3160 #14-540 (121)

Kroh, Karen

From:	Mochon, Julie
Sent:	Tuesday, December 20, 2016 8:35 AM
To:	Kroh, Karen
Subject:	FW: Comments Ch 6100
Attachments:	2016.1218 iNDIVIDUAL Comments Chapter 6100.docx

From: Berry, Astrid [mailto:ABerry@nhsonline.org]
Sent: Monday, December 19, 2016 11:57 AM
To: Mochon, Julie
Subject: Comments Ch 6100

Please find comments regarding CH 6100
I am particularly troubled by the extensive unfunded mandates included in this draft. I think the ares to be modified include quality management plan, delete the concept of the rights team – this is redundant and covered in other activities, training changes are onerous/ un-needed and cost prohibitive, and the medication administration for life sharing is counter productive.
Thank you

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Looking for humble, hungry and smart young leaders..

Berry

KEY for reviewing Comments on Chapter 6100:
Strikethrough = text suggested to be deleted
Blue text = text suggested to be added.

GENERAL PROVISIONS

Comment and Suggestion 6100.1:

As proposed, subsection (a) omits mention of an essential and expressed principal purpose of chapter 6100 – the adoption of HCBS payment policies. Suggested text includes necessary reference to that purpose and also includes the reference to "Everyday Lives: Values in Action" (2016 edition) as adopted by the Office of Developmental Programs

§ 6100.1. Purpose.

(a) This chapter governs the provision of and payment for home and community based services (HCBS) and base-funded services to individuals with an intellectual disability or autism. ~~The purpose of this chapter is to~~ Its various subsections specify the program and operational requirements for applicants and providers and thetment's duties and responsibilities relating to payment for HCBS and base-funded services.

(b) This chapter supports each individual with an intellectual disability or autism to achieve greater independence, choice and opportunity in his/her life as expressed in "Everyday Lives: Values in Action" (2016 edition).

Comment and Suggestion 6100.2:

(a) As proposed, § 6100.2 does not address potential conflicts between duly promulgated regulations and the provisions within the waivers. The provisions of the federal waivers have not been subject to the regulatory review process including review and approval by the Independent Regulatory Review Commission (IRRC), the Attorney General, and the Legislative Standing Committee. It is essential that the intended mandatory provisions of the federal waivers be reflected in regulation consistent with the requirements of state statute and applicable case law. See: 71 P.S. §§ 745.1 et seq., and case law: NW. Youth Services, Inc. v. Department of Public Welfare, 66 A. 3d 301 (Pa. 2013); Borough of Bedford v. D.E.P., 972 A. 2d 53 (Pa. Cmwlth. 2009).

(b) PAR's suggested textual edits assure clarity and avoid conflict and controversy in the application of the regulations.

§ 6100.2. Applicability.

(a) This chapter applies to and governs HCBS provided through waiver programs approved under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) for individuals with an intellectual disability or autism. In the event of a conflict between the provisions of HCBS Waiver Programs or the approved State Plan and the regulations set out in this chapter, or where the Waiver Programs or State Plan do not address the provision of or payment for a service, the regulations shall apply.

(b) This chapter applies to ~~State plan~~ HCBS ~~for~~ provided to individuals with an intellectual disability or autism as authorized under the Department of Human Services' approved Medical Assistance Program's State Plan. In the event of a conflict between the regulations set out in this Chapter and related but separate licensing regulations, the licensing regulations apply and supersede this Chapter.

(c) This chapter applies to intellectual disability programs, staffing and individual supports that are funded exclusively by grants to counties under the Mental Health and Intellectual Disability Act of 1966 (50 P.S. §§ 4101—4704) or Article XIV-B of the Human Services Code (62 P.S. §§ 1401-B—1410-B).

(d) This chapter does not apply to the following:

(1) Intermediate care facilities licensed in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability), except as provided under § 6100.447(d) (relating to facility characteristics relating to location of facility).

(2) Hospitals licensed in accordance with 28 Pa. Code Chapters 101—158 (relating to general and special hospitals).

(3) Nursing facilities licensed in accordance with 28 Pa. Code Chapters 201—211 (relating to long-term care facilities).

(4) Personal care homes licensed in accordance with Chapter 2600 (relating to personal care homes).

(5) Assisted living residences licensed in accordance with Chapter 2800 (relating to assisted living residences).

(6) Mental health facilities licensed in accordance with Chapters 5200, 5210, 5221, 5230, 5300 and 5320.

(7) Privately-funded programs, supports and placements.

(8) Placements by other states into this Commonwealth.

(9) A vendor fiscal employer agent model for an individual-directed financial management service.

(10) The adult community autism program that is funded and provided in accordance with the Federally-approved 1915(a) waiver program.

(11) Schools that provide education to students with disabilities such as licensed private schools and approved private schools and other special education programs under the jurisdiction of the Pennsylvania Department of Education.

(12) Child Welfare and/or Managed Care funded placements.

(13) Child Residential and Day Treatment facilities licensed under chapter 3800.

(14) Targeted Supports Management (TSM) Providers.

(15) Summer Camp Programs.

(16) Agency with choice (AWC).

(17) OHCDS.

Comment and Suggestion 6100.3: Common definitions for the several sets of regulations should be included in Chapter 6100.3, and the applicability of Chapter 6100 should be noted in each of the other regulatory chapters to promote clarity and consistency across applicable services and programs. Unless otherwise noted in the comment and suggestion box, edits and additional definitions in this section are intended to facilitate the application of the regulations.

Emergency closure (referred to under Incident Management, 6100.402 (a)(12)) definition has been added. The inclusion of two or more days (instead of 1) was because of snow emergencies, which is consistent with the Department of Aging's requirements for their unusual incident reporting. Consistency with the Department of Aging on this matter is helpful for those buildings that have dual licenses.

Suggested definition for "family" endeavors to separate the term from "natural supports" and also adds the element of who the individual chooses to include as family.

Direct Support Professional: Most of the language came from the definition in the licensing regulations, but the term is also used in Chapter 6100 under the Training section. The term used should be consistent across 6100 and the licensing regulations (and is used under 6100.44 (13)). It is the commonly understood designation that is also used by the national associations, National Association of Direct Support Professionals and American Association on Intellectual and Developmental Disabilities.

Explanation for the definition of "Mechanical support" can be found under the comment for 6100.343

"Non-conformity" replaces the term "violation" when referring to a provider's failure to conform to or meet the expectations outlined within this chapter.

"SC" and "SCO" have been added consistent with Chapters 2380, 2390, 6400, and 6500 and both terms are used in PAR's proposed additions.

PAR recommends using the term "service" uniformly and consistently to refer to paid supports across Chapter 6100, the subsequent licensing regulations, and the Consolidated and PFDS waivers.

§ 6100.3. Definitions.

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

Adult Autism Waiver - An HCBS Federal waiver program approved under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) and designed to provide community-based services to meet the specific needs of adults with autism spectrum disorders

Agency with choice (AWC) - A type of individual-directed, financial management service in which the agency is the common law employer and the individual or his representative is the managing employer.

Allowable costs ~~— Expenses considered reasonable, necessary and related to the support provided.~~ documented costs that in their nature and amount are costs incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs and are ordinary and necessary for the provision of HCBS as prescribed in this Chapter.

Aversive Conditioning - The application of startling, painful or noxious stimuli in response to the exhibition of behavior in an effort to modify the behavior.

Autism spectrum disorder (ASD) - A developmental disorder defined and diagnosed in accordance with criteria established in the Diagnostic and Statistical Manual latest edition in effect at time of diagnosis.

~~*Base-funded support* — A support funded exclusively by a grant to a county under the Mental Health and Intellectual Disability Act of 1966 (50 P.S. §§ 4101 — 4704) or Article XIV-B of the Human Services Code (62 P.S. §§ 1401-B — 1410-B).~~

Base-funded services: A service funded by state and county funds ~~exclusively by a grant to a county~~ under the Mental Health and Intellectual Disability Act of 1966 or Article XIV-B of the Human Services Code.

Centers for Medicare and Medicaid Services (CMS)

Chemical restraint - Use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug prescribed by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as treatment prior to or following a medical or dental examination or treatment.

Conflict of interest - A situation in which a provider or provider staff can derive a personal benefit from actions or decisions made in the delivery of HCBS.

Consolidated Waiver - A federally-approved waiver (under section 1915 (c) of the Social Security Act) designed to support individuals with an intellectual disability to live more independently in their homes and in their community

~~*Corrective action plan* — A document that specifies the following:~~

~~— (i) Action steps to be taken to achieve and sustain compliance.~~

~~(ii) The time frame by which corrections will be made.~~

~~(iii) The person responsible for taking the action step.~~

~~(iv) The person responsible for monitoring compliance with the corrective action plan.~~

Corrective action plan - a document prepared by a provider following a written determination by the Department of non-compliance with a provision(s) of this Chapter. The plan establishes timelines, person(s) responsible for the implementation and monitoring of corrective action steps.

Cost Report - A data collection tool utilized by the Department to collect expense and utilization information from a provider that may include supplemental schedules or addenda as reasonably may be requested by the Department.

Dangerous behavior – A decision, behavior or action by an individual that creates or is highly likely to result in harm or to place the individual and/or other persons at risk of harm.

Department—The Department of Human Services of the Commonwealth.

~~*Designated managing entity* - An entity that enters into an agreement with the Department to perform administrative functions delegated by the Department, as the Department's designee. For base-funding, this includes the county mental health and intellectual disability program.~~

Designated managing entity - An entity that enters into an agreement with the Department to perform, as the Department's designee, administrative functions delegated by the Department. For base-funding, this includes the county mental health and intellectual disability program.

Direct support professional—A person who assists an individual with a disability to lead a self-directed life and to contribute to the community, assists with activities of daily living if needed, and encourages attitudes and behaviors that enhance community inclusion.

Eligible cost—Expenses related to the specific procedure codes for which the Department receives Federal funding.

Emergency Closure – An event that is unplanned for any reason that results in program closure two days or more.

~~*Family* - A natural person that the individual considers to be part of his core family unit.~~

Family—the person or people who are related to or determined by the individual as family.

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

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

HCBS—Home and community-based ~~support~~ service—An activity, service, assistance or product provided to an individual that is funded through a Federally-approved waiver program or the Medical Assistance State Plan.

Incident - A situation or occurrence that has a high likelihood of a negative impact on an individual.

Individual—An ~~woman, man~~ adult or child who receives ~~a~~ home and community-based intellectual disability or autism support or base-funded service or support.

Lead designated managing entity - The designated managing entity identified as the sole entity engaging in monitoring activity, audits, and conducting provider monitoring for a provider.

Mechanical restraint – use of a device that restricts the movement or function of an individual or portion of an individual's body in response to the individual's behavior, unless prescribed in the PSP.

Natural support—~~An activity or assistance that is provided voluntarily to the individual instead of a reimbursed support.~~ An activity or assistance that is provided by family, friends, or other community members without expectation of payment

Non-compliance - Failure to conform to or meet the expectations outlined within this chapter.

OVR—The Department of Labor and Industry's Office of Vocational Rehabilitation.

P/FDS – Person/Family Directed Support – A federally – approved waiver (under section 1915 (c) of the Social Security Act) designed to support individuals with an intellectual disability to live more independently in their homes and in their community without formal residential services and authorizes a finite amount of funds per person per year.

~~PSP—~~Person-centered support plan (PSP): The comprehensive plan for each ~~participant~~ person that is ~~developed using a~~ individualized, person-centered ~~process~~ and includes HCBS.

Physical restraint - A physical (manual) hands-on technique that lasts longer than 30 consecutive seconds and restricts, immobilizes, or reduces an individual's ability to move his/her arms, legs, head, or other body parts freely.

Positive interventions - actions or activities intended to prevent, modify, decrease or eliminate challenging behaviors. These interventions or positive behavior supports include, but are not limited to: environmental adaptations or modifications, identifying and addressing physical and behavioral health symptoms, voluntary physical exercise, health and wellness practices,

redirection, praise, modeling, conflict resolution, trauma informed care, de-escalation and anger management techniques, and reinforcing desired behavior.

Pressure point techniques - The application of pressure used as a physical restraint, except as necessary for release of a bite.

Provider—~~The person, entity or agency that is contracted or authorized to deliver the support to the individual.~~ The person, entity or organization that is authorized to deliver services under the Medical Assistance and base-funded programs, including approved Waiver Programs.

Provider Applicant—An entity that ~~is in the process of~~ applies ~~enrolling~~ to enroll in the Medical Assistance or base-funded programs ~~as a provider of HCBS~~.

Remediation action plan - A document that establishes expectations and action steps to remediate areas identified that are nonconforming with this chapter. The plan establishes timelines, person(s) responsible for the implementation and how the provider will monitor the action steps.

Restraint—A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the PSP or used on an emergency basis.

Support coordination - an HCBS waiver or base-funded service provided by a supports coordinator (SC) designed to locate, coordinate and monitor HCBS or base-funded services provided to an individual.

Supports coordination organization (SCO) —An entity that locates, coordinates and monitors HCBS or base-funded services provided to an individual.

Seclusion - Involuntary confinement of an individual in a room or area from which the individual is physically prevented from leaving.

Supplemental Security Income (SSI)— benefit to an individual provided by the Social Security Administration.

State plan—The Commonwealth's approved Title XIX State Plan.

~~*Support* Service~~ —An activity, ~~service,~~ assistance or product provided to an individual ~~that is provided~~ through a Federally-approved waiver program, or the Medical Assistance State plan or base-~~funding~~ funded service. A ~~support~~ service includes an HCBS, support coordination, targeted service management (TSM), agency with choice, organized health care delivery system, vendor goods and services, ~~and base-funding support,~~ unless specifically exempted in this chapter.

~~*Vacancy factor*—An adjustment to the full capacity rate to account for days when the *residential habilitation provider* cannot bill due to an individual not receiving supports.~~

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

Voluntary Exclusion - ~~The voluntary or willing removal of an individual from the immediate environment where the individual goes alone to another room or area.~~ An individual voluntarily or willingly removing himself/herself from his/her immediate environment and placing himself/herself alone to a room or area.

Volunteer - A person who works without compensation and under the supervision of an authorized provider or family member alone with an individual in the performance of a service.

GENERAL REQUIREMENTS

Comment and Suggestion 6100.41:

It is suggested that this section, similar to other regulatory chapters and common practice, be relocated to the end of the Chapter following the substantive program requirements. Suggested text promotes clarity.

§ 6100.41. Appeals.

Appeals related to the provisions of this chapter shall be ~~made~~ filed in accordance with 55 Pa. Code Chapter 41 (relating to Medical Assistance provider appeal procedures) and Chapter 4300 (relating to Base Funding).

Comment and Suggestion 6100.42:

This entire section also should be set forth toward the end of the Chapter rather than appear at the outset, similar to other Department regulatory chapters and common practice. Textual edits are suggested to reduce redundancy (i.e., provider cooperation with program/fiscal review already mandated by the Medical Assistance Provider Agreement and 55 Pa. Code Chapter 1101) and to promote clarity and reasonableness.

§ 6100.42. ~~Monitoring compliance~~ Review of Provider Performance

~~(a) The Department and the designated managing entity may monitor compliance with this chapter at any time through an audit, provider monitoring or other monitoring method.~~

(a) The Department and the Lead Designated Managing Entity may review provider compliance with the provisions this Chapter as set forth in this section. When services are provided across multiple counties or individual services are managed through multiple counties by various Designated Managing Entities, one Designated Managing Entity shall perform a provider performance review.

~~(b) The provider's policies, procedures, records and invoices may be reviewed, and the provider may be required to provide an explanation of its policies, procedures, records and invoices, related to compliance with this chapter or applicable Federal or State statutes and regulations, during an audit, provider monitoring or other monitoring method.~~

(b) The provider review process may include review of a provider's policies, procedures, and records (including invoices for applicable services) related to provision of services under this Chapter.

~~(c) The provider shall cooperate with the Department and the designated managing entity and provide the requested compliance documentation in the format required by the Department prior to, during and following an audit, provider monitoring or other monitoring method.~~

~~(d) The provider shall cooperate with authorized Federal and State regulatory agencies and provide the requested compliance documentation in the format required by the regulatory agencies.~~

~~(e) The provider shall complete a corrective action plan for a violation or an alleged violation of this chapter in the time frame required by the Department.~~

(c) A provider shall complete a required corrective action plan on a form specified by the Department within 20 days of receipt of a written notice of regulatory non-compliance.

~~(f) The provider shall complete the corrective action plan on a form specified by the Department.~~

~~(g)~~ (d) The Department or the designated managing entity, after and in consultation with the provider, may issue a directed corrective action plan that compels the provider to implement specified course of action to ~~correct~~ address a ~~violation~~ finding of regulatory non-compliance ~~or alleged violation of this chapter.~~ A directed action plan is not considered a routine action and shall be authorized only upon a written justification by the Department or managing entity of the need for the plan. The terms of the plan must demonstrate the need for the directed corrective action(s) and must identify the estimated costs to the provider to implement the plan.

~~(h) The directed corrective action plan in subsection (g) may include the following:~~

~~(1) The acquisition and completion of an educational program, in addition to that required under §§ 6100.141 – 6100.144 (relating to training).~~

~~(2) Technical consultation.~~

~~(3) Monitoring.~~

~~(4) Audit.~~

~~(5) Oversight by an appropriate agency.~~

~~(6) Another appropriate course of action to correct the violation.~~

~~(i) The directed corrective action plan shall be completed by the provider at the provider's expense and is not eligible for reimbursement from the Department.~~

~~(j)~~ (e) ~~The~~ A provider ~~shall~~ must comply with the corrective action plan ~~and~~ or directed corrective action plan as approved by the Department or the designated managing entity.

~~(k)~~ (f) The provider ~~shall keep~~ shall maintain documentation relating to ~~an audit, provider monitoring or other monitoring method, including supporting compliance documents~~ its implementation of a corrective action plan or directed corrective action plan.

§ 6100.43. Regulatory ~~waiver~~ exceptions.

Comment and Suggestion 6100.43:

As a matter of format, this sub-section should appear subsequent to substantive sections from which an exception may be requested, as noted also in the comment under 6100.41. Unnecessary and unduly prescriptive text, as noted, is recommended to be removed. Additional text has been added to promote clarity and reasonableness.

(a) A provider may submit a request for an ~~waiver~~ exception of a section, subsection, paragraph or subparagraph of this chapter~~, except for the following:~~

~~(1) Sections 6100.1—6100.3 (relating to general provisions).~~

~~(2) Sections 6100.41—6100.55 (relating to general requirements).~~

~~(3) Sections 6100.181—6100.186 (relating to individual rights).~~

~~(4) Sections 6100.341—6100.345 (relating to positive intervention).~~

(b) ~~The waiver~~ An exception shall be submitted on a form specified by the Department.

(c) The Department shall respond to a provider request for an exception within 15 calendar days of the receipt of the exception request. If the Department does not respond within 15 calendar days, the exception shall be automatically approved and should be added to the PSP. If

the Department disapproves the exception request, it must provide written explanation for the determination.

~~(e)~~ (d) The Secretary of the Department or the Secretary's designee ~~may~~ shall grant an ~~waiver~~ exception if the following conditions are met:

(1) The individual and individual's PSP team have reviewed and documented the benefits and risks associated with the proposed exception. Benefits that may result from granting the exception may include increased person-centeredness, integration, independence, safety, choice or community opportunities for an individual or a group of individuals.

~~(2) An individual or group of individuals benefit from the granting of the waiver through increased person-centeredness, integration, independence, choice or community opportunities for individuals.~~

~~(3) There is not a violation of the Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable.~~

~~(4) Additional conditions deemed appropriate by the Department.~~

(d e) ~~The Department will specify an effective date and an expiration date for a waiver that is granted.~~ Following approval by the Department, the exception shall automatically renew annually as part of the PSP review and approval process unless circumstances have changed that require modification to or removal of the exception.

