

# RULES AND REGULATIONS

## Title 55—PUBLIC WELFARE

### DEPARTMENT OF PUBLIC WELFARE

#### [ 55 PA. CODE CH. 51 ]

#### Office of Developmental Programs Home and Community-Based Services

The Department of Public Welfare (Department) adds Chapter 51 (relating to Office of Developmental Programs home and community-based services) to read as set forth in Annex A under the authority of sections 201(2), 403(b) and 403.1 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b) and 403.1), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

#### *Omission of Proposed Rulemaking*

On July 1, 2011, the General Assembly enacted Act 22, which amended the code. Act 22 added several new provisions to the code, including section 403.1. Section 403.1(a)(4) and (6), (c) and (d) of the code authorizes the Department to promulgate final-omitted regulations under section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(v)), known as the Commonwealth Documents Law (CDL), to establish or revise provider payment rates or fee schedules, reimbursement models and payment methodologies for particular services and to establish provider qualifications. Section 204(1)(iv) of the CDL authorizes an agency to omit or modify notice of proposed rulemaking when a regulation relates to Commonwealth grants and benefits. The Medical Assistance (MA) Program is a Commonwealth grant program through which eligible recipients receive coverage of certain health care benefits. In addition, to ensure the Department's expenditures for State Fiscal Year (FY) 2011-2012 do not exceed the aggregate amount appropriated by the General Assembly, section 403.1 of the code expressly exempts these regulations from the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is adding Chapter 51 in accordance with section 403.1 of the code because this final-omitted rulemaking establishes payment rates, fee schedules, payment methodologies and provider qualifications. This final-omitted rulemaking applies to providers participating in the Adult Autism, Consolidated and Person/Family Directed Support Home and Community-Based Services (HCBS) waiver programs, as well as providers of targeted services management.

#### *Purpose*

The purpose of this final-omitted rulemaking is to help bring expenditures for State FY 2011-2012 within the aggregate amount appropriated for HCBS programs by the General Appropriations Act of 2011.

#### *Background*

The Secretary of the United States Department of Health and Human Services is authorized under 42 CFR 441.302 (relating to state assurances) to waive certain Medicaid statutory requirements. These waivers enable states to cover a broad array of HCBS for targeted populations as an alternative to institutionalization. The Office of Developmental Programs (ODP) operates three HCBS waiver programs: Adult Autism; Consolidated; and Person/Family Directed Support. These waiver programs

have grown 141% in the past 11 years. The cost of these programs has also increased from \$752 million in FY 2000 to \$1.81 billion in FY 2011.

Beginning in 2009, the Department began implementation of a Statewide rate-setting system for ODP-administered waiver programs to establish provider payment rates consistently across this Commonwealth, ensure program integrity and further promote efficient use of Federal and State resources. To further provide clarity regarding program requirements and to improve the cost-effectiveness of these programs, the Department is promulgating this final-omitted rulemaking. The promulgation of this final-omitted rulemaking will enable the Commonwealth to efficiently use Federal funding for HCBS programs and will ensure that the Department's expenditures for State FY 2011-2012 do not exceed the aggregate amount appropriated by the General Assembly.

This final-omitted rulemaking focuses on establishing payment methodologies for HCBS that are efficient and economical and establishes provider qualifications to ensure the quality of care being rendered by providers applying for and rendering MA HCBS and providers of targeted services management. This chapter supersedes Chapters 4300 and 6200 (relating to county mental health and mental retardation fiscal manual; and room and board charges) when a provider provides an HCBS to both waiver and base-funded participants from a waiver service location.

#### *Requirements*

The following is a summary of the major provisions of the final-omitted rulemaking.

#### *§ 51.4. Incorporation by reference*

This section incorporates by reference the approved applicable waivers, including future approved waiver amendments. The approved applicable Consolidated and Person/Family Directed Support Federal waivers can be found on the Department's web site at <http://www.dpw.state.pa.us/dpworganization/officeofdevelopmentalprograms/index.htm>.

The approved applicable Adult Autism Waiver can be found on the Department's web site at [http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p\\_011923.pdf](http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_011923.pdf).

#### *§ 51.11. Prerequisites for participation*

This section provides provider enrollment requirements to verify providers are qualified to provide a service. A provider is required to complete an MA application and sign an MA provider agreement and an HCBS waiver provider agreement. A provider is also required to complete the provider enrollment application and submit supporting qualification documents to the Department or the Department's designee. In addition, a provider is required to comply with the approved applicable waiver, including future approved waiver amendments.

#### *§ 51.13. Ongoing responsibilities of providers*

This section provides the ongoing requirements for providers, including qualification and training requirements. A provider is required to be qualified at least every 2 years or more frequently as required by the approved waiver. A provider that fails to submit qualification documentation is precluded from receiving payment under the MA Program.

§ 51.15. *Provider records*

This section establishes standards for certification that the services or items for which the provider claims payment were provided and that information submitted in support of the claim is accurate and complete.

§ 51.23. *Provider training*

This section requires a provider to ensure that employees providing HCBS have met the training requirements based on participant needs as specified in a participant's Individual Service Plan (ISP). In addition, providers are required to implement a standard annual training on various topics, including meeting each participant's needs related to communication, mobility, behavior interventions, prevention of abuse, reporting and investigating incidents, participant grievance resolution, and billing and documentation of service delivery.

§ 51.25. *Quality management*

This section requires a provider to create, implement and update a quality management plan as required by the approved applicable waiver. The plan must detail how the provider will measure, remediate and improve its performance in accordance with criteria to be established by the Department.

§ 51.31. *Transition of participants*

This section requires a provider to send written notification to each participant, the Department, a licensing or certifying entity and the Supports Coordinator 30 calendar days prior to transitioning a participant to another provider when the provider is no longer willing to provide an HCBS. A provider is also required to send the Department a copy of the notification sent to a participant.

§ 51.32. *Back-up plans*

This section requires a provider to have a back-up plan as required by the approved applicable waiver. The back-up plan is necessary for HCBS to be implemented as authorized in a participant's ISP.

§ 51.43. *Department rates and HCBS classification*

§ 51.44. *Payment policies*

Section 51.43 provides that an HCBS will be paid under one of four categories: (1) the MA fee schedule; (2) a vendor good and service charge; (3) a cost-based rate; or (4) a Department-established fee. Section 51.44 provides the Department's payment policies regarding HCBS. The Department will only pay for compensable HCBS in the amount, duration and frequency listed on a participant's approved ISP.

§ 51.46. *Audit requirements*

This section requires a provider to comply with audit standards and to retain books, records and documents for audit and inspection.

§ 51.52. *Fee schedule rate*

§ 51.53. *Fee schedule rate reimbursement*

§ 51.62. *Vendor goods and services reimbursement*

§ 51.72. *Cost-based rate assignment*

§ 51.131. *Department-established fees*

These sections identify the services and payment methodology for which HCBS will be reimbursed. The MA fee schedule reimbursement payment methodology includes a review of the HCBS service definitions and a determination of allowable cost components which reflect costs that are reasonable, necessary and related to the delivery of

the service. The Department will publish the fee schedule rates under the MA Program fee schedule as a notice in the *Pennsylvania Bulletin*.

A limited number of goods and services are reimbursed at the actual cost. The Department will publish the list of these vendor goods and services as a notice in the *Pennsylvania Bulletin*.

The cost-based rate methodology is based on cost report data submitted by providers and approved in a desk review process. The Department will identify changes in HCBS being classified as a cost-based service by publishing a notice in the *Pennsylvania Bulletin*.

Under § 51.131, the Department will establish a fee for the portion of payment for residential habilitation HCBS which is ineligible for Federal reimbursement. The Department uses State-only funds to make this fee payment. The Department will publish the fee as a notice in the *Pennsylvania Bulletin*.

§ 51.81. *Allowable costs*

This section sets forth the parameters that must be met prior to a cost being considered an allowable cost under the cost-based rate-setting methodology. Costs must be documented, conform to the limitations in the approved applicable waiver and relate to the provision of an HCBS.

§ 51.152. *Termination of provider agreement*

§ 51.153. *Sanctions*

These sections set forth provider sanctions in the event of noncompliance with the regulations. Sanctions include the following: withholding or disallowing all or a portion of future payments; suspending payment or future payment pending compliance; and recouping payments for services the provider cannot verify as being provided in the amount, duration and frequency billed.

*Affected Individuals and Organizations*

The final-omitted rulemaking affects providers who deliver HCBS through the Adult Autism, Consolidated and Person/Family Directed Support HCBS programs. This final-omitted rulemaking also applies to providers of targeted services management.

*Accomplishments and Benefits*

The Department is implementing cost savings to ensure that the expenditures for State FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011. This final-omitted rulemaking also provides the Department with authority to enforce provisions of its HCBS programs, specifies the payment provisions for waiver services and establishes provider qualifications and monitoring requirements.

*Fiscal Impact*

The Commonwealth will realize an estimated savings of \$8.028 million in State funds in FY 2011-2012 with implementation of this final-omitted rulemaking.

*Paperwork Requirements*

There are new paperwork requirements under the final-omitted rulemaking. However, there is not a reasonable alternative to this increased paperwork. The final-omitted rulemaking contains the paperwork requirements for providers to apply for enrollment in the MA Program to deliver a waiver service. In addition, providers who do not meet the provisions of the regulations are required to

create a corrective action plan to demonstrate how the provider will remediate the areas of noncompliance.

#### *Public Process*

The Department published advance notice at 42 Pa.B. 1006 (February 18, 2012) announcing its intent to adopt regulations regarding HCBS provider payment rates, fee schedules, reimbursement models, payment methodologies and provider qualifications. The Department invited interested persons to comment. In addition, the Department discussed the payment rates and methodologies with the Medical Assistance Advisory Committee at the February 23, 2012, meeting.

The Department also posted a draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department again invited interested persons to submit written comments regarding the regulations to the Department. The Department received over 1,000 individual comments from 260 commentators. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

The Department carefully considered the comments received in response to the draft regulations.

#### *Discussion of Comments*

Following is a summary of the major comments received within the public comment period and the Department's response to the comments.

#### *Comment*

Several commentators stated that the Department did not allow sufficient time for review and comment on the regulations. In addition, commentators requested the public comment period be extended an additional 30 days due to the policy changes and the volume of regulations.

#### *Response*

The Department engaged in a transparent public process through which the Department solicited and received numerous comments and input from stakeholders and other interested parties.

As previously mentioned, the Department published advance public notice at 42 Pa.B. 1006 announcing its intent to adopt regulations regarding HCBS provider payment rates, fee schedules, reimbursement models, payment methodologies and provider qualifications. The Department invited interested persons to comment. The Department also posted the draft regulations on the Department's web site on February 24, 2012. The Department again invited interested persons to submit written comments, on or before March 9, 2012, regarding the regulations to the Department. As a final-omitted rule-making under Act 22, the Department was not required to have a public comment process. However, to encourage transparency and public input, the Department provided an opportunity for comment by publishing the notice and posting the draft regulations on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments, as supported by the number of comments that were submitted.

#### *§ 51.14. Residential habilitation service providers*

#### *Comment*

Several commentators objected to these new provider qualification requirements on the basis that changes in existing residential habilitation service locations and the

establishment of new residential habilitation service locations will require a provider to receive prior approval from the Department.

#### *Response*

The Department is not revising the language in this section as the requirement is based on standards provided in the approved applicable waivers.

#### *§ 51.20. Criminal history checks*

#### *Comment*

Commentators suggested that criminal history checks for "contracted" personnel would be a new requirement, is overly burdensome and should be revised to apply to staff who work directly with participants.

#### *Response*

The Department concurs and revised the regulation accordingly.

#### *§ 51.23. Provider training*

#### *Comment*

Eighteen commentators suggested that the standard list of required staff training in this section is a new and overly burdensome requirement for every staff and contractor to complete. The commentators suggested that the training should only apply to staff and contracted personnel who work directly with participants.

#### *Response*

The Department agrees that § 51.23 should be revised to apply to staff and contracted personnel who work directly with participants. Therefore, the Department revised the definition of "staff" in § 51.3 (relating to definitions) to include employees and contracted personnel when they have direct contact with a participant for the provision of an HCBS.

#### *§ 51.25. Quality management*

#### *Comment*

Eighteen commentators suggested that the Quality Management (QM) plan criteria in the regulation will require additional resources currently not available in the system.

#### *Response*

The Department did not make revisions to the language requiring providers to develop a QM plan. The QM plan is an essential element for the Department and the providers to fulfill the assurances in the approved applicable waiver and provide quality services to participants.

#### *§ 51.27. Misuse and abuse of funds and damage of participant's property*

#### *Comment*

Sixteen commentators suggested that the language which requires the provider to be responsible to replace a participant's personal property be revised to state that the provider is only responsible to replace or compensate for property that was lost or damaged by the provider while providing HCBS to the participant.

#### *Response*

The Department concurs and has revised this section so it is clear that the provider is only responsible to replace or compensate for property that was lost or damaged by the provider while providing HCBS to a participant.

§ 51.28. *SCO requirements for Consolidated and P/FDS Waiver*

*Comment*

Several commentators suggested that the residential habilitation service criteria which the supports coordinator shall review prior to that service being added to an ISP would preclude many participants from receiving residential habilitation services in a family home environment.

*Response*

The Department concurs and deleted the language that the commentators found objectionable.

§ 51.32. *Back-up plans*

*Comment*

Eighteen commentators suggested the Department delete the requirement for a provider to have a back-up plan for the provision of HCBS. The commentators stated that they do not understand the difference between a back-up plan and the ISP.

*Response*

The Department did not delete the requirement for a provider to develop a back-up plan. The Department did, however, revise the language to explain that a back-up plan assures that HCBS is provided at the frequency and duration established in the participant's ISP. Detailed information on the back-up plan for each HCBS the provider renders for a participant is then added to the ISP.

§ 51.83. *Bidding and procurement*

*Comment*

Twelve commentators opposed this section. They contended it is not practical or cost-efficient for providers to obtain bids for the supplies they purchase.

*Response*

The Department concurs and revised the language in this section to require competitive bidding for supplies and HCBS over \$5,000.

§ 51.92. *Rental of administrative, residential and non-residential buildings*

*Comment*

Eleven commentators suggested the language should be clarified with regard to real estate tax since the regulation does not allow the lessee to obtain a profit.

*Response*

The Department finds that this provision promotes fiscal accountability. As a result, a change was not made to the regulation.

§ 51.94. *Fixed assets*

*Comment*

Several commentators objected to this section. They argued that the fixed asset is the property of the provider and the provider should be able to use it at its discretion.

*Response*

The Department is not revising this section. The goal of the Department is to maintain program assets which have been paid for with MA Program funds and to allow a provider to reinvest the proceeds of any sale of a program asset back into the MA Program.

§ 51.96. *Capital assets—administrative and nonresidential buildings*

*Comment*

Several commentators opposed the requirements for providers to receive prior written approval from the Department for a planned major renovation of an administrative or nonresidential building with a cost above 10% of the original cost of the building being renovated. The commentators stated that the providers should be able to use the property at their discretion and should not have to obtain prior approval from the Department to renovate a building. The commentators also objected to the provision on recoupment of funds.

*Response*

The Department revised the threshold percentage for required prior approval from 10% to 25% of the original cost of the building being renovated for a planned major renovation of an administrative or nonresidential building. The Department also added language that as an alternative to recoupment, with Department approval, the provider can reinvest the proceeds from the sale of a service location into any capital asset used in the MA Program.

§ 51.97. *Capital assets—residential buildings*

*Comment*

Several commentators suggested that the requirement to return funded equity in a property if it is sold is unreasonable and removes the flexibility that is essential for a provider to change service structures by eliminating the provider's capital base.

*Response*

The Department revised the threshold percentage for required prior approval from 10% to 25% of the original cost of the building being renovated for a planned major renovation of a residential building. The Department also added language that as an alternative to recoupment, with Department approval, the provider can reinvest the proceeds from the sale of the service location into a capital asset used in the MA Waiver Program.

§ 51.98. *Residential habilitation vacancy*

*Comment*

Several commentators recommended that the regulation should contain a provider-specific vacancy factor and the commentators expressed concern that the language included in the regulation needed to be managed at the participant level and not the provider level.

*Response*

The Department did not agree with the comments. The vacancy factor will remain a standard vacancy factor and not a provider-specific factor. In addition, the vacancy factor will be managed at the provider level. The Department added subsection (e) to further clarify the Department's intent to maintain the management of the vacancy factor at the provider level. Further, the vacancy factor will be established for all waiver residential habilitation services by publication as a notice in the *Pennsylvania Bulletin*.

*Regulatory Review Act*

Under section 403.1 of the code, this final-omitted rulemaking is not subject to the Regulatory Review Act.

*Findings*

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL and 1 Pa. Code § 7.4(1)(iv) because the regulations relate to Commonwealth grants and benefits.

(2) The adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

*Order*

The Department, acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code, are amended by adding §§ 51.1—51.4, 51.11—51.34, 51.41—51.48, 51.51—51.53, 51.61, 51.62, 51.71—51.75, 51.81—51.103, 51.111, 51.121—51.128, 51.131, 51.141 and 51.151—51.157 to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Office of General Counsel for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this order and Annex A with the Legislative Reference Bureau as required by law.

(d) This order shall take effect July 1, 2011, in accordance with section 403.1(e) of the code. Sections 51.14(a) and (b), 51.28(d)—(h), 51.74(9) and (15), 51.75(3) and 51.98(d) shall take effect upon written notification that the Centers for Medicare and Medicaid Services has granted approval of the Consolidated and Person/Family Directed Support HCBS Waivers. Upon written notification of approval, the Department will publish a notice in the *Pennsylvania Bulletin*. Sections 51.73(e), 51.87, 51.92(a)(1), 51.94(f), 51.95(b)(1), 51.96(b) and (g), 51.97(4) and (5), 51.103(a), 51.111 and 51.131(b) and (c) shall take effect upon publication.

GARY D. ALEXANDER,  
*Secretary*

**Fiscal Note:** 14-533. No fiscal impact; (8) recommends adoption.

**Annex A**

**TITLE 55. PUBLIC WELFARE**

**PART I. DEPARTMENT OF PUBLIC WELFARE**

**Subpart E. HOME AND COMMUNITY-BASED SERVICES**

**CHAPTER 51. OFFICE OF DEVELOPMENTAL PROGRAMS HOME AND COMMUNITY-BASED SERVICES**

**Subchap.**

- A. GENERAL PROVISIONS**
- B. PROVIDER QUALIFICATIONS AND PARTICIPATION**
- C. PAYMENTS FOR SERVICES**
- D. CLOSURES AND TERMINATION**

**Subchapter A. GENERAL PROVISIONS**

**Sec.**

- 51.1. Purpose.
- 51.2. Scope.
- 51.3. Definitions.
- 51.4. Incorporation by reference.

**§ 51.1. Purpose.**

This chapter specifies the program and payment requirements for providers participating in the Adult Autism, Consolidated and P/FDS Waivers.

**§ 51.2. Scope.**

This chapter applies to providers applying for and rendering MA waiver HCBS and providers of targeted services management. This chapter supersedes Chapters 4300 and 6200 (relating to county mental health and mental retardation fiscal manual; and room and board charges) when a provider provides an HCBS to both waiver and base-funded participants from a waiver service location.

