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[Continued from previous Web Page]

PART VIII. INTELLECTUAL DISABILITY AND AUTISM MANUAL

Subpart C. ADMINISTRATION AND FISCAL MANAGEMENT

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

GENERAL PROVISIONS

Sec.

GENERAL REQUIREMENTS

ENROLLMENT

TRAINING

INDIVIDUAL RIGHTS

INDIVIDUAL PLAN

COMMUNITY PARTICIPATION AND EMPLOYMENT

TRANSITION TO A NEW PROVIDER

RESTRICTIVE PROCEDURES

INCIDENT MANAGEMENT

PHYSICAL ENVIRONMENT OF HCBS

MEDICATION ADMINISTRATION

GENERAL PAYMENT PROVISIONS

FEE SCHEDULE

COST-BASED RATES AND ALLOWABLE COSTS

ROOM AND BOARD

DEPARTMENT-ESTABLISHED FEE FOR INELIGIBLE PORTION OF RESIDENTIAL SERVICE

ENFORCEMENT

SPECIAL PROGRAMS

GENERAL PROVISIONS

§ 6100.1. Purpose.

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

(b) This chapter assists 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 services 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 services 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).

(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, services and placements.

(8) Services funded by other states and provided to individuals in this Commonwealth.

(9) A vendor fiscal employer agent model for self-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 service provided.

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

Base-funding—Reimbursement provided 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 regulatory 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.

Cost report—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.

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.

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

Health care practitioner—A person who is authorized to prescribe medications under a license, registration or certification by the Department of State.

Individual—A woman, man or child who receives a home and community-based service or base-funding service.

Individual plan—A coordinated and integrated description of person-centered activities, including services and supports for an individual.

Life sharer—An employee or a contracted person who shares a common home and daily life experience with an individual, providing service and support as needed in both the home and the community.

Provider—The person, entity or agency that is contracted or authorized to deliver the service 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 individual plan or used on an emergency basis.

SSI—Supplemental security income.

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

Service—An activity, assistance or product provided to an individual and paid through a Federally-approved waiver program, the State plan or base-funding. A service includes an HCBS,

support coordination, TSM, agency with choice, organized health care delivery system, and vendor goods and services, unless specifically exempted in this chapter.

Support—An unpaid activity or assistance provided to an individual that is not planned or arranged by a provider.

TSM—Targeted support management.

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

Volunteer—A person who is an organized and scheduled component of the service system and who does not receive compensation, but who provides a service through the provider that recruits, plans and organizes duties and assignments.

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 shall provide the Department and the designated managing entity free and full access to the provider's policies and records and the individuals receiving services in accordance with this chapter.

(c) The provider shall cooperate with the designated managing entity and provide the requested compliance documentation in the format required by the Department.

(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 non-compliance or a preliminary determination of non-compliance 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 non-compliance or a preliminary determination of non-compliance of this chapter.

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

(i) The provider shall keep documentation relating to an audit, provider monitoring or other monitoring method, including 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.

(2) Sections 6100.41—6100.56.

(3) Sections 6100.181—6100.186.

(4) Sections 6100.341—6100.350.

(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-centered practices, integration, independence, choice or community opportunities for individuals.

(3) 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) The provider shall provide a written copy of the waiver request to the affected individuals, and to persons designated by the individuals before or at the same time the waiver request is submitted to the Department.

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

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

(h) A request for the renewal of a waiver shall follow the procedures in subsections (a)—(g).

§ 6100.44. Innovation project.

(a) A provider may submit a proposal to the Department to demonstrate an innovation 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-centered practices, integration, independence, choice and community opportunities for individuals.

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

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

(4) The geographic location of the innovation project.

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

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

(7) A description of who will advise the innovation project, how individuals will be involved in evaluating the success of the innovation project and the community partners who will be involved in implementing the innovation project.

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

(9) Proposed changes to services.

(10) A detailed budget for the innovation project.

(c) 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-centered practices, integration, independence, choice and community opportunities for individuals.

(3) The soundness and viability of the proposed budget.

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

(d) 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.

(b) The quality management plan shall include the following:

(1) Performance measures.

(2) Performance improvement targets and strategies.

(3) Methods to obtain feedback relating to personal experience from individuals, staff persons and other affected parties.

(4) Data sources used to measure performance.

(5) Roles and responsibilities of the staff persons related to the practice of quality management.

(c) The provider shall analyze and revise the quality management plan every 3 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) The Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) 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, household member, consultant, intern or volunteer, the involved staff person, household member, consultant, intern or volunteer may not have direct contact with an individual until the investigation is concluded and the investigating agency has confirmed that no abuse occurred or that the findings are inconclusive.

(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, if applicable.

§ 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 coordinators.

(3) Adult household members residing in licensed and unlicensed life sharing homes and in out-of-home overnight respite service.

(4) Life sharers.

(5) Consultants, paid and unpaid interns and volunteers who provide a service.

(b) Criminal history checks as specified in subsection (a) 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) The Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) and applicable regulations.

(c) This section does not apply to an individual and a person who provides a support. This does not exempt those adult household members requiring a criminal history check in subsection (a)(3).

§ 6100.48. Funding, hiring, retention and utilization.

Funding, hiring, retention and utilization of persons who provide a reimbursed service shall be in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

§ 6100.49. Child abuse history certification.

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

§ 6100.50. Communication.

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.

§ 6100.51. Complaints.

(a) The provider shall develop procedures to receive, document and manage complaints about a service that are submitted by or on behalf of an individual.

(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 complaint and the procedure for filing a complaint.

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

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

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

(f) The provider shall document and manage a complaint, including a repeated complaint.

(g) The provider shall document the following information for each complaint, including an oral, written or anonymous complaint, submitted by or on behalf of an individual:

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

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

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

(4) The nature of the complaint.

(5) The provider's investigation process, findings and actions to resolve the complaint, if applicable.

(6) The date the complaint was resolved.

