3160

14-540-248

Kroh, Karen

From:	Mochon, Julie
Sent:	Tuesday, December 20, 2016 3:22 PM
To:	Kroh, Karen
Subject:	FW: Comments regarding 6100 Regulations
Attachments:	arcoverletter.pdf; Reg Comments 6100.pdf

From: Amber Roeder [mailto:aroeder@friendshipcommunity.net]
Sent: Tuesday, December 20, 2016 3:16 PM
To: Mochon, Julie
Subject: Comments regarding 6100 Regulations

Good Afternoon,

Please see attached documents.

Best,

Amber Roeder
Program Specialist

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Friendship COMMUNITY

December 20, 2016

Julie Mochon
Human Service Program Specialist Supervisor
Office of Developmental Programs
Room 502, Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120

Re: Comments on Regulation No. 14 – 540

Dear Ms. Mochon:

Friendship Community wishes to submit the following comments and suggestions to the proposed rulemaking published by the Department of Human Services ("Department") on November 5, 2016. As a Provider of supports and services for Individuals with intellectual disabilities and/or autism, the regulations are of vital importance as we strive to assist Individuals to achieve meaningful community integration and to achieve greater independence consistent with their person centered support plans. Our comments and suggestions relate to individual regulations and include recommended adoption of text or deletion of text in order to further clarify our comments and suggestions.

In working with Individuals and their families over the past 44 years, it is our desire to provide thoughtful comments and suggestions, guided by the varied experiences throughout our Organization. We wish to advocate for regulations and policies that will best support Individuals, consistent with the principles contained in the "Everyday Lives" Office of Developmental Programs publication. This industry is dependent on a single payer system, therefore, the scope of regulatory oversight of service provision and the formulation of the criteria for continued licensure will have a definite effect on the economic viability of continued service provision. As a Provider of varied services, we request a rate setting process that reflects sustainability and predictability in order to align costs with payments consistent to support each consumer's mandated support plan.

The Notice of proposed rulemaking published on November 5, 2016 invites public comment and neither imposes nor references any conditions or limitations or restrictions on the format and wording of public comments. We understand that, in proposing and adopting regulations, the Department itself is subject to requirements relating to style, usage and format

(e.g., the use of "shall" as opposed to "will"). But, and as confirmed by the Independent Regulatory Review Commission, those style and format rules applicable to the Department do not constrain the style and format of public comments, which the Department must respond to if submitted within the comment period to the location identified in *The Pennsylvania Bulletin*.

We appreciate the opportunity to make public comments and suggestions regarding this vital change in regulations (which will replace Chapter 51 rulemaking) for Pennsylvania citizens supported by a trained and dedicated workforce that are in dire need of fair and competitive wages and benefits. We believe well written and supportive, general regulations will lead to a sustainable system for these most vulnerable Pennsylvania citizens, well into the future.

Sincerely,

Amber Roeder

Amber Roeder, Program Specialist
Friendship Community

Suggested deletions in ~~RED STRIKETHROUGH~~. Suggested additions in BLUE UNDERLINE. Comments are in YELLOW HIGHLIGHTS.

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Friendship COMMUNITY

PART VIII. INTELLECTUAL DISABILITY AND AUTISM MANUAL

Subpart C. ADMINISTRATION AND FISCAL MANAGEMENT

(*Editor's Note*: The following chapter is new and printed in regular type to enhance readability.)

CHAPTER 6100. SUPPORT FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR AUTISM

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GENERAL PROVISIONS

§ 6100.1. Purpose.

(a) The purpose of this chapter is to specify the program and operational requirements for applicants and providers of HCBS and supports to individuals provided through base-funding.

(b) This chapter supports individuals with an intellectual disability or autism to achieve greater independence, choice and opportunity in their lives through the effective and efficient delivery of HCBS and supports to individuals provided through base-funding.

§ 6100.2. Applicability.

(a) This chapter applies to HCBS provided through waiver programs under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) for individuals with an intellectual disability or autism.

(b) This chapter applies to State plan HCBS for individuals with an intellectual disability or autism.

(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.

§ 6100.3. Definitions.

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

Allowable cost—Expenses considered reasonable, necessary and related to the support provided.

Applicant—An entity that is in the process of enrolling in the Medical Assistance program as a provider of HCBS.

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).

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.

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.

