Regulatory Analysis Form

(Completed by Promulgating Agency)

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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:

IRRC Number: 2881

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

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

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

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(6) Primary Contact for Public Comments (List Telephone Number, Address, Fax Number and Email Address) – Complete if different from #5:

Yvette Sanchez-Roberts
Email gsanchez-r@state.pa.us
Phone. (717) 265-7569

(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 proposed rulemaking 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 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: 30 days after publication as proposed

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: August 17, 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, specific regulatory issues raised by members of the Medical Assistance Advisory Committee (MAAC) and the Long-Term Care Subcommittee of the MAAC 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.

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 proposed regulation is not directly mandated by federal or state law, court order, or federal regulation, changes being implemented by the Centers for Medicare and Medicaid Services (CMS) make the amendments necessary. CMS has 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, will be 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 in making certain county nursing facility incentive payments (pay for performance (P4P) payments), the Department must implement a 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 proposed 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 the implementation of MDS 3.0 by CMS, effective October 1, 2010. In addition, the proposed regulation is needed to apply the use of a more timely measurement of a nursing facility resident's care needs by adopting the most recent resident assessment of any type when classifying residents into groups and assigning a CMI score. Using the most recent 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 proposed regulation is consistent with the Department's ongoing efforts to ensure that 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 the change in the RUG-III version and use of the most recent 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 proposed amendments may have on nonpublic nursing facilities the Department is proposing a three year phase-in for the transition to the RUG-III v. 5.12 44 Grouper and the use of the most recent resident assessment of any type, for rate setting periods beginning July 1, 2010 and ending June 30, 2013. Phasing-in these proposed 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 Department does not intend to provide 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 proposed regulation will affect all nonpublic nursing facilities participating in the MA Program and county nursing facilities enrolled in the MA Program as it relates to a county nursing facility's eligibility for P4P payments. There are approximately 593 nonpublic nursing facilities and 32 county nursing facilities in PA 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.

Not applicable.

(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.

(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 proposed regulation for fiscal year 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 fiscal year 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 cost impact of this proposed regulation for future years is predicated on the assumption that the application of a BAF will continue after Fiscal Year 2010-2011.

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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						
Total Savings	$0	$0	$0	$0	$0	$0
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	584,081

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

This proposed regulation will benefit the Commonwealth's Medical Assistance (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, the Pennsylvania Association of Non-profit 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 industry 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 as to what the Department intended to change in the rate setting methodology due to CMS's move from MDS 2.0 to MDS 3.0. This letter included nonpublic nursing facility specific shadow rates for the 2008-2009 rate year. The Department has been responding to individual nursing facility questions and has 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 six 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 three year phase-in related to these provisions.

A public notice was published in the *Pennsylvania Bulletin* at 40 Pa.B. 3627 (June 26, 2010).

(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.

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(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 proposed 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 use the RUG-III v. 5.01 in its payment system and CMS has 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 proposed 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 proposed 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 proposed regulation includes provisions for a 3-year phase-in for the transition to the RUG-III v. 5.12 44 Grouper and the latest 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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FACE SHEET
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

By: Amy M. Elliott
(Deputy Attorney General)

OCT 20 2010
Date of Approval

☐ Check if applicable
Copy not approved.
Objections attached.

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

DEPARTMENT OF PUBLIC WELFARE
(Agency)

LEGAL COUNSEL: Mary Frances Delozier

DOCUMENT/FISCAL NOTE NO. 14-520

DATE OF ADOPTION:

BY: Harold Dutton

TITLE: SECRETARY OF PUBLIC WELFARE
(Executive Officer, Chairman or Secretary)

Copy below is hereby approved as to form and legality. Executive or Independent Agencies.

BY: Andrew C. Clark
SEP 21 2010

Date of Approval

(Deputy General Counsel)
(~~Chief Counsel, Independent Agency~~)
(~~Strike inapplicable~~ title)

☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.

NOTICE OF PROPOSED 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

Notice is hereby given that the Department of Public Welfare (Department), under 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), intends to amend the regulations as set forth in Annex A,

Purpose of Rulemaking

The purpose of this proposed rulemaking 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 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.

