RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 52]

Long-Term Living Home and Community-Based Services

The Department of Public Welfare (Department) adds Chapter 52 (relating to long-term living home and community-based services) to read as set forth in Annex A under the authority of sections 201(2), 403(b), and 403.1 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b) and 403.1), as amended by the act of June 30, 2011 (P. L. 89, No. 22) (Act 22).

Omission of Proposed Rulemaking

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

The Department is adding Chapter 52 in accordance with section 403.1 of the code because this final-omitted rulemaking establishes the following: provider payment rates and fee schedules and payment methodologies for particular services; and provider qualifications for providers participating in the Aging, Attendant Care, COMMCARE, Independence and OBRA home and community-based (HCBS) waiver programs and the Act 150 program.

Purpose

The purpose of this final-omitted rulemaking is to establish payment rates, fee schedules and payment methodologies for HCBS and to establish HCBS provider qualifications. This final-omitted rulemaking establishes provider qualifications and provider fee schedules to ensure that expenditures for FY 2011-2012 remain within the aggregate amount appropriated for HCBS programs by the General Appropriations Act of 2011.

Background

The Commonwealth's HCBS programs have grown 452% in the past 11 years. The cost of these programs has increased from $66 million in FY 2000 to $1.014 billion in FY 2011. To strengthen program integrity and to improve cost efficiencies of these programs, the Department is promulgating regulations.

Currently, the Department pays for many HCBS program services through a locally-negotiated rate between providers and public and private local entities. The final-omitted rulemaking creates two payment methods for the payment of services under the HCBS programs. The first method establishes a fee schedule rate for the provision of a service. The Department will publish these fee schedule rates as a notice as part of the MA fee schedule in the *Pennsylvania Bulletin*.

The second payment method is for a limited number of goods and services provided through the HCBS programs. As with current practice, the Department will continue to reimburse the actual cost of the good or service. In the final-omitted rulemaking, these goods and services are referred to as a vendor good or service. A vendor good or service makes up a small portion of the HCBS program and has traditionally been reimbursed for the actual cost. The list of vendor goods or services will also be published as a notice in the *Pennsylvania Bulletin*.

Requirements

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

§ 52.4. Incorporation by reference

This section incorporates by reference the approved applicable Federal waivers including approved waiver amendments. The approved applicable Federal waivers can be found at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2.

§ 52.11. Prerequisites for participation

§ 52.14. Ongoing responsibilities of providers

§ 52.27. Service coordinator qualifications and training

These sections establish provider qualifications that shall be met to provide services and to continue to provide these services. These provider requirements include completion and submission of an MA application, MA provider agreement and waiver addendum; verification of fiscal solvency; and creation of various policies and procedures. In addition to the enumerated requirements, providers are required to comply with the approved applicable waivers.

§ 52.17. Critical incident and risk management

This section requires providers to report critical incidents and requires the development and implementation of written policies and procedures on the prevention, reporting, notification, investigation and management of critical incidents. Providers are also required to meet the risk management requirements as specified in the approved applicable waivers.

§ 52.22. Provider monitoring

§ 52.23. Corrective action plan

Section 52.22 specifies that the Department will conduct provider monitoring at least once every 2 years. Section 52.23 details how a corrective action plan will be developed and implemented by a provider who is found to be in noncompliance with this chapter.

§ 52.24. Quality management

This section requires providers to create and implement quality management plans to ensure that providers meet

the requirements of this chapter, Chapter 1101 (relating to general provisions) and other chapters under which a provider may be licensed.

§ 52.28. Conflict free service coordination

This section prohibits a service coordination entity from providing a waiver or Act 150 program service, other than service coordination, except under limited circumstances. These circumstances include when a service coordination entity is providing the service as an organized health care delivery system or is providing community transition services to a participant transitioning from a nursing home facility into a community setting.

§ 52.42. Payment policies

This section outlines that services are to be paid as either a fee schedule service or a vendor good or service. The Department will publish services specific to each waiver and the Act 150 program as a notice in the *Pennsylvania Bulletin*. This section also provides that the Department will pay for a service in the type, scope, amount, duration and frequency as specified in a participant's service plan as approved by the Department.

§ 52.43. Audit requirements

This section clarifies the audit requirements for providers.

§ 52.45. Fee schedule rates

This section establishes a fee schedule rate for a waiver or Act 150 service under the MA Program fee schedule. These fee schedule rates and the methods and standards for setting the fee schedule rates will be published as a notice in the *Pennsylvania Bulletin*. The section also specifies that services specific to each waiver and the Act 150 program will be published as a notice in the *Pennsylvania Bulletin*.

§ 52.51. Vendor good or service payment

This section provides that an amount charged for a vendor good or service may not exceed the amount for a similar vendor good or service charged to the general public. This section also requires a provider to retain documentation related to the amount charged for a vendor good or service. In addition, this section specifies that a vendor good or service specific to each waiver and the Act 150 program will be published as a notice in the *Pennsylvania Bulletin*.

§ 52.64. Payment sanctions

This section provides the sanctions that may be taken if a provider fails to meet a specified requirement of this chapter. Sanctions may include the disallowance of payments, the suspension of current or future payments, or the recoupment of payments for services the provider cannot verify as being provided in the amount, duration and frequency billed.

