Regulatory Analysis Form

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REVIEW COMMISSION

IRRC Number: 2034

(1) Agency

Department of Health

(2) I.D. Number (Governor's Office Use)

10-129

(3) Short Title

Head Injury Program Regulations

(4) PA Code Cite

28 PA Code
Chapter 4

(5) Agency Contacts & Telephone Numbers

Primary Contact: Elaine Terrell, M.P.H.
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(6) Type of Rulemaking (Check One)

__ Proposed Rulemaking

_✓_ Final Order Adopting Regulation

__ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

_✓_ No

__ Yes: By the Attorney General

__ Yes: By the Governor

(8) Briefly explain the regulation in clear and non-technical language.

Regulations set forth the rules governing the Head Injury Program (HIP), describe the type of services available under the program and describe eligibility criteria for applicants.

Regulatory Analysis Form
(9) State the statutory authority for the regulation and any relevant state or federal court decisions. 35 P.S. §6934(e) Meleneyzer et al. v. Commonwealth of Pennsylvania, Department of Health, et al. Commonwealth Court Docket No. 0135 MD 1993
(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action. No.
(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses? Orderly operation of program and help more citizens in need.
(12) State the public health, safety, environmental or general welfare risks associated with non-regulation. Program requires standards to be effective and help more citizens in need. Non-regulation will lead to abuses.
(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.) All persons who qualify for HIP benefits will have a clearer understanding of the program. Each person will qualify for one year of rehabilitation services and 6 months of transitional case management services from the Head Injury Program.

Regulatory Analysis Form

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

There are currently 15 rehabilitation clients and 167 case management clients in the program indefinitely. The current 15 rehabilitation clients will be transitioned to DPW ComCare Waiver Program or will receive an additional 12 months rehabilitation and 6 month transitional case management. The current 167 clients receiving case management services only will receive an additional 6 months of case management.

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

1. Approximately 15,000 Pennsylvania residents sustain head trauma annually. An indeterminate number of those may be eligible for and wish to receive benefits. During implementation of the regulations up to 167 current clients who are eligible for case management services and 15 current rehabilitation clients will be affected by the regulations. Thereafter, approximately 30 new clients per year will be affected by the regulations. There are also166 individuals on the waiting list that will be affected by the regulations.

2. Providers of services including case managers and rehabilitation facilities.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

The HIP shared the proposed regulations with the Pennsylvania Association of Rehabilitation Facilities (PARF) and persons involved in providing the necessary services. List of persons making comments:

Mrs. Elayne Klein
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Yardley, PA 19067

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Erie, PA 16505-3447

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Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102-1714

Senator Vincent Hughes
Minority Chair
Senate Public Health & Welfare Comm.
Senate Box 203007
Harrisburg, PA 17120-3007

Independent Regulatory Review
Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

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

These regulations do not have a significant fiscal impact to the regulated community. Providers are currently required by contract to obtain CARF accreditation which costs $3,000. The regulations will document this existing requirement that is now in current contracts.

Regulatory Analysis Form

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

None.

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

These regulations do not have a significant fiscal impact on state government. The state government will have minimal costs associated with possible appeals of Department of Health decisions on eligibility. Costs would include hearing officer, legal time and expert witnesses and usual staff and clerical support.

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

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$0	$0	$0	$0	$0	$0
Regulated Community	$0	0	0	0	0	0
Local Government	$ 0	0	0	0	0	0
State Government	$ 0	0	0	0	0	0
Total Savings	$0	0	0	0	0	0
COSTS:						
Regulated Community	$0			$0		
Local Government	0	0	0	0	0	0
State Government	$0					
Total Costs	$0			$0		
REVENUE LOSSES:						
Regulated Community	0	0	0	0	0	0
Local Government	0	0	0	0	0	0
State Government	0	0	0	0	0	0
Total Revenue Losses	0	0	0	0	0	0

Regulatory Analysis Form

(20a) Explain how the cost estimates listed above were derived.

These regulations will not have a significant fiscal impact on the regulated community, state government or local government.

(20b) Provide the past three-year expenditure history for programs affected by the regulation. SFY 99/00 represents encumbrances and expenditures as of 6/30/00. SFY 00/01 represents the allocation level as of 7/1/00.

Program	FY - 3 - SFY 97/98	FY - 2 - SFY 98/99	FY - 1 - SFY 99/00	Current FY- SFY 00/01
Head Injury Program	$2,710,680	$2,027,829	$2,751,000	$3 Million

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

The benefits of the regulations clearly outweigh all costs associated. This is particularly true since costs to the regulated community will not increase because of the requirements for CARF accreditation are already in their existing contracts. The only increased costs will be to state government to provide appropriate due process.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

The regulatory alternative is the use of administrative policy. This has been challenged and the policies of the Head Injury Program are difficult to defend without regulations.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

Since the regulation attempts to regulate the service and not the provider, no other regulatory scheme was considered.

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

There are no federal standards in this area.

Regulatory Analysis Form
(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states? In general, when PA is compared to other states with a dedicated state funding source such as ours (AZ, FL, MA, and MO), PA is the only state placing time and cost limits on service. There is no competitive disadvantage to Pennsylvania.
(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations. Possible effect on Department of Public Welfare and Office of Vocational Rehabilitation.
(27) Will any public hearings or information meetings be scheduled? Please provide the dates, times, and locations, if available. Not planned at this time.
(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports which will be required as a result of implementation, if available. Yes, new HIP application, new applicant assessment form and provider will be required to submit a service plan and any updates as necessary.
(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers. N/A
(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained? 30 days after being published as final.
(31) Provide the schedule for continual review of the regulation. Annual.

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

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REVIEW COMMISSION

#2034

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Copy below is hereby approved as to form and legality. Attorney General.	Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:	Copy below is hereby approved as to form and legality. Executive or Independent Agencies.
BY _____ DEPUTY ATTORNEY GENERAL	DEPARTMENT OF HEALTH (AGENCY)	BY _____
_____ DATE OF APPROVAL	DOCUMENT/FISCAL NOTE NO. 10-129	3/6/01 DATE OF APPROVAL
	DATE OF ADOPTION: _____	(Deputy General Counsel) ~~(Chief Counsel, Independent Agency)~~ (Strike inapplicable title)
	BY: Robert S. Zimmerman, Jr.	
Check if applicable. Copy not approved. Objections attached.	TITLE: Secretary of Health	Check if applicable. No Attorney General approval or objection within 30 days after submission.

FINAL RULEMAKING
DEPARTMENT OF HEALTH
TITLE 28. HEALTH AND SAFETY
PART I. GENERAL HEALTH
[28 Pa. Code Ch. 4)]
Head Injury Program

CONTINUATION SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU
(Pursuant to Commonwealth Documents Law)

The Department of Health (Department) hereby adopts amendments to 28 Pa. Code Part I (relating to general health) by adopting Chapter 4 (relating to Head Injury Program) as set forth in Annex A hereto.

Scope and Purpose

The regulations establish standards by which the Department will administer the Catastrophic Medical and Rehabilitation Fund (Fund). The Emergency Medical Services Act (Act) (P.L. 164, No. 45) (35 P.S. §§6921 – 6928) establishes the Fund. Section 14(e) of the Act (35 P.S. §6934(e)) states that the Fund "shall be available to trauma victims to purchase medical, rehabilitation and attendant care services when all alternative financial resources have been exhausted . . .". Section 14(e) also permits the Department to adopt regulations to prioritize the distribution of moneys from the Fund by classification of traumatic injury. The final rulemaking provides that the Department will use moneys from the Fund to provide designated services to persons who have incurred a traumatic brain injury (TBI).

The Department has established a Head Injury Program (HIP or Program), administered by its Division of Special Health Care Programs (Division) to make distributions from the Fund. Parameters for participation in the Program, including eligibility requirements, are established in the final rulemaking. The regulations also address Program administration, including assessment procedures, services to be reimbursed by HIP, funding and time limitations on participation, and appeal procedures.

Public Comments

Notice of proposed rulemaking was published as 29 Pa.B. 2671 (May 22, 1999), with an invitation to submit written comments within 30 days.

Within the 30-day comment period the Department received several comments. Subsequently, the Department received comments from the Independent Regulatory Review Commission (IRRC); Senator Vincent Hughes, Minority Chair of the Senate Public Health and Welfare Committee; and Representative Linda Bebko-Jones of the 1st Legislative District. A meeting to discuss these comments prior to the preparation of the final rulemaking was held on July 13, 1999, among representatives of the Department, IRRC, the House Health and Human Services Committee and the Senate Committee on Public Health and Welfare.

It should be noted that, although the regulations and the underlying program have not substantively changed, the final version of the regulations virtually rewrites and reorganizes the proposed regulations in order to improve organization and clarity. The regulations have been restructured first in order to follow the process of the applicant's placement on the waiting list, applying, being assessed, and enrollment, in the chronological order that each actually takes place. This enables an individual seeking to understand the Program to get a clearer picture of "what happens next". Although this process is no different than it was when the regulations were originally proposed, it was not presented in serial fashion at that time.

The final regulations also clarify the two separate stages of evaluating eligibility for the Program, with the first stage being consideration of requirements that can be evaluated on paper, including domicile, general financial situation, and absence of certain pre-existing medical conditions. Meeting these requirements makes an applicant eligible for an in-depth assessment, discussed further below. The outcome of this assessment will determine whether the applicant is eligible to be accepted into the Program and receive rehabilitation services. Again, this is how the Program was conceived at the time the regulations were first proposed; the process is simply made clearer in the final version.

A considerable amount of the information in the final version of the regulations was taken from the regulations as they were first proposed. Although detail has been added in a number of areas, those details are largely not ones that have been newly conceived. Rather, it was determined that the addition of the information would assist readers of the regulations to understand how the Program works.

In addition, a number of changes have been made in response to comments, as discussed below. Because the changes in form, if not in content, are so sweeping, the comments to the proposed regulations are addressed under the current section in which the subject matter addressed by the comment appears. Following is a discussion of the comments received by the Department and the Department's response to them.

Section 4.1 – Scope and Purpose

No comments addressing this section were received. The proposed section was revised to remove the statement that the Department will provide rehabilitation services "facilitated through case management." This phrase was inserted elsewhere because it is a substantive provision that is too specific to be included in a section addressing the scope and purpose of the chapter. Language is inserted to follow the statute more closely by specifying that the Fund may be used to pay for "medical, rehabilitation, and attendant care services" for persons with TBIs.

Section 4.2 – Definitions

This section contains definitions of terms used in the chapter.

Comment

The definition of "day services" should be revised to include physical abilities as one of the abilities day services are designed to improve.

Response

The Department accepts the recommendation, and has made the suggested change to the definition of "day services."

Comment

The Division of Special Health Care Programs should be specifically mentioned in the proposed definition of "Division" as the division that will be responsible to administer HIP.

Response

The Department accepts the recommendation.

Comment

It is proposed that the term "exhausted" be defined as the point at which alternative financial resources have been applied for and denied or fully utilized. It is unclear what "exhausted" means in terms of alternative financial resources. This term may not be necessary if the financial eligibility criteria are specified in more detail.

Response

The Department agrees with the comment. The term "exhausted" is not defined in the final regulations. The financial eligibility criteria for participation in HIP are now specified in §4.6(a)(1)(v) (relating to assessment), which requires applicants to have alternative financial resources not in excess of 300% of Federal poverty guidelines to participate in the Program. "Alternative financial resources" (AFRs) are defined as all income subject to Federal income tax, funds available to an individual by virtue of experiencing a TBI, and funds available to an individual through other State or Federal programs. These are resources that must be used to pay for HIP services until these resources are reduced to the threshold amount. Because the regulations now make clear that an applicant or client cannot have AFRs in excess of 300% of the Federal poverty level, it is not necessary to require that AFRs be "exhausted."

Comment

The term "legal representative" is used but not defined in the proposed regulations. This term should be defined to refer to one who is legally empowered to act for a head injury

applicant or client. This will clarify who can act in this capacity and will also avoid repeatedly iterating a list of persons who may or may not be so empowered.

Response

The Department agrees with the comment. The term "authorized representative" is now defined in this section to include any individual authorized by law to make a decision for an applicant or client. Defining "authorized representative" as one who is legally authorized to act for an applicant or client clarifies that the input of an authorized substitute decisionmaker is acceptable. Whether or not an authorized representative exists, the applicant or client, of course, is free to share information with, and solicit the assistance of, parents, guardians, or anyone else the applicant or client chooses.

Comment

The definition of "legal representative" should include a reference to "minor."

Response

The Department disagrees. The regulations provide that only individuals who are 21 years of age or older may participate in HIP. Therefore, no reference to minors is needed.

Comment

The definition of "rehabilitation" should include "home facilitation" in the list of services that are included.

Response

The Department accepts the recommendation. The defined term that appears in the final rulemaking is "rehabilitation services," as opposed to "rehabilitation." "Home facilitation" is included in the list of services contemplated by the term "rehabilitation services." Additionally, part of the remaining substance of the proposed definition was moved to §4.9 (relating to rehabilitation period).

Comment

The final sentence of the definition of "rehabilitation service plan" should be deleted, as it inappropriately contains substantive provisions and duplicates language found in the substantive portions of the regulations.

Response

The Department agrees with this comment. The final sentence has been deleted.

Comment

The definition of "rehabilitation service plan" should include "the client's parent, guardian, or representative" among those who collaborate in the development of the rehabilitation service plan.

Response

The Department agrees with the recommendation in part. Much of the proposed definition of "rehabilitation service plan," including the part that addressed with whom the provider could collaborate in developing the plan, has been moved to §4.8 (relating to rehabilitation service plan). The term "authorized representative" is now used. It is more comprehensive than "parent, guardian, or representative." Section 4.8 does state that the provider may collaborate with the applicant's or client's significant others, such as family or healthcare providers, in the development of a rehabilitation service plan. This permits the provider the flexibility to consult with members of the individual's support system, who may be most aware of the individual's needs, when developing and revising a rehabilitation service plan for an applicant or client.

Comment

The definition of "rehabilitation services" should include therapeutic recreation and pre-vocational services. These services assist community integration and community re-entry skills.

Response

The Department agrees with the comment, and has incorporated these services in the definition of "rehabilitation services."

Section 4.3 – Services eligible for payment.

This section lists the services that may be paid for through HIP.

Comment

Proposed §4.7 appears to limit payment for services to "clients." However, the services that will be paid by HIP include assessments. It would seem that assessments are for applicants, who are not necessarily clients. This should be revised to be consistent.

Response

The Department agrees. Paragraph (1) states that assessments of applicants by providers are among the services for which HIP will pay.

Comment

Case managers should be reimbursed for travel time.

Response

The Department disagrees. The fee schedule utilized by HIP establishes the rate at which case managers can be reimbursed for their time. This rate assumes delivery of services to clients, and does not reimburse for travel time. The fee schedule does, however, allow for reimbursement for mileage. Because HIP funds are limited, the Department has determined that case management reimbursement will be limited to actual services delivered.

Comment

Education and training sessions should be offered to case managers to improve their knowledge and resource bases, and facilitate information exchange among them.

Response

The Department disagrees. It will be the responsibility of the providers with whom the Department contracts to ensure that useful educational opportunities are available to case managers and other staff in their employ.

Section 4.4 – Requirements for provider participation.

Comment

The proposed regulations do not indicate what the "appropriate National accrediting [bodies] as approved by the Department," referred to in proposed §4.7(4), are, or how a member of the public could find out what they are. The regulation should specify approved National accrediting bodies, or should state how a list of these may be obtained.

Response

The Department agrees. Subsection (a) states that a list of Department-approved National accrediting bodies will be published from time to time in the *Pennsylvania Bulletin*. Additionally, such a list can be obtained by contacting the Division. At this time, the only National accrediting body approved by the Department is the Commission for Accreditation of Rehabilitation Facilities (CARF). CARF is currently the predominant national accrediting body for rehabilitation providers in the field of brain injury rehabilitation. The Department will certainly consider other qualified bodies for approval as the opportunity arises.

Comment

Requiring rehabilitation facilities to obtain accreditation makes voluntary accreditation mandatory. A requirement of specific accreditation of head injury programs could result in lack of access to HIP and head injury services for patients in some regions of the Commonwealth. Minimum standards for head injury programs should be defined in the regulations and not deferred to accreditation.

Response

The Department rejects the recommendation. The Department believes that the requirement that HIP providers be certified by qualified accrediting bodies assures that uniform national recognized standards of care are available to all enrolled HIP clients, and serves as a continued quality assurance tool and measure.

Section 4.5 – Application for enrollment as a HIP client.

This section addresses the procedures for securing and filing an application for enrollment in HIP.

Comment

Is there a specific application form? How do applicants obtain a copy?

Response

Subsection (a) provides a contact address and phone number at the Department. Individuals who are interested in enrolling in HIP or arranging enrollment for another should contact the Eligibility Specialist at the number or address provided. If there is not sufficient funding to enable HIP to consider accepting a new client at the time the individual makes contact with the Division, the individual will be placed on a waiting list pursuant to subsection (c). Subsection (d) makes clear that the Division will provide application materials, including an application form, when the individual qualifies to receive an application; that is, whenever there is sufficient funding for HIP to be able to consider new applicants and the individual is next on the waiting list.

Comment

What verifying documentation must accompany the application form?

Response

The application must be accompanied by a physician's statement (the format for which will be provided by the Department), a completed Commonwealth income tax form, documentation of insurance including copies of any insurance cards, and documentation of citizenship and residency. This will be explained to the applicant or the applicant's

authorized representative at the appropriate time. The explanation will be in the instructions the Division provides for completing the application form.

Comment

The regulations should contain a provision that clearly addresses the status of the individuals currently on the waiting list. This provision should also outline the process of notifying those individuals of the Department's changes to HIP policy.

Response

The Department accepts the recommendation in part. Subsection (c) states that individuals on the waiting list will be asked to submit applications in the order that their requests to be placed on the list were received by the Division. Consequently, those individuals who are on the waiting list as of the date these regulations are adopted will be able to apply for enrollment before individuals who are placed on the list after them. The section also states that individuals who are on the waiting list who have already received case management services through HIP, but never received rehabilitation services through HIP, will be given first priority. This class of individuals, that is, those who receive case management services before receiving rehabilitation services, will cease to exist after the individuals who currently comprise the class are handled by the Program. The section further states that those persons who have never received rehabilitation services through HIP will be given priority over those who have previously received rehabilitation services through HIP.

The Department will send letters to all current HIP clients upon the adoption of these final regulations, explaining the new policies and the benefits to which they will be entitled. The Department will also send letters to all individuals on the waiting list. Additionally, the final rulemaking will be published in the *Pennsylvania Bulletin* and will be posted on the Department's web site.

Comment

The Department should clarify how the waiting list referenced in proposed §4.5(b) will be prioritized – for example, by date of application, degree of injury, or some other criteria.

