RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CHS. 1187 AND 1189]

Nursing Facility Services; County Nursing Facility Services

The Department of Public Welfare (Department) amends Chapter 1187 (relating to nursing facility services) and adds Chapter 1189 (relating to county nursing facility services) to read as set forth in Annex A under the authority of sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (code) (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1(5)(iii)), as amended by the act of July 7, 2005 (P. L. 177, No. 42) (Act 42).

Act 42 amended, among other things, provisions of the code regarding payment for nursing facility services under the Medical Assistance (MA) Program. More specifically, Act 42 added subparagraph (iii) to § 443.1(5) of the code. This subparagraph authorizes the Department to adopt regulations specifying the methods and standards that the Department will use to set rates and make payments for nursing facility services effective July 1, 2006. This section also specifies that, until June 30, 2006, notwithstanding any other provision of law, including section 814-A of the code (62 P. S. § 814-A), provider payment rate regulations effective July 1, 2006, must be promulgated under section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(iv)), act of July 31, 1968 (P. L. 769, No. 240), known as the Commonwealth Documents Law (CDL), which permits an agency to omit or modify proposed rulemaking when the regulation pertains to Commonwealth grants or benefits. Furthermore, under section 204(3) of the CDL, any delay in the effective date of this final-omitted rulemaking beyond July 1, 2006, would be impracticable and contrary to the public interest since it would violate the requirement of section 443.1(5) of the code. In addition, section 443.1 of the code expressly exempts these provider payment rate regulations from review under the Regulatory Review Act (71 P. S. §§ 745.1—745.15) and from review by the Attorney General under section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

Justification for Adoption of Final-Omitted Rulemaking

In accordance with sections 443.1(5)(iii) of the code, the Department is adopting the final-omitted rulemaking because:

• As recognized by section 443.1(5)(iii) of the code, the final-omitted rulemaking relates to MA provider payments, which are Commonwealth grants or benefits.

• The final-omitted rulemaking relates to payments for MA nursing facility services provided on or after July 1, 2006.

Purpose

The purposes of this final-omitted rulemaking are to institute a new rate-setting methodology for county-owned nursing facilities that are enrolled in the MA Program as providers of nursing facility services (county nursing facilities) and to modify the rate-setting methodology for all other enrolled providers of nursing facility services (nursing facilities), effective as of July 1, 2006.

Background

In January 1996, the Department implemented the current case-mix payment methodology for nursing facilities participating in the MA Program. See 25 Pa.B. 4477 (October 14, 1995). The purpose of the case-mix payment system was to establish a prospective payment system that would both serve the needs of the Commonwealth's MA nursing facility residents and promote the economic and efficient operation of MA nursing facilities. The system was intended to encourage MA nursing facilities to admit and provide care for individuals who require higher levels of care and to channel a higher level of MA funds to activities involving direct resident care activities, and to provide for an environment of economic predictability and moderate increases in MA Program expenditures.

Over the past 10 years the Department has monitored and evaluated the case-mix payment system to determine whether the initial objectives of the system have been realized and whether modifications to the system are needed. The Department has found that the current case-mix payment system, as designed, has not adequately fulfilled the objective of moderating MA Program costs. To the contrary, since the case-mix payment system was implemented in 1996, MA nursing facility payment rates have risen more than 56% and, since 2000, have increased by 27.4% overall. During this same period, expenditures for MA nursing facility services have grown to nearly $3 billion and expenditures for MA services to the elderly and disabled now consume approximately 70% of the $14 billion MA Program budget.

The amendments to Chapter 1187 refine the case-mix payment system so that it can better achieve its original intended objective of serving the needs of this Commonwealth's MA nursing facility residents while providing for reasonable and adequate payments to MA nursing facility providers and, at the same time, establishing a mechanism that permits the controlled expansion of public expenditures. In addition, the amendments support the balancing of long-term care by encouraging consumer choice in long-term care services.

The addition of Chapter 1189 as the exclusive mechanism for reimbursing county nursing facilities will permit the Department to receive matching Federal funds for all allowable public expenditures made on behalf of MA residents in county nursing facilities. Under Chapter 1187, matching Federal funds are only received for payments made by the Department to the county nursing facilities. Under Chapter 1187, if a county nursing facility incurs costs that exceed its MA payments, there is no mechanism for obtaining matching Federal funds for those costs. As a result, inclusion of county nursing facilities in Chapter 1187 has caused the Commonwealth to receive less in matching Federal funds than it is eligible to receive. The function of Chapter 1189 is to permit the Commonwealth to qualify for the maximum amount of matching Federal funds on public expenditures made to provide services to MA residents of county nursing facilities.

An overview and explanation of the major regulatory changes adopted by this final-omitted rulemaking follows.

Chapter 1187—Requirements

Definitions

The final-omitted rulemaking adds definitions for "CMI Report," "initial Federally-approved PA specific MDS" and

"Resident Data Reporting Manual" and amended the definitions of "county nursing facility," "hospital-based nursing facility," "Medicare Provider Reimbursement Manual" and "nursing facility."

Removal of County Nursing Facilities from the Case-Mix Payment System

As discussed as follows, the final-omitted rulemaking creates a new payment methodology for county nursing facilities which will be in Chapter 1189. Corresponding amendments to Chapter 1187 make the case-mix payment system applicable solely to nonpublic nursing facilities. To mitigate the impact of these changes on the rates of nonpublic nursing facilities, the final-omitted rulemaking also provides that the case-mix payment system in Chapter 1187 will continue to include county nursing facilities in the process of computing the peer group prices used to set per diem rates for nonpublic facilities for the 2006-2007 and 2007-2008 rate years.

Resident Assessment Submission Requirements

Under the case-mix payment system, the Department uses resident assessment data to issue reports to nursing facilities each calendar quarter that identify the resident acuity information for the calendar quarter picture date that will be used in the case-mix rate-setting process. Nursing facilities review the reports and may submit corrections to the resident assessment data used to generate the reports and eventually certify that the information in the report is accurate for the picture date. Prior to this final-omitted rulemaking, the reports for all 4 quarters included acuity information for the MA residents of the nursing facilities on the four picture dates. However, only the first quarter report for the February picture date included acuity information for all residents of the nursing facilities, regardless of payor source. This final-omitted rulemaking changes the quarterly reporting and verification requirements for the second, third and fourth calendar quarters to include resident acuity information for all nursing facility residents on the picture date, rather than only MA residents. The additional data for the non-MA residents collected from the Case-Mix Index (CMI) report will be used for analysis purposes only and will not be used in the rate-setting process.

The final-omitted rulemaking also clarifies which residents are included in the CMI report for quarterly reporting purposes.

