PROPOSED RULEMAKING

DEPARTMENT OF HUMAN SERVICES

[55 PA. CODE CHS. 1187 AND 1189]

Transition to Patient Driven Payment Model

Statutory Authority

Notice is hereby given that the Department of Human Services (Department), under the authority of sections 201(2), 403(b) and 443.1(7) of the Human Services Code (62 P.S. §§ 201(2), 403(b) and 443.1(7)), proposes to amend Chapters 1187 and 1189 (relating to nursing facility services; and county nursing facility services) to read as set forth in Annex A.

Purpose of Proposed Rulemaking

The purpose of this proposed rulemaking is to amend a data element in the Department's case-mix payment system for nonpublic and county nursing facilities to utilize the patient driven payment model (PDPM) in place of the Resource Utilization Groups, Version III (RUG-III) classification system in setting Medical Assistance (MA) payment rates for nursing facilities. This proposed rulemaking is to ensure the health and safety of individuals residing in nonpublic and county nursing facilities by supporting rate setting methodologies for payment of the services in nursing facilities.

Background

Chapters 1187 and 1189 govern the MA payments to nursing facilities based on the Commonwealth's approved State Plan for reimbursement. The MA Program pays for nursing facility services provided to MA-eligible recipients by participating nursing facilities at per diem rates that are computed using the case-mix payment system implemented in January 1996. Currently, the case-mix rate setting methodology for nonpublic and county nursing facilities uses the RUG-III classification system. The RUG-III is a category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs. Case-mix payments are developed using a Case-Mix Index (CMI), a number value score that describes the relative resource use for the average resident in each of the groups under the RUG-III classification system based on the assessed needs of the resident. As part of the RUG-III classification system, the MA Program uses the RUG-III utilization group as the data element on the Federally approved Pennsylvania specific Minimum Data Set (MDS), which is used for the classification of a resident into one of the RUG-III categories.

The Federal Centers for Medicare & Medicaid Services (CMS), however, is ending support for RUG-III and Resource Utilization Groups, Version IV (referred to as RUG-IV)[1] classification systems on Federally required assessments for residents in nursing facilities and skilled nursing facilities. Previously, CMS provided states additional resources to continue to use RUGs called "Optional State Assessment," or OSA, to gather the needed assessment data. However, CMS will only allow the use of the OSA until October 1, 2025.

CMS released State Medicaid Director Letter # 22-005,[2] which provides an alternative to the current RUGs classification system; states may choose to utilize the classification called the PDPM.

The Department, with this proposed rulemaking, announces its intent to adopt the PDPM beginning August 1, 2025. This proposed rulemaking is needed to allow the Department to continue to make payments to nursing facilities participating in the MA program. Absent this proposed rulemaking, the Department would not have a regulation in place to allow for CMS-supported rate setting methodologies and payment since the RUGs classification system and OSA will no longer be supported after October 1, 2025.

Requirements

The specific regulatory changes to Chapters 1187 and 1189 included in this proposed rulemaking are set forth as follows:

§ 1187.2. Definitions

Under this proposed rulemaking, the Department proposes to:

- Amend the definitions of "CMI—case-mix index," "CMI Report" and "classifiable data element" to delete reference to the RUG-III classification system and RUG category and replace them with the PDPM classification system and PDPM nursing component case-mix groups.
- Add definitions for "case-mix group," "nursing component" and "PDPM—patient driven payment model." These newly provided definitions describe elements of the PDPM classification system and are based on Federal guidance at https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model.
- Delete the definition of "RUG-III—Resource Utilization Group, Version III" as it is the basis for a rate setting methodology that will no longer be supported by CMS or used by the Commonwealth. As provided previously, the Department proposes to use the PDPM in place of the RUG-III classification system to set MA payment rates for nursing facilities.

§ 1187.33. Resident data and picture date reporting requirements

References to RUG-III are proposed to be deleted and replaced with PDPM.