**§ 51.3. Definitions.**

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

*AWC/FMS—Agency with choice/financial management service provider*—A type of financial management service provider.

*Abuse*—The allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation.

*Additional individualized staffing*—Additional staffing as part of the licensed waiver residential habilitation services to meet the long-term needs of a participant when those needs cannot be met as a part of the usual residential habilitation staffing pattern.

*Adult Autism Waiver*—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) designed to help participants with Autism Spectrum Disorder who are 21 years of age and older to live more independently in their homes and communities.

*Agency provider*—An entity that employs staff to provide an HCBS.

*Annual review ISP*—The document that outlines the results of the annual review meeting.

*Applicant*—An individual provider, SSW or agency provider in the process of enrolling as an HCBS provider with the Department.

*Approved program capacity*—The maximum number of participants who are authorized by the Department to receive services in a waiver residential habilitation service location.

*Assessed need*—A documented need of a participant.

*Assessment*—Instruments and documents used by the ISP team and the Department to identify a participant's specific needs for HCBS.

*Back-up plan*—

(i) A strategy developed by a provider to ensure the HCBS the provider is authorized to provide is delivered in the amount, frequency and duration as specified in the participant's ISP.

(ii) The term is referred to as a contingency plan in the Adult Autism Waiver.

*Base-funded services*—A State-funded HCBS.

*Behavioral specialist HCBS*—Support to a participant that demonstrates behavioral challenges through specialized interventions that assist a participant to increase adaptive behaviors to replace or modify challenging behaviors that prevent or interfere with the participant's inclusion in the community.

*Behavioral support plan*—A set of interventions to be used by people coming into regular contact with the

participant to increase and improve the participant's adaptive behaviors, consistent with the outcomes identified in the participant's ISP.

*CAP—Corrective Action Plan—*

(i) A plan developed by a provider to resolve noncompliance and avoid recurrence of noncompliance.

(ii) The term is referred to as a Plan of Correction in the Adult Autism Waiver.

*Chemical restraint*—A drug used to control acute, episodic behavior that restricts the movement or function of a participant.

*Common law employer*—The person under the vendor fiscal/employer agent FMS option who is the legal employer.

*Conflict of interest*—A situation in which a person, corporation or entity has a personal or professional relationship which is able to be exploited by that person, corporation or entity for personal, professional or financial benefit or gain.

*Consolidated Waiver*—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act designed to help participants with an intellectual disability 3 years of age and older to live more independently in their homes and communities.

*DCAP—Directed Corrective Action Plan*—A document developed or approved by the Department or the Department's designee to resolve noncompliance.

*Department*—The Department of Public Welfare of the Commonwealth.

*Department designee*—An entity designated by the Department to perform specific administrative functions on behalf of the Department.

*EPLS—Excluded Parties List System*—A database maintained by the United States General Services Administration that provides information about parties that are excluded from receiving Federal contracts, certain subcontractors and certain Federal financial and nonfinancial assistance and benefits.

*FMS—Financial management service*—An entity that fulfills specific employer or employer agent responsibilities for a participant that has elected to self-direct some or all of their HCBS.

*Finding*—An identified violation of this chapter, Chapter 1101 (relating to general provisions) or other Federal or State standards.

*Grievance*—The formal expression of dissatisfaction with the provision of a waiver service or a provider's delivery of a waiver service.

*HCBS—Home and Community-Based Services*—An array of medical, financial and social services or goods not covered by third-party medical resources or other funding sources that are necessary and paid for by the Department to assist a participant to live in the community.

*HCSIS—Home and Community Services Information System*—A secure web-enabled information system which manages information regarding participants and providers of waiver services.

*ISP—Individual support plan*—The comprehensive plan for each participant that includes HCBS, risks and mitigation of risks and individual outcomes for a participant.

*ISP team*—A group of people designated by the participant or required to participate in supporting the participant's outcomes.

*Incident*—An occurrence or allegation of an action or situation that may negatively affect a participant's health, welfare, safety or rights.

*Incident investigation*—The process of identifying, collecting and assessing facts from a reportable incident in a systemic manner by a person certified by the Department's approved Certified Investigation Training Program.

*Incident target*—The person who may have caused the incident to occur.

*Individual outcome—*

(i) The level of achievement the participant is working towards.

(ii) The term is referred to as goal in the Adult Autism Waiver.

*Individual provider*—A person who is not employed by an agency and who directly provides the HCBS, including an individual practitioner, independent contractor or SSW provider.

*Integrated and dispersed in the community in noncontiguous locations*—Waiver residential habilitation service locations that are located throughout the community, surrounded by individuals and businesses that are not funded by the Office of Developmental Programs, are not next to each other, side-by-side or back-to-back. Locations that share one common party wall are not considered contiguous.

*Intellectual disability*—Documented subaverage general intellectual functioning that occurs prior to the participant's 22nd birthday and is accompanied by significant limitations in adaptive functioning in at least two areas.

*Invoice*—A bill for an HCBS rendered that is submitted through the Department's designated MMIS billing system.

*LEIE—List of Excluded Individuals/Entities*—A database maintained by the United States Department of Health and Human Services, Office of Inspector General, for use by health care providers, the public and the government which provides information relating to parties excluded from participation in Medicare, Medicaid or other Federal health care programs.

*MA—Medical Assistance.*

*MMIS—Medicaid Management Information System*—The Department's claims processing system.

*Managing employer*—The person who enters into a joint employment arrangement with the AWC/FMS.

*Mechanical restraint*—A device used to control acute, episodic behavior that restricts the movement or function of a participant or portion of a participant's body. Examples include anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices.

*Medicheck*—A Departmental list identifying providers, individuals and other entities precluded from participation in the MA Program.

*Natural supports*—Supports provided by friends, family, spiritual organizations, neighbors, local businesses and civic organizations that are not funded under the waivers.

*ODP*—The Office of Developmental Programs.

*OHCHDS*—*Organized Health Care Delivery System*—An arrangement in which a provider that renders at least one direct MA waiver service also chooses to offer a different vendor HCBS by subcontracting with a vendor to facilitate the delivery of vendor goods or services to a participant.

*Outcomes*—Levels of achievement as described in the ISP.

*P/FDS*—*Person/Family Directed Support*—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act designed to support participants with an intellectual disability 3 years of age and older to live more independently in their homes and communities.

*Participant*—A person receiving HCBS.

*Participant-directed services*—A service managed by an eligible participant who has elected to self-direct through one of the FMS options.

*Performance measure*—Data results collected systematically over time to indicate provider performance.

*Preventable incident*—An event that may have been avoided if preventive measures were designed and implemented to reduce the likelihood of an incident occurring.

*Preventive measures*—Strategies or actions designed to reduce the likelihood of known factors that can result in an adverse event or outcome for a participant.

*Private home*—A home that is not agency owned, leased or operated and is leased or owned by a participant.

*Prone position manual restraint*—A method used to control acute, episodic behavior by holding the participant so that the front of the body is turned toward the supporting surface.

*Provider*—An individual or agency that provides HCBS.

*Provider monitoring*—A scheduled or unscheduled review conducted by the Department, or the Department's designee, to determine a provider's compliance with regulations and the MA and waiver provider agreements.

*Provider performance review data*—Performance data that may be used by the provider to devise QM plans while at the same time giving the provider an early indication of performance below Statewide averages.

*QM plan*—*Quality Management plan*—A written document describing how the provider will measure and remediate its performance to provide quality services and comply with the approved applicable waiver, including approved waiver amendments and this chapter.

*Qualification documentation*—Documentation that supports that a provider or applicant meets the provider qualification requirements for each service as prescribed in the approved applicable waiver, including approved waiver amendments.

*Quarterly summary report*—Information from providers of HCBS that provide services to a particular participant during the previous 3 months that detail the participant's progress towards goals and objectives included in the participant's ISP.

*Remediation*—Actions that are taken to correct deficiencies as a result of an incident or finding.

*Residential habilitation enhanced staffing*—An enhancement to the licensed residential habilitation service which can be residential habilitation services provided by a licensed nurse, supplemental habilitation staffing or

additional individualized staffing. A licensed nurse can also provide residential enhanced staffing in an unlicensed residential habilitation service location.

*Residential habilitation service*—Support in the general areas of self-care, communication, fine and gross motor skills, mobility, socialization and use of community resources for participants that reside in a residential habilitation service location.

*Respite care*—Supervision and support to a participant on a short-term basis due to the absence or need for relief of those persons normally providing care to the participant.

*Risk*—The likelihood of some undesirable event or negative outcome occurring to a participant.

*Risk factors*—Attributes, behaviors, health conditions, features of the environment, actions, events or other determinants that increase the probability of an incident or negative outcome for a participant.

*Risk mitigation strategies*—Proactive action steps to avoid an incident.

*SC*—*Supports coordinator*—A person providing supports coordination services to a participant.

*SCA*—*Supports coordination agency*—A provider that delivers supports coordination services under the Adult Autism Waiver.

*SCO*—*Supports coordination organization*—A provider that delivers:

(i) Supports coordination services under the Consolidated and P/FDS Waivers.

(ii) Targeted services management and base-funded supports coordination.

*SCO monitoring*—Ongoing oversight of the participant's services to ensure services are implemented as specified in a participant's ISP.

*SSW*—*Support service worker*—An individual provider hired by a participant who is self-directing HCBS through the vendor fiscal/employer agent FMS option.

*SSW agreement*—The standard agreement that the SSW signs prior to delivering HCBS to a self-directing participant in the vendor fiscal/employer agent FMS option.

*Satisfaction survey*—A survey designed to measure a participant's approval of HCBS.

*Seclusion*—Placing a participant in a locked room with any type of locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

*Self-direction*—A participant's management of some or all of the participant's approved and authorized services using the assistance of the vendor fiscal/employer agent FMS or agency with choice FMS.

*Service location*—The address identified in HCSIS by an HCBS provider where HCBS are provided or managed.

*Staff*—Employees, contractors or consultants that provide an HCBS through direct contact with a participant, or are responsible for the provision of an HCBS.

*Supplemental habilitation staffing*—Additional staffing as part of the licensed residential habilitation service to meet the temporary medical or behavioral needs of a participant.

*Supports coordination*—A service that includes locating, coordinating and monitoring needed HCBS and other supports for a participant.

*Surrogate*—A person identified under State law to make decisions for a participant who is incompetent or incapacitated or a person designated by a participant that is self-directing HCBS in one of the FMS options.

*TSM—Targeted services management*—Supports coordination services funded through the MA State Plan for individuals receiving MA who are not enrolled in a Medicaid waiver.

*Target objective*—The level of performance a provider desires to achieve within a specified period of time.

*Third-party medical resource*—MA, Medicare, CHAMPUS, workers' compensation, for-profit and non-profit health care coverage and insurance policies, and other forms of insurances that are required to cover a participant's HCBS.

*Vendor fiscal/employer agent FMS*—A nongovernmental entity that is a fiscal agent for a participant who is self-directing using the vendor fiscal/employer agent FMS option.

*Waiver*—The Adult Autism, Consolidated and Person/Family Directed Support Home and Community-Based Waivers approved by the Centers for Medicare and Medicaid Services under section 1915(c) of the Social Security Act.

**§ 51.4. Incorporation by reference.**

The approved applicable waiver, including approved waiver amendments, is incorporated by reference herein. The Consolidated, Person/Family Directed Support and Adult Autism Federal waivers can be found on the Department's web site.

**Subchapter B. PROVIDER QUALIFICATIONS AND PARTICIPATION**

Sec.	
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**§ 51.11. Prerequisites for participation.**

(a) In addition to the requirements under Chapter 1101 (relating to general provisions) to become an enrolled provider, the provider shall:

- (1) Complete the provider enrollment application on a form prescribed by the Department.
- (2) Sign an MA provider agreement and an HCBS waiver provider agreement.

(3) Submit supporting qualification documents identified on the Department's web site to the Department or the Department's designee.

(4) Comply with the approved applicable waiver, including approved waiver amendments, and any other applicable licensing requirements as identified in § 51.4 (relating to incorporation by reference).

(5) Send a complete enrollment package to the Department or the Department's designee.

(b) New providers shall complete and submit the provider monitoring documentation designated for new providers before being authorized to provide HCBS.

(c) A provider shall be qualified by the Department for each HCBS the provider intends to provide prior to rendering the HCBS.

(d) The provider shall submit any missing supporting qualification documentation materials requested by the Department or Department's designee within 30 days of notification by the Department.

(e) If missing supporting qualification documentation is not submitted within 30 days of notification, the enrollment application will be considered withdrawn by the Department and will not be processed.

(f) A provider may submit a new enrollment application after the previous enrollment application is withdrawn by the Department.

(g) A provider will not be paid until the provider is qualified and authorized by the Department or the Department's designee to provide an HCBS.

(h) A provider shall comply with the training requirements as specified in § 51.23 (relating to provider training).

(i) A provider may not influence a participant's freedom of choice in selecting a new provider.

(j) Subsection (b) does not apply to a provider of HCBS in the Adult Autism Waiver.

(k) This section does not apply to an SSW provider.

**§ 51.12. SSW provider enrollment.**

(a) An SSW provider hired by a common law employer under the vendor fiscal/employer agent FMS option shall:

- (1) Enroll with the vendor fiscal/employer agent FMS and complete the State and Federal required paperwork.
- (2) Complete the required criminal history background checks and child abuse checks under §§ 51.20 and 51.21 (relating to criminal history checks; and child abuse clearances).

(b) This section does not apply to a provider of HCBS in the Adult Autism Waiver.

**§ 51.13. Ongoing responsibilities of providers.**

(a) A provider shall be qualified for each HCBS the provider continues to render by meeting the requirements under this subchapter.

(b) A provider shall be qualified for an HCBS the provider will render at the interval specified in the approved applicable waiver, including approved waiver amendments.

(c) A provider may be required to be qualified for each HCBS the provider shall render more frequently than the

interval specified in the approved applicable waiver, including approved waiver amendments due to the following:

(1) Transition to a new interval established by the Department as specified in the approved applicable waiver, including approved waiver amendments.

(2) Noncompliance with a provider's CAP.

(3) Findings as a result of provider monitoring.

(4) Receipt of a provisional license.

(5) Receipt of a DCAP.

(6) A circumstance resulting in a review of the provider by the Department or the Department's designee.

(d) A provider shall submit qualification documentation by the due date specified by the Department in a written notification and no later than 61 days prior to the provider's expiration of its qualification.

(e) A provider that fails to submit qualification documentation by the due date specified by the Department in a written notification shall participate in transition planning for the participants currently receiving HCBS from the provider under § 51.31 (relating to transition of participants).

(f) A provider that fails to submit qualification documentation by the expiration date of the provider's qualification:

(1) Will not receive payment for HCBS rendered beyond the provider's expiration qualification date.

(2) Will no longer be qualified to provide that HCBS and have its name removed from the list of qualified providers of that HCBS.

(g) A provider shall update information within HCSIS and the Department's MMIS system to maintain that it is current.

(h) A provider shall contact the Department under the following circumstances:

(1) The provider is willing to continue to provide an HCBS to current participants, but no longer willing to provide that HCBS to a new participant.

(2) The provider intends to discontinue an HCBS.

(3) The provider intends to add an HCBS.

(4) The provider intends to change a service location.

(i) A provider shall comply with Chapter 1101 (relating to general provisions).

(j) A provider shall have a QM plan in accordance with the approved applicable waiver, including approved waiver amendments and this chapter.

(k) A provider shall implement a training curriculum in compliance with § 51.23 (relating to provider training) and applicable HCBS requirements in this chapter.

(l) A provider shall report and investigate incidents as required under § 51.17 (relating to incident management).

(m) A provider shall complete and comply with any CAP or DCAP as required by the Department, the Department's designee or Federal or other State agency as required under § 51.24 (relating to provider monitoring).

(n) A provider shall comply with the terms of the MA provider agreement and HCBS waiver provider agreement or SSW agreement.

(o) A provider shall ensure that the provider and staff possess valid Social Security Numbers.

(p) A provider shall only deliver and provide an HCBS after the provider is qualified and authorized to provide the HCBS.

(q) A provider shall implement the HCBS it is qualified and authorized to provide in accordance with the requirements outlined in the approved applicable waiver, including approved waiver amendments, and the authorized ISP.

(r) A provider shall only render HCBS to a participant who is authorized to receive a service from that provider.

(s) A provider that renders HCBS to a participant, who is not qualified and authorized when the HCBS is provided, will not be reimbursed by the Department for the HCBS during the period the provider was not qualified and authorized.

(t) A provider shall implement the outcomes of a participant to meet the assessed needs of a participant.

(u) A provider shall meet and maintain the applicable licensure and certification requirements for each HCBS the provider renders.

(v) A provider may not submit a claim until an authorized HCBS has been rendered.

(w) A provider may not use the following:

(1) Seclusion.

(2) Chemical restraint.

(3) Mechanical restraint.

(4) Prone position manual restraint.

(5) Manual restraint that:

(i) Inhibits the respiratory and digestive system.

(ii) Inflicts pain.

(iii) Causes hypertension of joints and pressure on the chest or joints.

(iv) Uses a technique in which the participant is not supported and allows for free fall as the participant moves to the floor.

(x) A provider rendering HCBS to a participant shall participate in the assessment of the participant when the participant is identified to receive a Department assessment in accordance with the approved applicable waiver, including waiver amendments.

(y) Subsection (k) does not apply to an SSW provider.

(z) Subsections (g), (j) and (k) do not apply to a provider of HCBS in the Adult Autism Waiver.

#### § 51.14. Residential habilitation service providers.

(a) A residential habilitation service provider authorized or identified to provide residential habilitation to a participant shall submit a written request to the Department or the Department's designee to:

(1) Open a new residential habilitation service location.

(2) Close an existing residential habilitation service location and to establish a new residential habilitation service location.

(3) Combine more than one residential habilitation service location.

(4) Change the approved program capacity of a residential habilitation service location.

(b) To receive prior written approval from the Department or the Department's designee to open a new residential habilitation service location, to close an existing residential habilitation service location and open a new residential habilitation service location, or to combine residential habilitation service locations, the provider shall submit the following in writing:

(1) A description of the circumstances surrounding the need for the new residential habilitation service location, closure of existing residential habilitation service location and opening a new residential habilitation service location, or to combine residential habilitation service locations.

(2) A description of how the new residential habilitation service location, closure of existing residential habilitation service location and opening a new residential habilitation service location or combining residential habilitation service locations will meet the setting size, staffing patterns, and assessed needs and outcomes of the participants identified to reside in that residential habilitation service location.

(3) A description of the residential habilitation service location including properties surrounding the location.

(i) The provider shall affirm that the property meets the definition of "integrated and dispersed in the community in noncontiguous locations" in § 51.3 (relating to definitions).

(ii) The property may not be located on a campus setting.

(iii) The property must be surrounded by individuals and businesses that are not funded through the ODP.

(c) A provider licensed under Chapters 3800, 5310, 6400 and 6500 shall receive prior authorization to provide residential habilitation enhanced staffing through the use of supplemental habilitation or additional individualized staffing due to a change in the participant's needs.