Response

As previously stated, individuals on the waiting list will be asked to submit applications in the order that their requests to be placed on the waiting list were received. The exceptions to this are individuals who are receiving or have received case management services prior to formal enrollment in HIP, who will be given first priority as stated in subsection (c), and individuals who previously received HIP services and who are reapplying. Individuals who have never received HIP rehabilitation services will be given priority over former HIP clients, as stated in subsection (e).

Comment

The Department should clarify whether an applicant must reapply once he or she is placed on the waiting list, and how re-applicants will be prioritized.

Response

As explained in subsection (a), individuals do not formally begin the application process until the Division notifies them that it is their turn to apply. They are placed on the waiting list because there are no funds available to add them to the Program when they initially contact the Division. Their addition to the waiting list is accomplished via a signed letter sent to the Division. Individuals on the waiting list are then invited to submit an application for enrollment in HIP as funding becomes available and their turn arrives. If an application were to be filed at the time an individual is placed on the waiting list, it would probably be stale by the time the Division is ready to consider the individual for enrollment in HIP.

Section 4.6 – Assessment.

This section first sets forth the criteria an applicant must meet to be eligible for an assessment, and then explains the assessment process.

Comment

According to proposed §4.4(f), the Department will notify an applicant of his or her eligibility within 30 days from the receipt of a complete application. How will the date when an application is "complete" be determined and recorded?

Response

Information dealing with the application process is now included in §4.5 (relating to application for enrollment as a HIP client). An application will be considered to be complete on the day that the Division has received all of the information necessary to process the application. For example, an applicant is permitted to claim that his or her income as it appears on the Federal income tax form or other reporting document is no longer representative, as long as the applicant is able to support that claim. If the applicant fails to include supporting documentation, the Division may have to request it in order to verify that claim. The Division will record the date that it has received all of the required and requested information such that it is able to proceed with evaluating the application. When the application is complete the Division will determine whether an applicant is eligible for an assessment.

Comment

Proposed §4.6 states that the Department will conduct evaluations to determine an applicant's initial eligibility for HIP, as well as a client's eligibility for continuing

enrollment. Proposed §4.4 does not refer to these evaluations. The referenced language in proposed §4.6(a) should be placed in the section dealing with eligibility.

Response

The Department agrees with this comment and has revised this section to fully describe the assessment process.

Comment

The use of the phrase "the Department will deem" in proposed §4.4(a) through (c) is unnecessary and should be deleted.

Response

The Department agrees with the comment, and has deleted the phrase.

Comment

The requirement in proposed §4.4(a)(1) that an applicant must have sustained a traumatic brain injury "on or after" July 3, 1985, in order to be eligible, is confusing. It should simply read "The applicant suffered a traumatic brain injury after July 2, 1985."

Response

The Department agrees with the comment. Subsection (a)(1)(i) now reads, "[t]he applicant sustained a traumatic brain injury after July 2, 1985."

Comment

It is unclear why it is necessary, as required by proposed §4.4(a)(2), for an applicant to demonstrate the intent to maintain a permanent home in Pennsylvania for the indefinite future, and how the Department would enforce this requirement.

Response

The Department disagrees with the comment, but has revised the regulation to improve clarity. The final rule no longer requires the applicant to "demonstrat[e] the intent to maintain a permanent home in this Commonwealth for the indefinite future." Rather, subsection (a)(1)(ii) states that an applicant must have been domiciled in the Commonwealth both at the time of the injury and at the time application is made, to be eligible to participate in HIP.

"Domicile" is a generally accepted legal concept. It is defined as an individual's true, fixed, and permanent home, to which that individual intends to return. A person can have only one legal domicile at any given time. If a person goes to a place and intends to

make it a permanent home for an indefinite period, the person is domiciled there. If an individual takes up temporary residence in Pennsylvania, but intends to return to a fixed address elsewhere, the person is not a domiciliary of Pennsylvania.

The Department believes that the domicile requirement is reasonable, and may be ascertained rather simply. The Division need only ascertain where the applicant resided when the accident occurred, whether the applicant resides in the Commonwealth at the time of application, and the applicant's intentions regarding place of future residence. The requirement is difficult to enforce only in that one cannot keep an applicant from taking up temporary residence in Pennsylvania and misrepresenting his or her true intentions. However, the requirement that an individual must have been a domiciliary of the Commonwealth at both the time of the injury and the time of application to HIP goes a long way to ensuring that only true domiciliaries can present themselves as such. This requirement has been established to ensure that HIP's limited funds are used to assist Pennsylvanians. It would not be appropriate to allow HIP funds to be utilized by domiciliaries of other states when there are eligible Pennsylvania domiciliaries whom HIP will be unable to assist due to financial limitations.

Comment

The Department proposes to restrict enrollment in HIP to individuals who are 21 years of age or older, and has stated that individuals under 21 are eligible to receive services through other programs administered by the Departments of Education (DOE), Labor and Industry (L&I), and Public Welfare (DPW). However, individuals under 21 years of age are not automatically eligible for these programs. The Department should clarify the need to restrict eligibility for HIP to individuals who are 21 or over, as stated in proposed §4.4(a)(4), and explain how the programs provided by DOE, L&I, and DPW are appropriate alternatives for head injured individuals under 21 years of age. Note, for example, that individuals who are under 21 years of age but have graduated from high school may not be eligible for services from DOE.

Response

Due to limitations on the amount of funding available for HIP, the Department seeks to serve underserved individuals through the Program. Because there are a number of programs that make services similar to those afforded by HIP available to individuals under 21 years of age, the Department has elected to make HIP available only for individuals who are at least 21 years old.

The Office of Social Programs of DPW has established the Community Services Program for Persons with Physical Disabilities (CSPPPD). The CSPPPD provides services to individuals who have severe, chronic disabilities that have manifested before the age of 22, including disabilities due to head injuries, and who are residents of or applicants to nursing facilities. Clients of this program have substantial functional limitations. Through CSPPPD, they live in the community and are provided with services such as

service coordination, advocacy, peer counseling and support groups, community-integration activities, equipment-related assessment and transportation.

The Office of Social Programs also offers the Attendant Care Program and Centers for Independent Living (CILs), both of which are funded through the Federal Rehabilitation Act of 1973 (P.L. 93-112). Although the primary focus of the Federal legislation is on vocational rehabilitation, the Attendant Care Program provides for care services for severely disabled persons without job potential. Services include personal care attendants. The legislation additionally establishes independent living centers that serve people with all types of disabilities, including those stemming from head injury. These centers offer housing referral, training in independent living skills, training for personal assistants, assistive technology, and peer counseling.

All children under the age of 21 with disabilities, including those due to traumatic brain injury, are guaranteed a free, appropriate education in the least restrictive environment pursuant to the Federal Individuals with Disabilities Education Act (IDEA) (P.L. 101-476). DOE has the responsibility for public education, including education under IDEA. Schools must prepare an Individual Education Plan (IEP) for each child with a disability in cooperation with the parents. The IEP is very important to the brain-injured child, who requires a high level of repetition, cueing, and practice.

While it is true that individuals who are under the age of 21 who have graduated from high school are no longer eligible for services from DOE, an alternative source of services to head-injured minors is the Office of Medical Assistance, which provides a broad range of medically necessary services to enrolled children under the age of 21. DPW now works closely with the Department, DOE, and L&I to ensure that the service needs of children with disabilities are met. Further, L&I's Office of Vocational Rehabilitation (OVR) administers joint State-and-Federal-funded vocational rehabilitation services to assist persons with mental and physical disabilities to find jobs. The federal Rehabilitation Act of 1973, which establishes this program, includes provisions for supportive employment so that all persons have the opportunity to work in jobs in the community, regardless of the level of their disability. According to its 1998-2000 State and Strategic Plan, OVR has a number of plans, policies and procedures regarding the transition of students with disabilities to vocational rehabilitation services. Students are to receive transition services. These services, as defined in the 1992 amendments to the Rehabilitation Act and the IDEA, are a coordinated set of outcome-oriented activities designed to promote movement from school to post-school activities, including post-secondary education, vocational training, and integrated employment (including supported employment), continuing and adult education, adult services, and independent living or community participation. Transition services are based on the student's preferences and interests, and include instruction, community experiences, the development of post-school adult living objectives and, when appropriate, the acquisition of daily living skills and functional vocational evaluation. OVR partners with DOE to coordinate these programs and services to assist students through the transition out of the public education system.

Comment

The proposed regulations limit participation to individuals over the age of 21, but do not state an upper age limit. The maximum age of participation in HIP should be limited to individuals under the age of 60-65. Scientific studies of head-injured patients indicate that those over 55-60 years of age do not benefit meaningfully from aggressive inpatient rehabilitation. Limiting participation in this way would save funding for younger individuals who would be far more likely to benefit from HIP services.

Response

The Department disagrees with the recommendation. A maximum age limit is both unnecessary and unfair to older head trauma sufferers. The individual applicant's potential to benefit from HIP services is gauged through an assessment prior to enrollment in the Program. If the completed assessment indicates that HIP services will not be beneficial, the applicant will not be enrolled as a client in HIP.

Comment

Proposed §4.4(a)(3) refers to "HIP financial eligibility criteria," but fails to state what those criteria are. The regulations should define this term and specify these important criteria so potential applicants are on notice as to the requirements that they will have to meet.

Response

The Department agrees with the recommendation. Although "financial eligibility criteria" is not a defined term, the final rulemaking states what financial eligibility criteria applicants must meet. Subsection (a)(1)(v) provides that an applicant's AFRs must be at or below 300% of Federal poverty level. Subsection (a)(1)(v)(A) and (B) state how AFRs will be assessed.

Comment

Proposed §4.3(c) states that the Department "will use the Fund to pay for clients' HIP services which would not otherwise be available to clients with traumatic brain injury who have exhausted alternative financial resources." The last part of this sentence is redundant and unnecessary because, under the eligibility requirements found in proposed §4.4(a)(3), alternative financial resources must be exhausted for a person to become a client in the first place.

Response

The Department agrees with this comment. The final regulation does not contain the referenced statement. The regulation also does not require AFRs to be "exhausted." Rather, subsection (a)(1)(v) establishes a requirement that applicants have AFRs in the amount of 300% of the Federal poverty level or less.

Comment

The proposed regulations are not clear as to the extent that a client must use resources before becoming eligible for HIP services. For example, the definition of "alternative financial resources" that must be "exhausted" includes income that must be used for needs other than rehabilitation services, and seems to indicate that an individual must be impoverished before being considered eligible for HIP. The regulations should specify the income and/or assets that the Department will consider in making a determination of financial eligibility.

Response

The Department agrees with the comment. Because of the confusion engendered by the use of the term "exhausted," the final regulations do not include it. Instead, the regulations provide simply that individuals must have AFRs in the amount of 300% or less of Federal poverty level. AFRs include: any income subject to Federal income tax; funds available to the individual by virtue of having experienced the TBI; and funds available to the individual through other State or Federal programs. AFRs do not include other assets.

Comment

The Department should describe the procedures and standards it will use for the evaluations to determine an applicant's initial eligibility.

Response

The final rulemaking distinguishes between an individual's eligibility for an assessment and enrollment. An applicant is initially determined to be eligible for an assessment, which assessment will be used to determine whether HIP services would be appropriate for that person. An applicant's eligibility for an assessment will be evaluated based on the application form and its accompanying documentation. Subsection (a) contains all of the criteria that must be met for an applicant to be eligible for an assessment. The requirements of subsection (a)(1) are largely self-explanatory. The application form will require the applicant to identify the date the TBI was sustained. Documentary proof of residence and United States citizenship will be required. Although the applicant can answer as to age, documents, including insurance forms, will be required and will serve as a check on the other information provided. Documentary proof of income must be provided and will be evaluated as explained in subsection (a)(1)(v)(A) and (B). The required proof will include, but will not be limited to, a completed Federal income tax form.

Subsection (a)(2) provides that, to be eligible for an assessment, an applicant cannot have an impairment that is attributable to certain listed conditions. A physician's statement will be requested pursuant to subsection (a)(1)(iv). It will be on a form provided by the

Department and is to be completed by the applicant's physician. It will ask whether the applicant's impairment is attributable to any of the enumerated conditions. The physician is, therefore, responsible to provide this information. The Division will use that statement in determining whether the applicant is eligible for an assessment.

Subsection (a)(3) states that an applicant must not manifest any symptom that would prevent the applicant from participating in the assessment, or would prevent the provider from completing a full assessment. Again, the Division will request the applicant's physician to provide this information on the physician's statement.

Finally, subsection (a)(4) requires the applicant to complete an assignment agreement assigning to the Department rights in future proceeds which may accrue to the applicant as a result of the TBI, up to the amount expended for HIP services for that individual. If an applicant refuses to complete it, the applicant will not be deemed eligible for enrollment in HIP.

Comment

An applicant is ineligible for HIP if the applicant has significant preexisting psychiatric, organic, or degenerative brain disorders, pursuant to proposed §4.4(c)(4). Who makes the determination that an applicant's impairment is the result of a preexisting condition?

Response

Ultimately, the Division makes that determination. The subject matter addressed in proposed §4.4(c)(4) is addressed in subsection (a)(2) in the final rulemaking. As stated above, the Division will require applicants to submit a statement that must be completed and signed by their attending physicians. Additionally, the Division may request access to an applicant's medical record. The applicant will be ineligible for HIP due to a pre-existing condition if either the physician's statement or the patient record demonstrates that the applicant's impairment is due to one of the conditions listed in subsection (a)(2).

Comment

What if an individual with a history of emotional illness sustains a TBI?

Response

Proposed subsection (c)(4), now subsection (a)(2)(iv), specifically makes patients with certain conditions, including significant preexisting psychiatric disorders, ineligible for HIP.

Comment

An applicant is ineligible for HIP if the impairment is due to a "cerebral vascular accident," pursuant to proposed §4.4(c)(5). The Department should define this term, which has previously been defined in *Stedman's Medical Dictionary* (Williams & Williams, 1982) as "an obsolete and inappropriate term for 'stroke.'"

Response

The Department agrees with this comment, and has replaced the term "cerebral vascular accident" with "stroke" in subsection (a)(2)(v).

Comment

How will an individual's eligibility be affected if he or she has a TBI and then sustains a stroke as a result of the TBI?

Response

Subsection (a)(2)(v) provides that applicants are not eligible for HIP services for any impairment which is the result of a stroke. However, if an individual has sustained a stroke subsequent to the TBI, the affected individual could still apply for HIP services. Eligibility for an assessment would depend upon whether the impairment is attributable to the TBI rather than the stroke. If an assessment is necessary in order to be able to make this determination, the applicant will be assessed. If the applicant's impairment is determined to be due to TBI, eligibility will depend upon the applicant's ability to benefit from HIP services, just as it would for an applicant who had not suffered a stroke subsequent to the TBI.

Comment

How will an individual's eligibility be affected if he or she is transitioning through an agitated phase of Ranchos Level IV? Is there a duration level?

Response

Subsections (b)(4) and (d) provide that applicants who demonstrate suicidal or homicidal behavior or potentially harmful aggression are precluded from participating in HIP. Therefore, applicants who are transitioning through an agitated phase of Ranchos Level IV would be ineligible for the Program if they exhibit aggressive or homicidal behavior because of it. Individuals who are transitioning through an agitated phase of Ranchos Level IV have to demonstrate the ability to benefit from HIP services at the time the application is made, just like any other applicant. The duration of the agitated phase is therefore irrelevant except as it affects the applicant at the time application is made. The applicant is free to reapply if he or she is initially rejected due to transitioning through an agitated phase of Ranchos Level IV.

Comment

What are the criteria and the process by which an applicant's eligibility for enrollment in HIP is evaluated?

Response

As discussed previously, an applicant is eligible for an initial assessment if he or she meets the criteria specified in subsection (a)(1), if the impairment is not caused by the conditions described in subsection (a)(2), if he or she does not exhibit the symptoms described in subsection (a)(3), and signs the assignment agreement as required by subsection (a)(4). A HIP provider will then perform an assessment to enable the Division to determine whether the applicant is eligible for HIP enrollment. The applicant will choose the provider who will perform the assessment from a list of approved providers that will be supplied by the Division. As providers are approved, they will be added to the list.

The Division will determine whether the applicant is eligible for enrollment, and the period during which the applicant will be enrolled and receive rehabilitation services, based upon the outcome of the assessment. The assessment process includes face-to-face interviews with both the applicant and the applicant's significant other, close family members, or authorized representative if appropriate. The part of the assessment directly involving the applicant may take place at the facility, or may be conducted at the applicant's home or the facility where the applicant is residing at the time. In addition to the interviews, pursuant to subsection (c), the applicant's medical records, including, but not limited to, all treatment records relating to the TBI, are examined.

The assessment process is intended to identify the applicant's areas of need, upon which rehabilitation will be focused. The assessment will identify: the applicant's physical, emotional, and psychological needs; potential for improvement; areas to be addressed through rehabilitation services; facility and community resources needed; and how choices can be provided for the applicant. This identification of the applicant's needs and ability, and how to best serve the applicant, is accomplished by consulting several sources, including medical records, significant others, and the applicant. A team of professionals from relevant disciplines who will be designated by the provider conducts the assessment, as required by the contract between the Department and the provider. If it is determined that the applicant can benefit from services offered by the provider, the assessment team will establish ultimate discharge goals, assign the applicant a treatment team of professionals from each identified area of need, and draft a rehabilitation service plan for submission to the Department.

Best practice measures will be used to make the initial determination as to whether the applicant can benefit from services offered by the provider. Providers will be given a standardized intake form, developed by the Department and its consulting neuropsychologist, that measures the applicant's current functional living abilities, including degree of independence, as well as whether the applicant can make progress in

various functional abilities, including physical, cognitive, and psychosocial functions. If appropriate, the applicant's readiness for vocational training is assessed. The form draws upon a number of generally accepted performance measures, and will be revised as best practice standards change.

Comment

The statement in proposed §4.4(b) that an applicant's eligibility will be determined based on a case manager's recommendation and "other neuropsychological evaluations as deemed appropriate by the Department" is confusing and unclear. If the Department intends to require each applicant to undergo a neuropsychological evaluation, the requirement should be clearly established.

Response

At this time, a neuropsychological evaluation no older than one year is necessary as part of the assessment. In many cases, the provider will not need to perform such an evaluation because one may have already been done at the acute-care facility and will be part of the applicant's medical record. The Department's contract with the provider will require that, if a current neuropsychological evaluation is not available, the provider will perform one or ensure that one is performed. Ordinarily, the Department's consulting neuropsychologist will not perform the evaluation.

Comment

The Department should provide more information about the role and term of its neuropsychological consultant, and the role of the Department's neuropsychological consultant in providing neuropsychological evaluations should be clarified.

Response

The Department's neuropsychological consultant provides technical assistance and advice to the Program on clinical issues as requested. The Department presently contracts with the consultant for a term of three years. As previously explained, the Department's consulting neuropsychologist will not ordinarily perform the neuropsychological evaluation necessary to the assessment.