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

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

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—An activity, service, assistance or product provided to an individual that is funded through a Federally-approved waiver program or the State plan.

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

Natural support—An activity or assistance that is provided voluntarily to the individual instead of a reimbursed support.

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

PSP—Person-centered support plan.

Provider—The person, entity or agency that is contracted or authorized to deliver the support to the individual.

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.

SSI—Supplemental security income.

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

Support—An activity, service, assistance or product provided to an individual that is provided through a Federally-approved waiver program, the State plan or base-funding. A support includes an HCBS, support coordination, 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.

GENERAL REQUIREMENTS

§ 6100.41. Appeals.

Appeals related to this chapter shall be made in accordance with Chapter 41 (relating to Medical Assistance provider appeal procedures).

§ 6100.42. Monitoring compliance.

(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.

(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.

(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.

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

(g) The Department or the designated managing entity may issue a directed corrective action plan to direct the provider to complete a specified course of action to correct a violation or alleged violation of this chapter.

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

(k) The provider shall keep documentation relating to an audit, provider monitoring or other monitoring method, including supporting compliance documents.

§ 6100.43. Regulatory waiver.

(a) A provider may submit a request for a waiver 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 shall be submitted on a form specified by the Department.

(c) The Secretary of the Department or the Secretary's designee may grant a waiver if the following conditions are met:

(1) There is no jeopardy to an individual's health, safety and well-being.

(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) The Department will specify an effective date and an expiration date for a waiver that is granted.

(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) The provider shall discuss and explain the request for a waiver with the affected individuals, 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.

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

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

(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.

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

(3) A discussion of alternate health and safety protections, if applicable.

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

(5) The geographic location of the innovation project.

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

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

(8) A description of the advisory committee who will advise the innovation project.

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

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

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

(12) Proposed changes to supports.

(13) A detailed budget for the innovation project.

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

(15) 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 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.

(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, at its discretion.

§ 6100.45. Quality management.

(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.

§ 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 direct contact with an individual until the abuse investigation is concluded and the investigating agency has confirmed that no abuse occurred.

(c) In addition to the reporting required under subsection (a), the provider shall immediately report the abuse, suspected abuse or alleged abuse to the following:

(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.

§ 6100.47. Criminal history checks.

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

(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 included in the PSP:

(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.

§ 6100.48. Funding, hiring, retention and utilization.

(a) Funding, hiring, retention and utilization of persons who provide reimbursed support 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.

§ 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 understood by the individual or a person designated by the individual.

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

§ 6100.51. Grievances.

(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.

(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.

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

§ 6100.52. Rights team.

(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.

§ 6100.53. Conflict of interest.

(a) The provider shall develop 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) An individual or a friend or family member of an individual may serve on the governing board.

§ 6100.54. Recordkeeping.

(a) The provider shall keep individual records confidential and in a secure location.

(b) The provider may not make individual 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 under this chapter shall be kept 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 audit or litigation is resolved.

(3) In accordance with 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 years from the date of termination.

§ 6100.55. Reserved capacity.

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.

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

(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:

(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.

(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.

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.

(a) The provider shall comply with the Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable.

(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.

(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) 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:

(1) System for award management.

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

(3) Medicheck list.

§ 6100.86. Delivery of HCBS.

(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 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.

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

TRAINING

§ 6100.141. Annual training plan.

(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.

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

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

(d) The annual training plan must include the following:

(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.

§ 6100.142. Orientation program.

(a) 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 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) Job-related knowledge and skills.

§ 6100.143. Annual training.

(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.

(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).

(b) An individual shall be continually supported to exercise the individual's rights.

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

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

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

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

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

§ 6100.182. Rights of the individual.

(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 choice or to practice no religion.

(c) An individual may not be abused, neglected, mistreated, exploited, abandoned or 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.

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

(g) An individual has the right to control the individual's own schedule and activities.

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

(n) 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.

(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.

Comment [a1]: Does this mean any food item at any item or the ability to access some food? Would a doctor's order to avoid certain foods or limit portion sizes be taken into consideration?

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

§ 6100.184. Negotiation of choices.

(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.

(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 facilitate and make the accommodations necessary to involve the individual's family, friends and others in decision making, planning and other activities, at the direction of the individual.

PERSON-CENTERED SUPPORT PLAN

§ 6100.221. Development of the PSP.