Affected Individuals and Organizations

The final-omitted rulemaking affects approximately 2,000 providers who deliver services through the Aging, Attendant Care, COMMCARE, Independence, OBRA waivers and the Act 150 program.

Accomplishments and Benefits

The Department is implementing cost savings to ensure that the expenditures for FY 2011-2012 for assistance programs administered by the Department do not exceed the aggregate amount appropriated for the program by the General Appropriations Act of 2011. This final-omitted rulemaking also provides the Department with authority to enforce provisions of its HCBS programs, specifies the payment provisions for waiver and Act 150 program services, establishes provider qualifications and monitoring requirements, gives the Department the ability to initiate corrective action plans and sanctions for noncompliance and reinforces the billing requirements under § 1101.68 (relating to invoicing for services).

Fiscal Impact

The Department anticipates that these changes will result in savings of $0.917 million ($0.444 million in State funds) in FY 2011-2012.

Paperwork Requirements

There are new paperwork requirements under the final-omitted rulemaking. However, there is not an alternative to this new paperwork. The new paperwork requirements include the development and implementation of a corrective action plan and a quality management plan. The Department will prepare a recommended format for the creation and implementation of a corrective action plan and quality management plan.

Public Process

The Department published advance public notice at 42 Pa.B. 1003 (February 18, 2012) announcing its intent to adopt regulations regarding HCBS and submit waiver amendments, as necessary, regarding provider qualifications and provider payment methodology and rates. This final-omitted rulemaking applies to HCBS providers rendering services for the Aging, Attendant Care, COMMCARE, Independence and OBRA HCBS waivers (waivers) and the Act 150 program.

The Department invited interested persons to submit comments. In addition, the Department discussed this final-omitted rulemaking with the Medical Assistance Advisory Committee at the February 23, 2012, meeting.

The Department also posted the draft regulation on the Department's web site on February 24, 2012, with a 15-day comment period. The Department again invited interested persons to submit written comments to the Department regarding the regulations. The Department received 777 comments from 344 commentators. The Department also discussed the regulations and responded to questions at the House Health Committee hearing on March 8, 2012.

Discussion of Comments

The Department considered comments received in response to the draft regulations. The following is a summary of the major comments received within the public comment period and the Department's responses to those comments.

Comment

Several commentators stated that the Department did not allow sufficient time for review and comment of the regulations.

Response

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

As previously mentioned, the Department published advance public notice at 42 Pa.B. 1003 announcing its intent to adopt a regulation regarding HCBS and submit waiver amendments, as necessary, regarding provider qualifications and provider payment methodology and rates. The Department invited interested persons to

comment. The Department also posted the draft regulations on the Department's web site on February 24, 2012. The Department again invited interested persons to submit written comments, on or before March 9, 2012, regarding the regulations to the Department. As a final-omitted rulemaking under Act 22, the Department was not required to have a public comment process. However, to encourage transparency and public input, the Department provided an opportunity for comment by publishing the notice and posting the draft regulations on the Department's web site. This public comment process provided sufficient opportunity for interested parties to submit comments, as supported by the number of comments that were submitted.

Background—Service coordination

A majority of the comments received related to care management services in the Aging Waiver. These comments related to the following: the absence of the term "care manager" in the regulation; the assertion that Aging Waiver care management services are more expansive than service coordination services; and that Aging Waiver participants are frailer and more at risk than participants in other waivers. Most of these concerns came from Area Agencies on Aging (AAA), AAA care managers and Aging Waiver participants and their families and advocates.

Response

Service coordination for the Department's Aging Waiver is performed by individuals who are known as "care managers." Individuals who perform this function in the Department's other HCBS programs are called "service coordinators."

Although different terminology is used, there is not a distinction between service coordination and care management. In addition, recipients of waiver services have specific needs. Each person is assessed for his specific needs. Therefore, the aging population is no more at risk than other HCBS waiver populations. Thus, the Department did not revise the regulations.

General comments—Aging Waiver

Several commentators suggested that the regulations should not apply to the Aging Waiver, fearing that its inclusion will negatively impact the function of AAAs in the aging community.

Response

The Department recognizes the important role that AAAs serve in coordinating services for those 60 years of age or older. Most people 60 years of age or older who need long-term living services will likely continue to use AAAs for information, referral, assessment and service coordination. AAAs will continue to be the location where Federal Administration on Aging services are offered. The difference, however, is that Aging Waiver participants shall have the option to receive service coordination services from a provider other than the AAA if they so choose. The Department, while recognizing the importance of AAAs at the local level, will not exclude the Aging Waiver from the scope of the regulations.

§ 52.3. Definition of "service coordinator"

§ 52.25. Service coordination services—registered nurse involvement

Commentators indicated that the absence of the term "care management" in § 52.3 (relating to definitions) meant that neither care management nor service coordination services would be available to Aging Waiver participants under the regulations.

Other commentators commented that service coordination does not equate to care management. These commentators held that care management involves more extensive services than service coordination, including registered nurse (RN) review of each care plan; RN home visits; benefits counseling and access to services; unlimited monthly contacts as needed; health promotion and prevention services; serving as representative payees as needed and involvement of family members and caregivers. Commentators asserted that service coordinators do not perform these functions and that Aging Waiver participants will suffer if entities other than AAAs provide service coordination for them.

