Regulatory Analysis Form

(Completed by Promulgating Agency)

IRRC

Independent Regulatory Review Commission

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SECTION I: PROFILE

(1) Agency:
Department of Public Welfare/Department of Aging
Office of Long-Term Living

(2) Agency Number:

Identification Number: 14-520

IRRC Number: 2881

(3) Short Title: Transition to RUG-III Version 5.12 and Latest Assessment

(4) PA Code Cite: 55 Pa.Code Chapters 1187 and 1189

(5) Agency Contacts (List Telephone Number, Address, Fax Number and Email Address):

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(All Comments will appear on IRRC'S website)

Regulatory Analysis Form

(7) Type of Rulemaking (check applicable box):

- ☐ Proposed Regulation
- ☒ Final Regulation
- ☐ Final Omitted Regulation
- ☐ Emergency Certification Regulation;
- ☐ Certification by the Governor
- ☐ Certification by the Attorney General

(8) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

The purpose of this final-form regulation is to change the Department's payment methodology to phase-in the use of the Resource Utilization Group III (RUG-III) classification system, version 5.12 44 Grouper, and the most recent classifiable resident assessments in determining the case-mix indices that are used in setting case-mix per diem rates for nonpublic nursing facilities and in making certain incentive payments to county nursing facilities.

(9) Include a schedule for review of the regulation including:

A. The date by which the agency must receive public comments: December 13, 2010

B. The date or dates on which public meetings or hearings will be held: _____

C. The expected date of promulgation of the proposed regulation as a final-form regulation: September 3, 2011

D. The expected effective date of the final-form regulation: July 1, 2010

E. The date by which compliance with the final-form regulation will be required: July 1, 2010

F. The date by which required permits, licenses or other approvals must be obtained: N/A

(10) Provide the schedule for continual review of the regulation.

The Department will review the regulation on an ongoing basis to ensure compliance with Federal and State law and to assess the appropriateness and effectiveness of the regulation. In addition, if specific regulatory issues are raised by members of the Medical Assistance Advisory Committee (MAAC) and the Long-Term Care Delivery System Subcommittee of the MAAC, the Department will research and address those issues as appropriate. The Department will also monitor the effect of the regulation through regular audits and utilization management reviews to determine the effectiveness of the regulation with respect to consumers of long-term care services and the industry.

SECTION II: STATEMENT OF NEED

(11) State the statutory authority for the regulation. Include specific statutory citation.

The Public Welfare Code, Act of June 13, 1967, P.L. 31, No. 21, §§ 201(2), 206(2), 403(b) and 443.1 (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1).

(12) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as, any deadlines for action.

Although this regulation is not directly mandated by Federal or State law, court order, or Federal regulation, changes made by the Centers for Medicare and Medicaid Services (CMS) make the amendments necessary. CMS developed a new version of the Minimum Data Set (MDS) resident assessment, MDS version 3.0, which all nursing facilities participating in the Medicare and/or Medicaid Program are required to use effective October 1, 2010. The MDS 3.0 does not support the version of the RUG-III classification system currently used by the Department in the nursing facility case-mix payment system to classify residents into groups and assign a CMI score. Therefore, in order for the Department to assess a resident's acuity for use in the case-mix payment system and for use in making certain county nursing facility incentive payments (pay for performance (P4P) payments), the Department must use the newer version of the RUG-III classification system.

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(13) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

This final-form regulation is needed to modify the version of the RUG-III classification system used by the Department in the case-mix payment system and in making county nursing facility P4P payments as a result of CMS's adoption of MDS 3.0, effective October 1, 2010. In addition, the regulation will allow the use of a more timely measurement of a nursing facility resident's care needs by adopting the most recent classifiable resident assessment of any type when classifying residents into groups and assigning a CMI score. Using the most recent classifiable resident assessment of any type for each nursing facility resident will enable the Department to make acuity adjustments and P4P payments using the most up-to-date resident data available without any additional administrative burdens or costs to either the nursing facilities or the Department.

This final-form regulation is consistent with the Department's ongoing efforts to ensure that Medical Assistance (MA) recipients continue to receive access to medically necessary nursing facility services while encouraging MA nursing facility efficiency and economy.

There are approximately 593 nonpublic nursing facilities and 32 county nursing facilities in Pennsylvania enrolled in the MA Program. There are approximately 48,558 MA recipients currently residing in those nursing facilities and an average of 56,498 MA recipients who receive nursing facility services in a typical year.

(14) If scientific data, studies, references are used to justify this regulation, please submit material with the regulatory package. Please provide full citation and/or links to internet source.

There were no scientific data, studies, or references used.

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(15) Describe who and how many will be adversely affected by the regulation. How are they affected?

The Department recognizes that an immediate change to the new RUG-III version and to the use of the most recent classifiable resident assessment of any type may cause a reduction in per diem rates for some nonpublic nursing facilities. Therefore, to mitigate any adverse impact these amendments may have on nonpublic nursing facilities the regulation establishes a 3-year phase-in for the transition to the RUG-III v. 5.12 44 Grouper and the use of the most recent classifiable resident assessment of any type, for rate setting periods beginning July 1, 2010, and ending June 30, 2013. Phasing-in these amendments will provide nonpublic nursing facilities the opportunity to gain competency using MDS 3.0 and become familiar with the new RUG-III Grouper and resident assessment selection process.