Comment

The Department should explain how applicants' medical histories would be utilized in the evaluation process.

Response

Provider examination of the applicant's medical history is an important part of the assessment. It assists in determining whether the applicant can benefit from HIP services

and, if so, what specific rehabilitation services the applicant needs. The Division may also request the applicant's medical records to use in making the determination as to whether an applicant meets the subsection (a)(2) and (3) symptom and condition criteria for enrollment.

Comment

It is inappropriate to have a determination of achievement of maximum medical improvement made by a case manager and/or neuropsychologist. A physiatrist, neurosurgeon, neurologist or other person with medical experience in brain injury rehabilitation should review applicants to determine their potential to benefit from HIP services. These board-certified professionals are best qualified to recognize subtle changes in a patient's neurologic recovery.

Response

The Department disagrees with the comment. HIP focuses upon rehabilitation. HIP providers are not medical facilities. Rather, they are facilities that provide post-acute rehabilitation services, which consist of physical and mental therapies that are most often directly provided by non-physician professionals who may or may not be supervised by a physician. Although the facilities are all under the supervision of physicians who practice in relevant areas and who will be involved in the assessment process as appropriate, those physicians will not necessarily be neurosurgeons, neurologists, or physiatrists. While the persons who directly provide HIP rehabilitation services are not likely to be neurosurgeons, neurologists, or physiatrists, such medical specialists may have worked with the applicant during the applicant's treatment in an acute care facility prior to entering the Program, and their expertise and conclusions as evidenced in the medical record are an important part of the evidence weighed in the assessment process.

Comment

The determination of ability to benefit and live more independently should be accomplished through the use of generally accepted performance measures such as the Functional Independence Measure. Specific outcome measures can show improvement when more global outcome measures show no change. A more systemized and careful determination of a patient's ability to benefit from rehabilitation services should be mandatory.

Response

The Department will use best practice measures to determine whether an applicant is able to benefit from HIP services. These may incorporate or include the use of the Functional Independence Measure and other specific outcome measures.

Comment

Proposed §4.4 states that an individual would be ineligible for HIP if the Department deems that he or she lacks the potential to benefit and live more independently as a result of HIP services. Individuals who suffer from TBI may not show improvement in a consistent fashion. The regulations should stipulate that the patient should be given three months over which to demonstrate progress when the eligibility determination is being made.

Response

The recommendation is rejected. Substantial funding would be needed to pay for a three-month assessment period. The Department lacks sufficient funds to provide HIP services to all persons who may benefit from such services. The Fund can be used to serve more persons with TBI if the applicants are ready and able to benefit from rehabilitation services at the time of the assessment. An applicant who is initially found ineligible is free to reapply, and may later qualify to participate in HIP if progress is made after the initial application.

Section 4.7 – Enrollment.

This section discusses client enrollment, including determination of eligibility and maximum term of enrollment.

Comment

Proposed §4.4(f) should provide that applicants will be notified when they are ineligible, as well as when they are eligible.

Response

The Department accepts the recommendation. This matter is addressed in subsection (a). It states that an applicant will be notified of the Division's decision on an application for enrollment (whatever that decision may be) within 16 days of the Division receiving the completed assessment from a provider.

Comment

Pursuant to proposed §4.4(b), a case manager with only two years of experience makes the critical determination as to the applicant's potential to benefit from HIP services. This is inappropriate. The Department should clarify the case manager's role in determining an applicant's potential to benefit from HIP services.

Response

The Department agrees with the comment. The Department has removed from proposed §4.4(b) the reference to the case manager's recommendation. Subsection (b) states that the provider shall assess the applicant and determine whether the applicant can benefit from HIP services. Case managers employed by the provider may or may not participate in the assessment of the applicant as part of the assessment/treatment team assigned by the provider. In this capacity, the case manager would provide information and input relevant to the determination of whether an applicant can benefit from services. The team assigned by the provider will make recommendations to the Division. As clarified in subsections (a) and (b), the Division will make the ultimate determination of an applicant's potential to benefit.

Comment

The written notice referred to in proposed §4.4(f) should include the reasons that an applicant is ineligible; any time, dollar or other limits on services and the reasons for those limits; and a reference to the section relating to "Appeals."

Response

The Department agrees with the comment. Subsection (a) addresses the written notice the Department will send to applicants as to its determinations on their applications. It specifies that, if the Division determines that the applicant is ineligible to participate in HIP, the notice will include the reasons for that determination and will advise of appeal rights.

The specific limit on the time that clients may receive services (one year for rehabilitation services followed by a six-month transition period during which case management services only may be provided) is now addressed in subsection (e). Section 4.12 (relating to funding limits) sets the maximum dollar amount for rehabilitation services at $100,000 per rehabilitation period, plus $1000 for case management services during the transition period. Any additional limits on the duration of, or funds available for, a client's participation in the Program will be explained in the written notice of the determination of eligibility. Limits below the maximum dollar amount will be imposed where the necessary services for a client are ascertainable from the assessment and will cost less than the maximum permitted.

Comment

A time limit should be set within which the Division must approve or disapprove the proposed rehabilitation service plan.

Response

The Department agrees with the comment in part. Subsection (a) states that the Division will accept or reject the rehabilitation service plan within 16 days after receiving it from the provider, and will provide written notice of that decision to the applicant. This is a time limit the Division will strive to meet with the utmost diligence. However, it should be understood that the plan would not be accepted by default should some extraordinary event prevent the Division from acting within that time.

Comment

Rehabilitation services are limited to a 12-month period, beginning with the date of the client's enrollment in HIP. Proposed §4.8(a) indicates that development of a rehabilitation service plan will not begin until enrollment begins. A client could lose a significant amount of rehabilitation time while waiting for the rehabilitation service plan to be approved. The regulation should provide that the 12-month rehabilitation period does not begin until actual rehabilitation services commence.

Response

The Department agrees with the comment. Subsection (d) clarifies that a client's enrollment begins on the day the client begins receiving rehabilitation services from a provider after the Division issues a written notification that the client will be enrolled. Section 4.6(d) of the final rulemaking provides that the rehabilitation service plan is developed prior to the beginning of enrollment.

Comment

The Department should clarify whether the notice of eligibility given to the applicant is considered to be the starting date for enrollment.

Response

The Department agrees with the comment. The notice of eligibility given to the applicant is not considered to be the starting date for enrollment. Under the final regulations, an applicant may actually receive two notices of eligibility. The first notice of eligibility informs an applicant that he or she is eligible for an assessment. If the assessment demonstrates that the applicant would be able to benefit from HIP services pursuant to this section, the Division will notify the applicant of his or her acceptance into the Program within 16 days of receiving the completed assessment, as stated in subsection (a). Neither of these notices is the starting date for enrollment. The starting date for enrollment is the date upon which a provider actually starts providing rehabilitation services, as stated in subsection (d).

Comment

The Department should clarify how and when the "maximum available funding and time limits for [HIP] services," as those terms are used in proposed §4.5(a) and (f), are determined.

Response

The Department agrees with this comment. The maximum time limit on the enrollment period is 18 months, consisting of 12 months of rehabilitation, and a 6-month transition period during which case management services only will be provided, as stated in subsection (e). The maximum available funding for each HIP client per enrollment period is $101,000, as stated in §4.12 (relating to funding limits).

Comment

The Department should describe the procedures and standards it will use for the evaluations to determine a client's continuing enrollment.

Response

The Department agrees with this recommendation. The criteria for premature termination are set forth in subsection (e). Subsection (f) addresses the specifics of the notification that will be used to inform the client of the decision to terminate the client's participation in HIP. Reviews of a client's progress are required at least quarterly, as prescribed by §4.8 (d) (relating to rehabilitation service plan).

Comment

Evaluations to determine continuing enrollment should be discussed at the beginning of proposed §4.5(f).

Response

The criteria to terminate participation in HIP are enumerated in subsection (e).

Comment

The Preamble to the proposed regulations states that the average head injury client completes a rehabilitation program in one to three years. Why, then, is it appropriate to limit rehabilitation in HIP to one year under proposed §4.6(b)? For example, there are a number of people in their 20s and 30s who may require up to three years to realize maximum benefit from rehabilitation therapy. Limiting the duration of funding to one year would restrict the maximum potential recovery of those patients.

Response

The Department believes that it is appropriate to retain the one-year limit on rehabilitation in the final regulations, which now appears at subsection (e). The greatest gains from rehabilitation services are generally experienced during the first year. Further, one year is a reasonable time in which clients may be expected to make significant progress, after which they may be able to transition to other programs or less intensive services to complete their recovery. Additionally, individuals who have been discharged from HIP may reapply. Also, restricting payment for rehabilitation services to one year will enable the Department to assist more people with TBIs.

Comment

Criteria should be established to allow a client to qualify for an exemption to the one-year limit on the rehabilitation period. Such criteria should include an exception for clients who are continuing to make tangible, concrete progress in rehabilitation.

Response

The Department rejects this recommendation. A number of commenters were concerned with the one-year limit. The Department agrees that there are patients who could continue to benefit from rehabilitation services after one year. However, HIP funds are limited, and there are far more applicants to the Program than there is money available to help them. The greatest gains from rehabilitation services are generally experienced in the first year. In short, the limits established will enable HIP to do the greatest good for the greatest number. The final rulemaking therefore retains the one-year limit and also establishes a $100,000 cap on expenditures for rehabilitation services in a single rehabilitation period.

Comment

There is a lack of available, appropriate alternatives to HIP for those individuals who must transition out of HIP after one year. Many individuals who will be removed from HIP will of necessity be placed back in the family home or in a nursing home, neither of which can meet the needs of a young adult requiring significant assistance and continued rehabilitation and therapy. How will the chronic needs of patients be addressed, and how will they secure services beyond the twelve months funded by HIP?

Response

The Department acknowledges that in some cases there may be a lack of available and appropriate services for those who are transitioning out of HIP. The function of the Program, however, is to provide rehabilitation services, not chronic care. Providers are required to begin planning for the client's eventual transition out of HIP when they write the initial rehabilitation service plan. The rehabilitation service plan is reviewed and modified as needed on a quarterly basis. The goal of the rehabilitation service plan is to

affect the smooth transition to other services as appropriate, based on the patient's need. To further address the transitional needs of clients, the final rulemaking establishes a 6-month transition period immediately following the rehabilitation period. During the transition period, HIP will provide up to $1000 in case management services to help connect clients, including those with chronic needs, to other programs and services that may be available to them.

There are programs available through other State and Federal agencies that are geared toward meeting chronic needs. As previously discussed, L&I offers Occupational and Vocational Rehabilitation (OVR) services, for which individuals who have been HIP clients are frequently eligible, to train and assist individuals to become employable and employed. The Attendant Care Program and Centers for Independent Living (CILs), which provide a wide range of services to individuals with chronic needs, are available as already discussed. Also discussed previously is the Community Services Program for Persons with Physical Disabilities (CSPPPD), which provides services to individuals who have severe, chronic disabilities that have manifested before the age of 22, including disabilities due to head injuries. The DPW Office of Social Programs has proposed a Home and Community Based Waiver (CommCare Waiver) to allow Medicaid funds to be used for non-medical home and community-based support services for individuals with traumatic brain injuries. It is expected that many HIP clients who are not eligible for other programs would be eligible for this one. Funds from HIP are currently appropriated to DPW for state fiscal years 1999-2000 and 2000-2001 so that eligible HIP clients can be transferred to this program, and other head-injured clients can be accepted into HIP.

Comment

The Department should clarify whether or not rehabilitation services can be continued, and for how long, following an interruption within the 12-month period.

Response

If there is an interruption that will last for an indeterminate period of time within the 12-month rehabilitation period described in subsection (e), rehabilitation services cannot be continued following the interruption. The Department has determined that the fairest, most reasonable, and most administratively feasible course of action with regard to this issue is to limit enrollment in HIP to a 12-consecutive-month-rehabilitation period, followed by a 6-consecutive-month-transition period. The administrative demands of the Program do not permit a policy of tolling the enrollment period or holding funds. There are certainly circumstances, such as a temporary illness, where a client could reasonably be anticipated to resume participation in the Program within a short, determinable period of time. In such a case, the enrollment period would not be tolled, but the client would not be removed from HIP. The client could resume services upon recovering, if recovery occurs during the enrollment period.

Comment

There are some head injured patients who may initially benefit from a 6-week to 3-month course of inpatient rehabilitation therapy, be discharged to either home or a nursing home, and at a later date experience a spontaneous recovery such that they would again be able to benefit from inpatient rehabilitation. For this reason, funding should not be limited to consecutive months.

Response

The Department disagrees with the comment. A client who has been discharged whose return is not anticipated, as in the situation described, cannot automatically be readmitted to the Program at an unscheduled later date. The purpose of this Program is to facilitate client transition to appropriate care settings. It should be noted that clients may reapply for HIP services after being discharged from the Program.

Comment

HIP services should not be limited to consecutive months. It is critical that funding be intermittently available as persons with brain injury undergo life changes such as changes in support systems, and normal developmental changes such as graduating from college or a vocational program. Services should therefore be scrutinized at 3 to 6 month intervals, and should be used at points in time when clients are most in need of those services.

Response

The Department rejects the recommendation. The Department does not prohibit reapplication to HIP after the client is discharged. Lifetime HIP services are therefore not capped, and may be available intermittently. The limits described in the regulations are applicable to each enrollment period.

Comment

Proposed §4.5(f)(5) results in stopping payments if it is "no longer feasible" to implement a rehabilitation service plan. It is not clear who would make such a determination, or how the client would be notified. The Department should clarify the process and conditions under which it would discontinue payment for this reason.

Response

The Department agrees that clarification is necessary. The final rulemaking is more specific as to when a client's enrollment in HIP will be discontinued. Subsection (e)(2) states that a client will be discharged from the Program if the client fails to cooperate or exhibits unmanageable behavior such that HIP cannot provide the appropriate services to meet the client's needs. A provider who believes that the client is exhibiting behavior of

this kind and feels that it can no longer appropriately provide services to the client must notify the Division. The Division will consider evidence presented to it, including quarterly patient status reports, and will request such additional information as is necessary for it to determine whether to end the client's enrollment in HIP. In all cases, efforts will be made to transition the client to appropriate settings as available.

Comment

The regulations should contain a provision that clearly addresses the status of the individuals currently enrolled in the Program.

Response

The Department agrees with the comment. Subsection (g) is entitled "Grandfather clause." This subsection makes clear that clients who are receiving HIP rehabilitation services as of the effective date of the regulations will be eligible for the maximum enrollment period of 18 months, which enrollment period will begin on the effective date of the regulations. Those who are receiving only case management services as of the effective date will be eligible for the 6-month transition period, also beginning on the effective date of the regulations.

Other changes

The proposal listed triggers that would cause the Department to stop paying for HIP services. Subsection (e) states when a client's enrollment will end. This is a significant distinction between terminating enrollment and stopping payment, because the Department may stop paying for services while the client remains enrolled in HIP. For example, if a client receives or gains access to AFRs in excess of 300% of poverty level, the client is expected to pay for HIP services up to the amount of the AFRs received. If the client can pay for the HIP services, the Department will stop paying. However, the client will not be discharged from HIP, as the amount of AFRs received may not be enough to pay for services over the entire remaining enrollment period.

It was also proposed that the Department would stop paying for HIP services if alternative financial resources became available. As stated above, it is true that the Department will stop paying for HIP services if that happens. However, that statement does not appear in the final regulations, as the availability of AFRs will not automatically end the client's HIP enrollment. If the AFRs are legitimately exhausted due to paying for appropriate services, and the client becomes again financially eligible for HIP during the period of enrollment, the Program may resume paying for HIP services for the remainder of the enrollment period.

The final regulation states that a client's enrollment will end when the client reaches the maximum limits on funding and duration. Subsection (e)(1) states that a client's enrollment will end prior to the time designated in the client's rehabilitation service plan

if the Division determines that the continuation of services will not enable the client to make further progress. This statement combines proposed §4.5(f)(1) and (5), as it contemplates both that a client may make such positive progress that the services that HIP can offer are no longer needed, or that a client's condition may deteriorate such that the client can no longer benefit from HIP services.

Subsection (e)(4) states that a client's enrollment will end if the client becomes eligible for other services offered as a result of the TBI, and those services meet the client's needs such that HIP services are no longer necessary. This was not stated in the proposed version of the regulations because the availability of other services was included in the definition of AFRs. However, including other services in that definition caused a difficulty -- that of trying to quantify "other services" in order to determine if the income cap was exceeded. This problem is solved by simply providing that, if a client can obtain other services which meet the client's needs, the client's HIP enrollment will terminate. If a client has access to other services that do not meet his or her needs entirely, the availability of those services will be taken into account when assessing the client's needs and writing and revising the rehabilitation service plan.

Section 4.8 –Rehabilitation service plan

This section requires providers to develop a rehabilitation service plan for each HIP client, states what must be specified in each plan, and sets a schedule for review and updates.

Comment

Proposed §4.8(b) should be revised to require the rehabilitation service plan to state the specific anticipated outcomes to be achieved and the time frame for their achievement, and should specify that those outcomes should be stated in objective and measurable terms

Response

The Department agrees with this comment. The recommendation has been incorporated into subsection (c)(1).

Comment

The proposed regulation requires beginning and ending dates for each service. This is difficult to estimate, since it depends on the patient's progress.

Response

Subsection (c)(1) requires providers to establish estimated time periods for the client to meet goals based upon an individual client assessment. Therefore, the provider, the client, the Division, and the Peer Review Committee will have timed objectives by which

to measure performance. However, the rehabilitation service plan is a planning document subject to quarterly review, evaluation, and modification. As part of this process, it is expected that beginning and ending dates of services will be modified as necessary, as addressed in subsections (d) and (e).

Comment

Proposed §4.8(c) requires an evaluation of client progress, but does not specify the content of the procedure. The outcome of an evaluation is significant, as it could result in the modification of the rehabilitation service plan or discontinuation of services. The regulation should therefore specify the procedure and the requirements or criteria used for such an evaluation.

Response

The Department agrees. The treatment team assigned by the provider is primarily responsible for measuring client progress. Drawing on its experiences with the patient and the patient records, the team should use the quarterly reviews of the rehabilitation service plan required by subsection (d) to assess how the client has progressed towards the established goals. If the team becomes aware that satisfactory progress is not being made, additional reviews should be scheduled pursuant to subsection (e). The modifications to the rehabilitation service plan should closely track client progress. Reviews of the rehabilitation service plan are done in conjunction with the client and the client's family and/or authorized representative, as required by subsections (a) and (e). The ultimate goal is always for the client to be more independent, as stated in subsection (b). In addition to updating the rehabilitation service plan on a quarterly basis, providers must send to the Division quarterly written patient progress reports. The Division will be reviewing these progress reports against the rehabilitation service plan and plan modifications, to ensure that progress is being made and reported appropriately. In addition, the Peer Review Committee will be reviewing the progress reports and rehabilitation service plans for at least one patient from every HIP provider each quarter. The Division will have access to the complete patient records of the facility, and may obtain for the Committee any additional documents as appropriate. The reviews are intended to ensure that the patients of a given facility make appropriate progress toward timely transition to less restrictive environments.