(a) An individual shall have one approved and authorized PSP that identifies the need for supports, the supports to be provided and the expected outcomes.

(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 with the individual and the individual's PSP team.

(d) The initial PSP shall be developed prior to the individual 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.

(f) The initial PSP and PSP revisions must be based upon a current assessment.

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

§ 6100.222. The PSP process.

(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.

The PSP must include the following:

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

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

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

Comment [a2]: Does a goal need to be identified and tracked for each area and documented similarly to an outcome?

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

(5) Support necessary to assist the individual to achieve desired outcomes.

(6) The provider of the support.

(7) Natural supports.

(8) The type, amount, 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) Active pursuit of competitive, integrated employment as a first priority, before other activities or supports are considered.

(12) Education and learning history and goals.

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

(14) Modification of individual rights as necessary to mitigate risks, if applicable.

Comment [a3]: Is there an approval process beyond the PSP team and the AE that needs to occur to modify the individual's rights? Does this include all rights listed in 182 and 183?

(15) 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) Financial information, including how the individual chooses to use personal funds.

(19) A back-up 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) The person responsible for monitoring the implementation of the PSP.

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

§ 6100.224. Implementation of the PSP.

The provider 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.

Comment [a4]: Does this mean that any time during the year a change needs to be made, including relatively minor changes/corrections, that the PSP needs to go to the AE 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 support delivery.

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

(b) Documentation of support 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) Documentation of support delivery may be made on the same form if multiple supports 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) The provider shall keep documentation of support delivery.

EMPLOYMENT, EDUCATION AND COMMUNITY PARTICIPATION

§ 6100.261. Access to the community.

(a) The provider shall provide the individual with the support necessary to access the community in accordance with the individual's PSP.

(b) The individual shall be provided ongoing opportunities and support necessary to participate in community activities of the individual's choice.

(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.

(a) The individual shall have active and ongoing opportunities and the supports necessary to seek and retain employment and work in competitive, integrated settings.

(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 shall be offered appropriate opportunities related to the individual's skills and interests, and encouraged to seek competitive, integrated employment.

(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:

(1) Technical education.

(2) College and university programs.

(3) Lifelong learning.

(4) Career development.

TRANSITION

§ 6100.301. Individual choice.

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

(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.

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

(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 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.

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

(b) The provider may not change a support provider or transfer an individual against the individual's 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.

(a) If the individual chooses another provider, the PSP team shall provide written notice to the following at least 30 days prior to the transition to a new provider:

(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:

(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.

(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.

§ 6100.305. Continuation of support.

The provider shall continue to provide the authorized support during the transition period to ensure continuity of care 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.

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.

(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.

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied 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.

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.

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.

Comment [a5]: Would this apply for a helmet ordered by a health care practitioner to prevent significant self-injury?

(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 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 restraint.

(8) A manual 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.

§ 6100.344. Permitted interventions.

(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) 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) 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) A physical protective restraint 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) 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.

(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 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 presence 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.

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

(1) Death.

(2) Suicide attempt.

(3) Inpatient admission to a hospital.

(4) Emergency room visit.

(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) Theft or misuse of individual funds.

(15) A violation of individual rights.

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

Comment [a6]: The provider previously had 72 hours to report a medication error which appeared to be a reasonable timeframe. Is this changing?

(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.

(c) The provider shall keep documentation of the notification in subsection (b).

(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 investigation.

(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 suspected incident.

(b) The provider shall initiate an investigation of an incident within 24 hours of discovery by a staff person.

(c) A Department-certified incident investigator shall conduct the investigation of the incident listed in § 6100.401(a) (relating to types of incidents and timelines for reporting).

Comment [a7]: Is there a list of which incidents required certified investigations and which do not?

§ 6100.403. Individual needs.

(a) In investigating an incident, the provider shall review and consider the following needs of the affected individual:

(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.

§ 6100.404. Final incident report.

(a) The provider shall finalize the incident report in the Department's information management system within 30 days of discovery of the incident by a staff person.

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

(1) Additional detail about the incident.

(2) The results of the incident investigation.

(3) A description of the corrective action taken in response to an incident.

(4) Action 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.

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

(c) The provider shall identify and implement preventive measures to reduce:

(1) The number of incidents.

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

(3) The likelihood of an incident recurring.

(d) The provider shall educate staff persons, others and the individual based on the circumstances of the incident.

