NOTICE
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

Payment for Nursing Facility Services Provided by General Nursing Facilities
Notice of Change in Methods and Standards of Setting Payment Rates

Purpose of Notice

The purpose of this notice is to announce that the Department of Public Welfare (Department) is proposing to adopt final-omitted regulations and amend the Commonwealth's Title XIX State Plan to change its methods and standards for payment of Medical Assistance (MA) nursing facility services provided by general nursing facilities beginning fiscal year 2006-2007.

Background

In January 1996, the Department implemented the current case-mix payment methodology for nursing facility providers participating in the MA Program.[1] The purpose of the system was to establish a prospective payment system (PPS) that would both serve the needs of the Commonwealth's MA nursing facility residents and promote the economic and efficient operation of nursing facilities. Among other things, the system was intended to eliminate the undesired incentives for nursing facilities to admit and provide care for the least disabled individuals; to channel a higher level of MA funds to direct resident care activities; and to provide for an environment of economic

predictability and controlled MA Program cost increases.

Over the past 10 years the Department has monitored and evaluated the case-mix payment system to determine whether the initial objectives of the system have been realized and whether modifications to the system are needed. The Department has concluded that while the case-mix system did improve access to care for higher acuity individuals, the system as designed also produced unintended and undesirable outcomes. For example, the system has created disincentives for right-sizing of nursing facilities and has fostered an increasingly adversarial and litigious environment which has placed undue costs and administrative burdens on both the Department and nursing facility providers.

Moreover, the Department has found that the current case-mix system, as designed, has not served to effectively moderate MA Program costs as originally intended. To the contrary, since the case-mix payment system was implemented in 1996, MA nursing facility payment rates have risen more than 56%, and since 2000, have increased by 29.74% overall. During this same period, expenditures for MA nursing facility services have climbed to nearly $3 billion and expenditures for MA services to the elderly and disabled now consume approximately 70% of the $14 billion MA Program budget. The Department has determined that some nursing facility operating practices, which are technically reimbursable under the current payment system but have no impact on the quality of services to nursing facility residents, have contributed to the steep escalation in Program costs for MA nursing facility services.

[1] See 25 Pa.B. 4477-4505 (October 14, 1995).

Although State revenues are slowly rebounding, the Department simply cannot maintain a payment system that generates such inflated payment rate increases, particularly given that they are not tied to the quality of care provided to consumers or to the facility's effort to provide consumer choice as to where long-term care is provided.

The Department is proposing amendments that will refine the case-mix payment system so that it can achieve its original intended objective of serving the needs of the Commonwealth's MA nursing facility residents while providing for reasonable and adequate payments to MA nursing facility providers. In addition, the amendments will support the balancing of long-term care by encouraging consumer choice in long-term care services and the right-sizing of nursing facilities. An overview and explanation of each major proposed revision follows.

Nursing Facilities Subject to the Case-Mix Payment System

Currently the Department uses the rate-setting methodology contained in 55 Pa.Code Chapter 1187 (relating to nursing facility services) to set payment rates for all types of nursing facilities participating in the MA Program, including county nursing facilities. The Department is proposing to amend Chapter 1187 to make the rate-setting methodology apply only to general nursing facilities, effective July 1, 2006. As of that date, it is the Department's intent that county nursing facilities will no longer be reimbursed based on the rate-setting methodology contained in 55 Pa.Code Chapter 1187. Instead, the Department intends to create a new payment methodology for

county nursing facilities. [2]

Definitions

The Department is proposing to eliminate and revise current definitions and add new definitions at § 1187.2 (relating to definitions). The following definitions will be eliminated: a*ppraisal, bed cost limitation, FRV - fair rental value, initial appraisal, Intergovernmental Transfer Agreement, limited appraisal, MA-11 - Financial and Statistical Report Schedules (uniform nursing facility cost report), movable property appraisal, reappraisal,* and *updated appraisal.*

The following definitions will be revised: *audited cost reports, Department of Health, resident assessment, special rehabilitation facility, supply,* and the definitions for *Years One, Two and Three of Implementation.*

The following definitions will be added: *cost reports* and *cognitive performance scale.*

Provisions related to Special Rehabilitation Nursing Facilities

[2] To make this change, the Department intends to establish a new Chapter 1189 under Title 55 of the Pennsylvania Code. That Chapter will set forth the methodology that the Department will use to reimburse county nursing facilities. Information related to this change in payment methodology will be provided in the publication of a separate advance public notice.

