xiv) Supplies and minor movable property acquired during cost report periods beginning on or after January 1, 2001, used in a nursing facility in connection with an activity identified in this paragraph.

(4) *Capital costs.*

(i) Fair rental value of fixed property.

(ii) Movable property.

(A) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning prior to January 1, 2001, the fair rental value of major and minor movable property.

(B) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning on or after January 1, 2001, the audited acquisition cost of major movable property.

(iii) Real estate tax cost.

§ 1187.56. Selected administrative cost policies.

Policies for selected administrative costs are as follows:

(1) *Administrative allowance.*

(i) The allowable administrative costs incurred by a nursing facility to provide services are subject to the following limitation: the allowable administrative costs will be determined so that all other allowable costs, excluding capital costs, equal no less than 88% of the allowable net operating costs.

(ii) Home office cost allocations and management fees are subject to the following conditions and limitations:

(A) Home office cost allocations and management fees between related parties shall be reported without markup by the nursing facility.

(B) Costs which are not allowable, such as those related to nonworking officers or officers' life insurance, may not be included in home office allocations or management fees.

(C) Documentation relating to home office and management costs shall be provided to the Department's auditors upon request.

(D) Home office allocations, including administratively allowable depreciation and interest costs shall be reported on the administrative line in the MA-11.

(iii) A nursing facility providing nursing, residential and other services shall allocate the total administrative cost to nursing, residential and other services on the basis of a percentage of these costs to the total net operating costs.

(2) *Other interest allowance.*

(i) Other interest is an allowable administrative cost if it is necessary and proper. To be considered allowable, necessary and proper, the interest expense shall be incurred and paid within 90 days of the close of the cost reporting period on a loan made to satisfy a financial need of the nursing facility and for a purpose related to resident care. Interest incurred to pay interest is nonallowable.

(ii) Other interest may not exceed that amount which a prudent borrower would pay as described in the *Medicare Provider Reimbursement Manual* (CMS Pub. 15-1).

(iii) Other interest is allowable if paid on loans from the nursing facility's donor-restricted funds, the funded depreciation account or the nursing facility's qualified pension fund.

(iv) Moneys borrowed for the purchase or redemption of capital stock will be considered a loan for investment purposes. The interest paid on these borrowed funds is a nonallowable cost. The use of funds by the nursing facility for the redemption of capital stock will be considered as an investment of available funds.

(3) *Investment income.*

(i) Investment income is used to reduce allowable other interest unless the investment income is from one of the following:

(A) Gifts or grants of which the corpus and interest are restricted by the donor.

(B) Funded depreciation maintained in accordance with Federal regulations.

(C) The nursing facility's qualified pension fund, if the interest earned remains in the fund.

(D) Issuer specified designated capital bond funds or debt service reserve funds.

(ii) Investment income on funds found to be used for purposes other than their designated purpose or commingled with other funds will be used to reduce allowable administrative interest expense.

(4) *General administration expenses.*

(i) Salaries of the nursing facility's administrator, comptroller, purchasing agent, personnel director, pharmacy consultant and other persons performing general supervision or management duties are allowable as general administrative costs.

(ii) The salary or compensation costs of owners, operators or persons other than nursing facility employees shall be included as allowable costs only to the extent of their documented time and involvement in the required management of a nursing facility. These costs mean actual payment made during the cost reporting period on a current basis of salary or benefits for services rendered to the nursing facility.

(iii) If a person performs work customarily performed by different or several types of employees, the cost of the salary and other compensation allowable for the person shall be determined by the prorated customary salary and other compensation paid to employees for performing the same types of work. This cost is allowable only if adequate documentation verifying the cost is supplied by the nursing facility.

(iv) The allowable cost for a person performing necessary duties may not exceed the customary compensation and fringe benefits that an employee would normally receive while performing that work.

(5) *Contracted management services.*

(i) In lieu of home office allocations or management fees, a nursing facility may contract with a nonrelated management service. The cost of this contract shall be shown as an administrative cost and may not be allocated among other cost centers.

(ii) Management services contracted with a related party shall be treated as home office allocations.

§ 1187.57. Selected capital cost policies.

The Department will establish a prospective facility-specific capital rate annually for each nursing facility. That rate will consist of three components: the fixed property component, the movable property component and the real estate tax component.

(1) *Fixed property component.*

(i) The Department will base the nursing facility's fixed property component on the depreciated replacement cost of the nursing facility's fixed property and the associated financial yield rate.

(ii) On an annual basis, the Department will determine the depreciated replacement cost of each nursing facility's fixed property as of March 31, and will use that determination in setting the fixed property component for the rate year beginning on the following July 1.

(iii) The basis for the Department's determination of the depreciated replacement cost of the nursing facility's fixed property will be the most recent of the following appraisals, as modified by any limited appraisals, as of March 31:

(A) An initial appraisal.

(B) A reappraisal.

(C) An updated appraisal.

(iv) An initial appraisal of the nursing facility's fixed property will be conducted for any new nursing facility.

(v) A reappraisal of the nursing facility's fixed property will be conducted at least every 5 years.

(vi) In situations where neither an initial appraisal nor a reappraisal has been done within the 12-month period

preceding March 31, the depreciated replacement cost will be based upon an updated appraisal.

(vii) A limited appraisal will be conducted if the nursing facility notifies the Department that a limited appraisal is needed. For the results of a limited appraisal to be included in the determination of a nursing facility's fixed property component for the next rate year, a limited appraisal must be requested by the nursing facility by January 31 of the preceding rate year.

(viii) The depreciated replacement cost of the nursing facility's fixed property is subject to the cost per bed limitation in § 1187.112 (relating to cost per bed limitation adjustment) and, if applicable, the bed moratorium limitation in § 1187.113 (relating to capital component payment limitation).

(ix) The cost to purchase, construct or renovate the fixed property of the nursing facility will not be a factor in determining the appraised depreciated replacement cost.

(x) When there is a change in nursing facility ownership, the new nursing facility owner is deemed to have the same appraised depreciated replacement cost as the former owner.

(xi) The appraisals of fixed property will be performed by qualified personnel from an independent appraisal firm under contract with the Department.

(2) *Movable property component.*

(i) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning prior to January 1, 2001, the Department will determine the movable property component of each nursing facility's capital rate as follows:

(A) The Department will base the nursing facility's movable property component on the depreciated replacement cost of the nursing facility's major and minor movable property and the associated financial yield rate.

(B) On an annual basis, the Department will determine the depreciated replacement cost of each nursing facility's movable property as of March 31, and will use that determination in setting the movable property component for the rate year beginning on the following July 1.

(C) The Department will base the determination of the depreciated replacement cost of each nursing facility's movable property on a movable property appraisal.

(D) When there is a change in nursing facility ownership, the new nursing facility owner is deemed to have the same appraised depreciated replacement cost as the former owner.

(ii) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning on or after January 1, 2001, the Department will determine the movable property component of each nursing facility's capital rate as follows:

(A) The Department will base the nursing facility's movable property component on the nursing facility's audited cost of major movable property, as set forth in that MA-11.

(B) Each nursing facility shall report the acquisition cost of all major movable property on the major movable property line of its MA-11 and shall report the cost of minor movable property and the cost of supplies as net operating costs in accordance with § 1187.51 (relating to scope) and instructions for the MA-11.