~~(e) At least 45 days prior to the submission of a request for a waiver the provider shall provide a written copy of the waiver request to the affected individuals, and to persons designated by the individuals, allowing at least 20 days for review and comment to the provider, the designated managing entity and the Department.~~

~~(f) If the request for a waiver involves the immediate protection of an individual's health and safety, the provider shall provide a written copy of the waiver request to the affected individuals, and to persons designated by the individuals, at least 24 hours prior to the submission of the request for a waiver, allowing at least 20 hours for review and comment to the provider, the designated managing entity and the Department.~~

(g)(f) The provider shall discuss and explain ~~the request for a waiver with the affected individual,~~ the outcome of the request with the affected individual(s). As necessary, modification shall be made to the individuals PSP as a result of the approval of an exception request. ~~and with persons designated by the individuals.~~

~~(h) The request for a waiver submitted to the Department must include copies of comments received by the individuals and by persons designated by the individuals.~~

~~(i) The provider shall notify the affected individuals, and persons designated by the individuals, of the Department's waiver decision.~~

~~(j) The provider shall submit a request for the renewal of a waiver at least 60 days prior to the expiration of the waiver.~~

~~(k) A request for the renewal of a waiver shall follow the procedures in subsections (a)—(j).~~

~~(l) The provider shall notify an individual not previously notified under this section of an existing waiver that affects the individual.~~

§ 6100.44. Innovation project.

Comment and Suggestion 6100.44:

It is recommended that this section also be moved to follow sections that detail day to day program standards. Text has been added to promote clarity, flexibility, individualization, reasonableness and responsiveness.

Section 6100.44 (d) (5) is proposed to be deleted. As written, this subsection affords the Department unfettered discretion essentially to adopt substantive criteria that supersedes criteria that have been subject to public review and the regulatory process. The application of ad hoc and undisclosed additional criteria is inconsistent with the notion of objective review transparency in rulemaking.

(a) A provider may submit a proposal to the Department to ~~demonstrate~~ implement an innovative project ~~on a temporary basis.~~

(b) The innovation project proposal must include the following elements:

(1) A comprehensive description of how the innovation encourages best practice and promotes the mission, vision and values of person-centeredness, integration, independence, choice and community opportunities for individuals and impact on consumers.

~~(2) A description of the positive impact on the quality of life including the impact on individual choice, independence and person-centeredness.~~

~~(3)~~(2) A Comment and Suggestion of alternate health and safety protections, if applicable.

~~(4)~~(3) The number of individuals included in the innovation project.

~~(5)~~(4) The geographic location of the innovation project.

~~(6)~~(5) The proposed beginning and end date for the innovation project.

~~(7)~~(6) The name, title and qualifications of the manager who will oversee and monitor the innovation project.

(~~8~~)(7) A description of the advisory committee ~~who~~ that ~~will advise the innovation project~~ will be involved in designing and evaluating the success of the innovation project.

~~(9) A description of how individuals will be involved in designing and evaluating the success of the innovation project.~~

(~~10~~) (8) The community partners (if any) who will be involved in implementing the innovation project.

(~~11~~) (9) A request for a waiver form as specified in § 6100.43 (relating to regulatory waiver), if applicable.

(~~12~~) (10) Proposed changes to ~~supports~~ services.

(~~13~~) (11) A detailed budget for the innovation project.

(~~14~~) (12) A description of who will have access to information on the innovation project.

(~~15~~) (13) The impact on living wage initiatives for direct support professionals, if applicable.

(c) The innovation project must comply with the Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable.

(d) The Deputy Secretary for the Office of Developmental Programs of the Department will review a proposal for an innovation project in accordance with the following criteria:

(1) The effect on an individual's health, safety and well-being.

(2) The benefit from the innovation project to an individual or group of individuals by providing increased person-centeredness, integration, independence, choice and community opportunities for individuals.

(3) Compliance with the Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable.

(4) The ~~soundness and viability~~ reasonableness of the proposed budget.

~~(5) Additional criteria the Department deems relevant to its review, funding or oversight of the specific innovation project proposal.~~

(e) If the innovation project proposal is approved by the Deputy, the provider shall be subject to the fiscal procedures, reporting, monitoring and oversight ~~as directed by the Department~~ pursuant to this Chapter.

(f) The provider shall submit a comprehensive annual report to the Department~~, to be made available to the public, at the Department's discretion~~.

(g) The annual report must include the following:

(1) The impact on the quality of life outcomes for individuals.

~~(2) Budget.~~

(3) Costs.

(4) Cost benefit analysis.

~~(5) Other relevant data, evaluation and analysis.~~

(h) The Department may expand, renew or continue an innovation project, or a portion of the project, upon request and a determination that the project is compliant with terms of this subsection ~~at its discretion~~.

§ 6100.45. Quality ~~management~~ improvement.

Comment and Suggestion 6100.45:

The purpose of this section is more accurately described as quality "improvement" than quality "management." The proposed redraft reflects statewide provider experience with licensing reviews, HCBS monitoring and best practices. Text has been added and deleted to incorporate those providers' experiences, which will provide clarity and reasonableness within this section.

~~(a) The provider shall develop and implement a quality management plan on a form specified by the Department.~~

~~(b) The provider shall conduct a review of performance data in the following areas to evaluate progress and identify areas for performance improvement:~~

~~(1) Progress in meeting the desired outcomes of the PSP.~~

~~(2) Incident management, to encompass a trend analysis of the incident data including the reporting, investigation, suspected causes and corrective action taken in response to incidents.~~

~~(3) Performance in accordance with 42 CFR 441.302 (relating to state assurances).~~

~~(4) Grievances, to encompass a trend analysis of the grievance data.~~

~~(5) Individual and family satisfaction survey results and informal comments by individuals, families and others.~~

~~(6) An analysis of the successful learning and application of training in relation to established core competencies.~~

~~(7) Staff satisfaction survey results and suggestions for improvement.~~

~~(8) Turnover rates by position and suspected causes.~~

~~(9) Licensing and monitoring reports.~~

~~(c) The quality management plan must identify the plans for systemic improvement and measures to evaluate the success of the plan.~~

~~(d) The provider shall review and document progress on the quality management plan quarterly.~~

~~(e) The provider shall analyze and revise the quality management plan every 2 years~~.

(a) A provider shall adopt and implement an evidenced based, quality improvement strategy that promotes continuous improvement, monitoring, remediation, measurement performance and experience of care. In developing its quality improvement strategy, a provider should take into account the following factors:

(1) The provider's performance data and available reports from the Department's information reporting system.

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

(3) The results of licensing.

(4) Incident management data, including data on incident target(s), repeated or serious incidents, root cause analyses, and quarterly review of incidents.

(5) Feedback from persons receiving services and their families.

(b) The provider shall adopt the following tasks as part of its quality improvement strategy:

(1) Goals that measure individual outcomes, experience, and quality of care associated with the receipt of HCBS and related to the implementation of PSP.

(2) Target objectives that support each identified goal.

(3) Performance measures the provider shall use to evaluate progress.

(4) Identity of the person(s) responsible for the quality improvement strategy and structure that support this implementation.

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

(c) A provider must review progress on the quality improvement strategy and update at least every 2 years.

(d) A provider shall maintain a written copy of the quality improvement strategy to be available for the Department to review as part of provider monitoring.

(e) This section does not apply to a provider of HCBS in the Adult Autism Waiver and an individual provider hired by a participant who is self-directing HCBS through the vendor fiscal/employer agent FMS option (SSW).

Comment and Suggestion 6100.46

It is suggested that (b) take in to account other outcomes of an investigation such as inconclusive or unconfirmed. In addition, the corrective actions, regardless of outcome, are critical in the protection of the individual. A broader range of options is available and appropriate as reflected in our changes to the text.

(c) The list of persons or entities who must report are redundant to 6100.401- 6100.405, Incident Management.

§ 6100.46. Protective services.

(a) Abuse, suspected abuse and alleged abuse of an individual, regardless of the alleged location or alleged perpetrator of the abuse, shall be reported and managed in accordance with the following:

(1) The Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable regulations.

(2) 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law) and applicable regulations.

(3) The Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102) and applicable regulations.

(b) If there is an incident of abuse, suspected abuse or alleged abuse of an individual involving a staff person, consultant, intern or volunteer, the staff person, consultant, intern or volunteer ~~may not have~~ shall have no direct or unsupervised contact with an individual until the ~~abuse~~ investigation is concluded and it has been ~~the investigating agency has~~ confirmed that no abuse occurred, or if abuse has been confirmed or is inconclusive, that appropriate protective correction action measures have been implemented.

(c) In addition to the reporting required under subsection (a), the provider shall immediately report the alleged or suspected abuse~~, suspected abuse or alleged abuse to the following:~~ in accordance with the requirements of 6100.401 – 6100.405 Incident Management of this Chapter.

~~(1) The individual.~~

~~(2) Persons designated by the individual.~~

~~(3) The Department.~~

~~(4) The designated managing entity.~~

~~(5) The county government office responsible for the intellectual disability program.~~

Comment and Suggestion 6100.47

(b) Direct contact is suggested to be moved to a position where it would apply to all of the categories for purpose of clarification.

(c) References two authorities, OAPSA and CPS, but a reference to APS has not been included. It should be included.

§ 6100.47. Criminal history checks.

(a) Criminal history checks shall be completed for the following persons:

(1) Full-time and part-time staff persons in any staff position.

(2) Support coordinators, targeted support managers and base-funding support managers.

(b) Criminal history checks shall be completed for the following persons who provide a ~~support~~ service included in the PSP and who have direct contact with an individual:

(1) Household members ~~who have direct contact with an individual~~.

(2) Life sharers.

(3) Consultants.

(4) Paid or unpaid interns.

(5) Volunteers.

(c) Criminal history checks as specified in subsections (a) and (b) -shall be completed in accordance with the following:

(1) The Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102) and applicable regulations.

(2) 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law) and applicable regulations.

(d) This section does not apply to natural supports.

Comment and Suggestion 6100.48

PAR supports the subsection as written. Except that we note again that APS is not included under subsection (a).

§ 6100.48. Funding, hiring, retention and utilization.

(a) Funding, hiring, retention and utilization of persons who provide reimbursed ~~support~~ service shall be in accordance with the applicable provisions of the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), 6 Pa. Code Chapter 15 (relating to protective services for older adults), 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law) and Chapter 3490 (relating to protective services). This subsection applies to the following:

(1) Household members who have direct contact with an individual.

(2) Full-time and part-time staff persons in any staff position.

(3) Life sharers.

(4) Consultants.

(5) Paid or unpaid interns.

(6) Volunteers.

(7) Support coordinators, targeted support managers and base-funding support coordinators.

(b) Subsection (a) does not apply to natural supports.

§ 6100.49. Child abuse history certification.

A child abuse history certification shall be completed in accordance with 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law) and applicable regulations.

Comment and Suggestion 6100.50

PAR applauds the recognition of the need for clear communications between providers and the individuals they serve. There are significant costs associated with accommodating (a) and (b). These costs are not included within the standard rate setting process and must be paid by the Department separately at the market rate.

§ 6100.50. Communication.

(a) Written, oral and other forms of communication with the individual, and persons designated by the individual, shall occur in a language and means of communication as best and to the extent understood by the individual or a person designated by the individual.

(b) The individual shall hall be provided with the assistive technology necessary to effectively communicate.

Comment and Suggestion 6100.51

The title should specify that this section provides guidance on grievance related to the provision of HCBS services.

PAR suggests that (h) be altered to allow a more reasonable amount of time for the wide variety and complexity of grievances. Subsection (i) should be altered accordingly.

§ 6100.51. Grievances related to the provision of an HCBS service.

(a) The provider shall develop procedures to receive, document and manage grievances.

(b) The provider shall inform the individual, and persons designated by the individual, upon initial entry into the provider's program and annually thereafter of the right to file a grievance and the procedure for filing a grievance.

(c) The provider shall permit and respond to oral and written grievances from any source, including an anonymous source, regarding the delivery of a ~~support~~ service.

(d) The provider shall assure that there is no retaliation or threat of intimidation relating to the filing or investigation of grievances.

(e) If an individual indicates the desire to file a grievance in writing, the provider shall offer and provide assistance to the individual to prepare and submit the written grievance.

(f) The providers shall document and manage grievances, including repeated grievances.

(g) The provider shall document the following information for each grievance, including oral, written and anonymous grievances, from any source:

(1) The name, position, telephone, e-mail address and mailing address of the initiator of the grievance, if known.

(2) The date and time the grievance was received.

(3) The date of the occurrence, if applicable.

(4) The nature of the grievance.

(5) The provider's investigation process and findings relating to the grievance.

(6) The provider's actions to investigate and resolve the grievance, if applicable.

(7) The date the grievance was resolved.

(h) The grievance shall be resolved ~~within 21 days from the date the grievance was received~~ as promptly as possible but in no more than 45 days.

(i) The initiator of the grievance shall be provided a written notice of the resolution or findings within ~~30~~ 60 days from the date the grievance was received.

~~**§ 6100.52. Rights team.**~~

Comment and Suggestion 6100.52:

I am very encouraged by the enhanced focus on individual rights and protections throughout these regulations and in associated licensing regulations. We believe that the values represented in Everyday Lives are the core elements of encouraging increased individual participation in community, and exercising their choice, control, and rights.

This section, however, as written, merely adds an unnecessary bureaucratic layer to providers and families.

The concept of evaluating the potential and actual violation of rights is essential and, in fact, is already appropriately covered in the Incident Management process which includes a thorough investigation by an investigator who has been certified in the Department-approved training. As part of the already well-established and robust Incident Management system, outlined in 6100.401, all allegations of rights violations must be investigated. If a violation of rights is confirmed, the existing process has established corrective action follow-up. I support the clear and currently existing requirements that thoroughly address any rights violations. The proposed additional administrative duties and their associated costs are unnecessary, inefficient and uneconomical. For example, according to the regulations, the "rights team" is to meet every three months, regardless of whether any actual rights violations occurred during

that quarter. It appears to be an arbitrary requirement without any productive purpose.

~~(a) The provider shall have a rights team. The provider may use a county mental health and intellectual disability program rights team that meets the requirements of this section.~~

~~(b) The role of the rights team is to:~~

~~(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified in §§ 6100.181—6100.186 (relating to individual rights).~~

~~(2) Review each use of a restraint as defined in §§ 6100.341—6100.345 (relating to positive intervention) to:~~

~~(i) Analyze systemic concerns.~~

~~(ii) Design positive supports as an alternative to the use of a restraint.~~

~~(iii) Discover and resolve the reason for an individual's behavior.~~

~~(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate appointed by the designated managing entity if the individual is unable to speak for himself, the individual's support coordinator or targeted support manager, a representative from the designated managing entity and a provider representative.~~

~~(d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.~~

~~(e) If a restraint was used, the individual's health care practitioner shall be consulted.~~

~~(f) The rights team shall meet at least once every 3 months.~~

~~(g) The rights team shall report its recommendations to the affected PSP team.~~

~~(h) The provider shall document the rights team meetings and the decisions made at the meetings.~~

Comment and Suggestion 6100.53:

PAR supports this section as written with the changes below for purpose of clarity.

§ 6100.53. Conflict of interest.

(a) The provider shall develop and comply with a conflict of interest policy that is reviewed and approved by the provider's full governing board.

~~(b) The provider shall comply with the provider's conflict of interest policy.~~

(c) (b) An individual or a friend or family member of an individual may serve on the governing board but are to recuse themselves from decisions where they may have a conflict of interest.

Comment and Suggestion 6100.54:

The added text clarifies the stated intent of the proposed regulation. Electronic methods of format should be considered acceptable for maintaining records. Subsection (d) has been made consistent with (c)(1).

§ 6100.54. ~~Recordkeeping~~ Maintenance of records.

(a) ~~The~~ A provider ~~shall~~ may ~~keep~~ maintain individuals' records in an electronic format, including the records of individuals. Individuals' records shall be maintained in confidence.

(b) The provider may not make an individual's records accessible to anyone other than the Department, the designated managing entity, and the support coordinator, targeted support manager or base-funded support coordinator without the written consent of the individual, or persons designated by the individual.

(c) Records, documents, information and financial books ~~as~~ required to be preserved under this chapter shall be ~~kept~~ maintained by the provider in accordance with the following:

(1) For at least 4 years from the Commonwealth's fiscal year-end or 4 years from the provider's fiscal year-end, whichever is later.

(2) Until any pending audit or litigation involving such records, documents, or information (financial or otherwise) is completed ~~is resolved~~.

(3) In accordance with applicable Federal and State statutes and regulations.

(d) If a program is completely or partially terminated, the records relating to the terminated program shall be kept for at least ~~5~~ 4 years from the date of termination.

~~§ 6100.55. Reserved capacity.~~

Comment and Suggestion 6100.55

This proposed regulation must be rewritten to incorporate the Department's proposed timelines to be included in its waivers regarding an individual's right to return to a residential

habilitation. Correspondingly, the Department must propose a regulation that details how the provider will be paid for days when an individual is absent from service at the location due to hospitalization or therapeutic leave.

~~An individual has the right to return to the individual's residential habilitation location following hospital or therapeutic leave in accordance with reserved capacity timelines specified in the Department's Federally-approved waivers and waiver amendments.~~

ENROLLMENT

§ 6100.81. HCBS provider requirements.

Comment and Suggestion 6100.81

Proposed regulatory text was deleted and new text is proposed for purposes of clarity, reasonableness and fairness.

~~(a) The provider shall be qualified by the Department for each HCBS the provider intends to provide, prior to providing the HCBS.~~

(a) New HCBS providers must complete and submit the following completed documents and verifications to the Department prior to providing HCBS:

(1) A provider enrollment application, on a form specified by the Department.

(2) A medical assistance provider agreement, on a form specified by the Department.

(3) A home and community-based waiver provider agreement, on a form specified by the Department.

(4) Verification of compliance with § 6100.81(2) (relating to pre-enrollment provider qualifications).

(5) Verification of compliance with § 6100.476 (related to criminal history background checks).

(6) Documents required in accordance with the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

(7) Verification of successful completion of the Department's pre-enrollment provider training as specified in § 6100.142 (related to pre-enrollment training).

(8) Monitoring documentation.

~~(b) Prior to enrolling as a provider of HCBS, and on an ongoing basis following provider enrollment, the applicant or provider shall comply with the following:~~

(b) Enrolled HCBS providers must maintain:

~~(1) Chapter 1101 (relating to general provisions).~~

~~(2) The Department's monitoring documentation requirements as specified in § 6100.42 (relating to monitoring compliance).~~

~~(3) The Department's pre-enrollment provider training.~~

~~(4) Applicable licensure regulations, including Chapters 2380, 2390, 3800, 5310, 6400, 6500 and 6600, Department of Health licensure regulations in 28 Pa. Code Chapters 51, 601 and 611 (relating to general information; home health care agencies; and home care agencies and home care registries) and any other applicable licensure regulations.~~

(1) Copies of current licenses, as applicable and as specified in § 6100.81(2) (relating to provider qualifications).

(2) Verification of compliance with § 6100.46 (related to criminal history background checks).

(c) The Department shall timely review and shall approve completed applications to provide HCBS.