(h) The provider shall resolve the complaint and report the findings or resolution to the complainant within 30 days of the date the complaint was submitted unless the provider is unable to resolve the complaint within 30 days due to circumstances beyond the provider's control. In such instances, the provider shall document the basis for not resolving the complaint within 30 days and shall report the complaint findings or resolution within 30 days after the circumstances beyond the provider's control no longer exist.

§ 6100.52. Applicable statutes and regulations.

The provider shall comply with applicable Federal and State statutes and regulations and local ordinances.

§ 6100.53. Conflict of interest.

(a) The provider shall develop a conflict of interest policy.

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

(c) An individual or a friend or relative of an individual may serve on the governing board, if applicable.

§ 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-funding 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 applicable Federal and State statutes and regulations.

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

§ 6100.55. Reserved capacity.

(a) Except as provided under subsection (b), the provider may not limit an individual's medical, hospital or therapeutic leave days.

(b) The provider shall reserve an individual's residential placement during the individual's medical, hospital or therapeutic leave not to exceed 180 days from the individual's departure from the residential service location.

(c) The Department may approve an adjustment to the provider's program capacity not to exceed 150 days of an individual's medical, hospital or therapeutic leave from the residential service

location.

§ 6100.56. Children's services.

(a) This chapter shall apply to HCBS and base-funding services for children.

(b) The child, the child's parents and the child's legal guardian shall be provided the opportunity to participate in the exercise of rights, decision-making and individual plan activities, unless otherwise prohibited by court order.

(c) The provisions of this chapter regarding rights, decision-making and individual plan activities shall be implemented in accordance with generally accepted, age-appropriate parental decision-making and practices for children, including bedtimes, privacy, school attendance, study hours, visitors and access to food and property, and do not require a modification of rights in the individual plan in accordance with § 6100.223 (relating to content of the individual plan).

(d) The individual plan in § 6100.223 shall include desired outcomes relating to strengthening or securing a permanent caregiving relationship for the child.

(e) An unrelated child and adult may not share a bedroom.

(f) For purposes of this section, a child is an individual who is under 18 years of age.

ENROLLMENT

§ 6100.81. HCBS provider requirements.

(a) The provider shall meet the qualifications 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; 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 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 appropriate state licensure agency.

(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) If the Department issued a sanction in accordance with §§ 6100.741—6100.744 (relating to enforcement), the Department may deny enrollment as a provider of HCBS.

§ 6100.82. HCBS enrollment documentation.

An applicant who wishes to provide 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(c) (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 applicable Federal and State statutes and regulations.

§ 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. 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 only the HCBS to an individual who is authorized to receive that HCBS.

(c) The provider shall deliver the HCBS in accordance with the individual plan.

TRAINING

§ 6100.141. Training records.

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

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

§ 6100.142. Orientation.

(a) Prior to working alone with individuals, and within 30 days after hire or starting to provide a service to an individual, the following shall complete the orientation as described in subsection (b):

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

(2) Dietary, housekeeping, maintenance and ancillary staff persons, except for persons who provide dietary, housekeeping, maintenance or ancillary services and who are employed or contracted by the building owner and the licensed facility does not own the building.

(3) Direct service professionals, including full-time and part-time staff persons.

(4) Life sharers.

(5) Volunteers who will work alone with individuals.

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

(7) Consultants and contractors who are paid or contracted by the provider and who will work alone with individuals, except for consultants and contractors who provide an HCBS or a base-funding service for fewer than 30 days within a 12-month period and who are licensed, certified or registered by the Department of State in a health care or social service field.

(b) The orientation must encompass the following areas:

(1) The application of person-centered practices, community integration, individual choice and assisting individuals to develop and maintain 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), the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386), 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 shall complete 24 hours of training related to job skills and knowledge each year:

(1) Direct service professionals and life sharers who provide an HCBS or base-funding service to the individual.

(2) Direct supervisors of direct service professionals.

(b) The following shall complete 12 hours of training each year:

(1) Management, program, administrative, fiscal, dietary, housekeeping, maintenance and ancillary staff persons, except for persons who provide dietary, housekeeping, maintenance or

ancillary services and who are employed or contracted by the building owner and the licensed facility does not own the building.

(2) Consultants and contractors who are paid or contracted by the provider and who work alone with individuals, except for consultants and contractors who provide an HCBS or base-funding service for fewer than 30 days within a 12-month period and who are licensed, certified or registered by the Department of State in a health care or social service field.

(3) Volunteers who work alone with individuals.

(4) Paid and unpaid interns who work alone with individuals.

(c) The annual training hours specified in subsections (a) and (b) must encompass the following areas:

(1) The application of person-centered practices, community integration, individual choice and assisting individuals to develop and maintain 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), the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386), 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 behavior supports if the person works directly with an individual.

(6) Implementation of the individual plan if the person provides an HCBS or base-funding service.

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 service location).

(b) The provider shall educate, assist and provide the accommodation necessary for the individual to make choices and understand the individual's rights.

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

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

(e) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with the conditions of guardianship as specified in the court order.

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

(g) An individual has the right to designate persons to assist in decision-making and exercising rights 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, practice the religion of the individual's choice and 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 services.

(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 services.

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

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

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

(o) An individual and persons designated by the individual have the right to access the individual's record.

§ 6100.183. Additional rights of the individual in a residential service location.

(a) An individual has the right to receive scheduled and unscheduled visitors, and to communicate and meet privately with whom the individual chooses, 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, including the right to share contact information with whom the individual chooses.

(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 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 (relating to negotiation of choices).

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

(1) Locking may be provided by a key, access card, keypad code or other entry mechanism accessible to the individual to permit the individual to lock and unlock the door.

(2) 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.

(3) Assistive technology shall be provided as needed to allow the individual to lock and unlock the door without assistance.

(4) The locking mechanism shall allow easy and immediate access by the individual and staff persons in the event of an emergency.

(5) Direct service professionals who provide service to the individual shall have the key or entry device to lock and unlock the door.

(h) An individual has the right to have a key, access card, keypad code or other entry mechanism to lock and unlock an entrance door of the home.

(1) Assistive technology shall be provided as needed to allow the individual to lock and unlock the door without assistance.

