

CHAPTER 1189. COUNTY NURSING FACILITY SERVICES

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Authority

The provisions of this Chapter 1189 issued under sections 201(2), 206(2), 403(b) and 443.1(5) of the Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1(5)(iii)), unless otherwise noted.

Source

The provisions of this Chapter 1189 adopted June 23, 2006, effective July 1, 2006, 36 Pa.B. 3207, unless otherwise noted.

Cross References

This chapter cited in 55 Pa. Code § 1187.1 (relating to policy).

Subchapter A. GENERAL PROVISIONS

Sec.	
1189.1.	Policy.
1189.2.	Definitions.
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§ 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).

Cross References

This section cited in 55 Pa. Code § 1189.71 (relating to cost reporting).

§ 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—

(i) One of the following:

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

(B) 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.

(ii) For the purposes of this definition, “controlled” in clause (B) means the power to direct or cause to direct the management and policies of the nursing facility, whether through equitable ownership of voting securities or otherwise.

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.

Authority

The provisions of this § 1189.2 amended under sections 201(2), 206(2), 403(b) and 443.1 of the Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1).

Source

The provisions of this § 1189.2 amended July 18, 2014, effective July 19, 2014, 44 Pa.B. 4498. Immediately preceding text appears at serial page (361700).

§ 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 (relating 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(b) (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).

(6) Subchapter L (relating to nursing facility participation requirements and review process).

(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.

Source

The provisions of this § 1189.3 amended June 29, 2012, effective June 30, 2012, 42 Pa.B. 3733. Immediately preceding text appears at serial pages (353364) and (32079).

Subchapter B. ALLOWABLE PROGRAM COSTS AND POLICIES

Sec.

1189.51. Allowable costs.

1189.52. Allocating cost centers.

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

1189.54. Costs of related parties.

1189.55. Prudent buyer concept.

§ 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.

1189.72. Cost reporting for Medicare Part B type services.

1189.73. Accountability requirements related to resident personal fund management.

1189.74. Auditing requirements related to resident personal fund management.

1189.75. Auditing requirements related to MA cost report.

§ 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.

1189.102. Utilizing Medicare as a resource.

1189.103. Limitations on payment for reserved beds.

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

1189.105. Incentive payments.

1189.106. Adjustments relating to sanctions and fines.

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

1189.108. County nursing facility supplementation payments.

§ 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).

Cross References

This section cited in 55 Pa. Code § 1189.72 (relating to cost reporting for Medicare Part B type services).

§ 1189.103. Limitations on payment for reserved beds.

(a) A county facility may be eligible for payments 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.

(b) 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) A county nursing facility's overall occupancy must meet the occupancy requirements in this subparagraph. For each rate quarter, the criteria for meeting the overall occupancy limits will be calculated and applied to the rate quarter based on the highest of the overall occupancy calculated for three picture dates. The three picture dates will be the picture date for the current rate quarter (July 1 rate quarter—February 1 picture date; October 1 rate quarter—May 1 picture date; January 1 rate quarter—August 1 picture date; and April 1 rate quarter—November 1 picture date) and the two picture dates directly preceding this picture date. Overall occupancy for each picture date will be calculated by dividing the total number of assessments listed in the facility's CMI report for the picture date by the number of the facility's certified beds on file with the Department on the picture date. The highest of the results will be used to determine whether the county nursing facility meets the overall occupancy criteria set forth as follows:

(A) During rate year 2009-2010, the county nursing facility's overall occupancy rate for the rate quarter in which the hospital reserved bed day occurred must be equal or exceed 75%.

(B) Beginning with rate year 2010-2011 and thereafter, the county nursing facility's overall occupancy rate for the rate quarter in which the hospital reserved bed day occurs must equal or exceed 85%.

(iii) County nursing facilities not submitting a valid CMI report for the three picture dates do not meet the criteria for payment for reserved bed days, unless subparagraph (iv) applies.

(iv) New county nursing facilities are eligible for payment for reserved bed days as set forth in subparagraph (i) until CMI Reports for the three picture dates used to calculate overall occupancy as set forth in subparagraph (ii) are available for the rate quarter.

(v) If the resident's hospital stay exceeds 15 consecutive days, the county nursing facility shall readmit the resident to the 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.

(vi) If the resident's hospital stay is less than or equal to 15 consecutive days, the county nursing facility shall readmit the resident to the same bed the resident occupied before the hospital stay regardless whether the county nursing facility is eligible for payment for hospital reserved beds under subparagraph (b)(1)(ii), if, at the time of readmission, the resident requires the services provided by the nursing facility.