Comment

Will HIP have a specific form with timeline guidelines for submission of periodic patient status reports?

Response

Yes. Providers are required to complete written patient status reports for the Division on a quarterly basis. This requirement is in addition to the Provider's obligation to review the rehabilitation service plan on a quarterly basis.

Comment

The proposed regulations impose a number of requirements on the development of a rehabilitation service plan. These include participation by the provider, case manager, client, and representatives of the client, approval by the Department, and specific components that the plan must contain. However, no such requirements are specified for modifications of the rehabilitation service plan, so it is unclear whether modifications must meet any of these requirements.

Response

Subsection (e) clarifies that all modifications must meet the regulatory requirements for the original rehabilitation service plan as established in subsections (a) through (d). As with the original rehabilitation service plan, modifications must be made by the provider's treatment team in collaboration with the client or authorized representative and significant others, if applicable, and contain the elements specified in subsection (c). Subsection (e) further provides that modifications must indicate whether previous goals were met. Where goals were not met, the modified plan must address the reasons why, and modify or change the goals appropriately. The provider will be required to submit all modifications to HIP along with the quarterly patient progress reports, so that the Program and, if applicable, the Peer Review Committee, can consider those documents.

Section 4.9 – Rehabilitation period.

This section establishes requirements with which providers must comply when providing rehabilitation services, and the purposes for which rehabilitation services may be provided.

Comment

The proposed definition of "rehabilitation" should address cognitive needs as well as physical, social, and other aspects of a client's rehabilitation.

Response

The Department accepts the suggested change, and has incorporated it in subsection (a). In addition, the final rulemaking has added a definition of "rehabilitation services," which definition includes cognitive remediation. The final regulations do not include a definition of "rehabilitation." This is pertinent to the next comment also.

Comment

The proposed definition of "rehabilitation" should be revised to enumerate the list of professionals who can supervise the provision of rehabilitation services, which list should include psychologists.

Response

The Department disagrees with the recommendation. The phrase "other appropriate health professional" as used in subsection (b), includes psychologists where the services provided may be supervised in accordance with standards prevailing in their field. The phrase adequately describes who can provide and supervise the provision of rehabilitation services. Further enumeration is not necessary.

Comment

The regulations should indicate that physical therapy, occupational therapy, speech therapy, and psychological services may be provided in a home setting.

Response

The Department agrees that it should be possible for services to be provided in a home setting. Neither the definition of "rehabilitation services" nor any other provision of the final regulations limits the setting in which services may be provided.

Comment

The treatment offered by rehabilitation facilities should be monitored more closely to ensure that clients are being given actual rehabilitation services and not just care and maintenance.

Response

The regulations implement practices aimed at monitoring providers to ensure that patients are being provided with appropriate rehabilitation services. The regulations require providers to be accredited by a National accrediting body approved by the Department. The Department requires providers to send quarterly patient progress reports, and to update rehabilitation service plans on a quarterly basis. These documents will be reviewed by the Division and, in some cases, by the Peer Review Committee, to ascertain the appropriateness of services provided and progress made. Additionally, the Division will conduct annual on-site reviews.

Section 4.10 – Transition period.

This section establishes a 6-month period immediately following the rehabilitation period, during which HIP will provide case management services to clients.

Comment

The Department should indicate how transition from the rehabilitation programs will be managed after the 12-month limit on HIP-funded services is up.

Response

Providers must address discharge planning in the initial rehabilitation service plan, as goals and outcomes must be established for the entire enrollment period pursuant to §4.8(c)(1). Additionally, the Department has added a 6-month transition period that will follow the 12-month rehabilitation period, and affords a maximum of $1000 in funding to facilitate transition. Case management services will be provided during this time to assist the client with the transition from HIP-funded services to other existing programs.

Section 4.11 – Case management services.

This section establishes requirements with which providers must comply when providing case management services for HIP.

Comment

The proposed definition of "case manager" states that a case manager is an individual "approved" by HIP to provide case management to HIP clients. The regulations should contain a section describing the qualifications necessary for approval, and outlining the approval process.

Response

The Department accepts the recommendation in part. Case management services will be provided to HIP clients through their HIP providers. This enhances continuity of care and eliminates the need for the Department to contract with individual case managers. The Department believes that this is more efficient and will result in appropriate oversight and more contact between the case manager and other care providers. It will further ensure continuity between the establishment of rehabilitation goals and discharge planning. The final rulemaking therefore does not include the requirement of HIP "approval" of case managers. A case manager is defined in the final rulemaking as "[a]n individual who delivers case management services to a client through a provider." This section requires case managers to have at least one year of experience in traumatic brain injury case management.

Comment

Case managers should be given full-time employment and be available on a full-time basis.

Response

The Department disagrees. The definition of "case management services" states that case management services will be provided to HIP clients through rehabilitation providers. Generally, those providers employ full-time case managers. Clients currently receiving HIP case management services will continue with their current case managers for the duration of their transition periods. The Department contracts with those case managers directly, on an as-needed basis. Consequently, some of them are part-time and some are full-time.

Section 4.12 –Funding limits.

This section establishes limits on HIP funding for the rehabilitation and transition periods.

Comment

Proposed §4.6 specifies time limits, but does not specify any limit on the money to be spent. If the Department intends to impose a per-client funding cap, this maximum limit should be specified in the regulations.

Response

The Department accepts this recommendation. This section of the final rulemaking establishes that the maximum funding available is $100,000 for rehabilitation services provided during the 12-month rehabilitation period, and an additional $1000 for case management services provided during the 6-month transition period.

Comment

The establishment of a monetary limit for services would be an incentive to rehabilitation centers to provide cost-efficient outpatient services.

Response

The Department agrees with the comment, and has established such a limit in this section of the final rulemaking.

Section 4.13 – Payment for HIP services.

This section addresses the Department-provided notice to a client regarding services and funding for which HIP will be responsible, client responsibility to update financial information, client responsibility for payment, and when the Department will seek reimbursement for its use of HIP funds.

Comment

It is not clear what amount of AFRs will result in the discontinuation of HIP services. If a small amount of AFRs becomes available, or certain services can be obtained from another source, will that result in the discontinuation of HIP services? The regulation should specify some reasonable threshold at which the availability of AFRs will result in HIP services being discontinued.

Response

The Department agrees with the recommendation. The Department will not discharge a client from the Program because AFRs in some small amount over the permitted 300% of poverty level become available to a client, or limited services will be provided by another source. A client who receives AFRs over the threshold amount of 300% of poverty level will be expected to pay for services up to the excess amount, as provided in subsection (b)(2). HIP will, however, continue to pay for those services not covered by the excess AFRs. Likewise, the availability of services from another source will not result in the client's discharge from HIP unless they duplicate or otherwise render HIP services unnecessary. Rather, they will affect the determination of the client's needs, whether that determination is being made as part of the initial assessment or as part of modifying the service plan. Where appropriate, services available to the client through other programs will substitute for HIP-funded services in the rehabilitation service plan.

Comment

Will HIP have a fee schedule for reimbursement?

Response

The Department does have a fee schedule that establishes rates for specific HIP services. All providers will be paid the same set rate for services, which will encourage them to provide those services efficiently. The fee schedule is not set forth in these regulations. It will be revised from time to time, as the need arises, and will be made a part of each contract between the Department and a provider.

Section 4.14 – Peer review.

This section states that the Department will establish a Peer Review Committee. It establishes some procedures and duties of the Committee.

Comment

What are the specific criteria that the Peer Review Committee will use to review rehabilitation service plans and recommend actions? Is there a specific form that will be used?

Response

The Department has developed forms for use by the Peer Review Committee. Subsection (b)(1) provides that the Committee will, on a quarterly basis, review a random sampling of cases, including at least one client from each provider. The review may include the quarterly progress reports, the rehabilitation service plan and all modifications, and any other documents deemed necessary by the Committee or by the Department. The review will be aimed at ascertaining whether best practices were followed in HIP-related service areas provided at the facility. The criteria envisioned at this time will include analyses of: whether the rehabilitation service plan is being followed; whether goals are being met; whether the rehabilitation service plan is properly modified in response to the changing needs of clients; whether the provider recognizes when clients have met goals and when further service in an area is not needed, and; whether the provider is willing to transition clients to the next level of independence when appropriate. The Peer Review Committee must provide written recommendations to the Department within 30 days of completion of any review of services.

Comment

The Department should provide more information on the membership of the Peer Review Committee, and the process that will be used to select the Committee members.

Response

The Department will revise the number of members and the configuration of the Peer Review Committee based upon its review of the Committee's performance and needs. Department plans for the Peer Review Committee at this time are that it will include 9 members, at least 6 of whom will be from the post-acute rehabilitation provider community. Since the rehabilitation services under review by the Committee are solely those provided in a post-acute setting by HIP providers, it is appropriate that the majority of Committee members should be experienced in providing rehabilitation services of this kind. The Department will try to fill at least two of the remaining three positions with individuals who work in the acute rehabilitation hospital community. Acute rehabilitation hospitals provide medical as well as rehabilitation services. The services provided in these facilities are aimed primarily at stabilizing the patient to a point where he or she can benefit from post-acute rehabilitation. Services provided in the acute setting are not funded by HIP. However, the input of individuals who work in this setting and who may be more medically oriented, is invaluable in reviewing the post-acute rehabilitation services provided to, and progress made by, HIP clients.

Peer Review Committee members will be appointed by the Department. The Department will contact its providers and PARF to solicit recommendations. Facilities not directly contacted by the Department, including both acute and post-acute facilities, are welcome to recommend candidates for the Committee to the Department in writing. A member of the Peer Review Committee may not participate in a review that presents a conflict of interest, including reviews of service provided to a client of the member or the member's employer, or a close relative of the member.

Comment

The Peer Review Committee should be made up of board-certified physiatrists, neurosurgeons, and neurologists. Comprising the Peer Review Committee of social workers, psychologists, or medical doctors who have specialties other than those named above is inappropriate and leads to inaccurate assessments of neurologic progress of head-injured individuals who otherwise could make a good recovery. At the very least, there should be sufficient physician representation drawn from these specialties to ensure that the more global and holistic needs of brain-injured patients are addressed.

Response

As stated previously, the Department will revise the number of members and the configuration of the Peer Review Committee based upon review of the Committee's performance and needs. Practitioners of specialties mentioned by the commenter, or the facilities they practice at, are welcome to contact the Division and recommend specialist candidates for membership on the Peer Review Committee.

Section 4.15 – Administrative review.

This section establishes a two-step review process for applicants and clients who disagree with decisions made by the Division.

Comment

There is a discrepancy between proposed §4.10(a)(1) and (2). Subsection (a)(1) states that an "applicant" may file a request for administrative review. Subsection (a)(2) states that the "applicant or client" must file the request within a specified time limit. This should be clarified.

Response

The Department agrees. Subsections (a)(1) and (b)(1) clarify that an applicant, client, or authorized representative may file a request for "reconsideration" and may "appeal" the outcome of the request for reconsideration. These terms are used consistently throughout

the section, and throughout the Chapter. Seeking reconsideration or an appeal is discretionary; compliance with the times specified for doing either is mandatory.

Comment

It should be clear in the regulations that the person legally empowered to act on behalf of the applicant or client is also empowered to seek administrative review and file an appeal on behalf of the applicant or client.

Response

The Department agrees. Pursuant to subsections (a)(1) and (b)(1), an authorized representative, as well as an applicant or client, is permitted to file a request for reconsideration and appeal the outcome of that request.

Comment

It is unclear whether a person may immediately appeal an adverse determination, or whether an administrative review must first be requested. The regulations should be rewritten to clarify this.

Response

The Department agrees and has revised the final rulemaking to address this concern. Subsection (b)(1) clarifies that, as a precondition to filing an administrative appeal, reconsideration by the Division must have been sought and the requested relief denied.

Comment

There should be a time limit imposed upon the Department for administrative review, to ensure that adverse determinations are resolved expeditiously.

Response

The Department accepts the recommendation in part. The time for completing the adjudicatory process will vary based upon a number of factors, including the complexity of the case and the volume of reviews sought. However, the Department has set forth a time period for completion of a request for reconsideration, so that requestors have some idea of when a decision should be forthcoming. Subsection (a)(4) states that when a request for administrative reconsideration is made, the Division will notify the requestor of its decision within 30 days of receiving the request. Every effort will be made to issue a decision within the stated time limits. If the Department fails to meet these time limits, however, the reconsideration is not automatically resolved in favor of the appellant. The request will be honored as expeditiously as possible. Subsection (c) provides that the General Rules of Administrative Practice and Procedure, 1 Pa. Code Part II, govern the administrative appeal.

Comment

The regulation should indicate who is involved in an administrative review, and whether the applicant or client may attend or participate in such a review.

Response

As set forth in subsection (a), the Division will perform the initial reconsideration. This is a paper review, so there is no opportunity for attendance. The request for reconsideration should contain any information the applicant, client, or authorized representative wants the Division to consider, and must meet the requirements of subsection (a)(3). The applicant, client and authorized representative may attend any hearing held in connection with an appeal of the decision on reconsideration.

Comment

Proposed §4.10 limits requests for administrative review to the eligibility determination, and fails in general to specify which other issues may be appealed. There are numerous other determinations that could be subject to appeal.

Response

The Department agrees with the comment and has addressed the concern. Subsection (a)(1) enumerates the decisions that may give rise to a request for reconsideration and then an appeal.

Comment

This section should explicitly state that the one-year time limit is subject to appeal.

Response

The Department disagrees. The one-year time limit for a rehabilitation period, as well as the six-month limit on the transition period, are strict standards imposed by the final regulations. No hearing will be held in these matters.

Comment

Proposed §4.10(b)(2) gives an applicant or client 15 days to file an appeal, beginning on the date the Division mails its determination. Postal delays could shrink this time considerably. In order to account for unforeseeable postal delays, the rule should provide that three days be added to the time for filing an appeal when the determination is sent by mail.

Response

The Department disagrees. The regulation provides 15 days to request reconsideration. The Department initially intended to give appellants 10 days to make such a request. That is the time afforded by 1 Pa. Code §35.20 to appeal to the agency head actions taken by subordinate officials (administrative appeal). The regulation affords, not 10, but 30 days to file an administrative appeal.

Comment

The Department should indicate how it will communicate information on appeals and the rights of applicants and clients to individuals who may be unable to comprehend formal legal letters, or who may have difficulty in doing so.

Response

The Department agrees. Subsection (a)(2) states that the Division will notify an applicant, client, or authorized representative in writing of the right to seek administrative review. It further states that the notification will advise the recipient to seek assistance from legal counsel, family members, and others who may serve in an advisory role, and will include contact information for a HIP representative who will be available to answer any questions the applicant, client, or person assisting them may have.

Comment

The regulation should include a provision similar to that proposed for the Women, Infants and Children (WIC) Program, which requires that the hearing location be no further from the appellant than the county seat of his or her county of residence. That regulation further requires that the hearing be moved to an alternative location more accessible to the applicant or client under certain circumstances. Accessibility of a hearing location would be important to the population served by HIP.

Response

It is not administratively feasible for this program to hold hearings in the 67 counties of the state. The Department agrees that the hearing location should be as close to the appellant as possible, and will make every effort to be accommodating in this regard as resources allow.

Comment

Proposed §4.10 allows an applicant or client to be represented at a formal hearing by a relative, friend, or other person of their choice. This constitutes the unlawful practice of law pursuant to the Judicial Code at 42 Pa.C.S. §2524, which practice cannot be authorized by an administrative agency.

Response

The provision has been removed.

Comment

The regulation should state whether or not HIP services will continue during the pendency of a review or hearing. If services are not to continue, the regulation should include a specific time limit for the administrative review.

Response

The Department agrees. Subsection (d) states that applicants, including those who were eligible for and received an assessment, are not entitled to receive HIP services during the time that a reconsideration or appeal is pending, and that services to clients continue while review or a hearing is pending. If the time or dollar amount of services to which a client is entitled is exhausted while the reconsideration or appeal is pending the reconsideration or appeal is, of course, mooted.

Comment

The regulation should provide that, immediately upon the issuance of a favorable decision, HIP services will be reinstated for the remainder of the 12-month period based upon the date on which services were terminated.

Response

The regulations do not need to provide for reinstatement of services, as subsection (d) provides that services continue for clients during the pendency of an appeal.

General comments

Comment

A periodic review or audit of program expenditures would be useful to ensure that the limited dollars in the Fund are used as efficiently as possible to meet Program goals. The Department should explain how it would review Program expenditures to protect the financial integrity of the fund.

Response

HIP funds are generally subject to the same control and audit procedures utilized in the administration of all Commonwealth funds. The Auditor General conducts audits of the Emergency Medical Services Operating Fund, which includes the Fund as a component. In addition, the Program itself conducts an annual site visit to each provider, at which

time a representative sample of invoices is verified against the medical records, and compliance in a number of other areas is assessed.

Further, the final regulations limit the duration of funding to one year and cap the amount of funding that can be spent during that time. The Program reviews quarterly reports and updated rehabilitation service plans submitted by providers; additionally, the Peer Review Committee will review client progress in some cases, and submit recommendations to the Department as to all ongoing services. These reviews are intended to ensure that providers deliver necessary services to clients in an efficient manner, and that clients are getting results from utilizing these services. Once a review process is under way only providers whose performance has been deemed appropriate will remain on the list of approved HIP providers. Providers whose services or performance are unsatisfactory will be removed from the list until such time as they are able to demonstrate through the Peer Review or other monitoring process that they are meeting best practice standards and clients are getting value for the time and money spent at the facility.

Comment

DPW is seeking a waiver from the Federal Health Care Financing Administration to be able to use Medicaid funding for head injured individuals. How will the waiver program, and the transfer of funds from the Department to DPW, affect the operation of HIP?

Response

The DPW CommCare Waiver will complement HIP. HIP will fund eligible clients' rehabilitation for one year plus 6 months of transitional case management services. The DPW CommCare Waiver will meet the long-term needs of clients who require maintenance services. The Department has appropriated funds to DPW to be used to transfer Medicaid-eligible HIP rehabilitation clients to the CommCare program. Any funds appropriated to DPW for the CommCare Waiver which are not used will revert back to the Fund to be used for HIP services.

Comment

The proposed HIP regulations should not go into effect until the above-referenced waiver program is in place.

Response

The Department disagrees. Although the Department and DPW are both confident that the waiver program will go into effect, the Department's ability to administer HIP should not under any circumstances be held hostage to the success of an initiative on the part of another Commonwealth agency.

Comment

A bill, H.B. 1467, which would create a head injury program in the Office of Social Programs of DPW, was introduced in the House and referred to the House Health and Human Services Committee. This bill, coupled with the above-mentioned application for waiver by the DPW indicate that the Commonwealth is moving in the direction of transferring responsibility for HIP from the Department to DPW. The timing of the regulations is therefore inopportune.