Early Notification

As a condition of participating as providers in the Medicare and Medicaid Programs, nursing facilities are required to submit various resident assessment records and tracking forms using the Federally-approved PA Specific MDS. This final-form rulemaking requires nursing facilities to submit the initial Federally-approved PA Specific MDS record for each resident admitted to the facility within 7 calendar days of the completion of the assessment record. Through this prompt notification of a resident's admission to a nursing facility, the Department will be able to educate residents on their long-term care options while their housing is still available for their return or transition into the community, before they and their caregivers have become acclimated to the facility environment and before they lose their social supports in the community.

Cost Neutrality

The final-omitted rulemaking authorizes the Department to apply a budget adjustment factor (BAF) in setting quarterly rates for nursing facilities for the 2006-2007 and 2007-2008 rate years. The BAF will be based on the funding that is appropriated for nursing facility services in the General Appropriations Act and will be determined in accordance with a formula specified in the Commonwealth's approved State Plan. For Fiscal Year (FY) 2006-2007, 19.1074% of the amount included in the General Appropriations Act for nursing facility per diem payments will be available for reimbursing county nursing facilities and 80.8926% will be available for nonpublic nursing facilities.

Chapter 1189—Requirements

Subchapter A. General Provisions

Chapter 1189 establishes a new rate-setting and payment methodology for county nursing facilities. However, it also incorporates Chapter 1187, Subchapters B—D, I and K.

The terms defined in Chapter 1187 are also incorporated into the regulations for county nursing facilities in Chapter 1189. In addition, § 1189.2 (relating to definitions) sets forth a few additional terms specific to Chapter 1189.

Subchapter B. Allowable Program Costs and Policies

The final-omitted rulemaking adds § 1189.51 (relating to allowable costs) to identify the costs incurred by county nursing facilities that are recognized as allowable for MA Program purposes. The intent of this section is to define allowable county nursing facility costs in a manner that will enable the Commonwealth to obtain additional Federal matching funds for the necessary and reasonable expenditures incurred by county nursing facilities in the course of providing services to their MA residents.

The final-omitted rulemaking also adds provisions in this subchapter that ensure that county nursing facilities act as prudent purchasers and that relate to cost allocation, changes in bed complements during a cost reporting period and related-party transactions. These provisions are based on analogous requirements in Chapter 1187 and impose no new obligations on county nursing facilities.

Subchapter C. Cost Reporting and Audit Requirements

The final-omitted rulemaking adds provisions in this subchapter that set forth the requirements that county nursing facilities must meet regarding the submission of acceptable cost reports, the exhaustion of Medicare Part B and reporting of Medicare Part B costs and the management of resident personal funds. The final-omitted rulemaking also specifies the auditing standards that will be used in auditing county nursing facility resident personal fund accounts and MA cost reports. These provisions are based on analogous requirements in Chapter 1187 and impose no new obligations on county nursing facilities.

Subchapter D. Rate Setting

The final-omitted rulemaking adds provisions in this subchapter that specify how per diem rates are set for county nursing facilities. Generally, under these provisions, the Department will calculate a county nursing facility's per diem rate for rate year 2006-2007 by taking the facility's April 1, 2006, case-mix rate, multiplied by a BAF as determined in accordance with a formula set forth in the Commonwealth's approved State Plan. For rate years beginning on or after July 1, 2007, the Department will determine a county nursing facility's per diem rate by taking the facility's prior rate year per diem rate multiplied by the BAF as determined by the formula

in the Commonwealth's approved State Plan. County nursing facilities may also be eligible for various incentive payments based on the requirements in § 1189.105 (relating to incentive payments).

Subchapter E. Payment Conditions, Limitations and Adjustments

The final-omitted rulemaking adds provisions in this subchapter that incorporate the requirements in §§ 1187.101—1187.106 and 1187.116. These provisions impose no new obligations on county nursing facilities.

The final-omitted rulemaking also adds provisions in § 1189.105 which authorize additional payments to qualifying county nursing facilities in the form of disproportionate share and pay for performance incentive payments. The disproportionate share incentive payment provisions are based on analogous provisions in Chapter 1187, except that the amounts identified in subsection (a)(2) are based on the most recent disproportionate share payments that were made to qualifying nursing facilities for the FY ending June 30, 2005, cost reports.

Subchapter F. Right of Appeal

The final-omitted rulemaking includes provisions in this subchapter outlining the situations in which a county nursing facility may file an appeal and explains the requirements that the facility must meet when filing an appeal.

Disproportionate Share Incentive Payments

The double disproportionate share provisions have been extended through June 30, 2009, for Chapters 1187 and 1189 in accordance with Intergovernmental Transfer agreements and the Commonwealth's approved State Plan.

Affected Individuals and Organizations

This final-omitted rulemaking affects nonpublic and county nursing facilities enrolled in the MA Program. The final-omitted rulemaking institutes a new rate-setting methodology for county nursing facilities and amends the rate-setting methodology for other enrolled providers of nursing facility services (nursing facilities), effective as of July 1, 2006.

Accomplishments and Benefits

This final-omitted rulemaking benefits Commonwealth residents by assuring that, upon admission to a county or nonpublic nursing facility, they are promptly given information that will enable them to determine whether home and community-based services are an appropriate alternative to institutional long term care services.

This final-omitted rulemaking further assures that county MA nursing facility residents will continue to have access to medically necessary nursing facility services, particularly MA day one eligible residents, by moderating the rate at which long-term care expenditures increase, and enhancing the Commonwealth's ability to obtain matching Federal funds on the full amount of allowable MA program public expenditures.

Fiscal Impact

The change in payment rates, effective July 1, 2006, and the quarterly case-mix adjustments are estimated to cost the Department $120.374 million ($30.918 million in State funds) in FY 2006-2007.

Paperwork Requirements

Implementation of this final-omitted rulemaking may result in minimal additional paperwork for the MA nonpublic nursing facilities, MA county nursing facilities and the Department.

Public Process

Federal law requires that the Department undertake a public process whenever it proposes to change how it sets payment rates for nursing facility services so that providers, consumers and other concerned State residents have a reasonable opportunity to comment on the Department's proposed changes. See section 1396a(a)(13)(A) of the Social Security Act (42 U.S.C.A. § 1396a(a)(13)(A)). In compliance with this Federal requirement, the Department has taken several steps to solicit input from affected stakeholders and the public.

The Department sought advice on how it should amend its nursing facility payment system at the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee on March 3, 2006, and April 12, 2006, and the Consumer Subcommittee meeting on March 22, 2006.