Since county nursing facility MA CMIs are used only for the purpose of making P4P payments, the regulation does not provide for a phase-in of the proposed changes as it relates to these payments.

(16) List the persons, groups or entities that will be required to comply with the regulation. Approximate the number of people who will be required to comply.

This final-form regulation will affect all nonpublic nursing facilities participating in the MA Program and all county nursing facilities enrolled in the MA Program that qualify for P4P payments. There are approximately 593 nonpublic nursing facilities and 32 county nursing facilities in the Commonwealth enrolled in the MA Program.

SECTION III: COST AND IMPACT ANALYSIS

(17) Provide a specific estimate of the costs and/or savings to the **regulated community** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

There are no new costs or savings to the regulated community associated with the implementation of this final-form regulation for Fiscal Year (FY) 2010-2011. Act 44 of 2007 directs the Department to apply a budget adjustment factor (BAF) in the calculation of rates for nonpublic and county nursing facilities through FY 2010-2011. The application of a BAF in the nursing facility rate setting process assures that nursing facility payment rates are limited to the percentage rate of increase permitted by the funds appropriated by the General Assembly.

The fiscal impact will remain budget neutral as long as the BAF is reauthorized. The fiscal impact after 2010-2011 makes the assumption that the BAF is not reauthorized beyond June 30, 2011. The implication of the change of the 5.12 is that nursing facilities' rates would be reduced by approximately $166.912 million ($74.994 million in state funds) on an annual basis.

(18) Provide a specific estimate of the costs and/or savings to **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

Not applicable.

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(19) Provide a specific estimate of the costs and/or savings to **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

There are no new costs or savings to state government associated with the implementation of this final-form regulation for FY 2010-2011. Act 44 of 2007 directs the Department to apply a BAF in the calculation of rates for nonpublic and county nursing facilities through FY 2010-2011. The application of a BAF in the nursing facility rate setting process assures that nursing facility payment rates are limited to the percentage rate of increase permitted by the funds appropriated by the General Assembly.

The fiscal impact will remain budget neutral as long as the BAF is reauthorized. The fiscal impact after 2010-2011 makes the assumption that the BAF is not reauthorized beyond June 30, 2011. The implication of the change of the 5.12 is that nursing facilities' rates would be reduced by approximately $166.912 million ($74.994 million in state funds) on an annual basis.

David Lyttle 4/13/11

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(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community						
Local Government						
State Government	$0	$37,497	$56,245	$74,994	$74,994	$74,994
Total Savings	$0	$37,497	$56,245	$74,994	$74,994	$74,994
COSTS:						
Regulated Community						
Local Government						
State Government						
Total Costs	$0	$0	$0	$0	$0	$0
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses	$0	$0	$0	$0	$0	$0

(20a) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY
Long-Term Care	692,585	672,597	540,266	713,831

(21) Explain how the benefits of the regulation outweigh any cost and adverse effects.

This final-form regulation will benefit the Commonwealth's MA nursing facility residents by assuring they will continue to have access to medically necessary nursing facility services while providing for reasonable and adequate payment rates to MA nursing facility providers consistent with the fiscal resources of the Commonwealth.

(22) Describe the communications with and input from the public and any advisory council/group in the development and drafting of the regulation. List the specific persons and/or groups who were involved.

On August 13, 2009, the Department met with representatives of the Pennsylvania Association of County Affiliated Homes, PANPHA, the Pennsylvania Health Care Association (PHCA) and the Hospital and Healthsystems Association of Pennsylvania to discuss the implications of CMS's move from MDS 2.0 to MDS 3.0. At that meeting, the associations agreed to the RUG-III v. 5.12 and suggested a 3-year phase-in. In addition, interactive rate models for two fiscal periods were provided to these same representatives in order to provide impact analysis on a facility-by-facility basis.

On September 22, 2009, a letter was sent to each nonpublic nursing facility with information identifying the Department's proposed changes to the rate setting methodology. This letter included nonpublic nursing facility specific shadow rates for the 2008-2009 rate year. The Department responded to individual nursing facility questions and had posted a Question & Answer section on the Department's website. In November of 2009, the Department held four provider meetings across the state to discuss various topics of interest which included the changes needed to best accommodate CMS's change.

Ongoing discussions continued with representatives from PHCA and PANPHA during the remainder of calendar year 2009 and the first 6 months of 2010. During these discussions, final agreement was reached regarding the use of the RUG III v. 5.12 44 Grouper, the adoption of the latest resident assessment of any type and the implementation of a 3 year phase-in related to these provisions.

A public notice was published in the *Pennsylvania Bulletin* at 40 Pa.B. 3627 (June 26, 2010) with a 30-day comment period. No comments were received. The proposed regulations were published in the *Pennsylvania Bulletin* at 40 Pa.B. 6525 (November 13, 2010). During the 30-day comment period, one comment was received from PANPHA which was generally supportive of using the RUG III v. 5.12 44 Grouper and the most recent assessment for rate-setting.