(e) The provider shall analyze incident data continuously and take actions to mitigate and manage risks.

PHYSICAL ENVIRONMENT

§ 6100.441. Request for and approval of changes.

(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.

(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.

§ 6100.443. Access to the bedroom and the home.

(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.

Comment [a8]: Are there any exceptions to this as not all individuals would desire a key or have the ability to safely carry key? An individual carrying keys to the home could pose a security risk.

(b) Assistive technology, as needed, 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 and the home.

(e) Only authorized persons shall access the individual's bedroom.

(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.

§ 6100.444. Lease or ownership.

(a) In residential habilitation, the individual shall have a legally enforceable 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.

§ 6100.445. Integration.

A setting in which a support is provided shall be integrated in the community and the individual shall have 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.

§ 6100.446. Facility characteristics relating to size of facility.

(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.

(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.

(2) With the Department's written approval, a residential facility with a program capacity of eight may move to a new location and retain the program capacity of eight.

(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.

(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 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 continue to be eligible for HCBS participation.

(d) 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 eight or less individuals may be eligible for HCBS participation.

MEDICATION ADMINISTRATION

§ 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 helping the individual to remember 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 shall provide or arrange for assistive technology to support the individual's self-administration of medications.

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

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

(1) Recognize and distinguish the individual's medication.

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

(3) 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) Take or apply the individual's medication with or without the use of assistive technology.

§ 6100.462. Medication administration.

(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.

(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.

(a) Prescription and nonprescription medications shall be kept in their original labeled containers.

(b) A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.

(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.

(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.

(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.

(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.

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.

§ 6100.465. Prescription medications.

(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.

§ 6100.466. Medication records.

(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.

§ 6100.467. Medication errors.

(a) Medication errors include the following:

(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 the prescriber's response shall be kept in the individual's record.

§ 6100.468. Adverse reaction.

(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.

§ 6100.469. Medication administration 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.

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 rates and classifications.

(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.

(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.

§ 6100.482. Payment.

(a) The Department will only pay for an HCBS in accordance with this chapter, 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 is inconsistent with this chapter, this chapter applies.

(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.

§ 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 claims 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 claims.

(c) The provider shall only submit 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.

§ 6100.485. Audits.

(a) The provider shall comply with the following audit requirements:

(1) 2 CFR Part 200 (relating to uniform administrative requirements, cost principles, and audit requirements for Federal awards).

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

(3) Applicable Office of Management 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.

§ 6100.486. Bidding.

(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 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.

(a) Fee schedule rates will be established by the Department using a market-based approach based on current data and independent data sources.

(b) The Department will refresh the market-based data used in subsection (a) to establish fee schedule rates at least every 3 years.

(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.

(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.

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 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 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 a cost report on a form specified by and in accordance with the instructions provided by the Department.

(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 cost and the allowable administrative cost of the HCBS provided.

(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.

§ 6100.645. Rate setting.

(a) The Department will use the 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) The provider shall complete the cost report in accordance with this chapter.

(d) The cost data submitted by the provider on the approved cost report will be used to set the rates.

(e) The Department will adjust the cost report form and instructions based on changes in the support definitions in the Federally-approved waivers and waiver amendments from the prior cost reporting period.

(f) Prior to the effective date of the rates, the Department will publish as a notice in the *Pennsylvania Bulletin* the cost-based rate setting methodology, including the cost report review, outlier analysis, vacancy factor and rate assignment processes.

§ 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 will apply a vacancy factor to residential habilitation rates.

(d) A provider may request 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.

(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.

§ 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).

§ 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 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.

§ 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.

(c) 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 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 is an allowable cost if the rental is more cost-efficient than purchasing.

§ 6100.658. Communication.

The following communication costs that support the administration or provision of an HCBS are allowable costs:

(1) Telephone.

(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.

(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, 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.

§ 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.

(c) The provider may not limit the individual's leave days.

(d) 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) 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.

§ 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 the provider prevails at the hearing.

§ 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.

(a) A cap on start-up cost will be established by the Department.

(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 by the Department, 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.

§ 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

§ 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.

(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

§ 6100.741. Sanctions.

(a) The Department has the authority to enforce compliance with this chapter through an array of sanctions.

(b) A sanction may be implemented by the Department for the following:

(1) One or more regulatory violations of this chapter.