Response

The Department disagrees. The possibility that there will be a change in policy exists in every aspect of government. That such a possibility exists does not mean that those who are responsible for administering programs should "wait and see" which way the wind will blow. The Department is currently responsible for administering HIP, and will be responsible to do that for the foreseeable future. A need for these regulations was perceived, and the Department responded.

Comment

If HIP is transferred to DPW, the proposed regulations will be obsolete. Promulgation of the regulations should therefore be precluded.

Response

The Department disagrees. It would be inappropriate to delay the implementation of necessary regulations for an indefinite period of time pending the outcome of uncertain events. The Department is responsible for the Program, and must continue to administer it unless and until an actual transfer of authority takes place. The administration of HIP will be simpler, as well as fairer to head-injured individuals who are still waiting to receive rehabilitation services through HIP, if these regulations are implemented.

Comment

One of the factors to be considered by IRRC in approving or disapproving a regulation is whether the regulation "represents a policy decision of such a substantial nature that it requires legislative review." (71 P.S. §745.5a(i)(4)). Transfer of the HIP from DOH to DPW does present a substantial policy decision that deserves legislative review. In fact, that legislative review has begun through the introduction of H.B. 1467 and its referral to the House Health and Human Services Committee. The publication of these regulations at this time ignores that overriding policy issue.

Response

The Department disagrees. The Regulatory Review Act requires IRRC to review regulations and to consider certain factors in determining whether the regulations are in the public interest. Among these factors, as stated by the commenter, is "[w]hether the final-form or final-omitted regulation represents a policy decision of such a substantial nature that it requires legislative review." However, the commenter then goes on to state that it is *the transfer of HIP from the Department to DPW* that presents the substantial policy decision which deserves legislative review. That transfer is not before the IRRC; these regulations are. These regulations do not have as their subject matter the contemplated transfer of HIP to DPW. Their sole focus is the Department's administration of moneys from the Fund, which responsibility has been placed upon the Department by statute. The regulations provide that the Department will use Fund money to provide rehabilitation and case management services to persons who have incurred a TBI, set parameters for participation in the Program, and establish a system of administration for the Program. These are matters that are appropriately addressed through the promulgation of regulations. These regulations do not present a policy decision of such nature that legislative review is required, other than that which is provided through the rulemaking process. IRRC's determination as to these regulations should be made based upon their content, and not upon its consideration of proposed legislation.

Comment

The Department lacks the statutory authority to promulgate the regulations. Section 14(e) of the Emergency Medical Services Act gives the Department only the ability to decide which class or type of injury to fund, in order of priority. The Department does not have the authority to develop detailed administrative regulations relating to the operation of HIP.

Response

The Department disagrees that it lacks the statutory authority to promulgate these regulations. The Department has the statutory power and duty to promulgate rules and regulations to facilitate its administration of the Fund pursuant to §2102(g) of the Administrative Code (71 P.S. §532(g)).

Section 14(e) of the Emergency Medical Services Act (35 P.S. §6934(e)) allocates money to the Fund, which fund is under the authority of the Department. The Fund, pursuant to the Act, can be used to pay for any and all traumatic injuries. Clearly, however, there is not enough money to fund each and every one. Section 14(e), therefore, allows the Department to decide which traumatic injuries to fund by category, as opposed to on an individual basis. The Department already has the statutory authority, pursuant to §2102(g) of the Administrative Code (71 P.S. §532(g)), to promulgate rules and regulations for any program administered by it, including the Head Injury Program. Nothing in the Emergency Medical Services Act indicates that the Legislature intended to

remove this general authority when it gave the Department the specific authority to, " . . . by regulation, prioritize the distribution of funds by classification of traumatic injury."

Finally, reading the language of the Act so as to prevent the Department from making any administrative decisions with regard to the Fund, other than deciding what types of injuries the money may be used for, leads to an absurd result. Such a reading would effectively tie the Department's hands with regard to proper and effective administration of the Fund. The Legislature could not logically have intended to give the Department the authority to decide to whom a significant amount of Fund money would be given, without also giving it the authority to ensure that the Fund is utilized properly and efficiently.

Comment

It is a matter for concern that HIP has not accepted any new applicants for services in over one year.

Response

The regulations restrict the type of services a client will receive through HIP, the cost of services per enrollment period for which HIP will pay, and the length of time that each enrollment period may last. These provisions are designed to open HIP up to a greater number of qualified people. A main purpose of these regulations is to make HIP resources available to a greater number of persons across the Commonwealth who have suffered TBIs. The HIP waiting list demonstrates that there are many individuals who would like to participate in HIP. The Department believes that a number of these people have not been able to secure rehabilitation services, and will not be able to do so except through HIP. The limitations on client participation in the regulations are aimed at ensuring that individuals with TBIs have an opportunity to receive rehabilitation services for at least one year. If one year of services does not enable a client to function as fully as before the TBI was sustained, it is likely to at least prepare that individual to be able to utilize other services and programs appropriately.

Fiscal Impact

Implementation of the proposed regulations will entail administrative costs associated with contract development, data analysis, fiscal monitoring and other program activities. HIP currently has similar administrative costs from current program operations. Additional costs may be incurred due to the review and administrative appeal process, depending upon the frequency of appeals. The regulations are intended to channel the bulk of funding into rehabilitation services for clients who are able to progress as a result of those services.

Paperwork Requirements

The Department will experience some increase in paperwork related to Program review of rehabilitation service plans and plan modifications, as well as the quarterly patient reports required from providers. Providers will have to provide quarterly patient status reports. Rehabilitation service plans and modifications are a part of rehabilitation treatment; the necessity for them does not arise from these regulations. Persons applying to HIP must complete an application and provide verifying documentation.

Effective Date/Sunset Date

The regulations will become effective upon final publication in the *Pennsylvania Bulletin*. A sunset date has not been established. The Department will continue to monitor these regulations on an ongoing basis, and they will be subject to revision as it becomes necessary.

Statutory Authority

Section 14(e) of the Emergency Medical Services Act (35 P.S. §6934(e)) authorizes the Department to promulgate regulations prioritizing distribution of moneys in the Fund by classification of traumatic injury. The Department has the statutory power and duty to promulgate its rules and regulations pursuant to §2102(g) of the Administrative Code (71 P.S. §532(g).

Regulatory Review

Under section 5(a) of the Regulatory Review Act (Act), the Act of June 30, 1989 (P.L. 73, No. 19) (71 P.S. §§745.1- 745.15), on May 22, 1999, the Department submitted a copy of Notice of Proposed Rulemaking, published at 29 Pa.B. 2671, to IRRC and the Chairpersons of the House Health and Human Service Committee and the Senate Public Health and Welfare Committee for review and comment. In compliance with Section 5(c) of the Act, the Department also provided IRRC and the Committees with copies of all comments received, as well as other documentation.

In compliance with Section 5.1(a) of the Act, the Department submitted a copy of the final form regulation to IRRC and the Committees on May 3, 2001. In addition, the Department provided IRRC and the Committees with information pertaining to commentators and a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation". A copy of this material is available to the public upon request.

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

This final form regulation was (deemed) approved by the House Health and Human Services Committee on __ and (deemed) approved by the Senate Public Health and

Welfare Committee on ___. IRRC met on __ and approved the regulation in accordance with Section 5.1(e) of the Act.

Contact Person

Questions regarding these regulations may be submitted to: Elaine Terrell, Head Injury Program, Department of Health, P.O. Box 90, Harrisburg, PA 17108-0090, Ph. (717) 783-5436. Persons with disabilities may submit questions in alternative formats such as by audio tape, Braille, or by using V/TT: 717-783-6514 or the Pennsylvania AT&T Relay Service at 1-800-654-5984 (TT).

Persons with disabilities who would like to obtain this document in an alternative format (i.e., large print, audiotape, Braille) should contact Ms. Terrell so she can make the necessary arrangements.

Findings

The Department finds that:

(1) Public notice of intention to adopt the regulations adopted by this order has been given under sections 201 and 202 of the Act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. §§1201 and 1202), and the regulations thereunder, 1 Pa. Code §§7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) The adoption of regulations in the manner provided by this order is necessary and appropriate for the administration of the authorizing statute.

Order

The Department, acting under the authorizing statutes, orders that:

(1) The regulations of the Department at 28 Pa. Code. Part I, are amended by adding Chapter 4, §§4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 4.10, 4.11, 4.12, 4.13, 4.14, 4.15, as set forth at 29 Pa.B. 2671 and Annex A hereto.

(2) The Secretary of Health shall submit this Order and Annex A to the Office of General Counsel and the Office of Attorney General for approval as required by law.

(3) The Secretary of Health shall submit this Order, Annex A, and a Regulatory Analysis Form to IRRC, the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for their review and action as required by law.

(4) The Secretary of Health shall certify this Order and Annex A and deposit it with the Legislative Reference Bureau as required by law.

(5) This Order shall take effect 30 days after publication in the *Pennsylvania Bulletin.*

ANNEX A

TITLE 28 - HEALTH AND SAFETY

PART I - GENERAL HEALTH

***

CHAPTER 4 - HEAD INJURY PROGRAM

§4.1. Scope and purpose.

(a) This chapter establishes standards for the Department to administer the fund ~~to provide rehabilitation services, facilitated through case management, to persons who incur a traumatic brain injury.~~

(b) THE DEPARTMENT WILL USE THE FUND TO ADMINISTER A HEAD INJURY PROGRAM, AS SET FORTH IN THIS CHAPTER, TO PAY FOR MEDICAL, REHABILITATION, AND ATTENDANT CARE SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURY.

§4.2. Definitions.

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

Agency Head - The Secretary or a deputy secretary designated by the Secretary.

Alternative financial resources –

(I) ~~Income (including income from assets and public benefits)~~ ALL INCOME SUBJECT TO TAX PURSUANT TO SECTION 61 OF THE INTERNAL REVENUE CODE (26 USCS §61).

(II) ~~Court awards and insurance settlements~~ FUNDS WHICH ARE AVAILABLE TO THE APPLICANT OR CLIENT BY VIRTUE OF EXPERIENCING A TRAUMATIC BRAIN INJURY. THESE INCLUDE BUT ARE NOT LIMITED TO COURT AWARDS, INSURANCE SETTLEMENTS AND OTHER FINANCIAL SETTLEMENTS MADE AS A RESULT OF THE TRAUMATIC BRAIN INJURY AND RECEIVED BY ANY PERSON ON BEHALF OF OR FOR THE USE OF THE APPLICANT OR CLIENT.

(III) ~~Funding from~~ FUNDS WHICH ARE AVAILABLE TO THE APPLICANT OR CLIENT THROUGH other State or Federal programs including BUT NOT LIMITED TO Medicaid, Medicare, Social Security Disability Insurance (Title II), Supplemental Security Income (Title XVI), veterans' benefits, ~~and~~ workers' compensation insurance, AND UNEMPLOYMENT COMPENSATION INSURANCE.

~~(iv) Other funds or services which are available to the applicant or client by virtue of experiencing a traumatic brain injury.~~

Applicant - An individual for whom ~~an~~ A COMPLETED application for enrollment in HIP ~~is~~ HAS BEEN submitted to the Department.

AUTHORIZED REPRESENTATIVE – AN INDIVIDUAL WHO IS AUTHORIZED BY LAW TO MAKE A DECISION FOR, OR ENTER INTO AN AGREEMENT ON BEHALF OF, AN APPLICANT OR CLIENT. THIS SHALL NOT INCLUDE AN EMPLOYEE OF THE PROVIDER UNLESS THE EMPLOYEE IS APPOINTED BY A COURT TO SERVE AS THE LEGAL GUARDIAN OF THE APPLICANT OR CLIENT.

Case management SERVICES – ~~The planning, coordination, and securing of services determined by the Department to be necessary to assist the client in obtaining required services~~ SERVICES

TO BE OFFERED BY THE PROVIDER TO A CLIENT DURING THE ENROLLMENT PERIOD.

Case manager - ~~The~~ AN individual ~~approved and assigned by HIP to provide case management for a client~~ WHO DELIVERS CASE MANAGEMENT SERVICES TO A CLIENT THROUGH A PROVIDER.

Client - An individual enrolled in HIP.

Day services - Non-residential services intended to improve the PHYSICAL, cognitive, behavioral or functional abilities of the client through therapeutic intervention and supervised activities which are provided ON AN OUTPATIENT BASIS at a facility BELONGING TO A PROVIDER ~~on an outpatient basis.~~

Department – The Department of Health of ~~the~~ THIS Commonwealth.

Division - The ~~organizational unit, within the Department, having responsibility for the administration of the HIP~~ DIVISION OF SPECIAL HEALTH CARE PROGRAMS.

~~*Eligibility* - Determination by the Department that the applicant or client may receive services.~~

ENROLLMENT PERIOD – THE PERIOD OF TIME, COMPRISED OF THE REHABILITATION PERIOD AND THE TRANSITION PERIOD, DURING WHICH A CLIENT IS ENROLLED IN HIP.

~~*Exhausted* - The point at which alternative financial resources for a HIP funded service required by an applicant or a client have been applied for and been denied or fully utilized.~~

Fund - The Catastrophic Medical and Rehabilitation Fund.

HIP - Head Injury Program - The traumatic brain injury program of the Department.

HIP Peer Review Committee - A committee, composed of professionals and REPRESENTATIVES OF organizations offering rehabilitation services in this Commonwealth

to persons with traumatic brain injury, whose members are appointed by the Department to review rehabilitation plans and services offered to clients and to recommend actions to improve services.

HIP services - Rehabilitation AND CASE MANAGEMENT services~~, facilitated through case management,~~ for which the Department authorizes payment through HIP.

Home facilitation - A formal rehabilitation program which provides a community reentry specialist in the client's home to continue therapy learned by the client and to assist the client in the practice of techniques and strategies for living independently.

Peer review - A review of services and rehabilitation service plans for clients conducted by the HIP Peer Review Committee for the purpose of advising the Department on best practices to be followed in offering services to clients.

Provider - An individual, organization or facility ~~delivering~~ THAT DELIVERS REHABILITATION AND CASE MANAGEMENT services to clients pursuant to A contractual agreement with the Department.

~~*Rehabilitation* - Providing to a client who has progressed to a post acute phase of traumatic brain injury, in a coordinated manner, services deemed appropriate to the needs of the client to improve health, welfare and the realization of the client's maximum physical, social, psychological, and vocational potential for useful and productive activity:~~

~~(i) These services include case management, neuropsychological evaluation, physical therapy, occupational therapy, speech or language therapy, behavior management, and psychological services which may include cognitive remediation.~~

~~(ii) These services shall be provided or their provision shall be supervised by a physician or other appropriate health professional who contracts with the Department to provide these services.~~

REHABILITATION PERIOD – THE PERIOD OF TIME THAT A CLIENT RECEIVES REHABILITATION SERVICES THROUGH HIP.

Rehabilitation service plan - The written plan, developed by the ~~rehabilitation~~ provider ~~in collaboration with the client and the case manager~~, which ~~outlines~~ STATES specific goals to be achieved and expected time frames for achievement of each goal. ~~The primary focus of goals shall be progression toward a higher level of functioning to enable transfer of the client to a less restrictive environment.~~

REHABILITATION SERVICES – SERVICES PROVIDED TO ASSIST THE CLIENT TO RECOVER FROM TBI, IMPROVE THE CLIENT'S HEALTH AND WELFARE, AND REALIZE THE CLIENT'S MAXIMUM PHYSICAL, SOCIAL, COGNITIVE, PSYCHOLOGICAL, AND VOCATIONAL POTENTIAL FOR USEFUL AND PRODUCTIVE ACTIVITY, WHICH SERVICES INCLUDE NEUROPSYCHOLOGICAL EVALUATION, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH OR LANGUAGE THERAPY, BEHAVIOR MANAGEMENT, HOME FACILITATION, THERAPEUTIC RECREATION, PRE-VOCATIONAL SERVICES, CASE MANAGEMENT SERVICES, AND PSYCHOLOGICAL SERVICES WHICH MAY INCLUDE COGNITIVE REMEDIATION.

Secretary - The Secretary of the Department.

~~*Subrogation* - The Department's right to seek reimbursement for payments made on behalf of a client from an insurer which may offer coverage to the client or from the proceeds of any litigation arising out of the injury which qualified the individual for enrollment in HIP.~~

TRANSITION PERIOD – THE PERIOD OF TIME FOLLOWING THE REHABILITATION PERIOD DURING WHICH A CLIENT RECEIVES CASE MANAGEMENT SERVICES THROUGH HIP TO GUIDE AND ASSIST THE CLIENT TO MAKE THE TRANSITION OUT OF HIP.