In addition, from late December 2005 through late June 2006, the Department met with representatives of the four nursing facility associations: Pennsylvania Health Care Association (PHCA), Hospital and Healthsystem Association of Pennsylvania (HAP), Pennsylvania Association of Non-Profit Homes for the Aging (PANPHA) and Pennsylvania Association of County Affiliated Homes (PACAH) on numerous occasions both before and after publication of a public notice to confer with, solicit and obtain input and recommendations on how the Department might best improve the case-mix payment system and contain the steady inflation of nursing facility payment rates. The Department also discussed the changes at a PACAH conference on April 26, 2006, with PHCA members on May 3, 2006, with HAP's long-term care providers on May 12, 2006, with the Pennsylvania Association of Area Agencies on Aging on February 15, 2006, and with Pennsylvania Home Care Association on June 2, 2006, as well as with various individual nursing facilities throughout the process.

As the public process took place, the Department continued to consider and make refinements in the methodology that would be used to set nursing facility payment rates and implement other changes to the system. On April 13, 2006, the Department met with and shared the latest rate-setting model with the four nursing facility associations. In early May and early June 2006, the Department met with the four associations as well as legislative staff to discuss the proposed rate-setting methodology. As a result of these discussions, the Department made additional changes to the rate-setting model.

The Department published an advance public notice at 36 Pa.B. 1804 (April 15, 2006) in which it announced its intent to amend its State Plan to change its methods and standards for payment of MA nursing facility services provided by nonpublic nursing facilities beginning FY 2006-2007 and invited interested persons to comment on the proposed amendment.

The Department also published an advance public notice at 36 Pa.B. 1803 (April 15, 2006) in which it announced its intent to amend its State Plan to change its methods and standards for payment of MA nursing facility services provided by county nursing facilities beginning FY 2006-2007 by implementing a new regulation specific to county nursing facilities, and invited interested persons to comment on the proposed amendments.

The Department also held public hearings throughout this Commonwealth to educate the public and solicit comments regarding amendments to Chapter 1187 for nonpublic nursing facilities and the addition of Chapter

1189 for county nursing facilities. The meetings were held in Harrisburg on April 17, 2006; in Pittsburgh on April 18, 2006; in Sharon on April 19, 2006; two meetings in State College on April 20, 2006; in Scranton on April 21, 2006; in Philadelphia on April 25, 2006; in Lancaster on April 27, 2006; and two meetings in Allentown on April 28, 2006.

In response to the notice to amend Chapter 1187, the Department received a total of 30 comment letters and 102 statements were presented both orally and in writing at the public hearings. The Department received three comment letters and nine statements concerning the notice published at 36 Pa.B. 1803 regarding a separate reimbursement system for county nursing facilities. In addition, although not required by Act 42, the Department shared this final-omitted rulemaking with the associations and legislative staff on June 9, 2006, prior to publication in the *Pennsylvania Bulletin*.

Through these various efforts, the Department obtained thoughtful, substantive comments and recommendations. The Department considered all of that input in the course of developing this final-omitted rulemaking. More detailed information on these comments and recommendations and the Department's responses to them are posted on the Department's website at www.dpw.state.pa.us/omap/provinf/ltc/omapltc.asp.

Sunset Date

There is no sunset date for Chapter 1187. Section 1189.108 (relating to county nursing facility supplementation payments) sunsets on June 30, 2009. There is no sunset date for the remainder of Chapter 1189. However, the Department will review the effectiveness of Chapters 1187 and 1189 as part of its continuing discussions with the nursing facility industry, consumers and other stakeholders and evaluate the need for further amendments.

Regulatory Review Act

Under section 443.1(5)(iii) of the code, this final-omitted rulemaking is not subject to review under the Regulatory Review Act.

Order

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) and (3) of the CDL and 1 Pa. Code § 7.4(1)(iv) and (3) because this final-omitted rulemaking relates to Commonwealth grants and benefits.

(2) The adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

(3) Any delay in the effective date of this final-omitted rulemaking beyond July 1, 2006, would be impracticable and contrary to the public interest since it would violate the requirement of section 443.1(5) of the code.

Order

The Department, acting under sections 201(2), 206(2), 403(b) and 443.1(5) of the code, orders that:

(a) The regulations of the Department, 55 Pa. Code, are amended by amending §§ 1187.1, 1187.2, 1187.22, 1187.31—1187.33, 1187.51, 1187.91, 1187.93, 1187.95—1187.97, 1187.103 and 1187.111; by deleting § 1187.116; and by adding §§ 1187.98, 1189.1—1189.3, 1189.51—1189.55, 1189.71—1189.75, 1189.91, 1189.92, 1189.101—1189.108 and 1189.141 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations, contingent upon approval of the State Plan amendment.

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

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

(d) This order shall take effect July 1, 2006. Sections 1187.22(18) and 1187.33(a) (relating to ongoing responsibilities of nursing facilities; and resident data and picture date reporting requirements) shall take effect October 1, 2006.

ESTELLE B. RICHMAN,
Secretary

Fiscal Note: 14-507. (1) General Fund; (2) Implementing Year 2006-07 is $30.918 million; (3) 1st Succeeding Year 2007-08 is $37.694 million; 2nd Succeeding Year 2008-09 is $37.694 million; 3rd Succeeding Year 2009-10 is $37.694 million; 4th Succeeding Year 2010-11 is $37.694 million; 5th Succeeding Year 2011-12 is $37.694 million; (4) 2004-05 Program—$476.116 million; 2003-04-$588.528 million; 2002-03—$250.568 million; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1187. NURSING FACILITY SERVICES

Subchapter A. GENERAL PROVISIONS

§ 1187.1. Policy.

(a) This chapter applies to nursing facilities, and to the extent specified in Chapter 1189 (relating to county nursing facility services), to county nursing facilities.

(b) This chapter governs MA payments to nursing facilities on the basis of the Commonwealth's approved State Plan for reimbursement.

(c) The MA Program provides payment for nursing facility services provided to eligible recipients by enrolled nursing facilities. Payment for services is made subject to this chapter and Chapter 1101 (relating to general provisions).

(d) Extensions of time will be as follows:

(1) The time limits established by this chapter for the filing of a cost report, resident assessment data, an appeal or an amended appeal cannot be extended, except as provided in this section.

(2) Extensions of time in addition to the time otherwise prescribed for nursing facilities by this chapter with respect to the filing of a cost report, resident assessment data, an appeal or an amended appeal may be permitted only upon a showing of fraud, breakdown in the Department's administrative process or an intervening natural disaster making timely compliance impossible or unsafe.

(3) This subsection supersedes 1 Pa. Code § 31.15 (relating to extensions of time).

§ 1187.2. Definitions.

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

* * * * *

CMI Report—A report generated by the Department from submitted resident assessment records and tracking forms and verified by a nursing facility each calendar quarter that identifies the total facility and MA CMI average for the picture date, the residents of the nursing facility on the picture date and the following for each identified resident:

(i) The resident's payor status.