(2) The locking mechanism shall allow easy and immediate access by the individual and staff persons in the event of an emergency.

(3) Direct service professionals who provide service to the individual shall have the key or entry device to lock and unlock the door.

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

(j) An individual has the right to make 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) The provider shall assist the affected individuals to negotiate choices in accordance with the provider's procedures for the individuals to resolve differences and make choices.

(c) An individual's rights may only be modified in accordance with § 6100.223(9) (relating to content of the individual plan) to the extent necessary to mitigate a significant health and safety risk to the individual or others.

§ 6100.185. Informing of rights.

(a) The provider shall inform and explain individual rights and the process to report a rights violation 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. Facilitating personal relationships.

(a) The provider shall facilitate and make accommodations to assist an individual to visit with whom the individual chooses, at the direction of the individual.

(b) The provider shall facilitate and make accommodations to involve the persons designated by the individual in decision-making, planning and activities, at the direction of the individual.

(c) The provider shall facilitate the involvement of the individual's relatives and friends, unless the individual indicates otherwise.

INDIVIDUAL PLAN

§ 6100.221. Development of the individual plan.

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

(b) The support coordinator, base-funding support coordinator or targeted support manager shall be responsible for the development of the individual plan, including revisions, in cooperation with the individual and the individual plan team.

(c) The initial individual plan shall be developed prior to the individual receiving a reimbursed service.

(d) The individual plan shall be revised when an individual's needs change, the service system changes or upon the request of an individual.

(e) The initial individual plan and individual plan revisions must be based upon a current assessment.

(f) The individual and persons designated by the individual shall be involved and assisted in the initial development and revisions of the individual plan.

(g) The provider's implementation plan, if applicable, must be consistent with the individual plan in subsection (a). The provider's implementation plan is a detailed description of the specific activities to assist the individual to achieve the broader desired outcomes of the individual plan.

§ 6100.222. Individual plan process.

(a) The individual plan process shall be directed by the individual to the extent possible and as desired by the individual.

(b) The individual plan process shall:

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

(2) Facilitate and assist persons designated by the individual to attend the individual plan meeting, as desired by the individual.

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

(4) Provide information and assistance to ensure that the individual directs the individual plan process to the extent possible.

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

(6) Occur timely 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) Include guidelines for solving disagreements among the individual plan team members.

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

§ 6100.223. Content of the individual plan.

The individual plan must include the following:

(1) The individual's strengths, functional abilities and need for services and supports.

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

(3) The individual's desired outcomes.

(4) Service and support necessary to assist the individual to achieve the desired outcomes.

(5) The provider of the service and support.

(6) The amount, duration and frequency for the service specified in a manner that reflects the needs and preferences of the individual. The schedule of service delivery shall be determined by the individual plan team and provide sufficient flexibility to provide choice by the individual.

(7) Competitive integrated employment as a first priority, for individuals of employment age in accordance with applicable Federal and State statutes and regulations, before other services are considered.

(8) Risks to the individual's health, safety or well-being, behaviors likely to result in immediate physical harm to the individual or others and risk mitigation strategies, if applicable.

(9) Modification of individual rights as necessary to mitigate a significant health and safety risk to the individual or others, if applicable.

(10) A plan to identify a needed service or support as identified by the individual plan team if the absence of staffing would place the individual at a health or safety risk.

§ 6100.224. Implementation of the individual plan.

The provider identified in the individual plan shall implement the individual plan, including revisions.

§ 6100.225. Support coordination, base-funding support coordination and TSM.

(a) A support coordinator, base-funding support coordinator or targeted support manager shall assure the completion of the following activities when developing an initial individual plan and the annual review of the individual plan:

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

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

(3) Distribution of meeting invitations to individual plan team members.

(4) Facilitation of the individual plan meeting, or assistance for an individual who chooses to facilitate the individual's own meeting.

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

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

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

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

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

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

(c) A support coordinator, base-funding support coordinator or targeted support manager shall maintain a current record for each individual, including the following:

(1) Health care information, including diagnosis, a medical history since birth and medical records.

(2) Evidence of the individual's choice of provider and service location.

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

(4) The individual's court-appointed legal guardian, power of attorney, representative payee and designated persons for purposes of this chapter, if applicable.

(5) The list of persons who participated in the individual plan team meetings.

§ 6100.226. Documentation of claims.

(a) Documentation to provide a record of services delivered to an individual shall be prepared by the provider for the purpose of substantiating a claim.

(b) The provider shall document service delivery on the date the service is delivered.

(1) A service note shall be completed for each continuous span of billing units or each day unit.

(2) A new service note shall be completed when there is an interruption of service within a 24-hour period, if service is reinitiated within that 24-hour period, except for a service that is billed as a day unit.

(3) If there is a change in the staff person providing the service or a change in shift involving multiple staff persons during a 24-hour period, a new service note shall be completed, except for a service that is billed as a day unit.

(c) Documentation of service delivery must include the following:

(1) The name of the individual.

(2) The name of the provider.

(3) The date of the service delivery.

(4) The date, name and signature of the person completing the documentation.

(5) Identification of the service delivered, the nature or description of the activities involved in the service, who delivered the service and where the service was delivered.

(6) The total number of units of service delivered from the beginning to the end of the service on the specified date.

(d) The provider shall maintain a record of the time worked or the time that a service was delivered to support the claim.

(e) The amount, frequency and duration of the service delivered shall be consistent with the individual plan.

(f) Documentation of claims, including supporting documentation, shall be kept.

§ 6100.227. Progress notes.

(a) The provider, in cooperation with the support coordinator, base-funding support coordinator or targeted support manager, and the individual, shall review the documentation of service delivery in § 6100.226 (relating to documentation of claims) and document the progress made to achieve the desired outcome of the service provided, at least every 3 months, beginning with the date of the initial claim relating to service for the individual.

(b) The documentation of progress in subsection (a) shall be verified through the observation of service delivery and discussion with the individual or the person designated by the individual, as appropriate.

(c) The documentation of progress in subsection (a) shall include the following:

(1) If the service was provided in accordance with the individual plan.