(1) The provider shall initiate the prior authorization request process by completing the provider portion of the supplemental habilitation and additional individualized staffing checklist or any approved revisions which can be found on the Department's web site.

(2) A provider who renders residential habilitation enhanced staffing through supplemental habilitation or additional individualized staffing without authorization longer than 30 days from the date the Department receives the request will not receive payment.

(d) A residential habilitation service provider that does not comply with subsections (a)–(c) will not receive payment until Department approval is obtained.

(e) A residential habilitation service provider shall ensure staff providing the residential habilitation service to a participant meets the staff qualifications included in the approved applicable waiver, including approved waiver amendments.

(f) A residential habilitation provider shall participate in the 6-month review of the residential habilitation service the provider renders under § 51.28(h) (relating to SCO requirements for Consolidated and P/FDS Waiver).

(g) This section does not apply to a provider of HCBS in the Adult Autism Waiver and an SSW provider.

**§ 51.15. Provider records.**

(a) In addition to the requirements under § 1101.51 (relating to ongoing responsibilities of providers), a provider shall:

(1) Document that the HCBS for which it claims payment were provided to the participant and that information submitted in support of the payment is true, accurate and complete.

(2) Maintain records verifying compliance with this chapter for a minimum of 5 years.

(b) A provider shall keep participant records confidential.

(c) A provider may not make participant records accessible to anyone without the written consent of the participant, the person holding the participant's power of attorney for health care or health care proxy, or if a court orders disclosure other than the following:

(1) The participant.

(2) A provider's staff for the purpose of providing HCBS to the participant.

(3) The Department or the Department's designee.

(4) An entity that is permitted to access records under law.

(d) A provider shall provide records, as requested, to the Department regarding HCBS delivered and payments received for HCBS.

(e) A provider may use electronic record documentation under the following conditions:

(1) The electronic record must be readable.

(2) The electronic format conforms to the requirements of Federal and State laws.

(3) The medium used to produce the electronic record accurately reproduces the paper original records.

(4) The medium used is not subject to subsequent deletion, change or manipulation.

(5) The electronic record constitutes a duplicate or substitute copy of the original paper record and has not been altered or if altered shows the original and altered versions, dates of creation and creator.

(6) The electronic record can be converted back into legible paper copies and assessed by an auditing agency.

(7) Providers shall have a back-up system for electronic records.

(f) A provider shall have records management policies in place to comply with this section.

(g) A provider shall document in the participant's record when the participant voluntarily chooses to use the participant's personal funds to purchase items and a description of the item purchased in accordance with the ISP.

(h) Subsections (a)(2), (e) and (f), do not apply to an SSW provider.

**§ 51.16. Progress notes.**

(a) A provider shall complete a monthly progress note that substantiates the claim for the provision of an HCBS it provides at least monthly. A provider shall maintain the progress notes in a participant's record.

(b) A provider shall complete a progress note each time the HCBS is provided if the HCBS is occurring on a less than monthly frequency.

(c) A provider may complete progress notes for multiple HCBS rendered to the same participant on the same form when the HCBS are rendered by the same provider from the same waiver HCBS location. Progress notes that are completed for multiple HCBS must include progress for each HCBS included on the form.

(d) Progress notes must include the following:

- (1) The name of the participant receiving the HCBS.
- (2) The name of the provider.
- (3) The name, title, signature and date of the person completing the progress note.
- (4) The name of the HCBS.
- (5) The amount, frequency and duration of the authorized and delivered HCBS.
- (6) The outcome of the HCBS.
- (7) A description of what occurred during the delivery of the HCBS.

(e) A provider shall complete a progress note if there is a recommended change to the HCBS rendered that requires discussion with the ISP team due to lack of progress in achieving an outcome as documented on the ISP.

(f) A provider may use technology that allows staff to submit progress notes as required throughout a work shift.

(g) Subsection (f) does not apply to an SSW provider.

(h) This section does not apply to an SCO provider. For SCO service note requirements, see § 51.28(l) (relating to SCO requirements for Consolidated and P/FDS Waiver).

(i) This section does not apply to an SCA provider under the Adult Autism Waiver.

#### § 51.17. Incident management.

(a) In accordance with Chapter 6000, Subchapter Q (relating to incident management) and the Department's Certified Investigator Manual on the Department's web site, a provider shall report incidents to the Department and ensure that a certified investigation is conducted.

(b) A provider shall take prompt action to protect the participant's health, safety and rights when an incident has been discovered or has occurred. The Department will establish participant rights by Departmental guidelines.

(c) A provider shall report any of the following incidents in HCSIS within 24 hours of the discovery or occurrence of the incident:

- (1) Death.
- (2) Suicide attempt.
- (3) Hospitalization.
- (4) Psychiatric hospitalization.
- (5) Emergency room visit.
- (6) Abuse as follows:
  - (i) Physical abuse.
  - (ii) Psychological abuse.
  - (iii) Sexual abuse.
  - (iv) Verbal abuse.
  - (v) Improper or unauthorized use of restraint.
- (7) Individual to individual abuse.
- (8) Neglect.

- (9) Missing person.
- (10) Law enforcement.
- (11) Injury requiring treatment beyond first aid.
- (12) Disease reportable to the Department of Health.
- (13) Fire.
- (14) Misuse of funds.
- (15) Participant rights violation.
- (16) Emergency closure.
- (17) Crisis event.
- (18) Restraint.

(d) A provider shall report any of the following incidents in HCSIS within 72 hours of the discovery or occurrence of an incident:

- (1) Medication administration error.
- (2) Restraint unless the restraint falls into the definition of "abuse" in § 51.3 (relating to definitions).

(e) A provider shall fax or scan an incident report to the Department if HCSIS is not available within 24 hours or 72 hours depending on the incident type as described under subsections (a)—(c). When HCSIS becomes available, the provider shall immediately enter the incident into HCSIS.

(f) For incidents that are to be reported within 24 hours of the discovery or occurrence, a provider shall finalize the incident report in HCSIS by including additional information about the incident, results of a required investigation and corrective actions within 30 days of the discovery or occurrence of the incident, unless the deadline is extended in HCSIS.

(g) A provider shall provide a detailed description in HCSIS of the actions taken in response to an incident to include:

- (1) The prompt action to protect the health and welfare of the participant.
- (2) The results of the incident investigation.
- (3) Corrective actions taken.
- (4) The staff that is responsible for implementing the actions.
- (5) The date the actions were implemented or are planned.
- (6) Specific information regarding disciplinary actions taken with staff to assure the health and welfare of participants.

(h) A provider shall review and analyze incidents at least quarterly or more frequently as required by the Department. This quarterly review must contain information on the incident target.

(i) A provider shall submit reports regarding its review and analysis of incidents to the Department or the Department's designee, upon request.

(j) A provider shall identify and implement actions to assure a participant is safeguarded from risk so the number of preventable incidents is reduced.

(k) A provider shall assure that its staff receive annual incident management training on preventing, recognizing, reporting and responding to incidents and assuring a participant is safe as required under § 51.23 (relating to provider training).

(l) A provider shall provide additional training to the participant and staff as needed based on the incident circumstances.

(m) A provider shall analyze data on a participant to continuously improve HCBS delivery and to mitigate and manage risk factors.

(n) A provider shall respond to actions designated by the Department or the Department's designee as a result of the management review of an incident.

(o) An SSW provider is responsible to report incidents to the common law employer.

(p) Subsections (a)—(m) do not apply to an SSW provider.

(q) Subsections (d)(2), (h), (i), (k) and (m) do not apply to a provider of HCBS in the Adult Autism Waiver.

(r) Subsection (c)(17) and (18) does not apply to a provider of HCBS in the Consolidated and P/FDS Waiver.

**§ 51.18. Risk management.**

(a) A provider shall complete the following risk management activities:

- (1) Remedy the cause of the incident.
- (2) Complete an incident report and investigation as required under § 51.17 (relating to incident management).
- (3) Conduct an analysis to determine the root cause of the incident and include corrective actions in the participant's incident report.
- (4) Update strategies to address risk factors and risk levels.
- (5) Work cooperatively with the SC to update the ISP, as needed, by integrating risk mitigation into the participant's ISP.

(b) A provider shall implement the following risk mitigation strategies to prevent, reduce and manage the severity of incidents during the delivery of the authorized HCBS and share the information with the SC for inclusion in the participant's ISP:

- (1) Identify risk factors of the participant:
  - (i) Health status, family medical history and medical risks.
  - (ii) Medication history and current medication.
  - (iii) Behavioral history and behavior risks.
  - (iv) Incident history.
  - (v) Social environment needs.
  - (vi) Physical environment needs.
  - (vii) Personal safety.
- (2) Identify strategies to reduce the frequency of incidents or reduce the severity of associated effects.
- (3) Train the participant and staff on the risk factors and risk mitigation strategies.
- (4) Implement preventive measures to reduce the level of risk of an incident or negative outcome from occurring.
- (5) Monitor participant's risk mitigation strategies and update the strategies, as needed.

(c) This section does not apply to an SSW provider and a provider of HCBS in the Adult Autism Waiver.

**§ 51.19. Certified investigations.**

(a) A provider shall ensure that incidents requiring an investigation are conducted and completed by a certified investigator and analyzed by the provider.

(b) A provider shall ensure an individual completing an investigation on behalf of the provider is a trained certified investigator and has completed the training course offered by the Department.

(c) To be a certified investigator, the certified investigator shall:

- (1) Have a high school diploma or general education diploma.
- (2) Be 21 years of age or older.
- (3) Meet the criminal history checks under § 51.20 (relating to criminal history checks) and, if applicable, the child abuse clearance provisions under § 51.21 (relating to child abuse clearances).

(4) Complete the Department web-based portion of the training within 3 months of enrolling in the course.

(5) Attend the certification training and pass the exam. A certified investigator shall be recertified every 3 years.

(d) To maintain certification, a certified investigator shall:

- (1) Complete three certified investigations during the 3-year certification period.
- (2) Attend a 1-day recertification class.

(e) If a certified investigator wishes to continue to conduct certified investigations and has done fewer than three investigations during the certification period, the investigator shall actively participate in a quarterly or semiannual review of the quality of investigations by serving as a member of a peer review committee or a risk management committee. Active participation includes reviewing at least three investigations and discussing the results with the committee.

(f) This section does not apply to an SSW provider.

**§ 51.20. Criminal history checks.**

(a) A provider shall ensure that a criminal history check is obtained for staff.

(b) The reporting requirements listed in this chapter are in addition to reporting requirements under Chapters 2380, 2390, 3800, 5310, 6400 and 6500, 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and, when applicable, 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries).

(c) A provider shall apply for a criminal history check for staff prior to hiring.

(d) A provider shall obtain a criminal history check in compliance with the following:

(1) A report of criminal history record information from the Pennsylvania State Police or a statement from the Pennsylvania State Police that the State Police Central Repository does not contain information relating to that person under 18 Pa.C.S. §§ 9101—9183 (relating to Criminal History Record Information Act) if staff has been a resident of this Commonwealth for at least 2 years.

(2) A report of Federal criminal history record information under the Federal Bureau of Investigation (FBI) appropriation of Title II of the act of October 25, 1972 (Pub. L. No. 92-544, 86 Stat. 1109) if staff has been a

resident of this Commonwealth for less than 2 years or is currently a resident of another state.

(e) Criminal history checks shall be in accordance with the Older Adults Protective Services Act (35 P. S. §§ 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

(f) The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site at <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616725&mode=2>.

(g) A copy of the final reports received from the Pennsylvania State Police and the FBI, if applicable, shall be kept in accordance with § 51.15 (relating to provider records).

(h) Subsections (b), (c), (f) and (g) do not apply to an SSW provider.

#### § 51.21. Child abuse clearances.

(a) A provider shall assure that a child abuse clearance is obtained for each staff that provides an HCBS to a minor.

(b) If the provider serves a participant who is 17 years of age or younger, 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law) is applicable.

(c) A copy of the final child abuse clearance shall be kept in accordance with § 51.15 (relating to provider records).

(d) Subsection (c) does not apply to an SSW provider.

#### § 51.22. Provisional hiring.

(a) A provider may provisionally hire staff pending receipt of a criminal history check and child abuse clearance, as applicable, if the following conditions are met:

(1) A provisionally-hired staff person shall have applied for a criminal history check and child abuse clearance, as required under §§ 51.20 and 51.21 (relating to criminal history checks; and child abuse clearances), and give the provider a copy of the completed criminal history request form and child abuse clearance form.

(2) A provider may not hire a person provisionally if the provider has knowledge that the person would be disqualified for employment under 18 Pa.C.S. § 4911 (relating to tampering with public records or information).

(3) A provisionally-hired staff person shall swear or affirm in writing that he has not been disqualified from employment or referral under this chapter.

(4) A provider may not permit the provisionally-hired staff person awaiting a criminal history background check or child abuse clearance to work alone with a participant.

(5) A provider shall monitor a provisionally-hired staff person awaiting a criminal history check or child abuse clearance through random, direct observation and participant feedback. The results of monitoring shall be documented in the provisionally-hired staff person's file.

(6) The period of provisional hire of a staff person that is and has been for 2 years or more a resident of this Commonwealth may not exceed 30 days. The period of provisional hire of a staff person who has not been a resident of this Commonwealth for 2 years or more may not exceed 90 days.

(b) When subsection (a) conflicts with Chapter 2380, 2390, 3800, 5310, 6400 or 6500, 6 Pa. Code Chapter 11

(relating to older adult daily living centers) or 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries), subsection (a) is not applicable.

(c) This section does not apply to an SSW provider.

#### § 51.23. Provider training.

(a) A provider shall implement a standard annual training for the provider and staff. The standard annual training must contain at least the following:

(1) Department policy on intellectual disability principles and values.

(2) Training to meet the needs of a participant as identified in the ISP.

(3) QM plan.

(4) Identification and prevention of abuse, neglect and exploitation of a participant.

(5) Recognizing, reporting and investigating an incident.

(6) Participant grievance resolution.

(7) Department-issued policies or procedures.

(8) Accurate billing and documentation of HCBS delivery.

(b) Before providing an HCBS to a participant, a provider shall ensure that its staff have met any additional pre- and in-service training requirements as detailed in a participant's ISP.

(c) A provider shall retain documentation of completion of training for each staff.

(d) A provider shall update annual training to reflect the Department's current policies and procedures and emerging practices.

(e) This section does not apply to an SSW provider or to a provider of HCBS in the Adult Autism Waiver.

#### § 51.24. Provider monitoring.

(a) The Department will monitor a provider at the frequency specified in the approved applicable waiver, including approved waiver amendments.

(b) A provider shall review and analyze performance data provided by the Department and take appropriate steps to improve its performance based on the results of performance data.

(c) A provider shall complete the Department-approved provider monitoring documents during the provider monitoring process for the provider and the participants identified by the Department or the Department's designee.

(d) A provider shall submit the completed provider monitoring documents electronically to the Department or the Department's designee.

(e) A provider shall cooperate with the Department or the Department's designee during a monitoring review.

(f) A provider shall ensure each finding discovered during a monitoring review is successfully remediated through a CAP.

(g) A provider shall include the following information on the CAP form:

(1) The specific action to correct each instance of noncompliance identified on the CAP form.

(2) The target date for the corrective action to occur.

(3) The corrective actions that will be employed to identify and prevent recurrence of the specific noncompliance.

(4) The name and title of the person responsible for preparing and submitting the CAP form to the Department's designee and the date the CAP form was submitted to the Department's designee.

(h) The provider shall return the CAP form within 15 days of receipt of request for a CAP.

(i) The provider shall respond to the Department or the Department's designee if a proposed CAP is rejected and revise the CAP form in accordance with subsection (k).

(j) The provider shall remediate noncompliance within 30 days of receiving the Department-approved CAP.

(k) A provider shall implement a DCAP in response to the statement of findings developed by the Department or the Department's designee.

(l) Failure to comply with a DCAP will result in sanctions as provided in § 51.153 (relating to sanctions).

(m) The provider shall cooperate with follow-up monitoring by the Department or the Department's designee.

(n) The provider shall provide the Department or the Department's designee with additional information needed to complete a provider monitoring.

(o) The provider shall cooperate with Federal or other State provider monitoring.

(p) Subsections (a)—(d), (f)—(l) and (n) do not apply to an SSW provider.

(q) Subsections (c) and (d) do not apply to a provider of HCBS in the Adult Autism Waiver.

**§ 51.25. Quality management.**

(a) A provider shall meet the QM plan criteria developed by the Department.

(b) The provider shall create and implement a QM plan.

(c) The provider shall evaluate the following when developing a QM plan:

(1) The manner in which the provider will meet the Department's QM plan criteria.

(2) The provider's quarterly performance review data and available reports in HCSIS.

(3) The results from provider monitoring and SCO monitoring.

(4) Compliance with the requirements in 42 CFR 441.302 (relating to state assurances).

(5) Incident management data, including data on the incident target under § 51.17 (relating to incident management).

(6) Results of satisfaction surveys and reviews of grievances.

(d) The provider shall include the following criteria when developing a QM plan:

(1) Goals of the QM plan, which include how the provider will meet Department priorities that are published as a notice in the *Pennsylvania Bulletin*.

(2) Target objectives that support each goal.

(3) Performance measures the provider will use to evaluate progress in achieving the target objectives.

(4) The data source for each performance measure.

(5) The person responsible for the QM plan.

(6) Actions to be taken to meet the target objectives.

(e) A provider shall update its QM plan at least every 2 years.

(f) The provider shall submit a copy of its QM plan and verification that the provider reviewed performance data to the Department or the Department's designee upon request.

(g) This section does not apply to an SSW provider and to a provider of HCBS in the Adult Autism Waiver.

**§ 51.26. Grievance procedures.**

(a) A provider shall develop grievance procedures to document, respond and resolve grievances including:

(1) Processes to resolve a grievance within 21 days.

(2) Instructions for participants and their families regarding grievance procedures, including how to seek help in filing a grievance.

(b) A provider shall provide a copy of its grievance procedures to the Department or the Department's designee upon request.

(c) A provider shall review and document the following information to resolve a participant grievance:

(1) The name of the participant filing or the name of the person filing the grievance on behalf of the participant.

(2) The nature of the grievance.

(3) The date of occurrence and date of filing of the grievance.

(4) The provider's actions to resolve the grievance.

(5) The resolution of the grievance as agreed by the provider, the participant or the person filing the grievance on behalf of the participant.

(6) The date the grievance was resolved.

(d) A provider shall review its grievance procedures at least annually to determine the number of grievances and their disposition.

(e) This section does not apply to an SSW provider.

**§ 51.27. Misuse and abuse of funds and damage of participant's property.**

(a) A provider's records and invoices may be reviewed and the provider may be required to provide a written explanation of billing practices during an audit, fiscal review or provider monitoring.

(b) If the Department's audit, fiscal review or provider monitoring indicates that a provider has been billing for HCBS that are inconsistent with this chapter, unnecessary or inappropriate to a participant's needs or contrary to the participant's ISP, the Department will suspend payment for not more than 120 days pending the Department's review of billing and HCBS.

(c) The Department will notify a provider in writing of a suspension of payment under subsection (b).

(d) In addition to sanctions provided for in this chapter, a provider shall adhere to §§ 1101.74, 1101.75, 1101.76 and 1101.77.