(ii) The resident's RUG category and CMI.

(iii) The resident assessment used to determine the resident's RUG category and CMI and the date and type of the assessment.

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County nursing facility—

(i) A long-term care nursing facility that is:

(A) Licensed by the Department of Health.

(B) Enrolled in the MA program as a provider of nursing facility services.

(C) Controlled by the county institution district or by county government if no county institution district exists.

(ii) The term does not include intermediate care facilities for the mentally retarded controlled or totally funded by a county institution district or county government.

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

Hospital-based nursing facility—A nursing facility that was receiving a hospital-based rate as of June 30, 1995, and is:

(i) Located physically within or on the immediate grounds of a hospital.

(ii) Operated or controlled by the hospital.

(iii) Licensed or approved by the Department of Health and meets the requirements of 28 Pa. Code § 101.31 (relating to hospital requirements) and shares support services and administrative costs of the hospital.

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Initial Federally-approved PA Specific MDS—The first assessment or tracking form completed for a resident upon admission.

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Medicare Provider Reimbursement Manual (Centers for Medicare and Medicaid Services (CMS) Pub. 15-1)—Guidelines and procedures for Medicare reimbursement.

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Nursing facility—

(i) A long-term care nursing facility, that is:

(A) Licensed by the Department of Health.

(B) Enrolled in the MA Program as a provider of nursing facility services.

(C) Owned by an individual, partnership, association or corporation and operated on a profit or nonprofit basis.

(ii) The term does not include intermediate care facilities for the mentally retarded, Federal or State-owned long-term care nursing facilities, Veteran's homes or county nursing facilities.

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Resident Data Reporting Manual—The Department's Manual of instructions for submission of resident assessment records and tracking forms and verification of the CMI report.

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Subchapter C. NURSING FACILITY PARTICIPATION

§ 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:

* * * * *

(5) Assure that the data in each resident's Federally-approved PA Specific MDS are accurate and that all assessment records and tracking forms for the resident are completed and submitted to the Department as required by applicable Federal and State regulations and instructions, including the *Centers for Medicare and Medicaid Services Long-Term Care Resident Assessment Instrument User's Manual* and the *Resident Data Reporting Manual.*

(6) Assure and verify that the information contained on the quarterly CMI report is accurate for the picture date as specified in § 1187.33(a)(5) (relating to resident data and picture date reporting requirements) and the *Resident Data Reporting Manual.*

* * * * *

(18) Submit the initial Federally-approved PA Specific MDS record for each resident admitted to the nursing facility to the Department within 7 calendar days of the date the record is completed.

Subchapter D. DATA REQUIREMENTS FOR NURSING FACILITY APPLICANTS AND RESIDENTS

§ 1187.31. Admission or MA conversion requirements.

A nursing facility shall meet the following admission or MA conversion requirements:

(1) *Prescreening.* The nursing facility shall ensure that individuals applying for admission to the facility are 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) *Preadmission or MA conversion evaluation and determination.*

(i) The nursing facility shall ensure that before an MA applicant or recipient is admitted to a nursing facility, or before authorization for MA payment for nursing facility services in the case of a resident, the MA applicant,

recipient or resident has been evaluated by the Department or an independent assessor and found to need nursing facility services.

(ii) The nursing facility shall maintain a copy of the Department's or the independent assessor's notification of eligibility in the business office.

(3) *Notification to the Department.*

(i) The nursing facility shall notify the Department on forms designated by the Department whenever an MA applicant or recipient is admitted to the nursing facility or whenever a resident is determined eligible for MA.

(ii) The nursing facility shall submit information regarding target residents to the Department on forms designated by the Department within 48 hours of the admission of a target resident to the nursing facility.

(4) *Physician certification.* Within 48 hours of admission of a resident to a nursing facility or, if a resident applies for MA while in the nursing facility before the Department authorizes payment for nursing facility services, the nursing facility shall ensure that a resident's attending physician certifies in writing in the resident's clinical record that the resident requires nursing facility services.

§ 1187.32. Continued need for nursing facility services requirements.

A nursing facility shall meet the following continued need for nursing facility services requirements:

(1) The nursing facility shall complete a new prescreening form for a resident whenever there is a change in the resident's condition that affects whether the resident is a target resident. The nursing facility shall maintain a copy of the new prescreening form in the resident's clinical record and notify the Department within 48 hours of the change in the resident's condition on forms designated by the Department.

(2) The nursing facility shall ensure that a resident's attending physician, or a physician assistant or nurse practitioner acting within the scope of practice as defined by State law and under the supervision of the resident's attending physician, recertifies the resident's need for nursing facility services in the resident's clinical record at the time the attending physician's orders are reviewed and renewed, consistent with Department of Health licensure time frames for renewing orders.

(3) The nursing facility shall notify the Department within 48 hours whenever the facility or resident's attending physician determines that the resident no longer requires nursing facility services. The notification shall be submitted on forms designated by the Department.

(4) The nursing facility shall obtain a physician's certification and written order for the resident's discharge whenever a resident no longer requires nursing facility services.

§ 1187.33. Resident data and picture date reporting requirements.

(a) *Resident data and picture date requirements.* A nursing facility shall meet the following resident data and picture date reporting requirements:

(1) The nursing facility shall submit the resident assessment data necessary for the CMI report to the Department as specified in the *Resident Data Reporting Manual.*

(2) The nursing facility shall ensure that the Federally approved PA specific MDS data for each resident accurately describes the resident's condition, as documented in the resident's clinical records maintained by the nursing facility.

(i) The nursing facility's clinical records shall be current, accurate and in sufficient detail to support the reported resident data.

(ii) The Federally approved PA specific MDS shall be coordinated and certified by the nursing facility's RNAC.

(iii) The records listed in this section are subject to periodic verification and audit.

(3) The nursing facility shall maintain the records pertaining to each Federally-approved PA Specific MDS record and tracking form submitted to the Department for at least 4 years from the date of submission.

(4) The nursing facility shall ensure that resident assessments accurately reflect the residents' conditions on the assessment date.

(5) The nursing facility shall correct and verify that the information in the quarterly CMI report is accurate for the picture date and in accordance with paragraph (6) and shall sign and submit the CMI report to the Department postmarked no later than 5 business days after the 15th day of the third month of the quarter.

(6) The CMI report must include resident assessment data for every MA and every non-MA resident included in the census of the nursing facility on the picture date. Assessments completed solely for Medicare payment purposes are not included on the CMI report.

(i) A resident shall be included in the census of the nursing facility on the picture date if all of the following apply:

(A) The resident was admitted to the nursing facility prior to or on the picture date.