(2) If the service met the needs and preferences of the individual.

(3) How progress will be addressed, if there was a lack of progress on a desired outcome.

(4) Impact on the individual's health, safety, well-being, preferences and routine.

(d) Documentation of progress notes shall be kept.

COMMUNITY PARTICIPATION AND EMPLOYMENT

§ 6100.261. Access to the community.

The provider shall provide the individual with the assistance necessary to access the community in accordance with the individual plan.

§ 6100.262. Employment.

(a) The provider shall provide active and ongoing opportunities, information about employment options appropriate for the individual and the services necessary to seek and retain competitive integrated employment.

(b) Competitive integrated employment is work performed on a full-time or part-time basis, including self-employment for which an individual is:

(1) Compensated at not less than Federal minimum wage requirements or State or local minimum wage law, whichever is higher, and not less than the customary rate paid by the employer for the same or similar work performed by persons without a disability.

(2) At a location where the employee interacts with people without a disability, not including supervisory personnel or persons who are providing services to such employee.

(3) Presented, as appropriate, opportunities for similar benefits and advancement like those for other employees without a disability and who have similar positions.

TRANSITION TO A NEW PROVIDER

§ 6100.301. Individual choice.

(a) A provider may not exert influence when the individual is considering a transition to a new provider.

(b) The support coordinator, base-funding support coordinator or the targeted support manager shall assist the individual 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. Cooperation during individual transition.

(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, base-funding 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 service.

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

§ 6100.303. Involuntary transfer or change of 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 service location, even with the provision of supplemental services.

(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 services.

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

(4) Closure of the service location.

(b) The provider may not transfer an individual to another service provider against the individual's wishes in response to an individual's exercise of rights, voicing choices or concerns or in response to a complaint.

§ 6100.304. Written notice.

(a) If the provider is no longer able or willing to provide a service for an individual in accordance with § 6100.303 (relating to involuntary transfer or change of provider), the provider shall provide written notice to the following at least 45 days prior to the date of the proposed change of provider or transfer:

(1) The individual.

(2) Persons designated by the individual.

(3) The individual plan team members.

(4) The designated managing entity.

(5) The support coordinator, base-funding support coordinator or targeted support manager.

(6) The Department.

(b) The Department or designated managing entity may authorize a transfer or change date earlier than the date specified in subsection (a) to protect the health and safety of the individual or others.

(c) The provider's written notice specified in subsection (a) 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 service that the provider is unable or unwilling to provide.

(4) The location where the service is currently provided.

(5) The reason the provider is no longer able or willing to provide the service 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 service.

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

§ 6100.305. Continuation of service.

The provider shall continue to provide the authorized service during the transition period to ensure continuity of service until a new provider is approved and the new service is in place, unless otherwise directed by the Department or the designated managing entity.

§ 6100.306. Transition planning.

The support coordinator, base-funding 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 complete 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).

RESTRICTIVE PROCEDURES

§ 6100.341. Definition of restrictive procedures.

A restrictive procedure is a practice that does one or more of the following:

(1) Limits an individual's movement, activity or function.

(2) Interferes with an individual's ability to acquire positive reinforcement.

(3) Results in the loss of objects or activities that an individual values.

(4) Requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.

§ 6100.342. Written policy.

The provider shall develop and implement a written policy that defines the prohibition or use of specific types of restrictive procedures, describes the circumstances in which a restrictive procedure may be used, the staff persons who may authorize the use of a restrictive procedure and a mechanism to monitor and control the use of restrictive procedures.

§ 6100.343. Appropriate use of restrictive procedures.

(a) A restrictive procedure may not be used as retribution, for the convenience of staff persons or as a substitute for staffing or appropriate services.

(b) For each use of a restrictive procedure:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using techniques less intrusive than a restrictive procedure.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

§ 6100.344. Human rights team.

(a) If a restrictive procedure is used, the provider shall use a human rights team. The provider may use a county mental health and intellectual disability program human rights team that meets the requirements of this section.

(b) The human rights team shall include a professional who has a recognized degree, certification or license relating to behavior support, who did not develop the behavior support component of the individual plan.

(c) The human rights team shall include a majority of persons who do not provide direct services to the individual.

(d) A record of the human rights team meetings shall be kept.

§ 6100.345. Behavior support component of the individual plan.

(a) For each individual for whom a restrictive procedure may be used, the individual plan shall include a component addressing behavior support that is reviewed and approved by the human rights team in § 6100.344 (relating to human rights team), prior to use of a restrictive procedure.

(b) The behavior support component of the individual plan shall be reviewed and revised as necessary by the human rights team, according to the time frame established by the team, not to exceed 6 months between reviews.

(c) The behavior support component of the individual plan shall include:

(1) The specific behavior to be addressed.

(2) An assessment of the behavior, including the suspected reason for the behavior.

(3) The outcome desired.

(4) A target date to achieve the outcome.

(5) Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing and treating physical and behavioral health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.

(6) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(7) The amount of time the restrictive procedure may be applied.

(8) The name of the staff person responsible for monitoring and documenting progress with the behavior support component of the individual plan.

(d) If a physical restraint will be used or if a restrictive procedure will be used to modify an individual's rights in § 6100.223(9) (relating to content of the individual plan) the behavior support component of the individual plan shall be developed by a professional who has a recognized degree, certification or license relating to behavior support.

§ 6100.346. Staff training.

(a) A staff person who implements or manages a behavior support component of an individual plan shall be trained in the use of the specific techniques or procedures that are used.

(b) If a physical restraint will be used, the staff person who implements or manages the behavior support component of the individual plan shall have experienced the use of the physical restraint directly on the staff person.

(c) Documentation of the training provided, including the staff persons trained, dates of training, description of training and training source, shall be kept.

§ 6100.347. Prohibited procedures.

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. Seclusion includes physically holding a door shut or using a foot pressure lock.

(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. A pressure-point technique does not include a clinically-accepted bite release technique that is applied only as long as necessary to release the bite.