(2) Failure 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) Failure to implement a corrective action plan or a directed corrective action plan, including the compliance steps and the timelines in the plan.

(4) Fraud, deceit or falsification of documents or information related to this chapter.

(5) Failure to provide free and full access to the Department, the designated managing entity, or other authorized Federal or State officials.

(6) Failure to provide documents or other information in a timely manner upon the request of the Department, the designated managing entity, or an authorized Federal or State agency.

§ 6100.742. Array of sanctions.

The Department may implement the following sanctions:

(1) Recouping, suspending or disallowing payment.

(2) Terminating a provider agreement for participation in an HCBS waiver program.

(3) Prohibiting the delivery of supports to a new individual.

(4) Prohibiting the provision of specified supports at a specified location.

(5) Prohibiting 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) Removing an individual from a premise.

§ 6100.743. Consideration as to type of sanction utilized.

(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) The Department may consider the following variables when determining and implementing a sanction or combination of sanctions:

(1) The seriousness of the condition specified in § 6100.741(b).

(2) The continued nature of the condition specified in § 6100.741(b).

(3) The repeated nature of the condition specified 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.

§ 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.

SPECIAL PROGRAMS

§ 6100.801. Adult autism waiver.

(a) The adult autism waiver is an HCBS Federal waiver program under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) designed to provide community-based supports to meet the specific needs of adults with autism spectrum disorders.

(b) The following requirements of this chapter do not apply to the adult autism waiver program:

(1) Section 6100.441 (relating to request for and approval of changes) does not apply to the adult autism waiver program.

(2) Section 6100.481(d) (relating to Departmental rates and classifications).

(3) Section 6100.571(c)(5) (relating to fee schedule rates).

(4) Sections 6100.641—6100.672 (relating to cost-based rates and allowable costs).

(5) Section 6100.711(d)(7) (relating to fee for the ineligible portion of residential habilitation).

§ 6100.802. Agency with choice.

(a) Agency with choice (AWC) is 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.

(b) The requirements in this chapter do not apply to an AWC, with the exception of the following provisions:

(1) General provisions as specified in §§ 6100.1—6100.3 (relating to general provisions).

(2) General requirements as specified in §§ 6100.41—6100.44 and 6100.46—6100.55.

(3) Training as specified in §§ 6100.141—6100.144 (relating to training).

(4) Individual rights as specified in §§ 6100.181—6100.186 (relating to individual rights).

(5) PSP as specified in §§ 6100.221—6100.224.

(6) Positive interventions as specified in §§ 6100.341—6100.345 (relating to positive intervention).

(7) Incident management as specified in §§ 6100.401—6100.405 (relating to incident management).

(c) The AWC shall ensure that the managing employer complies with the requirements of the managing employer agreement.

(d) The AWC shall fulfill unmet responsibilities of the managing employer.

(e) The AWC shall identify and implement corrective action for managing employer performance in accordance with the managing employer agreement.

(f) The AWC shall develop and implement procedures to ensure that the managing employer reports incidents in accordance with this chapter.

(g) The AWC shall process and provide vendor goods and services authorized by the Department or the designated managing entity covered by the monthly per individual administrative fee.

(h) The AWC shall distribute a customer satisfaction survey to individuals who receive the financial management services, collect and analyze survey responses, and act to improve services.

(i) If an AWC intends to close, a written notice shall be provided to the Department at least 60 days prior to the planned closure date. The written notice must include the following:

(1) The effective date of closure.

(2) A transition plan for each individual that affords choice.

(j) If an AWC intends to close, the provider shall complete the following duties:

(1) Provide suggested time frames for transitioning the individual to a new provider.

(2) Continue to provide financial management services to individuals in accordance with this chapter and the managing employer agreement until the date of the closure or until the Department directs otherwise.

(3) Notify each individual in writing of the closure.

(4) Prepare individual records for transfer to the selected provider within 14 days of the selected provider's accepting the transfer.

(5) Maintain data and records in accordance with this chapter until the date of the transfer.

§ 6100.803. Support coordination, targeted support management and base-funded support coordination.

(a) Support coordination is an HCBS Federal waiver program under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) designed to provide community-based support to locate, coordinate and monitor needed HCBS and other support for individuals.

(b) Targeted support management (TSM) is a service under the State plan that is designed to provide community-based support to locate, coordinate and monitor needed support for an individual. TSM is not an HCBS.