(B) The resident was not discharged with return not anticipated prior to or on the picture date.

(C) Any resident assessment is available for the resident from which data may be obtained to calculate the resident's CMI.

(ii) A resident who, on the picture date, is temporarily discharged from the nursing facility with a return anticipated shall be included in the census of the nursing facility on the picture date as a non-MA resident.

(iii) A resident who, on the picture date, is on therapeutic leave shall be included in the census of the nursing facility on the picture date as an MA resident if the conditions of § 1187.104(2) (relating to limitations on payment for reserved beds) are met on the picture date. If the conditions of § 1187.104(2) are not met, the resident shall be included in the census of the nursing facility as a non-MA resident.

(b) *Failure to comply with the submission of resident assessment data.*

* * * * *

(3) If a valid CMI report is not received in the time frame outlined in subsection (a)(5), the facility will be assigned the lowest individual RUG-III CMI value for the computation of the facility MA CMI and the highest RUG-III CMI value for the computation of the total facility CMI.

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* (CMS Pub. 15-1) and the Federal regulations in 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 CMS Pub. 15-1 and applicable Federal regulations may be used as a source for more detailed information on that cost. The CMS 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 CMS 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.

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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 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).

(ii) Subparagraph (i)(B) does not apply if a nursing facility is under investigation by the Office of Attorney General. In this situation, the Department will use a maximum of the three most recent available audited cost reports in the NIS database used for price setting.

(iii) 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.

(iv) 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 1st Quarter issue of the CMS Nursing Home Without Capital Market Basket Index.

(v) Total facility and MA CMI averages from the quarterly CMI reports will be used to determine case-mix adjustments for each price-setting and rate-setting period as specified in § 1187.96(a)(1)(i) and (5) (relating to price- and rate-setting computations).

* * * * *

§ 1187.93. CMI calculations.

The Pennsylvania Case-Mix Payment System uses the following three CMI calculations:

(1) An individual resident's CMI shall be assigned to the resident according to the RUG-III classification system.

(2) The facility MA CMI shall be the arithmetic mean of the individual CMIs for MA residents identified on the nursing facility's CMI report for the picture date. The facility MA CMI shall be used for rate determination under § 1187.96(a)(5) (relating to price and rate-setting computations.) If there are no MA residents identified on the CMI report for a picture date, the Statewide average MA CMI shall be substituted for rate determination under § 1187.96(a)(5).

(3) The total facility CMI is the arithmetic mean of the individual resident CMIs for all residents, regardless of payor, identified on the nursing facility's CMI report for the picture date. The total facility CMI for the February 1 picture date shall be used for price and rate setting computations as specified in § 1187.96(a)(1)(i).

§ 1187.95. General principles for rate and price setting.

* * * * *

(b) Rates will be set prospectively each quarter of the calendar year and will be in effect for 1 full quarter. Net operating rates will be based on peer group prices as limited by § 1187.107 (relating to limitations on resident care and other resident related cost centers). The nursing facility per diem rate will be computed as defined in § 1187.96(e) (relating to price- and rate-setting computations). Resident care peer group prices will be adjusted for the MA CMI of the nursing facility each quarter and be effective on the first day of the following calendar quarter.

§ 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:

* * * * *

(iii) The Department will calculate the 3-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.

(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) For rate years 2006-2007 and 2007-2008, the median used to set the resident care price will be the phase-out median as determined in accordance with § 1187.98 (relating to phase-out median determination).

(4) 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.

(5) The price derived in paragraph (4) 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:

* * * * *

(ii) 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) For rate years 2006-2007 and 2007-2008, the median used to set the other resident related price will be the phase-out median as determined in accordance with § 1187.98.

(4) 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:

* * * * *

(iii) 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 determined for each peer group.

(3) For rate years 2006-2007 and 2007-2008, the median used to set the administrative price will be the phase-out median as determined in accordance with § 1187.98.

(4) 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.

* * * * *

(e) The following applies to the computation of nursing facilities' per diem rates:

* * * * *

(2) For each quarter of the 2006-2007 and 2007-2008 rate-setting years, the nursing facility per diem rate will be computed as follows:

(i) *Generally*. If a nursing facility is not a new nursing facility or a nursing facility experiencing a change of ownership during the rate year, that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with subsections (a)—(d) and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(ii) *New nursing facilities*. If a nursing facility is a new nursing facility for purposes of § 1187.97(1) (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with § 1187.97(1), and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(iii) *Nursing facilities with a change of ownership and reorganized nursing facilities*. If a nursing facility undergoes a change of ownership during the rate year, that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with § 1187.97(2), and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(iv) *Budget adjustment factor*. The budget adjustment factor for the rate year will be determined in accordance with the formula set forth in the Commonwealth's approved State Plan.

§ 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, unless a former county 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 and

picture date reporting requirements) is used in a rate determination under § 1187.96(a)(5) (relating to price-and rate-setting computations).

(B) For a former county nursing facility, the county nursing facility's assessment data and MA CMI will be transferred to the new nursing facility.

(C) 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.

* * * * *

(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, except that, if a county nursing facility becomes a nursing facility between July 1, 2006, and June 30, 2008, the per diem rate for the nursing facility will be computed in accordance with § 1187.96, using the data contained in the NIS database. Net operating and capital rates for the old nursing facility provider will be assigned to the new nursing facility provider.

* * * * *

§ 1187.98. Phase-out median determination.

For rate years 2006-2007 and 2007-2008, the Department will determine a phase-out median for each net operating cost center for each peer group to calculate a peer group price. The Department will establish the phase-out median as follows:

(1) Peer groups will be established in accordance with §§ 1187.91 and 1187.94 (relating to database; and peer grouping for price-setting).

(2) County nursing facilities will be included when determining the number of nursing facilities in a peer group in accordance with § 1187.94(1)(iv).

(3) Audited county nursing facilities' costs from the 3 most recent audited cost reports audited in accordance with this chapter, will be included in the established peer groups when determining a median in accordance with § 1187.96 (relating to price and rate setting computations).

Subchapter H. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

§ 1187.103. Cost finding and allocation of costs.

(a) A nursing facility shall use the direct allocation method of cost finding. The costs will be apportioned directly to the nursing facility and residential or other facility, based on appropriate financial and statistical data.

(b) Allowable operating cost for nursing facilities will be determined subject to this chapter and the *Medicare Provider Reimbursement Manual*, CMS Pub. 15-1, except that if this chapter and CMS Pub. 15-1 differ, this chapter applies.

§ 1187.111. Disproportionate share incentive payments.