(4) A chemical restraint, defined as use of a drug 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 for the following use or event:

(i) Treatment of the symptoms of a specific mental, emotional or behavioral condition.

(ii) Pretreatment prior to a medical or dental examination or treatment.

(iii) An ongoing program of medication.

(iv) A specific, time-limited stressful event or situation to assist the individual to control the individual's own behavior.

(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. A mechanical restraint includes a geriatric chair, a bedrail that restricts the movement or function of the individual, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, restraint board, restraining sheet, chest restraint and other similar devices. A mechanical restraint does not include the use of a seat belt during movement or transportation. A mechanical restraint does not include a device prescribed by a health care practitioner for the following use or event:

(i) Post-surgical or wound care.

(ii) Balance or support to achieve functional body position, if the individual can easily remove the device or if the device is removed by a staff person immediately upon the request or indication by the individual, and if the individual plan includes periodic relief of the device to allow freedom of movement.

(iii) Protection from injury during a seizure or other medical condition, if the individual can easily remove the device or if the device is removed by a staff person immediately upon the request or indication by the individual, and if the individual plan includes periodic relief of the device to allow freedom of movement.

§ 6100.348. Physical restraint.

(a) A physical restraint, defined as a manual method that restricts, immobilizes or reduces an individual's ability to move the individual's arms, legs, head or other body parts freely, may only be used in the case of an emergency to prevent an individual from immediate physical harm to the individual or others.

(b) Verbal redirection, physical prompts, escorting and guiding an individual are permitted.

(c) A prone position physical restraint is prohibited.

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

(e) A physical restraint may not be used for more than 30 cumulative minutes within a 2-hour period.

§ 6100.349. Emergency use of a physical restraint.

If a physical restraint is used on an unanticipated, emergency basis, §§ 6100.344 and 6100.345 (relating to human rights team; and behavior support component of the individual plan) do not apply until after the restraint is used for the same individual twice in a 6-month period.

§ 6100.350. 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. The following consent provisions apply unless there is a court-ordered restitution:

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

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

(3) The provider may not coerce the individual to provide consent.

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) A physical act by an individual in an attempt to complete suicide.

(3) Inpatient admission to a hospital.

(4) Abuse, including abuse to an individual by another individual.

(5) Neglect.

(6) Exploitation.

(7) An individual who is missing for more than 24 hours or who could be in jeopardy if missing for any period of time.

(8) Law enforcement activity that occurs during the provision of a service or for which an individual is the subject of a law enforcement investigation that may lead to criminal charges against the individual.

(9) Injury requiring treatment beyond first aid.

(10) Fire requiring the services of the fire department. This provision does not include false alarms.

(11) Emergency closure.

(12) Theft or misuse of individual funds.

(13) A violation of individual rights.

(b) The provider shall report the following incidents, alleged incidents and suspected incidents through the Department's information management system within 72 hours of discovery by a staff person:

(1) Use of a restraint.

(2) A medication error as specified in § 6100.466 (relating to medication errors), if the medication was ordered by a health care practitioner.

(c) The individual, and persons designated by the individual, shall be notified within 24 hours of discovery of an incident relating to the individual.

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

(e) The incident report, or a summary of the incident, the findings and the actions taken, 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 or suspected incident.

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

(c) A Department-certified incident investigator shall conduct the investigation of the following incidents:

(1) Death that occurs during the provision of a service.

(2) Inpatient admission to a hospital as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.

(3) Abuse, including abuse to an individual by another individual.

(4) Neglect.

(5) Exploitation.

(6) Injury requiring treatment beyond first aid as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.

(7) Theft or misuse of individual funds.

(8) A violation of individual rights.

§ 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 individual plan team to revise the individual plan if indicated by the incident.

§ 6100.404. Final incident report.

(a) The provider shall finalize the incident report through the Department's information management system within 30 days of discovery of the incident by a staff person, unless the provider notifies the Department in writing that an extension is necessary and the reason for the extension.

(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) Action taken to protect the health, safety and well-being of the individual.

(4) A description of the corrective action taken in response to an incident and to prevent recurrence of the incident.

(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 cause of the incident.

(2) Corrective action, if indicated.

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

(b) The provider shall review and analyze incidents and conduct and document 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 monitor incident data and take actions to mitigate and manage risks.

PHYSICAL ENVIRONMENT OF HCBS

§ 6100.441. Request for and approval of changes.

(a) A 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 service location.

(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 service location size, staffing patterns, assessed needs and outcomes for the individuals.

(c) 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 be provided services in the service location 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 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. Integration.

A service location 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.

§ 6100.444. Size of service location.

(a) A residential service location that serves primarily persons with a disability, which was funded in accordance with Chapter 51 prior to February 1, 2020, 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 service location with a program capacity of eight may move to a new location and retain the program capacity of eight.

(b) A residential service location that serves primarily persons with a disability, which is newly funded in accordance with this chapter on or after February 1, 2020, 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 service location funded in accordance with this chapter exceeding the program capacity of four.

(c) A day service location 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 provide service to more than 25 individuals in the service location at any one time, including individuals funded through any funding source such as private-pay.

§ 6100.445 Locality of service location.

(a) A residential or day service location, which is newly-funded in accordance with this chapter on or after February 1, 2020, notwithstanding the exceptions in § 6100.444(a)(1) and (b)(1) (relating to size of service location) may not be located adjacent to the following:

(1) Another human service residential service location.

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

(b) No more than 25% of the units in an apartment, condominium or townhouse building may be newly-funded in accordance with this chapter on or after February 1, 2020. The exceptions relating to a duplex, two bi-level units and two side-by-side apartments in § 6100.444(a)(1) and (b)(1) apply.

(c) With the Department's written approval, a residential or day service location that is licensed in accordance with Chapter 2380, 2390, 6400 or 6500 prior to February 1, 2020, and funded in accordance with Chapter 51 prior to February 1, 2020, may continue to 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 assist the individual to self-administer medications.

(d) The individual plan 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. Assistance may be provided by staff persons to remind the individual of the schedule and to offer the medication at the prescribed times as specified in subsection (b).