~~(c) Evidence of compliance with applicable licensure regulations in subsection (b)(4) is the possession of a valid regular license issued by the Department or the Department of Health.~~

~~(1) If the applicant possesses a provisional license for the specific HCBS for which the applicant is applying, the applicant is prohibited from enrolling in the HCBS program for that specific HCBS.~~

~~(2) This subsection does not prohibit a provider that possesses a provisional license from continuing participation in the HCBS program once a provider is enrolled.~~

~~(d) An applicant may not be enrolled as a provider of HCBS if the Department issued a sanction in accordance with §§ 6100.741—6100.744 (relating to enforcement).~~

~~§ 6100.82. HCBS documentation.~~

Comment and Suggestion 6100.82: The core aspects of this section can be easily consolidated into section 6100.81. It is recommended that this section be deleted and core aspects be streamlined and combined in to 6100.81 as noted above.

~~An applicant who wishes to operate an HCBS in accordance with this chapter shall complete and submit the following completed documents to the Department:~~

~~(1) A provider enrollment application on a form specified by the Department.~~

~~(2) An HCBS waiver provider agreement on a form specified by the Department.~~

~~(3) Copies of current licenses as specified in § 6100.81(b)(4) (relating to HCBS provider requirements).~~

~~(4) Verification of compliance with § 6100.47 (relating to criminal history checks).~~

~~(5) Verification of completion of the Department's monitoring documentation.~~

~~(6) Verification of completion of the Department's pre-enrollment provider training.~~

~~(7) Documents required in accordance with the Patient Protection and Affordable Care Act (Pub.L. No. 111-148).~~

§ 6100.83. Submission of HCBS qualification documentation.

The provider of HCBS shall submit written qualification documentation to the designated managing entity or to the Department at least 60 days prior to the expiration of its current qualification.

§ 6100.84. Provision, update and verification of information.

The provider of HCBS shall provide, update and verify information within the Department's system as part of the initial and ongoing qualification processes.

§ 6100.85. Ongoing HCBS provider qualifications.

Comment and Suggestion 6100.85:

Suggested text is added to 6100.85 to assure consistency with state law regarding the applicability and enforcement of Department policy and procedures through the adoption of regulations. Mandates that are expressed in the form of duties and obligations must be adopted in accordance with the Commonwealth's rulemaking process.

Consistent with the 5-year waiver renewal, subsection (b) is suggested to require 5-year provider qualification.

(a) ~~The~~ A provider shall comply with the ~~Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable~~ provisions of applicable HCBS waivers, State Plan and amendments thereto, as the provisions of those waivers and the state plan are reflected in duly promulgated state regulations.

(b) The provider's qualifications to continue providing HCBS will be verified ~~at intervals specified in the Federally-approved waiver, including applicable Federally-approved waiver amendments, or the State plan, as applicable~~ every 5 years.

~~(c) The Department may require a provider's qualifications to be verified for continued eligibility at an interval more frequent than the Federally-approved waiver, including applicable Federally-approved waiver amendments, or the Medical Assistance State plan, due to one of the following:~~

~~(1) Noncompliance with this chapter as determined by monitoring as specified in § 6100.42 (relating to monitoring compliance).~~

~~(2) Noncompliance with a corrective action plan, or a directed correction action plan, as issued or approved by the designated managing entity or the Department.~~

~~(3) The issuance of a provisional license by the Department.~~

~~(4) Improper enrollment in the HCBS program.~~

(~~d~~)(c) ~~Neither a provider nor its staff persons who may come into contact with an individual may be listed on the Federal or State lists of excludable persons such as the following:~~ Providers may not employ, contract with or be governed by a person or persons listed on the Federal or Commonwealth current applicable lists of persons excluded from participation in the Medicare and Medicaid programs.

~~(1) System for award management.~~

~~(2) List of excludable persons, individuals and entities.~~

~~(3) Medicheck list.~~

§ 6100.86. Delivery of HCBS.

Comment and Suggestion 6100.86

This regulation is unnecessary. Its terms are otherwise included in other sections of this chapter. If the Department, however, determines to maintain this regulation, it must be redrafted as suggested below.

(a) The provider shall deliver only the HCBS for which the provider is determined to be qualified by ~~the designated managing entity or~~ the Department.

(b) The provider shall deliver the HCBS in accordance with this Chapter. ~~the Federally-approved waiver, including applicable Federally-approved waiver amendments, and the Medical Assistance State plan, as applicable~~.

(c) ~~The provider shall deliver only the HCBS to an individual who is authorized to receive that HCBS.~~ A provider shall only be reimbursed for the delivery of HCBS to an individual who is authorized to receive that HCBS.

(d) The provider shall deliver the HCBS in accordance with the individual's PSP.

TRAINING

§ 6100.141. Annual training plan.

Comment and Suggestion 6100.141: The purpose and intent of a training plan is to address the needs of the clients or the organization. The training plan must be created based on an assessment that is, by definition, unique to the individual. As provider organizations analyze the needs of the people they support, the knowledge created in the field and their assessment of performance, a flexible, customized, quality focused plan will emerge. As proposed, the regulation is overly prescriptive. This new section collapses the critical elements of section 141 and 143 into one streamlined and accountable set of standards that maintain the basics, and account for changing best practices.

Interns and volunteers should not be included as required to go through the training process (originally in 6100.143 (b)(3)). The interns and volunteers are time limited, and, additionally, the information they need should already be included in the orientation. Requiring the same training plan for these positions as paid/contracted persons is not only costly to the provider but would prevent many otherwise engaged people from volunteering. Removing them from the required personnel list will cut down the training cost.

This section, as it relates to Chapter 6500, creates significant disincentives for contracted and potential lifesharers as it implicates IRS and Department of Labor requirements regarding independent contractor status.

Collapse 6100.141 and 6100.143 into one section.

(a) ~~The provider shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, the provider's quality management plan and other data and analysis indicating training needs.~~ The provider shall design an annual training plan based on the needs specified in the individual's PSP and the provider's quality improvement strategy.

(b) The annual training plan ~~must~~ shall include the provider's orientation program as specified in § 6100.142 (relating to orientation program).

(c) The annual training plan ~~must~~ shall include training ~~aimed at~~ intended to improv~~inge~~ the knowledge, skills and core competencies of the staff persons and others to be trained.

(d) ~~The annual training plan must include the following:~~ The plan shall address the need for training in such matters as rights, facilitating community integration, honoring individual choice and supporting individuals to maintain relationships.

~~(1) The title of the position to be trained.~~

~~(2) The required training courses, including training course hours, for each position.~~

~~(e) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending, shall be kept.~~

~~(f) The provider shall keep a training record for each person trained.~~

(e) The plan will train staff about their responsibilities regarding the promotion of individual rights and the reporting of suspected rights violations, abuse or neglect in accordance with the regulations that define those rights and responsibilities.

(f) The plan will train staff about the safe and appropriate use of positive interventions, including the training in the plans which are unique for any one person served.

(g) The plan shall include paid staff with client contact.

(h) The annual training plan shall include the following:

(1) the title of the position to be trained.

(2) the required training courses including the training course hours for each position.

(i) Records of orientation and training including the training source, content, dates, length of training, copies of certificate receive and persons attending shall be maintained.

(j) The provider shall maintain a training record for each person trained

§ 6100.142. Orientation program.

Comment and Suggestion 6100.142

As written, the regulation mandates training persons who will rarely or never be involved in direct service. It adds unnecessary cost and misuses resources. The proposed edits reduce the need for unnecessary training and related costs.

This section pertains to licensed providers. Accordingly, references to AWC (agency with

choice), OHCDS should be deleted. Payment rates must account for the significant additional costs that will be incurred by unlicensed providers and transportation trip providers to comply with this section. This list is not inclusive and presumes that transportation mile individuals (OHCDS/AWC) who are reimbursed but not household members do not require training. Also, the inclusion of volunteers and management staff is problematic for unlicensed providers, transportation trip, AWC and OHCDS providers. The Department must reconsider this section as it relates to all services, provider types and service delivery models.

For example, requiring clinicians, insofar as they are classified as consultants, to undergo the training in (b) has been identified by experts in the ID/A field as a barrier to receiving the supports and services of those clinicians. Other fields do not require clinicians to undergo this type of training. Requiring them to undergo this training is neither practical nor necessary and would incur significant additional cost.

(a) Program and direct support professional staff, prior to working alone with individuals, and within 30 days after hire ~~or starting to provide support to an individual, the following~~ shall complete the orientation program as described in subsection (b)~~:~~

~~(1) Management, program, administrative and fiscal staff persons.~~

~~(2) Dietary, housekeeping, maintenance and ancillary staff persons.~~

~~(3) Direct support staff persons, including full-time and part-time staff persons.~~

~~(4) Household members who will provide a reimbursed support to the individual.~~

~~(5) Life sharers.~~

~~(6) Volunteers who will work alone with individuals.~~

~~(7) Paid and unpaid interns who will work alone with individuals.~~

~~(8) Consultants who will work alone with individuals.~~

(b) The orientation program ~~must~~ shall encompass the following areas:

~~(1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.~~

~~(2)~~(1) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), 6 Pa. Code Chapter 15 (relating to protective services for older adults), 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

~~(3)~~ (2) Individual rights.

~~(4)~~ (3) Recognizing and reporting incidents.

~~(5) Job-related knowledge and skills.~~

(c) Records of orientation training, including the training source, content, dates, length of training, copies of certificates received and persons attending shall be maintained for each person trained.

~~§ 6100.143. Annual training.~~

Comment and Suggestion 6100.143: I recommend that AWC and OHCDS be removed from the regulations and that Transportation Trip and Unlicensed home and community based providers be excluded from 6100.143 as written. Training list pertains to licensed providers and impedes the promotion of family support models of service delivery. A prescribed number of hours for training will not support appropriate training specific for the individual and does not afford the opportunity for families/participants and the unlicensed providers and Transportation trip providers that support them with the type and frequency of training that is needed for the individual. When there are established mandates to hours versus individuality, the service quality and the opportunity to support the values of ODP and Everyday Lives is lost. Also, the current unit rates will not support the increase in training requirements. Optimally, AWC and OHCDS providers will be removed from 6100 regulations and unlicensed providers and transportation trip providers should have separate training requirements that do not include a specific number of hours.

Content from this section should be incorporated into 6100.141 as noted in the prior comment.

~~(a) The following persons shall complete 24 hours of training each year:~~

~~(1) Direct support staff persons, including household members and life sharers who provide a reimbursed support to the individual.~~

~~(2) Direct supervisors of direct support staff persons.~~

~~(b) The following staff persons and others shall complete 12 hours of training each year:~~

~~(1) Management, program, administrative, fiscal, dietary, housekeeping, maintenance and ancillary staff persons.~~

~~(2) Consultants who provide reimbursed supports to an individual and who work alone with individuals.~~

~~(3) Volunteers who provide reimbursed supports to an individual and who work alone with individuals.~~

~~(4) Paid and unpaid interns who provide reimbursed supports to an individual and who work alone with individuals.~~

~~(c) A minimum of 8 hours of the annual training hours specified in subsections (a) and (b) must encompass the following areas:~~

~~(1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.~~

~~(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), 6 Pa. Code Chapter 15 (relating to protective services for older adults), 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.~~

~~(3) Individual rights.~~

~~(4) Recognizing and reporting incidents.~~

~~(5) The safe and appropriate use of positive interventions if the person will provide a support to an individual with a dangerous behavior.~~

~~(d) The balance of the annual training hours must be in areas identified by the provider in the provider's annual training plan in § 6100.141 (relating to annual training plan).~~

~~(e) All training, including the training courses identified in subsections (c) and (d), must be included in the provider's annual training plan.~~

§ 6100.144. Natural supports.

Sections 6100.141—6100.143 (relating to annual training plan; orientation program; and annual training) do not apply to natural supports.

INDIVIDUAL RIGHTS

§ 6100.181. Exercise of rights.

Comment and Suggestion 6100.181

Suggested text is added for clarity. Deleted text appears redundant or otherwise unnecessary.

(a) An individual may not be deprived of rights as provided under §§ 6100.182 and 6100.183 (relating to rights of the individual; and additional rights of the individual in a residential

facility) except if modifications to rights are necessary to mitigate risk, the modifications will be determined by the PSP Team and represented in the PSP.

(b) ~~An individual shall be continually supported to exercise the individual's rights.~~ An individual shall be provided services and accommodations to assist the individual to understand and to actively exercise rights as he/she chooses. The services and accommodations necessary for the individual to understand and actively exercise rights as he/she chooses shall be funded by the Department as part of the PSP.

~~(c) An individual shall be provided the support and accommodation necessary to be able to understand and actively exercise the individual's rights.~~

(~~d~~)(c) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.

(e)(d) A court's written order that restricts an individual's rights shall be followed.

(f)(e) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with a court order.

(g)(f) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in decision making in accordance with the court order.

(~~h~~)(g) An individual has the right to designate persons to assist in decision making on behalf of the individual.

§ 6100.182. Rights of the individual.

Comment and Suggestion 6100.182:

Suggested edits reflect the recommendations of qualified intellectual disability professionals and families.

(a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

(b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely, and practice the religion of his/her choice or to practice no religion.

(c) ~~An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.~~ An individual has the right to be free from abuse, neglect, mistreatment, exploitation, abandonment or be subjected to corporal punishment.

(d) An individual shall be treated with dignity and respect.

(e) ~~An individual has the right to make choices and accept risks.~~ An individual has the right to make informed choices and accept personal risks that do not pose a threat to the individual's and/or another person's health, safety, or well-being.

(f) An individual has the right to refuse to participate in activities and ~~supports~~ services.

(g) An individual has the right to control ~~the~~ his/her ~~individual's~~ own schedule and activities in accordance to their PSP.

~~(h) An individual has the right to privacy of person and possessions.~~

~~(i) An individual has the right of access to and security of the individual's possessions.~~

(~~j~~)(h) An individual has the right to choose a willing and qualified provider.

~~(k) An individual has the right to choose where, when and how to receive needed supports.~~

~~(l) An individual has the right to voice concerns about the supports the individual receives.~~

~~(m)~~ (i) An individual has the right to assistive devices and support to enable communication ~~at all times~~.

(~~n~~) (j) An individual has the right to participate in the development and implementation of the PSP.

§ 6100.183. Additional rights of the individual in a residential facility.

Consistent with an individual's PSP, individuals have the following additional rights:

(a) An individual has the right to receive scheduled and unscheduled visitors, and to communicate and meet privately with persons of the individual's choice, at any time.

(b) An individual has the right to unrestricted access to send and receive mail and other forms of communications, unopened and unread by others.

(c) An individual has the right to unrestricted and private access to telecommunications.

(d) An individual has the right to manage and access the individual's own finances.

(e) An individual has the right to choose persons with whom to share a bedroom.

(f) An individual has the right to furnish and decorate the individual's bedroom and the common areas of the home in accordance with §§ 6100.184 and 6100.444(b) (relating to negotiation of choices; and lease or ownership).

(g) An individual has the right to lock the individual's bedroom door.

(h) An individual has the right to access food at any time.

(i) An individual has the right to make informed health care decisions.

6100.184. Negotiation of choices.

Comment and Suggestion 6100.184:

I support this section as written.

(a) An individual's rights shall be exercised so that another individual's rights are not violated.

(b) Choices shall be negotiated by the affected individuals in accordance with the provider's procedures for the individuals to resolve differences and make choices.

§ 6100.185. Informing of rights.

(a) The provider shall inform and explain individual rights to the individual, and persons designated by the individual, upon entry into the program and annually thereafter.

(b) The provider shall keep a statement signed by the individual, or the individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

§ 6100.186. Role of family and friends.

Comment and Suggestion 6100.186: Suggested text is intended to clarify providers' responsibilities in balancing individuals' interests and decision making.

The nature and extent of family involvement is determined at the PSP planning meeting.

(a) The provider shall facilitate and make the accommodations necessary to support an individual's visits with family, friends and others, at the direction of the individual.

(b) The provider shall take reasonable steps to facilitate appropriate involvement and encourage participation of an individual's ~~and make the accommodations necessary to involve the individual's~~ family~~,~~ and friends and others in decision making, planning and other activities~~, at the direction of the individual~~.

PERSON-CENTERED SUPPORT PLAN

§ 6100.221. Development and revisions of the PSP.

Comment and Suggestion 6100.221:

I am pleased to see the inclusion of an expectation that there is one plan for the individual as

included in 6100.221(a) and supports this provision.

New text is proposed to add clarity.

6100.221 (d) has been changed to be consistent with the language in the corresponding licensing chapters and to allow the PSP team sufficient time to develop a comprehensive PSP and not to delay individuals' receipt of services.

Suggest that 6100.221(g) be deleted as redundant after the proposed changes.

(a) An individual shall have one approved and authorized PSP that identifies the need for ~~supports~~ services, the ~~supports~~ services to be provided and the expected outcomes. The PSP is intended to ensure that services are delivered in a manner reflecting individual preferences consistent with an individual's health, safety, well-being and personal preferences as agreed upon by the PSP team so as to promote individuals' opportunities in accordance with "Everyday Lives: Values in Action" (2016 edition).

(b) An individual's service implementation plan must be consistent with the PSP in subsection (a).

(c) The support coordinator or targeted support manager shall be responsible for the development of the PSP, including revisions, in ~~cooperation~~ collaboration with the individual and the individual's PSP team.

(d) The initial PSP shall be developed ~~prior to the individual~~ within 60 days of completion of the individual's assessment ~~receiving a reimbursed support~~.

(e) The PSP shall be revised when an individual's needs or support system changes and upon the request of an individual or the individual's family.

(f) ~~The initial PSP and PSP revisions must be based upon a current assessment.~~ The PSP and PSP revisions will be developed with a current valid assessment and the input of the individual and the PSP team.

~~(g) The individual and persons designated by the individual shall be involved in and supported in the initial development and revisions of the PSP.~~

(~~h~~) (g) The initial PSP and PSP revisions shall be documented on a form specified by the Department.

~~§ 6100.222. The PSP process.~~

Comment and Suggestion 6100.222:

Essential content has been incorporated into 6100.221

~~(a) The PSP process shall be directed by the individual.~~

~~(b) The PSP process shall:~~

~~(1) Invite and include persons designated by the individual.~~

~~(2) Provide accommodation and facilitation to enable the individual's family, friends and others to attend the PSP meeting, at the direction of the individual.~~

~~(3) Be conducted to reflect what is important to the individual to ensure that supports are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.~~

~~(4) Provide necessary information and support to ensure that the individual directs the PSP process to the maximum extent possible.~~

~~(5) Enable the individual to make informed choices and decisions.~~

~~(6) Be timely in relation to the needs of the individual and occur at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.~~

~~(7) Be communicated in clear and understandable language.~~

~~(8) Reflect cultural considerations of the individual.~~

~~(9) Specify and follow guidelines for solving disagreements among the PSP team members.~~

~~(10) Establish a method for the individual to request updates to the PSP.~~

~~(11) Record the alternative supports that were considered by the individual.~~

§ 6100.223. Content of the PSP.

Comment and Suggestion 6100.223

Text is proposed or deleted to reflect input of industry professionals and to enhance clarity and avoid confusion.

The PSP must include the following elements:

(1) The individual's strengths, preferences and functional abilities.

(2) The individual's assessed diagnoses, clinical and support needs.

(3) The individual's goals and preferences such as those related to relationships, community participation, employment, income and savings, health care, wellness and education.

(4) Individually identified, person-centered desired outcomes.

(5) ~~Supports~~ Services necessary to assist the individual to achieve desired outcomes.

(6) The provider of the support.

(7) Natural supports.

(8) The type, amount of units, duration and frequency for the support specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team and provide sufficient flexibility to provide choice by the individual.

(9) The individual's communication mode, abilities and needs.

~~(10) Opportunities for new or continued community participation.~~

~~(11)~~ (10) Active pursuit of competitive, integrated employment as a first priority, before other activities or supports are considered, as applicable.

~~(12) Education and learning history and goals.~~

~~(13)~~ (11) The level of needed support, risk factors, dangerous behaviors and risk mitigation strategies, if applicable.