(e) A provider shall either replace property that was lost or damaged, or pay the participant the replacement value for the lost or damaged item if confirmed by the provider, Department or the Department's designee through a review of the circumstances that a participant's

personal property was lost or damaged by the provider while providing an HCBS to the participant.

(f) Subsections (a)—(c) do not apply to an SSW provider.

**§ 51.28. SCO requirements for Consolidated and P/FDS Waiver.**

(a) Payment for supports coordination services is limited to waiver supports coordination, provision of TSM supports coordination and base-funded supports coordination.

(b) An SCO provider shall ensure the following information is included in the ISP:

(1) The assessed need and outcome of the participant that each HCBS addresses.

(2) The type, amount, duration and frequency of each HCBS.

(3) Risk factors and risk mitigation strategies the ISP team determined will mitigate risk factors.

(4) Participant preferences.

(5) Medical history.

(6) Health information.

(7) Functional ability information.

(8) Communication abilities and needs.

(9) Financial information.

(10) HCBS and supports.

(c) An SCO shall ensure the SC completes the following when developing an initial ISP and annual review ISP:

(1) Collaboration with the participant, family, provider and other ISP team members to coordinate a date, time and location for the annual review ISP meeting at least 90 days prior to the end date of the ISP.

(2) Coordination of information gathering and assessment activity, which includes the results from the State-wide needs assessment for the annual review ISP meeting at least 90 days prior to the end date of the ISP.

(3) Distribution of invitations to ISP team members at least 30 days before the ISP meeting is held.

(4) Facilitation of the ISP meeting with team members invited at least 60 days prior to the end date of the ISP.

(5) Submission of the annual review ISP to the Department's designee for approval and authorization at least 30 days prior to the end date of the ISP.

(6) Resubmission of the ISP for approval and authorization within 7 days of the date it was returned to the SCO for revision.

(7) Distribution of the ISP to the participant, family and ISP team members who do not have access to HCSIS within 14 days of its approval and authorization.

(8) Revision of the ISP when there is a change in an assessed need for a participant during an ISP year.

(d) An SCO shall review the Department's residential habilitation service criteria in subsection (e) with the participant and ISP team during the initial ISP, annual review ISP, any other ISP team meeting when a residential habilitation service is being considered for a participant who is currently not authorized for a residential habilitation service and during the 6-month review of the residential habilitation service.

(e) The following residential habilitation service criteria shall be utilized to assist the ISP team in determining if a residential habilitation service is needed or continues to be recommended by the ISP team at the 6-month review:

(1) A person is not willing or able to provide the needed natural supports or paid supports for the participant in a private home.

(2) The participant health, safety and welfare would not be met with a nonresidential habilitation service or natural supports in a private home.

(3) Others would be at risk of harm if a residential habilitation service was not provided for the participant.

(4) Assessments indicate the participant's needs can only be met through the provision of a residential habilitation service.

(5) The residential habilitation setting is the least restrictive and most appropriate size to ensure the participant's health and welfare while continuing to meet the assessed need.

(f) If a residential habilitation service is determined to be needed by the ISP team during the initial ISP, annual review ISP or other ISP team meeting when a residential habilitation service is being considered for a participant who is currently not authorized for a residential habilitation service based on the residential habilitation criteria in subsection (e), the family living residential habilitation service shall be considered first by the ISP team.

(g) When the ISP team proposes a residential habilitation service other than family living residential habilitation services, the proposal must be in accordance with the ISP manual developed by the Department and found on the Department's web site.

(h) For a participant authorized for a residential habilitation service, the SCO shall conduct a monitoring visit and review the residential habilitation service criteria in subsection (e) at least once every 6 months to determine if the participant continues to need the authorized residential habilitation HCBS.

(i) If the 6-month review during a monitoring visit identifies a change in need, an ISP meeting will be convened to discuss potential changes to the ISP.

(j) When an SCO receives a request for enhanced staffing to the residential habilitation service, the SCO shall ensure the SC documents the following in the ISP:

(1) The change in the participant need, including how this change affects the participant's health and welfare.

(2) The assessments used to support the need for residential habilitation enhanced staffing.

(3) What the enhanced staffing support will specifically provide to address the participant's needs.

(4) The plan to reduce the residential habilitation enhanced staffing based on specific outcomes of the participant.

(5) The time frames and the person responsible for monitoring the progression of the plan to reduce the residential habilitation enhanced staffing.

(6) The results of meetings held to re-evaluate the need for continuation of the residential habilitation enhanced staffing.

(7) Adjustments to the participant's ISP.

(k) An SCO shall monitor risk factors and the implementation and impact of risk mitigation strategies during participant monitoring activities.

(l) An SCO shall ensure the SC documents the results of discussions regarding services that require a review more frequently than annually as determined in the approved applicable waiver, including approved waiver amendments.

(m) An SCO shall ensure the SC documents contacts and actions regarding a participant in a service note in HCSIS.

(n) An SCO shall ensure the SC completes the monitoring documents in HCSIS to document findings and concerns of monitoring, as well as resolution of those findings and concerns.

(o) An SCO shall ensure the SC includes in the ISP the participant and ISP team's decision regarding how the participant chooses to use personal funds in the ISP.

(p) This section does not apply to an SCA provider in the Adult Autism Waiver.

**§ 51.29. SCA requirements for Adult Autism Waiver.**

(a) Payment for SC HCBS is limited to participants who are enrolled in waivers which include SC HCBS.

(b) An SCA shall:

(1) Use assessments to inform HCBS planning.

(2) Develop the participant's ISP when the participant enrolls in the waiver.

(3) Ensure each participant is offered choice of willing and qualified providers by providing the participant and ISP team a list of willing and qualified providers at the annual review ISP meeting or as requested by the participant.

(4) Document annually that the participant or his representative understands the right of choice of willing and qualified providers and have the participant sign the documentation.

(5) Convene the ISP team to conduct a comprehensive review of the ISP at least annually.

(c) An SCA shall complete the following when developing an ISP:

(1) Collaborate with the participant, family, provider and other ISP team members to coordinate a date, time and location for the annual review ISP meeting at least 90 days prior to the end date of the ISP.

(2) Coordinate information gathering and assessment activity for the annual review ISP meeting at least 90 days prior to the end date of the ISP.

(3) Distribute invitations to ISP team members at least 30 days before the ISP meeting is held.

(4) Facilitate the ISP meeting with all ISP team members invited at least 60 days prior to the end date of the ISP.

(5) Submit the ISP to the Department for approval and authorization at least 30 days prior to the end date of the ISP.

(6) Resubmit the ISP for approval and authorization within 7 days of the date it was returned to the SCA for revision.

(7) Distribute the ISP to the participant, family and ISP team members who do not have access to HCSIS within 14 days of its approval and authorization.

(8) Review ongoing HCBS quarterly to ascertain the participant's progress towards each goal specified in the ISP.

(9) Ensure an HCBS is necessary to achieve goals identified in the participant's ISP.

(10) Contact the participant, his guardian or a representative designated by the participant at least once per month to ensure the participant's health and welfare.

(11) Meet with the participant in person at least quarterly. At least one visit each year shall occur in the participant's home and if the participant receives HCBS outside the home one other visit each year shall occur while the participant is receiving the HCBS at the location outside the home and do the following:

(i) Monitor the participant's health and welfare.

(ii) Complete a quarterly summary report and enter it in the Department's designated information system.

(iii) Inform the Department immediately whenever the participant's health and welfare is in jeopardy.

(iv) Take immediate action to assure a participant's health and welfare if the SC believes that a participant's health and welfare is in jeopardy.

(v) Convene an ISP team meeting within 10 days of a crisis to discuss the need to change the ISP if a participant has exhibited serious challenging behaviors or has experienced a crisis episode and does not presently have behavioral specialist HCBS in the ISP or other additional services to ensure a participant's health and welfare.

(12) Ensure that the ISP is being implemented as written.

(13) Assess whether the ISP needs to be revised.

(14) For all ISP updates that change the amount and frequency of an HCBS, the SC shall meet with the participant or reconvene the ISP team to discuss needed changes and revise the ISP.

(15) Review by the SC of the right to fair hearing procedures during the annual review of the ISP and at any time requested by the participant or participant's representative or when HCBS are denied or decreased in the ISP.

(16) Ensure the participant's behavioral support plan and crisis intervention plan are consistent with the ISP if the participant receives Behavioral Specialist HCBS. The SC shall reconvene the ISP team if the behavioral support plan is not consistent with the ISP or the behavioral support plan indicates a change in the ISP may be warranted.

(17) Ensure that the participant's annual level of care re-evaluation is completed and documented by the anniversary date of the current level of care evaluation.

(18) Document activities in HCSIS.

(19) Ensure that staff providing SC are qualified.

(20) Ensure that the maximum caseload for an SC does not exceed the number of participants specified in the approved applicable waiver, including approved waiver amendments, including participants in other HCBS waivers, unless the requirement is waived by the Department or the Department's designee.

(21) Ensure that a conflict of interest does not exist in the delivery of the supports coordination service.

(22) Not provide any other HCBS for a participant unless it enrolls as an OHCD to provide other HCBS in

accordance with the approved applicable waiver, including approved waiver amendments.

**§ 51.30. AWC/FMS requirements.**

(a) In addition to meeting the requirements in § 51.13 (relating to ongoing responsibilities of providers), an AWC/FMS provider shall ensure the Department's standard AWC/FMS-managing employer agreement is completed with each managing employer when:

(1) A participant is choosing to self-direct HCBS that are determined to be needed and authorized by the Department or the Department's designee in the ISP.

(2) A participant has elected to enroll in the AWC/FMS-managing employer option.

(b) An AWC/FMS provider shall ensure the managing employer complies with the responsibilities outlined in the signed AWC/FMS-managing employer agreement.

(c) An AWC/FMS provider shall fulfill unmet responsibilities of the managing employer.

(d) An AWC/FMS provider shall identify and implement corrective action for managing employer performance issues in accordance with the AWC/FMS-managing employer agreement.

(e) An AWC/FMS provider shall be qualified for participant-directed services.

(f) An AWC/FMS provider shall process and provide vendor goods and services authorized by the Department or the Department's designee to self-directing participants covered by their monthly per participant administrative fee.

(g) An AWC/FMS provider shall distribute a Department-approved satisfaction survey to participants in AWC/FMS.

(h) This section does not apply to a provider of HCBS in the Adult Autism Waiver.

**§ 51.31. Transition of participants.**

(a) When a participant selects another willing and qualified provider to replace the current provider, both providers shall cooperate with the Department or the Department's designee, the participant and the participant's SCO or SCA during the transition between providers.

(b) The current provider shall ensure the following:

(1) Participation in transition planning meetings to aid in the successful transition to the new willing provider.

(2) Cooperation with visitation schedules identified during the transition meeting.

(3) Arrangement for transportation of the participant to support the visitation schedule.

(4) Closing of open incidents in HCSIS.

(5) Undue influence is not exerted when the participant is making the choice to a new willing and qualified provider.

(c) A provider that is no longer willing to provide an HCBS to a participant shall provide written notice at least 30 days prior to the date of discharge to the participant, the Department, the Department's designee and the SC when the provider is not the SCO or SCA.

(d) The provider shall provide written notification that includes the following:

(1) The HCBS the provider is unwilling or unable to provide.

(2) The HCBS location where the HCBS is currently provided.

(3) The reason the provider is no longer willing to provide the HCBS to the participant.

(4) A description of the efforts made to address or resolve the issue that has led to the provider becoming unwilling or unable to deliver the HCBS to the participant.

(5) Suggested time frames for transitioning the delivery of the HCBS to a selected willing and qualified provider.

(6) The current provider name and Master Provider Index number.

(e) A provider shall continue to provide the authorized HCBS during the transition period to ensure continuity of care until a willing and qualified provider is selected unless otherwise directed by the Department or the Department's designee.

(f) A provider shall provide written notification to the Department or the Department's designee if the provider cannot continue to provide the HCBS until another willing provider is selected due to emergency circumstances.

(g) A selected willing provider shall cooperate with transition planning activities including participation in transition planning meetings.

(h) A current SCO provider shall cooperate with transition planning activities including utilization of HCSIS transfer functionality and participation in all transition planning meetings that occur during the transition period.

(i) A provider shall provide available records to the selected willing provider within 7 days of the date of transfer.

(j) This section does not apply to an SSW provider and an AWC/FMS provider.

**§ 51.32. Back-up plans.**

(a) A provider shall develop and provide detailed information on the back-up plan for each HCBS the provider renders for a participant to the participant and the SC for inclusion in the ISP.

(b) A provider shall develop a written protocol to ensure the successful implementation of each participant's back-up plan that contains information that:

(1) Assures and verifies the HCBS is being provided at the frequency and duration established in the participant's ISP.

(2) Verifies that the HCBS is provided during a change in staff, such as shift changes or changes in staffing patterns.

(c) A provider shall implement the participant's back-up plan when a participant is available for the authorized HCBS to be delivered and an event occurs which requires the provider to implement the back-up plan so the HCBS continues to be rendered as specified in the approved ISP.

(d) A deviation in frequency or duration of HCBS as specified in the ISP due to failure to implement a back-up plan when a participant is available to receive the HCBS will result in an incident report of provider neglect as specified in § 51.17 (relating to incident management).

(e) This section does not apply to an SSW provider.

**§ 51.33. Conflict of interest.**

(a) A provider shall develop an internal conflict of interest protocol that, at a minimum, addresses the following areas:

(1) Unbiased decision making by the provider, managers and staff.

(2) No involvement of board members with other provider agencies that are not in accordance with ethical standards of financial and professional conduct.

(3) Documented procedures to determine whether a conflict of interest exists within the organization, including the steps to take if a change in circumstances occurs.

(4) Documented procedures to follow when a conflict of interest is disclosed within the organizational structure.

(5) Documented procedures to follow when a conflict of interest is determined to exist.

(b) A provider shall self-disclose a conflict of interest to the Department.

(c) For payment to be provided for supports coordination HCBS, an SCO shall comply with the conflict free requirements in the approved applicable waiver, including approved waiver amendments.

(d) Subsection (c) does not apply to a provider of HCBS in the Adult Autism Waiver.

(e) Subsections (a), (c) and (d) do not apply to an SSW provider.

**§ 51.34. Waiver of a provision of this chapter.**

(a) The Department may grant a waiver to a provision of this chapter which is not otherwise required by Federal, State or local requirements and does not jeopardize the health, safety or well-being of the participant.

(b) A waiver request shall be in writing on a form prescribed by the Department.

**Subchapter C. PAYMENTS FOR SERVICES**

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**§ 51.41. SSW provider.**

This subchapter does not apply to an SSW provider.

**§ 51.42. Definitions.**

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

*Allowable cost*—A necessary cost directly or indirectly associated with the provision of a cost-based services.

*Approved cost report*—A cost report which complies with the Department's cost-based reporting instructions and passes the Department's desk review.

*Attestation engagement*—The term includes audits, examinations, reviews, compilations and agreed-upon procedures.

*Board*—The participant's share of food and food preparation costs.

*Cost-based rate-setting methodology*—The Department's process of reviewing approved cost reports, aggregating the cost of each cost-based service and then determining the provider specific rate for each cost-based services.

*Cost-based services*—An HCBS reimbursed through a rate established by aggregating provider cost reports.

*Cost report*—A data collection tool issued by the Department to collect cost and utilization information from providers that includes supplemental schedules or addenda requested by the Department.

*Department-established fee*—A non-MA funded fee established by the Department for a portion of an HCBS not eligible for Federal financial participation.

*Eligible expenses*—Allowable costs that are eligible for Federal financial participation.

*FASB*—The Financial Accounting Standards Board.

*Fee schedule HCBS*—An HCBS listed on the MA Program fee schedule.

*Fiscal review*—A review of billing records against provider documentation to ensure HCBS were provided in the type, amount, duration and frequency as required by the approved ISP.

*Fixed asset*—A major item, excluding real estate, which can be expected to have a useful life of more than 1 year or that can be used repeatedly without materially changing or impairing its physical condition by normal repair, maintenance or replacement of components.

*Funded equity*—The value of property over the liability on the property.

*GAAP—Generally Accepted Accounting Principles*—The standard framework of guidelines for financial accounting used in any given jurisdiction which are generally known as accounting standards.

*Indirect cost*—Expense allocations and functions which are needed for program operations but not directly related to participant HCBS.

*Ineligible costs*—Allowable costs that are not eligible for Federal financial participation but are eligible for reimbursement by the Department.

*Management fees*—Expenses related to charges from a parent or affiliated company of the provider.

*Market-based approach*—A process used to develop MA or Department-established fees based on independent data sources for a particular waiver service's cost components, including the consideration of reasonable and necessary costs for the delivery of a waiver service.

*OMB Circular A-122*—Office of Management and Budget Circular A-122, Cost Principles for Non-Profit Organizations.

*Rate adjustment factor*—A downward adjustment to a rate based on an analysis of State and Federal expenditures that are projected using the proposed payment rates and projected provider utilization compared to the appropriation amounts.

*Related party*—The term as defined in FASB Accounting Standards Codification Section 850-10-20 as may be amended or superseded by FASB or a successor organization.

*Representative payee*—A person or organization appointed by the Social Security Administration to receive benefits on behalf of a participant.

*Reserved capacity*—The capacity held for a participant when the participant has been discharged from the waiver and has been identified by the Department for re-enrollment into the waiver.

*Respite care ineligible*—The portion of payment for respite care HCBS that is not eligible for Federal financial participation.

*Restricted gift*—A donation or gift given to an HCBS provider for a specific purpose.

*Room*—A participant's share of lodging costs which includes utility costs such as electricity, heating, water and sewage. The term also includes annual upkeep costs of the residential habilitation service location including trash collection, general maintenance, necessary repairs and renovation costs.

*SNAP*—Supplemental Nutrition Assistance Program. The term is also known as food stamps.

*SSI*—Supplemental Security Income.

*Third-party resource*—Private or governmental health insurance benefits.

*Vacancy factor*—A standard factor applied to a provider's cost-based rate to account for when a participant is absent from the residential habilitation service location.

#### § 51.43. Department rates and HCBS classification.

(a) An HCBS will be paid as one of the following under §§ 51.53, 51.62, 51.72 and 51.131:

- (1) MA fee schedule service.
- (2) Vendor good and services.
- (3) Cost-based service.
- (4) Department-established fee.

(b) The Department will reimburse providers of vendor goods and services in accordance with § 51.62 (relating to vendor goods and services reimbursement).

(c) The Department may establish a fee per unit of HCBS as a Department-established fee by publishing a notice in the *Pennsylvania Bulletin*.

(d) The Department-established fees are the maximum amount the Department will pay.

(e) A provider may not negotiate a fee or rate with another ODP-funded entity when there is a Department-established fee or rate for the same HCBS at the waiver HCBS location.

#### § 51.44. Payment policies.

(a) The Department will only pay for HCBS in accordance with this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies).

(b) When a provision specified in Chapter 1101 or 1150 is inconsistent with this chapter, this chapter is applicable.

(c) The Department will only pay for compensable HCBS up to the amount, duration and frequency as listed on the participant's ISP as approved by the Department or the Department's designee and rendered by the provider.