§ 1187.92. Resident classification system

In § 1187.92(a) (relating to resident classification system), the Department is proposing to delete the RUG-III and replace it with the PDPM nursing component to adjust payment for resident care services based on the case-mix classification of nursing facility residents.

In § 1187.92(b), the Department is proposing to delete RUG-III and state that each resident be included in the PDPM nursing component and be assigned into the first case-mix group for which the resident meets the criteria.

The Department is proposing to delete § 1187.92(c) because it refers to RUG-III and will become obsolete with the proposed rulemaking, as the Department will no longer use RUG-III.

In § 1187.92(d), the Department explains how the PDPM nursing component case-mix group and PDPM CMI scores will be announced. Specifically, since the Department is proposing to delete Appendix A and replace it with Appendix D, the Department will be announcing,

[1] Pennsylvania uses only the RUG-III in nursing facility rate setting.
[2] https://www.medicaid.gov/sites/default/files/2023-02/smd22005.pdf

by notice, the PDPM nursing component case-mix group, PDPM CMI scores in Appendix D.

In § 1187.92(e) the Department is proposing to delete the reference to "PA normalized RUG-III index scores" and replace it with the updated language, "PDPM CMI scores."

In § 1187.92(f), the Department is proposing to delete the reference to RUG-III and replace it with the PDPM nursing component.

§ 1187.93. CMI calculations

In § 1187.93(1) (relating to CMI calculations), the Department is proposing to delete references to "RUG-III" and replace them with the revised terminology, "PDPM nursing component."

In § 1187.93(4), the Department is proposing to indicate that picture dates for rate setting, beginning April 1, 2026, will be based on the PDPM CMIs in Appendix D.

§ 1187.96. Price-setting and rate-setting computations

The Department is proposing to delete § 1187.96(a)(3) (relating to price-setting and rate-setting computations) as it addresses past rate years and will be obsolete.

The Department is also proposing to delete § 1187.96(a)(6) as it addresses past rate years.

In § 1187.96(a)(7), the Department is proposing to amend this section by deleting outdated text because it will be obsolete. Under this proposed rulemaking, the Department proposes to replace with text to provide that the Department will calculate the nursing facility's resident care rate in accordance with the PDPM.

The Department is proposing to delete § 1187.96(b)(3), (c)(3) and (e)(2) and (3) as they address past rate years.

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

Under this section, the Department proposes to delete references to "RUG-III" and replace the text with the PDPM nursing component. Specifically, beginning April 1, 2026, the Statewide average MA CMI assigned to a new nursing facility will be calculated using the PDPM nursing component case-mix group values in Appendix D. Further, beginning July 1, 2026, a new nursing facility will be assigned the peer group price for resident care using the PDPM nursing component case-mix group values in Appendix D.

§ 1187.98. Phase-out median determination

The Department is proposing to delete this section as it applies to past rate years and will be obsolete.

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

As previously provided, the Department is proposing to delete Appendix A because it provided RUG-III scores and will be obsolete.

Appendix D. Patient Driven Payment Model for Case-Mix Adjusted Nursing Categories in the Nursing Facility Reimbursement System

The Department is proposing to add Appendix D. Appendix D is a chart that lists the PDPM nursing component case-mix groups and PDPM CMI scores that the Department will use to set each nursing facility's PDPM resident care rate beginning April 1, 2026, and thereafter. The CMS Fact Sheets provide additional details on the groupers and each classification, available at https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model (nursing component begins on page 5 on PDPM Patient Classification Fact Sheet).

§ 1189.105. Incentive payments

In § 1189.105(b) (relating to incentive payments), references to "RUG-III" are proposed to be deleted and replaced with "PDPM nursing component case-mix group values."

Affected Individuals and Organizations

This proposed rulemaking affects nonpublic and county nursing facilities enrolled in the MA Program. There are approximately 592 nonpublic nursing facilities and 15 county nursing facilities in this Commonwealth enrolled in the MA Program. There is an average of 41,777 MA recipients who receive nursing facility services in a typical year. In each facility, the nurse assessment coordinators complete the MDS for each resident. Nursing facilities have already made required systems and procedural changes needed to implement collection of PDPM data elements. There would be no additional MDS assessments required for a nursing facility other than what is already Federally required. Likewise, there is no impact to county nursing facilities because the case-mix rate methodology for county nursing facilities does not rely on CMI scores. Moving to the PDPM classification system may increase payments to some nursing facilities and decrease payments to other nursing facilities.