(3) *Real estate tax cost component.* A nursing facility's real estate tax component will be based solely upon the audited cost of that nursing facility's 12-month real estate tax cost, as set forth on the most recent audited MA-11 cost report available in the NIS database.

§ 1187.58. Costs of related parties.

Costs applicable to services, movable property and supplies, furnished to the nursing facility by organizations related to the nursing facility by common ownership or control shall be included as an allowable cost of the nursing facility at the cost to the related organization. This cost may not exceed the price of comparable services, movable property or supplies that could be purchased elsewhere.

§ 1187.59. Nonallowable costs.

(a) *Nonallowable costs related to expenses and revenues.* The Department will not recognize as allowable costs the expenses or revenues of a nursing facility related to:

(1) Nonworking officers' or owners' salaries.

(2) Fundraising expenses for capital and replacement items exceeding 5% of the amount raised and, for operating expenses and cash flow, fundraising expenses exceeding 10% of the amount raised.

(3) Free care or discounted services.

(4) Parties and social activities not related to resident care.

(5) Organizational memberships not necessary to resident care.

(6) Personal telephone service.

(7) Personal television service.

(8) The direct and indirect costs related to nonallowable cost centers, including gift, flower and coffee shops, homes for administrators or pastors, convent areas and nurses' quarters, except as provided in § 1187.55(3) (relating to selected resident care and other resident related cost policies).

(9) Vending machines.

(10) Charitable contributions.

(11) Employee and guest meals.

(12) Pennsylvania Capital Stock and Franchise Tax.

(13) Income tax.

(14) Ambulance costs.

(15) Promotional advertising, including a yellow page listing larger than a minimum insert.

(16) Late payment penalties.

(17) Taxes based upon net income.

(18) Officers' and directors' life insurance, including life insurance premiums necessary to obtain mortgages and other loans.

(19) Bad debts or contractual adjustments.

(20) Collection expenses associated with bad debts.

(21) Losses on the sale of fixed and movable assets.

(22) Remuneration of any kind for any purpose, including travel expenses for members of the Board of Directors.

(23) Dry cleaning, mending or other specialty laundry services.

(24) Depreciation on fixed or movable property, capital interest, amortization—capital costs and rental expense for fixed property.

(25) Expenses or revenues not necessary to resident care.

(26) Costs, including legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies, attributable to the negotiation or settlement of the sale or purchase of a capital asset—by acquisition or merger—for which payment has previously been made under Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395yy) if the sale or purchase was made on or after July 18, 1984.

(27) Letter of credit costs.

(28) Legal expenses related to an appeal or action challenging a payment determination under this chapter until a final adjudication is issued sustaining the nursing facility's appeal. If the nursing facility prevails on some but not all issues raised in the appeal or action, a percentage of the reasonable legal expenses is allowable based upon the proportion of additional reimbursement received to the total additional reimbursement sought on appeal.

(29) Nonstandard or nonuniform fringe benefits.

(30) Return on net equity and net worth.

(b) *Nonallowable costs related to revenue producing items.* In determining the operating costs of a nursing facility, the Department will not allow costs related to:

(1) The sale of laundry and linen service.

(2) The sale of drugs to nonresidents.

(3) The sale of medical and surgical supplies to nonresidents.

(4) The sale of clinical records and abstracts.

(5) The rental of quarters to employees and others.

(6) The rental of space within the nursing facility.

(7) The payments received from clinical specialists.

(8) Discounts on purchases which include trade, quantity and time.

(9) Rebates and refunds of expenses.

(c) *Income that reduces allowable costs.*

(1) Except as provided in § 1187.56(3)(i) (relating to selected administrative cost policies), any form of investment income shall be used to reduce the allowable administrative interest expense.

(2) Grants, gifts and income designated by the donor for specific operating expenses are used to reduce the allowable costs relating to the specific operating expense.

(3) Recovery of insured loss shall be used to reduce the allowable costs relating to the insured loss.

(4) Applicable revenue producing items, other than room and board, shall be used to reduce the related allowable costs.

(5) Payments received under an exceptional DME grant reduce the allowable cost of the major movable property and related services and items in the cost centers where the costs were originally reported in the MA-11.

(d) *Nonallowable direct nursing facility payments.* Costs for prescription drugs, physician services, dental services, dentures, podiatry services, eyeglasses, appliances, X-rays, laboratory services and other materials or services covered by payments, other than MA or Medicare Part A, made directly to nursing facilities, including Medicare Part B, Champus, Blue Cross, Blue Shield or other insurers or third parties, are not allowable in determining net operating costs.

§ 1187.60. Prudent buyer concept.

The purchase or rental by a nursing facility of services, movable property and supplies, including pharmaceuticals, may not exceed the cost that a prudent buyer would pay in the open market to obtain these items, as described in the *Medicare Provider Reimbursement Manual* (CMS Pub. 15-1).

§ 1187.61. Movable property cost policies.

(a) *Actual acquisition cost during cost report period.* Except as otherwise specified in this section and subject to §§ 1187.58 and 1187.60 (relating to costs of related parties; and prudent buyer concept), a nursing facility's allowable movable property shall be limited to the nursing facility's actual acquisition cost of movable property placed in service during the cost report period.

(b) *Determination of acquisition cost.* Except in situations where an item of movable property is obtained from a related party, the acquisition cost of that item shall be determined as follows:

(1) Acquisition cost is determined on a per-unit basis.

(2) When an item is purchased, the acquisition cost of that item is equal to the total actual purchase price of the item, regardless of whether the total price is paid in full at the time of purchase or over a period of time, plus the following: any required sales tax, shipping charges and installation charges.

(3) When an item of movable property is leased or rented, the acquisition cost is limited to the lower of: the actual annual lease or rental payments made by the nursing facility; or the imputed purchase price of the item, pro-rated on a straight-line basis over the useful life of the item, as identified in the most recent Uniform Chart of Accounts and Definitions for Hospitals published by the American Hospital Association at the time the item is leased or rented. For purposes of this section, the imputed purchase price of a leased or rented item is the lesser of:

(i) The suggested list price from the manufacturer of the item.

(ii) The actual discounted price of the item available at the time of lease or rental.

(iii) The purchase price for the item set forth in the lease or rental agreement.

(iv) If the lessor is a related party, the related party's acquisition cost as determined in accordance with paragraph (2).

(4) When an item is acquired as the result of a gift or donation, the acquisition cost of that item is deemed to be the appraised depreciated replacement cost of the item provided that, on a date prior to the submission of the MA-11 for the period in which the item is acquired, the nursing facility obtains an appraisal of the item's depreciated replacement cost from a licensed appraiser and submits a copy of the written report of the appraisal to the Department with its MA-11. If the nursing facility fails to obtain an appraisal of the item's depreciated replacement cost from a licensed appraiser within the time period set forth in this section or if the nursing

facility fails to submit a copy of the written report of the appraisal to the Department with its MA-11, the acquisition cost of the donated item or gift is deemed to be $0.