~~(14)~~ (12) Modification of individual rights as necessary to mitigate risks, if applicable. The PSP as approved by the PSP team is presumed to be consistent with an individual's rights and is the governing document for rights purposes.

~~(15)~~ (13) Health care information, including a health care history.

~~(16) The individual's choice of the provider and setting in which to receive supports.~~

~~(17) Excluded, unnecessary or inappropriate supports.~~

~~(18)~~ (14) Financial information, including how the individual ~~chooses~~ may choose to use personal funds based on history and communicated interest.

~~(19)~~ (15) ~~A back-up~~ An alternative plan to identify a needed support as identified by the PSP team if the absence of the designated support person would place the individual at a health and safety risk.

~~(20)~~ (16) The person or entity responsible for monitoring the implementation of the PSP.

~~(21)~~ (17) Signatures of the PSP team members and the date signed.

(18) If the individual has a known behavioral support need, it must be identified in the PSP, or if a new behavior is identified, it must be added to the PSP.

(19) The individual's participation in community employment and other integrated services will be based on the PSP process.

§ 6100.224. Implementation of the PSP.

Comment and Suggestion 6100.224:
Text has been revised to clarify responsibility regarding implementation of the PSP.

The PSP should identify any providers who have agreed to implement the plan (including any revisions). The provider(s) identified in the PSP shall implement the PSP~~, including revisions~~.

§ 6100.225. Support coordination and TSM.

(a) A support coordinator or targeted support manager shall assure the completion of the following activities when developing an initial PSP and the annual review of the PSP:

(1) Coordination of information gathering and assessment activity, which includes the results from assessments prior to the initial and annual PSP meeting.

(2) Collaboration with the individual and persons designated by the individual to coordinate a date, time and location for initial and annual PSP meetings.

(3) Distribution of invitations to PSP team members.

(4) Facilitation of the PSP meeting, or the provision of support for an individual who chooses to facilitate his own meeting.

(5) Documentation of agreement with the PSP from the individual, persons designated by the individual and other team members.

(6) Documentation and submission of the PSP reviews, and revisions to the PSP, to the Department and the designated managing entity for approval and authorization.

(7) If the PSP is returned for revision, resubmission of the amended PSP for approval and authorization.

(8) Distribution of the PSP to the PSP team members who do not have access to the Department's information management system.

(9) Revision of the PSP when there is a change in an individual's needs.

(b) A support coordinator or targeted support manager shall monitor the implementation of the PSP, as well as the health, safety and well-being of the individual, using the Department's monitoring tool.

§ 6100.226. Documentation ~~of~~ for support delivery.

Comment and Suggestion 6100.226:

Subsections (c) and (e) should be deleted regarding documentation every time a service is rendered, as they are overly prescriptive and simply paraphrase the provisions of Chapter 51.16 (d) (1) – (7). The Department recognizes that it is inappropriate to require such documentation each time a service is provided, rather than on a monthly basis.

Subsection (f) is suggested to be deleted as it is an unnecessary task and is overly prescriptive.

Suggest replacing "for" with "of" in 6100.226 to more clearly state that a service must be documented for billing purposes.

(a) Documentation ~~of~~ for ~~support~~ service delivery related to the individual shall be prepared by the provider for the purposes of substantiating a claim.

(b) Documentation ~~of~~ for ~~support~~ service delivery must relate to the implementation of the PSP rather than the individual's service implementation plan as specified in § 6100.221(b) (relating to development of the PSP).

~~(c) The provider shall document support delivery each time a support is delivered.~~

(~~d~~) (c) Documentation ~~of~~ for ~~support~~ service delivery may be made on the same form if multiple ~~supports~~ services are provided to the same individual, by the same provider and at the same location.

~~(e) Documentation of support delivery must include the following:~~

~~(1) The name of the individual.~~

~~(2) The name of the provider.~~

~~(3) The date, name, title and signature of the person completing the documentation.~~

~~(4) A summary documenting what support was delivered, who delivered the support, when the support was delivered and where the support was delivered.~~

~~(5) The amount, frequency and duration of the support as specified in the PSP.~~

~~(6) The outcome of the support delivery.~~

~~(7) A record of the time worked, or the time that a support was delivered, to support the claim.~~

~~(f) The provider, in cooperation with the support coordinator or the targeted support manager and the individual, shall complete a review of the documentation of support delivery for each individual, every 3 months, and document the progress made to achieving the desired outcome of the supports provided.~~

~~(g)~~ (d) The provider shall ~~keep~~ maintain documentation of support delivery.

EMPLOYMENT, EDUCATION AND COMMUNITY PARTICIPATION

§ 6100.261. Access to the community.

Comment and Suggestion 6100.261: The individual must have access to the community; this is not only a right that must be supported but a requirement of the Community Rule. I fully support this initiative. To enable successful and complete access requires essential policy and financial support from the Commonwealth.

6100.261(b) includes the term "ongoing" as it relates to opportunities for access to community. This is a subjective term which is not measurable and must be removed.

(a) ~~The provider shall provide the individual with the support necessary to access the community in accordance with the individual's PSP.~~ The Department shall ensure the availability of necessary and essential funding to support access by individuals to their communities in accordance with their PSPs.

(b) ~~The individual shall be provided ongoing opportunities and support necessary to participate in community activities of the individual's choice.~~ An individual shall be afforded the same degree of community access and choice to participate in community activities as an individual who is similarly situated in the community, who does not have a disability and who does not receive an HCBS. A provider shall assist the individual in accessing opportunities to participate his/her community consistent with (a) above.

~~(c) The individual shall be afforded the same degree of community access and choice as an individual who is similarly situated in the community, who does not have a disability and who does not receive an HCBS.~~

§ 6100.262. Employment Supports and Opportunities.

Comment and Suggestion 6100.262:

Revised text is suggested for clarity and reasonableness.

(d) Is suggested to be deleted and added to 6100.263

(a) ~~The individual shall have active and ongoing opportunities and the supports necessary to seek and retain employment and work in competitive, integrated settings.~~ The Department shall assure that the SC or TSM have the technical resources to assist individuals who want to seek and retain employment in competitive, integrated settings though the provision of information and education about employment opportunities, including the availability of OVR services.

(b) Authorization for a new prevocational support for an individual who is under 25 years of age shall be permitted only after a referral is made to the OVR and the OVR either determines that the individual is ineligible or closes the case.

(c) ~~At the annual PSP revision, the individual~~ Eligible individuals shall be offered appropriate opportunities related to the individual's skills and interests, and encouraged to seek competitive, integrated employment, at each annual PSP review.

~~(d) The support coordinator or targeted support manager shall provide education and information to the individual about competitive, integrated employment and the OVR services.~~

§ 6100.263. Education.

If identified in the individual's PSP as necessary to support the individual's pursuit of a competitive, integrated employment outcome or identified in the individual's PSP for employment approved by the OVR, an individual shall have access to a full range of options that support participation in the following post-secondary education and the SC shall assist the individual to obtain the funding source for such options:

(1) Technical education.

(2) College and university programs.

(3) Lifelong learning.

(4) Career development.

TRANSITION OF SERVICES

Comment and Suggestion: This term can refer to a number of different forms of transition, and so might be confused with transition services between education and adult services. To clarify, the word "of services" should be added to the title and to 6100.301 (a).

§ 6100.301. Individual choice.

(a) Influence may not be exerted by a provider when the individual is considering a transition of services to a new provider.

(b) An individual shall be supported by the support coordinator or the targeted support manager in exercising choice in transitioning to a new provider.

(c) An individual's choice to transition to a new provider shall be accomplished in the time frame desired by the individual, to the extent possible and in accordance with this chapter.

§ 6100.302. Transition to a new provider.

Comment and Suggestion 6100.302: It is suggested that §§ 6100.306 and 6100.307 be incorporated into 6100.302 for clarity.

An individual should be provided a copy of their medical information if they move to an independent setting.

(a) When an individual transitions to a new provider, the current provider and new provider shall cooperate with the Department, the designated managing entity and the support coordinator or the targeted support manager during the transition between providers.

~~(b) The current provider shall:~~

~~(1) Participate in transition planning to aid in the successful transition to the new provider.~~

~~(2) Arrange for transportation of the individual to visit the new provider, if transportation is included in the support.~~

~~(3) Close pending incidents in the Department's information management system.~~

(b) The SC or TSM shall assist in coordination of the transition planning activities during the transition period.

(c) The current provider shall: Participate in transition planning to aid in the successful transition to the new provider.

(1) Arrange for transportation of the individual to visit the new provider, if transportation is included in the support.

(2) Close pending incidents in the Department's information management system.

(d) The previous provider shall:

(1) transfer copies of individual records to the new provider prior to the date of transfer.

(2) maintain a copy of the individual records in accordance with § 6100.52 concerning records.

§ 6100.303. Reasons for a transfer or a change in a provider.

Comment and Suggestion 6100.303:

As drafted, this section does not reflect common experiences of providers. Providers work with individuals and their families to develop and maintain services in accordance with each individual's PSP as the individual's needs change and preferences change. When the provider believes it cannot meet the individuals' needs or expectations the provider notifies ODP to assist in transitioning the individual to another provider or program. The provider should not be responsible for finding another program and continuing service when it has notified the individual, SC, and the Department that it is no longer able to serve that individual. It is the Department's responsibility to provide individuals with access to services and to find appropriate and willing provider. Text is suggested to clarify responsibilities and outcomes.

(a) The following are the only grounds for a change in a provider or a transfer of an individual against the individual's wishes:

(1) The individual is a danger to ~~the individual's self~~ himself/herself or others, at the particular support location, even with the provision of supplemental supports.

(2) The individual's needs have changed, advanced or declined so that the individual's needs cannot be met by the provider, even with the provision of supplemental supports and/or additional funding.

(3) Meeting the individual's needs would require a significant alteration of the provider's program or building or additional funding.

(4) Circumstances outside of the provider's control that create an undue burden, safety risk, irreconcilable rights violation or inability to effectively provide the HCBS as necessary in the PSP, or based on changing needs that cannot be accommodated by the provider.

(b) ~~The~~ A provider may not change a support provider or transfer an individual against ~~the individual's~~ his/her wishes in response to an individual's exercise of rights, voicing choices or concerns or in retaliation to filing a grievance.

§ 6100.304. Written notice.

Comment and Suggestion 6100.304:

Text is proposed to provide clarity and consistency.

(a) If the individual chooses another provider, the PSP team shall provide written notice to the provider, the individual, the individual's guardian(s), the individual's family, the PSP team members, the designated managing entity and the SC or TSM ~~following~~ at least 30 days prior to the transition to a new provider. The transition of service providers may be sooner than 30 days, if agreed upon by both parties.

~~(1) The provider.~~

~~(2) The individual.~~

~~(3) Persons designated by the individual.~~

~~(4) The PSP team members.~~

~~(5) The designated managing entity.~~

~~(6) The support coordinator or targeted support manager.~~

(b) ~~If the provider is no longer able or willing to provide a support for an individual in accordance with § 6100.303 (relating to reasons for a transfer or a change in a provider), the provider shall provide written notice to the following at least 45 days prior to the date of the proposed change in support provider or transfer:~~ For service providers such as transportation, homemaker and vendor services, a PSP Team meeting may not be necessary. The SC shall assist the individual to make such changes in those circumstances.

~~(1) The individual.~~

~~(2) Persons designated by the individual.~~

~~(3) The PSP team members.~~

~~(4) The designated managing entity.~~

~~(5) The support coordinator or targeted support manager.~~

~~(6) The Department.~~

~~(c) The provider's written notice specified in subsection (b) must include the following:~~

~~(1) The individual's name and master client index number.~~

~~(2) The current provider's name, address and master provider index number.~~

~~(3) The support that the provider is unable or unwilling to provide or for which the individual chooses another provider~~.

(c) If a provider is no longer able or willing to provide a support(s)for an individual in accordance with the provisions specified in § 6100.303 (relating to reasons for a change in a provider or a transfer), the provider shall provide written notice to the individual, guardian(s), the individual's family, the PSP team members, the designated managing entity, the SC or TSM and the Department, at least 30 days prior to the date of the proposed change in service provider or transfer.

~~(4) The location where the support is currently provided.~~

~~(5) The reason the provider is no longer able or willing to provide the support as specified in § 6100.303.~~

~~(6) A description of the efforts made to address or resolve the issue that has led to the provider becoming unable or unwilling to provide the support or for which the individual chooses another provider.~~

~~(7) Suggested time frames for transitioning the delivery of the support to the new provider~~.

(d) A provider shall provide written notification to the Department and the designated managing entity immediately if the provider is no longer able to provide a home and community-based support due to an immediate health and safety risk to the individual.

(e) The provider's written notice specified in (c) shall include the following:

(1) The individual's name and master client index number.
(2) The current provider's name, address and master provider index number.
(3) The service that the provider is unable or unwilling to provide or for which the individual chooses another provider.
(4) The location where the service is currently provided.
(5) The reason the provider is no longer able or willing to provide the service's specified in § 6100.303.
(6) Suggested time frames for transitioning the delivery of the service to the new provider.

§ 6100.305. Continuation of support.

Comment and Suggestion 6100.305:
In some instances, providers will need additional resources and funds to continue services.

The provider shall continue to provide the authorized support during the mutually agreed upon transition period to ensure continuity of care with additional reimbursable services as necessary. If agreement is unable to be reached concerning a transition period, a provider shall provide services to the time of the discharge date. The parties may enter in to an expedited grievance process with the Department to immediately address the individual's needs. The Department shall pay the provider for the actual costs incurred by the provider to care for and support the individual during the transition period. ~~until a new provider is approved by the Department and the new support is in place, unless otherwise directed by the Department or the designated managing entity.~~

~~**§ 6100.306. Transition planning.**~~

Comment and Suggestion 6100.306:

This section should be included within section 6100.302

~~The support coordinator or targeted support manager shall coordinate the transition planning activities, including scheduling and participating in all transition planning meetings during the transition period.~~

~~**§ 6100.307. Transfer of records.**~~

Comment and Suggestion 6100.307:

This section should be included within section 6100.302

~~(a) The provider shall transfer a copy of the individual record to the new provider prior to the day of the transfer.~~

~~(b) The previous provider shall maintain the original individual record in accordance with § 6100.54 (relating to recordkeeping).~~

POSITIVE INTERVENTION

§ 6100.341. Use of a positive intervention.

Comment and Suggestion 6100.341:

This section can be incorporated into 6100.343

~~(a)~~ A positive intervention shall be used ~~to prevent, modify and eliminate a dangerous behavior~~ when ~~the~~ challenging behaviors ~~is~~ are anticipated and/or ~~occurring~~ in response to challenging behaviors to prevent escalation of behaviors, or in attempts to modify, decrease or eliminate behaviors.

~~(b) The least intrusive method restrictive intervention shall be applied will be utilized when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.~~

~~(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:~~

~~*Dangerous behavior* An action with a high likelihood of resulting in harm to the individual or others.~~

~~*Positive intervention* An action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communication, reinforcing appropriate behavior,~~

~~an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise, wellness practice, redirection, praise, modeling, conflict resolution and de-escalation.~~

~~§ 6100.342. PSP.~~

Comment and Suggestion 6100.342: It is recommended that this section be included within 6100.223.

~~If the individual has a dangerous behavior as identified in the PSP, the PSP must include the following:~~

~~(1) The specific dangerous behavior to be addressed.~~

~~(2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.~~

~~(3) The outcome desired.~~

~~(4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.~~

~~(5) A target date to achieve the outcome.~~

~~(6) Communication needs.~~

~~(7) Health conditions that require special attention.~~

§ 6100.343. Prohibition of restraints.

Comment and Suggestion 6100.343:

All definitions have been moved to 6100.3

In the definition of "mechanical restraint" it is also noted that some restraints (e.g. geriatric chairs) are prescribed in the individual's PSP and thus do not qualify as the definition of "incident" in 6100.3 and are unnecessary to report.

The following procedures are prohibited:

(1) Seclusion~~, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving~~.

(2) Aversive conditioning~~, defined as the application of startling, painful or noxious stimuli~~.

(3) Pressure point techniques~~, defined as the application of pain for the purpose of achieving compliance~~.

(4) A chemical restraint~~, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment~~.

(5) A mechanical restraint~~, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.~~

~~(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.~~

~~(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.~~

(6) A ~~manual~~ physical restraint~~, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a nonemergency basis, or for more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to a support as specified in the individual's PSP.~~

(7) A prone position ~~manual~~ physical restraint.

(8) A ~~manual~~ physical restraint that inhibits digestion or respiration, inflicts pain~~, causes embarrassment or humiliation,~~ causes hyperextension of joints, applies pressure on the chest or joints, or allows for a free fall to the floor.

(9) A physical restraint may not be used as a substitute for positive behavioral interventions, or as retribution, punishment, noncompliance, or for the convenience of staff persons.

§ 6100.344. Permitted interventions.

Comment and Suggestion 6100.344
The definition of "voluntary exclusion" has been moved to 6100.3
Suggest that (h) has been incorporated into (e)
Text has been added and deleted for clarity

(a) Voluntary exclusion~~, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP~~.

(b) The least intrusive intervention shall be used to deescalate the dangerous behaviors when the behavior is occurring.

(c) A physical restraint may be used in the case of a dangerous behavior to prevent an individual from injuring the individual's self or others.

(d) If the individual has a known dangerous behavior, it must be identified and addressed in the PSP, or if a new dangerous behavior is identified it should be added to the PSP through a revision.

~~(b) A physical protective restraint may be used only in accordance with § 6100.343(6)(8) (relating to prohibition of restraints).~~

~~(c) A physical protective restraint may not be used until §§ 6100.143(c)(5) and 6100.223(13) (relating to annual training; and content of the PSP) are met.~~

(~~d~~)(e) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.

(~~e~~)(f) A physical protective restraint (i.e. a hands-on hold of an individual) may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.

(~~f~~)(g) A physical protective restraint may not be used for more than 15 minutes within a 2-hour period.

~~(g) A physical protective restraint may only be used by a person who is trained as specified in § 6100.143(c)(5).~~

~~(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.~~

§ 6100.345. Access to or the use of an individual's personal property.

Comment and Suggestion 6100.345

There are individuals who understand the consequences of having to make restitution for damages they cause to the property of other persons. In those cases, there should be a mechanism for this natural consequence to occur, in coordination with the PSP team.

(a) Access to or the use of an individual's personal funds or property may not be used as a reward or punishment.

(b) An individual's personal funds or property may not be used as payment for damages unless legally ordered or the individual consents to make restitution for the damages as follows:

(1) A separate written consent is required for each incidence of restitution.

(2) Consent shall be obtained in the with the support of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.

(3) There may not be coercion in obtaining the consent of an individual.

INCIDENT MANAGEMENT

§ 6100.401. Types of incidents and timelines for reporting.

Comment and Suggestion 6100.401:

It is suggested that subsection (a) (13) & (16) be moved to a newly proposed subsection (b), and to allow the provider more time to report the incident.

(a) ~~The~~ A provider shall report the following incidents~~,~~ and alleged incidents ~~and suspected incidents~~ through the Department's information management system within 24 hours of ~~discovery by a staff person~~ having knowledge of the incident:

(1) Death.

(2) Suicide attempt.

(3) Inpatient admission to a hospital.

(4) ~~Emergency room visit.~~ Visit to an emergency room.

(5) Abuse.

(6) Neglect.

(7) Exploitation.

(8) Missing individual.

(9) Law enforcement activity.

(10) Injury requiring treatment beyond first aid.

(11) Fire requiring the services of the fire department.

(12) Emergency closure.

~~(13) Use of a restraint.~~

(~~14~~ 13) Theft or misuse of individual funds.

(~~15~~ 14) A violation of individual rights.