(vii) Hospital reserved bed days may not be billed as therapeutic leave days and may not be billed to the resident if the resident's hospital stay is less than or equal to 15 consecutive days regardless whether the county nursing facility is eligible for payment for hospital reserved beds under subparagraph (b)(1)(ii).

(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.

Source

The provisions of this § 1189.103 amended November 26, 2010, effective November 27, 2010, 40 Pa.B. 6782. Immediately preceding text appears at serial page (320685).

§ 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 ser-

vices. 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:

	<i>Overall Occupancy</i>	<i>MA Occupancy (y)</i>	<i>Per Diem Incentive</i>
Group A	90%	$\geq 90\% y$	\$3.32
Group B	90%	$88\% \leq y < 90\%$	\$2.25
Group C	90%	$86\% \leq y < 88\%$	\$1.34
Group D	90%	$84\% \leq y < 86\%$	\$0.81
Group E	90%	$82\% \leq y < 84\%$	\$0.41
Group F	90%	$80\% \leq y < 82\%$	\$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 in accordance with the formula and qualifying criteria in the Commonwealth's approved State Plan. For pay for performance payment periods beginning on or after July 1, 2010, in determining whether a county nursing facility qualifies for a quarterly pay for performance incentive, the facility's MA CMI for a picture date will equal the arithmetic mean of the individual CMIs for MA residents identified in the facility's CMI report for the picture date. An MA resident's CMI will be calculated using the RUG-III version 5.12 44 group values in Chapter 1187, Appendix A (relating to resource utilization group index scores for case-mix adjustment in the nursing facility reimbursement system) and the most recent classifiable assessment of any type for the resident.

(c) *Supplemental ventilator care and tracheostomy care payments.*

(1) *Supplemental ventilator care payments.*

(i) A supplemental ventilator care payment will be made each calendar quarter, effective July 1, 2012, through June 30, 2014, to county nursing facilities subject to the following:

(A) To qualify for the supplemental ventilator care payment, the county nursing facility shall satisfy both of the following threshold criteria on the applicable picture date:

(I) The county nursing facility shall have a minimum of ten MA-recipient residents who receive medically necessary ventilator care.

(II) The county nursing facility shall have a minimum of 10% of its MA-recipient resident population receiving medically necessary ventilator care.

(B) For purposes of subparagraph (i), the percentage of the county nursing facility's MA-recipient residents who require medically necessary ventilator care will be calculated by dividing the total number of MA-recipient residents who receive medically necessary ventilator care by the total number of MA-recipient residents as described in subparagraph (ii)(A). The result of this calculation will be rounded to two percentage decimal points. (For example, 0.0945 will be rounded to 0.09 (or 9%); 0.1262 will be rounded to 0.13 (or 13%).)

(C) To qualify as an MA-recipient resident who receives medically necessary ventilator care, the resident shall be listed as an MA resident and have a positive response for the MDS item for ventilator use on the Federally-approved PA-specific MDS assessment listed on the county nursing facility's CMI report for the applicable picture date.

(D) The number of total MA-recipient residents is the number of MA-recipient residents listed on the county nursing facility's CMI report for the applicable picture date. MA-pending individuals or those individuals found to be MA eligible after the county nursing facility submits a valid CMI report for the picture date as provided under § 1187.33(a)(5) (relating to resident data and picture date reporting requirements) may not be included in the count and may not result in an adjustment of the percent of ventilator dependent MA residents.

(E) The applicable picture dates and the authorization of a quarterly supplemental ventilator care payment are as follows:

<i>Picture Dates</i>	<i>Authorization Schedule</i>
February 1	September
May 1	December
August 1	March
November 1	June

(F) If a county nursing facility fails to submit a valid CMI report for the picture date as provided under § 1187.33(a)(5), the facility cannot qualify for a supplemental ventilator care payment.

(ii) A county nursing facility's supplemental ventilator care payment is calculated as follows:

(A) The supplemental ventilator care per diem is ((number of MA-recipient residents who receive medically necessary ventilator care/total MA-recipient residents) × \$69) × (the number of MA-recipient residents who receive medically necessary ventilator care/total MA-recipient residents).

(B) The amount of the total supplemental ventilator care payment is the supplemental ventilator care per diem multiplied by the number of paid MA facility and therapeutic leave days.