(4) Take or apply the individual's own 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, licensed paramedic or other health care professional who is licensed, certified or registered by the Department of State to administer medications.

(2) A person who has completed the medication administration course requirements as specified in § 6100.468 (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.

(vi) Medications, injections, procedures and treatments as permitted by applicable statutes and regulations.

(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) Prepare 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 order, measure vital signs and administer medications according to the prescriber's order.

(6) Injection of insulin and injection of 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. Prescription medications shall be labeled with a label issued by a pharmacy.

(b) A prescription medication may not be removed from its original labeled container in advance of the scheduled administration, except for the purpose of packaging the medication for the individual to take with the individual to a community activity for administration the same day the medication is removed from its original container.

(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 applicable Federal and State statutes and regulations.

(i) This section does not apply for an individual who self-administers medication and stores the medication in the individual's private bedroom or personal belongings.

§ 6100.464. 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 health care professional who is licensed, certified or registered by the Department of State to accept oral orders. The individual's medication record shall be updated as soon as a written notice of the change is received.

§ 6100.465. Medication record.

(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 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 as directed by the prescriber or if there is harm to the individual.

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

§ 6100.466. 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 dose 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.

(7) Administration while the individual is in the wrong position.

(8) Improper preparation of the medication.

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

(c) A medication error shall be reported to the prescriber under any of the following conditions:

(1) As directed by the prescriber.

(2) If the medication is administered to the wrong person.

(3) If there is harm to the individual.

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

§ 6100.467. 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.

§ 6100.468. Medication administration training.

(a) A person who has successfully completed a Department-approved medication administration course, including the course renewal requirements, may administer the medications, injections, procedures and treatments as specified in § 6100.462(b)(2) (relating to medication administration).

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

(1) The medication administration 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 medication administration course specified in subsection (a).

(2) Training within the past 24 months relating to the use of an auto-injection epinephrine injection device provided by a professional who is licensed, certified or registered by the Department of State in the health care field.

(d) The medication administration course in § 6100.462(b)(2) and subsection (a) will be a modified course for life sharers and service locations that are not licensed by the Department.

(e) 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.

§ 6100.469. Exceptions.

(a) Sections 6100.461—6100.468 do not apply to the following:

(1) Respite care provided for fewer than 30 days in a 12-month period.

(2) Job coaching provided for fewer than 30 days in a 12-month period.

(b) Sections 6100.461—6100.468 apply to the administration of medication by an adult relative of an individual who receives services in the following:

(1) A service location that is licensed by the Department.

(2) An unlicensed life sharing home.

(c) Sections 6100.461—6100.468 do not apply to the administration of medication by an adult relative of an individual who receives services in a service location other than the service locations specified in subsection (b).

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 service.

(4) Managed care or other capitated payment methods.

(5) Vendor goods and services.

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

(c) The fee per unit of an HCBS is the maximum amount the Department will pay.

(d) The fee per unit of an HCBS 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 service location.

§ 6100.482. Payment.

(a) The Department will only pay for an HCBS in accordance with this chapter and Chapter 1101 (relating to general provisions).

(b) When a provision in Chapter 1101 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 approved and documented individual plan 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 for payment 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) Medical Assistance payment, once accepted by the provider, constitutes payment in full.

(h) A provider who receives a supplemental payment for a service that is included as a service in the individual plan, or that is eligible for payment as an HCBS, shall return the supplemental payment to the payer. If the payment is for an activity that is beyond the services specified in the individual plan or for an activity that is not eligible as an HCBS, the private payment from the individual or another person is permitted.

§ 6100.483. 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 claims).

(d) The provider may not submit a claim for a service that is inconsistent with this chapter, inappropriate to an individual's needs or inconsistent with the individual plan.

§ 6100.484. 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.

§ 6100.485. Loss or damage to property.

If an individual's personal property is lost or damaged during the provision of an HCBS as a result of the provider's action or inaction, the provider shall repair or replace the lost or damaged property or pay the individual the replacement value for the lost or damaged property.

FEE SCHEDULE

§ 6100.571. Fee schedule rates.

(a) The Department will establish fee schedule rates, based on the factors in subsection (b), using a market-based approach so that payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services are available to at least the extent that such services are available to the general population in the geographic area.

(b) In establishing the fee schedule rates in subsection (a), the Department will examine and use data relating to the following factors:

(1) The service needs of the individuals.

(2) Staff wages, including education, experience, licensure requirements and certification requirements.

(3) Staff-related expenses, including benefits, training, recruitment and supervision.

(4) *Productivity*. Productivity is the amount of service delivered relative to the level of staffing provided.

(5) *Occupancy*. Occupancy is the cost related to occupying a space, including rent, taxes, insurance, depreciation and amortization expenses.

(6) Direct and indirect program and administration-related expenses.

(7) Geographic costs based on the location where the HCBS is provided.

(8) Federally-approved HCBS definitions in the waiver and determinations made about cost components that reflect reasonable and necessary costs related to the delivery of each HCBS.

(9) The cost of implementing applicable Federal and State statutes and regulations and local ordinances.

(10) Other factors that impact costs.

(c) The Department will update the data used in subsection (b) at least every 3 years.

(d) The Department will publish a description of its rate setting methodology used in subsection (a) as a notice in the *Pennsylvania Bulletin* for public review and comment. The description will include a discussion of the use of the factors in subsection (b) to establish the fee schedule rates; a discussion of the data and data sources used; and the fee schedule rates.

(e) The Department will make available to the public a summary of the public comments received in response to the notice in subsection (d) and the Department's response to the public comments.

COST-BASED RATES AND ALLOWABLE COSTS

§ 6100.641. Cost-based rate.

Sections 6100.642—6100.672 apply to cost-based rates.

§ 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 entity review or an audit, as necessary.

§ 6100.643. Submission of cost report.

(a) The provider shall submit a cost report on a form specified by and in accordance with the instructions provided by the Department.

(b) 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 or on or before the last business day in the third week of February for transportation.

(c) A provider with one master provider index number shall submit one cost report for the master provider index number.

(d) 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.