(d) If an HCBS is allowable under a third-party medical resource, the provider shall bill the third-party medical resource in accordance with § 1101.64 (relating to third-party medical resources (TPR)) before billing a Federal or State-funded program.

(e) If the HCBS is billable under the MA State Plan, a provider shall bill the program under the MA State Plan before billing the HCBS waiver or State-funded programs.

(f) The provider shall retain documentation of the third-party medical resource denial and billing attempts and submissions for an HCBS under the MA State Plan or a third-party medical resource agency for at least 5 years from the provider's State fiscal year-end.

(g) Payments made to a provider under the MA Program constitute payment in full to the provider.

(h) A provider who receives a supplemental payment other than room and board from the Department, the participant or another person for an HCBS shall return the supplemental payment to the payer.

(i) A provider shall comply with §§ 1101.63 and 1101.68 (relating to payment in full; and invoicing for services).

(j) The Department will only pay for HCBS in accordance with the approved applicable waiver and this chapter.

(k) The Department will recoup payments which are not made in accordance with this section.

**§ 51.45. Provider billing.**

(a) A provider shall submit claims in accordance with § 1101.68 (relating to invoicing for services).

(b) A provider shall use the Department's MMIS to submit claims.

(c) A provider shall only submit claims that are substantiated by documentation in the participant's record.

(d) A provider shall complete and maintain documentation on HCBS delivery in accordance with §§ 51.15 and 51.16 (relating to provider records; and progress notes).

**§ 51.46. Audit requirements.**

(a) A provider shall comply with audit requirements including:

(1) The Single Audit Act of 1984 (31 U.S.C.A. §§ 7501—7507).

(2) The revised OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations.

(3) Part 92 of 45 CFR (relating to uniform administrative requirements for grants and cooperative agreements to state, local, and tribal governments).

(4) Other applicable Federal and State audit requirements.

(b) A provider that is required to receive a Single Audit or an audit in accordance with 45 CFR 74.26 (relating to non-Federal audits) shall comply with the audit requirements.

(c) The Department or the Department's designee may request a provider to have the provider's auditor perform an attestation engagement in accordance with any of the following:

(1) Government Auditing Standards issued by the Comptroller General of the United States (Generally Accepted Government Auditing Standards).

(2) Standards issued by the Auditing Standards Board.

(3) Standards issued by the American Institute of Certified Public Accountants.

(4) Standards issued by the International Auditing and Assurance Standards Board.

(5) Standards issued by the Public Company Accounting Oversight Board.

(6) Standards of a successor organization to the organizations in paragraphs (1)—(5).

(d) The Department or the Department's designee may perform an attestation engagement in accordance with subsection (c).

(e) A Federal or State agency may request a provider to have the provider's auditor perform an attestation engagement in accordance with subsection (c).

(f) The Department may perform nonaudit services such as technical assistance or consulting engagements.

(g) The Department or the Department's designee may conduct a performance audit in accordance with the standards in subsection (c).

(h) The Department or the Department's designee a Federal agency or State agency may direct the provider to conduct a performance audit in accordance with the standards in subsection (c).

(i) A provider which is not required to have a Single Audit during the State fiscal year shall maintain records in compliance with subsection (c).

(j) The Department or the Department's designee may perform a fiscal review on a provider.

(k) Electronic records must be in accordance with § 51.15 (relating to provider records) and accessible to an auditing agency.

(l) A provider shall make audit documentation available, upon request, to authorized representatives of the Department.

(m) A provider shall preserve books, records and documents related to the State fiscal year for a period that is the greatest of the following:

(1) At least 5 years from the provider's State fiscal year-end.

(2) Until all opened audit issues are closed.

(3) As required under applicable Federal law.

(n) If a program is completely or partially terminated, the records relating to the terminated program shall be preserved and made available for at least 5 years from termination.

(o) A provider shall retain records that relate to litigation or the settlement of claims arising out of performance or expenditures under this program until the litigation, claim or exceptions have reached final disposition or for at least 5 years from the provider's State fiscal year-end, whichever is greater.

**§ 51.47. Reporting requirements for ownership change.**

(a) A change in ownership or control interest of 5% or more shall be reported in writing to the Department or the Department's designee at least 30 days prior to the date the change is to occur.

(b) If the provider is unable to report an ownership or controlling interest change at least 30 days prior to the date the change is to occur, the provider shall report the change as soon as possible, but no later than 2 business days after the change occurs.

(c) The notification to the Department or the Department's designee must include the following:

(1) The effective date of sale or change.

(2) A copy of the sales agreement or document that related to the change in controlling interest.

(3) A detailed explanation regarding why the provider was unable to report the change within 30 days as specified in subsection (a).

(d) If the provider fails to notify the Department or the Department's designee as specified in subsections (a)—(c), the provider forfeits payment in full for each day after the change occurred.

**§ 51.48. Provider in the Adult Autism Waiver.**

Sections 51.71—51.75 and 51.81—51.103 (relating to cost-based services; and cost-based allowable costs) do not apply to an HCBS provider in the Adult Autism Waiver.

**FEE SCHEDULE SERVICES**

**§ 51.51. Fee schedule applicability.**

Sections 51.52 and 51.53 (relating to fee schedule rate; and fee schedule rate reimbursement) apply to HCBS provided under the P/FDS, Consolidated or Adult Autism waiver.

**§ 51.52. Fee schedule rate.**

(a) Fee schedule rates are established using the following methodology:

(1) Market-based approach using the following cost considerations:

- (i) Wages for staff.
- (ii) Staff-related expenses.
- (iii) Productivity.
- (A) Indirect program expenses.
- (B) Administration-related expenses.
- (C) Geographical cost considerations.

(2) Review of approved HCBS definitions and determinations made about cost components which reflect costs that are necessary and related to the delivery of each HCBS.

(3) Use of independent data sources such as the Pennsylvania-specific compensation study and data from previously approved cost reports, as applicable.

(b) The Department will pay for fee schedule services at the rate determined by the Department.

(c) The Department will update the fee schedule rates under the MA Program fee schedule as a notice in the *Pennsylvania Bulletin*.

(d) Subsection (a)(1)(iii)(C) does not apply to a provider under the Adult Autism Waiver.

**§ 51.53. Fee schedule rate reimbursement.**

(a) A provider of a fee schedule service shall keep fiscal records as required under § 51.46 (relating to audit requirements).

(b) The following fee schedule services apply to HCBS in the Consolidated and P/FDS Waiver, providers of targeted services management and when a provider provides an HCBS to both waiver and base-funded participants in a waiver HCBS location for the following periods:

(1) For the period July 1, 2011, through November 14, 2011:

- (i) Nursing.
- (ii) Physical therapy.
- (iii) Occupational therapy.
- (iv) Speech and language therapy.
- (v) Behavior therapy.
- (vi) Visual/mobility therapy.
- (vii) Companion.
- (viii) Supplemental habilitation.
- (ix) Additional individualized staffing.
- (x) Older adult day habilitation.
- (xi) Behavior support.
- (xii) Supports broker.
- (xiii) Home finding.
- (xiv) Homemaker/chore.

(2) For the period beginning November 15, 2011:

- (i) Nursing.
- (ii) Physical therapy.
- (iii) Occupational therapy.

- (iv) Speech and language therapy.
- (v) Behavior therapy.
- (vi) Visual/mobility therapy.
- (vii) Companion.
- (viii) Supplemental habilitation.
- (ix) Additional individualized staffing.
- (x) Older adult day habilitation.
- (xi) Behavior support.
- (xii) Supports broker.
- (xiii) Home finding.
- (xiv) Homemaker/chore.
- (xv) Supports coordination.

(c) AWC/FMS HCBS billed on a fee schedule in accordance with the approved applicable waiver, including approved waiver amendments, must include the following HCBS:

- (1) Companion.
- (2) Home and community habilitation (unlicensed).
- (3) Supports broker.
- (4) Supported employment.
- (5) Unlicensed respite with the exclusion of respite camp.
- (6) Homemaker/chore.

(d) Changes in the list of HCBS under the MA Program fee schedule will be published as a notice in the *Pennsylvania Bulletin*.

(e) HCBS provided through the Adult Autism Waiver are a fee schedule HCBS in accordance with the approved Adult Autism Waiver.

(f) Subsections (b) and (c) do not apply to a provider of HCBS in the Adult Autism Waiver.

**VENDOR GOODS AND SERVICES****§ 51.61. Vendor goods and services applicability.**

Section 51.62 (relating to vendor goods and services reimbursement) applies to HCBS provided as part of the Consolidated, P/FDS and Adult Autism Waivers and when a provider provides an HCBS to both waiver and base-funded participants from a waiver HCBS location as specified in the approved applicable waiver, including approved waiver amendments.

**§ 51.62. Vendor goods and services reimbursement.**

(a) The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise:

*Vendor*—A company that sells goods and services to the general public that also agrees to sell those goods or services to a participant at the same cost they charge to the general public.

*Vendor goods and services*—A type of service that is offered to the general public and a participant.

(b) In accordance with the approved applicable waiver, including approved waiver amendments, vendor goods and services include the following in the Consolidated and P/FDS Waiver:

- (1) Public and mile transportation.
- (2) Education support.
- (3) Home accessibility adaptations.

- (4) Vehicle accessibility adaptations.
- (5) Assistive technology.
- (6) Respite camp.
- (7) Specialized supplies

(c) In accordance with the approved applicable waiver, including approved waiver amendments, vendor goods and services include the following in the Adult Autism Waiver:

- (1) Community transition.
- (2) Assistive technology.
- (3) Environmental modification.

(d) The Department will publish changes to vendor goods and services as a notice in the *Pennsylvania Bulletin*.

(e) For a provider of a vendor goods and services to receive payment directly from the Department, the vendor shall meet the requirements in §§ 51.11 and 51.13 (relating to prerequisites for participation; and ongoing responsibilities of providers).

(f) A provider of a vendor goods and services may only include administrative expenses in the cost of the vendor goods and services when the following are met:

- (1) The amount does not exceed \$25 or 15% of the cost of the good or service, whichever is less.
- (2) The administrative activity performed must be required for the provider to deliver the vendor goods or services to a participant.
- (3) A provider of a vendor goods and services shall document the activity that supports the administrative expense included in the cost of the vendor goods and services.

(g) A provider of vendor goods and services may not be reimbursed for rendering vendor goods and services if it contracts with an entity or participant who is listed on the LEIE, EPLS or Medichex list.

(h) A provider of vendor goods and services may not be reimbursed for rendering vendor goods and services if it contracts with a provider or individual who employs staff that are listed on the LEIE or EPLS.

(i) A provider of vendor goods and services is responsible for ensuring that each subcontractor with which it contracts meets the applicable provisions of this chapter and the HCBS is rendered in accordance with the approved applicable waiver, including approved waiver amendments.

(j) A vendor shall provide the SCO, the Department or the Department's designee with a signed statement that attests that the:

- (1) Cost of the vendor goods or services is the same cost charged to the general public.
- (2) Amount added to the cost for administration expenses is in accordance with the Department's requirements in subsection (f)(1)—(3).

(k) The Department or the Department's designee may review documentation of a provider of vendor goods and services at any time.

(l) Subsections (b) and (f) do not apply to a provider of HCBS in the Adult Autism Waiver.

(m) Subsection (c) does not apply to a provider of HCBS in the Consolidated and P/FDS Waivers.

**COST-BASED SERVICES**

**§ 51.71. Definitions.**

The following words and terms, when used in §§ 51.72—51.75, have the following meaning, unless the context clearly indicates otherwise.

*Area adjusted average*—The assigned rate for an HCBS based on a designated geographical area and mathematical formula.

*Cost of Living Adjustment*—An annual adjustment, as appropriated by the General Assembly, applied to a provider's total unit costs.

*SSD—Services and Supports Directory*—An online database of HCBS providers by geographical area.

**§ 51.72. Cost-based rate assignment.**

(a) The following HCBS are cost-based services for the Consolidated and P/FDS Waivers, providers of targeted services management and when a provider provides an HCBS to both waiver and base-funded participants from a waiver service location for the following periods as specified in the approved applicable waiver:

- (1) For the period July 1, 2011, through November 14, 2011:
  - (i) Residential habilitation (eligible and ineligible).
  - (ii) Transportation trip.
  - (iii) Transportation per diem.
  - (iv) Supports coordination.
  - (v) Home and community habilitation (unlicensed).
  - (vi) Licensed day habilitation under Chapter 2380 (relating to adult training facilities).
  - (vii) Prevocational.
  - (viii) Supported employment.
  - (ix) Transitional work.
  - (x) Respite, excluding respite camp.
- (2) For the period beginning November 15, 2011:
  - (i) Residential habilitation (eligible and ineligible).
  - (ii) Transportation trip.
  - (iii) Transportation per diem.
  - (iv) Home and community habilitation (unlicensed).
  - (v) Licensed day habilitation under Chapter 2380.
  - (vi) Prevocational.
  - (vii) Supported employment.
  - (viii) Transitional work.
  - (ix) Respite, excluding respite camp.

(b) Changes in the list of HCBS as cost-based services will be published as a notice in the *Pennsylvania Bulletin*.

(c) A provider shall be assigned a cost-based rate for an existing service and service location if the following apply:

- (1) The provider is currently billing and is reimbursed for a service that is a cost-based service.
- (2) A provider is signed up for both the service and service location in the SSD.
- (3) A provider submitted both the service and service location in its approved cost report.
- (d) A provider shall be assigned the average of the provider's cost-based rates for an existing service at a

new service location if the provider has an approved cost-based rate at another service location.

(e) A provider shall be assigned the area adjusted average of provider cost-based rates for new HCBS if:

(1) The cost report of the provider did not contain the new HCBS because the HCBS was not delivered during the reporting period.

(2) A provider is a new provider who was not delivering HCBS during the reporting period of the cost report.

(f) A provider shall be assigned the lowest rate calculated Statewide based on all provider cost reports for HCBS if a provider was required to submit a cost report and failed to submit a cost report.

(g) A provider who is required to submit an audit who then fails to submit an audit shall receive the lowest rate calculated Statewide.

(h) A provider who submits an audit which indicates the information in the cost report requires adjustment and the provider does not submit a revised cost report, the provider shall be assigned the lowest rate calculated Statewide.

(i) A provider that chooses to not submit a cost report or the cost report the provider submitted is not approved will be assigned the lowest rate calculated Statewide for each cost-based services the provider provides.

#### § 51.73. Cost report requirements.

(a) A provider of cost-based services shall submit a cost report as instructed by the Department.

(b) A provider who has one Master Provider Index number shall submit one cost report for that Master Provider Index number.

(c) A provider with multiple Master Provider Index numbers may submit one cost report for all of its Master Provider Index numbers or one cost report for each Master Provider Index number.

(d) Information on the cost report must meet the following:

(1) The cost report must accurately reflect:

- (i) The actual cost of the HCBS provided.
- (ii) The allowable administration fee for the HCBS provided.

(2) An allowable cost must meet the requirements in § 51.81 (relating to allowable costs).

(e) A cost report or a cost report addenda must:

(1) Comply with the Department's cost report instructions.

(2) Be consistent with this chapter.

(3) Be on a form prescribed by the Department.

(4) Be submitted to the Department by the provider on or before the last business day in the second week of November for nontransportation cost-based services and on or before the last business day in the third week of February for transportation cost-based services as provided in the cost report instructions.

(f) A provider shall do the following to obtain approval of a cost report:

(1) Submit a completed cost report by the due date established by the Department as indicated in the cost

report instructions. The cost report must contain information for the development of a cost-based rate as required under this section.

(2) Pass the Department's desk review process.

(3) Include an audit, if required under § 51.46 (relating to audit requirements).

(4) Submit a revised cost report if a provider's audited financial statement differs from a provider's cost report.

(g) When applicable, a provider of a cost-based service shall allocate allowable costs, both eligible and ineligible appropriately in accordance with OMB Circular A-122 or any approved revisions to the OMB Circular A-122.

(h) The Department or the Department's designee will review the cost report for completeness and accuracy based on the Department's cost report instructions.

(i) The Department will use the cost-based rate-setting methodology to establish a rate for cost-based services for each provider with an approved cost report.

(j) The Department will publish the cost-based rate-setting methodology as a public notice in the *Pennsylvania Bulletin*.

(k) The Department will use the providers' approved cost report as the initial factor in the rate setting methodology to develop the allowable costs for cost-based services.

#### § 51.74. Approval of a cost-based rate for nontransportation HCBS.

To establish a cost-based rate, the Department will:

(1) Utilize cost data submitted by providers on the standardized cost report developed by the Department.

(2) Review each cost report to ensure the cost report is completed in accordance with § 51.73 (relating to cost report requirements).

(3) Adjust current cost report information based on any changes in the service definitions in the approved applicable waiver, including approved waiver amendments, from the prior cost reporting period.

(4) Identify provider cost reports which are an outlier in comparison to other cost reports submitted. An outlier occurs when the cost report information is at least one standard deviation outside the average unit cost.

(5) Review the outlier information by identifying the average of the unit costs and determining how far above or below the standard deviation they fall.

(6) From July 1, 2011, through June 30, 2012, unit costs flagged as outliers that are determined to be within 5% of the provider's prior year rate for an HCBS will be used to determine the cost-based rate.

(7) From July 1, 2011, through June 30, 2012, the Department will review unit costs flagged as outliers that are not within 5% of the provider's prior year rate for an HCBS and these costs will undergo further review as follows:

(i) If the outlier unit costs are justified by the review, the outlier rate will be accepted.

(ii) If the outlier unit costs are not justified by the review, the outlier rate will be adjusted to be within the standard deviation.

(8) Prior to the effective date of rates, the Department will publish the methodology for calculating unit costs that includes the outlier review process and rate assignment process as a notice in the *Pennsylvania Bulletin*.

(9) The Department may apply a cost of living adjustment during the rate development and assignment process.

(10) A rate adjustment factor may be applied during the rate development and assignment process.

(11) Prior to rates being established each fiscal year, the outlier analyses, cost of living adjustment and a rate adjustment factor are calculated and may be applied to all cost-based rates.

(12) The Department will publish changes in the rate-setting methodology, including the cost report review, outlier analyses, vacancy factor, rate adjustment factor and rate assignment process, as a notice in the *Pennsylvania Bulletin*.

(13) The cost-based rate for the residential habilitation service includes necessary household goods and furniture provided for the participant.

(14) A vacancy factor shall be applied to finalize a provider's residential rate.

(15) A provider may request additional staffing costs above what is included in the approved cost report rate for current staffing if there is a new participant entering the program that has above average staffing needs.

(16) If a provider did not submit a cost report, the lowest rate calculated Statewide will be assigned for the HCBS offered in the SSD. If there was a new provider that started HCBS and did not have historical experience, the area average rate will be assigned.

**§ 51.75. Approval of a cost-based rate for transportation.**

A cost-based rate for transportation is established as follows:

(1) From July 1, 2011, through November 14, 2011, the Department will use data in the Year 2 transportation cost reports (Version 5.0 SFY 2008-2009 Historical Expense Period) submitted by providers and approved by the Department when the procedure codes in the transportation cost reports were the same as those entered in the SSD as of February 2010.