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(23) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

Although alternative resident classification methodologies were modeled, no alternative regulatory provisions were developed.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

There are no provisions that are more stringent than Federal law.

(25) How does this regulation compare with those of other states? How will this affect Pennsylvania's ability to compete with other states?

This final-form regulation is consistent with the Department's ongoing efforts to ensure that MA recipients continue to receive access to medically necessary nursing facility services. This regulation will not put Pennsylvania at a competitive disadvantage. In fact, Pennsylvania is only one of two states that still used the RUG-III v. 5.01 in its payment system, and CMS stated that it will no longer support this version of RUG-III with the implementation of MDS 3.0.

(26) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

This final-form regulation will not affect existing or proposed regulations of the Department or other state agencies.

(27) Submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

No new reports, forms, recordkeeping or paperwork are required by this regulation.

(28) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

The final-form regulation includes provisions for a 3-year phase-in for the transition to the RUG-III v. 5.12 44 Grouper and the latest classifiable resident assessment of any type. This phase-in will provide nonpublic nursing facilities with the opportunity to gain competency using the MDS 3.0 and become familiar with the new RUG-III Grouper and resident assessment selection process.

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FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

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Copy below is hereby approved as to form and legality. Attorney General	Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:	Copy below is hereby approved as to form and legality. Executive or Independent Agencies.
By: _____ (Deputy Attorney General)	DEPARTMENT OF PUBLIC WELFARE (Agency)	BY: _____ Andrew G. Clark JUN 13 2011
_____ Date of Approval	LEGAL COUNSEL: _____	_____ Date of Approval
	DOCUMENT/FISCAL NOTE NO. 14-520	(Deputy General Counsel) ~~(Chief Counsel, Independent Agency)~~ ~~(Strike inapplicable title)~~
☐ Check if applicable Copy not approved. Objections attached.	DATE OF ADOPTION: _____	☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.
	BY: _____	
	TITLE: SECRETARY OF PUBLIC WELFARE (Executive Officer, Chairman or Secretary)	

NOTICE OF FINAL-FORM RULEMAKING

DEPARTMENT OF PUBLIC WELFARE

OFFICE OF LONG-TERM LIVING

[55 Pa.Code Chapter 1187 Nursing Facility Services]
[55 Pa.Code Chapter 1189 County Nursing Facility Services]

Transition to RUG-III Version 5.12 and Latest Assessment

Statutory Authority

The Department of Public Welfare (Department) by this order, adopts the regulations set forth in Annex A pursuant to the authority of 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). Notice of proposed rulemaking was published at 40 Pa.B. 6525 on November 13, 2010.

Purpose of Regulation

The purpose of this regulation is to amend the payment methodology for Medical Assistance (MA) nursing facility services to phase-in the use of the Resource Utilization Group III (RUG-III) classification system, version (v.) 5.12 44 Grouper, and the most recent classifiable resident assessments in determining the case-mix indices that are used in setting case-mix per diem rates for nonpublic nursing facilities and in making certain incentive payments to county nursing facilities.

This regulation is needed to modify the version of the RUG-III classification system used by the Department in the case-mix payment system and in making county nursing facility pay for performance (P4P) payments as a result of the implementation of Minimum Data Set (MDS) 3.0 by Centers for Medicare and Medicaid Services (CMS), effective October 1, 2010. In addition, the regulation will permit the Department to use a more timely measurement of a nursing facility resident's care needs, by permitting the use of the most recent classifiable resident assessment of any type when classifying residents into groups and assigning a Case-Mix Index (CMI) score. The proposed rulemaking, published at 40 Pa.B. 6525 on November 13, 2010, stated the Department

would use the most recent resident assessment of any type. However, the Department has found that not all resident assessments are classifiable under MDS 3.0 as they were under MDS 2.0; therefore, the Department will use the most recent classifiable resident assessment of any type.

The following is a summary of the major provisions in the final-form rulemaking:

§§ 1187.2 and 1187.33 (relating to definitions; and resident data and picture date reporting requirements)—Resident assessment

The Department revised the definition of "resident assessment" in § 1187.2 by removing the term "comprehensive" from the definition, and amended § 1187.33(a)(6) (relating to resident data and picture date reporting requirements) by removing the language related to Medicare assessments.

Nursing facilities are required to conduct and electronically submit assessments other than "comprehensive assessments" for their residents. These assessments contain all MDS data elements needed to calculate each resident's RUG category and CMI score. When these assessments are completed after the latest comprehensive assessment, they provide more current information on a resident's condition and care needs than the resident's "comprehensive assessment."

The Department determines the RUG category and CMI score for each nursing facility resident using the assessment data from the resident's most recent comprehensive MDS assessment as submitted by the nursing facility. Using the CMI scores calculated for each resident, the Department calculates a total facility CMI score, and a facility MA CMI score for each nursing facility and a Statewide average MA CMI score.

Rather than continuing to use older assessment data to determine a resident's RUG category and CMI score, the Department is amending its regulations to require use of the most recent classifiable assessment of any type for each resident, whether the assessment is comprehensive, effective July 1, 2010. This change will enable the Department to make acuity adjustments and P4P payments using the most up-to-date resident data available without additional administrative burdens or costs to either nursing facilities or the Department.