(5) When an item is acquired by a trade-in, the acquisition cost of the item shall be the sum of the remaining book value of the item traded-in plus any acquisition cost of the newly acquired item, computed in accordance with paragraphs 2, 3 and 4. The remaining book value of the item shall be determined based upon the useful life of the item, using the Uniform Chart of Accounts and Definitions for Hospitals published by the American Hospital Association, and depreciation computed on a straight-line basis.

(6) When an item is loaned to the nursing facility without charge, the acquisition cost of that item is deemed to be $0.

(7) When an item is covered by a standard express warranty, the cost of that warranty is included in the acquisition cost of the item. The cost of any extended warranty is not included in the acquisition cost of the item.

(8) When an item is acquired from a related party, the acquisition cost of the item shall be determined under § 1187.58 (relating to costs of related parties).

(c) *Offsets to reported cost of movable property.*

(1) If a nursing facility conveys or otherwise transfers movable property acquired during a cost report period beginning on or after January 1, 2001, to any other person as the result of a sale, trade-in, gift, assignment or other transaction, an offset will be made against the nursing facility's allowable movable property costs in the year in which the conveyance or transfer occurs. The amount of the offset will be the greater of the amount paid or credited to the nursing facility for the item by the person to whom the item is conveyed or transferred or the remaining book value of the item on the date the item is conveyed or transferred, as determined based upon the useful life of the item, using the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, and depreciation computed on a straight-line basis.

(2) If a nursing facility removes from service an item acquired during a cost report period beginning on or after January 1, 2001, before the expiration of the useful life of the item, determined using the Uniform Chart of Accounts and Definitions for Hospitals published by the American Hospital Association, an offset will be made against the nursing facility's allowable movable property costs in the year in which the item is removed from service. The amount of the offset will be the remaining book value of the item, as determined based upon the *Uniform Chart of Accounts and Definitions for Hospitals* published by the American Hospital Association, and depreciation computed on a straight-line basis.

(3) If, for movable property acquired during a cost report period beginning on or after January 1, 2001, a nursing facility receives a refund, money or credit under a lease or rental agreement; or money or credit as a result of a trade-in; or money, including insurance proceeds or damages, as the result of recovery of a loss related to that movable property, the amount received by the nursing facility will be offset against the nursing facility's allowable movable property costs in the year in which the refund money or credit is received.

(4) If a nursing facility fails to liquidate all or part of the acquisition cost of an item reported on the MA-11 during a cost report period beginning on or after January 1, 2001 in accordance with § 1187.52(b) (relating to allowable cost policies) the unliquidated amount will be offset against the nursing facility's allowable movable property cost in a subsequent fiscal period.

(5) If a nursing facility receives a rebate on an item acquired during a cost report period beginning on or after January 1, 2001, the rebate amount received by the nursing facility will be offset against the nursing facility's allowable movable property costs in the year in which the refund money or credit is received.

(d) Losses incurred on the sale, transfer or disposal of movable property are not allowable costs.

(e) The acquisition cost of movable property that is rented or leased is an allowable cost only if the following requirements are met:

(1) The agreement to rent or lease the movable property shall be in writing, identify each item of movable property that is being rented or leased, identify any other services or supplies that are being provided under the agreement, identify the term of the agreement, the payment intervals, and the amount of the periodic payments and total payments due under the agreement.

(2) The agreement to rent or lease the movable property shall set forth a suggested purchase price for each item of movable property rented or leased.

Subchapter F. COST REPORTING AND AUDIT REQUIREMENTS

§ 1187.71. Cost reporting.

(a) A nursing facility shall report costs to the MA Program by filing an acceptable MA-11 with the Department. Costs in the MA-11 are:

(1) *Resident care costs.*

(i) Nursing.

(ii) Director of nursing.

(iii) Related clerical staff.

(iv) Practitioners.

(v) Medical director.

(vi) Utilization and medical review.

(vii) Social services.

(viii) Resident activities.

(ix) Volunteer services.

(x) Pharmacy-prescription drugs.

(xi) Over-the-counter drugs.

(xii) Medical supplies.

(xiii) Laboratory and X-rays.

(xiv) Physical, occupational and speech therapy.

(xv) Oxygen.

(xvi) Beauty and barber services.

(xvii) Minor movable property.

(xviii) Other supplies and other resident care costs.

(2) *Other resident related costs.*

(i) Dietary, including food, food preparation, food service, and kitchen and dining supplies.

(ii) Laundry and linens.

(iii) Housekeeping.

(iv) Plant operation and maintenance.

(v) Minor movable property.

(vi) Other supplies and other resident related costs.

(3) *Administrative costs.*

(i) Administrator.

(ii) Office personnel.

(iii) Management fees.

(iv) Home office costs.

(v) Professional services.

(vi) Determination of eligibility.

(vii) Gift shop.

(viii) Advertising.

(ix) Travel/entertainment.

(x) Telephone.

(xi) Insurance.

(xii) Other interest.

(xiii) Legal fees.

(xiv) Federal/State Corporate/Capital Stock Tax.

(xv) Officers' life insurance.

(xvi) Amortization-administrative costs.

(xvii) Office supplies

(xviii) Minor movable property.

(xix) Other supplies and other administrative costs.

(4) *Capital costs.*

(i) Real estate tax cost.

(ii) Major movable property.

(iii) Depreciation.

(iv) Capital interest.

(v) Rent of nursing facility.

(vi) Amortization—capital costs.

(b) The MA-11 shall identify allowable direct, indirect, ancillary, labor and related party costs for the nursing facility and residential or other facility.

(c) The MA-11 shall identify costs of services, movable property and supplies furnished to the nursing facility by a related party and the rental of the nursing facility from a related party.

(d) The MA-11 shall be based on accrual basis financial and statistical records maintained by the nursing facility. The cost information contained in the cost report and in the nursing facility's records shall be current, accurate and in sufficient detail to support the reported costs.

(e) An acceptable cost report is one that meets the following requirements:

(1) Applicable items are fully completed in accordance with the instructions incorporated in the MA-11, including the necessary original signatures on the required number of copies.

(2) Computations carried out on the MA-11 are accurate and consistent with other related computations.

(3) The treatment of costs conforms to the applicable requirements of this chapter.

(4) Required documentation is included.

(5) The MA-11 is filed with the Department within the time limits in §§ 1187.73, 1187.75 and 1187.76 (relating to annual reporting; final reporting; and reporting for new nursing facilities).

(f) The nursing facility shall maintain adequate financial records and statistical data for proper determination of costs under the MA Program. The financial records shall include lease agreements, rental agreements, ledgers, books, records and original evidence of cost—purchase requisitions, purchase orders, vouchers, vendor invoices, inventories, time cards, payrolls, bases for apportioning costs and the like—which pertain to the determination of reasonable costs.

(g) Records and other information described in subsection (d) are subject to periodic verification and audit. Costs which are adequately documented are allowable.

(h) The nursing facility shall maintain the records pertaining to each cost report for at least 4 years following the date the nursing facility submits the MA-11 to the Department.

§ 1187.80. Failure to file an MA-11.

(a) Failure by the nursing facility to file a timely MA-11, other than a final MA-11 and annual MA-11s due along with a final MA-11, may result in termination of the nursing facility's provider agreement and will result in adjustment of the nursing facility's per diem rate as provided in this subsection. An MA-11 is considered timely filed if the MA-11 is received within 120 days following the June 30 or December 31 close of each fiscal year as designated by the nursing facility, or if an extension has been granted, within the additional time allowed by the extension. The Department may also seek injunctive relief to require proper filing, as the Department may deem is in the best interest of the efficient and economic administration of the MA program.