(15) Individual to individual incident.

~~(16) A medication administration error, including prescription and over the counter medication administration errors.~~

~~(17) A critical health and safety event that requires immediate intervention such a significant behavioral event or trauma.~~

(b) ~~The individual, and persons designated by the individual, shall be notified immediately upon discovery of an incident relating to the individual.~~ A provider shall report the following in the Department's information management system within 72 hours of the occurrence or discovery of the incident:

(1) Medication administration error

(2) Use of a restraint outside the parameters of the PSP.

(c) The individual and person(s) designated by the individual shall be notified upon discovery of an incident related to the individual.

(d) The incident report, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual, and persons designated by the individual, upon request.

§ 6100.402. Incident response and investigations.

Comment and Suggestion 6100.402:
Individual to individual abuse [(b)(9)] was determined to require certified investigation in the event of serious injury and/or sexual violation. Additional/ deleted text added for clarity.

(a) The provider shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or notice of an incident, alleged incident and/or suspected incident.

(b) The provider shall initiate an investigation of ~~an incident~~ certain incidents within 24 hours of the occurrence or discovery by a staff person of the incident of the following:

(1) Death
(2) Abuse
(3) Neglect
(4) Exploitation
(5) Missing person
(6) Theft or misuse of an individual's funds
(7) Violations of individuals rights
(8) Unauthorized or inappropriate use of a restraint
(9) Individual to individual sexual abuse and serious bodily injury.

(c) A Department-certified incident investigator shall conduct the incident investigation of the incident listed in 6100.401 subsection (a).

§ 6100.403. Individual needs in incident investigation.

Comment and Suggestion 6100.403

Title has been modified the title to make it more descriptive and text has been revised to focus on a serious incident or pattern of incidents.

Inclusion of supports coordinator and TSM in (c) is redundant as they are already included in the PSP Team.

(a) ~~In investigating an incident, the provider shall review and consider the following needs of the affected individual:~~ In reviewing a serious incident, or pattern of incidents, a provider shall review and consider the following needs of the affected individual(s):

(1) Potential risks.

(2) Health care information.

(3) Medication history and current medication.

(4) Behavioral health history.

(5) Incident history.

(6) Social needs.

(7) Environmental needs.

(8) Personal safety.

(b) The provider shall monitor an individual's risk for recurring incidents, and implement corrective action, as appropriate.

(c) The provider shall work cooperatively with the ~~support coordinator or targeted support manager and the~~ PSP team to revise the ~~individual's PSP if indicated by the incident.~~ PSP as needed.

§ 6100.404. Final incident report.

Comment and Suggestion 6100.404

Text is suggested to add clarity to the regulation and recognize the opportunity to file an extension if an investigation cannot be completed in the original time frame, e.g. when certain steps in the investigation cannot be completed for reasons beyond the provider's control, such as waiting for lab results or a police report.

(a) ~~The~~ A provider shall finalize the incident report in the Department's information management system by including additional information about the incident, results of a required investigation and corrective actions taken within 30 days of discovery of the incident by a staff person unless an extension is filed.

(b) ~~The~~ A provider shall provide the following information to the Department as part of the final incident report:

(1) Any known additional detail about the incident.

(2) The results of the incident investigation.

(3) A description of the corrective action(s) taken or planned in response to ~~an~~ the incident as necessary.

(4) Additional action(s) taken to protect the health, safety and well-being of the individual.

(5) The person responsible for implementing the corrective action.

(6) The date the corrective action was implemented or is to be implemented.

§ 6100.405. Incident analysis.

Comment and Suggestion 6100.405:

(b) As proposed, this mandates a fourfold increase from the current requirement of annual review.

(a) A ~~The~~ provider shall complete the following for each confirmed incident:

(1) Analysis to determine the root cause of the incident.

(2) Corrective action.

(3) A strategy to address the potential risks to the individual.

(b) A ~~The~~ provider shall review and analyze incidents and conduct a trend analysis ~~at least every 3 months~~ annually.

(c) As part of the review, a ~~The~~ provider shall identify and implement preventive measures when appropriate to attempt to reduce:

(1) The number of incidents.

(2) The severity of the risks associated with the incident.

(3) The likelihood of ~~an~~ incident(s) recurring.

(4) The occurrence of more serious consequences if the incident recurs.

(d) A ~~The~~ provider shall provide training/retraining ~~educate~~ to staff persons~~, others~~ and the individual based on the ~~circumstances~~ outcome of the incident analyses as necessary.

(e) A ~~The~~ provider shall ~~analyze~~ monitor incident data ~~continuously~~ and take actions to mitigate and manage ~~risks~~ risk factors as necessary.

PHYSICAL ENVIRONMENT

§ 6100.441. Request for and approval of changes.

Comment and Suggestion 6100.441:

There are many situations within which individuals would benefit from rapid placement. These situations include natural disasters, program closures, and removal from abuse. It is important that this chapter allow for an expedited capacity change process to accommodate individuals' needs in their Everyday Lives.

(a) A residential provider shall submit a written request to the Department on a form specified by the Department and receive written approval from the Department prior to increasing or decreasing the Department-approved program capacity of a residential facility.

(b) To receive written approval from the Department as specified in subsection (a), the provider shall submit a description of the following:

(1) The circumstances surrounding the change.

(2) How the change will meet the setting size, staffing patterns, assessed needs and outcomes for the individuals.

(c) If a facility is licensed as a community home for individuals with an intellectual disability or autism, the program capacity, as specified in writing by the Department, may not be exceeded. Additional individuals funded through any funding source, including private-pay, may not live in the home to exceed the Department-approved program capacity.

(d) A copy of the written request specified in subsections (a) and (b) shall be provided to the affected individuals, and persons designated by the individuals, prior to the submission to the Department.

(e) A copy of the Department's response to the written request specified in subsections (a) and (b) shall be provided to the affected individuals, and persons designated by the individuals, within 7 days following the receipt of the Department's response.

§ 6100.442. Physical accessibility.

Comment and Suggestion 6100.442

This item can cause providers to incur significant and non-recognized costs. The Department must develop capacity to compensate providers for these costs in the rate-setting process.

(a) The provider shall provide for or arrange for physical site accommodations and assistive equipment to meet the health, safety and mobility needs of the individual.

(b) Mobility equipment and other assistive equipment shall be maintained in working order, clean, in good repair and free from hazards.

(c) The Department shall recognize the necessary costs incurred by providers to comply with (a) and (b) above.

§ 6100.443. Access to the bedroom and the home.

Comment and Suggestion 6100.443:

6100.443 (a) has been modified to reflect applicable direction from the Community Rule.

(a) ~~In a residential facility, an individual shall have a lock with a key, access card, keypad code or other entry mechanism to unlock and lock the individual's bedroom door and the entrance of the home~~ Each individual enjoys privacy in their individual sleeping or living unit. Units shall have entrance doors that the individual may lock, with only appropriate staff having keys to the doors.

(b) Assistive technology, as ~~needed~~ necessary, shall be used to allow the individual to open and lock the door without assistance.

(c) The locking mechanism shall allow easy and immediate access in the event of an emergency.

(d) Appropriate persons shall have the key and entry device to lock and unlock the doors to the bedroom(s) and the home.

(e) ~~Only authorized persons shall access the individual's bedroom.~~ The rights of the individual to privacy in his/her bedroom should be respected in accordance with sections 6100.181-183, with consideration for the needs of the health, safety, and welfare of the individual as determined in the PSP, or as needed in an unforeseen or emergency circumstance.

(f) ~~Access to an individual's bedroom shall be provided only in a life-safety emergency or with the express permission of the individual for each incidence of access.~~ Provider staff should request permission whenever possible when entering a bedroom in circumstances other than a health and safety emergency.

§ 6100.444. ~~Lease or ownership~~. Occupancy.

Comment and Suggestion 6100.444:

I recommend that the Department rely on the standard Room and Board Agreements as the occupancy document required under the Community Rule.

I recommend that the term "landlord" be stricken from the regulations, reflecting experience with zoning ordinances.

(a) In residential habilitation, the individual shall have a ~~legally enforceable~~ room and board agreement ~~such as the lease or residency agreement for the physical space, or ownership of the physical space, that offers the same responsibilities and protections from eviction that tenants have under The Landlord and Tenant Act of 1951 (68 P.S. §§ 250.101—250.602)~~.

(b) ~~Landlords may establish reasonable limits for the furnishing and decorating of leased space as long as the limits are not discriminatory and do not otherwise deny rights granted to tenants under applicable laws and regulations.~~ Providers may establish reasonable limits consistent with law for the furnishing and decorating of living units.

§ 6100.445. Integration.

Comment and Suggestion 6100.445:

Text is suggested to add clarity to the regulation.

A setting in which a ~~support~~ service is provided shall be integrated ~~in~~ into the community and the individual shall have the same degree of community access as reasonably possible consistent with the individual's needs and choice as would an individual who is similarly situated in the community who does not have a disability and who does not receive an HCBS.

§ 6100.446. Facility characteristics relating to size of facility.

Comment and Suggestion 6100.446:

The relocation of a residential facility of 8 to another residential facility of 8 must be approved upon a provider's reasonable demonstration of comparability of service provision and cost.

The Community Rule does not impose an absolute cap on program size. Consideration must be given to additional staffing levels required, additional facility costs, and workforce shortage. Federal regulation expressly provides: "We do not believe there is a maximum number that we could determine with certainty that the setting would meet the requirements of HCBS setting. The focus should be on the experience of the individual in the setting." [79 Fed. Reg. 2968 (January 16, 2014)]

What is ODP's rationale for imposing the specific limit of 15 persons? What analysis and data is ODP relying on to establish a 15-person limit? Has ODP calculated the operational and fiscal consequences that will arise due to the imposition of a 15-person limit?

(a) A residential facility that serves primarily persons with a disability, which was funded in accordance with Chapter 51 prior to _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), may not exceed a program capacity of eight persons.

(1) A duplex, two bilevel units and two side-by-side apartments are permitted as long as the total in both units does not exceed a program capacity of eight persons.

(2) ~~With the~~ The Department~~'s written approval,~~ shall approve the relocation of a residential facility with a program capacity of eight ~~may move~~ to a new location and retain the program capacity of eight so long as the move is consistent with the PSPs of the affected individuals.

~~(b) A residential facility that serves primarily persons with a disability, which is newly funded in accordance with this chapter on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), may not exceed a program capacity of four.~~

~~(1) A duplex, two bilevel units and two side-by-side apartments are permitted as long as the total in both units does not exceed a program capacity of four.~~

~~(2) With the Department's written approval, an intermediate care facility for individuals with an intellectual disability licensed in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability) with a licensed capacity of five, six,~~

~~seven or eight individuals may convert to a residential facility funded in accordance with this chapter exceeding the program capacity of four.~~

~~(c) A day facility that serves primarily persons with a disability, which is newly-funded in accordance with this chapter on or after March 17, 2019, including an adult training facility licensed in accordance with Chapter 2380 (relating to adult training facilities) and a vocational facility licensed in accordance with Chapter 2390 (relating to vocational facilities), may not exceed a program capacity of 15 at any one time.~~

~~(1) The program capacity includes all individuals served by the facility including individuals funded through any funding source such as private pay.~~

~~(2) Additional individuals funded through any funding source, including private pay, may not be served in the day facility to exceed the program capacity of 15 individuals at any one time.~~

§ 6100.447. Facility characteristics relating to location of facility.

Comment and Suggestion 6100.447

In subsection (a) "in close proximity" is undefined and so provides no guidance providers as to the Department's proposed expectation.

The Department needs to reconsider the 10% maximum limit in subsection (b). How did the Department determine that "10%" is the appropriate limit? E.g., what data, survey analysis or studies did the Department rely on in support of a 10% limit? As written, subsection (b) has the unintended consequence of forcing people only into larger apartment complexes, which may not exist in small communities, urban areas, etc. For example, you could have one person receiving HCBS in a complex of ten apartment units but not even one person would be free to live in a small complex of four apartment units.

The suggested text for (d) is consistent with the Department's practice of urging ICF/IDs to convert to HCBS.

(a) A residential or day facility, which is newly-funded in accordance with this chapter on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), may not be located adjacent ~~or in close proximity~~ to the following:

(1) Another human service residential facility.

(2) Another human service day facility serving primarily persons with a disability.

(3) A hospital.

(4) A nursing facility.

(5) A health or human service public or private institution.

(b) No more than ~~10%~~ of the units in an apartment, condominium or townhouse development may be funded in accordance with this chapter.

(c) ~~With the Department's written approval, a~~ A residential or day facility that is licensed in accordance with Chapter 2380, 2390, 6400 or 6500 prior to _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), and funded in accordance with Chapter 51 prior to _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), ~~may~~ shall continue to be eligible for HCBS participation.

(d) ~~With the Department's written approval, an~~ An intermediate care facility for individuals with an intellectual disability licensed in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability) with a licensed capacity of eight or less individuals ~~may~~ shall be eligible for HCBS participation.

MEDICATION ADMINISTRATION

Comment and Suggestion: Medication Administration

There are two extremely important issues concerning the proposed new regulations pertaining to medication administration. These issues must be carefully reconsidered by the Department.

1. Codifying content that requires modifications over time into regulations will lock a crucial component of service provision into temporal practices which will become obsolete as new information, prevailing practices and technology emerge. Duplicating content which is as detail-specific as the proposed five-and-a-half pages of regulation across 5 sets of regulations when the state already has an externally - accepted training module invites discrepancy between the regulations and the training manual and prohibits the training module from staying current as new information, prevailing practices and technology emerge.

2. Requiring 6500 LifeSharing providers to complete and adhere to ODP's Medication Administration Module is a new and counterproductive requirement which is in direct contrast to Everyday Lives principals and the Department's stated intent to develop more integrated and natural life opportunities for individuals.

As a ready example of the problem with codifying material which requires change over time, an area has been identified in which the proposed regulations are at odds with prevailing practices as detailed by Title 49 of the State Nursing Board. 49 PA. CODE CH. 21 explicitly provides for Licensed Practical Nurses to accept oral orders for administering medication. The proposed 6100.465 provision only allows this practice for Registered Nurses.

This discrepancy is instructive both to the specific issue regarding LPN's and to the process issue of codifying Nursing Practices content which changes from time to time according to authorities outside of the Department. It is noted that the provider system needs LPN's to be able to do all that state law provides for them to do. In the second case, we need regulations

which do not lock providers to standards which may soon become obsolete due to new and emerging best practices and advances.

A second example of the problem with trying to maintain this content in multiple places is that there are already discrepancies between the proposed 6100's and the Department's Approved Medication Administration Training. The training's required checklist for medication self-administration has discrepancies with the proposed regulation. There is also a notable practice discrepancy regarding pre-pouring of medications.

For all of these reasons, and based upon years of provider experience and informed by ID/A professionals and experts, I strongly recommend and urge the Department to delete the sections of the proposed regulations noted below and to require instead compliance with the Department's approved Medication Administration Training module.

§ 6100.461. Self-administration.

(a) The provider shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.

(b) Assistance in the self-administration of medication ~~includes~~ may include helping the individual to ~~remember~~ adhere to the schedule for taking the medication, ~~offering the individual the medication at the prescribed times, opening a medication container~~ and storing the medication in a secure place.

(c) The ~~provider~~ PSP team shall ~~provide or arrange for~~ facilitate the utilization of assistive technology to support the individual's self-administration of medications.

(d) The PSP must identify if the individual is ~~unable~~ able to self-administer medications.

(e) To be considered able to self-administer medications, an individual shall ~~do all of the following~~:

(1) Be able to recognize and distinguish the ~~individual's~~ his/her medication.

(2) Know how much medication is to be taken.

(3) Know and understand the purpose for taking the medication.

(4) Know when the medication is to be taken. This knowledge may include reminders of the schedule and offering the medication at the prescribed times as specified in subsection (b).

~~(4)~~ (5) Be able to take or apply ~~the individual's~~ his/her own medication with or without the use of assistive technology.

§ 6100.462. Medication administration.

Comment and Suggestion 6100.462:

It appears that there was an inadvertent problem created by the inclusion of standardized medications content across these four program areas that includes the 6500 regulations. If the 6500 LifeSharing programs are included in this requirement, significant unintended consequence are likely to arise and cause severe negative impact on the viability and expansion of this program – a program that the Department has repeatedly stated it desires to expand. A consequence as well for the inclusion of this provision for 6500 programs will be more institutional style program expectations in a program which should increasingly exemplify the ideals of Everyday Lives principals in an integrated and typical family fashion to the retest degree. LifeSharing (6500) service providers are not currently required to complete the ODP Medication Training Module. The Module is necessarily a very detailed training requiring at least two full days of training plus four subsequent observations. This level of intensive training is possible in 2380, 2390 and 6400 programs because they have staff who are employees with employer-controlled schedules and they have centralized access to administrative supports, in perhaps a less intrusive way than entering a family's home. These conditions do not exist and are not desirable for LifeSharing. LifeSharing is provided in people's homes.

LifeSharing providers are not employees who spend regular time at training locations, nor should they – they are typical families who work and live in the community. These families work their own independent jobs in the community and would be challenged just to have the physical access to go through this process. There is already a shortage of certified medication administration trainers contributing to this access problem. Requiring this additional training would necessarily result in losing some providers who are unable to connect with the available training times and places, and potentially separating an already established shared life situation with an individual. It would also add a new barrier for new family-providers at a time when the Department is trying to expand this service and providers trying to find and recruit willing families.

Another problem with this expansion of the Training Module into the 6500's involves the respite services which are crucial to helping LifeSharing providers to support individuals over the long-haul. Respite providers are often potential LifeSharing providers who are interested in gaining experience with the service and with individuals. These new/potential providers have not gone through full process as providers yet – adding this considerable step when they are not yet committed to the service would be destructive to the service.

Further concerns with requiring specific detailed training that can only come from service agencies to the 6500's is the necessity that we maintain LifeSharing providers' relationship as contracted supports rather than employees. The level of training specificity, the fact that it would be the "presumed employer" providing the training and the likelihood that LifeSharing providers would be taking the training alongside employees with no differentiation from the employees all implies an employee relationship which needs to be avoided if LifeSharing is going to continue to be an efficient, community-based model. Clear expectations are established by the IRS and DOL which providers must explicitly follow to maintain explicit

differences between independent contractors and employees.

Finally, there is also a simple matter of proportionality. LifeSharing providers generally only serve one individual and the individuals in Life Sharing are typically able to take more responsibility for themselves than individuals in the other licensure groups. LifeSharing providers are able to focus-in on the needs of their lifesharer. They do not need days of general information. To require the Medication Administration Module of them would be disproportionate to their task – in fact, it would change the nature of the service from family-like supports to medical-model "administration" of medical care.

~~(a) A provider whose staff persons or others are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer the individual's prescribed medication.~~

Persons who administer prescription medication or insulin injections to individuals shall receive training by the individual's source of healthcare or satisfactorily complete the Department's/ODP's most current Medication Training Module.

~~(b) A prescription medication that is not self-administered shall be administered by one of the following:~~

~~(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.~~

~~(2) A person who has completed the medication administration training as specified in § 6100.469 (relating to medication administration training) for the medication administration of the following:~~

~~(i) Oral medications.~~

~~(ii) Topical medications.~~

~~(iii) Eye, nose and ear drop medications.~~

~~(iv) Insulin injections.~~

~~(v) Epinephrine injections for insect bites or other allergies.~~

~~(c) Medication administration includes the following activities, based on the needs of the individual:~~

~~(1) Identify the correct individual.~~

~~(2) Remove the medication from the original container.~~

~~(3) Crush or split the medication as ordered by the prescriber.~~

~~(4) Place the medication in a medication cup or other appropriate container, or into the individual's hand, mouth or other route as ordered by the prescriber.~~

~~(5) If indicated by the prescriber's 00.163.163 order, measure vital signs and administer medications according to the prescriber's order.~~

~~(6) Injection of insulin or epinephrine in accordance with this chapter.~~

§ 6100.463. Storage and disposal of medications.