Commentators also stated that under the regulations, service coordination does not require involvement of a RN in the development of a service plan, nor does it require home visits by RNs. Commentators held that RNs are involved in the development of all Aging Waiver service plans.

Response

The regulation does not exclude service coordination services for Aging Waiver participants. As previously stated, the function of care management will remain but will be known as "service coordination." "Service coordination" is defined as a "service that assists a participant in gaining access to needed waiver services, MA State Plan services and other medical, social and educational services regardless of funding source." The Department, therefore, did not alter the regulation to include "care management" as a definition.

In addition, the Aging Waiver does not require that RNs be involved in the development of service plans or that RNs do home visits. Service coordination services, as with other waiver services, are person-centered and are provided based on the needs of each participant. If RN involvement is called for in the development of a service plan, RNs may be brought in by the service coordination agency as part of the service coordination service. However, they are not required.

Waivers covered by this regulation allow for service coordination services based on the needs of each waiver participant and allow for representative payees and involvement of family members and caregivers as part of the service coordination service. The Department maintains that health promotion and prevention services are not and have never been services provided under the Aging Waiver. They are, instead, services provided through other funding streams and should not be included in this regulation.

The Department further maintains that service coordination needs are fundamentally the same across waivers and has not revised the regulation as requested by the commentators.

§ 52.11. Prerequisites for participation

AAAs, along with other commentators, expressed concern that the final-omitted regulation would exclude county-based AAAs from providing service coordination services. Commentators cited § 52.11(a)(3), which requires that, as a condition of participation in a waiver or Act 150 program, an applicant shall verify fiscal solvency. Commentators stated that county-operated AAAs would not qualify because they are not corporate or nonprofit organizations.

Commentators also cited § 52.11(a)(5)(ix) and § 52.19 (relating to criminal history checks). County-based AAA care managers fall under State Civil Service provisions

and commentators asserted that the requirements in the regulation conflicted with these provisions.

Response

The Department concurs concerning § 52.11(a)(3) and excludes county-based AAAs in subsection (a)(4). However, the Department reviewed §§ 52.11(a)(5)(ix) and 52.19 and did not find conflicts. Therefore, the Department has not changed the regulation.

§ 52.27. Service coordinator qualifications and training

Commentators suggested that a conflict exists between the regulation and the care manager requirements published by the State Civil Service Commission. The Department also received 76 comments inquiring about the impact of service coordinator qualifications on employees of disability service coordination agencies.

Response

The Department reviewed the care manager requirements published by the State Civil Service Commission. Because there were differences between the provisions of the draft regulation and the qualifications published by the State Civil Service Commission for care managers, the Department revised the regulation to mirror the State Civil Service Commission publication.

With respect to service coordination qualifications for employees of disability service coordination entities, the Department, in developing the basic requirements of this provision, reviewed the HCBS waivers and determined that uniformity is needed. The Department maintains that it is important for providers to be held to the same standard. Therefore, a change was not made to this provision.

§ 52.28. Conflict free service coordination

Commentators asserted that this section will result in consumers not being able to choose the same entity for service coordination and direct services.

Eleven commentators also expressed concern that the transition to conflict free service coordination under this section would jeopardize the safety of participants.

Response

There is an inherent conflict of interest when the same agency prescribing services is also the agency providing those services. The Department does not agree with the comments and, therefore, has not revised this section to allow the same entity to serve as a service coordination entity and a direct service provider.

The Department is aware that when participants leave one provider and transition to another, safeguards must be in place. The Department will work with providers to ensure that participants have a seamless transition. Additionally, in response to this concern, the Department added § 52.28(a)(3), which also excludes providers of financial management services from the conflict free service coordination provisions.

§ 52.45. Fee schedule rates

Many commentators requested public input on the establishment of rates.

Response

As provided by under § 1150.61 (relating to guidelines for fee schedule changes), the Department will publish a notice in the *Pennsylvania Bulletin* when MA Program fee schedule rates are changed or when procedures, services or items are added to or deleted from the MA Program fee schedule. When the notice is published, it will provide for a public comment period, which includes the review and consideration of public comments in subsequent revisions of the MA Program fee schedule.

Regulatory Review Act

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

Findings

The Department finds that:

(1) Notice of proposed rulemaking is omitted in accordance with § 204(1)(iv) of the CDL, 1 Pa. Code § 7.4(1)(iv) and section 403.1 of the code because the rulemaking relates to Commonwealth grants and benefits.

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

(3) The final-omitted rulemaking ensures that the Department's expenditures do not exceed the aggregate amount appropriated by the General Assembly.

Order

The Department acting under the code, orders that:

(a) The regulations of the Department, 55 Pa. Code, are amended by adding §§ 52.1—52.4, 52.11—52.30, 52.41—52.45, 52.51—52.53 and 52.61—52.65 to read as set forth in Annex A.

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

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

(d) This order shall take effect upon publication in the *Pennsylvania Bulletin*, with the exception of §§ 52.26(g) and (i) and 52.28. Sections 52.26(g) and (i) and 52.28 take effect upon written notification that the United States Department of Health and Human Services has granted approval of related waiver amendments. Upon receipt of written notification of approval, the Department will publish a notice in the *Pennsylvania Bulletin*.