(1) *Cost report periods prior to January 1, 2001.*

(i) If an MA-11 is not timely filed, the nursing facility's per diem rate will be adjusted downward by 5% beginning the first day of the next month and will remain in effect until the date that an acceptable MA-11 is filed with the Department.

(ii) If an MA-11 is timely filed and is unacceptable, the Department will return the MA-11 to the nursing facility for correction. If an acceptable MA-11 is not filed by the end of the 30th day from the date of the letter returning the unacceptable MA-11 from the Department, the nursing facility's per diem rate will be adjusted downward by 5% beginning the first day of the next month and will remain in effect until the date that an acceptable MA-11 is filed with the Department.

(2) *Cost report periods beginning January 1, 2001, and thereafter.*

(i) If an MA-11 is not timely filed, the net operating components of the nursing facility's per diem rate will be adjusted downward by 5% and the movable property component of the nursing facility's capital per diem rate will be reduced to $0. This per diem rate reduction will begin the first day of the next month and remain in effect until the date that an acceptable MA-11 is filed with the Department.

(ii) If an MA-11 is timely filed and is unacceptable, the Department will return the MA-11 to the nursing facility for correction. If an acceptable MA-11 is not filed by the end of the 30th day from the date of the letter returning the unacceptable MA-11 from the Department, the net operating components of the nursing facility's per diem rate will be adjusted downward by 5% and the movable property component of the nursing facility's capital per diem rate will be reduced to $0. This per diem rate

reduction will begin the first day of the next month and remain in effect until an acceptable MA-11 is filed with the Department.

(b) If a nursing facility fails to file a timely final MA-11 and outstanding annual MA-11s:

(1) The net operating components of the nursing facility's per diem rate will be determined on the basis of the nursing facility's peer group medians, prior to the percent of median adjustment in accordance with § 1187.96 (relating to price and rate setting computations), for the last fiscal period for which the nursing facility has an acceptable MA-11 on file.

(2) The capital component of the nursing facility's per diem rate will be set at $0.

Subchapter G. RATE SETTING

§ 1187.91. Database.

The Department will set rates for the case-mix payment system based on the following data:

(1) *Net operating costs.*

(i) The net operating prices for year 1 of implementation will be established based on the most recent audited nursing facility cost report adjusted for inflation, for those nursing facilities receiving audit reports issued by the Department on or before March 31, 1995.

(ii) If an Intergovernmental Transfer Agreement has been executed on or before January 15, 1996, and the State Plan Amendment with sufficient funds to carry out the terms of this subparagraph has been approved by the Health Care Financing Administration (HCFA), the net operating prices for year 2 of implementation will be established based on the following:

(A) Audited nursing facility costs for the 2 most recent years available in the NIS database adjusted for inflation. This database includes audited MA-11 cost reports that are issued by the Department on or before March 31, 1996, of the July 1 price setting period.

(B) If a nursing facility that has participated in the MA Program for 3 or more consecutive years has fewer than two audited cost reports in the NIS database that are issued by the Department on or before March 31, 1996, of the July 1 price setting period, the Department will use reported costs, as adjusted to conform to this title, for those years not audited within 15 months of the date of acceptance, until audits have been completed and are available in the NIS database for price setting.

(C) If a nursing facility, that has not participated in the MA Program for 2 consecutive years, has fewer than two audited cost reports in the NIS database that are issued by the Department on or before March 31, 1996, of the July 1 price setting period, the Department will use all available audited cost reports in the NIS database.

(iii) If an Intergovernmental Transfer Agreement has not been executed on or before January 15, 1996, and the State Plan Amendment with sufficient funds to carry out the terms of subparagraph (ii) has not been approved by HCFA, the net operating prices in year 2 of implementation will be established based on the provisions contained in subparagraph (iv).

(iv) The net operating prices for year 3 of implementation and thereafter will be established based on the following:

(A) Audited nursing facility costs for the 3 most recent years available in the NIS database adjusted for inflation. This database includes audited MA-11 cost reports that are issued by the Department on or before March 31 of each July 1 price setting period.

(B) If a nursing facility that has participated in the MA Program for 3 or more consecutive years has fewer than three audited cost reports in the NIS database that are issued by the Department on or before March 31 of each July 1 price setting period, the Department will use reported costs, as adjusted to conform to Department regulations, for those years not audited within 15 months of the date of acceptance, until audits have been completed and are available in the NIS database for price setting.

(C) If a nursing facility, that has not participated in the MA Program for 3 or more consecutive years, has fewer than three audited cost reports in the NIS database that are issued by the Department on or before March 31 of each July 1 price setting period, the Department will use all available audited cost reports in the NIS database.

(D) For net operating prices effective on or after July 1, 2001, the Department will revise the audited costs specified in clauses (A)—(C) by disregarding audit adjustments disallowing or reclassifying to capital costs, the costs of minor movable property (as defined in § 1187.2 (relating to definitions), effective on July 1, 2001) or linens reported as net operating costs on cost reports for fiscal periods beginning prior to January 1, 2001. The Department will not adjust the audited statistics when revising the nursing facility audited Resident Care, Other Resident Care and Administrative allowable costs to disregard the adjustments relating to minor movable property and linen costs. After revising the audited costs to disregard these adjustments, the Department will recalculate the maximum allowable administrative cost, and will disallow administrative costs in excess of the 12% limitation as specified in § 1187.56(1)(i) (relating to selected administrative cost policies).

(v) Subparagraphs (ii)(B), (iii) and (iv)(B) do not apply, if a nursing facility is under investigation by the Office of Attorney General. In these situations, the Department will use a maximum of the three most recent available audited cost reports in the NIS database used for price setting.

(vi) A cost report for a period of less than 12 months will not be included in the NIS database used for each price setting year.

(vii) During the second calendar quarter of each year, prior to price setting, cost report information will be indexed forward to the 6th month of the 12-month period for which the prices are set. The index used is the most current HCFA Nursing Home Without Capital Market Basket Index.

(viii) Resident data as reported on the Federally approved PA specific MDS will be used to determine case-mix adjustments for each price setting and rate setting period. The resident data requirements are specified in § 1187.33(a) (relating to resident data reporting requirements).

(2) *Capital costs.*

(i) *Fixed property component.* The fixed property component of a nursing facility's capital rate will be based upon the fair rental value of the nursing facility's fixed property.

(ii) *Movable property component.*

(A) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate

setting is for a cost report period beginning prior to January 1, 2001, the movable property component of a nursing facility's capital rate will be based upon the fair rental value of the nursing facility's major and minor movable property.

(B) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning on or after January 1, 2001, the movable property component of a nursing facility's capital rate will be based upon the audited costs of the nursing facility's major movable property as set forth in the nursing facility's most recent audited MA-11 cost report available in the NIS database.

(iii) *Real estate tax cost component.* The real estate tax component of a nursing facility's capital rate will be based upon the nursing facility's actual audited real estate tax costs as set forth in the nursing facility's most recent audited MA-11 cost report available in the NIS database.