Background

A case-mix index (CMI) is a numerical score that is assigned to a resident of a nursing facility. The score is determined by a classification system that analyzes data about the resident's medical condition and functional status and classifies the resident into a group based on the resident's characteristics and clinical needs. Each group has

a CMI or numerical score which is intended to reflect the relative resource use of the average resident assigned to the group. The group's CMI score is assigned to each resident who is classified in the group. Generally, a resident with a higher CMI score has greater needs and, therefore, requires more nursing facility resources than a resident with a lower CMI score.

In this rulemaking, the Department is proposing to change the source of the data and the classification system that is used in determining nursing facility residents' CMIs. Because the Department recognizes that these changes may impact nonpublic nursing facility case-mix payment rates, the Department is also proposing to phase-in these changes over a 3-year period. Before describing these changes, a review of how the Department currently calculates CMIs and uses them to set and adjust per diem rates for nonpublic nursing facilities and to make certain incentive payments to county nursing facilities is being provided.

CMI Calculations. Currently, the Department calculates a CMI score for each nursing facility resident present in a nursing facility on the first calendar day of the second month of each calendar quarter (i.e., February 1, May 1, August 1 and November 1). These four days are known as "picture dates." To determine a resident's CMI score for a picture date, the Department extracts data from the most recent comprehensive assessment of the resident, which was transmitted by the nursing facility using the Federally Approved Pennsylvania Specific MDS version 2.0.[1] Then,

[1] The MDS, or Minimum Data Set, is a Federally-mandated standardized assessment of a resident's clinical and functional status that all nursing facilities participating in the MA Program must complete and submit for each of their nursing

using the RUG-III, version (v.) 5.01 44 Grouper classification system, the Department classifies the resident into one of the 44 groups and assigns the resident a CMI score. These CMI scores are used in rate setting and making incentive payments to county nursing facilities.

Medical Assistance (MA) Payments to Nonpublic Nursing Facilities. Currently, the MA Program pays for nursing facility services provided to MA eligible recipients by participating nonpublic nursing facilities at per diem rates that are computed using the case-mix payment system set forth in the Department's regulations at 55 Pa.Code Chapter 1187, Subchapter G (relating to rate setting). A new case-mix payment rate is established for each nonpublic nursing facility once each fiscal year, also referred to as the rate year. The rate established for each nursing facility takes effect July 1, the start of the State fiscal year, and remains in effect until the close of the fiscal year on June 30.

Each nonpublic nursing facility's case-mix per diem rate consists of four rate components, one for each of the three net operating cost centers ("resident care" costs; "other resident related" costs; "administrative" costs) and a fourth component for the "capital" cost center. To determine the rate components of each of the three net operating cost centers the Department groups nursing facilities into peer groups based on bed size and geographic location. See § 1187.94 (relating to peer grouping for price setting). For each peer group, the Department calculates a "peer group price" for the three net operating cost centers and uses the prices to set the amounts of the

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facility residents at prescribed periods during the resident's stay at the facility. (See 42

respective rate components for the individual nursing facilities assigned to the peer groups. As part of setting the peer group prices for the resident care cost center, the Department neutralizes each nursing facility's resident care costs using the facility's total facility CMI, which is the arithmetic mean CMI, or average CMI, of all residents of the facility on the applicable February 1st picture date. See §1187.96(a)(5) (relating to price and rate setting computations).[2]

Once the Department calculates the resident care peer group price for the rate year, the Department computes each nursing facility's resident care rate component, and then adjusts that component every quarter during the rate year using the facility's MA CMI for the picture date designated for the rate quarter. See §1187.96(a)(5). The MA CMI is the arithmetic mean CMI or average CMI of all MA residents of the nursing facility on a picture date. The Department pays each nonpublic nursing facility for nursing facility services provided to MA recipients during the quarter using the facility's adjusted quarterly case-mix per diem rate calculated for the respective calendar quarter.