GARY D. ALEXANDER,
Secretary

Fiscal Note: 14-531. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART I. DEPARTMENT OF PUBLIC WELFARE

Subpart E. HOME AND COMMUNITY-BASED SERVICES

Chap.
52. LONG-TERM LIVING HOME AND COMMUNITY-BASED SERVICES

CHAPTER 52. LONG-TERM LIVING HOME AND COMMUNITY-BASED SERVICES

Subchap.
A. GENERAL PROVISIONS
B. PROVIDER QUALIFICATIONS AND PARTICIPATION
C. PAYMENT FOR SERVICES
D. PROVIDER DISQUALIFICATION

Subchapter A. GENERAL PROVISIONS

Sec.
52.1. Purpose.
52.2. Scope.
52.3. Definitions.
52.4. Incorporation by reference.

§ 52.1. Purpose.

This chapter specifies the provider qualifications and payment provisions for providers rendering services under the Aging, Attendant Care, COMMCARE, Independence and OBRA Home and Community-Based Service waivers and the Act 150 program.

§ 52.2. Scope.

This chapter sets forth the regulations which apply to providers applying to participate and render MA-funded waiver services under the Federally-approved Aging, Attendant Care, COMMCARE, Independence and OBRA Home and Community-Based Service waivers or the Act 150 program.

§ 52.3. Definitions.

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

ADL—Activities of daily living—The term includes eating, drinking, ambulating, transferring in and out of a bed or chair, toileting, bladder and bowel management, personal hygiene, self-administering medication and proper turning and positioning in a bed or chair.

Act 150—A State-funded program under the Attendant Care Services Act (62 P. S. §§ 3051—3058).

Aging waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act (42 U.S.C.A § 1396n(c)) that authorizes services to participants 60 years of age or older.

Applicant—An individual or legal entity in the process of enrolling as a provider.

Attendant Care waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act that authorizes services to participants 18 years of age or older but under 60 years of age with physical disabilities.

Attestation engagement—Financial services that result in the issuance of a report on a subject matter or an assertion about the subject matter that is the responsibility of another party. The term includes audits, examinations, reviews, compilations and agreed-upon procedures.

Back-up plan—A component of the service plan that is comprised of the individualized back-up plan and the emergency back-up plan.

CAP—Corrective action plan—A plan created by the provider or the Department to address provider noncompliance with this chapter.

CHAMPUS—Civilian Health and Medical Program of Uniformed Services.

COMMCARE—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act called the Community Care waiver that authorizes services to participants 21 years of age and older with traumatic brain injuries.

Community transition service—A one-time service which assists a participant to move from an institution to the participant's home, apartment or another noninstitutional living arrangement.

Community transition service provider—A provider who renders community transition services.

Complaint—Dissatisfaction with program operations, activities or services received, or not received, involving HCBS.

Critical incident—An occurrence of an event that jeopardizes the participant's health or welfare including:

(i) Death, serious injury or hospitalization of a participant. Pre-planned hospitalizations are not critical incidents.

(ii) Provider and staff member misconduct including deliberate, willful, unlawful or dishonest activities.

(iii) Abuse, including the infliction of injury, unreasonable confinement, intimidation, punishment or mental anguish, of the participant. Abuse includes the following:

(A) Physical abuse.

(B) Psychological abuse.

(C) Sexual abuse.

(D) Verbal abuse.

(iv) Neglect.

(v) Exploitation.

(vi) Service interruption, which is an event that results in the participant's inability to receive services and that places the participant's health or welfare at risk.

(vii) Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

Department—The Department of Public Welfare of the Commonwealth.

Direct care worker—A person employed for compensation by a provider or participant who provides personal assistance services or respite services.

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

Emergency back-up plan—A plan which outlines the steps to be taken by the provider and the participant to ensure that the participant's needs are met in an emergency.

Fee schedule service—A service paid based on the MA Program fee schedule rates established by the Department.

Financial management services—A service which provides payroll, invoice processing and payment, fiscal reporting services, employer orientation, skills training and other fiscal-related services to participants choosing to exercise employer or participant-directed budget authority.

Financial review—A review of billing records against provider documentation to ensure services were provided in the type, scope, amount, duration and frequency as required by the participant's service plan and to ensure that a billing for a service rendered by a provider is accurate.

Finding—An identified violation of the following:

(i) This chapter.

(ii) The MA provider agreement, including the waiver addendum.

(iii) Chapter 1101 (relating to general provisions).

(iv) The approved applicable waiver, including approved waiver amendments.

(v) A State or Federal requirement.

HCBS—Home and community-based services—Services offered as part of a Federally-approved MA waiver or Act 150 program.

IADL—Instrumental activities of daily living—The term includes the following activities when done on behalf of a participant:

(i) Laundry.

(ii) Shopping.

(iii) Securing and using transportation.

(iv) Using a telephone.

(v) Making and keeping appointments.

(vi) Caring for personal possessions.

(vii) Writing correspondence.

(viii) Using a prosthetic device.

(ix) Housekeeping.

ICF/ORC—Intermediate care facility/other related conditions.

Independence waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act that authorizes services to participants 18 years of age and older but under 60 years of age with physical disabilities.

Individualized back-up plan—A plan which outlines the steps to be taken by the provider and participant to ensure that services are delivered to the participant in a situation where routine service delivery is interrupted.