The Department reviewed whether nursing facility residents would be affected by this proposed rulemaking, and it was determined that they would not be affected because this proposed rulemaking makes no revisions to the nursing facility services provided to residents and it does not increase or reduce any staffing requirements.

Accomplishments and Benefits

The PDPM system classifies residents into case-mix categories based on clinical characteristics, resident assessments, resident diagnosis and predicted resources needed to care for a resident during their stay; therefore, the PDPM acuity scores are more accurate than RUG-III based on the resident's characteristics which leads to a more accurate rate setting.

Fiscal Impact

Section 1602-T of the Fiscal Code (72 P.S. § 1602-T) directs the Department to apply a revenue adjustment neutrality factor, commonly referred to as a budget adjustment factor (BAF), through June 30, 2026, that limits the average payment rate in effect in a fiscal year to the amount of funds appropriated by the General Appropriation Act for each fiscal year. The reauthorization of the BAF beyond June 30, 2026, would make the overall fiscal impact budget neutral to the Department because final case-mix per diem rates would be limited to the amount permitted by the funds appropriated by the General Appropriation Act for each fiscal year.

If, however, the General Assembly does not continue to reauthorize the BAF, the increased CMI scores resulting from the PDPM methodology will result in higher case-mix per diem rates for 591 of 592 nursing facilities (99%) compared to the RUG-based methodology. The average increase in case-mix per diem rates for nursing facilities in this scenario is 28.92%, with four nursing facilities having rate increases of more than 100%. This scenario results in an overall cost increase to the Department of

$3.9 billion ($1.8 billion in State funds) between State Fiscal Year 2026-2027 and State Fiscal Year 2029-2030.

If the BAF is reauthorized beyond June 30, 2026, the overall fiscal impact to the Department is neutral and the impact to individual nursing facility rates varies. In this scenario, the PDPM methodology results in higher BAF-adjusted rates for approximately 40% of nursing facilities compared to the RUG-based methodology. The four nursing facilities with the highest CMI acuity scores will see BAF-adjusted rate increases of between 73% and 81%. Approximately 359 nursing facilities will see BAF-adjusted rates decrease. It is important to note that by definition, the BAF-adjusted per diem rates under the current RUG-based methodology also result in increases in rates for some nursing facilities and decreases in rates for others. In this analysis, the nursing facility with the largest gain has an 80.26% BAF-adjusted per diem rate increase, while the nursing facility with the largest loss has a 24.91% BAF-adjusted per diem rate decrease.

Paperwork Requirements

Under this proposed rulemaking, there will be no increase or decrease in paperwork requirements as nursing facilities will continue to do the same number of assessments. Nursing facilities have already made required systems and procedural changes needed to implement collection of PDPM data elements. There would be no additional MDS assessments required for a facility other than what is already Federally required. Likewise, there is no impact to county nursing facilities because the case-mix rate methodology for county nursing facilities does not rely on CMI scores.

Effective Date

This proposed rulemaking, if approved on final-form rulemaking, will take effect August 1, 2025.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed rulemaking to the Department of Human Services, Office of Long-Term Living, Bureau of Policy and Regulatory Management, Attention: Jennifer Hale, P.O. Box 8025, Harrisburg, PA 17105-8025 or at RA-PWOLTLNFPUBLICCOM@pa.gov within 30 calendar days after the date of publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Reference Regulation No. 14-556 when submitting comments.