(e) 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 cost-based rates.

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

§ 6100.646. Cost-based rates for residential service.

(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 service 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 plan.

§ 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.

(e) To be an allowable cost, the cost must be documented and comply with the following:

(1) Applicable Federal and State statutes and regulations.

(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. 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 of the supply or equipment must be the best price paid by a prudent buyer.

(c) If only one bid is obtained for a purchase, the provider shall keep records justifying the cost-effectiveness of the purchase.

§ 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.

§ 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 a provider may supplement for expenses of the governing board.

(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 not part of a compensation 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 staff person 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 for staff persons, 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 a provider may supplement for staff person travel.

(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 of administrative equipment and furnishing.

Rental of administrative equipment or furnishing is an allowable cost if the rental is more cost-efficient than purchasing.

§ 6100.658. Communication.

The following communication costs that relate to 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) The cost of rent may not exceed the rental charge for similar space in that geographical area.

(2) 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 space 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 expenses 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.

(5) Maintenance costs.

(6) Utility costs.

(b) The cost of real estate taxes, net of available rebates and discounts, whether the rebate or discount is taken, is an allowable cost.

(c) The cost of a penalty resulting from a delinquent tax payment, including a legal fee, is not an allowable cost.

§ 6100.661. Administrative fixed assets.

(a) A fixed asset cost used for administrative purposes 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 apply the revenue amount received through the disposal of a fixed asset to any eligible or ineligible expenditure. This revenue amount is not reportable on 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 HCBS expenditures.

(3) Perform an annual physical inventory. 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 allowances 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 service 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. Administrative buildings.

(a) An administrative building acquired prior to June 30, 2009, that is in use and 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 current value of the administrative building being renovated.

(d) The provider shall use the depreciation methodology in accordance with § 6100.661 (relating to administrative fixed assets).

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

§ 6100.664. Residential vacancy.

(a) The Department will establish a vacancy factor for residential service that is included in the cost-based rate setting methodology.

(b) The vacancy factor for residential service shall be calculated based on all the provider's residential service locations.

§ 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.

§ 6100.666. Moving expenses.

(a) The actual cost associated with the relocation of a service location is allowable.

(b) Moving expenses for an individual are allowable.

§ 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.

(6) Auxiliary aids and services, including interpreters, that are not otherwise covered as an HCBS.

(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 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 service.

(3) Conducting business in a new geographic area.

(4) Initiating a new process.

(5) Starting a new operation.

§ 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 annually by the Department.

(b) 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 for an individual.

(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 in provider owned or leased residential service locations and in life sharing homes that are not owned or leased by the individual.

§ 6100.682. Assistance to the individual.

(a) If an individual is not currently receiving SSI benefits, the provider shall provide assistance 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.

(c) The provider shall assist the individual to secure information regarding the continued eligibility of SSI for the individual.

(d) The provider shall keep documentation of the individual's application for SSI benefits, the SSI eligibility determination and, if applicable, the appeal filed under subsection (b).

§ 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 the provider 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 room and board costs at the individual's residential service location, 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.

(d) The following items are included as room and board costs:

(i) Standard toiletries, towels and bedding.

(ii) One telephone with local telephone service.

(iii) Internet service.

(iv) Cleaning products.

(v) Household furniture.

(vi) Food choices of the individual, with consideration of the food cost and nutrition, including the individual's preference, culture, religion and beliefs, and an individual's prescribed diet, if the prescribed diet is not covered by the individual's health care plan or another funding source.

(vii) Laundry of towels, bedding and the individual's clothing.

(viii) Lawn care, food preparation, maintenance and housekeeping, including staff wages and benefits, to perform these tasks.

(ix) Meals provided away from the residential service location that are arranged by a staff person in lieu of meals provided in the residential service location.

(x) Incontinence products, if the incontinence product is not covered by the individual's health care plan or another funding source.

(xi) Building and equipment repair, renovation and depreciation.

(xii) Rent, taxes, utilities and property insurance.

§ 6100.685. Benefits.

(a) The provider shall assist an individual in applying for energy assistance, rent rebates, food and nutrition assistance and similar benefits.

(b) If energy assistance, rent rebates, food and nutrition assistance 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 and nutrition assistance or similar benefits may not be considered as part of an individual's income.

(d) The provider may not use the value of energy assistance, rent rebates, food and nutrition assistance 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 plus the Pennsylvania supplement, 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 plus the Pennsylvania supplement.

(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 plus the Pennsylvania supplement.

(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 Social Security Administration related to the specific type of residential service location, for the individual's personal needs allowance.

§ 6100.687. 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 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 service.

(2) Prior to an individual's transfer from one residential service location or provider to another residential service location or provider.

(3) Within 15 days after an emergency residential service placement.

§ 6100.688. 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 plus the Pennsylvania supplement for board.

(2) If an individual's income is less than the SSI maximum rate plus the Pennsylvania supplement, 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 plus the Pennsylvania supplement for room.

(2) If an individual's income is less than the SSI maximum rate plus the Pennsylvania supplement, 40% of the available income shall be charged to fulfill the individual's monthly obligations for room.

§ 6100.689. 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.

§ 6100.690. Respite care.

There may not be a charge for room and board to the individual for respite care.

§ 6100.691. 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 considered in reserved capacity.

§ 6100.692. Exception.

There may not be a charge for board to the individual if the individual does not take food by mouth.

§ 6100.693. 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 negotiated

amount of room and board payment 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.

§ 6100.694. Managing individual finances.

The provider may not charge a fee for managing an individual's finances or for serving as an individual's designated financial representative.

DEPARTMENT-ESTABLISHED FEE FOR INELIGIBLE PORTION OF RESIDENTIAL SERVICE

§ 6100.711. Fee for the ineligible portion of residential service.

(a) The Department will establish a fee for the ineligible portion of payment for residential services.

(b) The fee in subsection (a) will be based on the factors in subsection (c) using a market-based approach so that payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services are available to at least the extent that such services are available to the general population in the geographic area.