The CMI scores will be used to calculate the total facility CMIs and the MA CMIs for setting nonpublic nursing facility rates effective on and after July 1, 2010. In addition, the CMI scores will be used in determining which county nursing facilities are eligible to receive P4P payments beginning with the July 1 – September 30, 2010, P4P payment period.

§ 1187.93 and Chapter 1187, Appendix A (relating to CMI calculations; and resource utilization group index scores for case-mix adjustment in the nursing facility reimbursement system)—Case-mix classification tool

CMS developed a new version of the MDS resident assessment, MDS 3.0, which nursing facilities participating in the Medicare or MA Program, or both, were required to use effective October 1, 2010. The new version of the MDS has been designed to improve the reliability, accuracy and usefulness of the assessment tool, to include the resident in the assessment process and to incorporate the use of standard protocols used in other health care settings. According to CMS, the enhanced accuracy of the MDS 3.0 will improve clinical assessments and bolster programs that rely on the MDS for assessing the needs of consumers.

The MDS 3.0 assessment does not contain all the elements necessary for resident classification with the RUG-III v. 5.01 44 Grouper, which has been used to set nonpublic nursing facility rates since January 1, 1996. CMS no longer supports this Grouper with implementation of MDS 3.0. The Department changed the Grouper used in determining nursing facility residents' CMI scores effective for rate setting periods on and after July 1, 2010, to the RUG-III v. 5.12 44 Grouper. This RUG-III version, which is compatible with the MDS 3.0, is based on updated time studies conducted in 1995 and 1997 and reflects changes in nursing facility resident conditions and care since the original studies conducted in 1990. The combination of the use of the latest classifiable assessment to more accurately measure current resident acuity and a classification system based on more recent time studies will result in better distribution of scarce MA resources.

The Department amended § 1187.93 and updated Chapter 1187, Appendix A to reflect both the associated Nursing Only CMI scores established by CMS for the RUG-III v. 5.12 44 Grouper classification system and the CMI scores normalized for nursing facilities in this Commonwealth. Normalization of CMI scores is a common process used by states when implementing a RUG-III based case-mix payment system or when changing to a new RUG version. Scores are normalized so that the average statewide CMI score equals 1.00. The normalized CMI scores the Department will use range from 0.48 to 1.75.

The Department will use the RUG-III v. 5.12 44 Grouper classification system in determining the CMIs of residents of both nonpublic and county nursing facilities. The CMI scores will be used to calculate the total facility CMIs and the MA CMIs used in setting nonpublic nursing facility rates effective on and after July 1, 2010. In addition, the CMI scores are used in determining which county nursing facilities are eligible to receive P4P payments beginning with the July 1 – September 30, 2010 P4P payment period. The CMIs include the February 1, 2010, picture date total facility CMI and MA CMI; the total facility CMI for the February 1 picture dates from all of the cost report periods of the MA cost reports used in the July 1, 2010, rate setting database; the MA CMIs from the May 1, 2010, picture date, the August 1, 2010, picture date, the November 1, 2010, picture date; and the total facility CMIs and MA CMIs for all subsequent picture dates.

§ 1187.96 (relating to price- and rate-setting compu- tations)—Phase-In—RUG-III v. 5.12 44 Grouper and the most recent resident assessment

The Department recognizes that the change in RUG-III Grouper and use of the most recent classifiable resident assessment of any type may cause a reduction in per diem rates for some nonpublic nursing facilities. Because there may be an adverse impact on nonpublic nursing facilities, the Department is applying a 3-year phase-in for the transition to the RUG-III v. 5.12 44 Grouper and the use of the most recent classifiable resident assessment, for rate setting periods beginning July 1, 2010, and ending June 30, 2013. Phasing in the amendments provides nursing facilities the opportunity to gain competency using MDS 3.0 and become familiar with the new RUG-III Grouper and resident assessment selection process. The Department amended §1187.96 to specify that for July 1, 2010, through June 30, 2013, unless the nursing facility is a new facility, the resident care rate that the Department will use to establish a nursing facility's case-mix per diem rate will be a blended resident care rate that will consist of a portion of a 5.01 resident care rate and a portion of a 5.12 resident care rate.

A phase-in provision, however, will not be applied to new nonpublic nursing facilities since the phase-in period is for a transition from one system to another. Therefore, the Department amended §1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities) to specify that new facilities will be assigned a Statewide average MA CMI calculated using the RUG-III v. 5.12 44 group

values in Chapter 1187, Appendix A and the most recent classifiable assessments. When a new nursing facility's assessment data is used in a rate determination the CMI values used to determine the new nursing facility's total facility CMIs and MA CMIs will be the RUG-III v. 5.12 44 group values in Chapter 1187, Appendix A and the most recent classifiable assessment.