Under the current case-mix payment system, a nursing facility is a “special rehabilitation facility” (SRF) if more than 70% of its residents have a neurological/neuromuscular diagnosis and severe functional limitations. See § 1187.2. All SRFs are classified into a singe statewide peer group for rate-setting purposes. Under the proposed amendments the Department will maintain the single statewide SRF peer group but will increase the 70% resident threshold to 85%. In addition, for those MA residents in the facility who do not have a diagnosis of comatose, cerebral palsy, multiple sclerosis, paraplegia, quadriplegia, or traumatic brain injury, or who are not dependent on a ventilator or respirator, under the proposed amendments the Department will assign the resident a case-mix index (CMI) score of .60 for purposes of calculating the nursing facility’s average MA CMI. These changes will help to ensure that the rehabilitative services available in SRFs are appropriately directed to those individuals who are most likely to benefit from the services and to encourage SRFs to work with residents and their families on discharge planning.

Resident Assessment Submission

Under the current case-mix payment system, nursing facilities are required to report individual resident minimum data set (MDS) assessment data for each calendar quarter of the calendar year. For the first calendar quarter, the nursing facilities report resident data for every MA and every non-MA resident in the nursing facility as of the first day of February. For the remaining calendar quarters, the nursing facilities report

resident data for only MA residents in the nursing facility as of the first day of the second month of the calendar quarter.

Under the proposed amendments, in addition to the Federal requirements outlined in 42 CFR § 483.20 (relating to resident assessment) the Department will expand the reporting requirement for the second, third and fourth calendar quarters of a calendar year to include individual MDS resident assessment data for every MA and non-MA resident in the nursing facility as of the first day of the second month of the respective calendar quarter. The Department will also clarify that residents will not be included in the picture date census if no MDS assessment is available to obtain a CMI score, and that residents temporarily discharged with a return anticipated will be included in the picture date census as a non-MA resident. These changes will provide the Department with more current information to calculate a nursing facility's total overall nursing facility occupancy rate to be used in the proposed bed hold provisions outlined in this notice and will be used to calculate an average total facility CMI to neutralize costs for rate-setting as described under the proposed case-mix index calculations provisions.

Case-Mix Classification Tool

Currently, the Department uses the Resource Utilization Group (RUG-lll) version 5.01 classification system to classify nursing facility residents into groups based on their characteristics and clinical needs. Under the proposed amendments, the Department

will use a more recent version of the RUG III classification system, version 5.12b as modified for Pennsylvania (5.12b-PA). This RUG version 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 Department is proposing to modify several of the classifications under this RUG version to address concerns raised by nursing facilities that serve residents in need of ventilator services and to assure that residents who are ventilator-dependent continue to have access to quality nursing facility care. Specifically, the Department will modify the qualifiers for the highest RUG III category (SE3 – Extensive Services) to include residents who would have qualified for this category under the RUG III 5.01 version (require suctioning, tracheotomy care and ventilator care and have a score in their activities of daily living of 7 or greater). As a result of this change, these residents will receive the highest CMI of 2.10 for both MA CMI and total facility CMI averages. In addition, for MA residents who are ventilator-dependent or respirator-dependent and placed in either SE2 or SE3 RUG III 5.12b-PA categories, the assigned CMI will be multiplied by 1.20 and the result will be used in calculating the MA CMI average.

In conjunction with the change in RUG version, the Department will also assign CMI scores for each of the 34 RUG categories. The CMI scores will range from .59 to 2.10.

To implement this change from the RUG III version 5.01 to the RUG III version 5.12b-PA for the July 1, 2006 rate, the Department will recalculate each nursing facility's

total facility and MA CMI scores, prior to the May 1, 2006 Picture Date, which will be used to neutralize costs and set rates.