(2) From November 15, 2011, through June 30, 2012, the Department will use data in the Year 3 transportation cost reports (Version 6.0 SFY 2009-2010 Historical Expense Period) submitted by providers and passed the Department's desk review, when available, when the procedure codes in the transportation cost reports were the same as those entered in the SSD as of January 2011.

(3) The Department will review unit costs on a provider transportation cost report that are at the upper or lower end of the range of unit cost for each transportation trip service. When there is an exact match between the procedure code reported on the cost report and the procedure code in the SSD, and the provider was not at the upper or lower end of the range of unit cost, the cost-based rate will be assigned.

(4) If there was not an exact match between the cost report and SSD, the area-average rate will be assigned to the HCBS offered in the SSD but not reported on the cost report.

(5) If the transportation provider did not submit a cost report, the lowest rate calculated Statewide will be assigned for the HCBS offered in the SSD. If there was a new provider that started HCBS and did not have historical experience, the area average rate will be assigned.

**COST-BASED ALLOWABLE COSTS**

**§ 51.81. Allowable costs.**

(a) The allowable cost must be the best price made by a prudent buyer.

(b) Costs must relate to the administration or provision of the HCBS.

(c) Costs must be allocated and distributed to various HCBS or other lines of business among cost categories in a reasonable and fair manner in proportion with the benefits provided to the HCBS or other lines of business among cost categories.

(d) To be an allowable cost under this chapter, the cost must be documented and meet the following:

(1) Be reasonable for the performance of the HCBS.

(2) Conform to any limitations or exclusions in the regulation in accordance with the requirements in the approved applicable waiver, including approved waiver amendments.

(3) Be consistent with policies and procedures that apply uniformly to both Federally-funded and other activities of the organization.

(4) Be determined in accordance with GAAP as a notice in the *Pennsylvania Bulletin*.

(5) Not be included as a cost or used to meet cost sharing or matching requirements of any other Federally-financed program in either the current or a prior period adjustment.

(e) Transactions involving allowable costs between related parties shall be disclosed to the Department on the cost report.

(f) A cost not listed in this chapter is not an allowable cost.

(g) Effective July 1, 2011, through June 30, 2012, allowable costs that are ineligible may be included in the cost report as instructed.

**§ 51.82. Revenues that off-set allowable costs.**

(a) A provider shall report donations and contributions according to the following:

(1) List unrestricted cash donations which benefit the direct or indirect expenditures on the cost report as income.

(2) Reduce gross eligible expenditures in arriving at the amount eligible for Departmental participation by the amount of the donation or contribution.

(3) Fully disclose noncash donations to include estimated value and intended use of the donated item.

(4) Treat the proceeds from the sale of a donated item as a cash donation when the donated item is sold rather than used in the HCBS program.

(b) If a donated item is used in an HCBS program, the provider shall claim an expense and offsetting revenue on the donated or contributed item.

(c) A restricted gift used for HCBS may include eligible or ineligible costs to receive the restricted gift.

(d) When a provider solicits for donations, the provider shall publicly identify the purpose for which contributions are solicited and their restricted use, if any.

(e) To receive the donation or gift, the provider shall adhere to the donor's intent for the gift.

**§ 51.83. Bidding and procurement.**

(a) The provider shall obtain supplies and HCBS at the lowest cost and use a system of competitive bidding or written estimates for any supply and HCBS over \$5,000.

(b) Fixed assets for which the contracted agency will hold the title shall be obtained at the lowest cost. Provisions for accomplishing this objective are competitive bidding and written estimates. Should sole source purchases be necessary, a provider is required to obtain and maintain records supporting the justification for the sole source purchase.

**§ 51.84. Management fees.**

A cost included in a provider's management fees must meet the standards under § 51.81 (relating to allowable costs).

**§ 51.85. Consultants and contracted personnel.**

(a) The cost of an independent consultant and contracted personnel necessary for the administration or provision of an HCBS is an allowable cost.

(b) A provider shall have a written agreement with a consultant or contracted personnel which must include the following:

(1) The administration or provision of HCBS to be provided.

(2) The method of payment.

(c) The provider shall not include benefits as an allowable cost for contracted staff.

**§ 51.86. Corporate boards.**

(a) The Department will not participate in wage compensation for members of boards.

(b) Allowable expenses for board members includes payments for actual expenses incurred in connection with meetings and authorized work of the board and the following:

(1) Meals.

(2) Lodging.

(3) Transportation.

(4) Liability insurance coverage for claims against board members that were a result of the board members acting in their official duties.

(5) Training expenses related to the delivery of HCBS.

**§ 51.87. Staff development.**

The Department will allow the cost of staff training or the cost of continued training to the extent that the training is related to the delivery or improvement of an HCBS.

**§ 51.88. Staff recruitment.**

The cost incurred in staff recruitment activity is an allowable cost as follows:

(1) Informational mailings to recruit potential staff.

(2) Informational mailings to prospective staff, upon request by a participant or family member.

(3) Job fairs.

(4) Creation and maintenance of web sites providing information.

(5) Responses to participant and family member inquiries regarding recruiting potential staff.

(6) Market research.

(7) Advertisements.

**§ 51.89. Travel.**

(a) Travel costs related to supporting the administration or provision of an HCBS are allowable and include the following:

(1) Transportation.

(2) Lodging.

(3) Meals.

(b) A provider shall ensure the transportation cost is limited to the Department-established travel reimbursement provisions.

**§ 51.90. Supplies and rental of equipment.**

(a) The purchase of supplies and equipment are allowable costs in accordance with OMB Circular A-122.

(b) A provider claiming supplies or equipment as an allowable cost shall only claim supplies or equipment used in the normal course of business.

(c) Rental of program equipment or furnishings are allowable costs if normal usage does not warrant its purchase or if renting is more cost-efficient.

(d) A provider shall ensure equipment not expensed in the current fiscal year is depreciated by using the straight line method of depreciation.

**§ 51.91. Communications.**

Communication and supply costs to support the administration or provision of an HCBS are allowable costs, which include the following:

(1) Telephone—conventional and cellular.

(2) Internet connectivity.

(3) Digital imaging.

(4) Postage.

(5) Stationery.

(6) Printing.

**§ 51.92. Rental of administrative, residential and nonresidential buildings.**

(a) The cost of a building or office rented or leased from a related or unrelated party for a programmatic purpose for an HCBS is an allowable cost, subject to the following:

(1) A provider shall ensure a new lease with an unrelated party contains a provision that the cost of rent may not exceed the rental charge for similar space in that geographical area.

(2) A provider shall ensure that under a lease with a related party the cost of rent is limited to the lessor's actual allowable costs, as provided in § 51.96 (relating to capital assets—administrative and nonresidential buildings).

(3) A provider shall ensure the rental cost under a sale-leaseback transaction, as described in FASB Accounting Standards Codification Section 840-40, as may be amended or superseded by FASB, or any successor organization, is only considered an allowable cost up to the amount that would have been allowed had the provider continued to own the property.

(b) The allowable cost amount may include an expense for the following:

(1) Maintenance.

(2) Real estate taxes, as limited by § 51.93 (relating to other occupancy and allocated occupancy expenses).

(c) A provider shall only include expenses related to the minimum amount of space necessary for the provision of the HCBS.

(d) A rental cost under a lease which is required to be treated as a capital lease under FASB Accounting Standards Codification Section 840-10-25-1, as may be amended or superseded by FASB or a successor organization, is allowable up to the amount that would have been allowed had the provider purchased the property on the date the lease agreement was executed. An unallowable cost includes an amount paid for the following:

- (1) Profit.
- (2) Management fee.
- (3) A tax not incurred had the provider purchased the facility.

**§ 51.93. Other occupancy and allocated occupancy expenses.**

- (a) The following are considered allowable costs:
  - (1) The cost of a required occupancy-related tax and payment made instead of a tax.
  - (2) An associated occupancy cost charged to a given service location. The provider shall ensure the cost is prorated in direct relation to the amount of space utilized by the service location.
  - (3) The cost of an occupancy-related tax or payment made instead of a tax, if it is stipulated in a lease agreement.
  - (4) The cost of a required occupancy permit.
- (b) A provider shall maintain documentation in accordance with § 51.46 (relating to audit requirements) that a utility charge is at fair market value.
- (c) The cost of real estate taxes, net of rebates or discounts available to the provider, whether taken or not, is an allowable cost.
- (d) The cost of a penalty resulting from a delinquent tax payment, including a legal fee, is not an allowable cost.

**§ 51.94. Fixed assets.**

- (a) A fixed asset is an allowable cost.
- (b) A provider shall determine whether an allowable fixed asset shall be capitalized, depreciated or expensed under the following conditions:
  - (1) The maximum allowable fixed asset threshold as defined in the OMB Circular A-122 or subsequent updates.
  - (2) Purchases below the maximum allowable fixed asset threshold shall be expensed.
- (c) A provider shall select the method used to determine the amount of depreciation charged in that year for the year of acquisition.
- (d) A provider shall include depreciation based on the number of months or quarters the asset is in service or a half-year or full-year of depreciation expense.
- (e) A provider may not change the method or procedure, including the estimated useful life and the convention used for an acquisition, for computing depreciation without prior written approval from the Department.
- (f) A provider acquiring a new asset shall have the asset capitalized and depreciated in accordance with GAAP. The provider shall continue using the depreciation

method previously utilized by the provider for assets purchased prior to July 1, 2011.

- (g) A provider shall retain the following:
  - (1) The title to any fixed assets which are depreciated.
  - (2) The title to any fixed assets which are expensed or loans amortized using Department funding.
- (h) A provider shall use income received when disposing of fixed assets to reduce gross eligible expenditures in determining the amount eligible for Departmental participation as determined by the cost report.
  - (i) A provider in possession of a fixed asset shall do the following:
    - (1) Maintain a fixed asset ledger or equivalent document.
    - (2) Utilize reimbursement for loss, destruction or damage of a fixed asset by using the proceeds towards eligible waiver program expenditures.
    - (3) Perform an annual physical inventory at the end of the funding period or State fiscal year. An annual physical inventory is performed by conducting a physical verification of the inventory listings.
    - (4) Document discrepancies between physical inventories or fixed asset ledgers.
    - (5) Maintain inventory reports and other documents in accordance with § 51.46 (relating to audit requirements).
    - (6) Offset the provider's total depreciation expense in the period in which the asset was sold or retired from service by the gains on the sale of assets.
  - (j) The cost basis for depreciable assets must be determined and computed as follows:
    - (1) The purchase price if the sale was between unrelated parties.
    - (2) The seller's net book value at the date of transfer for assets transferred between related parties.
    - (3) The cost basis for assets of an agency acquired through stock purchase will remain unchanged from the cost basis of the previous owner.
- (k) Participation allowance is permitted up to 2% of the original acquisition cost for fully depreciated fixed assets.
  - (1) Participation allowances can only be taken for as long as the asset is in use.
  - (2) Participation amounts must be used for maintaining assets, reinvestment in the program or restoring the program due to an unforeseen circumstance.
  - (3) Depreciation and participation allowance cannot be expensed at the same time for the same asset.

- (l) Participation allowance is permitted up to 2% of the original acquisition cost for fully depreciated fixed assets.
  - (1) Participation allowances can only be taken for as long as the asset is in use.
  - (2) Participation amounts must be used for maintaining assets, reinvestment in the program or restoring the program due to an unforeseen circumstance.
  - (3) Depreciation and participation allowance cannot be expensed at the same time for the same asset.

**§ 51.95. Motor vehicles.**

- (a) The Department will pay for the cost of the purchase or lease of motor vehicles and the operating costs of the vehicles.
- (b) The Department will pay for the cost of the purchase or lease of motor vehicles according to the following:
  - (1) The Department will participate in the cost of motor vehicles through depreciation, expensing or amortization of loans for the purchase. The Department will limit depreciation or lease payments, or both, in accordance with the annual limits established under section 280F of the Internal Revenue Code (26 U.S.C.A. § 280F).

(2) A provider shall maintain a daily log detailing the use, maintenance and services activities of vehicles.

(3) Cost differentials between leasing and purchase of vehicles shall be explored and the most feasible economic alternative selected. Documentation showing the options that were explored shall be maintained.

(4) The personal use of a provider's motor vehicles used by staff is prohibited unless a procedure for payback is established and the staff reimburses the program for the personal use of the motor vehicle.

**§ 51.96. Capital assets—administrative and nonresidential buildings.**

(a) An administrative or nonresidential building acquired prior to June 30, 2009, that is in use for which a provider has an outstanding original loan with a term of 15 years or more is an allowable cost for the provider to continue to claim principal and interest payments for the administrative or nonresidential building over the term of the loan.

(b) A provider shall ensure a down payment made as part of the asset purchase must be considered part of the cost of the administrative or nonresidential building or capital improvement and depreciated over the useful life of the administrative or nonresidential building or capital improvement.

(c) A provider shall receive prior written approval from the Department for a planned major renovation of an administrative or nonresidential building with a cost above 25% of the original cost of the administrative or nonresidential building being renovated.

(d) A provider shall use the depreciation methodology in accordance with § 51.94 (relating to fixed assets).

(e) A provider may not claim a depreciation allowance on an administrative or nonresidential building that is donated.

(f) If an administrative or nonresidential building is sold or the provider no longer provides an HCBS at the administrative or nonresidential building, the Department shall recoup the funded equity either directly or through rate setting. The provider shall be responsible for calculating the amounts reimbursed and the amounts shall be verified by an independent auditor. As an alternative to recoupment, with Department approval, the provider can reinvest the reimbursement amounts from the sale of the administrative or nonresidential building into any capital asset used in the program.

(g) The title of any administrative or nonresidential building acquired and depreciated shall remain with the enrolled provider.

**§ 51.97. Capital assets—residential buildings.**

For a provider owning new or existing residential buildings, the following shall apply for the costs of the residential buildings to be an allowable cost:

(1) A provider shall ensure an allowable cost for a capital asset for a residential building acquired prior to July 1, 2011, is governed by applicable agreements in place at the time of purchase.

(2) A provider shall depreciate a capital improvement of a residential building or land identified over the estimated useful life of the residential building or improvements using the straight line method of depreciation.

(3) A down payment made by the provider as part of the asset purchase shall be considered part of the cost of

the residential building or capital improvement and depreciated over the useful life of the residential building or capital improvement.

(4) A provider shall receive written approval from the Department prior to a planned major renovation of a residential building with a cost above 25% of the original cost of the residential building being renovated.

(5) If a residential building is sold or the provider no longer provides an HCBS in that residential building, the Department shall recoup the funded equity either directly or through rate setting. The provider shall be responsible for calculating the amounts reimbursed and the amounts shall be verified by an independent auditor. As an alternative to recoupment, with Department approval, the provider can reinvest the reimbursement amounts from the sale of the residential building into any capital asset used in the program.

(6) The title of any residential building acquired and debt-free shall remain with the enrolled provider.

**§ 51.98. Residential habilitation vacancy.**

(a) From July 1, 2011, through November 14, 2011, the Department's residential habilitation vacancy policy consists of the following:

(1) Payments to residential habilitation service providers operating waiver service locations for an unlimited number of medical leave days per participant each fiscal year are as follows:

(i) The first day of absence for medical leave is the date the participant is admitted to the medical facility regardless of the length of the absence.

(ii) The last day of the medical leave is the day before the date of discharge from the medical facility.

(iii) On the date of discharge, the HCBS is considered a residential habilitation service day, not a medical leave day, regardless of the number of hours the residential habilitation service is provided on that day.

(2) Payments to residential habilitation service providers operating waiver HCBS locations for up to 48 days of therapeutic leave per participant each State fiscal year. The first day of absence for therapeutic leave is defined as 12 to 24 hours of continuous absence within a 24-hour period between 12:00 a.m. and 11:59 p.m. when the participant is not accompanied by or receiving HCBS from the residential habilitation service provider.

(3) Payments to licensed residential habilitation providers under Chapters 3800, 5310 and 6400 (relating to child residential and day treatment facilities; community residential rehabilitation services for the mentally ill; and community homes for individuals with mental retardation) will be made for permanent vacancies for participants enrolled in the Consolidated Waiver up to 60 days unless the provider uses the permanent vacancy for an alternative purpose.

(b) From November 15, 2011, through June 30, 2012, the Department will make payments to residential habilitation service providers for therapeutic and medical leave days up to a combined maximum of 60 days per participant, per fiscal year.

(c) From November 15, 2011, through June 30, 2012, the Department will provide payments to licensed residential habilitation service providers under Chapters 3800, 5310 and 6400 up to a maximum of 30 days per participant per State fiscal year for a permanent vacancy that occurs in the licensed residential habilitation community home.

(d) The Department will establish a vacancy factor for all waiver residential habilitation services by publication of a notice in the *Pennsylvania Bulletin*.

(e) The vacancy factor for residential habilitation services shall be managed by the provider across all the provider's residential habilitation service locations.

(f) A provider may submit a request for a waiver to the Department under § 51.34 (relating to waiver of a provision of this chapter) for exception to the vacancy factor when a provider's total vacancy amount for waiver residential HCBS locations exceeds the vacancy factor.

(g) To submit a request for a waiver under § 51.34 to the Department for exception to the vacancy factor, the provider shall do the following:

(1) Demonstrate that without being granted an exception to the vacancy factor the provider's continued operation is jeopardized. This demonstration shall be based on actual utilization data from the provider's waiver residential habilitation service locations to show that leave days resulting from hospital and rehabilitation care for all residential sites the provider operates falls below the vacancy factor set by the Department.

(2) Describe the financial impact to the provider if a vacancy exception is not approved. The financial impact must include:

- (i) The information related to personnel expenses.
- (ii) The need for borrowing above historic numbers.
- (iii) The impacts on a provider's ability to fulfill ISP requirements.

(3) Explain the circumstances related to vacancies and revenue the provider has received for rendering another service in the vacancies.

(h) Approval of the request for a waiver under § 51.34 to the Department for exception to the vacancy factor will be at the sole discretion of the Department.

(i) A provider may not have a policy that limits the leave days to a participant.

(j) A provider may not discuss the vacancy factor with a participant or the participant's family.

(k) A provider may not initiate a discharge of a participant due to the participant's vacancy from the program until after the provider has contacted the Department to discuss and resolve the provider's concern related to the vacancy.

(l) A provider shall comply with reserved capacity requirements in the approved applicable waiver, including approved waiver amendments.

(m) A provider shall cooperate with the Department or the Department's designee when a participant is identified in reserved capacity to ensure the participant can return to the waiver residential habilitation service location in accordance with the reserved capacity timelines in the approved applicable waiver, including approved waiver amendments.

**§ 51.99. Indirect costs.**

(a) Indirect costs are allowable costs if the following criteria are met:

(1) The provider shall have a cost allocation plan.

(2) Costs are authorized in accordance with OMB Circular A-122 and § 51.81 (relating to allowable costs).

(b) A provider shall consider the actual circumstances impacting the expense when determining how to allocate the expense to each benefiting HCBS or function.

(c) If a cost is identified as an indirect cost, the cost will remain an indirect cost as long as circumstances remain unchanged.

(d) A provider shall select an allocation method to assign an indirect cost which must comply with the following:

(1) The method is best suited for assigning a cost with a benefit derived.

(2) The method has a traceable cause and effect relationship.