§ 1189.105 (relating to incentive payments)—County nursing facilities—P4P Payments

The Department calculates MA CMI scores for county nursing facilities and uses the scores in determining which county nursing facilities are eligible to receive quarterly P4P payments. To be eligible for a P4P payment, a county nursing facility must meet the definition of a "county nursing facility" at the time the quarterly P4P payment is being made. In addition, the county nursing facility's MA CMI for a picture date must be higher than the facility's MA CMI for the previous picture date. Since county nursing facility MA CMIs are used only for this limited purpose, the Department will not provide for a phase-in of the changes. The Department amended § 1189.105 to specify, that, in determining whether a county nursing facility qualifies for a quarterly P4P incentive for P4P periods beginning on and after July 1, 2010, the facility's MA CMI for a picture date equals the arithmetic mean of the individual CMIs for MA residents identified in the facility's CMI report for the picture date, and an MA resident's CMI is calculated using the RUG-III v. 5.12 44 group values in Chapter 1187, Appendix A and the most recent classifiable assessment of any type for the resident.

Affected Individuals and Organizations

This final-form rulemaking affects all nonpublic nursing facilities enrolled in the MA Program and county nursing facilities that seek to qualify for P4P payments under §1189.105(b) (relating to incentive payments).

Accomplishments and Benefits

This final-form rulemaking benefits this Commonwealth's MA nursing facility residents by assuring they will continue to have access to medically necessary nursing facility services while providing for reasonable and adequate payments to MA nursing facility providers consistent with the fiscal resources of this Commonwealth.

Fiscal Impact

There is no fiscal impact for Fiscal Year (FY) 2010-2011. The fiscal impact will remain budget neutral as long as the budget adjustment factor (BAF) is reauthorized. The fiscal impact after 2010-2011 makes the assumption that the BAF is not reauthorized beyond June 30, 2011. The implication of the change of the 5.12 is that nursing facilities' rates would be reduced by approximately $166.912 million ($74.994 million in state funds) on an annual basis.

Paperwork Requirements

There are no new or additional paperwork requirements.

Public Comment

The Department received one public comment letter from PANPHA, an association of Pennsylvania nonprofit aging services providers. The Independent Regulatory Review Commission (IRRC) also commented on the proposed rulemaking.

Discussion of Comments and Major Changes

Following is a summary of the comments received during the public comment period following publication of the proposed rulemaking and the Department's responses to those comments. A summary of major changes from proposed rulemaking is also included.

General – Use of RUG-III v. 5.12 44 Grouper and Most Recent Assessment.

PANPHA is generally supportive of using the RUG-III v. 5.12 44 Grouper and the most recent assessment for rate-setting to better align resources with the most recently available data. PANPHA commented that while this change may have a negative short-term effect on some nursing facilities, residents should ultimately benefit by more accurately measuring resident acuity and, therefore, better reflect the needs and necessary resources than the current regulations.

Response

The Department recognizes that with almost 600 nonpublic nursing facilities enrolled in the MA Program, these changes may have a negative short-term effect on some nursing facilities. However, the 3-year phase-in, suggested by the industry, for the transition to the RUG-III v. 5.12 44 Grouper and the use of the most recent classifiable resident assessment, should mitigate any adverse effect and provide nursing facilities the opportunity to gain competency using MDS 3.0 and become familiar with the new RUG-III Grouper and resident assessment selection process. Moreover, the combination of the use of the latest assessment to more accurately measure current resident acuity and a classification system based on more recent time studies will ultimately result in better distribution of the scarce MA resources.

General – Phasing-in Reimbursement Changes.

PANPHA also supports the concept of phasing-in the reimbursement changes. However, PANPHA asked that the Department and stakeholders continue to monitor and address the effects of the new system and the phase-in to determine if any of these components cause a degree of variability that is too unpredictable for effective operation of facilities or that cause other unanticipated adverse effects.

Response

The Department will review the regulation on an ongoing basis to ensure compliance with Federal and State law and to assess the appropriateness and

effectiveness of the regulation. In addition, if specific regulatory issues are raised by members of the Medical Assistance Advisory Committee (MAAC) and the Long-Term Care Delivery System Subcommittee of the MAAC, those issues will be researched and addressed as needed. The Department will also monitor the impact of the regulation through regular audits and utilization management reviews to determine the effectiveness of the regulation with respect to consumers of long-term care services and the industry.

§§ 1187.93, 1187.96, 1187.97, Appendix A, §1189.105 – Implementation Procedures.

IRRC asked that the Department clarify how the new rates will occur retroactive to July 1, 2010.

Response

Currently, nonpublic nursing facilities enrolled in the MA program are being paid at their respective April 1, 2010 rates. The Department submitted a State Plan Amendment (SPA) to CMS to phase-in the use of the most recent classifiable resident assessments and the RUG-III classification system v. 5.12 44 Grouper in determining nursing facility residents' CMIs used in setting case-mix per diem rates for nonpublic nursing facilities and in making P4P incentive payments to county nursing facilities. The SPA was approved by CMS on October 27, 2010. Once this final-form rulemaking is promulgated, the Department will prepare rate adjustments retroactive to July 1, 2010 – under §§ 1187.96, and 1187.97. A rate adjustment schedule will be sent by e-mail to

the nursing facility providers and nursing facility associations and will be posted to the Department's website. In addition, files will be created for the time periods (quarters) to be adjusted and will be loaded into PROMISe (claims processing system). Based on these files, a remittance advice will be generated for each nursing facility provider and the Treasury Department will generate the appropriate payment to the nursing facility providers.