§ 1187.96. Price and rate setting computations.

(a) Using the NIS database in accordance with this subsection and § 1187.91 (relating to database), the Department will set prices for the resident care cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total resident care cost for each cost report will be divided by the total facility CMI from the available February 1 picture date closest to the midpoint of the cost report period to obtain case-mix neutral total resident care cost for the cost report year.

(ii) The case-mix neutral total resident care cost for each cost report will be divided by the total actual resident days for the cost report year to obtain the case-mix neutral resident care cost per diem for the cost report year.

(iii) For year 2 of implementation, using the NIS database in accordance with § 1187.91(1)(ii), the Department will calculate the 2-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility. Using the NIS database in accordance with § 1187.91(1)(iii), subparagraph (iv) applies.

(iv) For year 3 of implementation and thereafter, the Department will calculate the 3-year arithmetic mean of the case-mix neutral resident care cost per deim for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

(2) The average case-mix neutral resident care cost per diem for each nursing facility will be arrayed within the respective peer groups, and a median determined for each peer group.

(3) The median of each peer group will be multiplied by 1.17, and the resultant peer group price assigned to each nursing facility in the peer group.

(4) The price derived in paragraph (3) for each nursing facility will be limited by § 1187.107 (relating to limitations on resident care and other resident related cost centers) and the amount will be multiplied each quarter by the respective nursing facility MA CMI to determine the nursing facility resident care rate. The MA CMI picture date data used in the rate determination are as follows: July 1 rate—February 1 picture date; October 1 rate—May 1 picture date; January 1 rate—August 1 picture date; and April 1 rate—November 1 picture date.

(b) Using the NIS database in accordance with this subsection and § 1187.91, the Department will set prices for the other resident related cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total other resident related cost for each cost report will be divided by the total actual resident days for the cost report year to obtain the other resident related cost per diem for the cost report year.

(ii) For year 2 of implementation, using the NIS database in accordance with § 1187.91(1)(ii), the Department will calculate the 2-year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility. Using the NIS database in accordance with § 1187.91(1)(iii), subparagraph (iii) applies.

(iii) For year 3 of implementation and thereafter, the Department will calculate the 3-year arithmetic mean of the other resident related cost for each nursing facility to obtain the average other resident related cost per diem of each nursing facility.

(2) The average other resident related cost per diem for each nursing facility will be arrayed within the respective peer groups and a median determined for each peer group.

(3) The median of each peer group will be multiplied by 1.12, and the resultant peer group price assigned to each nursing facility in the peer group. This price for each nursing facility will be limited by § 1187.107 to determine the nursing facility other resident related rate.

(c) Using the NIS database in accordance with this subsection and § 1187.91, the Department will set prices for the administrative cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total actual resident days for each cost report will be adjusted to a minimum 90% occupancy, if applicable, in accordance with § 1187.23 (relating to nursing facility incentives and adjustments).

(ii) The total allowable administrative cost for each cost report will be divided by the total actual resident days, adjusted to 90% occupancy, if applicable, to obtain the administrative cost per diem for the cost report year.

(iii) For year 2 of implementation, using the NIS database in accordance with § 1187.91(1)(ii), the Department will calculate the 2-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility. Using the NIS database in accordance with § 1187.91(1)(iii), subparagraph (iv) applies.

(iv) For year 3 of implementation and thereafter, the Department will calculate the 3-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

(2) The average administrative cost per diem for each nursing facility will be arrayed within the respective peer groups and a median price determined for each peer group.

(3) The median of each peer group will be multiplied by 1.04, and the resultant peer group price will be assigned to each nursing facility in the peer group to determine the nursing facility's administrative rate.

(d) Using the NIS database in accordance with this subsection and § 1187.91 (relating to database), the Department will set a rate for the capital cost category for each nursing facility by adding the nursing facility's fixed property component, movable property component and real estate tax component and dividing the sum of the three components by the nursing facility's total actual resident days, adjusted to 90% occupancy, if applicable.

(1) The Department will determine the fixed property component of each nursing facility's capital rate as follows:

(i) The Department will adjust the appraised depreciated replacement cost of the nursing facility's fixed property to account for the per bed limitation in § 1187.112 (relating to cost per bed limitation adjustment) and the bed moratorium addressed in § 1187.113 (relating to capital component payment limitation).

(ii) The Department will multiply the adjusted depreciated replacement costs of the fixed property by the financial yield rate to determine the fair rental value for the nursing facility's fixed property.

(iii) The nursing facility's fixed property component will equal the fair rental value of its fixed property.

(2) The Department will determine the movable property component of each nursing facility's capital rate as follows:

(i) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning prior to January 1, 2001:

(A) The Department will multiply the depreciated replacement costs of the movable property by the financial yield rate to determine the fair rental value for the nursing facility's movable property.

(B) The nursing facility's movable property component will equal the fair rental value of its movable property.

(ii) When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning on or after January 1, 2001, the amount of the movable property component will be based upon the audited actual costs of major movable property as set forth in the most recent audited MA-11 cost report available in the NIS database. This amount is referred to as the nursing facility's most recent movable property cost.

(3) The Department will determine the real estate tax cost component of each nursing facility's capital rate based on the audited actual real estate tax cost as set forth in the most recent audited MA-11 cost report available in the NIS database.

(e) The nursing facility per diem rate will be computed by adding the resident care rate, the other resident related rate, the administrative rate and the capital rate for the nursing facility.

§ 1187.97. Rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities.

The Department will establish rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities as follows:

(1) *New nursing facilities.*

(i) The net operating portion of the case-mix rate is determined as follows:

(A) A new nursing facility will be assigned the Statewide average MA CMI until assessment data submitted by the nursing facility under § 1187.33 (relating to resident data reporting requirements) is used in a rate determination under § 1187.96(a)(4) (relating to price and rate setting computations).

(B) The nursing facility will be assigned to the appropriate peer group. The peer group price for resident care, other resident related and administrative costs will be assigned to the nursing facility until there is at least one audited nursing facility cost report used in the rebasing process.

(ii) For nursing facilities enrolled in the MA Program prior to January 1, 2001, the three components of the capital portion of the case-mix rate are determined as follows:

(A) The fixed property component will be determined in accordance with § 1187.96 (d)(1) (relating to price and rate setting computations).

(B) The movable property component will be determined in accordance with § 1187.96 (d)(2).

(C) The real estate tax cost component will be determined based on the audited actual real estate tax cost.

(iii) For nursing facilities enrolled in the MA Program on or after January 1, 2001, the three components of the capital portion of the case-mix rate are determined as follows:

(A) *Fixed property component.* The fixed property component will be determined in accordance with § 1187.96 (d)(1).

(B) *Movable property component.* The movable property component will be determined as follows:

(I) The nursing facility's acquisition cost, as determined in accordance with § 1187.61(b) (relating to movable property cost policies), for any new items of movable property acquired on or before the date of enrollment in the MA program, will be added to the nursing facility's remaining book value for any used movable property as of the date of enrollment in the MA program to arrive at the nursing facility's movable property cost. If the nursing facility does not have a depreciation schedule for its used movable property, the allowable cost for those items will be the depreciated replacement cost as determined by qualified personnel of the Department's independent appraisal contractor.