Persons with a disability who require an auxiliary aid or service may submit comments using the Pennsylvania Hamilton 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. § 745.5a), on September 25, 2024, the Department submitted a copy of this proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the chairperson of the Committee on Health and Human Services of the Senate and the chairperson of the Committee on Human Services of the House of Representatives. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey comments, recommendations or objections to the proposed rulemaking within 30 days after the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria in section 5.2 of the Regulatory Review Act (71 P.S. § 745.5b) which have not been met. The Regulatory Review Act specifies detailed procedures for review prior to final publication of the rulemaking by the Department, the General Assembly and the Governor.

VALERIE A. ARKOOSH,
Secretary

Fiscal Note: 14-556. Under section 612 of The Administrative Code of 1929 (71 P.S. § 232), (1) General Fund;

(7) MA—Long-Term Living; (2) Implementing Year 2023-24 is $0; (3) 1st Succeeding Year 2024-25 and 2nd Succeeding Year 2025-26 are $0; 3rd Succeeding Year 2026-27 through 5th Succeeding Year 2028-29 are $54,000,000; (4) 2022-23 Program—$131,981,000; 2021-22 Program—$121,346,000; 2020-21 Program—$208,841,000;

(7) MA—Community HealthChoices; (2) Implementing Year 2023-24 is $0; (3) 1st Succeeding Year 2024-25 and 2nd Succeeding Year 2025-26 are $0; 3rd Succeeding Year 2026-27 through 5th Succeeding Year 2028-29 are $1,746,000,000; (4) 2022-23 Program—$4,460,000,000; 2021-22 Program—$4,251,000,000; 2020-21 Program—$3,165,000,000;

(8) recommends adoption. Funds have been included in the budget to cover this increase.

Annex A

TITLE 55. HUMAN SERVICES

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:

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Benefits, nonstandard or *nonuniform*—Employe benefits provided to selected individuals, which are not provided to all nursing facility employes in conjunction with their employment status, or benefits which are not normally provided to employes.

***Case-mix group*—A patient classification system that aggregates nursing facility residents by clinical similarities and resource use.**

CMI—**[** ***Case-Mix Index*** **]** ***case-mix index***—A number value score that describes the relative resource use for the average resident **[in each of the groups under the RUG-III classification system]** **utilizing the PDPM nursing component classification methodology and associated weights** based on the assessed needs of the resident.

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

(i) The resident's payor status.

(ii) The resident's **[RUG category]** **PDPM nursing component case-mix group** and CMI.

(iii) The resident assessment used to determine the resident's **[RUG category and CMI and the date and**

type of the assessment] PDPM nursing component case-mix group, PDPM CMI, the date and type of the assessment.

Classifiable data element—A data element on the Federally Approved Pennsylvania Specific Minimum Data Set (PA specific MDS) which is used for the classification of a resident into **[one of the RUG-III categories] the PDPM nursing component case-mix group**.

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New nursing facility—A newly constructed, licensed and certified nursing facility; or an existing nursing facility that has never participated in the MA Program or an existing nursing facility that has not participated in the MA Program during the past 2 years.

***Nursing component*—An element of PDPM used to determine a resident's acuity to assign a resident to a case-mix group.**

Nursing facility—

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

(A) Licensed by the Department of Health.

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

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

(ii) The term does not include intermediate care facilities for persons with an intellectual disability, Federal or State-owned long-term care nursing facilities, Veteran's homes or county nursing facilities.

***PDPM—patient driven payment model*—A case-mix classification system for classifying nursing facility residents into payment groups based on their characteristics and clinical needs. The system includes five case-mix adjusted components: Physical Therapy, Occupational Therapy, Speech Language Pathology, Nursing and Non-Therapy Ancillary.**

Peer groups—Groupings of nursing facilities for payment purposes under the case-mix system.

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RNAC—Registered Nurse Assessment Coordinator—An individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility, and who is responsible for coordinating and certifying completion of the resident assessment.

[*RUG-III—Resource Utilization Group, Version III*—A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs.]

Real estate tax cost—The cost of real estate taxes assessed against a nursing facility for a 12-month period, except that, if the nursing facility is contractually or otherwise required to make a payment in lieu of real estate taxes, that nursing facility's "cost of real estate taxes" is deemed to be the amount it is required to pay for a 12-month period.