No retroactive payments will be made to county nursing facilities as a result of these regulations. Under the existing regulations at § 1189.105(b), incentive payments are made in accordance with the formula and qualifying criteria set forth in the Commonwealth's State Plan. The Department submitted a SPA containing the formula as provided in the amended § 1189.105(b). This SPA was approved by CMS on October 27, 2010. Therefore, payments were made in accordance with the approved State Plan and retroactive payments are not necessary.

Additional Changes

As previously stated, the Department has found that not all resident assessments are classifiable under MDS 3.0 as they were under MDS 2.0. Therefore, the Department changed the language to "the most recent classifiable resident assessment of any type". In addition, the Department made a correction to § 1187.97 (1)(i)(A). This clause incorrectly cited § 1187.96 (s)(5) instead of § 1187.96 (a)(5). The Department also eliminated the numbering in § 1189.105 (b) to clarify that the items are not mutually

exclusive and the pay for performance incentive payment is dependent upon an approved state plan.

Regulatory Review Act

Under § 5.1(a) of the Regulatory Review Act (71 P.S. § 745.5a(a)), on JUN 16 2011, the Department submitted a copy of this regulation to the IRRC and to the Chairpersons of the House Committee on Human Services and the Senate Committee on Public Health and Welfare. In compliance with the Regulatory Review Act the Department also provided the Committees and the IRRC with copies of all public comments received, as well as other documentation.

In preparing the final-form regulation, the Department reviewed and considered comments received from the Committees, the IRRC and the public.

In accordance with § 5.1 (j.1) and (j.2) of the Regulatory Review Act, this regulation was approved by the Committees on . The IRRC met on and approved the regulation.

In addition to submitting the final-form rulemaking, the Department has provided the IRRC and the Committees with a copy of a Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

Order

The Department finds:

(a) The public notice of intention to amend the administrative regulation by this Order has been given pursuant to §§ 201 and 202 of the Commonwealth Documents Law (45 P.S. §§ 1201 and 1202) and the regulations at 1 Pa.Code §§ 7.1 and 7.2.

(b) That the adoption of this regulation in the manner provided by this Order is necessary and appropriate for the administration and enforcement of the Public Welfare Code.

The Department acting pursuant to Public Welfare Code (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1) orders:

(a) The regulation of the Department is amended to read as set forth in Annex A of this Order.

(b) The Secretary of the Department shall submit this Order and Annex A to the Offices of General Counsel and Attorney General 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 retroactive to July 1, 2010.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1187. NURSING FACILITY SERVICES

Subchapter A. GENERAL PROVISIONS

§ 1187.2. Definitions.

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

* * * * *

Federally Approved Pennsylvania (PA) Specific Minimum Data Set (MDS)—[One of three components of the Federally designed Resident Assessment Instrument (RAI). The RAI includes the MDS, the Resident Assessment Protocols and Utilization Guidelines. The MDS is a] A minimum core of assessment items with definitions and coding categories needed to comprehensively assess a nursing facility resident.

* * * * *

Preadmission screening and [annual] *resident review*—The preadmission screening process that identifies target residents regardless of their payment source; and the [annual] resident review process that reviews target residents to determine the continued need for nursing facility services and the need for specialized services.

* * * * *

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

* * * * *

Subchapter D. DATA REQUIREMENTS FOR NURSING FACILITY APPLICANTS AND RESIDENTS

§ 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:

* * * * *

(6) The CMI report [shall] 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.]

* * * * *

Subchapter G. RATE SETTING

§ 1187.93. CMI calculations.

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

* * * * *

(4) Picture dates that are used for rate setting beginning July 1, 2010, and thereafter will be calculated based on the RUG versions and CMIs set forth in Appendix A.

§ 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.

* * * * *

(6) For rate years 2010-2011, 2011-2012 and 2012-2013, unless the nursing facility is a new nursing facility, the resident care rate used to establish the nursing facility's case-mix per diem rate will be a blended resident care rate.

(i) The nursing facility's blended resident care rate for the 2010-2011 rate year will equal 75% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (iv) plus 25% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (iv).

(ii) The nursing facility's blended resident care rate for the 2011-2012 rate year will equal 50% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (v) and 50% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (v).

(iii) The nursing facility's blended resident care rate for the 2012-2013 rate year will equal 25% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (v) and 75% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (v).

(iv) For the rate year 2010-2011, each nursing facility's blended resident care rate will be determined based on the following calculations:

(A) For the first quarter of the rate year (July 1, 2010—September 30, 2010), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a 5.12 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values the Department will use to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent CLASSIFIABLE resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values the Department will use to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.01 44-group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent comprehensive resident assessment.

(III) The nursing facility's blended resident care rate for the quarter beginning July 1, 2010, and ending September 30, 2010, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.75 and the nursing facility's 5.12 resident care rate multiplied by 0.25.

(B) For the remaining 3 quarters of the 2010-2011 rate year (October 1 through December 31; January 1 through March 31; April 1 through June 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a quarterly adjusted 5.12 resident care rate for each nursing facility in accordance with paragraph (5). The CMI values used to determine each nursing facility's MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent CLASSIFIABLE resident assessment of any type.