Comment and Suggestion 6100.463:

As written, this section is far too prescriptive and subjective given the training that provider staff must complete. The suggested edits reflect clarity and brevity and are adapted from Chapter 6500.

(a) Prescription and nonprescription medications shall be kept in their original labeled containers, except for medications of individuals who self-administer medications and keep their medications in personal daily or weekly dispensing containers.

(b) ~~A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.~~ Prescription and potentially toxic nonprescription medications shall be kept in an area or container that is locked or made inaccessible to the individuals, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(c) ~~If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.~~ Prescription and potentially toxic nonprescription medications stored in a refrigerator shall be kept in a separate locked container or made inaccessible to the individuals, unless it is documented in each individual's assessment that each individual in the residence can safely use or avoid toxic materials.

(d) ~~Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.~~ Prescription and nonprescription medications of individuals shall be stored under proper conditions of sanitation, temperature, moisture and light.

(e) ~~Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.~~ Discontinued prescription medications of individuals shall be disposed of in a safe manner.

~~(f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.~~

~~(g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.~~

~~(h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to the Department of Environmental Protection and applicable Federal and State regulations.~~

~~(i) Subsections (a)—(d) and (f) do not apply for an individual who self-administers medication and stores the medication in the individual's private bedroom.~~

§ 6100.464. Labeling of medications.

Comment and Suggestion 6100.464:

As written, this section is far too prescriptive and subjective given the training that provider staff must complete. The suggested edits reflect clarity and brevity and are adapted from Chapter 6500.

~~The original container for prescription medications must be labeled with a pharmacy label that includes the following:~~

~~(1) The individual's name.~~

~~(2) The name of the medication.~~

~~(3) The date the prescription was issued.~~

~~(4) The prescribed dosage and instructions for administration.~~

~~(5) The name and title of the prescriber.~~

(a) The original container for prescription medications of individuals shall be labeled with a pharmaceutical on the original bottle or label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose, the expiration date, and the name of the prescribing physician.

(b) Nonprescription medications used by individuals shall be labeled with the original label.

§ 6100.465. ~~Prescription medications.~~ Use of a prescription.

Comment and Suggestion 6100.465:

Adapted from Chapter 6500. See comment under 6100.463

~~(a) A prescription medication shall be prescribed in writing by an authorized prescriber.~~

~~(b) A prescription order shall be kept current.~~

~~(c) A prescription medication shall be administered as prescribed.~~

~~(d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.~~

~~(e) Changes in medication may only be made in writing by the prescriber or, in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a registered nurse in accordance with regulations of the Department of State. The individual's medication record shall be updated as soon as a written notice of the change is received.~~

(a) A prescription medication shall only be used by the individual for whom the medication was prescribed.

(b) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a written protocol as part of the PSP to address the social, emotional and environmental needs of the individual related to the symptoms of the diagnosed psychiatric illness.

(c) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a review with documentation by a licensed physician or a certified nurse practitioner at least every 3 months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage.

§ 6100.466. Medication records.

Comment and Suggestion 6100.464

As written, this section is far too prescriptive and subjective given the training that provider staff must complete. The suggested edits reflect clarity and brevity and are adapted from Chapter 6500.

~~(a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:~~

~~(1) Individual's name.~~

~~(2) Name and title of the prescriber.~~

~~(3) Drug allergies.~~

~~(4) Name of medication.~~

~~(5) Strength of medication.~~

~~(6) Dosage form.~~

~~(7) Dose of medication.~~

~~(8) Route of administration.~~

~~(9) Frequency of administration.~~

~~(10) Administration times.~~

~~(11) Diagnosis or purpose for the medication, including pro re nata.~~

~~(12) Date and time of medication administration.~~

~~(13) Name and initials of the person administering the medication.~~

~~(14) Duration of treatment, if applicable.~~

~~(15) Special precautions, if applicable.~~

~~(16) Side effects of the medication, if applicable.~~

~~(b) The information in subsection (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.~~

~~(c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.~~

~~(d) The directions of the prescriber shall be followed.~~

(a) A medication log listing the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered, and the name of the person who administered the prescription medication or insulin shall be kept for each individual who does not self-administer medication.

(b) The information specified in subsection (a) shall be logged immediately after each individual's dose of medication.

(c) A list of prescription medications, the prescribed dosage and the name of the prescribing physician shall be kept for each individual who self-administers medication.

§ 6100.467. Medication errors.

Comment and Suggestion 6100.467:

As written, this section is far too prescriptive and subjective given the training that provider staff must complete. The suggested edits reflect clarity and brevity and are adapted from Chapter 6500.

(a) Medication errors ~~include~~ consist of the following actions:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong amount of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

~~(5) Administration to the wrong person.~~

(6) Administration through the wrong route.

(b) A medication error shall be immediately reported as an incident as specified in § 6100.401 (relating to types of incidents and timelines for reporting) and to the prescriber.

(c) Documentation of medication errors and follow-up action taken ~~the prescriber's response~~ shall be kept ~~in the individual's record.~~

~~**§ 6100.468. Adverse reaction.**~~

Comment and Suggestion 6100.468:

Adapted from Chapter 6500. See comment under 6100.463

~~(a) If an individual has a suspected adverse reaction to a medication, the provider shall immediately consult a health care practitioner or seek emergency medical treatment.~~

~~(b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction and the action taken shall be documented.~~

If an individual has a suspected adverse reaction to a medication, the healthcare provider shall be contacted immediately. Documentation of adverse reactions shall be maintained in the individual's medical record.

~~§ 6100.469. Medication administration training.~~

Comment and Suggestion 6100.469

It is suggested that this section be incorporated into section 6100.462

Epi-pen mandatory training will add a significant cost. This resource such as HCQU will be difficult to meet the needs of the agencies. There are some agencies that have had a video regarding this training; however, many regions of BHSL disagree with videos as an appropriate training.

~~(a) A person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer the following:~~

~~(1) Oral medications.~~

~~(2) Topical medications.~~

~~(3) Eye, nose and ear drop medications.~~

~~(b) A person may administer insulin injections following successful completion of both:~~

~~(1) The course specified in subsection (a).~~

~~(2) A Department-approved diabetes patient education program within the past 12 months.~~

~~(c) A person may administer an epinephrine injection by means of an auto-injection device in response to anaphylaxis or another serious allergic reaction following successful completion of both:~~

~~(1) The course specified in subsection (a).~~

~~(2) Training relating to the use of an auto-injection epinephrine injection device provided by a licensed, registered or certified health care professional within the past 12 months.~~

~~(d) A record of the training shall be kept including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.~~

§ 6100.470. Exception for family members.

Comment and Suggestion 6100.70

I generally agree with the regulation. What happens in the instance of a family member who becomes a life sharer? Does the exemption in 6100.407 still apply?

Sections 6100.461—6100.463 and 6100.466—6100.469 do not apply to an adult relative of the individual who provides medication administration. An adult relative of the individual may administer medications to an individual without the completion of the Department-approved medications administration course.

GENERAL PAYMENT PROVISIONS

§ 6100.481. Departmental established HCBS rates. ~~rates and classifications.~~

Comment and suggestion 6100.481 – 6100.641:

Pennsylvania's ability to provide necessary supports and services to over 50,000 Pennsylvanians with an intellectual disability or autism depends on a fair and rational rate methodology. The Medical Assistance Program is the sole payer of ID services in Pennsylvania and Medical Assistance eligible clients comprise 100% of the HCBS population. The state and federal governments have recognized that the principal cost driver for ID/A (intellectual disability and autism) services is the workforce, accounting for approximately 80-85% of the total HCBS costs and that workforce stability is threatened by the inability of providers to offer competitive, family sustaining wages. High staff turnover and vacancy rates, in turn, impact access to and quality of care. The proposed rate setting regulations require specifics that assure that Department-established payment rates and the actual incurred costs of providing mandated services are and will be consistently, fairly and reasonably aligned. This is particularly so given that services are provide under a single payer system, i.e., a system that is wholly dependent on Medical Assistance payments.

The Department, apart from its Notice of proposed rulemaking, has announced its intent to rebase its current fee schedule rates effective July 1, 2017, and to convert cost based services to fee schedule rates effective January 1, 2018. All of the necessary specifics concerning the costs, assumptions, presumptions and indexes of those rates have not yet been released. My comments, suggestions and concerns about the rate setting provisions included in the Department proposed rulemaking apply equally to the anticipated but still unpublished rate setting methods and formulas.

As drafted, the proposed section 6100.481 merely identifies the standard and traditional means by which the Department pays for medical assistance covered services. The Department explains the purpose of the regulation (46 Pa. B. 7063), as enabling it to choose from "an array of payment options that somehow creates a benefit to providers." Actually, the identified options have existed since the inception of the Department's Medical Assistance Program. Indeed, the use of managed care as an alternative to fees otherwise established by the Department (whether fee schedule based or cost based) is expressly authorized in statute

(62 P.S. § 443.5.) So, although framed as a regulation, this section merely explains existing payment for service options already available under federal and state law. Regardless of its intent, this section neither creates rights or benefits nor imposes any duties or obligations on consumers, providers or the Department. It does no more than restate payment options that would require promulgation as regulations to become effective. The inclusion of possible payment options in the regulation does not establish any new or needed authority to adopt such regulations. Since this section does not function as a regulation, it should be deleted.

Along with its reference to and emphasis on an "array of payment options," the Department comments that it and "some providers agree that the current system of cost-based reimbursement for residential habilitation is costly and inefficient" and that discussion will occur "to transition from the cost based system to a more viable payment system." (46 Pa. B. at 7063.) (To be clear, the current cost based system relies on allowable costs that are at least two years old without any adjustment made to account for the passage of time.) Apart from the unproven and unexplained assertions regarding the current cost based system, whatever requirements "a more viable payment system" should possess certainly will demand public discussion and input followed by adoption as viable regulations.

The regulation, at 6100.481 (b), purports to authorize the Department to "establish" an HCBS fee merely by "publishing a notice in the Pennsylvania Bulletin." This section, read in conjunction with proposed regulations at 6100.571 (a), (c), (d), and (e), would enable the Department to establish rates apart from and without compliance with an approved rate setting methodology that explains in reasonable detail the factors actually relied on in setting the rates, how the factors were actually developed and utilized in setting the rates, and the bases for any assumptions and presumptions relied upon in setting the rates. (In contrast, compare 55 Pa. Code § 1163.51 [Payment for Inpatient Hospital Services] and 55 Pa. Code § 1187 [Subpart G: Nursing Home Rate Setting] which set forth in detail the specific factors and calculations relied on in establishing payment rates.)

The Department, under state law, must follow the rule making requirements set forth in the Commonwealth Documents Law, 45 P.S. §§1102 et seq., the Regulatory Review Act, 71 P.S. §§7451, et. seq., and the Commonwealth Attorneys Act, 71 P.S. §§732 – 101 et. seq. And, in complying with these procedural provisions, it must formulate regulations that permit providers to have a reasonable and fair understanding of what is required of them if they seek to render HCBS and the methodology for the rates at which they will be paid for their services. It is simply not sufficient for the Department, as it proposes to do under 6100.481 – 647, to list generic, non-specific "factors" that it will "consider" and otherwise assume extraordinary discretion to pay rates that it determines to be appropriate. Rather, it must explain in detail the methods and procedures and methodologies that it will actually utilize in setting payment rates. Transparency in this regulation is essential.

Under the proposed 6100.571(c), the Department explains how it will "consider" (in contrast to "utilize) a list of generic "factors" to create its "market based data" to establish fee schedule rates. Among the referenced factors are "staff wages" and "staff related expenses" and "productivity" and "administration related expenses." Specifics regarding these and the other

"factors" are notably excluded from the regulation. Equally inappropriate, the factors include "determinations made [by whom?] about cost components [such as?] that reflect costs necessary and related to the delivery of each HCBS" (6100.571 (c)(8)). The draft regulation further contemplates a "review of the cost of implementing Federal, state, and local statutes, regulations and ordinances" (6100.571 (c) (9)). How this review might be accomplished and precisely what costs will be considered are unstated. And, finally, the regulation even includes as a factor what is defined as "[o]ther criteria that impact costs" (6100.571(c)(10). In other words, the Department may elect to unilaterally apply whatever undisclosed criteria that it may choose on an ad hoc basis.

It is essential to understand the constraints that apply to the Department's HCBS rate setting duties and obligations. In its response to paragraph (9) of the IRRC Regulatory Analysis Form that asks the Department to identify state or federal law or court order that mandates the adoption of the proposed regulations and whether "there are any relevant state or federal court decisions" to consider, the Department responded that: (1) the HCBS regulations "are mandated by 42 C.F.R §§441 – Service Requirements and Limits Applicable to specific Services"; and (2) "there are [n]o relevant court decisions."

The Department's responses to the IRRC forget applicable federal and state statute and case law that prescribe the requirements that the Department must adhere to in establishing payment rates for HCBS services. The fact that the HCBS regulations and payment rates relate to "waiver programs" does not excuse the Department from compliance with the federal statutes and case law nor, of course, with its separate responsibilities to comply with state statute and relevant state case law.

Under 42 U.S.C. §1396 a(a)(13)(A), the Department must provide public notice of the methodologies that underlie the rates that it proposes to adopt, the justifications used to establish the rates, and the estimate of the increase or decrease in annual aggregate expenditures. See also 42 C.F.R §447. 205.

In developing and adopting HCBS payment rates, the Department is compelled to comply with the requirements of 42 U.S.C. §1396 a(a)(30)(A) that directs it to adopt "methods and procedures" that assure that "payments [to providers] are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers to assure access to HCBS providers by waiver program eligible individuals." This statutory mandate has been interpreted to mean that the Department must adopt a rate setting methodology using a process that is reasonable, considers more than simple budgetary factors and results in payments to providers that are sufficient to meet [persons'] needs. And, under a single payer system, rate setting must necessarily address provider viability and so a retained revenue factor must be included in the cost based rates and similarly in the development of the schedule rates. (At one time, under 55 Pa. Code 4300.108(c), the Department permitted providers 3% retention.)

See: Christ the King Manor, Inc. v. Secretary HHS, 730 F. 3d 291 (3 Cir. 2013); Pa. Pharmacists v. Houstoun, 283 F. 3d 531 (3d Cir. 2002); Rite Aid v. Houstoun, 171 F. 3d 842

(3d Cir. 1999).

Consistent with the unfettered discretion that characterizes the Department's proposed regulations that would establish HCBS fee schedule rates (and also cost based rates under 6100.645), the Department, in the Fiscal Note to the proposed regulations, stated that the regulations will have "[n]o fiscal impact" (46 Pa. B. 7067). See also the Department's response to Paragraph 21 of the IRRC Regulatory Analysis Form that asks the agency to provide "a specific estimate of the costs and/or savings to **state government** (emphasis in original) associated with the implementation of the regulation." The Department responded that there will be "negligible cost to state government to administer the regulation" and in support thereof referenced an opportunity for "reduced paperwork." There is, of course, a clear distinction between the phrase "implementation of the regulation" and "to administer the regulation."

The need for specificity and accountability in the rate setting regulations is perhaps best evidenced by the Department's declaration regarding the regulations' proposed fiscal impact. Absent clear and precise standards that govern the establishment of payment rates there is no protection afforded to HCBS providers from the adoption of arbitrary and capricious rate setting policies such as has occurred under the discredited Chapter 51 regulations.

The Department will establish payment rates for HCBS as specified in subsections 6100.482 – 6100.711. Payment rates constitute the maximum payment for a particular HCBS.

(a) An HCBS will be paid based on one of the following:

(1) Fee schedule rates.

(2) Cost-based rates.

(3) Department-established fees for the ineligible portion of residential habilitation.

(4) Managed care or other capitated payment methods.

(5) Vendor goods and services.

~~(6) A method established in accordance with a Federally-approved waiver, including a Federally-approved waiver amendment.~~

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

~~(c) The fee is the maximum amount the Department will pay.~~

~~(d) The fee applies to a specific location and to a specific HCBS.~~

MOVE SUBSECTION (e) TO 6100.482 (j). ~~(e) The provider may not negotiate a different fee or rate with a county mental health and intellectual disability program if there is a fee or rate for the same HCBS at the specific HCBS location.~~

Comment and Suggestion 6100.482: The Department is obligated to pay for HCBS services consistent with the provisions of this chapter 6100. To the extent that the Department seeks to impose any of the provisions of "waiver amendments" or the state plans as mandates, those provisions must be adopted as regulations in accordance with the Commonwealth's regulatory review and approved process. Text is suggested to assure such essential and required consistency.

§ 6100.482. Payment for HCBS services.

(a) The Department will ~~only~~ pay for an HCBS in accordance with this chapter~~,~~ and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies)~~, the Department's Federally-approved waivers and waiver amendments, and the State plan.~~

(b) When a provision in Chapter 1101 or 1150, a provision in a state plan or waiver amendment, is inconsistent with ~~this~~ the provisions of chapter, ~~this~~ the provisions of this chapter shall ~~applies~~ apply.

(c) The Department will ~~only~~ pay for a reimbursable HCBS up to the maximum amount, duration and frequency as specified in the individual's approved PSP and as delivered by the provider.

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

(e) If the HCBS is eligible under the State plan, the provider shall bill the program under the State plan before billing the HCBS waiver or State-funded programs.

(f) The provider shall document a third-party medical resource claim submission and denial for an HCBS under the State plan or a third-party medical resource agency.

(g) Medicaid payment, once accepted by the provider, constitutes payment in full.

(h) A provider who receives a supplemental payment for a support that is included as a support in the PSP, or that is eligible as an HCBS, shall return the supplemental payment to the payer. If the payment is for an activity that is beyond the supports specified in the PSP and for an

activity that is not eligible as an HCBS, the private payment from the individual or another person is permitted.

~~(i) The Department will recoup payments that are not made in accordance with this chapter and the Department's Federally-approved waivers and waiver amendments.~~

(i) The provider may not negotiate a different fee or rate with a county mental health and intellectual disability program if there is a fee or rate for the same HCBS at the specific HCBS location. MOVED FROM 6100.481 SUBSECTION (e) TO 6100.482 (j).

Comment and Suggestion 6100.663:

6100.483 is unnecessary because title to real estate acquired by the provider clearly remains with the provider that owns it.

§ 6100.483. Title of a residential building.

~~The title of a debt-free residential building owned by an enrolled provider shall remain with the enrolled provider.~~

§ 6100.484. Provider billing.

(a) The provider shall submit payment claims consistent with the provisions of the chapter and in accordance with § 1101.68 (relating to invoicing for services).

(b) The provider shall use the Department's information system~~,~~ and forms specified by the Department~~,~~ to submit payment claims.

(c) The provider shall ~~only~~ submit payment claims ~~that are substantiated by documentation~~ as specified in § 6100.226 (relating to documentation of support delivery).

~~(d) The provider may not submit a claim for a support that is inconsistent with this chapter, inappropriate to an individual's needs or inconsistent with the individual's PSP.~~

Comment and Suggestion 6100.485: Providers have the right to know the precise standards that will govern an audit of payments received under this Chapter 6100. Explain the Department's policy and legal justification for imposing so many different standards on HCBS providers. What other Provider type is subject to so many different audit standards?

What is the purpose of requiring costly audits of a fee schedule rate based payment system?

§ 6100.485. Provider Audits.

(a) ~~The provider shall comply with the~~ The following audit requirements apply to cost based payments:

(1) 2 CFR Part 200 (relating to uniform administrative requirements, cost principles, and audit requirements for Federal awards).