(II) The nursing facility's movable property cost will then be amortized equally over the first 3 rate years that the nursing facility is enrolled in the MA program to determine the nursing facility's movable property component of the capital rate.

(III) After the first 3 rate years the nursing facility's movable property component will be based on the most recent audited MA-11 cost report available in the NIS database. If no MA-11 is available in the NIS database, the nursing facility will not receive the movable property component of the capital rate.

(C) *Real estate tax component.*

(I) For the first 3 rate years, the new nursing facility real estate tax component will be the nursing facility's annual real estate tax cost as of the date of enrollment in the MA program.

(II) After the first 3 rate years, the real estate tax component will be based on the audited MA-11 cost report available in the NIS database. If no audited MA-11 cost report is available in the NIS database, the nursing facility will not receive the real estate tax component of the capital rate.

(iv) Newly constructed nursing facilities are exempt from the adjustment to 90% occupancy until the nursing facility has participated in the MA Program for one full annual price setting period as described in § 1187.95 (relating to general principles for rate and price setting).

(2) *Nursing facilities with a change of ownership and reorganized nursing facilities.*

(i) *New provider.* The new nursing facility provider will be paid exactly as the old nursing facility provider. Net operating and capital rates for the old nursing facility provider will be assigned to the new nursing facility provider.

(ii) *Transfer of data.* Resident assessment data will be transferred from the old nursing facility provider number to the new nursing facility provider number. The old nursing facility's MA CMI will be transferred to the new nursing facility provider.

(iii) *Movable property cost policies.*

(A) The acquisition costs of items acquired by the old nursing facility provider on or before the date of sale are costs of the old nursing facility provider, and not the new nursing facility provider.

(B) Regardless of the provisions of any contract of sale, the amount paid by the new nursing facility provider to acquire or obtain any rights to items in the possession of the old nursing facility provider is not an allowable cost.

(C) If the new nursing facility provider purchases an item from the old nursing facility provider, the cost of that item is not an allowable cost for cost reporting or rate setting purposes.

(D) If the new nursing facility provider rents or leases an item from the old nursing facility provider, the cost of renting or leasing that item is not an allowable cost for cost reporting or rate setting purposes.

(3) *Former prospective payment nursing facilities.* A nursing facility that received a prospective rate prior to the implementation of the case-mix payment system will be treated as a new nursing facility under paragraph (1) for the purpose of establishing a per deim rate.

§ 1187.112. Cost per bed limitation adjustment.

(a) For year 1 of implementation the following cost per bed limitation adjustment will be made:

(1) The allowable capital costs will be limited to a maximum participation allowance cost per bed of $22,000. The cost per bed will be based on the capitalized cost of fixed property. The cost of movable property will not be included in the $22,000 per bed limit.

(2) When the appraisal value exceeds the cost per bed limitation, adjustment for the $22,000 per bed limitation will be made. The full appraisal value will not be recognized.

(b) For year 2 of implementation and year 3 of implementation and thereafter the following cost per bed limitation adjustment will be made:

(1) The allowable capital costs will be limited to a maximum participation allowance cost per bed of $26,000. The cost per bed will be based on the capitalized cost of fixed property. The cost of movable property will not be included in the $26,000 per bed limit.

(2) When the appraisal value exceeds the cost per bed limitation, adjustment for the $26,000 per bed limitation will be made. The full appraisal value will not be recognized.

§ 1187.113. Capital component payment limitation.

(a) *Conditions.* The capital component payment for fixed property is subject to the following conditions:

(1) The Department will make the capital component payment for fixed property on new or additional beds only if one of the following applies:

(i) The nursing facility was issued either a Section 1122 approval or letter of nonreviewability under 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 (relating to Certificate of Need Program) for the project by the Department of Health by August 31, 1982.

(ii) The nursing facility was issued a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 for the construction of a nursing facility and there was no nursing facility located within the county.

(2) The Department will not make the capital component payment unless the nursing facility substantially implements the project under 28 Pa. Code Chapter 401 within the effective period of the original Section 1122 approval or the original Certificate of Need.

(3) The capital component payment for replacement beds is allowed only if the nursing facility was issued a Certificate of Need or a letter of nonreviewability for the project by the Department of Health.

(4) The Department will not make the capital component payment unless written approval was received from the Department prior to the construction of the new beds.

(b) *Capital cost reimbursement waivers.* The Department may grant waivers of subsection (a) to permit capital cost reimbursement as the Department in its sole discretion determines necessary and appropriate. The Department will publish a statement of policy under § 9.12 (relating to statements of policy) specifying the criteria that it will apply to evaluate and approve applications for capital cost reimbursement waivers.

Subchapter K. EXCEPTIONAL PAYMENT FOR NURSING FACILITY SERVICES

Sec.

§ 1187.151. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Exceptional DME grant or *grant*—Authorization permitting exceptional payments under specified terms to a nursing facility, in addition to the nursing facility's case-mix per diem rate, for nursing facility services that are provided to a specified resident and that involve the use of certain exceptional DME. The amount of the additional payment authorized by a grant is based upon the necessary, reasonable and prudent cost of the exceptional DME and the related services and items specified in the grant.

Resident—An MA eligible resident of a nursing facility enrolled in the MA Program who, in a request for an exceptional DME grant, is identified as needing exceptional DME.

§ 1187.152. Additional reimbursement of nursing facility services related to exceptional DME.

(a) The necessary, reasonable and prudent costs incurred by a nursing facility related to the purchase or rental, and the use of DME in providing nursing facility services to residents are allowable costs and included in the calculation of the case-mix per diem rates subject to this chapter. Any costs incurred in excess of the costs identified in a grant are not allowable costs under this chapter.

(b) When a nursing facility provides nursing facility services involving exceptional DME to an MA eligible resident, the nursing facility may, in addition to the submission of invoices for payment based upon the nursing facility's case-mix per diem rate, seek authorization for additional payment by requesting a grant from the Department in accordance with § 1187.153(a) (relating to exceptional DME grants—process).

(c) The Department will issue a grant to a nursing facility if the Department determines that all of the following conditions are met:

(1) The nursing facility's request for the grant complies with all applicable Department instructions.

(2) The specified DME is medically necessary as defined in § 1101.21 (relating to definitions).

(3) The DME specified in the nursing facility's request is exceptional DME as defined in § 1187.2 (relating to definitions).

(4) The nursing facility's physical plant, equipment, staff, program and policies are sufficient to insure the safe, appropriate and effective use of the exceptional DME.

(5) The nursing facility certifies to the Department in writing, on a form designated by the Department, that it has read and understands the terms of the grant.

§ 1187.153. Exceptional DME grants—process.

(a) *Requests for exceptional DME grants.*

(1) A nursing facility shall request a grant in writing on forms designated by the Department and completed in accordance with all applicable Department instructions. The request shall be accompanied by the necessary supporting documentation specified in the Department's instructions and submitted to the Department within 30 days from the date on which the nursing facility purchases or rents the DME for which the nursing facility is requesting the grant.

(2) The nursing facility shall provide copies of the nursing facility's request to the resident and the resident's authorized representative, if any, when the nursing facility submits the request to the Department.