(2) *Supplemental ventilator care and tracheostomy care payment.*

(i) A supplemental ventilator care and tracheostomy care payment will be made each calendar quarter, effective July 1, 2014, to county nursing facilities subject to the following:

(A) To qualify for the supplemental ventilator care and tracheostomy care payment, the county nursing facility shall satisfy both of the following threshold criteria on the applicable picture date:

(I) The county nursing facility shall have a minimum of ten MA-recipient residents who receive medically necessary ventilator care or tracheostomy care.

(II) The county nursing facility shall have a minimum of 10% of its MA-recipient resident population receiving medically necessary ventilator care or tracheostomy care.

(B) For purposes of subparagraph (i), the percentage of the county nursing facility's MA-recipient residents who require medically necessary ventilator care or tracheostomy care will be calculated by dividing the total number of MA-recipient residents who receive medically necessary ventilator care or tracheostomy care by the total number of MA-recipient residents as described in subparagraph (ii)(A). The result of this calculation will be rounded to two percentage decimal points. (For example, 0.0945 will be rounded to 0.09 (or 9%); 0.1262 will be rounded to 0.13 (or 13%.))

(C) To qualify as an MA-recipient resident who receives medically necessary ventilator care or tracheostomy care, the resident shall be listed as an MA resident and have a positive response for the MDS item for ventilator use or tracheostomy care on the Federally-approved PA-specific MDS assessment listed on the county nursing facility's CMI report for the applicable picture date.

(D) The number of total MA-recipient residents is the number of MA-recipient residents listed on the county nursing facility's CMI report for the applicable picture date. MA-pending individuals or those individuals found to be MA eligible after the county nursing facility submits a valid CMI report for the picture date as provided under § 1187.33(a)(5) may not be included in the count and may not result in an adjustment of the percent of ventilator dependent or tracheostomy care MA residents.

(E) The applicable picture dates and the authorization of a quarterly supplemental ventilator care and tracheostomy care payment are as follows:

<i>Picture Dates</i>	<i>Authorization Schedule</i>
February 1	September
May 1	December
August 1	March
November 1	June

(F) If a county nursing facility fails to submit a valid CMI report for the picture date as provided under § 1187.33(a)(5), the facility cannot qualify for a supplemental ventilator care and tracheostomy care payment.

(ii) A county nursing facility's supplemental ventilator care and tracheostomy care payment is calculated as follows:

(A) The supplemental ventilator care and tracheostomy care per diem is ((number of MA-recipient residents who receive medically necessary ventilator care or tracheostomy care/total MA-recipient residents) × \$69) × (the number of MA-recipient residents who receive medically necessary ventilator care or tracheostomy care/total MA-recipient residents).

(B) The amount of the total supplemental ventilator care and tracheostomy care payment is the supplemental ventilator care and tracheostomy care per diem multiplied by the number of paid MA facility and therapeutic leave days.

(3) *Waiver to 180-day billing requirement.* If the Department grants a county nursing facility a waiver to the 180-day billing requirement, the MA-paid days that may be billed under the waiver and after the authorization date of the waiver will not be included in the calculation of the supplemental ventilator care payment under paragraph (1)(ii) or the supplemental ventilator care and tracheostomy care payment under paragraph (2)(ii). The Department will not retroactively revise the supplemental payment amount under paragraphs (1) and (2).

(4) *Calculation of quarterly payments.* The paid MA facility and therapeutic leave days used to calculate a qualifying facility's supplemental ventilator care or supplemental ventilator care and tracheostomy care payments under paragraphs (1)(ii) and (2)(ii) will be obtained from the calendar quarter that contains the picture date used in the qualifying criteria as described in paragraphs (1) and (2).

(5) *Quarterly payments.* The supplemental ventilator care or supplemental ventilator care and tracheostomy care payments will be made quarterly in each month listed in paragraphs (1) and (2).

Authority

The provisions of this § 1189.105 amended under sections 201(2), 206(2), 403(b) and 443.1 of the Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1).

Source

The provisions of this § 1189.105 amended August 26, 2011, effective retroactive to July 1, 2010, 41 Pa.B. 4630; amended June 13, 2014, section 1189(c)(1) shall take effect upon publication and apply retroactively from July 1, 2012, through June 30, 2014, section 1189.105(c)(3)—(5) shall take effect upon publication and apply retroactively from July 1, 2012, section 1189.105(c)(2) takes effect July 1, 2014, 44 Pa.B. 3565. Immediately preceding text appears at serial pages (358397) and (358398).

§ 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 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.

Cross References

This section cited in 55 Pa. Code § 1189.107 (relating to adjustments relating to errors and corrections of county nursing facility payments).

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