MA Payments to County Nursing Facilities. Currently, the Department makes payments to county nursing facilities for services provided to MA recipients as specified

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CFR 483.20 (relating to resident assessment).)

[2] Although the Department established a separate payment methodology for county nursing facilities in 2006, the Department has continued to use county nursing facility audited costs in determining the peer group prices for nonpublic nursing facilities. County nursing facility costs are also neutralized as part of the price-setting process. Consistent with Act 44 of 2008, the Department is seeking to amend the State Plan and Chapter 1187 (relating to nursing facility services) to phase out the use of county costs over a 3-year period ending June 30, 2012. See 39 Pa.B. 4179 (July 18, 2009).

in the Department's regulations at 55 Pa. Code Chapter 1189 (relating to county nursing facility services), and the Commonwealth's approved State Plan. As specified in the State Plan, the Department makes pay for performance (P4P) payments to county nursing facilities that have an MA CMI for a picture date which is higher than their MA CMI for the prior picture date. The Federal Centers for Medicare and Medicaid Services (CMS) recently approved a State Plan Amendment authorizing the Department to continue to make quarterly P4P payments in FYs 2009-2010, 2010-2011 and 2011-2012.

Requirements

The following is a summary of the major provisions in the proposed rulemaking:

§§ 1187.2 and §1187.33 (relating to resident data and picture date reporting requirements) – Resident assessment.

As noted above, 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 Minimum Data Set (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. Nursing facilities are required to conduct and electronically submit assessments other than "comprehensive assessments" for their residents. These assessments also contain all MDS data elements needed to calculate the resident's RUG category and CMI score. These assessments may be completed

after the latest comprehensive assessment and, therefore, provide more current information on the residents' condition and care needs.

Rather than continuing to use older assessment data to determine a resident's RUG category and CMI score, the Department is proposing to change its regulations to require use of the most recent assessment of any type for each resident, whether or not 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 any additional administrative burdens or costs to either nursing facilities or the Department.

To implement this change, the Department is proposing to revise the current definition of "resident assessment" by removing the term "comprehensive" from the definition, and to amend 1187.33(a)(6) (relating to resident reporting requirements) by removing the language related to Medicare assessments.

The Department is proposing to use the the most recent assessment of any type in determining the CMIs of residents of both nonpublic and county nursing facilities. The CMI scores affected by this proposed rulemaking will be used to calculate the total facility CMIs and the MA CMIs that will be used in setting nonpublic nursing facility rates effective on and after July 1, 2010. In addition, the CMI scores affected by this proposed change 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 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 .

As noted above, nursing facilities participating in the MA Program complete and submit resident assessments using the Federally Approved Pennsylvania Specific MDS 2.0. The Department takes data from the MDS 2.0 resident assessments and, using RUG-III v. 5.01 44 Grouper classification system, assigns a CMI score to each nursing facility resident. Pennsylvania is currently only one of two states that still use the RUG-III v. 5.01 44 Grouper.

CMS has developed a new version of the MDS resident assessment, MDS version 3.0 (MDS 3.0), which all nursing facilities participating in the Medicare or MA Program, or both, will be 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, and CMS has stated it will no longer support this Grouper once MDS 3.0 is implemented. In anticipation of the CMS move to the new MDS 3.0, the Department is proposing to change the Grouper used in determining nursing facility residents' CMI scores effective for rate setting periods commencing on and after July 1, 2010 to the 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 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.

To implement this proposed change, the Department will amend § 1187.93 and update 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 Pennsylvania nursing facilities.[3] The Pennsylvania normalized CMI scores the Department will use in the proposed amendments range from 0.48 to 1.75.

The Department is proposing to 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 affected by this proposed rulemaking will be used to calculate the total facility CMIs and the MA CMIs that will be used in setting nonpublic nursing facility rates effective on and after July 1, 2010. In addition, the CMI scores affected by this proposed change 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. The affected 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

[3] 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.

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.