(c) In establishing the fee in subsection (a), the Department will examine and use data relating to the following factors:

(1) *Occupancy*. Occupancy is the cost related to occupying a space, including rent, taxes, insurance, depreciation and amortization expenses.

(2) Meals for staff persons.

(3) Custodial and maintenance expenses.

(4) Geographic costs based on the location where the service is delivered.

(5) Other factors that impact costs.

(d) The Department will update the data used in subsection (c) at least every 3 years.

(e) The Department will publish a description of its fee setting methodology used in subsection (b) as a notice in the *Pennsylvania Bulletin* for public review and comment. The description will include a discussion of the use of the factors in subsection (c) to establish the fee; a discussion of the data and data sources used; and the fee.

(f) The Department will make available to the public a summary of the public comments received in response to the notice in subsection (e) and the Department's response to the public comments.

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) Failure to comply with 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 the Department, the designated managing entity and other authorized Federal and State officials, free and full access to the provider's policies and records and the individuals receiving services in accordance with this chapter.

(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 services to a new individual.

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

(5) Prohibiting the enrollment of a new service 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 service location.

§ 6100.743. Consideration as to type of sanction utilized.

(a) The Department may impose one or more of the sanctions in § 6100.742 (relating to array of sanctions), based on the Department's review of the facts and circumstances 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 will consider the following factors 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 provider's 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 and 1101.77.

(2) Other sanctions as provided by applicable statutes and regulations.

SPECIAL PROGRAMS

§ 6100.801. Agency with choice.

(a) Agency with choice (AWC) is a type of self-directed financial management service in which the agency is the common law employer and the individual or the individual's 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 (relating to general requirements) and 6100.46—6100.56.

(3) Training as specified in §§ 6100.141—6100.143 (relating to training), except for the following that do not apply:

(i) The number of annual training hours in § 6100.143 (relating to annual training).

(ii) The training course in § 6100.143(c)(5).

(iii) The requirements for training in §§ 6100.141—6100.143 for staff persons who work fewer than 30 days in a 12-month period.

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

(5) Individual plan as specified in §§ 6100.221—6100.227.

(6) Restrictive procedures as specified in §§ 6100.341—6100.350.

(7) Incident management as specified in §§ 6100.401—6100.404.

(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 AWC 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.

§ 6100.802. Support coordination, targeted support management and base-funding 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 service and 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 service and support for an individual. TSM is not an HCBS.

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

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

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

(2) Section 6100.227 (relating to progress notes).

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

(4) Sections 6100.461—6100.469.

(5) Sections 6100.641—6100.672, 6100.681—6100.694 and 6100.711.

(6) Section 6100.805 (relating to vendor goods and services).

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

(1) In addition to the training and orientation required under § § 6100.142—6100.143 (relating to orientation; and annual training), a support coordinator, base-funding support coordinator, targeted support manager and support coordinator 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, base-funding support coordinator, targeted support manager and support coordinator 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), unless the incident was reported and documented by another source.

(3) 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.

(4) 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-funding 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.

§ 6100.803. Organized health care delivery system.

(a) OHCDS is an organized health care delivery system. 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) Sections 6100.47—6100.49 (relating to criminal history checks; funding, hiring, retention and utilization; and child abuse history certification) for public transportation and indirect services and supplies.

(2) Training as specified in §§ 6100.141—6100.143 (relating to training).

(3) Section 6100.405 (relating to incident analysis).

(4) Medication administration as specified in §§ 6100.461—6100.469.

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

(6) Sections 6100.641—6100.672, 6100.681—6100.694 and 6100.711.

(7) Section 6100.805 (relating to vendor goods and services).

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

(1) An OHCDS shall:

(i) Be an enrolled Medical Assistance waiver provider.

(ii) Be enrolled in the Medicaid management information system.

(iii) Provide at least one Medical Assistance service.

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

(v) Bill the Medicaid management information system 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 Medicaid management information system.

(2) An OHCDS may bill a separate administrative fee in accordance with 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 justify the separate administrative fee.

(3) An OHCDS shall ensure that each vendor with which it contracts meets the applicable provisions of this chapter.

(4) Only vendor goods and services may be subcontracted through the OHCDS. A provider that 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 as or less than the cost charged to the general public.

§ 6100.804. Base-funding.

(a) A base-funding only service is a State-only funded service 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 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—6100.56.

(3) Training as specified in §§ 6100.141—6100.143 (relating to training).

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

(5) Individual plan as specified in §§ 6100.221—6100.227.

(6) Transition as specified in §§ 6100.301—6100.307.

(7) Restrictive procedures as specified in §§ 6100.341—6100.350.

(8) Incident management as specified in §§ 6100.401—6100.405.

(9) Medication administration as specified in §§ 6100.461—6100.469.

(10) Room and board as specified in §§ 6100.681—6100.694.

§ 6100.805. 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 (relating to protective services), 6100.47—6100.49 (relating to criminal history checks; funding, hiring, retention and utilization; and child abuse history certification) for services other than public transportation and indirect goods and services, 6100.51 (relating to complaints) and 6100.53—6100.56.

(3) Enrollment as specified in §§ 6100.81—6100.85.

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

(5) Individual plan as specified in §§ 6100.221—6100.226. Respite camps serving fewer than 25% of people with disabilities are exempt from §§ 6100.221—6100.225 and 6100.227 (relating to progress notes).

(6) Restrictive procedures as specified in §§ 6100.341—6100.350 for respite camps serving 25% or more people with disabilities.

(7) Incident management as specified in §§ 6100.401—6100.404 (relating to incident management) for respite camps serving 25% or more people with disabilities.

(8) General payment provisions as specified in §§ 6100.481—6100.485.

(9) Enforcement as specified in §§ 6100.741—6100.744.

(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 for the HCBS.

(h) A vendor shall ensure that a subcontractor, as applicable, provides the vendor good or service in accordance with this chapter.

CHAPTER 6200. (Reserved)

§§ 6200.1—6200.3. (Reserved).

§ 6200.3a. (Reserved).

§§ 6200.11—6200.20. (Reserved).

§§ 6200.31—6200.35. (Reserved).

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