Informal community supports—Services provided by a family member, friend, community organization or other entity for which funding is not provided by the Department.

LEIE—List of Excluded Individuals and Entities—A database maintained by the United States Department of Health and Human Services, Office of the Inspector General, that identifies individuals or entities that have been excluded Nationwide from participation in a Federal health care program.

Level of care re-evaluation—A redetermination of a participant's clinical eligibility under a waiver or the Act 150 program.

MA—Medical Assistance.

MA provider agreement—An enrollment agreement signed by the provider which establishes requirements relating to the provision of services.

Medicaid—MA provided under a State Plan approved by the United States Department of Health and Human Services under Title XIX of the Social Security Act (42 U.S.C.A. § 1396a).

Medicaid State Plan—A plan to provide MA developed by the Department and approved by the United States Department of Health and Human Services under Title XIX of the Social Security Act which serves as the basis for Federal financial participation in the program.

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

Monitoring—A review of a provider's compliance.

Nursing facility—

(i) A long-term care facility that is:

(A) Licensed by the Department of Health.

(B) Enrolled in the MA Program as a provider of nursing facility services.

(C) Owned by a person, partnership, association or corporation and operated on a profit or nonprofit basis.

(ii) The term does not include the following:

(A) Intermediate care facilities for individuals with developmental or intellectual disabilities or other related conditions

(B) Federal or State-owned long-term care nursing facilities.

OBRA waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act named for the Omnibus Budget and Reconciliation Act of 1981 (Pub. L. No. 97-35) that authorizes services to participants 18 years of age or older but under 60 years of age with developmental disabilities.

OHCDS—Organized Health Care Delivery System provider—A provider who is authorized by the Department to contract with an entity to provide a vendor good or service.

Participant—A person receiving services through a waiver or the Act 150 program.

Participant-directed budget authority—The spending authority granted to the participant through a waiver whereby the participant is authorized to spend the amount of money allocated in the participant's service plan on goods and services.

Participant goal—A service plan requirement that states a participant's objective towards obtaining or maintaining independence in the community.

Participant need—A service plan requirement based on a person-centered assessment.

Participant outcome—A service plan requirement that measures whether a service, TPR or informal community support is achieving a participant goal.

Person-centered approach—A holistic approach to serving participants which focuses on a participant's individual and specific strengths, interests and needs.

Person-centered assessment—A Department-approved questionnaire used to determine the specific needs of a participant by utilizing a person-centered approach.

Personal assistance services—Services aimed at assisting the participant to complete ADLs and IADLs that would be performed independently if the participant did not have a disability.

Preventable incident—A critical incident that could be avoided through appropriate training of a staff member or participant following established policies and procedures or implementation of other reasonable precautionary measures.

Provider—A Department-enrolled entity which provides a service.

QMP—Quality Management Plan—A provider-created plan to address areas of quality improvement identified by the provider or the Department.

Respite services—Personal assistance services which are provided on a temporary, short-term basis when a noncompensated caregiver is unavailable to provide personal assistance services.

Risk mitigation strategies—Methods to reduce risks to a participant's health and safety.

SCE—Service coordination entity—A provider authorized to render service coordination services in a waiver or Act 150 program.

Service—A benefit which a participant receives under an approved MA waiver or the Act 150 program.

Service coordination—Service that assists a participant in gaining access to needed waiver services, MA State Plan services and other medical, social and educational services regardless of funding source.

Service coordinator—A staff member who provides service coordination services at an SCE.

Service plan—The Department-approved comprehensive written summary of a participant's services, TPR and informal community supports.

TPR—Third party medical resource—Medical resources used to pay for participant services, including Medicare, CHAMPUS, workers' compensation, for profit and nonprofit health care coverage and insurance policies, and other forms of insurances.

Vendor good or service—A rendered item or service that is not on the MA fee schedule for which the Department reimburses an OHCDS or provider.

Waiver—The Aging, Attendant Care, COMMCARE, Independence, and OBRA Home and Community-Based Service waivers approved by the Federal Centers for Medicare and Medicaid Services.

§ 52.4. Incorporation by reference.

The approved applicable Federal waivers, including approved waiver amendments, are incorporated by reference and can be found on the Department's web site at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733116&mode=2.

Subchapter B. PROVIDER QUALIFICATIONS AND PARTICIPATION

Sec.
52.11. Prerequisites for participation.
52.12. Prerequisites for existing provider enrolling in a new service.
52.13. Review of application.
52.14. Ongoing responsibilities of providers.
52.15. Provider records.
52.16. Abuse.
52.17. Critical incident and risk management.
52.18. Complaint management.
52.19. Criminal history checks.
52.20. Provisional hiring.
52.21. Staff training.
52.22. Provider monitoring.
52.23. Corrective action plan.
52.24. Quality management.
52.25. Service plan.
52.26. Service coordination services.
52.27. Service coordinator qualifications and training.
52.28. Conflict free service coordination.
52.29. Confidentiality of records.
52.30. Waiver of a program qualification.

§ 52.11. Prerequisites for participation.

(a) As a condition of participation in a waiver or Act 150 program, an applicant shall meet the following qualifications:

(1) Complete and submit an MA application including a waiver addendum to that application.

(2) Complete and submit a signed MA provider agreement including the waiver addendum to that agreement.