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

~~(3) Applicable Office of Management (ADDED UNDERLINE) and Budget Circulars and related applicable guidance issued by the United States Office of Management and Budget.~~

~~(4) Applicable Federal and State statutes, regulations and audit requirements.~~

~~(b) A provider that is required to have a single audit or financial related audit, as defined in Generally Accepted Government Auditing Standards, in accordance with 45 CFR 75.501(i) (relating to audit requirements) shall comply with the Federal audit requirements.~~

~~(c) The Department or the designated managing entity may require the provider to have the provider's auditor perform an attestation engagement in accordance with any of the following:~~

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

~~(2) Standards issued by the Auditing Standards Board.~~

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

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

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

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

~~(d) The Department or the designated managing entity may perform an attestation engagement in accordance with subsection (c).~~

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

~~(f) The Department or the designated managing entity may perform nonaudit services such as technical assistance or consulting engagements.~~

~~(g) The Department or the designated managing entity may conduct a performance audit in accordance with the standards in subsection (c).~~

~~(h) The Department, a designated managing entity, an authorized Federal agency or an authorized State agency may direct the provider to have a performance audit conducted in accordance with the standards in subsection (c).~~

~~(i) A provider that is not required to have a single audit during the Commonwealth fiscal year shall keep records in accordance with subsection (c).~~

~~(j) The Department or the designated managing entity may perform a fiscal review of a provider.~~

Comment and Suggestion 6100.486:

If a provider is paid according to a fee schedule, why should the provider be compelled to obtain bids for services or supplies?

§ 6100.486. Provider Bidding Requirements.

~~(a) For a supply or equipment over $10,000, the provider shall obtain the supply or equipment using a process of competitive bidding or written estimates.~~

~~(b) The cost for will not exceed that. must be the best price made by a prudent buyer.~~

~~(c) If a sole source purchase is necessary, the provider shall keep records supporting the justification for the sole source purchase.~~

~~(d) As used in this section, a "sole source purchase" is one for which only one bid is obtained.~~

§ 6100.487. Loss or damage to property.

If an individual's personal property is lost or damaged during the provision of an HCBS, the provider shall replace the lost or damaged property, or pay the individual the replacement value for the lost or damaged property, unless the damage or loss was the result of the individual's actions.

FEE SCHEDULE

§ 6100.571. Fee schedule rates.

Comment and Suggestion 6100.571:

Providers are entitled to predictability, reliability, and accountability in the rate setting process. Reliance on statements about "review" and "consider" along with the vague reference to "criteria that impacts costs" are imprecise and contrary to the Department's legal obligation to develop payment rates that are sufficient to meet the obligations and requisite costs that providers must incur related to the needs of individuals who are receiving their services through the waiver program. And see comment and suggestion to 6100.481.

(a) Fee schedule rates, which include fees for residential ineligible services, will be established annually by the Department ~~using a market-based approach based on current data and independent data sources~~ as described in this section.

~~(b) The Department will refresh the market-based data used in subsection (a) to establish fee schedule rates at least every 3 years.~~

(b) For Fiscal Year 2017-2018 the Department shall apply the most recent CMS Home Health Market Basket Index to each fee schedule rate for each year from FY 2012-2013 through FY 2017-2018 to establish the FY 2017-2018 Fee Schedule Rates.

~~(c) The market-based approach specified in subsection (a) will review and consider the following factors:~~

~~(1) The support needs of the individuals.~~

~~(2) Staff wages.~~

~~(3) Staff related expenses.~~

~~(4) Productivity.~~

~~(5) Occupancy.~~

~~(6) Program expenses and administration related expenses.~~

~~(7) Geographic costs.~~

~~(8) A review of Federally-approved HCBS definitions in the waiver and determinations made about cost components that reflect costs necessary and related to the delivery of each HCBS.~~

~~(9) A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.~~

~~(10) Other criteria that impact costs.~~

(c) On or before July 30, 2017, the Department shall publish in the Pennsylvania Bulletin a notice that: (1) identifies the FY 2017-2018 Fee Schedule Rates; and (2) sets forth in specific detail the FY 2017-2018 rate setting methodology. The proposed rate setting methodology shall describe the provider costs, assumptions, presumptions, and indexes relied on by the Department to establish the proposed rates. The Department shall apply the most recent CMS Home Health Market Basket Index in establishing the fee schedule rates.

~~(d) The Department will publish as a notice in the *Pennsylvania Bulletin* the factors in subsection (c) used to establish the rates and the fee schedule rates for public review and comment.~~

~~(e) The Department will pay for fee schedule supports at the fee schedule rate determined by the Department.~~

(d) For Fiscal Year 2018-2019, the Department shall update the data base that it relies on to establish fees so as to reflect providers' current costs. On or before December 1, 2017, the Department shall publish its rate setting methodology for Fiscal Year 2018-2019 in the *Pennsylvania Bulletin* for public review and comment. The proposed rate setting methodology shall describe the provider costs, assumptions, presumptions, and indexes relied on by the Department to establish the proposed rates. The Department shall apply the most recent CMS Home Health Market Basket Index in establishing the fee schedule rates.

(e) On or before June 1, 2018, the Department shall publish in the *Pennsylvania Bulletin* the Fiscal Year 2018-2019 fee schedule rates, the details of the rate setting methodology used to establish the rates and its responses to all comments received regarding the proposed rates and rate and rate setting methodology.

(f) The Department shall update the cost data that it relies upon to establish Fee Schedule Rates every three years, and shall follow and comply with the rate setting and publication requirements in subsection (d).

(g) In every fiscal year after FY 2018-2019, in years when the Department does not update the cost data base, it shall apply the most current version of the Home Health Market Basket in establishing the annual fee schedule rates.

COST-BASED RATES AND ALLOWABLE COSTS

§ 6100.641. Cost-based rate.

(a) Sections 6100.642—6100.672 apply to cost-based rates.

(b) An HCBS eligible for reimbursement in accordance with §§ 6100.642—6100.672 includes residential habilitation and transportation.

§ 6100.642. Assignment of rate.

(a) The provider will be assigned a cost-based rate for an existing HCBS at the location where the HCBS is delivered, with an approved cost report and audit, as necessary.

(b) If the provider seeks to provide a new HCBS, the provider will be assigned the area adjusted average rate of approved provider cost-based rates.

(c) A new provider with no historical experience will be assigned the area adjusted average rate of approved provider cost-based rates.

(d) If the provider fails to comply with the cost reporting requirements specified in this chapter without good cause and after consultation with the Department, the provider will be

assigned the lowest rate calculated Statewide based on all provider cost-based rates for an HCBS.

(e) Compliance with cost reporting requirements will be verified by the Department through a designated managing agency review or an audit, as necessary.

§ 6100.643. Submission of cost report.

(a) A cost report is a data collection tool ~~issued~~ used by the Department to collect expense and utilization information from a provider that may include supplemental schedules or addenda as requested by the Department.

(b) The provider shall submit and the Department shall review a cost report on a form specified by and in accordance with the instructions provided by the Department on an annual basis.

(c) Unless a written extension is granted by the Department, the cost report or the cost report addenda shall be submitted to the Department on or before the last Thursday in October for residential habilitation and on or before the last business day in the third week of February for transportation.

(d) A provider with one master provider index number shall submit one cost report for the master provider index number.

(e) A provider with multiple master provider index numbers may submit one cost report for all of its master provider index numbers or separate cost reports for each master provider index number.

(f) The provider shall submit a revised cost report if the provider's audited financial statement is materially different from a provider's cost report by more than 1%.

§ 6100.644. Cost report.

(a) The provider shall complete the cost report to reflect the actual costs and the allowable administrative costs of the HCBS provided to Waiver Program consumers.

(b) The cost report must contain information for the development of a cost-based rate as specified on the Department's form.

(c) A provider of a cost-based service shall allocate eligible and ineligible allowable costs in accordance with the applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

Comment and Suggestion 6100.645:

The last two subsections were switched in order to more accurately reflect the chronology.

§ 6100.645. Cost based rate setting.

(a) The Department will use ~~the~~ each provider's most recently approved cost report, as adjusted by the most recent CMS Home Health Market Basket Index, to establish the provider's cost based rates in each fiscal year. ~~cost-based rate setting methodology to establish a rate for cost-based services for each provider with a Department-approved cost report.~~

~~(b) The approved cost report will be used as the initial factor in the rate-setting methodology to develop the allowable costs for cost-based services.~~

(~~c~~b) ~~The~~ A provider shall complete the cost report in accordance with this chapter.

(~~d~~c) ~~The cost data submitted by the provider on the approved cost report, will be used to set the provider's cost based rates.~~ A provider's cost based rates will be established by the cost data submitted by the provider in an approved cost report, as adjusted on the basis of the most recent CMS Home Health Market Basket Index.

(~~e~~d) Prior to the effective date of the cost based rates, the Department will publish ~~as~~ a notice in the *Pennsylvania Bulletin* that explains the cost-based rate setting methodology for the fiscal year. ~~including the cost report review, outlier analysis, vacancy factor and rate assignment processes.~~

(~~f~~e) The Department, upon the publication of advance public notice and after consideration of public comments, ~~will~~ may adjust the cost report form and instructions based on changes in the ~~support~~ service definitions in the Federally-approved waivers and waiver amendments from the prior cost reporting period.

Comment and Suggestion 6100.646:

The suggested edits assume that payments for service reflect unavoidable, common costs incurred by providers of residential services to maintain their residential programs.

§ 6100.646. Cost-based rates for residential habilitation.

(a) The Department will review unit costs reported on a cost report.

(b) The Department will identify a unit cost as an outlier when that unit cost is at least one standard deviation outside the average unit cost as compared to other cost reports submitted.

(c) The Department, in setting rates, will divide a Provider's allowable costs by the Provider's billed days. ~~will apply a vacancy factor to residential habilitation rates.~~

(d) A provider ~~may request~~ can qualify the additional staffing costs above what is included in the Department-approved cost report rate for current staffing if there is a new individual entering the program who has above-average staffing needs or if an individual's needs have changed significantly as specified in the individual's PSP.

§ 6100.647. Allowable costs.

Comment and Suggestion 6100.647:
This section is replaced by the definition under 6100.3 of "allowable cost." The proposed regulation is unnecessarily complex and vague. The suggested text incorporates the objective of the proposed regulation in reliance on 2 C.F.R 200.

~~(a) A cost must be the best price made by a prudent buyer.~~

~~(b) A cost must relate to the administration or provision of the HCBS.~~

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

~~(d) Allowable costs must include costs specified in this chapter and costs that are in accordance with the Department's Federally-approved waivers and waiver amendments.~~

~~(e) To be an allowable cost, the cost must be documented and comply with the following:~~

~~(1) Applicable Federal and State statutes, regulations and policies.~~

~~(2) Generally Accepted Government Auditing Standards and applicable Departmental procedures.~~

~~(f) A cost used to meet cost sharing or matching requirements of another Federally-funded program in either the current or a prior period adjustment is not allowable.~~

~~(g) Transactions involving allowable costs between related parties shall be disclosed on the cost report.~~

Comment and Suggestion 6100.648: In a single payer system, which does not reimburse a Provider's full allowable cost, why does the Department seek to impose limitations on donations?

~~§ 6100.648. Donations.~~

~~(a) A provider may not report a donation that is restricted for a purpose other than for an allowable HCBS cost, and a donation that is unrestricted, but not used for an allowable HCBS cost.~~

~~(b) If an unrestricted donation is used for an allowable HCBS cost, the provider shall claim an expense and offsetting revenue for the donation.~~

~~(c) The provider shall report unrestricted donations used for an HCBS in accordance with the following:~~

~~(1) List the cash donation that benefits the direct or indirect expenditures on the cost report as income.~~

~~(2) Reduce gross eligible expenditures in calculating the amount eligible for Departmental participation by the amount of the donation.~~

~~(3) Fully disclose a noncash donation that exceeds $1,000, either individually or in the aggregate, including the estimated value and intended use of the donated item.~~

~~(4) If a donated item is sold, treat the proceeds from the sale as an unrestricted cash donation.~~

§ 6100.649. Management fees.

A cost included in the provider's management fees must meet the standards in § 6100.647 (relating to allowable costs).

Comment and Suggestion 6100.650: The Department must explain the necessity for (b)(3) and (c)

§ 6100.650. Consultants.

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

(b) The provider shall have a written agreement with a consultant. The written agreement must include the following:

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

(2) The rate of payment.

~~(3) The method of payment.~~

~~(c) The provider may not include benefits as an allowable cost for a consultant.~~

§ 6100.651. Governing board.

(a) Compensation for governing board member duties is not an allowable cost.

(b) Allowable costs for a governing board member include the following:

(1) Meals, lodging and transportation while participating in a board meeting or function.

(2) Liability insurance coverage for a claim against a board member that was a result of the governing board member performing official governing board duties.

(3) Training related to the delivery of an HCBS.

(c) Allowable expenses for governing board meals, lodging and transportation, paid through HCBS funding, are limited to the Commonwealth-established reimbursement limits applicable for Commonwealth employees.

(1) Nothing in this subsection restricts the amount supplemented by the provider.

(2) Nothing in this subsection applies Commonwealth-established policies and practices beyond the reimbursement limits for meals, lodging and transportation.

Comment and Suggestion 6100.652: The provisions in (b) are covered in (c)

§ 6100.652. Compensation.

(a) Compensation for staff persons, including pension, health care and accrued leave benefits, is an allowable cost.

~~(b) A bonus or severance payment, that is part of a separation package, is not an allowable cost.~~

(e)(b) Internal Revenue Service statutes and regulations and applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget apply regarding compensation, benefits, bonuses and severance payments.

§ 6100.653. Training.

The cost of training related to the delivery of an HCBS is an allowable cost.

§ 6100.654. Staff recruitment.

The cost relating to staff recruitment is an allowable cost.

§ 6100.655. Travel.

(a) A travel cost, including meals, lodging and transportation, is allowable.

(b) Allowable expenses for meals, lodging and transportation, paid through HCBS funding, are limited to the Commonwealth-established reimbursement limits applicable for Commonwealth employees.

(1) Nothing in this subsection restricts the amount supplemented by the provider.

(2) Nothing in this subsection applies to Commonwealth-established policies and practices beyond the reimbursement limits for meals, lodging and transportation.

§ 6100.656. Supplies.

The purchase of a supply is an allowable cost if the supply is used in the normal course of business and purchased in accordance with applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

§ 6100.657. Rental equipment and furnishing.

Rental of equipment or furnishing(s) is an allowable cost if the rental is ~~more~~ as cost-efficient ~~than~~ as purchasing.

§ 6100.658. Communication.

The following are examples of communication costs that support the administration or provision of an HCBS are allowable costs:

(1) Telephone (phone conferencing and video conferencing).

(2) Internet connectivity.

(3) Digital imaging.

(4) Postage.

(5) Stationary.

(6) Printing.

§ 6100.659. Rental of administrative space.

(a) The cost of rental of an administrative space, from a related or unrelated party for a programmatic purpose for an HCBS, is allowable, subject to the following:

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

(2) The cost of rent under a lease with a related party is limited to the lessor's actual allowable costs as provided in § 6100.663 (relating to fixed assets of administrative buildings).

(3) The rental cost under a sale-leaseback transaction, as described in Financial Accounting Standards Board Accounting Standards Codification Section 840-40, as amended, is allowable up to the amount that would have been allowed had the provider continued to own the property.

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

(1) Maintenance.

(2) Real estate taxes as limited by § 6100.660 (relating to occupancy expenses for administrative buildings).

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

(d) A rental cost under a lease which is required to be treated as a capital lease under the Financial Accounting Standards Board Accounting Standards Codification Section 840-10-25-1, as amended, is allowable up to the amount that would have been allowed had the provider purchased the property on the date the lease agreement was executed.

~~(e) An unallowable cost includes the following:~~

~~(1) Profit.~~

~~(2) Management fee.~~

~~(3) A tax not incurred had the provider purchased the space.~~

§ 6100.660. Occupancy expenses for administrative buildings.

(a) The following costs are allowable costs for administrative buildings:

(1) The cost of a required occupancy-related tax and payment made instead of a tax.

(2) An associated occupancy cost charged to a specified service location. The associated occupancy cost shall be prorated in direct relation to the amount of space utilized by the service location.

(3) The cost of an occupancy-related tax or payment made instead of a tax, if it is stipulated in a lease agreement.

(4) The cost of a certificate of occupancy.

(b) The provider shall keep documentation that a utility charge is at fair market value.

(c) The cost of real estate taxes, net of available rebates and discounts, whether the rebate or discount is taken, is an allowable cost.

(d) The cost of a penalty resulting from a delinquent tax payment, including a legal fee, is not an allowable cost.

§ 6100.661. Fixed assets.

Comment and Suggestion 6100.661:

For (h): This is likely an oversight by the drafter: Fixed assets are overwhelmingly purchased with Fixed-Rate or Ineligible revenues (not by provider choice, they are not Eligible residential expenses). To start moving funds between the Eligible and Ineligible or Eligible and Fixed-Rate (Cost-Based and Set Cost) sides of accounting is problematic and invites co-mingling of funds in various directions. Under the existing methodology, segregation of accounts is necessary: Fixed-Rate funds should pay for Fixed Rate costs and Cost-Based funds should pay for Cost-Based expenses.

As proposed, section (h) does not consider that there may be fixed assets that are ineligible, in support of the homes and reimbursed as ineligible on the fee schedule, and other assets that are eligible in support of administration and reflected on the cost report.

For accounting purposes, any receipts from the disposal of a fixed asset, or, frankly any asset, should reduce depreciation expenses in that year, to the extent that the receipt exceeds any remaining depreciable amounts. So, for example, a $500 item is depreciated by $400 over several years. The remaining depreciable balance is $100. Should the receipts from the disposal be in excess of $100, the amount above $100 would be considered as income. The rationale here is that you spent $500 for the item so you are permitted to depreciate $500 over several years. As you still have $100 and as you disposed of the asset, you may not claim the $100 as expense, the first $100 of receipts for it should not offset current year depreciation. Any amount above $100 would be profit on the asset and should offset depreciation expense.

If the $500 was fully depreciated and you received $100 in disposal, then (h) would be ok assuming that the asset was an "eligible" cost based fixed asset.

Any asset solely used in support of a fee schedule service (h) should not apply.

(a) A fixed asset cost is an allowable cost.

(b) The provider shall determine whether an allowable fixed asset shall be capitalized, depreciated or expensed in accordance with the following conditions:

(1) The maximum allowable fixed asset threshold as defined in applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

(2) Purchases below the maximum allowable fixed asset threshold shall be expensed.

(c) The provider shall select the method used to determine the amount of depreciation charged in that year for the year of acquisition.

(d) The provider shall include depreciation based on the number of months or quarters the asset is in service or a half-year or full-year of depreciation expense.

(e) The provider may not change the method or procedure, including the estimated useful life and the convention used for an acquisition, for computing depreciation without prior written approval from the Department.

(f) The provider acquiring a new asset shall have the asset capitalized and depreciated in accordance with the Generally Accepted Government Auditing Standards. The provider shall continue using the depreciation method previously utilized by the provider for assets purchased prior to July 1, 2011.

(g) The provider shall keep the following:

(1) The title to any fixed assets that are depreciated.

(2) The title to any fixed assets that are expensed or loans amortized using Department funding.

~~(h) The provider shall use income received when disposing of fixed assets to reduce gross eligible expenditures in determining the amount eligible for Departmental participation as determined by the cost report.~~

(i) A provider in possession of a fixed asset shall do the following:

(1) Maintain a fixed asset ledger or equivalent document.

(2) Utilize reimbursement for loss, destruction or damage of a fixed asset by using the proceeds towards eligible waiver program expenditures.