* * * * *

(e) For the period July 1, 2005, to June 30, 2009, the disproportionate share incentive payment to qualified nursing facilities shall be increased to equal two times the disproportionate share per diem incentive calculated in accordance with subsection (c).

(1) For the period commencing July 1, 2005, through June 30, 2006, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2005, or June 30, 2006.

(2) For the period commencing July 1, 2006, through June 30, 2007, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2006, or June 30, 2007.

(3) For the period commencing July 1, 2007, through June 30, 2008, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2007, or June 30, 2008.

(4) For the period commencing July 1, 2008, through June 30, 2009, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2008, or June 30, 2009.

§ 1187.116. (Reserved).

CHAPTER 1189. COUNTY NURSING FACILITY SERVICES

Subchap.

Subchapter A. GENERAL PROVISIONS

Sec.

§ 1189.1. Policy.

(a) This chapter applies to county nursing facilities.

(b) This chapter sets forth conditions of participation for county nursing facilities, identifies the costs incurred by county nursing facilities to provide nursing facility services that will be recognized as allowable MA Program expenditures and specifies the methodology by which rates will be set and payments made to county nursing facilities for services provided to MA residents.

(c) Payment for nursing facility services provided by county nursing facilities is made subject to this chapter and Chapter 1101 (relating to general provisions).

(d) Extensions of time will be as follows:

(1) The time limits established by this chapter for the filing of a cost report, resident assessment data and picture date reporting, or other document or submission to the Department cannot be extended, except as provided in this section.

(2) Extensions of time in addition to the time otherwise prescribed by this chapter may be permitted only upon a showing of fraud, breakdown in the Department's administrative process or an intervening natural disaster making timely compliance impossible or unsafe.

(3) This subsection supersedes 1 Pa. Code § 31.15 (relating to extensions of time).

§ 1189.2. Definitions.

(a) Except for those terms defined in subsection (b), the defined words and terms set forth in § 1187.2 (relating to definitions), have the same meanings when used in this chapter, unless the context clearly indicates otherwise.

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

Allowable MA Program Expenditure—A cost incurred by a county nursing facility to provide nursing facility services to MA residents that is allowable under this chapter and that is reported and certified by the county nursing facility in a form and manner specified by the Department.

MA Cost Report—The package of certifications, schedules and instructions designated by the Department which county nursing facilities shall use to record and report the costs that they incur to provide nursing facility services during a calendar year.

New county nursing facility—One of the following:

(i) A newly constructed, licensed and certified county nursing facility.

(ii) An existing nursing facility that through a change of ownership, is controlled by the county institution district or by county government if no county institution district exists.

Per diem rate—The amount established under this chapter at which the Department makes payment to a county nursing facility for a resident day of care provided to an MA resident.

§ 1189.3. Compliance with regulations governing noncounty nursing facilities.

(a) Unless a specific provision of this chapter provides to the contrary, the following subchapters of Chapter 1187 (related to nursing facility services) are applicable to county nursing facilities:

(1) Subchapter B (relating to scope of benefits).

(2) Subchapter C (relating to nursing facility participation).

(3) Subchapter D (relating to data requirements for nursing facility applicants and residents), except for § 1187.33(d) (relating to resident data and picture data reporting requirements).

(4) Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

(5) Subchapter K (relating to exceptional payment for nursing facility services).

(b) If a provision of Chapter 1187 is made applicable to county nursing facilities by subsection (a) or other provision of this chapter, and the provision of Chapter 1187 uses the term "nursing facility," that term shall be understood to mean "county nursing facility," unless the context clearly indicates otherwise.

Subchapter B. ALLOWABLE PROGRAM COSTS AND POLICIES

Sec.

§ 1189.51. Allowable costs.

A cost incurred by a county nursing facility is an allowable cost if the cost was incurred in the course of providing nursing facility services and one of the following applies:

(1) The cost is allowable pursuant to the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).

(2) The cost is not allowable under the CMS Pub. 15-1 but is allowable as a net operating cost under Chapter 1187 (relating to nursing facility services).

(3) The cost is identified as an allowable county nursing facility cost in the Commonwealth's approved State Plan.

§ 1189.52. Allocating cost centers.

(a) The county nursing facility shall allocate costs in accordance with the allocation bases and methodology established by the Department as contained in this chapter and the MA cost report. If the nursing facility has its own more accurate method of allocation basis, it may be used only if the nursing facility receives written approval from the Department prior to the first day of the applicable cost report year.

(b) The absence of documentation to support allocation or the use of other methods which do not properly reflect use of the Department's required allocation bases or approved changes in bases shall result in disallowances being imposed for each affected line item.

§ 1189.53. Changes in bed complement during a cost reporting period.

(a) When the county nursing facility's bed complement changes during a cost reporting period, the allocation bases are subject to verification at audit.

(b) The county nursing facility shall keep adequate documentation of the costs related to bed complement changes during a cost reporting period. The county nursing facility shall submit the supplemental schedules as may be required by the Department to identify the costs being allocated by the required statistical methods for each period of change.

§ 1189.54. Costs of related parties.

Costs applicable to services, movable property and supplies, furnished to the county nursing facility by organizations related to the county nursing facility by common ownership or control shall be included as an allowable cost of the county 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.

§ 1189.55. Prudent buyer concept.

The purchase or rental by a county 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 CMS Pub. 15-1.

Subchapter C. COST REPORTING AND AUDIT REQUIREMENTS

Sec.

§ 1189.71. Cost reporting.

(a) A county nursing facility shall submit an acceptable MA cost report to the Department within 120 days following the close of each calendar year in a form and manner specified by the Department. Requests for an extension to file an annual cost report will not be granted except as provided under § 1189.1 (relating to policy).

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

(1) Applicable items are fully completed in accordance with the instructions provided for the cost report including the necessary original signatures on the required number of copies.

(2) Computations carried out on the cost report are accurate and consistent with other related computations.

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

(4) Required documentation is included.

(5) The cost report is filed with the Department within the time limits specified.

§ 1189.72. Cost reporting for Medicare Part B type services.

(a) County nursing facilities shall utilize Medicare as a primary payer resource when appropriate, under § 1189.102 (relating to utilizing Medicare as a resource).

(b) If Medicare is the primary payer resource, the county nursing facility shall exclude from allowable costs operating costs incurred in or income derived from the provision of Medicare Part B coverable services to nursing facility residents. The county nursing facility shall attach to the MA cost report a copy of the cost report the nursing facility submits to Medicare for the Part B services and, when available, submit a copy of the Medicare final audit, including audit adjustments.

(c) If there is a discrepancy between the costs on the Medicare cost report or, if available, the Medicare audit report, and the adjustments made by the county nursing facility on the MA cost report to exclude Medicare Part B costs, the Department will make the necessary adjustments to conform the county nursing facility's MA cost report to the Medicare report.