Case-Mix Index Calculations

Under the current case-mix payment system, the Department establishes a case-mix index score for each nursing facility resident based on the resident's comprehensive MDS assessment data as submitted by the nursing facility. Using the individual CMI scores calculated for each resident, the Department then calculates a total facility CMI score, and a facility MA CMI score for each nursing facility, and a statewide average MA CMI score. Under the current system, total facility CMI scores are only calculated for the February 1 Picture Date and are only used once, to neutralize each nursing facility's audited allowable costs. Under the proposed amendments, beginning with the May 1, 2006 Picture Date, the Department will calculate a total facility CMI average for each calendar quarter based on the resident comprehensive MDS assessment data submitted by the nursing facility for the respective calendar quarter. The Department will use an average of the four total facility CMI averages related to the cost report period used in the rate-setting process to neutralize the nursing facility's costs. To implement this change, up until the time when there are four total CMI averages for each cost report period used in the rate-setting process, the Department will use the average of the number of available total facility CMI averages, to neutralize the nursing facility's cost.

Alternative Placement Incentives

As a means of encouraging choice in long term care services, the Department is proposing to make an adjustment to the CMI scores of MA residents who require less intensive services and resources. The Department will assign an MA resident an individual CMI score of .30 for purposes of calculating the facility's average MA CMI for a picture date if the MA resident is a resident of a nursing facility, other than an SRF, has a CMI score of 0.65 or lower, does not have a dementia diagnosis and has a score of 2 or less on the Cognitive Performance Scale (meaning that, at most, the resident has only mild impairment in decision-making, retains short-term memory, and can make himself understood). As previously noted, if an MA resident of an SRF does not have a diagnosis of comatose, cerebral palsy, multiple sclerosis, paraplegia, quadriplegia, traumatic brain injury or is not dependent on a ventilator or respirator, under the proposed amendments, the Department will assign the resident a CMI score of .60 for purposes of calculating the SRF's average MA CMI.

Peer Groups

Currently, to set prices for the resident care, other resident related and administrative cost categories under the case-mix payment system, the Department classifies MA nursing facilities into 14 mutually exclusive peer groups. Twelve of the 14 peer groups are established based on geographic location using the Metropolitan Statistical Areas (MSA) and the nursing facility's bed size. The remaining two peer

groups, peer group 13 and 14, are designated for SRF and hospital-based nursing facilities respectively, regardless of geographic location or bed size.

Under the proposed amendments, the Department will maintain the 14 mutually exclusive peer groups. To determine the geographical groups, the Department will use the MSA group classification levels published in the Federal Office of Management and Budget Bulletin No. 99-04, applied to the statistical areas identified in the Federal Office of Management and Budget Bulletin No. 03-04 and updated based on the 2000 census. This will result in the reclassification of some counties into different MSA groups. Three counties (Armstrong, Mercer and Pike) will be reclassified into MSA groups with higher populations and three counties (Lebanon, Somerset and Columbia) will be reclassified into MSA groups with lower populations.

Cost Reports

Currently, as part of the final reporting requirements contained in § 1187.75 (relating to final reporting), nursing facilities that enter into a termination agreement or an agreement of sale, or are otherwise undergoing a change of ownership, or withdrawing or being terminated as an MA provider, or are newly MA-certified, are required to file an acceptable cost report even if the effective date of this action was within the nursing facility's respective cost report period. The Department does not use these short period cost reports in the rate-setting process. The Department is proposing to eliminate the requirement for filing final cost reports for final reporting

periods that are less than 12 months.

Under the current system, to compute the net operating rate components for the individual nursing facilities, the Department uses costs taken from the three most recent audited cost reports for each nursing facility. Under the proposed amendments, the Department will use costs taken from the most recent accepted, reviewed or audited cost report on file with the Department as of the rate database cut-off date.

Auditing Practices

Under the current regulations, the Department audits all nursing facility costs as reported on the cost report within 15 months from the date of acceptance. The corresponding audit reports set forth the auditors' determinations of the facility's allowable costs. Under the current system, to set peer group prices, the Department uses audited allowable costs taken from the three most recent audit reports for each nursing facility. Under the proposed amendments, the Department's auditors will no longer audit all of a nursing facility's reported costs. Instead, the Department's auditors will examine the nursing facility's major movable property costs, real estate tax costs and resident day information, and audit other reported costs based on a selection process.