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

The Department recognizes that the change in RUG-III Grouper and use of the most recent 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 proposed amendments may have on nonpublic nursing facilities, the Department is proposing a 3-year phase-in for the transition to the RUG-III v. 5.12 44 Grouper and the use of the most recent resident assessment, for rate setting periods beginning July 1, 2010 and ending June 30, 2013. Phasing in these proposed amendments will 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. Specifically, the Department is proposing to revise §1187.96 (relating to price and rate setting computations) to specify that for the period 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.

The Department does not intend to apply the phase-in provisions to new nonpublic nursing facilities, since the phase-in period is being proposed as a transition

from one system to another; rather, the Department will amend §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 the new facilities will be assigned a Statewide average MA CMI calculated using the RUG-III v. 5.12 44 group values set forth in Appendix A and the most recent 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 CMI will be the RUG-III v. 5.12 44 group values set forth in Appendix A and the most recent assessment.

County nursing facilities – Pay for Performance (P4P) Payments-§ 1189.105 (relating to incentive payments).

As noted above, 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 does not intend to provide for a phase-in of the proposed changes. The Department will amend §1189.105 to specify, that, in determining whether a county nursing facility qualifies for a quarterly pay for performance incentive for P4P periods beginning on and after July 1, 2010, 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, and an MA resident's CMI will be calculated using the RUG-III v. 5.12 44 group values as set forth in Appendix A to Chapter 1187 and the most recent assessment of any type for the resident.

Affected Individuals and Organizations

This proposed rulemaking will affect 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 proposed rulemaking will benefit 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

No fiscal impact is anticipated as a result of these changes.

Paperwork Requirements

There are no new or additional paperwork requirements.

Effective Date

The proposed effective date for the proposed rulemaking is July 1, 2010.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed rulemaking to, Yvette Sanchez-Roberts, Department of Public Welfare/Department of Aging, Office of Long-Term Living, 555 Walnut Street, Forum Place, 5th Floor, Harrisburg, PA 17101-1919, within 30 calendar days after the date of publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Reference Regulation No. 14-520 when submitting comments.

Persons with a disability who require an auxiliary aid or service may submit comments using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).

Regulatory Review Act

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on OCT 28 2010, the Department submitted a copy of this proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare (Committees). In addition to submitting the proposed rulemaking, the Department has provided 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.

Under section 5(g) of the Regulatory Review Act, if IRRC has any comments, recommendations or objections to any portion of the proposed rulemaking, it may notify the Department and the Committees within 30 days after the close of the public comment period. The notification shall specify the Regulatory Review Criteria that have not been met. The Regulatory Review Act specifies detailed procedures for review by the Department, the General Assembly and the Governor, of any comments, recommendations or objections raised, prior to final publication of the regulation.

ANNEX A

TITLE 55. PUBLIC WELFARE

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].

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Subchapter D. DATA REQUIREMENTS FOR NURSING FACILITY APPLICANTS AND RESIDENTS

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§ 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:

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(6) The CMI report shall 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.]

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Subchapter G. RATE SETTING

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§ 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 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 three 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 (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 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 three 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 (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 resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility by multiplying the nuring 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 three 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 (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 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 three 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 three 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 (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 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.

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

(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) (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 as set forth in Appendix A and the most recent 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 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 on 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 as set forth in Appendix A and the most recent assessments of any type.

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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 (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 5.12 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

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§ 1189.105. Incentive payments.

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(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 facililty 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 as set forth in Appendix A to Chapter 1187 and the most recent assessment of any type for the resident.

IRRC

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

Please sign all three copies and return one copy to:
Kim Kauffman
14th Floor, Harristown II
IRRC

TYPE OF REGULATION

X Proposed Regulation

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
2010 OCT 28 P 3:29

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
10-28-10		HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
10-28-10		MAJORITY CHAIRMAN Frank L. Oliver
10-28		SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
10/28/10		MAJORITY CHAIRMAN Patricia Vance
10/28/10	K Cooper	INDEPENDENT REGULATORY REVIEW COMMISSION
		~~ATTORNEY GENERAL (for Final Omitted only)~~
10/28/10	M. Nichols	LEGISLATIVE REFERENCE BUREAU (for Proposed only)