Traumatic brain injury (TBI) - An insult to the brain, not of a degenerative or congenital nature, caused by an external physical force that may produce a diminished or altered state of consciousness, which results in impairment of cognitive abilities or physical functioning or in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

~~**§4.3. HIP services and objectives.**~~

~~(a) The Department will administer the Fund through HIP.~~

~~(b) The Department will use the Fund to pay for HIP services to assist clients in meeting the goals established in their rehabilitation service plans.~~

~~(c) Subject to the availability of moneys from the Fund, and restrictions in §§4.5 and 4.6 (relating to payment for services and duration of funding), the Department will use the Fund to pay for clients' HIP services which would not otherwise be available to clients with traumatic brain injury who have exhausted alternative financial resources.~~

~~(d) Services designated by the Department to be funded through HIP are limited to post-acute traumatic brain injury rehabilitation services.~~

~~**§4.4. Eligibility for services.**~~

~~(a) *Conditions.* Except as otherwise set forth in this section, the Department will deem an applicant eligible for HIP services only if the following are satisfied:~~

~~(1) The applicant sustained a traumatic brain injury on or after July 3, 1985.~~

~~(2) The applicant has been a resident in this Commonwealth for 90 consecutive days at both the time of injury and the time of application to HIP, and demonstrates the intent to maintain a permanent home in this Commonwealth for the indefinite future.~~

~~(3) The applicant exhausted all alternative financial resources to pay for services covered by HIP as determined in accordance with HIP financial eligibility criteria.~~

~~(4) The applicant is 21 years of age or older.~~

~~(b) *Eligibility.* The Department will deem an applicant eligible for HIP services only if it determines based upon the case manager's recommendation and other neuropsychological evaluations as deemed appropriate by the Department, that the applicant has the potential to benefit from the services and to live more independently as a result of the services.~~

~~(c) *Ineligibility due to impairment.* The Department will deem an applicant ineligible for HIP services if the applicant's impairment is the result of one or more of the following conditions:~~

~~(1) Cognitive or motor dysfunction related to congenital or hereditary birth defects.~~

~~(2) Putative birth trauma or asphyxia neonatorum (hypoxic-ischemic encephalopathy).~~

~~(3) Hypoxic encephalopathy unrelated to traumatic brain injury.~~

~~(4) Significant pre-existing psychiatric, organic, or degenerative brain disorders.~~

~~(5) Cerebral vascular accidents.~~

~~(6) Spinal cord injuries in the absence of traumatic brain injury.~~

~~(d) *Ineligibility due to symptoms.*~~

~~(1) The Department will deem an applicant ineligible for HIP services if the applicant's condition manifests one or more of the following symptoms:~~

~~(i) Comatose conditions which preclude participation in HIP services.~~

~~(ii) Symptoms of suicidal behavior, homicidal behavior, potentially harmful aggression or other behaviors which preclude an individual from participating in HIP services.~~

~~(2) An applicant may reapply to HIP at any time the applicant's condition, which makes the applicant ineligible for HIP services, changes, and a new eligibility determination will be made.~~

~~(e) *Assignment agreement.* The Department will deem an applicant ineligible if the applicant or legal guardian fails to complete an assignment agreement with the Department which, conditioned upon the applicant's enrollment in HIP, would assign to the Department rights of future or expected court awards, insurance settlements or other proceeds, which are determined by the Department to have accrued to the applicant as a result or by virtue of the applicant's traumatic brain injury, up to the amount expended by the Department for HIP services on behalf of that individual at the time the award is made.~~

~~(f) The Department will notify an applicant, in writing, of eligibility for HIP services within 30 days from the date of receipt of a complete application.~~

~~**§4.5. Payment for services.**~~

~~(a) The Department will give written authorization, to the client and to the provider, as to HIP services for which the client is eligible and the maximum available funding and time limits for those services.~~

~~(b) The Department will authorize payment for HIP services for clients based on funding availability. Applicants for whom monies are not available will be placed on a waiting list maintained by HIP so they may be notified when funding becomes available, at which time they may reapply.~~

~~(c) The Department will not provide funding through HIP to pay for services to address conditions existing prior to the traumatic brain injury.~~

~~(d) The Department will not provide funding through HIP to pay for services available through other publicly funded programs.~~

~~(e) The Department will coordinate HIP with other public and private programs, to assist clients to access benefits for which they may be eligible.~~

~~(f) The Department will continue to pay for HIP services for a client until one of the following occurs:~~

~~(1) The client has reached the goals established in the client's rehabilitation service plan.~~

~~(2) The maximum funds available for allocation to the client are exhausted.~~

~~(3) The maximum duration for services has been reached in accordance with §4.6 (relating to duration of funding).~~

~~(4) Alternative financial resources or other services become available.~~

~~(5) The client's condition deteriorates such that the client is ineligible under §4.4(b) (relating to eligibility for services), or it is no longer feasible to implement a rehabilitation service plan for the client under §4.8 (relating to rehabilitation service plan).~~

~~(g) The Department may seek reimbursement for payments it makes on behalf of a client from an insurer which may provide coverage to the client or from the proceeds of litigation arising out of the injury which led to eligibility for enrollment in HIP.~~

~~§4.6. Duration of funding.~~

~~(a) The Department will conduct evaluations to determine an applicant's initial eligibility and a client's continuing enrollment in HIP.~~

~~(b) The Department will provide funding for rehabilitation services for no more than 12 consecutive months.~~

~~(c) The Department will provide funding for case management services for no more than 18 consecutive months (during 12 months of rehabilitation and six months of transition out of rehabilitation) from the beginning date of the client's enrollment in HIP.~~

~~(d) The Department will notify an applicant of these maximum time limits when it accepts the applicant as a client.~~

~~§4.7. Services eligible for payment.~~

~~The Department will pay for the following services for clients:~~

~~(1) *Assessments.* Assessments shall include neuropsychological and functional evaluations as deemed necessary by the Department for determining eligibility for rehabilitation services.~~

~~(2) *Rehabilitation service plan.* Development of a rehabilitation service plan for each client as provided for in §4.8 (relating to rehabilitation service plan).~~

~~(3) *Case management services.* HIP will approve the assignment of each client to a case manager who has a minimum of two years experience in traumatic brain injury~~

~~case management. Case management services include the following activities by the case manager:~~

~~(i) Collaborating with the rehabilitation provider, the client, and the client's family in the development of the rehabilitation service plan.~~

~~(ii) Assisting the client in gaining full access to all services from which the client may benefit and for which the client may be eligible.~~

~~(iii) Monitoring the client's progress with respect to the rehabilitation service plan and making modifications as needed.~~

~~(iv) Providing up to six months of follow-up case management upon a client's completion of rehabilitation.~~

~~(4) *Rehabilitation services.* Residential rehabilitation services shall be provided by licensed facilities accredited by an appropriate National accrediting body as approved by the Department. Outpatient, day and home-based rehabilitation services shall be provided by facilities or providers accredited by an appropriate National accrediting body as approved by the Department. Examples of these services include the following:~~

~~(i) Helping a client develop behaviors that enable the client to take responsibility for the client's own actions.~~

~~(ii) Facilitating a client's successful community integration.~~

~~(iii) Assisting the client to accomplish functional outcomes at home and in the community.~~

~~(iv) Teaching the client skills to live independently.~~

~~(v) Supervising a client living in a home setting through the following:~~

~~(A) Home facilitation.~~

~~(B) Cognitive remediation.~~

~~(C) Life skills coaching.~~

~~(vi) Assisting the client in maintaining independence.~~

~~(vii) Providing transitional living services to assist the client with community reentry skills.~~

~~§4.8. Rehabilitation service plan.~~

~~(a) The rehabilitation provider, the case manager, the client and, as appropriate, the client's parent, guardian or representative, shall jointly develop a rehabilitation service plan using forms and procedures provided by HIP. The rehabilitation provider shall submit the rehabilitation service plan to HIP for approval within 30 days after the date the client is enrolled in HIP.~~

~~(b) The rehabilitation service plan shall state the specific goals to be achieved and expected time frames for achievement of each goal. The primary focus of goals shall be progression toward a higher level of functioning to enable transfer of the client to a less restrictive environment. The service plan shall also specify the following:~~

~~(1) Services determined necessary to attain the agreed upon goals.~~

~~(2) Beginning and ending dates of each service.~~

~~(3) The terms and conditions for service delivery.~~

~~(4) The specific responsibilities of the client, case manager, and service provider relative to implementation of each service.~~

~~(5) The extent of financial responsibility of the client, HIP and any third party.~~

~~(c) The service plan shall include a procedure and schedule for quarterly review and evaluation of progress towards the specified goals.~~

~~(d) Modifications to the service plan shall be made concurrent and consistent with the scheduled evaluation of progress towards the specified goals.~~

~~§4.9. Peer Review.~~

~~(a) *Purpose.* The Department will appoint a HIP Peer Review Committee to conduct a review of services and rehabilitation service plans for HIP clients. The HIP Peer Review Committee shall advise the Department on best practices to be followed in offering services to clients.~~

~~(b) *Procedures.*~~

~~(1) Members of the HIP Peer Review Committee shall be appointed to serve terms of three years. Members may not serve consecutive terms.~~

~~(2) The HIP Peer Review Committee shall review client progress on a quarterly basis.~~

~~(3) Within 30 days after it completes its review, the HIP Peer Review Committee shall provide, in writing, recommendations to the Department for all ongoing services.~~

~~(4) A member of the HIP Peer Review Committee may not participate in a review conducted by the Committee which presents a conflict of interest for that member. Examples of conflicts are participating in a review conducted by the Committee for one of the following:~~

~~(i) A service provided to a client of that member or that member's employer.~~

~~(ii) A person who is in the immediate family of the member.~~

~~(5) The Department will notify the HIP Peer Review Committee of any actions taken on the recommendations of the Committee.~~

~~§4.10. Appeal procedures.~~

~~(a) *Administrative review.*~~

~~(1) An applicant who is dissatisfied with a HIP eligibility determination may file a request for an administrative review.~~

~~(2) The applicant or client shall file a request for an administrative review with the Division within 30 calendar days after the mailing date of the determination. The request shall state the following:~~

~~(i) Why the applicant or client disagrees with the HIP determination.~~

~~(ii) The relief that the applicant or client seeks. The request shall include specific averments of fact and supporting documentation establishing that the applicant or client has cause for review. The Division will not consider requests which do not include specific averments of fact and supporting documentation.~~

~~(3) The Division will review the request for an administrative review and may reconsider HIP's determination. The Division will provide written notice to the applicant or client as to the outcome of the administrative review.~~

~~(b) *Administrative hearing.*~~

~~(1) The Division will advise the applicant or client of the right to appeal an adverse decision relating to eligibility for HIP services.~~

~~(2) The applicant or client may file the appeal with the agency head within 15 days of the mailing of that decision.~~

~~(3) If an appeal is filed an administrative hearing will be scheduled. The agency head shall designate an impartial hearing officer to preside at the administrative hearing. The hearing officer shall conduct the administrative hearing in accordance with~~

~~applicable provisions of 1 Pa. Code Chapter 35, Subchapter E (relating to presiding officers).~~

~~(4) Within ten days of the receipt of the appeal, the Division will forward to the hearing officer the file containing the eligibility determination for that applicant or client. The hearing officer shall, within 5 days of receiving the file from the Division, notify the applicant or client of the following:~~

~~(i) The time and place for the hearing.~~

~~(ii) The applicant's or client's right to:~~

~~(A) Appear in person at the hearing.~~

~~(B) Represent himself, or be represented at the hearing by an attorney, relative, friend or another person of the applicant's or client's choice.~~

~~(C) Present oral and documentary evidence, witnesses and arguments to support his position.~~

~~(D) Request a subpoena from the hearing officer for the production of evidence or appearance of witnesses at the hearing.~~

~~(E) Be provided, upon request, with the names of witnesses who will be present at the hearing.~~

~~(F) Refute any testimony or other evidence, and confront and question adverse witnesses.~~

~~(G) Examine prior to and during the hearing any documents and records which are or will be presented to support the Division's decision.~~

~~(5) If the applicant or client, or that individual's representative, fails to appear at the scheduled hearing without good cause, as determined by the hearing officer, the appeal shall be dismissed with prejudice.~~

~~(6) An applicant or client may withdraw the appeal at any time before a decision is made by the hearing officer. This withdrawal shall be in writing and directed to the hearing officer.~~

~~(7) The hearing officer may order an independent medical assessment or professional evaluation of the applicant or client performed by a HIP service provider at HIP's expense.~~

~~(8) Following the receipt of evidence and testimony, or in lieu thereof, a stipulation of facts, the hearing officer shall afford the parties the opportunity to submit a written brief.~~

~~(9) The hearing officer shall, in writing, by certified mail, notify the applicant or client, or representative of that person, of the hearing officer's findings within 45 days after the record is closed.~~

~~(c) *Hearing decisions.*~~

~~(1) The hearing officer shall render a decision based exclusively on the hearing record. This decision shall be considered a proposed report as defined in 1 Pa. Code §§35.202—35.207.~~

~~(2) The hearing officer shall submit the hearing record, which shall include a verbatim transcript or recording of testimony, exhibits submitted during the hearing and all papers and requests filed in the proceedings, to the agency head along with the hearing officer's report.~~

~~(3) A party to the administrative hearing may appeal the proposed report, within 30 days after being served with it, by filing a brief on exceptions with the agency head. Unless a party files a brief on exceptions within the time allowed, the hearing officer's decision shall become final. If a brief on exceptions is filed, the agency head will review the hearing officer's decision and the record and the agency head will issue an adjudication and order.~~

~~(4) The rules in 1 Pa. Code Part II (relating to general rules of administrative practice and procedure) apply to appeal procedures under this chapter except when inconsistent with this chapter.~~

§4.3. SERVICES ELIGIBLE FOR PAYMENT.

HIP WILL PAY FOR THE FOLLOWING:

(1) ASSESSMENTS OF APPLICANTS BY PROVIDERS.

(2) THE DEVELOPMENT OF REHABILITATION SERVICE PLANS BY PROVIDERS.

(3) REHABILITATION SERVICES.

(4) CASE MANAGEMENT SERVICES.

§4.4. REQUIREMENTS FOR PROVIDER PARTICIPATION.

(A) PROVIDERS OF RESIDENTIAL OUTPATIENT, DAY AND HOME-BASED REHABILITATION SERVICES SHALL BE ACCREDITED BY A NATIONAL ACCREDITING BODY AS APPROVED BY THE DEPARTMENT. FROM TIME TO TIME THE DEPARTMENT WILL PUBLISH A LIST OF APPROVED NATIONAL ACCREDITING BODIES IN THE *PENNSYLVANIA BULLETIN*.

(B) PROVIDERS SHALL PROVIDE REHABILITATION SERVICES IN ACCORDANCE WITH THEIR CONTRACTUAL AGREEMENTS WITH THE DEPARTMENT.

(C) PROVIDERS SHALL USE FORMS AND PROCEDURES AS PRESCRIBED BY THE DIVISION IN THE PROVISION OF REHABILITATION SERVICES.

§4.5. APPLICATION FOR ENROLLMENT AS A HIP CLIENT.

(A) *INITIAL CONTACT.* AN INDIVIDUAL WHO IS INTERESTED IN ENROLLING IN HIP OR IN ARRANGING FOR ANOTHER INDIVIDUAL TO BE ENROLLED IN HIP SHALL CONTACT THE ELIGIBILITY SPECIALIST OF THE DIVISION BY WRITING TO: ELIGIBILITY SPECIALIST, DEPARTMENT OF HEALTH, DIVISION OF SPECIAL HEALTH CARE PROGRAMS, P.O. BOX 90, ROOM 724, HEALTH AND WELFARE BUILDING, HARRISBURG, PA 17108, OR CALLING (717) 787-2020.

(B) *FUNDING.* THE DIVISION WILL ACCEPT AN APPLICATION FOR ENROLLMENT IN HIP ONLY IF THE FUNDS DESIGNATED TO HIP FROM THE CATASTROPHIC MEDICAL AND REHABILITATION APPROPRIATION EXCEED PROJECTED EXPENDITURES IN PROVIDING HIP SERVICES TO CURRENT CLIENTS.

(C) *WAITING LIST.* IF THE FUNDS DESIGNATED TO HIP FROM THE CATASTROPHIC MEDICAL AND REHABILITATION APPROPRIATION ARE NOT ADEQUATE TO ENABLE THE DIVISION TO ACCEPT APPLICATIONS FOR INDIVIDUALS FOR WHOM ENROLLMENT IN HIP IS SOUGHT, THE DIVISION WILL PLACE THOSE INDIVIDUALS ON A WAITING LIST IF THEY SO ELECT. THE INDIVIDUAL ON THE WAITING LIST OR THE AUTHORIZED

REPRESENTATIVE SHALL IMMEDIATELY NOTIFY THE DIVISION OF ANY CHANGE IN MAILING ADDRESS. THE DIVISION WILL REQUEST INDIVIDUALS ON THE WAITING LIST, OR THEIR AUTHORIZED REPRESENTATIVES, TO SUBMIT APPLICATIONS FOR ENROLLMENT AS FUNDING BECOMES AVAILABLE. EXCEPT AS OTHERWISE PROVIDED IN THIS CHAPTER, THE DIVISION WILL REQUEST INDIVIDUALS ON THE WAITING LIST, OR THEIR AUTHORIZED REPRESENTATIVES, TO SUBMIT APPLICATIONS IN THE ORDER THAT THE REQUESTS TO BE PLACED ON THE WAITING LIST WERE RECEIVED BY THE DIVISION. INDIVIDUALS WHO ARE RECEIVING CASE MANAGEMENT SERVICES THROUGH HIP AS OF THE EFFECTIVE DATE OF THIS CHAPTER, BUT WHO HAVE NEVER RECEIVED REHABILITATION SERVICES THROUGH HIP, WILL BE GIVEN FIRST PRIORITY ON THE WAITING LIST.

(D) *APPLICATION.* WHEN AN INDIVIDUAL QUALIFIES TO RECEIVE AN APPLICATION FOR ENROLLMENT IN HIP, THE DIVISION WILL SEND TO THAT INDIVIDUAL OR THE PERSON WHO SOUGHT TO ENROLL THAT INDIVIDUAL IN HIP, AT THE MAILING ADDRESS PROVIDED TO THE DIVISION, INFORMATION ON HIP AND APPLICATION MATERIALS. IF THE INDIVIDUAL IS ON A WAITING LIST, THE DIVISION WILL ALSO REQUEST THAT THE INDIVIDUAL NOTIFY THE DIVISION IN WRITING WHETHER HE OR SHE IS STILL SEEKING ENROLLMENT IN HIP. THE NOTIFICATION SHALL BE TIMELY ONLY IF IT IS POSTMARKED WITHIN 21 DAYS AFTER THE DATE THE MATERIALS WERE SENT BY THE DIVISION. IF THE DIVISION RECEIVES

A TIMELY NOTIFICATION THAT ENROLLMENT IN HIP IS DESIRED, THE DIVISION WILL PROCEED WITH THE APPLICATION PROCESS. IF THE DIVISION IS APPRISED THAT ENROLLMENT IN HIP IS NO LONGER DESIRED, OR IF THE DIVISION DOES NOT RECEIVE TIMELY NOTIFICATION OF CONTINUED INTEREST IN ENROLLMENT, THE DIVISION WILL REMOVE THE INDIVIDUAL FROM THE WAITING LIST, CONTACT THE NEXT PERSON ON THE WAITING LIST, AND REPEAT THE PROCESS.

(E) *REQUEST AND APPLICATION FOR RE-ENROLLMENT.* A REQUEST FOR RE-ENROLLMENT MAY BE FILED FOR AN INDIVIDUAL WHO WAS PREVIOUSLY ENROLLED IN HIP. IF THERE IS A WAITING LIST, THE DIVISION WILL NOT ACCEPT AN APPLICATION FOR RE-ENROLLMENT. INSTEAD, IT WILL PLACE THE INDIVIDUAL ON THE WAITING LIST. THE DIVISION WILL GIVE PRIORITY TO INDIVIDUALS ON THE WAITING LIST WHO HAVE NOT PREVIOUSLY RECEIVED REHABILITATION SERVICES FROM HIP. THE DIVISION WILL REQUEST INDIVIDUALS WHO HAVE PREVIOUSLY RECEIVED REHABILITATION SERVICES FROM HIP WHO ARE ON THE WAITING LIST, OR THEIR AUTHORIZED REPRESENTATIVES, TO SUBMIT APPLICATIONS FOR RE-ENROLLMENT IN THE ORDER THAT THE REQUESTS FOR RE-ENROLLMENT WERE RECEIVED. EXCEPT AS PROVIDED IN SUBSECTION (C), THE DIVISION WILL ONLY ACCEPT A REQUEST OR APPLICATION FOR RE-ENROLLMENT FOR AN INDIVIDUAL WHO IS NOT A CLIENT AT THE TIME THE REQUEST OR APPLICATION IS MADE.