The Department will use each nursing facility's most recent audited, reviewed or accepted cost report and calculate a cost per diem for each of the net operating cost

centers for each nursing facility. Each nursing facility's cost per diem for each of the net operating cost centers will be arrayed within their respective peer groups and a preliminary median will be determined. The Department will then select a median facility group within each net operating cost center for each peer group. The median facility group will consist of the three nursing facilities whose cost per diems are equal to or immediately above the preliminary median and the two nursing facilities whose cost per diems are immediately below the preliminary median. The costs associated with the respective cost center for nursing facilities in the median facility group will be audited by the Department's auditors. After completion of the audits, the Department will compute an audited per diem cost for each of the nursing facilities in the median facility group. These audited per diem costs will be arrayed within the respective net operating cost center and a final median per diem cost determined for each peer group. The final median per diem costs will be used to compute the associated peer group prices.

For the 2006-2007 rate year, each nursing facility’s allowable costs will be taken from the facility’s most recent audited cost report issued on or before March 31, 2006.

Allowable Costs

The Department proposes to make changes to Subchapter E (relating to allowable program costs and policies) to more specifically define and clarify the items that are allowable and non-allowable for each of the three net operating cost centers.

Under the current provisions related to allocation of costs, allowable insurance costs are classified as administrative costs. Under the proposed amendments, the Department is proposing to classify allowable liability, property and boiler insurance costs as other resident related costs. This change in allocation will take effect when the Department has the nursing facility's cost report on file which includes a schedule to allocate insurance costs into the appropriate cost center.

Limitation on Median Peer Group Price

Currently during rebasing, the Department does not apply a limitation on the amount of increase of a peer group's median for each net operating cost center. As a result, peer groups containing a smaller number of nursing facilities have historically experienced a higher increase in their peer group medians used to set peer group prices. To control this increase, under the proposed amendments, the Department will limit the percentage increase of the net operating peer group medians of peer groups that contain ten or fewer nursing facilities. For nursing facilities in a peer group containing ten or fewer nursing facilities, the peer group median for each net operating cost center will be the lower of the peer group median as calculated in accordance with § 1187.96 (relating to price and rate setting computations) or the prior rate year peer group median for the cost center adjusted by the highest percent increase of a peer group median in that cost center of any of the peer groups containing more than ten nursing facilities.

Occupancy Efficiency Adjustment

Under the current case-mix system, the Department makes certain minimum occupancy adjustments. Specifically, if a nursing facility's overall nursing facility occupancy level is below 90%, the Department makes an adjustment to total nursing facility resident days as though the nursing facility were at 90% occupancy. The Department then applies the 90% occupancy adjustment as part of the computation of the nursing facility's administrative and capital rate components. Under the proposed amendments, the Department proposes to increase the occupancy level threshold to 92%. This amendment is intended to promote nursing facility efficiency and economy associated with nursing facility occupancy levels and encourage right-sizing.

Capital cost policy

Currently under the case-mix system, the Department annually computes a facility-specific capital rate component for each nursing facility. The nursing facility's capital rate component consists of a fixed property component, a movable property component, and a real estate tax component. The fixed property component is based on the fair rental value of the nursing facility's fixed property which is determined by an appraisal completed by an independent appraisal firm under contract with the Department in accordance with § 1187.57 (relating to selected capital cost policies). The nursing facility's fair rental value is adjusted by the appraised depreciated replacement cost of the nursing facility's fixed property to account for the per bed

limitation of $26,000 and the bed moratorium provision contained in § 1187.113 (relating to capital component payment limitation) and the adjusted amount is multiplied by the financial yield rate. Under the proposed amendments, the Department will compute a nursing facility's fixed property component by multiplying the facility's number of beds qualified for fixed property payment (allowable beds) as of the April 1 immediately preceding the rate year by $26,000 , then multiply that product by the financial yield rate.

Bed Hold Payments

Currently, the Department pays a nursing facility a maximum of 15 consecutive bed hold days per hospitalization to hold a bed for a resident who requires hospitalization. The payment is made at a rate of 1/3 of the nursing facility's per diem rate on file with the Department at the time of the hospitalization, and is paid regardless of the nursing facility's overall total occupancy rate. Under the proposed amendments, the Department proposes to only pay a nursing facility for a hospital bed hold day if the nursing facility's overall total occupancy for the applicable picture date is equal to or greater than 85%.