(c) Base-funded support coordination is a program designed to provide community-based support to locate, coordinate and monitor needed support for individuals who receive support through base-funding.

(d) The following requirements of this chapter do not apply to support coordination, TSM or base-funded support coordination.

(1) Section 6100.81(b)(4) (relating to HCBS provider requirements).

(2) Section 6100.226(d)(6) (relating to documentation of support delivery).

(3) Section 6100.441 (relating to request for and approval of changes).

(4) Sections 6100.461—6100.470 (relating to medication administration).

(5) Sections 6100.641—6100.672, 6100.681—6100.694 and 6100.711 (relating to cost-based rates and allowable costs; room and board; and fee for the ineligible portion of residential habilitation).

(6) Section 6100.806 (relating to vendor goods and services).

(e) In addition to this chapter, the following requirements apply for support coordination, TSM and base-funded support coordination.

(1) In addition to the training and orientation required under §§ 6100.141—6100.143 (relating to annual training plan; orientation program; and annual training), a support coordinator, targeted support manager, support coordinator supervisor and targeted support manager supervisor shall complete the following training within the first year of employment:

(i) Facilitation of person-centered planning.

(ii) Conflict resolution.

(iii) Human development over the lifespan.

(iv) Family dynamics.

(v) Cultural diversity.

(2) A support coordinator, targeted support manager, support coordinator supervisor and targeted support manager supervisor shall report incidents, alleged incidents and suspected incidents as specified in §§ 6100.401—6100.403 (relating to types of incidents and timelines for reporting; incident investigation; and individual needs), that the coordinator, manager or supervisor observes directly.

(3) If an individual is authorized for residential habilitation, the support coordinator or targeted support manager shall review and document if the individual continues to need the authorized level of residential habilitation every 6 months.

(4) If an individual is authorized for residential habilitation and a request for enhanced staffing is received, the support coordinator or targeted support manager shall review and document the following:

(i) The individual's need, and any change in need, including how the change affects the individual's health, safety and well-being.

(ii) Assessments used to support the need for enhanced staffing.

(iii) The specific enhanced staffing that will be provided to address the individual's needs.

(iv) The plan to reduce the enhanced staffing based on specific outcomes of the individual.

(v) The time frame and the staff person responsible for monitoring progress on the plan to reduce enhanced staffing.

(vi) The results of meetings held to re-evaluate the need for continued enhanced staffing.

(5) If a support coordination or TSM provider intends to close, a written notice shall be provided to the Department at least 90 days prior to the planned closure date. The written notice must include the following:

(i) The effective date of closure.

(ii) The intent to terminate the Medical Assistance provider agreement and the Medical Assistance waiver provider agreement.

(iii) A transition plan for each individual that affords individual choice.

(iv) A transition plan to transfer the provider's functions.

(6) If a support coordination or TSM provider intends to close, the provider shall complete the following duties:

(i) Continue to provide support coordination, TSM or base-funded support coordination to individuals in accordance with this chapter until the date of the transfer or until the Department directs otherwise.

(ii) Transfer an individual to the selected provider only after the Department or the designated managing entity approves the individual's transition plan.

(iii) Prepare individual records for transfer to the selected provider within 14 days of the selected provider's accepting the transfer.

(iv) Maintain data and records in accordance with this chapter until the date of the transfer.

§ 6100.804. Organized health care delivery system.

(a) An OHCDS is an arrangement in which a provider that renders an HCBS chooses to offer a different vendor of an HCBS through a subcontract to facilitate the delivery of vendor goods or services to an individual.

(b) The following requirements of this chapter do not apply to an OHCDS:

(1) Section 6100.571 (relating to fee schedule rates).

(2) Sections 6100.641—6100.672, 6100.681—6100.694 and 6100.7111 (relating to cost-based rates and allowable costs; room and board; and fee for the ineligible portion of residential habilitation).

(3) Section 6100.806 (relating to vendor goods and services).

(c) In addition to this chapter, the following requirements apply for OHCDS.

(1) The OHCDS shall:

(i) Be an enrolled Medical Assistance waiver provider.

(ii) Be enrolled in the MMIS.

(iii) Provide at least one Medical Assistance service.

(iv) Agree to provide the identified vendor goods or services to individuals.