(3) Verify fiscal solvency by submitting a copy of the following:

(i) Applicant's most recent corporate or nonprofit tax return. If an applicant does not have a corporate or nonprofit tax return, then the applicant shall submit the most recent individual tax return for the owner of the entity which is applying for enrollment.

(ii) Applicant's most recent monthly balance sheet. If an applicant does not have a balance sheet, then an applicant shall submit a copy of the business plan indicating assets, liabilities, and anticipated costs and revenues for the next fiscal year.

(iii) Articles of incorporation, if the applicant is incorporated.

(iv) Partnership agreement, if the applicant is a partnership.

(v) Most recent audit or financial review if the applicant has completed an audit or financial review within the previous 5 years.

(4) Area Agencies on Aging that are units of county government are not required to submit documentation under paragraph (3).

(5) Create and follow policies and procedures relating to the following:

(i) Compliance with this chapter.

(ii) Provision of services in a nondiscriminatory manner.

(iii) Compliance with the Americans with Disabilities Act of 1990 (42 U.S.C.A. §§ 12101—12213).

(iv) Compliance with the Healthcare Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191).

(v) Staff member training. The policy must be in accordance with this chapter and licensing requirements that the applicant is required to meet.

(vi) Participant complaint management process.

(vii) Critical incident management. The policy must be in accordance with this chapter and licensing requirements that the applicant is required to meet.

(viii) Quality management. The policy must be in accordance with this chapter and licensing requirements that the applicant is required to meet.

(ix) Staff member screening for criminal history.

(x) Employee Social Security Number verification.

(xi) Initial and continued screening for staff members and contractors to determine if they have been excluded from participation in Federal health care programs by reviewing the LEIE, EPLS and Medicheck.

(xii) Process for participants with limited English proficiency to access language services.

(6) Obtain and maintain appropriate licenses and certifications from other State or Federal agencies as required.

(7) Obtain the following insurances:

(i) Commercial general liability insurance.

(ii) Worker's compensation insurance.

(iii) Professional liability insurance if required by a profession.

(8) Comply with the applicable approved waiver, including approved waiver amendments as posted on the Department's publicly accessible web site.

(b) An applicant shall submit verification of compliance with subsection (a) to the Department.

(c) Application materials shall be submitted to the Department in a form and manner as prescribed by the Department.

(d) An applicant may apply to become a provider of more than one service as long as the provision of multiple services is not prohibited by this chapter or Federal or State requirement.

§ 52.12. Prerequisites for existing provider enrolling in a new service.

(a) If an existing provider enrolled in a waiver program wants to enroll to provide an additional waiver service, the provider shall submit the following to the Department:

(1) A written request to enroll as a provider of the additional service.

(2) A copy of the license required to provide the service if the service requires licensure.

(3) A completed and signed waiver addendum to the MA provider agreement for the new service.

(b) The provider shall submit the written request to enroll in an additional service to the Department in a form and manner prescribed by the Department.

§ 52.13. Review of application.

(a) The Department will only review complete application materials.

(b) The Department will review the application materials submitted under § 52.11 (relating to prerequisites for participation).

(c) The Department may request additional information from an applicant to verify the applicant is qualified to provide services in accordance with this chapter or other Federal or State requirements.

(d) Incomplete application materials are void after 30 days of receipt.

(e) The Department will notify the applicant if the applicant's application is incomplete.

(f) The Department is not required to return application materials to an applicant.

§ 52.14. Ongoing responsibilities of providers.

(a) An applicant is not a provider until the following are met:

(1) The Department approves the applicant's MA application.

(2) An MA provider agreement including a waiver addendum is signed.

(b) Within 180 days from the date of enrollment, a provider shall attend new provider training provided by the Department.

(c) A provider shall implement the policies under § 52.11(a)(5) (relating to prerequisites for participation).

(d) In addition to meeting the participation requirements under Chapter 1101 (relating to general provisions), a provider shall update and submit to the Department the provider qualifications under § 52.11(a)(3)—(7) at least every 2 years.

(e) In addition to meeting the requirements in § 1101.68 (relating to invoicing for services), the provider shall meet the requirements in the MA HCBS Provider Handbook, available on the Department's web site.

(f) A provider shall maintain appropriate licenses and certifications as required by State and Federal requirements. The provider shall submit a copy of a valid license or certification, or both, to the Department at the beginning of each applicable licensure period.

(g) The provider shall ensure the following prior to rendering services to a participant:

(1) The service plan is approved by the Department.

(2) The type, scope, amount, duration and frequency of the service to be rendered are listed in the service plan that the provider is assigned to implement.

(h) A provider shall ensure a participant is eligible to receive a service prior to rendering the service to the participant.

(i) A provider shall comply with the applicable approved waiver, including approved waiver amendments.

(j) The provider shall notify the Department at least 30 business days prior to any of the following occurrences:

(1) Changes in the provider's address, telephone number, fax number, e-mail address, provider name change or provider's designated contact person.

(2) Creation, changes or revocation of the provider's articles of incorporation or partnership agreements.

(3) Revisions to an audit previously submitted to the Department under § 52.11(a).

(4) Revocation or provisional status of a license or certification.

(5) Cancellation of the following insurances:

(i) Commercial general liability insurance.

(ii) Workers' compensation insurance.

(iii) Professional liability insurance if the profession authorized to provide a service requires professional liability insurance.