§ 1189.73. Accountability requirements related to resident personal fund management.

(a) A county nursing facility may not require residents to deposit their personal funds with the county nursing facility. A county nursing facility shall hold, safeguard and account for a resident's personal funds upon written authorization from the resident in accordance with this section and other applicable provisions in State and Federal law.

(b) A resident's personal funds may not be commingled with county nursing facility funds or with the funds of a person other than another resident.

(c) A resident's personal funds in excess of $50 shall be maintained in an interest bearing account, and interest earned shall be credited to that account.

(d) A resident's personal funds that do not exceed $50 may be maintained in a noninterest bearing account, interest bearing account or petty cash fund.

(e) Statements regarding a resident's financial record shall be available upon request to the resident or to the resident's legal representative.

(f) The county nursing facility shall notify each resident that receives MA benefits when the amount in the resident's personal fund account reaches $200 less than the SSI resource limit for one person.

(g) Within 60 days of the death of a resident, the county nursing facility shall convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

(h) The county nursing facility may not impose a charge against the personal funds of a resident for an item or service for which payment is made under MA or Medicare.

(i) The county nursing facility shall maintain records relating to its management of residents' personal funds for a minimum of 4 years. These records shall be available to Federal and State representatives upon request.

(j) The county nursing facility shall purchase a surety bond or otherwise provide assurances of the security of personal funds of the residents deposited with the county nursing facility.

§ 1189.74. Auditing requirements related to resident personal fund management.

(a) The Department will periodically audit residents' personal fund accounts.

(b) If discrepancies are found at audit, the county nursing facility shall make restitution to the residents for funds improperly handled, accounted for or disbursed. The Department may sanction the nursing facility in accordance with Chapter 1187, Subchapter I (relating to enforcement of compliance for nursing facility services).

§ 1189.75. Auditing requirements related to MA cost report.

(a) The Department will conduct an audit of each acceptable MA cost report with an end date of December 31, 2005, and thereafter to determine the county nursing facility's allowable MA Program expenditures for the calendar year.

(b) To determine the county nursing facility's audited allowable MA Program expenditures for a calendar year, the Department will audit the county nursing facility's MA cost report for compliance with:

(1) This chapter.

(2) Chapter 1101 (relating to general provisions).

(3) The schedules and instructions included in the MA cost report.

(c) A county nursing facility shall make financial and statistical records to support its MA cost reports available to the Department upon request and to other State and Federal representatives as required by Federal and State law and regulations.

(d) The Department will conduct audits in accordance with auditing requirements in Federal regulations and generally accepted government auditing standards.

(e) A county nursing facility that has certified financial statements, Medicare intermediary audit reports with adjustments and Medicare reports for the reporting period shall submit these reports with its cost report, at audit or when available.

Subchapter D. RATE SETTING

Sec.
1189.91. Per diem rates for county nursing facilities.
1189.92. Per diem rates for new county nursing facilities.

§ 1189.91. Per diem rates for county nursing facilities.

(a) For the rate year 2006-2007, the per diem rate paid to a county nursing facility for a rate year will be the facility's April 1, 2006, case-mix per diem rate as calculated under Chapter 1187, Subchapter G (relating to rate setting) multiplied by a budget adjustment factor determined in accordance with subsection (d).

(b) For each rate year beginning on or after July 1, 2007, the per diem rate paid to a county nursing facility for a rate year will be the facility's prior rate year per diem rate multiplied by a budget adjustment factor determined in accordance with subsection (d).

(c) The Department, at its discretion, may revise the per diem rates for county nursing facilities by calculating updated case-mix per diem rates in accordance with Chapter 1187, Subchapter G or under an alternative method specified in the Commonwealth's approved State Plan.

(d) The budget adjustment factor for the rate year will be determined in accordance with the formula in the Commonwealth's approved State Plan.

§ 1189.92. Per diem rates for new county nursing facilities.

The per diem rate for a new county nursing facility will be the Statewide average of all other county nursing facilities' per diem rates for the same rate year established in accordance with § 1189.91(relating to per diem rates for county nursing facilities).

Subchapter E. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

Sec.

§ 1189.101. General payment policy for county nursing facilities.

(a) Payment for nursing facility services provided by a county nursing facility will be made subject to the following conditions and limitations:

(1) This chapter and Chapter 1101 (relating to general provisions).

(2) Applicable State statutes.

(3) Applicable Federal statutes and regulations and the Commonwealth's approved State Plan.

(b) A per diem rate payment for nursing facility services provided by a county facility will not be made if full payment is available from another public agency, another insurance or health program or the resident's resources.

(c) Payment will not be made in whole or in part to a county nursing facility for nursing facility services provided during a period in which the nursing facility's participation in the MA Program is terminated.

(d) Claims submitted by a county nursing facility for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101. In addition, the Department will perform the reviews specified in this chapter for controlling the utilization of nursing facility services.

§ 1189.102. Utilizing Medicare as a resource.

(a) An eligible resident who is a Medicare beneficiary, is receiving care in a Medicare certified county nursing facility and is authorized by the Medicare Program to receive county nursing facility services shall utilize available Medicare benefits before payment will be made by the MA Program. If the Medicare payment is less than the county nursing facility's MA per diem rate for nursing facility services, the Department will participate in payment of the coinsurance charge to the extent that the total of the Medicare payment and the Department's and other coinsurance payments do not exceed the MA per diem rate for the county nursing facility. The Department will not pay more than the maximum coinsurance amount.

(b) If a resident has Medicare Part B coverage, the county nursing facility shall use available Medicare Part B resources for Medicare Part B services before payment is made by the MA Program.

(c) The county nursing facility may not seek or accept payment from a source other than Medicare for any portion of the Medicare coinsurance amount that is not paid by the Department on behalf of an eligible resident because of the limit of the county nursing facility's MA per diem rate.

(d) The Department will recognize the Medicare payment as payment in full for each day that a Medicare payment is made during the Medicare-only benefit period.

(e) The cost of providing Medicare Part B type services to MA residents not eligible for Medicare Part B services which are otherwise allowable costs under this part are reported in accordance with § 1189.72 (relating to cost reporting for Medicare Part B type services).

§ 1189.103. Limitations on payment for reserved beds.

The Department will make payment to a county nursing facility for a reserved bed when the resident is absent from the nursing facility for a continuous 24-hour period because of hospitalization or therapeutic leave. A county nursing facility shall record each reserved bed for therapeutic leave on the nursing facility's daily census record and MA invoice. When the bed reserved for a resident who is hospitalized is temporarily occupied by another resident, a county nursing facility shall record the occupied bed on the nursing facility's daily MA census record and the MA invoice. During the reserved bed period the same bed shall be available for the resident upon the resident's return to the nursing facility. The following limits on payment for reserved bed days apply:

(1) *Hospitalization.*

(i) A resident receiving nursing facility services is eligible for a maximum of 15 consecutive reserved bed days per hospitalization. The Department will pay a county nursing facility at a rate of 1/3 of the county nursing facility's current per diem rate on file with the Department for a hospital reserved bed day.