(v) Bill the MMIS for the amount of the vendor goods or services.

(vi) Pay the vendor that provided the vendor goods or services the amount billed for in the MMIS.

(2) An OHCDS may bill a separate administrative fee under the following:

(i) The administrative fee may not exceed the limit set by Federal requirements.

(ii) The administrative activities must be required to deliver the vendor good or HCBS to an individual and must be documented to support the separate administrative fee.

(3) The OHCDS shall ensure that each vendor with which it contracts meets the applicable provisions of this chapter and in accordance with the requirements specified in the Department's Federally-approved waivers and waiver amendments, and the State plan, as applicable.

(4) Only vendor goods and services may be subcontracted through the OHCDS. A provider who subcontracts shall have written agreements specifying the duties, responsibilities and compensation of the subcontractor.

(5) An OHCDS shall provide the Department with an attestation that the cost of the good or service is the same or less as the cost charged to the general public.

(d) As used in this section:

(1) OHCDS is an organized health care delivery system.

(2) MMIS is the Department's Medicaid management information statistics.

§ 6100.805. Base-funded support.

(a) A base-funding only support is a State-only funded, county program support provided through the county program to either an individual who is not eligible for an HCBS or for a support that is not eligible as an HCBS.

(b) The requirements in this chapter do not apply to base-funding only supports, with the exception of the following provisions that do apply.

(1) General provisions as specified in §§ 6100.1—6100.3 (relating to general provisions).

(2) General requirements as specified in §§ 6100.41—6100.55 (relating to general requirements).

(3) Training as specified in §§ 6100.141—6100.144 (relating to training).

(4) Individual rights as specified in §§ 6100.181—6100.186 (relating to individual rights).

(5) PSP as specified in §§ 6100.221—6100.225 (relating to person-centered support plan).

(6) Positive interventions as specified in §§ 6100.341—6100.345 (relating to positive intervention).

(7) Incident management as specified in §§ 6100.401—6100.405 (relating to incident management).

(8) Medications administration as specified in §§ 6100.461—6100.470 (relating to medication administration).

(9) Room and board as specified in §§ 6100.681—6100.694 (relating to room and board).

§ 6100.806. Vendor goods and services.

(a) A vendor is a directly-enrolled provider that sells goods or services to the general public, as well as to an HCBS program.

(b) The requirements in this chapter do not apply to vendor goods and services, with the exception of the following provisions that do apply.

(1) General provisions as specified in §§ 6100.1—6100.3 (relating to general provisions).

(2) General requirements as specified in §§ 6100.41—6100.44, 6100.46—6100.51 and 6100.53—6100.55.

(3) Enrollment as specified in §§ 6100.81—6100.86 (relating to enrollment).

(4) PSP as specified in § 6100.226 (relating to documentation of support delivery).

(5) Training as specified in §§ 6100.141—6100.144 (relating to training).

(6) Individual rights as specified in §§ 6100.181—6100.186 (relating to individual rights) for respite camps serving 25% or more people with disabilities.

(7) PSP as specified in §§ 6100.221—6100.226 (relating to person-centered support plan) for respite camps serving 25% or more people with disabilities.

(8) Positive interventions as specified in §§ 6100.341—6100.345 (relating to positive intervention) for respite camps serving 25% or more people with disabilities.

(9) Incident management as specified in §§ 6100.401—6100.405 (relating to incident management) for respite camps serving 25% or more people with disabilities.

(10) Medications administration as specified in §§ 6100.461—6100.470 (relating to medication administration) for respite camps serving 25% or more people with disabilities.

(11) General payment provisions as specified in §§ 6100.481—6100.487 (relating to general payment provisions).

(12) Enforcement as specified in §§ 6100.741—6100.744 (relating to enforcement).

(c) Payment for vendor goods and services will only be made after a good or service is delivered.

(d) The vendor may charge an administrative fee either as a separate invoice or as part of the total general invoice.

(e) The administrative fee specified in subsection (d) may not exceed the limit set by Federal requirements.

(f) A vendor shall charge the same fee for an HCBS as the vendor charges to the general public for the same good or service.

(g) A vendor shall document the fee for the good or service charged to the general public and to the HCBS.

(h) A vendor shall ensure that a subcontractor provides the vendor good or service in accordance with this chapter, the Department's Federally-approved waiver and waiver amendments, and the State plan, as applicable.