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Subchapter D. DATA REQUIREMENTS FOR NURSING FACILITY APPLICANTS AND RESIDENTS

§ 1187.33. Resident data and picture date reporting requirements.

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

(1) If a valid assessment is not received within the acceptable time frame for an individual resident, the resident will be assigned the lowest individual **[RUG-III] PDPM** CMI value for the computation of the facility MA CMI and the highest **[RUG-III] PDPM** CMI value for the computation of the total facility CMI.

(2) If an error on a classifiable data element on a resident assessment is not corrected by the nursing facility within the specified time frame, the assumed answer for purposes of CMI computations will be "no/not present."

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

Subchapter G. RATE SETTING

§ 1187.92. Resident classification system.

(a) The Department will use the **[RUG-III to adjust payment for resident care services based on the classification of nursing facility residents into 44 groups] PDPM nursing component to adjust payment for resident care services based on the case-mix classification of nursing facility residents**.

(b) Each resident shall be included in the **[RUG-III category with the highest numeric CMI for which the resident qualifies] PDPM nursing component and assigned into the first case-mix group for which the resident meets the criteria. Each resident will qualify for only one case-mix group**.

(c) **[The Department will use the RUG-III nursing CMI scores normalized across all this Commonwealth's nursing facility residents] [Reserved]**.

(d) The Department will announce, by notice submitted for recommended publication in the *Pennsylvania Bulletin* and suggested codification in the *Pennsylvania Code* as Appendix **[A, the RUG-III nursing CMI scores, and the PA normalized RUG-III index scores] D, the PDPM nursing component case-mix group and PDPM CMI scores**.

(e) The **[PA normalized RUG-III index] PDPM CMI** scores will remain in effect until a subsequent notice is published in the *Pennsylvania Bulletin*.

(f) Resident data for **[RUG-III] PDPM nursing component** classification purposes shall be reported by each nursing facility under § 1187.33 (relating to resident data and picture date reporting requirements).

§ 1187.93. CMI calculations.

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

(1) An individual resident's CMI shall be assigned to the resident according to the **[RUG-III] PDPM nursing component** classification system.

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(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] April 1, 2026, and thereafter will be calculated based on the PDPM CMIs in Appendix D.

§ 1187.96. Price-**setting** 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.

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(3) **[For rate years 2006-2007, 2007-2008, 2009-2010, 2010-2011 and 2011-2012, the median used to set the resident care price will be the phase-out median as determined in accordance with § 1187.98 (relating to phase-out median determination)]** [Reserved].

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(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] [Reserved].

(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.]** **Beginning with the fourth quarter of rate year 2025-2026, and thereafter, the Department will calculate each nursing facility's resident care rate in accordance with the PDPM. The CMI values used to determine each nursing facility's total facility CMI and facility MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the PDPM nursing component case-mix group values as set forth in Appendix D.** The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(b) Using the NIS database in accordance with this subsection and § 1187.91, the Department will set prices for the other resident related cost category.

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(3) **[For rate years 2006-2007, 2007-2008, 2009-2010, 2010-2011 and 2011-2012, the median used to set the other resident related price will be the phase-out median as determined in accordance with § 1187.98]** **[Reserved]**.

(4) The median of each peer group will be multiplied by 1.12, and the resultant peer group price assigned to each nursing facility in the peer group. This price for each nursing facility will be limited by § 1187.107 to determine the nursing facility other resident related rate.

(c) Using the NIS database in accordance with this subsection and § 1187.91, the Department will set prices for the administrative cost category.

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(3) **[For rate years 2006-2007, 2007-2008, 2009-2010, 2010-2011 and 2011-2012, the median used to set the administrative price will be the phase-out median as determined in accordance with § 1187.98]** **[Reserved]**.

* * * * *

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

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

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

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

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

by a budget adjustment factor determined in accordance with subparagraph (iv).

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

(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]** [Reserved].