(k) If the provider is unable to notify the Department due to an emergency prior to a change occurring as stated under subsection (j), the provider shall notify the Department within 2 business days of the change.

(l) A provider shall ensure that each employee possesses a valid Social Security Number.

(m) A provider may not render a service when the participant is unavailable to receive the service.

(n) A provider may not bill for a service when the participant is unavailable to receive the service.

(o) A provider which is not an SCE shall cooperate with the participant, the SCE and the Department to resolve delays in service provision.

(p) A provider shall complete and comply with a CAP as required by the Department or other Federal or State agency.

(q) A provider shall implement and provide services to the participant in the type, scope, amount, duration and frequency as specified in the service plan.

(r) A provider shall document the participant's progress towards outcomes and goals in the Department's designated information system.

(s) The provider shall comply with the terms of the MA provider agreement, including waiver addendum.

(t) A provider shall participate in Department-mandated trainings.

§ 52.15. Provider records.

(a) The following requirements are in addition to the recordkeeping provisions under § 1101.51(d) and (e) (relating to ongoing responsibilities of providers):

(1) A provider shall use the Department's designated information system to record service plan information regarding the participant as required under § 52.25 (relating to service plan).

(2) A provider shall complete and maintain documentation on service delivery.

(b) Electronic records are acceptable documentation when the provider meets the following:

(1) The electronic format conforms to Federal and State requirements.

(2) The electronic record is the original record and has not been altered or if altered shows the original and altered versions, dates of creation and the creator.

(3) The electronic record is readily accessible to the Department, the Department's designee and State and Federal agencies.

(4) The provider creates and implements an electronic record retention policy.

(5) Electronic imaging of paper documentation must result in an exact reproduction of the original record and conform to the provider's electronic record retention policy.

(c) The provider shall ensure records are compliant with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).

(d) The requirements of this section are in addition to the recordkeeping provisions in Chapters 2380 and 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries).

§ 52.16. Abuse.

(a) Abuse is an act or omission that willfully deprives a participant of rights or human dignity, or which may cause or causes actual physical injury or emotional harm to a participant including a critical incident and one or more of the following:

(1) Sexual harassment of a participant.

(2) Sexual contact between a staff member and a participant.

(3) Restraining a participant.

(4) Financial exploitation of a participant.

(5) Humiliating a participant.

(6) Withholding regularly scheduled meals from a participant.

(b) Abuse of a participant is prohibited.

§ 52.17. Critical incident and risk management.

(a) The requirements in this chapter are in addition to the reporting requirements under Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries).

(b) A provider shall report a critical incident involving a participant to the Department or the SCE, or both, on a form prescribed by the Department.

(c) A provider shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of critical incidents.

(d) A provider shall meet the risk management requirements as specified in the approved applicable waivers, including approved waiver amendments.

(e) If the Department requires additional follow-up information to a critical incident, then the provider shall submit additional information as requested to the Department.

(f) A provider shall reduce the number of preventable incidents. The methods used by the provider to reduce the number of preventable incidents shall be documented on the provider's QMP.

§ 52.18. Complaint management.

(a) The provider shall implement a system to record, respond and resolve a participant's complaint.

(b) The provider complaint system must contain the following:

(1) The name of the participant.

(2) The nature of the complaint.

(3) The date of the complaint.

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

(5) The participant's satisfaction to the resolution of the complaint.

(c) The provider shall review the complaint system at least quarterly to:

(1) Analyze the number of complaints resolved to the participant's satisfaction.

(2) Analyze the number of complaints not resolved to the participant's satisfaction.

(3) Measure the number of complaints referred to the Department for resolution.

(d) The provider shall develop a QMP when the numbers of complaints resolved to a participant's satisfaction are less than the number of complaints not resolved to a participant's satisfaction.

(e) The provider shall submit a copy of the provider's complaint system procedures to the Department upon request.

(f) The provider shall submit the information under subsection (c) to the Department upon request.

§ 52.19. Criminal history checks.

(a) The criminal history requirements in this section are in addition to the requirements in Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries) for providers licensed under these chapters.

(b) Prior to hiring an employee, a provider shall obtain a criminal history check which is in compliance with the following for each employee who may have contact with a participant:

(1) A report of criminal history record information from the Pennsylvania State Police or a statement from the Pennsylvania State Police that the Pennsylvania State Police Central Repository does not contain information relating to that person, under 18 Pa.C.S. Chapter 91 (relating to Criminal History Record Information Act), if the employee has been a resident of this Commonwealth for the 2 years immediately preceding the date of application.

(2) A report of Federal criminal history record information under the Federal Bureau of Investigation appropriation of Title II of the act of October 25, 1972 (Pub. L. No. 92-544, 86 Stat. 1109) if the employee has not been a resident of this Commonwealth for the 2 years immediately preceding the date of application.

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

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

(e) A copy of the final report received from the Pennsylvania State Police or the Federal Bureau of Investigation, as applicable, shall be kept in accordance with § 52.15 (relating to provider records).

§ 52.20. Provisional hiring.

(a) A provider may hire a person for employment on a provisional basis, pending receipt of a criminal history check, provided that the following are met:

(1) The provider is in the process of obtaining a criminal history check as required under § 52.19 (relating to criminal history checks).