~~(3) Perform an annual physical inventory at the end of the funding period or Commonwealth fiscal year. An annual physical inventory is performed by conducting a physical verification of the inventory listings.~~

~~(4) Document discrepancies between physical inventories or fixed asset ledgers.~~

(5) Maintain inventory reports and other documents in accordance with this chapter.

~~(6) Offset the provider's total depreciation expense in the period in which the asset was sold or retired from service by the gains on the sale of assets.~~

(j) The cost basis for depreciable assets must be determined and computed as follows:

(1) The purchase price if the sale was between unrelated parties.

(2) The seller's net book value at the date of transfer for assets transferred between related parties.

(3) The cost basis for assets of an agency acquired through stock purchase will remain unchanged from the cost basis of the previous owner.

(k) Participation allowance is permitted up to 2% of the original acquisition cost for fully depreciated fixed assets.

(1) Participation allowances shall only be taken for as long as the asset is in use.

~~(2) Participation amounts shall be used for maintaining assets, reinvestment in the program or restoring the program due to an unforeseen circumstance.~~

(3) Depreciation and participation allowance may not be expensed at the same time for the same asset.

§ 6100.662. Motor vehicles.

The cost of the purchase or lease of motor vehicles and the operating costs of the vehicles is an allowable cost in accordance with the following:

(1) The cost of motor vehicles through depreciation, participation allowance, expensing or amortization of loans for the purchase of a vehicle is an allowable expense. Depreciation and lease payments are limited in accordance with the annual limits established under section 280F of the Internal Revenue Code (26 U.S.C.A. § 280F).

(2) The provider shall keep a daily log detailing the use~~, maintenance and services activities~~ of vehicles.

(3) The provider shall analyze the cost differences between leasing and purchase of vehicles and the most practicable economic alternative shall be selected.

(4) The provider shall keep documentation of the cost analysis.

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

Comment and Suggestion 6100.663:

Subsection (f) must be deleted. The Department does not have the authority to retroactively create an entitlement to equity in real estate it does not own.

Subsection (g) is unnecessary. Title to real estate acquired by the provider clearly remains with the provider that owns it.

§ 6100.663. Fixed assets of administrative buildings.

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

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

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

(d) The provider shall use the depreciation methodology in accordance with § 6100.661 (relating to fixed assets).

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

~~(f) If an administrative building is sold or the provider no longer utilizes the administrative building for an HCBS, the Department shall recoup the funded equity either directly or through rate setting. As used in this subsection, "funded equity" is the value of property over the liability on the property.~~

~~(1) The provider shall be responsible for calculating the amounts reimbursed and the amounts shall be verified by an independent auditor.~~

~~(2) As an alternative to recoupment, with Department approval, the provider may reinvest the reimbursement amounts from the sale of the administrative or nonresidential building into any capital asset used in the program.~~

(g) The title of any administrative building acquired and depreciated shall remain with the enrolled provider.

§ 6100.664. Residential habilitation vacancy.

~~(a) The Department will establish a vacancy factor for residential habilitation that is included in the cost-based rate setting methodology.~~

~~(b) The vacancy factor for residential habilitation shall be calculated based on all the provider's residential habilitation locations.~~

(e)(a) ~~The~~ A provider may not limit ~~the~~ an individual's leave days.

(d)(b) The grounds for a change in a provider or a transfer of an individual against the individual's wishes under § 6100.303 (relating to reasons for a transfer or a change in a provider) do not apply to a transfer under subsection (e).

(e)(c) The provider may not transfer an individual due to the individual's absence until after the provider has received written approval from the Department.

§ 6100.665. Indirect costs.

(a) An indirect cost is an allowable cost if the following criteria are met:

(1) The provider shall have a cost allocation plan.

(2) Costs are authorized in accordance with applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget and § 6100.647 (relating to allowable costs).

(b) The provider shall consider the reason the cost is an indirect cost, as opposed to a direct cost, to determine the appropriate cost allocation based on the benefit to the HCBS.

(c) If a cost is identified as an indirect cost, the cost will remain an indirect cost as long as circumstances remain unchanged.

~~(d) The provider shall select an allocation method to assign an indirect cost in accordance with the following:~~

~~(1) The method is best suited for assigning a cost with a benefit derived.~~

~~(2) The method has a traceable cause and effect relationship.~~

~~(3) The cost cannot be directly attributed to an HCBS.~~

~~(e) The provider shall allocate a general expense in a cost group that is more general in nature to produce a result that is equitable to both the Department and the provider.~~

§ 6100.666. Moving expenses.

(a) The actual cost associated with the relocation of a waiver support location is allowable.

~~(b) Moving expenses for an individual is allowable if the provider receives approval from the Department or the designated managing entity prior to the move.~~

§ 6100.667. Interest expense.

(a) Short-term borrowing is a debt incurred by a provider that is due within 1 year.

(b) Interest cost of short-term borrowing from an unrelated party to meet actual cash flow requirements for the administration or provision of an HCBS is an allowable cost.

§ 6100.668. Insurance.

The cost for an insurance premium is allowable if it is limited to the ~~minimum~~ amount needed to cover the loss or provide for replacement value.~~, including the following:~~

~~(1) General liability.~~

~~(2) Casualty.~~

~~(3) Property.~~

~~(4) Theft.~~

~~(5) Burglary insurance.~~

~~(6) Fidelity bonds.~~

~~(7) Rental insurance.~~

~~(8) Flood insurance, if required.~~

~~(9) Errors and omissions.~~

Comment and Suggestion 6100.669: Where a Provider in good faith challenges actions/decisions by the Department and the parties resolve the dispute and so avoid the cost and uncertainty of time consuming litigation for both parties, the legal fees and costs incurred by the provider must be recognized. Suggested text addresses the proposed and unjustified absolute limitation on reasonable costs incurred to challenge Department action.

§ 6100.669. Other allowable costs.

(a) The following costs are allowable if they are related to the administration of HCBS:

(1) Legal fees with the exception of those listed in subsection (b).

(2) Accounting fees, including audit fees.

(3) Information technology costs.

(4) Professional membership dues for the provider, excluding dues or contributions paid to lobbying groups.

(5) Self-advocacy or advocacy organization dues for an individual, excluding dues or contributions paid to lobbying groups. This does not include dues paid to an organization that has as its members, or is affiliated with an organization that represents, individuals or entities that are not self-advocates or advocates.

(b) Legal fees for prosecution of claims against the Commonwealth and expenses incurred for claims against the Commonwealth are ~~not~~ allowable ~~unless~~ in full if the provider prevails ~~at the~~ hearing. In the event the Commonwealth and the Provider amicably resolve the Provider's claim(s), one-half of the provider's documented legal fees are allowable costs.

§ 6100.670. Start-up cost.

(a) A start-up cost shall be utilized only for a one-time activity related to one of the following:

(1) Opening a new location.

(2) Introducing a new product or support.

(3) Conducting business in a new geographic area.

(4) Initiating a new process.

(5) Starting a new operation.

(b) Within the approved waiver appropriation, a start-up cost may be approved and authorized by the Department in accordance with the Department's Federally-approved waivers and waiver amendments.

(c) A start-up cost shall be authorized in accordance with Standard Operating Procedure 98-5 issued by the American Institute of Certified Public Accountants (SOP 98-5), as amended.

§ 6100.671. Reporting of start-up cost.

(a) A start-up cost that has been reimbursed by the Department shall be reported as income.

(b) A start-up cost within the scope of Standard Operating Procedure 98-5 shall be expensed as the costs are incurred, rather than capitalized.

§ 6100.672. ~~Cap on~~ Start-up cost(s).

(a) ~~A cap on start-up cost will be established by the Department.~~ The Department shall pay a provider its allowable costs relating to the start-up of a new location.

(b) A request for a waiver in accordance with § 6100.43 (relating to regulatory waiver) may be requested if the waiver conditions in § 6100.43 and one of the following conditions are met:

(1) The start-up cost provides greater independence and access to the community.

(2) The start-up cost is necessary to meet life safety code standards.

(3) The cost of the start-up activity is more cost effective than an alternative approach.

ROOM AND BOARD

§ 6100.681. Room and board applicability.

Sections 6100.682—6100.694 apply for the room and board rate charged to the individual for residential habilitation.

§ 6100.682. Support to the individual.

(a) If an individual is not currently receiving SSI benefits, the provider shall provide support to the individual to contact the appropriate county assistance office.

(b) If an individual is denied SSI benefits, the provider shall assist the individual in filing an appeal, if desired by the individual.

(c) The provider shall assist the individual to secure information regarding the continued eligibility of SSI for the individual.

§ 6100.683. No delegation permitted.

The provider shall collect the room and board from the individual or the person designated by the individual directly and may not delegate that responsibility.

§ 6100.684. Actual provider room and board cost.

(a) The total amount charged for the individual's share of room and board may not exceed the actual documented value of room and board provided to the individual, minus the benefits received as specified in § 6100.685 (relating to benefits).

(b) The provider shall compute and document actual provider room and board costs each time an individual signs a new room and board residency agreement.

(c) The provider shall keep documentation of actual provider room and board costs.

§ 6100.685. Benefits.

(a) The provider shall assist an individual in applying for energy assistance, rent rebates, food stamps and similar benefits.

(b) If energy assistance, rent rebates, food stamps or similar benefits are received, the provider shall deduct the value of these benefits from the documented actual provider room and board cost as specified in § 6100.684 (relating to actual provider room and board cost) before deductions are made to the individual's share of room and board costs.

(c) An individual's energy assistance, rent rebates, food stamps or similar benefits may not be considered as part of an individual's income or resources.

(d) The provider may not use the value of energy assistance, rent rebates, food stamps or similar benefits to increase the individual's share of room and board costs beyond actual room and board costs as specified in § 6100.684.

§ 6100.686. Room and board rate.

(a) If the actual provider room and board cost as specified in § 6100.684 (relating to actual provider room and board cost), less any benefits as specified in § 6100.685 (relating to benefits), is more than 72% of the SSI maximum rate, the following criteria shall be used to establish the room and board rate:

(1) An individual's share of room and board may not exceed 72% of the SSI maximum rate.

(2) The proration of board costs shall occur after an individual is on leave from the residence for a consecutive period of 8 days or more. This proration may occur monthly, quarterly or semiannually as long as there is a record of the board costs that were returned to the individual.

(b) If an individual has earned wages, personal income from inheritance, Social Security or other types of income, the provider may not assess the room and board cost for the individual in excess of 72% of the SSI maximum rate.

(c) If available income for an individual is less than the SSI maximum rate, the provider shall charge 72% of the individual's available monthly income as the individual's monthly obligation for room and board.

(d) An individual shall receive at least the monthly amount as established by the Commonwealth and the Social Security Administration for the individual's personal needs allowance.

§ 6100.687. Documentation.

If the actual provider room and board cost charged to an individual as specified in § 6100.684 (relating to actual provider room and board cost) is less than 72% of the SSI maximum rate, the provider shall keep the following documentation:

(1) The actual value of the room and board is less than 72% of the current maximum SSI monthly benefit.

(2) The Social Security Administration's initial denial of the individual's initial application for SSI benefits and the upholding of the initial denial through at least one level of appeal.

§ 6100.688. Completing and signing the room and board residency agreement.

(a) The provider shall ensure that a room and board residency agreement, on a form ~~specified~~ approved by the Department (or where applicable, another government agency, e.g. Housing and Urban Development), is completed and signed by the individual annually.

(b) If an individual is adjudicated incompetent to handle finances, the individual's court-appointed legal guardian shall sign the room and board residency agreement.

(c) If an individual is 18 years of age or older and has a designated person for the individual's benefits, the designated person and the individual shall sign the room and board residency agreement.

(d) The room and board residency agreement shall be completed and signed in accordance with one of the following:

(1) Prior to an individual's admission to residential habilitation.

(2) Prior to an individual's transfer from one residential habilitation location or provider to another residential habilitation location or provider.

(3) Within 15 days after an emergency residential habilitation placement.

§ 6100.689. Modifications to the room and board residency agreement.

(a) If an individual pays rent directly to a landlord, and food is supplied through a provider, the room provisions shall be deleted from the room and board residency agreement and the following shall apply:

(1) The individual shall pay 32% of the SSI maximum rate for board.

(2) If an individual's income is less than the SSI maximum rate, 32% of the available income shall be charged to fulfill the individual's monthly obligations for board.

(b) If an individual pays rent to a provider, but the individual purchases the individual's own food, the board provisions shall be deleted from the room and board residency agreement and the following shall apply:

(1) The individual shall pay 40% of the SSI maximum rate for room.

(2) If an individual's income is less than the SSI maximum rate, 40% of the available income shall be charged to fulfill the individual's monthly obligations for room.

§ 6100.690. Copy of room and board residency agreement.

(a) A copy of the completed and signed room and board residency agreement shall be given to the individual, the individual's designated person and the individual's court-appointed legal guardian, if applicable.

(b) A copy of the completed and signed room and board residency agreement shall be kept in the individual's record.

§ 6100.691. Respite care.

There may not be a charge for room and board to the individual for respite care if respite care is provided for 30 days or less in a Commonwealth fiscal year.

Comment and Suggestion 6100.692: This provision is acceptable as long as it is understood that the Department is responsible for payment after 30 consecutive days' absence.

§ 6100.692. Hospitalization.

There may not be a charge for room and board to the individual after 30 consecutive days of being in a hospital or rehabilitation facility and the individual is placed in reserved capacity.

§ 6100.693. Exception.

There may not be a charge for board to the individual if the individual does not take food by mouth.

§ 6100.694. Delay in an individual's income.

If a portion or all of the individual's income is delayed for 1 month or longer, the following apply:

(1) The provider shall inform the individual, the individual's designated person or the individual's court-appointed legal guardian in writing that payment is not required or that only a small amount of room and board payments is required until the individual's income is received.

(2) Room and board shall be charged to make up the accumulated difference between room and board paid and room and board charged according to the room and board residency agreement.

~~**DEPARTMENT-ESTABLISHED FEE FOR INELIGIBLE PORTION**~~

Comment and Suggestion 6100.711: Language added to 6100.571 covers this section

~~**§ 6100.711. Fee for the ineligible portion of residential habilitation.**~~

~~(a) The Department will establish a fee for the ineligible portion of payment for residential habilitation services in accordance with….~~

~~(b) The Department-established fee will be established using a market-based approach based on current data and independent data sources.~~

~~(c) The Department will refresh the market-based data used in subsection (a) to establish Department-established fees at least every 3 years.~~

~~(d) The market-based approach specified in subsection (c) will review and consider the following factors:~~

~~(1) The support needs of the individuals.~~

~~(2) Staff wages.~~

~~(3) Staff-related expenses.~~

~~(4) Productivity.~~

~~(5) Occupancy.~~

~~(6) Custodial and maintenance expenses.~~

~~(7) Geographic costs.~~

~~(8) A review of approved HCBS definitions and determinations made about cost components that reflect costs necessary and related to the delivery of each HCBS.~~

~~(9) A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.~~

~~(10) Other criteria that impact costs.~~

~~(e) The Department will publish as a notice in the *Pennsylvania Bulletin* the factors in subsection (d) used to establish the rates and the fee schedule rates for public review and comment.~~

~~(f) The Department will pay for Department-established fee supports at the fees determined by the Department.~~

~~ENFORCEMENT~~ COMPLIANCE

Comment and Suggestion 6100.741:

Text has been added/deleted to reflect clarity, brevity and reasonableness. Terminology such as "enforcement" and "sanctions" and "array of sanctions" is outdated and not reflective of the purpose and intent of this section.

§ 6100.741. ~~Sanctions~~ Imposition of remedies.

(a) The Department ~~has the authority to~~ will ~~enforce~~ assure compliance with the provisions of this chapter through ~~an array of sanctions~~ the imposition of the remedies described in this section and 55 Pa Code § 1101.74 – 1101.77. The specific remedy that may be imposed will depend on facts relating to the regulatory infraction.

(b) ~~A sanction may be implemented by the Department for the following:~~ The Department may impose a sanction upon a finding that a provider has committed a regulatory violation(s) including but not limited to:

(~~2~~) (1) ~~Failure~~ refusal to submit an acceptable corrective action plan in accordance with the time frame specified by the Department and as specified in § 6100.42(e) (relating to monitoring compliance).

(~~3~~) (2) ~~Failure~~ refusal to implement a corrective action plan or a directed corrective action plan, including the compliance steps and the timelines in the plan.

~~(4)~~(3) ~~Fraud, deceit or falsification of~~ intentional submission of false or misleading documents or information related to the provision of services under this chapter.

(~~5~~)(4) ~~Failure~~ refusal to provide free and full access to the provider's premises for lawfully authorized purposes to the Department, the designated managing entity, or other authorized Federal or State officials.

(~~6~~)(5) failure to provide requested documents or other requested information in a timely manner upon the receipt of reasonable, advance written notice of the request ~~of~~ from the Department, the designated managing entity, or an authorized Federal or State agency.

§ 6100.742. ~~Array of sanctions.~~ Types of remedies.

(a) After affording a provider written notice of an alleged regulatory violation and the opportunity to challenge the violation(s) under 55 Pa. Code Chapter 41, the Department may apply the following remedies:

(1) Recoup~~ing~~, suspend~~ing~~ or disallow~~ing~~ a payment to the provider.

(2) Terminat~~ing~~e a provider agreement for participation in an HCBS waiver program.

(3) Prohibit~~ing~~ the delivery of ~~supports~~ services to a new individual.

(4) Prohibit~~ing~~ the provision of specified ~~supports~~ services at a specified location.

(5) Prohibit~~ing~~ the enrollment of a new support location.

~~(6) Ordering the appointment of a master as approved by the Department, at the provider's expense and not eligible for reimbursement from the Department, to manage and direct the provider's operational, program and fiscal functions.~~

(7) Remove~~ing~~ an individual from a premise.

~~**§ 6100.743. Consideration as to type of sanction utilized.**~~

Comment and Suggestion 6100.743: The Department, in determining the nature and scope of a particular remedy, may not act in capricious disregard of the facts that underlie the regulatory violation. The Department's notion that it "may" consider "variables" in determining a remedy is unsupported in law. Here again, the Department wrongly presumes unfettered discretion in its application of regulations. The Department is duty-bound to act in accordance with actual facts and must avoid the contrary, untenable and mistaken view that it possesses "full discretion" to take any action in an otherwise regulated environment.

~~(a) The Department has full discretion to determine and implement the type of sanction it deems appropriate in each circumstance specified in § 6100.741(b) (relating to sanctions).~~

~~(b) The Department has the authority to implement a single sanction or a combination of sanctions.~~

~~(c)~~ 6100.742 (b) The Department ~~may~~ shall consider the following ~~variables~~ facts when determining and implementing ~~a sanction or combination of sanctions~~ a remedy:

(1) The seriousness of the ~~condition~~ infraction~~. specified in § 6100.741(b).~~

(2) The ~~continued nature~~ duration of the ~~condition~~ infraction ~~in § 6100.741(b).~~

(3) The repeated nature of the ~~condition~~ infraction ~~in § 6100.741(b).~~

~~(4) A combination of the conditions specified in § 6100.741(b).~~

~~(5) The history of provisional licenses issued by the Department.~~

~~(6) The history of compliance with this chapter, Departmental regulations such as licensure regulations and applicable regulations of other State and Federal agencies.~~

Comment and Suggestion 6100.744: This section was incorporated into §6100.741.

~~**§ 6100.744. Additional conditions and sanctions.**~~

~~In addition to sanctions and sanction conditions specified in this chapter, the provider is subject to the following:~~

~~(1) Sections 1101.74, 1101.75, 1101.76 and 1101.77.~~

~~(2) Other Departmental sanctions as provided by applicable law.~~