(II) The Department will calculate a quarterly adjusted 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior quarter 5.01 resident care rate by the percentage change between the nursing facility's current quarter 5.12 resident care rate and the nursing facility's previous quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current quarter 5.12 resident care rate by the nursing facility's previous quarter 5.12 resident care rate.

(III) The nursing facility's blended resident care rate for the 3 remaining quarters of the rate year will be the sum of the nursing facility's quarterly adjusted 5.01 resident care rate multiplied by 0.75 and the nursing facility's quarterly adjusted 5.12 resident care rate multiplied by 0.25.

(v) For rate years 2011-2012 and 2012-2013, each nursing facility's blended resident care rate will be determined based on the following calculations:

(A) For the first quarter of each rate year (July 1—September 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a 5.12 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values

as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent CLASSIFIABLE resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior April 1st quarter 5.01 resident care rate by the percentage change between the nursing facility's current 5.12 resident care rate and the nursing facility's prior April 1st quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current 5.12 resident care by the nursing facility's April 1st quarter 5.12 resident care rate.

(III) The nursing facility's blended resident care rate for the quarter beginning July 1, 2011, and ending September 30, 2011, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.50 and the nursing facility's 5.12 resident care rate multiplied by 0.50.

(IV) The nursing facility's blended resident care rate for the quarter beginning July 1, 2012, and ending September 30, 2012, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.25 and the nursing facility's 5.12 resident care rate multiplied by 0.75.

(B) For the remaining 3 quarters of each rate year (October 1 through December 31; January 1 through March 31; April 1 through June 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a quarterly adjusted 5.12 resident care rate for each nursing facility in accordance with paragraph (5). The CMI values used to determine each nursing facility's MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent CLASSIFIABLE resident assessment of any type.

(II) The Department will calculate a quarterly adjusted 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior quarter 5.01 resident care rate by the percentage change between the nursing facility's current quarter 5.12 resident care rate and the nursing facility's previous quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current quarter 5.12 resident care rate by the nursing facility's previous quarter 5.12 resident care rate.

(III) For the remaining 3 quarters of rate year 2011-2012 (October 1 through December 31; January 1 through March 31; April 1 through June 30), each nursing facility's blended resident care rate will be the sum of the nursing facility's quarterly adjusted 5.01 resident care rate multiplied by 0.50 and the nursing facility's quarterly adjusted 5.12 resident care rate multiplied by 0.50.

(IV) For the remaining 3 quarters of rate year 2012-2013 (October 1 through December 31; January 1 through March 31; April 1 through June 30), each nursing facility's blended resident care rate will be the sum of the nursing facility's

quarterly adjusted 5.01 resident care rate multiplied by 0.25 and the facility's quarterly adjusted 5.12 resident care rate multiplied by 0.75.

(7) Beginning with rate year 2013-2014, and thereafter, the Department will calculate each nursing facility's resident care rate in accordance with paragraphs (1)—(5). The CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent CLASSIFIABLE resident assessment of any type.

* * * * *

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

* * * * *

(3) For rate years 2010-2011, 2011-2012 and 2012-2013, unless the nursing facility is a new nursing facility, the nursing facility per diem rate will be computed by adding the blended resident care rate, the other resident related rate, the administrative rate and the capital rate for the nursing facility.

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

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

(1) *New nursing facilities.*

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

(A) A new nursing facility, 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(s)(5)~~ 1187.96(A)(5) (relating to price- and rate-setting computations). Beginning, July 1, 2010, the Statewide average MA CMI assigned to a new nursing facility will be calculated using the RUG-III version 5.12 44 group values in Appendix A and the most recent CLASSIFIABLE assessments of any type. When a new nursing facility has submitted assessment data under § 1187.33, the CMI values used to determine the new nursing facility's total facility CMIs and MA CMI will be the RUG-III version 5.12 44 group values and the resident assessment that will be used for each resident will be the most recent CLASSIFIABLE assessment of any type.

* * * * *

(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. Beginning July 1, 2010, a new nursing facility will be assigned the peer group price for resident care that will be calculated using the RUG-III version 5.12 44 group values in Appendix A and the most recent CLASSIFIABLE assessments of any type.

* * * * *

Appendix A

Resource Utilization Group Index Scores for Case-Mix Adjustment in the Nursing Facility Reimbursement System

[The Department announces the Resource Utilization Group (RUG-III) index scores for case-mix adjustment in the nursing facility reimbursement system. The index scores shall be effective for nursing facility rates starting January 1, 1996, and these index scores will remain in effect until a subsequent notice is published in the *Pennsylvania Bulletin*.

Section 1187.92(d) (relating to resident classification system) authorizes the Department to announce these index scores by notice submitted for recommended publication in the *Pennsylvania Bulletin* and suggested codification in the *Pennsylvania Code* as Appendix A.

The National RUG-III nursing CMI scores were normalized for the average resident in a nursing facility participating in the MA Program on February 1, 1993.

The RUG-III PA normalized index scores are used to make case-mix adjustments in the computation of nursing facility rates. Subchapter G (relating to rate setting) defines the rate setting process.]