§ 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 will be assigned the Statewide average MA CMI until assessment data submitted by the nursing facility under § 1187.33 (relating to resident data and picture date reporting requirements) is used in a rate determination under § 1187.96(a)(5) (relating to price-**setting** and rate-setting computations). Beginning, **[July 1, 2010]** **April 1, 2026**, 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]** **PDPM nursing component case-mix group values in Appendix D** 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]** **PDPM nursing component case-mix** group values and the resident assessment that will be used for each resident will be the most recent classifiable assessment of any type.

(B) 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]** **July 1, 2026**, 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]** **PDPM nursing component case-mix group values in Appendix D** and the most recent classifiable assessments of any type.

* * * * *

§ 1187.98. **[Phase-out median determination]** [Reserved].

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

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

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

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

(b) For rate years, 2009-2010, 2010-2011 and 2011-2012, the Department will determine a phase-out median for each net operating cost center for each peer group to calculate a peer group price. The Department will establish the phase-out median as follows:

(1) The Department will establish an interim phase out median for the rate year as specified in subsection (a).

(2) The phase-out median for the 2009-2010 rate year will equal 75% of the interim median calculated in accordance with paragraph (1) plus 25% of the median calculated in accordance with § 1187.96.

(3) The phase-out median for the 2010-2011 rate year will equal 50% of the interim median calculated in accordance with paragraph (1) plus 50% of the median calculated in accordance with § 1187.96.

(4) The phase-out median for the 2011-2012 rate year will equal 25% of the interim median calculated in accordance with paragraph (1) plus 75% of the median calculated in accordance with § 1187.96.

(c) For the rate year, 2012-2013 and thereafter, county nursing facility MA allowable costs will not be used in the rate-setting process for nonpublic nursing facilities.]

APPENDIX A. [Reserved]

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

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**

RUG-III Group	*RUG-III Nursing CMI*	*RUG-III PA Normalized Index*
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]

(*Editor's Note*: Appendix D is proposed to be added and is printed in regular type to improve readability.)

APPENDIX D

PATIENT DRIVEN PAYMENT MODEL FOR CASE-MIX ADJUSTED NURSING CATEGORIES IN THE NURSING FACILITY REIMBURSEMENT SYSTEM

The following chart is a listing by group of the PDPM CMI scores that the Department will use to set each nursing facility's PDPM resident care rate.

PDPM Nursing Component: Case-Mix Group and CMI Scores	
PDPM Nursing Component Case-Mix Group	*PDPM Case-Mix Index Scores*
ES3	3.95
ES2	2.99
ES1	2.85
HDE2	2.33
HDE1	1.94
HBC2	2.18
HBC1	1.81
LDE2	2.02
LDE1	1.68
LBC2	1.67
LBC1	1.39
CDE2	1.82
CDE1	1.58
CBC2	1.51
CA2	1.06
CBC1	1.30
CA1	0.91
BAB2	1.01
BAB1	0.96
PDE2	1.53
PDE1	1.43
PBC2	1.19
PA2	0.69
PBC1	1.10
PA1	0.64

CHAPTER 1189. COUNTY NURSING FACILITY SERVICES

Subchapter E. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

§ 1189.105. Incentive payments.

* * * * *

(b) *Pay for performance incentive payment.* The Department will establish pay for performance measures that will qualify a county nursing facility for additional incentive payments in accordance with the formula and qualifying criteria in the Commonwealth's approved State Plan. For pay for performance payment periods beginning on or after July 1, 2010, in determining whether a county nursing facility qualifies for a quarterly pay for performance incentive, the facility's MA CMI for a picture date will equal the arithmetic mean of the individual CMIs for MA residents identified in the facility's CMI report for the picture date. An MA resident's CMI will be calculated using the **[RUG-III version 5.12 44 group values in Chapter 1187, Appendix A (relating to resource utilization group index scores for case-mix adjustment in the nursing facility reimbursement system)]** **PDPM nursing component case-mix group values in Chapter 1187, Appendix D (relating to patient driven payment model for case-mix adjusted nursing categories in the nursing facility reimbursement system)** and the most recent classifiable assessment of any type for the resident.

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