(3) The method is based on logic and reason when neither the cause nor the effect of the relationship is determinable.

(e) A provider shall allocate a general expense in a cost group which is more general in nature which produces a result that is equitable to both the Department and the provider.

(f) The Department may request the allocation method be reviewed by an auditor.

**§ 51.100. Moving expenses.**

(a) With prior written approval from the Department or the Department's designee, the actual cost associated with the relocation of a waiver service location is an allowable cost.

(b) Moving expenses for a participant's move are an allowable cost provided that the provider notifies and receives the Department's or the Department's designee authorization prior to the participant moving.

**§ 51.101. Interest expense.**

Interest cost of short-term borrowing from an unrelated party to meet actual cash flow requirements for the administration or provision of an HCBS is an allowable cost.

**§ 51.102. Insurance.**

The cost of insurance is an allowable cost if it is limited to the minimum amount needed to cover the loss or provide for replacement value. Cost of insurance includes the following:

- (1) General liability.
- (2) Casualty.
- (3) Property.
- (4) Theft.
- (5) Burglary insurance.
- (6) Fidelity bonds.
- (7) Rental insurance.
- (8) Flood insurance, if required.
- (9) Errors and omissions.

**§ 51.103. Other allowable costs.**

(a) The following fees and costs are allowable costs if they are related to the administration of HCBS:

- (1) Legal fees with the exception of those listed in subsection (b).
- (2) Accounting fees, including audit fees.
- (3) Information technology costs.
- (4) Membership dues.

(b) Legal fees for prosecution of claims against the Commonwealth and expenses incurred for claims against the Commonwealth are not allowable costs unless the provider prevails at the hearing.

**START-UP COSTS****§ 51.111. Start-up costs.**

(a) The Department will participate in start-up costs for residential habilitation service providers in accordance with SOP 98-5 issued by the American Institute of Certified Public Accountants or a statement of position that supersedes the current position.

(b) Start-up costs are contingent on Federal approval of a waiver or available State-only funds within the waiver appropriation.

(c) The Department shall recoup start-up costs if the residential habilitation service location is sold within a 5-year period. As an alternative to recoupment, with Department approval, the provider can reinvest the reimbursement amounts from the start-up funds into any capital asset used in the program.

(d) Start-up costs that have been reimbursed by the Department shall be reported as income.

(e) Start-up costs within the scope of SOP 98-5 need to be expensed as they are incurred, rather than capitalized.

(f) Start-up costs will be capped at \$5,000 per new participant to the provider.

(g) Start-up costs defined to be outside the scope of SOP 98-5 shall include the following:

- (1) Costs of acquiring or constructing long-lived assets and preparing them for intended uses.
- (2) Costs of acquiring or producing inventory.
- (3) Costs of acquiring intangible assets.
- (4) Costs related to internally developed assets.

(5) Costs that are within the scope of FASB Statement No. 2, Accounting for Research and Development Costs (superseded by FASB Accounting Standards Codification Section 730) and FASB Statement No. 71, Accounting for the Effects of Certain Types of Regulation (superseded by FASB Accounting Standards Codification Section 980) available at <http://cpaclass.com/gaap-accounting-standards/codification-900/asc-codification-900-index.htm>.

(6) Costs of raising capital.

(7) Costs incurred in connection with existing contracts as stated in paragraph 75d of AICPA Statement of Position No. 81-1, Accounting for Performance of Construction-Type and Certain Production Type Contracts (SOP 81-1) (superseded by FASB Accounting Standards Codification Section 605-35-25-41).

**ROOM AND BOARD REQUIREMENTS FOR RESIDENTIAL HABILITATION SERVICES****§ 51.121. Room and board.**

(a) A provider shall cooperate with monitoring of room and board charges and collections conducted by the Department or the Department's designee.

(b) If a participant is not currently receiving SSI benefits, assistance shall be provided to the participant to contact the appropriate county assistance office so that the participant can obtain benefits.

(c) If a participant is denied benefits, the provider shall assist the participant in filing an appeal if desired.

(d) If actual room and board costs are 72% or more of the SSI maximum rate, the Department will use the following criteria to establish room and board rates:

(1) A participant's share of room and board shall not exceed 72% of the SSI maximum rate.

(2) The proration of board costs is to occur for every day the participant is on leave from the residence. This proration can occur monthly, quarterly or semiannually as long as there is a record that the board costs were returned to the participant for every day of leave.

(e) If a participant has earned wages, personal income from inheritance, Social Security or other types of income, the agency provider may not assess the room and board cost for the participant in excess of 72% of the SSI maximum rate.

(f) If available income for a participant is less than the SSI maximum rate, the provider shall charge 72% of the participant's available monthly income as the participant's monthly obligation for room and board.

(g) A participant shall receive at least the monthly amount as established by the Commonwealth and the Social Security Administration for the participant's personal needs allowance.

(h) If actual room and board charges to a participant are less than 72% of the SSI maximum rate, the agency provider shall retain the following documentation:

(1) The actual value of the room and board is less than 72% of the current maximum SSI monthly benefit.

(2) The Social Security Administration's denial of the participant's initial application for SSI benefits, but also the upholding of the initial denial as a result of at least one appeal.

(i) The provider shall assist the participant to secure information regarding the continued eligibility benefits of the participant.

(j) There may not be a charge for room and board to the participant for respite care if respite care is provided for 30 or fewer days in a State fiscal year.

(k) There may not be a charge for room and board to the participant from the waiver after 30 consecutive days of being in a hospital or rehabilitation facility and the participant is placed in reserved capacity.

(l) The provider shall collect the room and board from the participant or representative payee directly and shall not delegate that responsibility.

(m) There may be no charge for board to the participant if the participant is tube-fed and takes nothing by mouth.

**§ 51.122. Room and board contract.**

(a) A Department-approved room and board contract shall be used by a provider for a participant receiving a residential habilitation service.

(b) A provider shall ensure a standard room and board contract is signed and complete for a participant as specified in subsection (a) on an annual basis.

**§ 51.123. Actual room and board costs.**

(a) A provider shall ensure the total amount charged for room and board to a participant does not exceed the actual documented value of room and board provided to the participant.

(b) A provider shall compute and document actual room and board costs each time a participant signs a new standard room and board contract under § 51.122 (relating to room and board contract).

(c) A provider shall keep documentation of actual room and board costs on file.

**§ 51.124. Modifications to the room and board contract.**

(a) If a participant pays rent directly to a landlord, but food is supplied through a provider, “room” shall be deleted from the room and board contract and the following shall apply:

(1) The participant shall pay 32% of the SSI maximum rate for board.

(2) If a participant’s income is less than the SSI maximum rate, 32% of the available income shall be charged to fulfill the participant’s monthly obligations for board.

(b) If a participant pays rent to a provider, but the participant purchases the participant’s own food, “board” shall be deleted from the room and board contract and the following shall apply:

(1) The participant shall pay 40% of the SSI maximum rate for room.

(2) If a participant’s income is less than the SSI maximum rate, 40% of the available income shall be charged to fulfill the participant’s monthly obligations for room.

**§ 51.125. Completing and signing the room and board contract.**

(a) If a participant is adjudicated incompetent to handle finances, the participant’s surrogate shall sign the room and board contract.

(b) If a participant is 18 years of age or older and is not the representative payee for the participant’s benefits, the representative payee and the participant shall sign the room and board contract.

(c) The written room and board contract shall be completed and signed in accordance with one of the following:

(1) Prior to a participant’s admission to a residential habilitation service location.

(2) Prior to a participant’s transfer from one residential habilitation service location or provider to another residential habilitation service location or provider.

(3) Within 15 days after an emergency residential habilitation service location placement.

**§ 51.126. Copy of room and board contract.**

(a) A copy of the completed and signed room and board contract shall be given to the participant or participant’s surrogate under § 51.125(a) (relating to completing and signing the room and board contract).

(b) A copy of the completed and signed room and board contract shall be maintained in the participant’s record at the agency provider.

**§ 51.127. Delay in a participant’s income.**

If a portion or all of the participant’s income is not received for a month or more, the following apply:

(1) The requirements for the completion and signing of the Department-approved room and board contract under §§ 51.121—51.126 shall be fulfilled.

(2) The participant shall be informed in writing that payment is not required or only a small amount of room and board payments will be required until retroactive monthly benefits are received.

(3) Room and board shall be charged to make up the accumulated difference between room and board actually paid and room and board charged according to the signed room and board contract under § 51.122 (relating to room and board contract).

**§ 51.128. SNAP, energy assistance, rent rebates and similar benefits.**

(a) A provider shall assist a participant in applying for SNAP, energy assistance, rent rebates and similar benefits.

(b) If energy assistance, rent rebates or similar benefits are received, the provider shall deduct the value of these benefits from the room and board costs before reductions are made from the participant’s share of room and board costs.

(c) A participant’s SNAP may not be considered as part of a participant’s income or resources.

(d) A provider may not use the value of SNAP to increase the participant’s share of room and board costs.

**DEPARTMENT-ESTABLISHED FEES**

**§ 51.131. Department-established fees.**

(a) From July 1, 2011, through June 30, 2012, the Department is authorized to establish fees for the ineligible portion of the payment for respite care ineligible HCBS.

(b) The Department will establish fees for the ineligible portion of payment for residential habilitation services and publish the fees as a notice in the *Pennsylvania Bulletin*.

(c) The Department will apply a vacancy factor to the ineligible portion of payment across the provider’s residential habilitation service locations.

(d) The Department-established fees are established using the following methodology:

(1) Market-based approach.

(2) Use of independent data sources including validation against previously approved cost reports, as applicable.

(3) Geographic cost considerations.

(e) Subsections (a) and (d)(3) do not apply to a provider of HCBS in the Adult Autism Waiver.

**ORGANIZED HEALTH CARE DELIVERY SYSTEM**

**§ 51.141. Organized health care delivery system.**

(a) An OHCDs shall:

(1) Be an enrolled MA waiver provider.

(2) Be enrolled in the Department’s MMIS.

(3) Provide at least one direct MA service.

(4) Agree to provide the identified vendor goods or services to participants.

(5) Bill the Department's MMIS for the amount of the vendor goods or services.

(6) Pay the vendor which provided the vendor goods or services the amount billed for in the MMIS.

(b) An OHCDS may bill a separate administrative fee under the following:

(1) The administrative per transaction fee may not exceed \$25 or 15% of the cost of the HCBS, whichever is less.

(2) The administrative activities must be required to deliver the vendor good or HCBS to a participant and must be documented to support the separate administrative fee.

(c) An OHCDS will not be reimbursed for the HCBS or the Department-established administrative fee if it contracts with a provider who is listed on the LEIE, EPLS or Medichex list.

(d) An OHCDS will not be reimbursed for rendering OHCDS if it contracts with a provider who employs staff who is listed on the LEIE or EPLS.

(e) The OHCDS is responsible for ensuring that each vendor with which it contracts meets the applicable provisions of this chapter and in accordance with the requirements specified in the approved applicable waiver, including approved waiver amendments.

(f) Only vendor goods and services may be subcontracted through the OHCDS. A provider who subcontracts shall have written agreements specifying the duties, responsibilities and compensation of the subcontractor.

(g) An OHCDS shall provide the SC, the Department or the Department's designee with a signed statement including the following:

(1) Attestation that the cost of the good is the same cost charged to the general public.

(2) Identification of the administrative fee that is in accordance with the Department's established administrative fee.

(h) Subsections (c)(1) and (2) and (h)(2) do not apply to an OHCDS under the Adult Autism Waiver.

#### Subchapter D. CLOSURES AND TERMINATION

Sec.

51.151.	Definitions.
51.152.	Termination of provider agreement.
51.153.	Sanctions.
51.154.	SCO and SCA provider closure requirements.
51.155.	Provider closure requirements.
51.156.	AWC/FMS closure requirements.
51.157.	Appeals.

#### § 51.151. Definitions.

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

*Attestation engagement*—The term includes audits, examinations, reviews, compilations and agreed-upon procedures.

*Closing provider*—A provider that is terminating HCBS for the participants it serves.

*Closing SCO provider*—An SCO or SCA that is terminating support coordination HCBS for the participants it serves.

*Compliance attestation*—A document issued by a third party that assures a provider's compliance with this chapter.

*Selected and willing provider*—The HCBS provider which the participant is transferring to.

*Selected and willing SCO provider*—The SCO provider the participant is transferring to.

#### § 51.152. Termination of provider agreement.

(a) A provider's MA provider agreement or MA waiver provider agreement, or both, may be terminated based upon one of the following:

(1) The provider has not complied with the terms of the MA waiver provider agreement or MA provider agreement.

(2) The provider has committed a violation as listed under §§ 1101.75 and 1101.77 (relating to provider prohibited acts; and enforcement actions by the Department).

(3) The provider fails to render the HCBS and protect the health and welfare of a participant.

(4) The provider fails to meet a provision of this chapter.

(5) The provider fails to deliver an HCBS in the type, amount, frequency and duration authorized in the ISP when the participant is available for the delivery of the HCBS.

(6) The provider submits a fraudulent claim.

(7) The provider fails to develop or implement a CAP or DCAP timely.

(8) The provider fails to comply with the provider monitoring requirements in § 51.24 (relating to provider monitoring).

(9) The provider fails to comply with applicable Federal and other State laws and this chapter.

(10) The provider is identified on one of the following lists:

(i) EPLS.

(ii) LEIE.

(iii) Medichex.

(b) This section does not apply to an SSW provider.

#### § 51.153. Sanctions.

If a provider fails to provide an attestation engagement, fiscal review or compliance attestation that is accepted by the Department or is in noncompliance with this chapter, the Department may initiate sanctions against the provider including the following:

(1) Withholding or disallowing all or a portion of future payments.

(2) Suspending payment or future payments pending compliance.

(3) Recouping payments for HCBS the provider cannot verify through documentation as rendered in the amount, duration and frequency billed.

#### § 51.154. SCO and SCA provider closure requirements.

(a) In addition to the requirements in § 51.155 (relating to provider closure requirements), a closing SCO or SCA shall meet the requirements of this section.

(b) A closing SCO or SCA provider shall provide written notice to the participant and the Department or the

Department's designee at least 90 days prior to the SCO or SCA closing. The written notice must include verification of the activities as required under subsection (c).

(c) A closing SCO or SCA shall complete the following activities when terminating supports coordination HCBS:

(1) Provide written notification to the Department of its intent to terminate the MA provider agreement and the MA waiver provider agreement.

(2) Provide an effective date of termination.

(3) Develop a transition plan for each participant that affords participant choice and provide it to the Department's designee for prior approval.

(4) Cooperate with the development of a participant's transition plan prior to the effective date of the participant's transition.

(5) Provide a transition plan for the SCO's or SCA's operations.

(6) Prepare SCO or SCA participant records for transfer to the selected and willing SCO or SCA provider within 14 days of the selected and willing SCO or SCA provider accepting the transfer.

(7) Update and maintain HCSIS data and records until the effective date of transfer.

(d) The closing SCO or SCA provider shall continue to provide supports coordination HCBS to a participant until the participant is transferred to the receiving selected and willing SCO or SCA provider unless otherwise directed by the Department or the Department's designee.

(e) The closing SCO or SCA provider may not transfer a participant during a closure until after the Department or the Department's designee approves the participant's transition plan.

**§ 51.155. Provider closure requirements.**

(a) A closing provider shall complete the following activities when terminating HCBS:

(1) The closing provider shall notify each participant to whom it renders HCBS, the Department or the Department's designee and each SCO and SCA providing supports coordination to the participant, that the provider is closing.

(2) The closing provider shall follow § 51.31 (relating to transition of participants).

(3) The closing provider shall notify applicable licensing or certifying entities of the provider's closure in accordance with the rules established by the licensing or certifying entity.

(b) The provider shall send the Department or the Department's designee a copy of the notification sent to the participant and SCO or SCA as required under subsection (a)(1).

(c) If the provider fails to notify the Department or the Department's designee as specified in subsections (a) and (b), the provider may not be paid for HCBS rendered after the date the notice is due to the Department or the Department's designee.

(d) The closing provider shall prepare participant records for transfer to the selected and willing provider within 14 days of the selected and willing provider accepting the transfer.

(e) A closing provider shall update and maintain records until the effective date of transfer.

(f) A closing provider shall maintain records verifying compliance with this chapter for a minimum of 5 years in addition to the current year, even after closure as specified in § 51.15 (relating to provider records).

(g) The section does not apply to an SSW provider.

**§ 51.156. AWC/FMS closure requirements.**

(a) A closing AWC/FMS provider shall complete the following activities:

(1) The AWC/FMS provider shall first notify the Department of its intent to close.

(2) The notice must be sent to the Department at least 60 days prior to closure.

(3) The AWC/FMS provider shall cooperate with transitioning participants to the new AWC/FMS provider that is identified by the Department.

(4) The AWC/FMS provider shall complete the following transition activities once notice has been provided by the Department:

(i) Notify each participant in writing of the AWC/FMS provider's decision to no longer provide AWC/FMS.

(ii) Provide the Department with suggested time frames for transitioning the participant to the new AWC/FMS provider.

(iii) Prepare participant records for transfer to the new AWC/FMS provider identified by the Department within 14 days of the new AWC/FMS provider becoming the AWC/FMS.

(iv) Update and finalize records until the effective date of the transfer to the new AWC/FMS.

(b) If the AWC/FMS provider fails to notify the Department as specified in subsection (a), the AWC/FMS provider may not be paid for HCBS and administrative fees after the date the notice is due to the Department.

(c) An AWC/FMS provider shall maintain records verifying compliance with this chapter for a minimum of 5 years in addition to the current year, even after closure as specified in § 51.15 (relating to provider records).

(d) The section does not apply to an SSW provider or a provider of HCBS in the Adult Autism Waiver.

**§ 51.157. Appeals.**

A provider may file an appeal of a Departmental action in accordance with Chapter 41 (relating to Medical Assistance provider appeal procedures).

[Pa.B. Doc. No. 12-1043. Filed for public inspection June 8, 2012, 9:00 a.m.]

**DEPARTMENT OF PUBLIC WELFARE  
[ 55 PA. CODE CH. 6211 ]**

**Allowable Cost Reimbursement for Non-State Operated Intermediate Care Facilities for Persons with an Intellectual Disability**

The Department of Public Welfare (Department) amends Chapter 6211 (relating to allowable cost reimbursement for non-State operated intermediate care facilities for persons with an intellectual disability) to read as set forth in Annex A under the authority of sections 201(2), 403(b) and 403.1 of the Public Welfare Code (code)

(62 P. S. §§ 201(2), 403(b) and 403.1), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

#### *Omission of Proposed Rulemaking*

On July 1, 2011, the General Assembly enacted Act 22, which amended the code. Act 22 added several new provisions to the code, including section 403.1. Section 403.1(a)(4), (c) and (d) of the code authorizes the Department to promulgate final-omitted regulations under section 204(1)(iv) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(1)(v)), known as the Commonwealth Documents Law (CDL), to establish or revise provider payment rates, reimbursement models and payment methodology. Section 204(1)(iv) of the CDL authorizes an agency to omit or modify notice of proposed rulemaking when a regulation relates to Commonwealth grants and benefits. The Medical Assistance Program is a Commonwealth grant program through which eligible recipients receive coverage of certain health care benefits. In addition, to ensure the Department's expenditures for State Fiscal Year 2011-2012 do not exceed the aggregate amount appropriated by the General Assembly, section 403.1 of the code expressly exempts these regulations from the Regulatory Review Act (71 P. S. §§ 745.1—745.12), section 205 of the CDL (45 P. S. § 1205) and section 204(b) of the Commonwealth Attorneys Act (71 P. S. § 732-204(b)).