(b) *Notification by the Department.* The Department will send written notice of the Department's decision to approve or deny a nursing facility's request for a grant to the nursing facility, the resident and the resident's authorized representative, if any.

§ 1187.154. Exceptional DME grants—general conditions and limitations.

(a) *Scope and effect of an exceptional DME grant.*

(1) A grant authorizes exceptional payments to a nursing facility in addition to the nursing facility's case-mix per diem payment rate for nursing facility services provided to the resident. The amount of the exceptional payments authorized by the grant is deemed to be the necessary, reasonable and prudent cost of the exceptional DME and the related services and items identified in the nursing facility's grant.

(2) A grant does not authorize exceptional payments for nursing facility services that are provided to MA residents other than the resident, nor does it limit costs that are, or must be, incurred by a nursing facility to provide services to any of the nursing facility's residents (including the resident) in accordance with applicable law and regulations.

(b) *Applicability of laws.* Nursing facility services provided by a nursing facility receiving a grant, including services paid by the grant, remain subject to applicable Federal and State laws and regulations, including the laws and regulations governing the MA Program.

(c) *Reporting of exceptional DME costs and grant payments.*

(1) The nursing facility shall report on the MA-11, the costs related to the acquisition of exceptional DME and related services and items paid by a grant. In identifying the nursing facility's allowable costs, the nursing facility shall adjust those reported costs to the necessary, reasonable and prudent cost amounts identified in the nursing facility's grant.

(2) The nursing facility shall offset all payments made by the Department under a grant against the allowable cost of the exceptional DME and related services and items paid by the grant.

(3) The nursing facility shall identify and report in the MA-11, the costs related to the acquisition of exceptional DME and related services and items, the adjustment to the amount identified in the grant, and the offset of the payment made by the Department under the grant using the accrual basis of accounting.

(d) *Payment in full.* A grant does not waive the preclusion on supplementation established by law. Payment made by the Department under a grant is payment in full for nursing facility services involving the exceptional DME and any related services and items. The entire payment for all MA nursing facility services provided to the resident, including the exceptional DME and any related services and items shall include both of the following:

(1) The nursing facility's case-mix per diem rate.

(2) The exceptional payments authorized by the grant.

(e) *Utilization review.* Nursing facility services paid by a grant are subject to utilization review by the Department, including assessments of the resident's continuing need for the exceptional DME.

(f) *Dispute resolution.* A dispute relating to a grant, including a dispute relating to payments which the

nursing facility believes are authorized by the grant and a dispute arising from the termination, suspension or recovery actions taken under § 1187.157 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments), shall be brought initially and exclusively for adjudication to the Department's Bureau of Hearings and Appeals.

(g) *Records.* In addition to the nursing facility's existing obligations to maintain and provide documents and records, a nursing facility receiving a grant shall maintain and, upon request, provide to the Department additional documents and records as may be necessary for the Department to determine the nursing facility's compliance with this subchapter and the terms of the nursing facility's grant, including documents and records as may be necessary for the Department to determine the maximum allowable cost of the exceptional DME as specified in § 1187.155(b) (relating to exceptional DME grants-payment conditions and limitations).

(h) *Term of the grant.* A grant is effective on the date specified in the nursing facility's grant and ends on the date the grant is terminated under § 1187.157.

(i) *Acquisition, maintenance, use and disposal of exceptional DME.*

(1) A nursing facility shall obtain exceptional DME and related services and items paid by a grant at the lowest practicable cost and shall purchase by means of competitive bidding whenever required by law.

(2) Unless otherwise approved in writing by the Department, a nursing facility may use exceptional DME paid by a grant only as specified by the nursing facility's grant.

(3) Except as specified otherwise in paragraph (5), a nursing facility has title to any exceptional DME and related items purchased by the nursing facility under the grant.

(4) If an item of exceptional DME purchased under a grant is no longer necessary to provide care and services to the resident, and subject to paragraph (2), the nursing facility shall make the item available for the use, as necessary, in the care and treatment of other MA residents of the nursing facility unless directed by the Department to transfer the exceptional DME in accordance with paragraph (5).

(5) Upon termination of a grant, the Department may direct that the nursing facility transfer the exceptional DME and related items to another provider designated by the Department or to the resident. Title to the transferred exceptional DME and related items shall then vest in the designated provider or the resident. If a transfer is required under this paragraph, § 1187.61(c)(1) (relating to movable property cost policies) does not apply.

(6) A nursing facility shall, in accordance with sound business practice, maintain and administer a program for the maintenance, repair, protection, preservation and insurance of exceptional DME paid by a grant.

(7) If a nursing facility is indemnified, reimbursed or otherwise compensated for any loss, destruction or damage to exceptional DME paid by a grant, the nursing facility shall, at the Department's direction, use the proceeds to replace, repair or renovate the property involved.

§ 1187.155. Exceptional DME grants—payment conditions and limitations.

(a) *Authorization of exceptional payments.* Exceptional payments authorized by an exceptional DME grant will be paid as follows:

(1) *Periodic payments.* Unless the grant authorizes a lump sum payment under paragraph (2), the grant will authorize exceptional payments to the nursing facility on a specified periodic basis. Authorization for periodic payments will continue during the term of the nursing facility's grant except during a period of suspension as specified in § 1187.157 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments).

(2) *Lump sum payment.* The grant may authorize a lump sum exceptional payment to the nursing facility if the Department determines that a lump sum payment is in the best interest of the MA Program. The amount of this payment will be based upon and limited by the necessary, reasonable and prudent costs incurred by the nursing facility to purchase exceptional DME and related items.

(b) *Maximum allowable payment.* The maximum allowable exceptional payment authorized by an exceptional DME grant is limited to the lowest of the following:

(1) The lower of the nursing facility's costs to acquire the exceptional DME and related services and items; or, in the event the nursing facility is acquiring the exceptional DME or related services and items from a related party as defined in § 1187.2 (relating to definitions), the related party's cost to furnish the exceptional DME and related services and items to the nursing facility.

(2) The applicable MA outpatient fee schedule amount, if any.

(3) Eighty percent of the amount, if any, that would be approved by Medicare if the DME or service or item were a Medicare Part B covered service or item.

(c) *Additional conditions and limitations.* Exceptional payments made by the Department to a nursing facility under a grant are subject to the following:

(1) The conditions and limitations set forth in Chapter 1101 (relating to general provisions), including §§ 1101.64 and 1101.68 (relating to third-party medical resources; and invoicing for services).

(2) The terms of the nursing facility's grant.

§ 1187.156. Exceptional DME notification and reporting requirements.

(a) *Status reports.* A nursing facility receiving a grant shall submit periodic status reports to the Department as specified in the nursing facility's grant.

(b) *Notices.* A nursing facility receiving a grant shall notify the Department in writing within 5 days of any of the following occurrences:

(1) The resident dies.

(2) The resident ceases to be MA eligible.

(3) The resident is transferred or discharged from the nursing facility, whether or not there is intent to return.

(4) The nursing facility determines, or is advised by the resident's attending physician, that the exceptional DME is no longer medically necessary.

(5) The resident notifies the nursing facility in writing that he exercises his right to refuse use of the exceptional DME.