(ii) If the resident's hospital stay exceeds the Department's 15 reserved bed days payment limitation, the county nursing facility shall readmit the resident to the county nursing facility upon the first availability of a bed in the county nursing facility if, at the time of readmission, the resident requires the services provided by the county nursing facility.

(iii) Hospital reserved bed days may not be billed as therapeutic leave days.

(2) *Therapeutic leave.* A resident receiving nursing facility services is eligible for a maximum of 30 days per calendar year of therapeutic leave outside the county nursing facility if the leave is included in the resident's plan of care and is ordered by the attending physician. The Department will pay a county nursing facility the county nursing facility's current per diem rate on file with the Department for a therapeutic leave day.

§ 1189.104. Limitations on payment during strike or disaster situations requiring resident evacuation.

Payment may continue to be made to a county nursing facility that has temporarily transferred residents, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the residents' needs, if the institution receiving the residents is licensed and certified to provide the required services. If the county nursing facility transferring the residents can demonstrate that there is no certified nursing facility available for the safe and orderly transfer of the residents, the payments may be made so long as the institution receiving the residents is certifiable and licensed to provide the services required. The resident assessment submissions for the transferring nursing facility residents shall be maintained under the transferring county nursing facility provider number as long as the transferring county nursing facility is receiving payment for those residents. If the nursing facility to which the residents are transferred has a different per diem rate, the transferring county nursing facility shall be reimbursed at the lower rate. The per diem rate established on the date of transfer will not be adjusted during the period that the residents are temporarily transferred. The county nursing facility shall immediately notify the Department in writing of an impending strike or a disaster situation and follow with a listing of MA residents and the nursing facility to which they will be or were transferred.

§ 1189.105. Incentive payments.

(a) *Disproportionate share incentive payment.*

(1) A disproportionate share incentive payment will be made based on MA paid days of care times the per diem incentive to facilities meeting the following criteria for a 12-month facility cost reporting period:

(i) The county nursing facility shall have an annual overall occupancy rate of at least 90% of the total available bed days.

(ii) The county nursing facility shall have an MA occupancy rate of at least 80%. The MA occupancy rate is calculated by dividing the MA days of care paid by the Department by the total actual days of care.

(2) The disproportionate share incentive payments will be based on the following:

	Overall Occupancy	*MA Occupancy (y)*	Per Diem Incentive
Group A	90%	$> 90\%$ y	$3.32
Group B	90%	$88\% < y < 90\%$	$2.25
Group C	90%	$86\% < y < 88\%$	$1.34
Group D	90%	$84\% < y < 86\%$	$0.81
Group E	90%	$82\% < y < 84\%$	$0.41
Group F	90%	$80\% < y < 82\%$	$0.29

(3) The disproportionate share incentive payments as described in paragraph (2) will be inflated forward using the first quarter issue CMS Nursing Home Without Capital Market Basket Index to the end point of the rate setting year for which the payments are made.

(4) These payments will be made annually within 120 days after the submission of an acceptable cost report provided that payment will not be made before 210 days of the close of the county nursing facility fiscal year.

(5) For the period July 1, 2005, to June 30, 2009, the disproportionate share incentive payment to qualified county nursing facilities shall be increased to equal two times the disproportionate share per diem incentive calculated in accordance with paragraph (3).

(i) For the period commencing July 1, 2005, through June 30, 2006, the increased incentive applies to cost reports filed for the fiscal period ending December 31, 2005.

(ii) For the period commencing July 1, 2006, through June 30, 2007, the increased incentive applies to cost reports filed for the fiscal period ending December 31, 2006.

(iii) For the period commencing July 1, 2007, through June 30, 2008, the increased incentive applies to cost reports filed for the fiscal period ending December 31, 2007.

(iv) For the period commencing July 1, 2008, through June 30, 2009, the increased incentive applies to cost reports filed for the fiscal period ending December 31, 2008.

(b) *Pay for performance incentive payment.* The Department will establish pay for performance measures that will qualify a county nursing facility for additional incentive payments. The incentive payments will be made in accordance with the formula and qualifying criteria set forth in the Commonwealth's approved State Plan.

§ 1189.106. Adjustments relating to sanctions and fines.

County nursing facility payments shall be withheld, offset, reduced or recouped as a result of sanctions and fines in accordance with Chapter 1187, Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

§ 1189.107. Adjustments relating to errors and corrections of county nursing facility payments.

County nursing facility payments shall be withheld, offset, increased, reduced or recouped as a result of errors, fraud and abuse or appeals under Chapter 1187, Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies) and § 1189.141 (relating to county nursing facility's right to appeal and to a hearing).

§ 1189.108. County nursing facility supplementation payments.

Supplementation payments are made according to a formula established by the Department to county nursing facilities, in which Medicaid funded resident days account for at least 80% of the facility's total resident days and the number of certified MA beds is greater than 270 beds. Payment of the supplementation payments is contingent upon the determination by the Department that there are sufficient State and Federal funds appropriated to make these supplementation payments.

Subchapter F. RIGHT OF APPEAL

Sec.
1189.141. County nursing facility's right to appeal and to a hearing.

§ 1189.141. County nursing facility's right to appeal and to a hearing.

(a) A county nursing facility has a right to appeal and have a hearing if the county nursing facility does not agree with the Department's decision regarding:

(1) The Department's denial, nonrenewal or termination of the county nursing facility's MA provider agreement.

(2) The Department's imposition of sanctions or fines on the county nursing facility under Chapter 1187, Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

(3) The per diem rate established by the Department.

(4) Other written orders or decisions of the Department that cause the county nursing facility to be aggrieved for purposes of 67 Pa.C.S. Chapter 11 (relating to Medical Assistance hearings and appeals).

(b) A county nursing facility appeal is subject to § 1101.84 (relating to provider right of appeal).

(c) If a county nursing facility wishes to contest any of the decisions listed in subsection (a)(1)—(4), it shall file a request for hearing within the time limits set forth in 67 Pa.C.S. Chapter 11.

(d) A county nursing facility's appeal is subject to the requirements set forth in 67 Pa.C.S. Chapter 11 and the Standing Practice Order of the Bureau of Hearings and Appeals (33 Pa.B. 3053 (June 28, 2003)), or in any regulations that supersede the Standing Practice Order.

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