(F) *ACCEPTANCE OF APPLICATION.* THE DIVISION WILL ACCEPT AN APPLICATION FOR ENROLLMENT ONLY FROM THE INDIVIDUAL FOR WHOM ENROLLMENT IS SOUGHT OR FROM AN AUTHORIZED REPRESENTATIVE.

§4.6. ASSESSMENT.

(A) *ELIGIBILITY FOR ASSESSMENT.* THE DIVISION WILL REVIEW AN APPLICATION FOR ENROLLMENT IN HIP TO DETERMINE WHETHER THE APPLICANT IS ELIGIBLE FOR AN ASSESSMENT, AS FOLLOWS:

(1) *GENERAL CRITERIA.* AN APPLICANT SHALL BE ELIGIBLE FOR AN ASSESSMENT ONLY IF ALL OF THE FOLLOWING REQUIREMENTS ARE MET:

(I) THE APPLICANT SUSTAINED A TRAUMATIC BRAIN INJURY AFTER JULY 2, 1985.

(II) THE APPLICANT IS A CITIZEN OF THE UNITED STATES AND WAS DOMICILED IN THIS COMMONWEALTH AT THE TIME OF THE INJURY AND AT THE TIME OF APPLICATION FOR ENROLLMENT IN HIP.

(III) THE APPLICANT IS 21 YEARS OF AGE OR OLDER.

(IV) THE APPLICATION IS COMPLETED AND IS ACCOMPANIED BY THE DOCUMENTATION THAT IS REQUESTED TO VERIFY THE APPLICANT'S SATISFACTION OF THE ELIGIBILITY CRITERIA IN THIS SUBSECTION.

(V) THE APPLICANT'S ALTERNATIVE FINANCIAL RESOURCES ARE AT OR BELOW 300% OF THE FEDERAL POVERTY GUIDELINES.

(A) THE APPLICANT'S INCOME WILL BE ASSESSED USING THE APPLICANT'S MOST RECENT FEDERAL INCOME TAX

FORM, WHICH THE APPLICANT SHALL PROVIDE. IF THAT FORM IS UNAVAILABLE, THE DIVISION MAY REQUEST OTHER DOCUMENTATION OF INCOME. IF THE MOST RECENT FEDERAL INCOME TAX FORM IS NOT REPRESENTATIVE OF THE APPLICANT'S INCOME AT THE TIME OF APPLICATION, THE APPLICANT MAY SUBMIT DOCUMENTS TO THAT EFFECT IN SUPPORT OF THE APPLICATION.

(B) THE APPLICANT SHALL PROVIDE, ON FORMS PROVIDED BY THE DIVISION, INFORMATION ABOUT ANY COURT AWARD OR FINANCIAL SETTLEMENT MADE OR PENDING AS A RESULT OF THE TBI, AND ANY OTHER FUNDS WHICH ARE AVAILABLE TO THE APPLICANT. IF ALL OR PART OF THE AWARD, SETTLEMENT, OR OTHER FUNDS IS UNAVAILABLE TO THE APPLICANT TO USE FOR HIP SERVICES, THE APPLICANT MAY SUBMIT DOCUMENTS TO THAT EFFECT IN SUPPORT OF THE APPLICATION.

(2) *CONDITION CRITERIA.* AN APPLICANT SHALL BE ELIGIBLE FOR AN ASSESSMENT ONLY IF THE APPLICANT'S IMPAIRMENT IS NOT THE RESULT OF ONE OR MORE OF THE FOLLOWING CONDITIONS:

(I) COGNITIVE OR MOTOR DYSFUNCTION RELATED TO CONGENITAL OR HEREDITARY BIRTH DEFECTS.

(II) PUTATIVE BIRTH TRAUMA OR ASPHYXIA NEONATORUM (HYPOXIC-ISCHEMIC-ENCEPHALOPATHY).

(III) HYPOXIC ENCEPHALOPATHY UNRELATED TO TRAUMATIC BRAIN INJURY.

(IV) SIGNIFICANT PRE-EXISTING PSYCHIATRIC, ORGANIC, OR DEGENERATIVE BRAIN DISORDER.

(V) STROKE.

(VI) SPINAL CORD INJURY IN THE ABSENCE OF TRAUMATIC BRAIN INJURY.

(3) *SYMPTOM CRITERIA.* AN APPLICANT SHALL BE ELIGIBLE FOR AN ASSESSMENT ONLY IF THE APPLICANT DOES NOT MANIFEST ANY SYMPTOM, SUCH AS A COMATOSE CONDITION, WHICH WOULD PREVENT THE APPLICANT FROM PARTICIPATING IN THE ASSESSMENT IN A MEANINGFUL WAY OR PREVENT THE PROVIDER FROM DOING A FULL AND COMPLETE ASSESSMENT.

(4) *ASSIGNMENT AGREEMENT.* AN APPLICANT SHALL BE ELIGIBLE FOR AN ASSESSMENT ONLY IF THE APPLICANT OR AUTHORIZED REPRESENTATIVE COMPLETES AN ASSIGNMENT AGREEMENT WHICH, CONDITIONED UPON THE APPLICANT'S RECEIPT OF HIP SERVICES, WOULD ASSIGN TO THE DEPARTMENT RIGHTS IN FUTURE COURT AWARDS, INSURANCE SETTLEMENTS OR ANY OTHER PROCEEDS WHICH HAVE ACCRUED OR WILL ACCRUE TO THE APPLICANT AS A RESULT OR BY VIRTUE OF THE

APPLICANT'S TRAUMATIC BRAIN INJURY, UP TO THE AMOUNT EXPENDED FOR HIP SERVICES ON BEHALF OF THAT INDIVIDUAL.

(B) *ASSESSMENT PROCESS.* THE DIVISION WILL REFER AN APPLICANT WHO IS ELIGIBLE FOR AN ASSESSMENT TO A PROVIDER. THE PROVIDER SHALL ASSESS THE APPLICANT FOR THE FOLLOWING:

(1) TO CORROBORATE THE DIVISION'S DETERMINATION THAT THE APPLICANT SATISFIES THE CONDITION AND SYMPTOM CRITERIA IN SUBSECTION (A)(2) AND (3).

(2) TO DETERMINE THAT THE APPLICANT HAS THE PHYSICAL, SOCIAL, COGNITIVE, PSYCHOLOGICAL, AND VOCATIONAL POTENTIAL FOR USEFUL AND PRODUCTIVE ACTIVITY WHICH CAN BE NURTURED BY REHABILITATION SERVICES AVAILABLE THROUGH HIP SO AS TO ENABLE THE APPLICANT TO PROGRESS TOWARD A HIGHER LEVEL OF FUNCTIONING AND TRANSITION TO A LESS RESTRICTIVE ENVIRONMENT.

(3) TO DETERMINE THAT THE APPLICANT HAS NEEDS THAT CAN BE ADDRESSED BY HIP SERVICES, THAT WILL NOT BE ADDRESSED BY ANY OTHER SERVICES TO WHICH THE APPLICANT IS ENTITLED.

(4) TO DETERMINE THAT THE APPLICANT DOES NOT MANIFEST SUICIDAL OR HOMICIDAL IDEATION, OR POTENTIALLY HARMFUL AGGRESSIVE BEHAVIOR, TO SUCH A DEGREE THAT HIP CANNOT PROVIDE THE APPROPRIATE SERVICES THROUGH ITS PROVIDERS TO SUFFICIENTLY ADDRESS THESE IDEATIONS OR BEHAVIORS.

(C) *FORMS AND PROCEDURE.* THE PROVIDER SHALL COMPLETE THE ASSESSMENT ON FORMS PROVIDED BY THE DIVISION. A PROVIDER CONDUCTING AN ASSESSMENT SHALL:

(1) REVIEW THE APPLICANT'S MEDICAL RECORDS.

(2) REVIEW ALL PERTINENT DOCUMENTATION SUBMITTED BY PHYSICIANS ON BEHALF OF THE APPLICANT.

(3) EVALUATE THE APPLICANT'S ABILITY TO BENEFIT FROM REHABILITATION SERVICES, PERFORMED IN ACCORDANCE WITH STANDARDS PREVAILING IN THE FIELD.

(D) *DEVELOPMENT OF REHABILITATION SERVICE PLAN.* IF THE PROVIDER CORROBORATES THE DIVISION'S INITIAL DETERMINATION UNDER SUBSECTION (A)(2) AND (3), AND DETERMINES THAT THE APPLICANT MEETS THE CRITERIA IN SUBSECTION (B)(2), (3) AND (4), THE PROVIDER SHALL DEVELOP A REHABILITATION SERVICE PLAN FOR THE APPLICANT AS SPECIFIED IN §4.8 (RELATING TO REHABILITATION SERVICE PLAN).

(E) *ASSESSMENT PERIOD.* THE PROVIDER SHALL COMPLETE ITS ASSESSMENT AND GIVE WRITTEN NOTIFICATION OF ITS DETERMINATION TO THE DIVISION AND THE APPLICANT OR AUTHORIZED REPRESENTATIVE WITHIN 14 DAYS AFTER THE PROVIDER BEGINS TO CONDUCT AN ASSESSMENT OF THE APPLICANT. IF THE PROVIDER DETERMINES THAT THE APPLICANT IS ELIGIBLE FOR ENROLLMENT IN HIP, THE PROVIDER SHALL ALSO COMPLETE A REHABILITATION SERVICE PLAN FOR THE APPLICANT WITHIN THAT 14-DAY PERIOD.

(F) *REAPPLICATION.* IF THE DIVISION DETERMINES THAT AN INDIVIDUAL IS NOT ELIGIBLE FOR AN ASSESSMENT OR THAT AN APPLICANT IS NOT ELIGIBLE FOR ENROLLMENT IN HIP AFTER AN ASSESSMENT HAS BEEN COMPLETED, THE INDIVIDUAL MAY REPEAT THE PROCESS FOR SEEKING ENROLLMENT IN HIP WHEN THE INDIVIDUAL OR AUTHORIZED REPRESENTATIVE BELIEVES THAT THE FACTOR OR FACTORS WHICH RENDERED THE INDIVIDUAL INELIGIBLE FOR ENROLLMENT IN HIP HAVE BEEN ELIMINATED.

§4.7. ENROLLMENT.

(A) *NOTIFICATION OF DECISION.* THE DIVISION WILL NOTIFY AN APPLICANT OR AUTHORIZED REPRESENTATIVE IN WRITING OF ITS DECISION REGARDING AN APPLICATION FOR ENROLLMENT WITHIN 16 DAYS AFTER RECEIVING FROM THE PROVIDER THE COMPLETED ASSESSMENT AND, IF APPLICABLE, ITS DECISION REGARDING THE REHABILITATION SERVICE PLAN. IF THE DIVISION DETERMINES THAT THE APPLICANT IS INELIGIBLE, THE NOTICE WILL INCLUDE THE REASON FOR THAT DETERMINATION AND WILL ADVISE OF APPEAL RIGHTS.

(B) *PROVIDER DETERMINATION THAT APPLICANT IS NOT ELIGIBLE FOR ENROLLMENT.* IF, AFTER ASSESSING THE APPLICANT THE PROVIDER DETERMINES THAT THE APPLICANT DOES NOT SATISFY THE CONDITION AND SYMPTOM CRITERIA IN §4.6(A)(2) AND (3) (RELATING TO ASSESSMENT), LACKS THE POTENTIAL TO BENEFIT OR THE NEED DESCRIBED IN §4.6(B)(2) AND (3), OR MANIFESTS IDEATION OR BEHAVIOR

WHICH WOULD RENDER THE APPLICANT UNFIT TO PARTICIPATE IN HIP UNDER §4.6(B)(4), THE PROVIDER SHALL SHARE ITS FINDINGS WITH THE DIVISION AND THE APPLICANT OR AUTHORIZED REPRESENTATIVE. THE DIVISION WILL PROVIDE THE APPLICANT OR AUTHORIZED REPRESENTATIVE THE OPPORTUNITY TO REBUT THE PROVIDER'S FINDINGS, AND THEN WILL MAKE A DETERMINATION AS TO WHETHER THE APPLICANT IS ELIGIBLE FOR ENROLLMENT IN HIP.

(C) *OVERTURNING PROVIDER DETERMINATIONS.* IF THE DIVISION DETERMINES THAT AN APPLICANT IS ELIGIBLE FOR ENROLLMENT IN HIP DESPITE THE PROVIDER'S DETERMINATION TO THE CONTRARY, OR THAT A REHABILITATION SERVICE PLAN IS UNACCEPTABLE, THE DIVISION SHALL DIRECT THE PROVIDER, OR ANOTHER PROVIDER AT THE DIVISION'S DISCRETION, TO DEVELOP A REHABILITATION SERVICE PLAN FOR THE APPLICANT WITHIN 14 DAYS OF RECEIVING THE DIVISION'S DECISION. THE DIVISION SHALL ACT ON THE REVISED REHABILITATION SERVICE PLAN WITHIN 16 DAYS AFTER RECEIPT.

(D) *COMMENCEMENT OF ENROLLMENT.* A CLIENT'S ENROLLMENT BEGINS ON THE FIRST DAY THAT A CLIENT RECEIVES REHABILITATION SERVICES FROM A PROVIDER AFTER THE DIVISION ISSUES ITS WRITTEN NOTIFICATION GRANTING ENROLLMENT IN HIP.

(E) *DURATION OF ENROLLMENT.* THE ENROLLMENT PERIOD OF A CLIENT SHALL BE SPECIFIED IN THE CLIENT'S REHABILITATION SERVICE PLAN. IT MAY NOT EXCEED 18 CONSECUTIVE MONTHS, COMPRISED OF A MAXIMUM

REHABILITATION PERIOD OF 12 CONSECUTIVE MONTHS FOLLOWED BY A MAXIMUM TRANSITION PERIOD OF 6 CONSECUTIVE MONTHS. A CLIENT'S ENROLLMENT SHALL END PRIOR TO THE TIME DESIGNATED IN THE CLIENT'S REHABILITATION SERVICE PLAN WHEN ONE OF THE FOLLOWING OCCURS:

(1) THE DIVISION DETERMINES THAT THE CONTINUATION OF HIP SERVICES WILL NOT ENABLE THE CLIENT TO PROGRESS TO A HIGHER LEVEL OF FUNCTIONING AND TRANSITION TO A LESS RESTRICTIVE ENVIRONMENT.

(2) THE CLIENT FAILS TO COOPERATE OR EXHIBITS UNMANAGEABLE BEHAVIOR SUCH THAT HIP CANNOT PROVIDE THE APPROPRIATE SERVICES TO MEET THE CLIENT'S NEEDS UNDER §4.6(B)(4).

(3) THE MAXIMUM FUNDS AVAILABLE FOR ALLOCATION TO THE CLIENT UNDER §4.12 (RELATING TO FUNDING LIMITS) ARE EXHAUSTED.

(4) THE CLIENT BECOMES ELIGIBLE FOR OTHER SERVICES OFFERED AS A RESULT OF THE TBI, WHICH SERVICES WILL MEET THE CLIENT'S NEEDS OR DUPLICATE HIP SERVICES SUCH THAT HIP SERVICES ARE RENDERED UNNECESSARY.

(F) *NOTIFICATION OF DISCHARGE FROM HIP.* THE DIVISION WILL NOTIFY A CLIENT OR AUTHORIZED REPRESENTATIVE IN WRITING OF ITS DECISION TO TERMINATE THE CLIENT'S PARTICIPATION IN HIP. THE NOTICE WILL INCLUDE THE REASON FOR THE DECISION AND WILL ADVISE OF APPEAL RIGHTS.

(G) *GRANDFATHER CLAUSE.* CLIENTS WHO ARE RECEIVING REHABILITATION SERVICES AS OF THE EFFECTIVE DATE OF THIS CHAPTER ARE ELIGIBLE FOR THE MAXIMUM ENROLLMENT PERIOD, BEGINNING ON THE EFFECTIVE DATE OF THIS CHAPTER. CLIENTS WHO ARE RECEIVING ONLY CASE MANAGEMENT SERVICES AS OF THE EFFECTIVE DATE OF THIS CHAPTER ARE ELIGIBLE FOR THE MAXIMUM TRANSITION PERIOD.

§4.8. REHABILITATION SERVICE PLAN.

(A) *DEVELOPMENT OF REHABILITATION SERVICE PLAN.* THE PROVIDER SHALL COLLABORATE WITH THE APPLICANT OR AUTHORIZED REPRESENTATIVE, AND MAY COLLABORATE WITH THE APPLICANT'S SIGNIFICANT OTHERS, SUCH AS FAMILY OR HEALTHCARE PROVIDERS, TO DEVELOP A REHABILITATION SERVICE PLAN FOR THE APPLICANT.

(B) *GOAL.* THE PRIMARY GOAL OF THE REHABILITATION SERVICE PLAN SHALL BE TO ENABLE THE CLIENT TO PROGRESS TO A HIGHER LEVEL OF FUNCTIONING, WHICH WILL, IN TURN, ENABLE THE CLIENT TO TRANSITION TO A LESS RESTRICTIVE ENVIRONMENT.

(C) *REQUIREMENTS.* THE INITIAL REHABILITATION SERVICE PLAN SHALL CONTAIN THE FOLLOWING:

(1) A DESCRIPTION OF DESIRABLE GOALS AND THE ANTICIPATED OUTCOMES IN OBJECTIVE AND MEASURABLE TERMS, INCLUDING THE EXPECTED TIME FRAMES FOR THE ACHIEVEMENT OF EACH GOAL AND OUTCOME, FOR THE ENTIRE ENROLLMENT PERIOD.

(2) A SPECIFICATION OF THE HIP SERVICES NECESSARY TO ATTAIN THE AGREED-UPON GOALS.

(3) A SPECIFICATION OF ANY OTHER SERVICES TO WHICH THE APPLICANT IS ENTITLED AND A DESCRIPTION OF THE IMPACT OF THOSE SERVICES UPON THE ATTAINMENT OF THE AGREED-UPON GOALS.

(4) BEGINNING AND ENDING DATES OF EACH HIP SERVICE.

(5) THE TERMS AND CONDITIONS FOR HIP SERVICE DELIVERY.

(6) THE SPECIFIC RESPONSIBILITIES OF THE APPLICANT AND SERVICE PROVIDER RELATIVE TO IMPLEMENTATION OF EACH HIP SERVICE.

(7) THE EXTENT OF FINANCIAL RESPONSIBILITY OF THE APPLICANT, HIP AND ANY THIRD PARTY.

(D) *QUARTERLY REVIEW.* THE REHABILITATION SERVICE PLAN SHALL INCLUDE A PROCEDURE AND SCHEDULE FOR QUARTERLY REVIEW AND EVALUATION OF PROGRESS TOWARDS THE SPECIFIED GOALS. THESE WRITTEN REVIEWS SHALL BE SUBMITTED TO THE DIVISION.