(6) The nursing facility ceases to use the exceptional DME or make that DME available to the resident in the course of providing nursing facility services to the resident.

§ 1187.157. Termination or suspension of exceptional DME grants and recovery of exceptional payments.

(a) *Termination or suspension of an exceptional DME grant.*

(1) *Automatic termination.* Any of the following conditions shall cause termination of a nursing facility's grant without further notice or action by the Department:

(i) The resident dies.

(ii) The resident ceases to be MA eligible.

(iii) The resident is transferred or discharged from the nursing facility with no intent to return.

(iv) The resident's attending physician notifies the nursing facility that the exceptional DME is no longer medically necessary.

(v) The resident notifies the Department or the nursing facility in writing that he exercises his right to refuse use of the exceptional DME.

(vi) The nursing facility is no longer enrolled in the MA Program.

(2) *Termination upon notice.* The Department may terminate a grant upon written notice to the nursing facility if any one or more of the conditions in subparagraphs (i)—(vi) occur. The Department will simultaneously provide a copy of the written notice to the resident and the resident's authorized representative, if any.

(i) The Department determines that the exceptional DME is no longer medically necessary.

(ii) The resident is temporarily discharged or transferred to a hospital or other health care provider.

(iii) There is a change in state or federal law or regulations governing payments to MA providers of nursing facility services.

(iv) Exceptional DME payments are no longer authorized under the Commonwealth's approved Medicaid State Plan.

(v) The nursing facility has violated the terms of the grant.

(vi) The nursing facility changes ownership.

(3) *Suspension of grant payments.* The Department may suspend payments under a grant upon written notice to the nursing facility if one or more of the conditions in subparagraphs (i) and (ii) occur. The Department will simultaneously provide a copy of the written notice to the resident and the resident's authorized representative, if any.

(i) The resident is temporarily discharged or transferred to a hospital or other health care provider.

(ii) The resident is absent from the nursing facility because of therapeutic leave.

(4) *Termination or suspension date.* A termination under paragraph (1) is effective as of the date on which the condition giving rise to the automatic termination first arises. A termination under paragraph (2) is effective on the date specified in the Department's written notice to the nursing facility. A suspension under paragraph (3) is effective on the date and for the period specified in the Department's written notice to the nursing facility.

(5) *Effect of termination.*

(i) Termination of an exceptional DME grant, whether automatic or by written notice, terminates the nursing facility's authorization to obtain exceptional payments for nursing facility services provided to the resident after the termination date.

(ii) Termination of the grant ends the nursing facility's grant and the nursing facility's duty and obligation to comply with the terms of the grant or the requirements of this subchapter, except as may be otherwise specified in the grant or in this subchapter.

(iii) Termination of a grant does not relieve the nursing facility of any of the nursing facility's duties and obligations relating to services provided to the resident or any other resident of the nursing facility.

(6) *Effect of suspension.*

(i) Suspension of payments under a grant terminates the nursing facility's authorization to obtain exceptional payments for nursing facility services provided to the resident for the period specified in the notice of suspension.

(ii) Suspension of payments under a grant does not terminate the nursing facility's grant or the nursing facility's duty and obligation to comply with the terms of the grant or the requirements of this subchapter.

(iii) Suspension of payments under a grant does not relieve the nursing facility of any of the nursing facility's duties and obligations relating to services provided to the resident or any other resident of the nursing facility.

(b) *Recovery of exceptional DME grant payments.*

(1) If a grant is terminated or if payments under a grant are suspended, the Department will recover any exceptional payments made to the nursing facility for services provided after the termination date or during the period of suspension.

(2) If the nursing facility violates this subchapter or the terms of its grant, the Department may recover exceptional payments made to the nursing facility in addition to or instead of terminating the nursing facility's grant.

(c) *Rights and remedies.* The rights and remedies available to the Department under this section are in addition to any rights, remedies and sanctions otherwise available to the Department under law and regulation.

§ 1187.158. Appeals.

(a) *Appeals.* An appeal may be filed by the resident or the resident's authorized representative, by the nursing facility, or by both, from the Department's decision to deny, terminate or suspend a grant, subject to the following:

(1) If the Department denies a grant because the DME is not exceptional DME, an appeal of the denial may be filed solely on the basis that the DME is exceptional DME as defined in § 1187.2 (relating to definitions).

(2) If the Department automatically terminates a grant under § 1187.157(a)(1) (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments), an appeal of the termination may be

filed solely on the basis that none of the conditions specified in § 1187.157(a)(1)(i)—(vi) has occurred.

(3) If a resident appeals the denial, termination or suspension of a grant, Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings) applies.

(4) If a nursing facility appeals the denial, termination or suspension of a grant, § 1187.141(b), (d) and (e) (relating to nursing facility's right to appeal and to a hearing) apply.

(5) An appeal from the Department's decision denying a request for a grant shall be received in the Department's Bureau of Hearings and Appeals within 30 days of the date of the Department's written notice.

(6) If the resident or the nursing facility timely appeals the Department's decision to deny, suspend or terminate a grant, the Department's decision is not final until the Department issues a final adjudication on the appeal.

(b) *Effect of decisions.*

(1) *Effect on subsequent grant requests.* The denial or termination of a grant, does not prohibit a nursing facility from submitting a new request for an exceptional DME grant for the same resident, if the nursing facility determines that there has been a change in the resident's condition since the denial or termination.

(2) *Effect on services.*

(i) If the Department determines that DME specified in the nursing facility's request is medically necessary but denies the request because the DME is not exceptional DME, the nursing facility shall, as a part of the nursing facility services that it provides to the resident, provide the DME to the resident, unless the resident refuses the DME, regardless of whether the nursing facility or resident appeals the Department's decision. If the resident refuses the DME, the nursing facility shall notify the Department in accordance with § 1187.22(17) (relating to ongoing responsibilities of nursing facilities).

(ii) If the Department determines that the DME specified in the nursing facility's request is exceptional DME but denies the request because the DME is not medically necessary, the nursing facility may provide the DME and charge the resident in accordance with and subject to applicable Federal and state requirements, including 42 CFR 483.10(c)(8) (relating to resident rights) and § 1101.63(a) (relating to payment in full), if, after receiving actual notice of the Department's denial, the resident requests that the nursing facility provide the DME. If the resident or nursing facility appeals the Department's determination to deny the exceptional DME grant and the appeal is sustained, the nursing facility shall refund any payment made by the resident within 60 days from the date of the Department's final adjudication sustaining the appeal.

(iii) If the Department terminates a grant or suspends payment under a grant under § 1187.157(a)(2) and (3) (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments), and the resident or the resident's authorized representative appeals the termination or suspension within 10-calendar days of the date on which the Department's notice was mailed, the Department will continue to make payments under the grant pending the outcome of the hearing on the resident's appeal. If, after the hearing, the Department denies the resident's appeal, the Department will recover any payments made under the grant on or after the termination date or during the period of suspension specified in the Department's notice.

(iv) If the Department terminates a grant or suspends payment under a grant under § 1187.157(a)(2) and (3), and the resident or the resident's authorized representative does not appeal the termination or suspension, or appeals more than 10-calendar days from the date on which the Department's notice was mailed, the Department will cease payments under the grant on the termination date or during the period of suspension specified in the Department's notice.

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