Incentive Payments

Disproportionate Share Incentive Payments

The current case-mix payment system provides for disproportionate share

incentive payments to be made to a nursing facility, if over a 12-month cost reporting period the facility has an annual overall occupancy rate of at least 90% and an MA occupancy rate of at least 80%. The amount paid to a qualifying facility is computed by multiplying the nursing facility's MA paid days of care by the per diem incentive amount. Under the proposed amendment, the Department proposes that the MA occupancy rate will continue to be subject to the same minimum occupancy rate; however, the minimum annual overall occupancy rate necessary to qualify for disproportionate share incentive payments will increase to 92%.

Pay for Performance Incentive Payments

In the current payment system, there are no provisions that provide for incentive payments to nursing facilities that meet or exceed performance standards. Under the proposed amendments, the Department intends to make payment to nursing facilities that meet certain performance objectives. An incentive payment is proposed for nursing facilities that submit a resident's initial MDS data within seven calendar days of the completion of the Admission or Medicare PPS assessment. Through this prompt notification of a resident's admission to a nursing facility, the Department will be able to educate residents on their long-term care options while their former housing is still available for their return or transition into the community and before they have become acclimated to the nursing facility environment. The incentive payment will be made on a monthly basis and will be based on the number of unduplicated initial assessments

submitted to the Department in which the completion date of the assessment is less than or equal to 7 days from the date of submission.

Cost Neutrality

Under the proposed amendments, each Fiscal Year the Department will apply a budget adjustment factor (BAF) based on the funding that is appropriated for nursing facility services in the General Appropriations Act. The BAF will be applied each quarter to the nursing facility's quarterly case-mix per diem rate calculated in accordance with the rate-setting methodology contained in 55 Pa.Code 1187 Subchapter G (relating to rate setting).

Phase-in Period

Under the proposed amendments, the Department is proposing to implement a three-year phase-in provision. This phase-in provision will prevent major disruptions to nursing facilities' business practices and allow nursing facilities time to modify their business practices to adjust to the rate-setting methodology changes.

The phase-in provision for Year One will assure that the per diem rate that a nursing facility receives for nursing facility services provided to an MA resident during fiscal year 2006-2007 will not deviate from the nursing facility's average 2005-2006 case-mix per diem rate by plus or minus 2.5%.

The phase-in provision for Year Two will assure that the per diem rate that a nursing facility receives for nursing facility services provided to an MA resident during fiscal year 2007-2008 will not deviate from the nursing facility's average 2005-2006 case-mix per diem rate by plus or minus 5%.

The phase-in provision for Year Three will assure that the per diem rate that a nursing facility receives for nursing facility services provided to an MA resident during fiscal year 2008-2009 will not deviate from the nursing facility's average 2005-2006 case-mix per diem rate by plus or minus 7.5%.

Future Programs

In addition to the changes being proposed by this notice, the Department is in the process of developing program initiatives that will encourage nursing facilities to review their current delivery of long-term care services and adjust their delivery system to better meet the long-term care service needs of MA consumers. The Department will provide information regarding these program initiatives with opportunity for public input in the future.

Fiscal Impact

This change will result in an estimated savings of $206.92 million in total funds ($103.3 million in State funds) in FY 2006-2007.

Public Comment

More detailed information related to the provisions contained in this notice will be presented at public hearings that will be scheduled for late April 2006. The locations for the public hearings will be as follows: Sharon, Wilkes-Barre/Scranton, Philadelphia, State College, Pittsburgh and Harrisburg.

More information regarding the public hearings may be obtained by contacting the Bureau of Long Term Care Programs at (717) 705-3705. The dates and locations will also be listed on the OMAP Website, when available.

A copy of this notice is available for review by contacting Gail Weidman in the Long-term Care Policy Section at (717) 705-3705. Interested persons are invited to submit written comments about the changes to the case-mix payment system to the Department within 15 days of publication of this notice in the *Pennsylvania Bulletin*. Comments should be addressed to: Department of Public Welfare, Division of Long Term Care Client Services, Attention Gail Weidman, P.O. Box 2675**,** Harrisburg, PA 17105.

Persons with a disability who require an auxiliary aid or service may submit comments using the AT&T Relay Service at 1-800-654-5984 (TDD users) or 1-800-654-5988 (voice users).

Following review and consideration of any comments received in response to this notice, the Department intends to publish a final-omitted rulemaking in the *Pennsylvania Bulletin* adopting changes to the Department's case-mix payment system regulations.

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Estelle B. Richman
Secretary of Public Welfare