(E) *MODIFICATIONS.* THE PROVIDER SHALL MAKE MODIFICATIONS TO THE REHABILITATION SERVICE PLAN AS OFTEN AS NECESSARY, AND IN ACCORDANCE WITH SUBSECTIONS (A) THROUGH (D). MODIFICATIONS SHALL INDICATE WHETHER PREVIOUSLY SET GOALS WERE MET. WHERE GOALS WERE NOT MET, MODIFICATIONS SHALL ADDRESS THE REASONS WHY, AND MODIFY OR CHANGE GOALS APPROPRIATELY.

§4.9. REHABILITATION PERIOD.

(A) *PROVISION OF REHABILITATION SERVICES.* DURING THE REHABILITATION PERIOD A PROVIDER SHALL COORDINATE THE PROVISION OF REHABILITATION SERVICES TO A CLIENT TO ENSURE ACHIEVEMENT OF GOALS CONSISTENT WITH THE REHABILITATION SERVICE PLAN, AND AS APPROPRIATE TO THE NEEDS OF THE CLIENT TO IMPROVE THE CLIENT'S HEALTH, WELFARE AND THE REALIZATION OF THE CLIENT'S MAXIMUM PHYSICAL, SOCIAL, COGNITIVE, PSYCHOLOGICAL, AND VOCATIONAL POTENTIAL FOR USEFUL AND PRODUCTIVE ACTIVITY.

(B) *SUPERVISION.* REHABILITATION SERVICES SHALL BE PROVIDED OR THEIR PROVISION SHALL BE SUPERVISED BY A PHYSICIAN OR OTHER APPROPRIATE HEALTH PROFESSIONAL QUALIFIED BY TRAINING OR EXPERIENCE TO PROVIDE OR SUPERVISE SUCH SERVICES.

(C) *PURPOSE.* IF AUTHORIZED UNDER THE REHABILITATION SERVICE PLAN, REHABILITATION SERVICES MAY BE PROVIDED FOR THE FOLLOWING PURPOSES:

(1) HELPING A CLIENT DEVELOP BEHAVIORS THAT ENABLE THE CLIENT TO TAKE RESPONSIBILITY FOR THE CLIENT'S OWN ACTIONS.

(2) FACILITATING A CLIENT'S SUCCESSFUL COMMUNITY INTEGRATION.

(3) ASSISTING A CLIENT TO ACCOMPLISH FUNCTIONAL OUTCOMES AT HOME AND IN THE COMMUNITY.

(4) TEACHING A CLIENT SKILLS TO LIVE INDEPENDENTLY.

(5) SUPERVISING A CLIENT LIVING IN A HOME SETTING THROUGH THE FOLLOWING:

(I) HOME FACILITATION.

(II) PHYSICAL REHABILITATION

(III) COGNITIVE REMEDIATION.

(IV) LIFE-SKILLS COACHING.

(V) ASSISTING THE CLIENT IN MAINTAINING INDEPENDENCE.

(6) PROVIDING TRANSITIONAL LIVING SERVICES TO ASSIST A CLIENT WITH COMMUNITY RE-ENTRY SKILLS.

(7) MAXIMIZING A CLIENT'S PHYSICAL POTENTIAL.

§4.10. TRANSITION PERIOD.

(A) *PROVISION OF CASE MANAGEMENT SERVICES.* FOLLOWING THE REHABILITATION PERIOD, HIP WILL PROVIDE CASE MANAGEMENT SERVICES TO ASSIST THE CLIENT IN MAKING THE TRANSITION OUT OF HIP.

(B) *COMMENCEMENT OF TRANSITION PERIOD.* THE TRANSITION PERIOD WILL COMMENCE IMMEDIATELY FOLLOWING THE END OF THE REHABILITATION PERIOD.

(C) *DURATION OF TRANSITION PERIOD.* THE TRANSITION PERIOD MAY NOT EXCEED 6 CONSECUTIVE MONTHS, AND SHALL END WHEN THE MAXIMUM FUNDS AVAILABLE FOR ALLOCATION TO THE CLIENT ARE EXHAUSTED UNDER §4.12 (RELATING TO FUNDING LIMITS).

§4.11. CASE MANAGEMENT SERVICES.

CASE MANAGEMENT SERVICES SHALL BE PROVIDED BY A CASE MANAGER WHO HAS A MINIMUM OF 1 YEAR OF EXPERIENCE IN TRAUMATIC BRAIN INJURY CASE

MANAGEMENT, AND SHALL INCLUDE THE FOLLOWING ACTIVITIES BY THE CASE MANAGER:

(1) MONITORING THE CLIENT'S PROGRESS WITH RESPECT TO THE REHABILITATION SERVICE PLAN AND COLLABORATING WITH THE CLIENT OR AUTHORIZED REPRESENTATIVE, THE CLIENT'S SIGNIFICANT OTHERS, AND THE REST OF THE TREATMENT TEAM IN THE DEVELOPMENT AND MODIFICATION OF THE REHABILITATION SERVICE PLAN.

(2) ASSISTING THE CLIENT IN GAINING ACCESS TO SERVICES FROM WHICH THE CLIENT MAY BENEFIT AND FOR WHICH THE CLIENT MAY BE ELIGIBLE.

(3) MONITORING AND EVALUATING THE CLIENT'S PROGRESS IN TRANSITIONING TO LIVING IN A HOME OR COMMUNITY SETTING AND ENSURING THAT ANY NECESSARY SUPPORTS ARE IN PLACE, OR FACILITATING PLACEMENT OF THE CLIENT IN A LONG-TERM CARE FACILITY.

(4) DETERMINING THAT THE CLIENT HAS FULLY TRANSITIONED TO THE HOME OR COMMUNITY OR HAS BEEN REFERRED TO THE APPROPRIATE LONG-TERM CARE FACILITY.

§4.12. FUNDING LIMITS.

(A) HIP WILL PROVIDE NO MORE THAN $100,000 FOR CASE MANAGEMENT AND REHABILITATION SERVICES FOR A CLIENT DURING A REHABILITATION

PERIOD. THIS AMOUNT WILL BE REDUCED BY ANY CLIENT SHARE OF COSTS UNDER §4.13(B) (RELATING TO PAYMENT FOR HIP SERVICES).

(B) HIP WILL PROVIDE NO MORE THAN $1000 FOR CASE MANAGEMENT SERVICES FOR A CLIENT DURING A TRANSITION PERIOD. THIS AMOUNT WILL BE REDUCED BY ANY CLIENT SHARE OF COSTS UNDER §4.13(B).

(C) THE DIVISION WILL NOTIFY AN APPLICANT OF THESE MAXIMUM FUNDING LIMITS WHEN IT ACCEPTS THE APPLICANT AS A CLIENT.

§4.13. PAYMENT FOR HIP SERVICES.

(A) *WRITTEN AUTHORIZATION.* THE DIVISION WILL PROVIDE WRITTEN AUTHORIZATION, TO THE CLIENT AND TO THE PROVIDER, AS TO HIP SERVICES FOR WHICH THE CLIENT IS ELIGIBLE AND THE MAXIMUM AVAILABLE FUNDING AND TIME LIMITS FOR THOSE SERVICES.

(B) *CLIENT RESPONSIBILITY FOR PAYMENT.* IF THE DIVISION DETERMINES THAT A CLIENT IS RESPONSIBLE TO PAY FOR ANY PART OF HIP SERVICES THE CLIENT WILL BE INFORMED OF THAT FACT, AND OF THE AMOUNT FOR WHICH THE CLIENT IS RESPONSIBLE, AS FOLLOWS:

(1) THE CLIENT SHALL BE ASSESSED A SHARE OF THE COST OF HIP, USING A SLIDING SCALE, BASED UPON ALTERNATIVE FINANCIAL RESOURCES BETWEEN 185% AND 300% OF THE FEDERAL POVERTY GUIDELINES.

(2) THE CLIENT WILL BE RESPONSIBLE TO PAY FOR HIP SERVICES UP TO THE AMOUNT OF ALTERNATIVE FINANCIAL RESOURCES WHICH EXCEED 300% OF THE FEDERAL POVERTY GUIDELINES.

(C) *NOTIFICATION OF DISCONTINUANCE OF HIP FUNDING.* THE DIVISION WILL NOTIFY A CLIENT IN WRITING OF ANY DISCONTINUANCE OF FUNDING. THE NOTICE WILL INCLUDE THE REASON FOR THE DISCONTINUANCE AND ADVISE OF APPEAL RIGHTS.

(D) *DUTY TO UPDATE FINANCIAL INFORMATION.* A CLIENT SHALL IMMEDIATELY REPORT TO THE DIVISION ALL CHANGES IN AVAILABILITY OF ALTERNATIVE FINANCIAL RESOURCES.

(E) *PRE-EXISTING CONDITIONS.* HIP WILL NOT PAY FOR SERVICES TO ADDRESS CONDITIONS EXISTING PRIOR TO THE TRAUMATIC BRAIN INJURY.

(F) *SERVICES FUNDED THROUGH OTHER BENEFIT PROGRAMS.* HIP WILL NOT PAY FOR SERVICES AVAILABLE THROUGH OTHER PUBLICLY FUNDED PROGRAMS. THE PROVIDER WILL COORDINATE HIP WITH OTHER PUBLIC AND PRIVATE PROGRAMS TO ASSIST CLIENTS TO ACCESS BENEFITS FOR WHICH THEY MAY BE ELIGIBLE.

(G) *REIMBURSEMENT.* THE DEPARTMENT MAY SEEK REIMBURSEMENT FOR PAYMENTS MADE WITH HIP FUNDS ON BEHALF OF A CLIENT FROM AN INSURER THAT PROVIDES COVERAGE TO THE CLIENT OR FROM THE PROCEEDS OF ANY LITIGATION ARISING OUT OF THE INJURY WHICH LED TO ELIGIBILITY FOR ENROLLMENT IN HIP.

§4.14. PEER REVIEW.

(A) *PURPOSE.* THE DEPARTMENT WILL APPOINT A PEER REVIEW COMMITTEE TO CONDUCT A REVIEW OF SERVICES AND REHABILITATION SERVICE PLANS FOR CLIENTS. THE HIP PEER REVIEW

COMMITTEE SHALL ADVISE THE DEPARTMENT ON BEST PRACTICES TO BE FOLLOWED IN OFFERING SERVICES TO CLIENTS.

(B) *PROCEDURES.*

(1) THE HIP PEER REVIEW COMMITTEE SHALL MEET QUARTERLY AND SHALL REVIEW SELECTED CLIENT CHARTS, INCLUDING CHARTS FOR AT LEAST ONE CLIENT FROM EACH PROVIDER PROVIDING SERVICES AT THE TIME OF THE QUARTERLY MEETING, TO EVALUATE THE APPROPRIATENESS OF PROVISION OF SERVICES AND CLIENT PROGRESS.

(2) WITHIN 30 DAYS AFTER IT COMPLETES ITS REVIEW, THE HIP PEER REVIEW COMMITTEE SHALL PROVIDE TO THE DEPARTMENT, IN WRITING, RECOMMENDATIONS REGARDING THE PROVISION OF SERVICES BY EACH PROVIDER.

(3) A MEMBER OF THE HIP PEER REVIEW COMMITTEE MAY NOT PARTICIPATE IN A REVIEW CONDUCTED BY THE COMMITTEE THAT PRESENTS A CONFLICT OF INTEREST FOR THAT MEMBER. EXAMPLES OF CONFLICTS INCLUDE, BUT ARE NOT LIMITED TO, PARTICIPATING IN A REVIEW CONDUCTED BY THE COMMITTEE FOR ONE OF THE FOLLOWING:

(I) A SERVICE PROVIDED TO A CLIENT OF THAT MEMBER OR THAT MEMBER'S EMPLOYER.

(II) A PERSON WHO IS IN THE IMMEDIATE FAMILY OF THE MEMBER.

(4) THE DIVISION WILL NOTIFY THE HIP PEER REVIEW COMMITTEE OF ANY ACTIONS TAKEN ON THE RECOMMENDATIONS OF THE COMMITTEE.

§4.15. ADMINISTRATIVE REVIEW.

(A) *RECONSIDERATION BY DIVISION.*

(1) AN APPLICANT, CLIENT, OR AUTHORIZED REPRESENTATIVE MAY FILE WITH THE DIVISION A REQUEST FOR IT TO RECONSIDER ANY OF THE FOLLOWING DECISIONS MADE BY THE DIVISION:

(I) AN APPLICANT IS NOT ELIGIBLE FOR AN ASSESSMENT.

(II) AN ASSESSED APPLICANT IS NOT ELIGIBLE FOR ENROLLMENT.

(III) A DISAPPROVAL OR REVISION OF A REHABILITATION SERVICE PLAN.

(IV) A CLIENT IS TO BE DISCHARGED FROM HIP PRIOR TO THE DATE SPECIFIED IN THE CLIENT'S REHABILITATION SERVICE PLAN.

(V) ALTERNATIVE FINANCIAL RESOURCES ARE AVAILABLE SUCH THAT THE CLIENT MUST PAY FOR HIP SERVICES.

(2) AT THE TIME A DECISION IS MADE, THE DIVISION WILL NOTIFY THE APPLICANT, CLIENT, OR AUTHORIZED REPRESENTATIVE IN WRITING OF THE RIGHT TO SEEK ADMINISTRATIVE REVIEW. THE LETTER WILL ADVISE THE RECIPIENT TO SEEK ASSISTANCE FROM LEGAL COUNSEL, FAMILY, AND OTHERS WHO MAY SERVE IN AN ADVISORY ROLE, AND

INCLUDE CONTACT INFORMATION FOR A HIP REPRESENTATIVE TO ANSWER QUESTIONS.

(3) AN APPLICANT, CLIENT OR AUTHORIZED REPRESENTATIVE SHALL FILE A REQUEST FOR RECONSIDERATION WITHIN 15 CALENDAR DAYS AFTER THE MAILING DATE OF THE DIVISION'S DETERMINATION. THE REQUEST SHALL MEET THE FOLLOWING STANDARDS:

(I) STATE THE SPECIFIC LEGAL AND FACTUAL REASONS FOR DISAGREEMENT WITH THE DECISION.

(II) IDENTIFY THE RELIEF THAT IS BEING SOUGHT FOR THE APPLICANT OR CLIENT.

(III) INCLUDE SUPPORTING DOCUMENTATION, IF ANY, TO SUPPORT THE FACTUAL AVERMENTS MADE.

(4) THE DIVISION WILL NOTIFY THE APPLICANT, CLIENT, OR AUTHORIZED REPRESENTATIVE IN WRITING OF ITS DECISION WITHIN 30 DAYS AFTER RECEIVING THE REQUEST FOR RECONSIDERATION.

(B) *ADMINISTRATIVE APPEAL.*

(1) AN APPLICANT, CLIENT, OR AUTHORIZED REPRESENTATIVE MAY FILE AN ADMINISTRATIVE APPEAL TO THE AGENCY HEAD WITHIN 30 DAYS AFTER THE MAILING DATE OF THE DIVISION'S DECISION ON THE REQUEST FOR RECONSIDERATION. AN APPLICANT, CLIENT, OR AUTHORIZED REPRESENTATIVE MAY NOT FILE AN ADMINISTRATIVE APPEAL UNLESS RECONSIDERATION HAS BEEN SOUGHT AND THE REQUESTED RELIEF HAS BEEN DENIED.

(2) A HEARING WILL BE HELD ONLY IF A MATERIAL ISSUE OF FACT IS IN DISPUTE.

(C) *GENERAL RULES.* THE GENERAL RULES OF ADMINISTRATIVE PRACTICE AND PROCEDURE, 1 PA. CODE PART II, SHALL APPLY EXCEPT WHERE INCONSISTENT WITH THIS SECTION.

(D) *STATUS OF CLIENTS AND APPLICANTS.* A CLIENT SHALL CONTINUE TO RECEIVE HIP SERVICES UNTIL THE CLIENT'S RIGHT TO ADMINISTRATIVE REVIEW HAS BEEN EXHAUSTED, UNLESS AND UNTIL THE MAXIMUM FUNDS AVAILABLE TO A CLIENT UNDER §4.12 (RELATING TO FUNDING LIMITS) ARE EXHAUSTED, OR THE MAXIMUM DURATION FOR ENROLLMENT UNDER §4.7(E) (RELATING TO ENROLLMENT) HAS EXPIRED. AN APPLICANT, INCLUDING ONE WHO HAS COMPLETED THE ASSESSMENT PERIOD, SHALL NOT RECEIVE HIP SERVICES PENDING THE DISPOSITION OF THE ADMINISTRATIVE REVIEW.

Commonwealth of Pennsylvania

DEPARTMENT OF HEALTH

HARRISBURG

ROBERT S. ZIMMERMAN, JR., MPH
SECRETARY OF HEALTH

May 3, 2001

Mr. Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown II
333 Market Street
Harrisburg, Pennsylvania 17101

Re: Department of Health Final Regulation No. 10-129
28 Pa. Code Chapter 4
Head Injury Program

Dear Mr. Nyce:

Enclosed is a copy of final-form regulations for review by the Commission pursuant to the Regulatory Review Act (Act) (P.L. 73, No. 19) (71 P.S. §§ 745.1-745.15). Section 5.1(a) of the Act provides that, upon completion of the agency's review of comments following proposed rulemaking, the agency is to submit to the Commission and the standing committees a copy of the agency's response to the comments received, the names and addresses of commentators who have requested additional information relating to the final-form regulations, and the text of the final-form regulations which the agency intends to adopt.

Two commentators have requested additional information relating to the final-form regulations. A list of the names and addresses of these commentators is enclosed. The Department received 10 comments to the proposed rulemaking. These comments, which discussed a number of provisions contained in the proposed regulations, were forwarded to your committee upon receipt by the Department.

Section 5.1(d) of the Act provides that within 10 days following the expiration of the standing committee review period, or at its next regularly scheduled meeting, the Commission shall approve or disapprove the final form regulations

The Department will provide the Commission with any assistance it requires to facilitate a thorough review of the regulations. If you have any questions, please contact Deborah Griffiths, Director, Office of Legislative Affairs, at (717) 783-3985.

Sincerely,

Robert S. Zimmerman, Jr.
Secretary of Health

Enclosures

List of Commentators
Requesting Final Form Regulations

1. Ms. Ruth E. Granfors
   Kirkpatrick and Lockhart LLP
   Payne-Shoemaker Building
   240 North Third Street
   Harrisburg, Pennsylvania 17101-1507
   (717) 231-4500

2. Mr. Gene Bianco
   President/CEO
   PA Association of Rehabilitation Facilities
   2400 Park Drive
   Harrisburg, PA 17110
   (717) 657-7608

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER:	10-129
SUBJECT:	Head Injury Program
AGENCY:	Department of Health

TYPE OF REGULATION

Proposed Regulation

X Final Regulation

Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

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

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
5/3/01	Lisa Burns	HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
5301		
5/3/01		SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
5/3/01		
5/3/01	Elena Pagán	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL
		LEGISLATIVE REFERENCE BUREAU

March 6, 2001