The following chart is a listing by group of the RUG-III index scores that the Department will use to set each nursing facility's 5.01 resident care rate for the quarter beginning July 1, 2010, and ending September 30, 2010, as set forth in § 1187.96 (relating to price- and rate-setting computations). The table has one column that is the RUG-III nursing CMI scores and a second column that is the RUG-III PA normalized index scores.

RUG-III VERSION 5.01 INDEX SCORES

RUG-III Group	RUG-III Nursing CMI	RUG-III PA Normalized Index
RLA	1.14	1.13
RLB	1.36	1.35
RMA	1.25	1.24
RMB	1.38	1.37
RMC	2.09	2.07
RHA	1.06	1.05
RHB	1.31	1.30
RHC	1.50	1.49

RHD	1.93	1.91
RVA	0.82	0.81
RVB	1.18	1.17
RVC	1.79	1.77
SE1	1.78	1.76
SE2	2.65	2.62
SE3	3.97	3.93
SSA	1.28	1.27
SSB	1.47	1.46
SSC	1.61	1.59
CA1	0.67	0.66
CA2	0.76	0.75
CB1	0.94	0.93
CB2	1.08	1.07
CC1	1.16	1.15
CC2	1.19	1.18
CD1	1.37	1.36
CD2	1.46	1.45
IA1	0.49	0.49
IA2	0.60	0.59
IB1	0.80	0.79

IB2	0.88	0.87
BA1	0.41	0.41
BA2	0.58	0.57
BB1	0.78	0.77
BB2	0.87	0.86
PA1	0.39	0.39
PA2	0.52	0.51
PB1	0.66	0.65
PB2	0.68	0.67
PC1	0.77	0.76
PC2	0.86	0.85
PD1	1.00	0.99
PD2	1.01	1.00
PE1	1.13	1.12
PE2	1.19	1.18

The following chart is a listing by group of the RUG-III index scores that the Department will use to set each nursing facility's 5.12 resident care rate for rate years 2010-2011, 2011-2012 and 2012-2013 and each nursing facility's resident care rate beginning with rate year 2013-2014, and thereafter, as set forth in § 1187.96. The table has one column that is the RUG-III nursing CMI scores and a second column that is the RUG-III PA normalized index scores.

RUG-III VERSION 5.12 INDEX SCORES

RUG-III 44 Grouper	*RUG-III Nursing Only CMIs*	*RUG-III PA Normalized Index*
RLA	0.87	0.82
RLB	1.22	1.15
RMA	1.06	1.00
RMB	1.20	1.13
RMC	1.48	1.39
RHA	0.96	0.90
RHB	1.16	1.09
RHC	1.30	1.22
RVA	0.89	0.84
RVB	1.14	1.07
RVC	1.24	1.16
RUA	0.85	0.80
RUB	1.05	0.99
RUC	1.43	1.34
SE1	1.28	1.20
SE2	1.52	1.43
SE3	1.86	1.75
SSA	1.11	1.04

SSB	1.15	1.08
SSC	1.24	1.16
CA1	0.82	0.77
CA2	0.91	0.85
CB1	0.92	0.86
CB2	1.00	0.94
CC1	1.08	1.01
CC2	1.23	1.15
IA1	0.58	0.54
IA2	0.63	0.59
IB1	0.73	0.69
IB2	0.76	0.71
BA1	0.52	0.49
BA2	0.61	0.57
BB1	0.71	0.67
BB2	0.75	0.70
PA1	0.51	0.48
PA2	0.53	0.50
PB1	0.55	0.52
PB2	0.56	0.53
PC1	0.70	0.66

PC2	0.72	0.68
PD1	0.73	0.69
PD2	0.78	0.73
PE1	0.84	0.79
PE2	0.86	0.81

CHAPTER 1189. COUNTY NURSING FACILITY SERVICES

Subchapter E. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

§ 1189.105. Incentive payments.

* * * * *

(b) Pay *for performance incentive payment.* ~~(1)~~ The Department will establish pay for performance measures that will qualify a county nursing facility for additional incentive payments. ~~(2) The incentive payments will be made~~ in accordance with the formula and qualifying criteria [set forth] in the Commonwealth's approved State Plan. ~~(3)~~ 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.

Commentator List—5.12 Regulation

W. Russell McDaid
V.P. of Public Policy
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1100 Bent Creek Blvd.
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TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER:	14-520
SUBJECT:	TRANSITION TO RUG-III VERSION 5.12 AND LATEST ASSESSMENT
AGENCY:	DEPARTMENT OF PUBLIC WELFARE

TYPE OF REGULATION

Proposed Regulation

X Final Regulation

Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

RECEIVED
IRRC
2011 JUN 16 P 2:32

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
6/16/11	Sally Kitch	HOUSE COMMITTEE ON ~~HEALTH &~~ HUMAN SERVICES
6-16-11	Pam Huss	MAJORITY CHAIRMAN DiGirolamo
6/16/11	Richard Tomy	SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
6/16/2011	Lara S Claudenslager	MAJORITY CHAIRMAN Vance
6/16/11	K Cooper	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL (for Final Omitted only)
		LEGISLATIVE REFERENCE BUREAU (for Proposed only)

June 14, 2011