The Department is amending Chapter 6211 in accordance with section 403.1 of the code. This final-omitted rulemaking revises the payment methodology for the establishment of the standard interim per diem rate for non-State operated intermediate care facilities for persons with an intellectual disability (previously referred to as non-State operated intermediate care facilities for the mentally retarded).

#### *Purpose*

The purpose of this final-omitted rulemaking is to revise the payment methodology for the standard interim per diem rate for non-State operated intermediate care facilities for persons with an intellectual disability (ICFs/ID) and non-State operated intermediate care facilities for persons with other related conditions (ICFs/ORC). Specifically, the Department is amending § 6211.16 (relating to establishment of standard interim per diem rate). In addition, the Department is replacing the term “mental retardation” with the term “intellectual disability” throughout this chapter.

#### *Background*

ICFs/ID and ICFs/ORC are facilities that provide Medicaid services defined in Title XIX of the Social Security Act (42 U.S.C.A. § 1396a(a)). ICFs/ID and ICFs/ORC are facilities which are designed to provide “active treatment services” to persons who are diagnosed with an intellectual disability or persons with other related conditions in accordance with 42 CFR 435.1010 (relating to definitions relating to institutional status). ICFs/ORC are included in § 6211.2 (relating to applicability) in accordance with 42 CFR 483.400 (relating to basis and purpose). To further provide clarity regarding the payment methodology that establishes the standard interim per diem rate for ICFs/ID-ICFs/ORC and to improve the cost effectiveness of these programs, the Department is promulgating this final-omitted rulemaking. The promulgation of this final-omitted rulemaking will enable the Commonwealth to ensure the Department's expenditures do not exceed the amount appropriated by the General Assembly for ICFs/ID and ICFs/ORC as required under Act 22.

#### *Requirements*

In this final-omitted rulemaking, the Department is amending § 6211.16. Subsection (c)(2) has been amended to delete references to the application of an inflationary factor and language has been added that the Department may apply a cost of living adjustment (COLA) to the interim per diem rates during the rate development process.

Section 6211.16 is also being amended by adding subsection (e). The addition of subsection (e) provides that the Department may apply a downward rate adjustment factor (RAF) to the standard interim per diem rate for each provider, including those providers who request a waiver of the standard interim per diem rate as specified in § 6211.31 (relating to request for waiver). The amount of funds resulting from the application of the RAF cannot be requested as a waiver of the standard interim per diem rate. The ability to apply a RAF enables the program to maintain fiscal stability and will enable the Commonwealth to ensure the Department's expenditures do not exceed the amount appropriated by the General Assembly.

The Department is also amending § 6211.31. Under subsection (a), to request additional funds for the fiscal year, the provider shall submit a request for a waiver of the standard interim per diem rate in accordance with the identified requirements under this subsection. Subsection (b) amends the deadline for waiver request submissions. Instead of the March 1 deadline for waiver request submissions to the Department, the subsection has been amended to provide an October 31 deadline of the fiscal year for which the waiver is being requested. This amendment aligns the regulation to current program practice.

Subsection (e)(2) is also amended to clarify that the written request for a waiver of the standard interim per diem rate must be in accordance with the budget instructions. Further, subsection (f) is amended to clarify that a provider with less than a 12-month cost report who fails to submit a request for waiver of the standard interim per diem rate, will have an interim per diem rate established under § 6211.15 (relating to failure to submit cost report).

Finally, the Department is amending the regulations to delete references to “mental retardation” and replacing this outdated language with “persons with an intellectual disability.” The Department is also replacing “Office of Mental Retardation” with “the Department” or “the Office of Developmental Programs.”

#### *Affected Individuals and Organizations*

The final-omitted rulemaking affects providers who operate ICFs/ID and ICFs/ORC. The Department's ICF/ID and ICF/ORC program has approximately 178 service locations and 33 providers in this Commonwealth.

#### *Accomplishments and Benefits*

The final-omitted rulemaking clarifies and revises the rate setting methodology for standard interim per diem rates for ICF/ID and ICF/ORC providers to ensure fiscal stability within the program. The final-omitted rulemaking also replaces outdated terminology with current terminology.

#### *Fiscal Impact*

This final-omitted rulemaking ensures that the Department's expenditures do not exceed the aggregate amount appropriated by the General Assembly.

*Paperwork Requirements*

There are no new paperwork requirements under the final-omitted rulemaking.

*Public Process*

The Department discussed these payment rates and methodologies with the Medical Assistance Advisory Committee at the February 23, 2012, meeting. The Department posted the draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department invited interested persons to submit written comments regarding the regulation to the Department. The Department received 39 comments from 16 commentators. The Department also discussed the Act 22 regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

In addition, the Department published advance public notice at 42 Pa.B. 2110 (April 14, 2012) announcing its intent to amend Chapter 6211 regarding provider payment methodologies, rates and terminology. The Department invited interested persons to comment. The Department received five comment letters during this comment period. The comment letters were reflective of the comments previously received on the draft regulation.

The Department considered the comments received in response to the draft regulation.

*Discussion of Comments*

Following is a summary of the major comments received within the public comment period and the Department's responses to the comments.

*Comment*

The commentators disagreed with the removal of language related to an inflationary factor from § 6211.16(c)(2) and also disagreed with the addition of § 6211.16(e) related to the application of an RAF. In addition, a commentator requested language be added to § 6211.16(c)(2) related to a COLA.

*Response*

The Department is maintaining the removal of the inflationary factor and inclusion of the language related to the RAF. The amended language will improve cost efficiencies and provide fiscal stability of the program. The Department does agree with the comment to add language related to a COLA. Therefore, the Department revised § 6211.16(c)(2) to provide for consideration of a COLA to the interim per diem rates.

*Comment*

Several commentators suggested revisions to § 6211.1 (relating to purpose) and § 6211.2 to include State-operated ICFs/ID under this chapter.

*Response*

Chapter 6211 does not apply to State-operated ICFs/ID. Therefore, the Department did not amend these sections.

*Comment*

Several commentators stated the language was unclear in § 6211.31(f).

*Response*

The Department is maintaining the language in § 6211.31(f). Under subsection (a)(1), a facility that has been certified as an ICF/ID for less than 18 months prior to the closing date of the most recently submitted cost report may submit a waiver of the interim per diem rate. Subsection (f) further outlines that if a provider with less

than a 12-month cost report does not submit a request for a waiver of the standard interim per diem rate under subsection (a)(1), a rate will be established under § 6211.15. The amended language will enable the Department to maintain consistency in the establishment of interim per diem rates for each provider.

*Regulatory Review Act*

Under section 403.1 of the code, this final-omitted rulemaking is not subject to the Regulatory Review Act.

*Findings*

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with section 204(1)(iv) of the CDL, 1 Pa. Code § 7.4(1)(iv) and section 403.1(d) of the code because the regulations relate to Commonwealth grants and benefits.

(2) The adoption of this final-omitted rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

*Order*

The Department, acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 6211, are amended by amending §§ 6211.1, 6211.2, 6211.4, 6211.11—6211.16, 6211.31, 6211.32, 6211.47, 6211.64, 6211.74, 6211.82, 6211.121, 6211.124 and 6211.131—6211.133 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Secretary of the Department shall submit this order and Annex A to the Office of General Counsel for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this order and Annex A with the Legislative Reference Bureau as required by law.

(d) This order shall take effect July 1, 2011, in accordance with section 403.1(e) of the code.

GARY D. ALEXANDER,  
*Secretary*

**Fiscal Note:** 14-534. No fiscal impact; (8) recommends adoption.

**Annex A**

**TITLE 55. PUBLIC WELFARE**

**PART VIII. INTELLECTUAL DISABILITY MANUAL**

**Subpart C. ADMINISTRATION AND FISCAL MANAGEMENT**

**CHAPTER 6211. ALLOWABLE COST REIMBURSEMENT FOR NON-STATE OPERATED INTERMEDIATE CARE FACILITIES FOR PERSONS WITH AN INTELLECTUAL DISABILITY**

**GENERAL PROVISIONS**

**§ 6211.1. Purpose.**

This subchapter specifies the requirements for MA reimbursement and allowable costs for non-State operated intermediate care facilities for persons with an intellectual disability.

**§ 6211.2. Applicability.**

(a) This chapter applies to non-State operated intermediate care facilities for persons with an intellectual

disability and non-State operated intermediate care facilities for persons with other related conditions.

(b) The following chapters apply to non-State operated intermediate care facilities for persons with an intellectual disability and non-State operated intermediate care facilities for persons with other related conditions: Chapters 1101 and 6210 (relating to general provisions; and participation requirements for the intermediate care facilities for the mentally retarded program).

(c) In addition to this chapter, the Medicare Provider Reimbursement Manual (HIM-15) applies for costs that are included in this chapter as allowable and for reimbursable costs that are not specifically addressed in this chapter.

(d) If this subchapter is inconsistent with Chapter 6210 or HIM-15, this chapter shall prevail.

#### § 6211.4. Definitions.

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

\* \* \* \* \*

*Cost report*—A summary of client occupancy, income and expenses for a given period, presented in a manner and on a form prescribed by the Department.

\* \* \* \* \*

*Facility*—A non-State operated intermediate care facility for persons with an intellectual disability or a non-State operated intermediate care facility for persons with other related conditions.

\* \* \* \* \*

*Standard interim per diem rate*—The rate established by the Department in accordance with § 6211.16 (relating to establishment of standard interim per diem rate) for the purpose of making interim payments to the facility pending a year-end cost settlement.

\* \* \* \* \*

### STANDARD INTERIM PER DIEM RATE

#### § 6211.11. Basis for standard interim per diem rate.

The standard interim per diem rate for each provider is based upon the cost report submitted to the Department by the provider.

#### § 6211.12. Submission of cost report.

(a) The provider shall submit a written report of the costs for the previous Fiscal Year to the Department by September 30 of each year, unless an extension is granted in accordance with procedures in the cost report.

(b) The cost report shall reflect at least 12 months of operation.

(c) The cost report shall be submitted on the form prescribed by the Department.

#### § 6211.13. Review of cost report.

The Department will review the cost report submitted by the provider for correctness, consistency with previous audits and cost reports, and compliance with the instructions for the cost report.

#### § 6211.14. Adjustments to cost report.

(a) The Department will adjust the cost report based upon the findings of closed audits and cost settlements.

(b) The Department will inform the provider in writing of adjustments to the submitted cost report by January 1

of each year, unless an extension is granted under § 6211.12(a) (relating to submission of cost report).

(c) If the Department does not inform the provider in writing of adjustments to the submitted cost report by January 1 of each year, the cost report submitted by the provider is accepted by the Department.

#### § 6211.15. Failure to submit cost report.

If the provider does not submit a cost report by September 30 of each year, or later if an extension is granted by the Department under the procedures of the cost report, the Department will establish an interim per diem rate for the provider equal to the lowest interim rate for any non-State operated intermediate care facility for persons with an intellectual disability issued for the current fiscal year.

#### § 6211.16. Establishment of standard interim per diem rate.

(a) The standard interim per diem rate shall be used for billing purposes throughout the current fiscal year.

(b) The standard interim per diem rate shall be established by dividing the total projected operating cost by 98% of the maximum possible number of days based on the number of certified beds of the facility.

(c) The total projected operating cost is derived under the following procedures:

(1) Taking the total MA allowable costs, including adjustments for income, and comparing this to the approved budget total, or the total projected operating costs if applicable, for the same fiscal year in order to determine the lesser amount. From the lesser amount, subtract depreciation on capital assets, limited to buildings and fixed equipment, and interest on capital indebtedness.

(2) The Department may apply a cost of living adjustment to the interim per diem rate during the rate development process.

(3) Adding depreciation on capital assets, limited to buildings and fixed equipment, and interest on capital indebtedness to the total projected cost to result in the total projected operating cost.

(d) The cost report submitted by the provider, in addition to adjustments made by the Department, as specified in § 6211.14 (relating to adjustments to cost report), shall be used for the calculation of the standard interim per diem rate.

(e) The Department may apply a downward rate adjustment factor to the standard interim per diem rate for each provider to remain within the amount appropriated by the General Assembly, including those providers who request a waiver of the standard interim per diem rate as specified in § 6211.31 (relating to request for waiver). The amount of funds resulting from the application of the rate adjustment factor cannot be requested as a waiver of the standard interim per diem rate as identified under § 6211.31.

### WAIVER OF STANDARD INTERIM PER DIEM RATE

#### § 6211.31. Request for waiver.

(a) To request additional funds for the fiscal year, the provider shall submit a request for a waiver of the standard interim per diem rate in accordance with the requirements of this section. A request can only be submitted if one or more of the following conditions exist:

(1) The facility has been certified as an ICF/ID for less than 18 months prior to the closing date of the most recently submitted cost report.

(2) There has been an increase or decrease in the certified capacity of a facility during the current fiscal year.

(3) An increase or decrease in the certified capacity is anticipated for the next fiscal year.

(4) The characteristics of a client have changed significantly causing significant program changes, resulting in demonstrably different costs.

(5) An unforeseen circumstance has resulted in demonstrably different costs.

(6) The facility has changed ownership.

(b) The request for waiver shall be submitted to the Department in writing by October 31 of the fiscal year for which the waiver is being requested.

(c) A waiver request may not be submitted for more than 1 fiscal year at a time.

(d) If there is an unforeseen circumstance that affects the providers' cost, the request for waiver shall occur during the current fiscal year. The provider shall request a budget review in writing immediately after the change occurs.

(e) A written request for a waiver of the standard interim per diem rate shall include all of the following:

(1) Identification of the specific condition in subsection (a) that exists.

(2) A proposed budget and a proposed per diem rate, on forms and in accordance with the budget instructions prescribed by the Department.

(3) A detailed profile of the providers' costs prior to and after the change.

(4) Detailed justification for the waiver.

(5) The fiscal year for which the waiver is being requested.

(f) For a provider with less than a 12-month cost report who does not submit a request for waiver of the standard interim per diem rate based under subsection (a)(1), an interim per diem rate will be established based upon § 6211.15 (relating to failure to submit cost report).

**§ 6211.32. Approved waiver.**

(a) After the Department has notified the provider that a waiver has been granted, the Department will establish the total approved revised budget level.

(b) If a waiver is granted, the Department will establish budget levels by major object of expenditure and cost center. The budget level will be based on this chapter and HIM-15.

(c) If a waiver is granted, the Department will establish an interim per diem rate by dividing the total approved budget level minus offsetting income, by 98% of the maximum potential certified occupancy or the occupancy percentage requested by the provider in the budget, whichever is higher.

(d) If a waiver is granted, the interim per diem rate shall be used for billing purposes throughout the fiscal year.

**REIMBURSEMENT**

**§ 6211.47. Operation of multiple program types.**

(a) If a provider operates intermediate care facilities for persons with an intellectual disability as well as other types of programs, the provider shall document at the time of audit, or if a waiver is requested the provider shall submit with the budget a detailed account of how various costs are allocated between the multiple programs, under § 6211.72 (relating to administrative costs).

(b) The detailed account of the allocation shall include at least all of the following:

(1) All salary costs for individuals responsible for more than one program.

(2) Employee fringe benefits for individuals responsible for more than one program.

(3) All rental costs that apply to multiple programs.

(4) All motor vehicles that are used by multiple programs.

(5) All other related expenses shared by multiple programs.

**BED OCCUPANCY**

**§ 6211.64. Waiver of minimum occupancy rate.**

A provider may request a waiver of the minimum occupancy requirement at the time that a final cost report is submitted to the Department. The request for waiver of the minimum occupancy requirement shall be submitted in writing to the Deputy Secretary for Office of Developmental Programs. Documentation shall be submitted related to one or more of the following conditions:

(1) The facility is in its first year of operation.

(2) The facility is increasing or decreasing the number of certified beds.

(3) The facility operates less than 16 beds.

**ALLOWABLE COSTS**

**§ 6211.74. Service contracts.**

Costs necessary for the operation of the facility and the establishment and maintenance of intermediate care facilities for persons with an intellectual disability certification are allowable to the extent that the costs do not duplicate services performed by staff on complement. Service contracts shall specify the nature and cost of the service. Documentation of service contracts shall be maintained by the facility with all documentation of services rendered.

**§ 6211.82. Rental costs.**

\* \* \* \* \*

(c) Exceptions to subsection (b) are allowed only upon advance approval from the Deputy Secretary for the Office of Developmental Programs or a designee. Approval will be based on a fair market rental appraisal as outlined in subsection (e), or documented costs of ownership, except that return on equity is not permitted. The provider is permitted to include documented mortgage interest charges and depreciation.

\* \* \* \* \*

**BUDGET**

**§ 6211.121. Submission of the budget.**

(a) For new programs that have never participated in the Intermediate Care Facility for persons with an intellectual disability program, or programs that have partici-

pated in the program for less than 12 months, a budget shall be prepared and submitted to the Department in accordance with forms and instructions provided by the Department.

(b) If a waiver of the standard interim per diem rate is requested, a budget shall be submitted to the Department in accordance with § 6211.31(e) (relating to request for waiver) and shall be prepared in accordance with forms and instructions provided by the Department.

**§ 6211.124. Budget adjustments.**

(a) The provider is permitted to move funds between major objects of expenditure and cost centers, within 10% of the approved amount per major object of expenditure and cost center, during the course of the fiscal year.

(b) Movement of funds greater than 10% requires submission of budget adjustment and shall meet the following conditions:

(1) Changes shall remain within the limit of the total approved budget level.

(2) Requests for adjustment shall be filed during the fiscal year in which the rate is effective, and budget adjustments may be filed a maximum of two per fiscal year.

(3) Budget adjustments shall be submitted on forms prescribed by the Department and in accordance with applicable instructions.

**MOVEMENT OF FUNDS**

**§ 6211.131. Conditions for movement of funds.**

(a) Agencies that operate multiple programs shall be permitted to move up to 10% of the approved funding

level of a program across other programs the facility operates.

(b) Movement of funds shall be permitted only once per Commonwealth fiscal year.

(c) The request for movement of funds shall be submitted to the Department by May 31 of the fiscal year for which the movement of funds is requested.

(d) Movement of funds will not be approved if there is an increase in the sum of the already approved funding levels for each of the programs the agency operates.

(e) Movement of funds shall be limited to 10% of a program's approved funding level.

(f) Movement of funds may be directed from several programs to a single program.

**§ 6211.132. Documentation.**

(a) Agencies requesting the movement of funds shall submit revised program budget pages to the Department for affected programs.

(b) For programs affected by the change with standard interim rates, a program budget page is not required. The agency shall document to the Department the change in the total projected operating cost as a result of the movement of funds.

**§ 6211.133. Related procedures.**

The Department will not process gross adjustments as a result of an approved request to move funds across programs and revised interim rates will not be issued.

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