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

(3) A provisionally-hired employee shall swear or affirm in writing that he is not disqualified from employment under this chapter.

(4) A provider shall monitor the provisionally-hired person awaiting a criminal history check through random, direct observation and participant feedback. The results of monitoring must be documented in the person's employment file.

(5) The period of provisional hire may not exceed 30 days for a person who has been a resident of this Commonwealth for at least 2 years.

(6) The period of provisional hire may not exceed 90 days for a person who has not been a resident of this Commonwealth for less than 2 years.

(b) If the information obtained from the criminal history check reveals that the person is disqualified from employment under § 52.19, the provider shall terminate the provisionally-hired person immediately.

(c) When subsection (a) conflicts with Chapters 2380 and 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) or 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries), subsection (a) is not applicable.

§ 52.21. Staff training.

(a) A provider shall meet the training requirements necessary to maintain appropriate licensure or certification, or both, in addition to meeting the training requirements of this chapter.

(b) Prior to providing a service to a participant, a staff member shall be trained on how to provide the service in accordance with the participant's service plan.

(c) A provider shall maintain documentation for the following:

(1) Staff member attendance at trainings.

(2) Content of trainings.

(d) A provider shall implement standard annual training for staff members providing services which contains at least the following:

(1) Prevention of abuse and exploitation of participants.

(2) Reporting critical incidents.

(3) Participant complaint resolution.

(4) Department-issued policies and procedures.

(5) Provider's quality management plan.

(6) Fraud and financial abuse prevention.

§ 52.22. Provider monitoring.

(a) The Department will monitor a provider at least once every 2 years.

(b) Monitoring may be announced or unannounced.

(c) A provider shall submit documentation as requested by the Department that the provider is in compliance with the following:

(1) This chapter.

(2) The MA provider agreement, including the waiver addendum.

(3) Chapter 1101 (relating to general provisions).

(4) The approved applicable waiver, including approved waiver amendments.

(5) A State or Federal requirement.

(d) The Department will issue a written statement of findings if the provider has not complied with subsection (c).

§ 52.23. Corrective action plan.

(a) The provider shall respond to the written statement of findings under § 52.22 (relating to provider monitoring) with a CAP when requested by the Department.

(b) The provider shall submit a CAP to the Department on a form prescribed by the Department.

(c) The CAP must contain at least the following:

(1) The provider's name.

(2) The provider's address.

(3) The provider's MA identification number.

(4) The action steps to address a specific finding.

(5) The dates action steps will be completed.

(6) An explanation on how the action steps will remediate the finding.

(7) The date when a finding will be remediated.

(8) The provider's signature indicating the provider will implement the CAP.

(d) The Department will review and monitor a provider-drafted CAP to ensure each finding is corrected.

(e) The Department may reject a provider-drafted CAP and request the provider to revise the CAP so the CAP is in compliance with this section.

(f) The Department may develop a CAP for a provider to implement in response to the statement of findings.

(g) The provider shall implement a Department-approved CAP.

(h) The Department may conduct a follow-up monitoring to ensure the provider is implementing the CAP.

§ 52.24. Quality management.

(a) The provider shall create and implement a QMP to ensure the provider meets the requirements of this chapter and Chapter 1101 (relating to general provisions).

(b) The QMP must contain at least the following:

(1) Measureable goals to ensure compliance with this chapter, Chapter 1101 and other chapters in this title under which the provider is licensed.

(2) Data-driven outcomes to achieve compliance with this chapter, Chapter 1101 and other chapters in this title which the provider is licensed.

(3) The current Department-approved CAP, if the provider has a CAP.

(c) The provider may add additional items to the QMP to address self-identified areas of quality improvement.

(d) The QMP must be updated at least annually by the provider.

(e) The Department may request a provider to update the provider's QMP if the provider receives a CAP.

(f) The provider shall submit a copy of the QMP to the Department upon request.

§ 52.25. Service plan.

(a) A service plan must be developed for each participant that contains the following:

(1) The participant need as identified on a standardized needs assessment provided by the Department.

(2) The participant goal.

(3) The participant outcome.

(4) Service, TPR or informal community support that meets the participant need, participant goal or participant outcome.

(5) The type, scope, amount, duration and frequency of services needed by the participant.

(6) The provider of each service.

(7) The participant's signature.

(8) Risk mitigation strategies.

(9) The participant's back-up plan.

(b) The participant's back-up plan must contain an individualized back-up plan and an emergency back-up plan.

(c) Each participant need must be addressed by an informal community support, TPR or service unless the participant chooses for a need to not be addressed.

(d) If a participant refuses to have a need addressed, then the SCE shall document when the participant refused to have the need addressed and why the participant chose for the need to remain unaddressed.

(e) The following services require a physician's prescription prior to being added to a participant's service plan:

(1) Physical therapy.

(2) Occupational therapy.

(3) Speech and language therapy.

(4) Nursing services.

(5) Telecare health status and monitoring services.

(6) Durable medical equipment.

(f) An SCE or the Department's designee shall use a person-centered approach to develop the participant's service plan.

(g) An SCE or the Department's designee shall use the Department's person-centered assessment and risk assessment to develop the participant's service plan.

(h) An SCE or the Department's designee shall complete the participant's service plan on a format prescribed by the Department and enter the service plan into the Department's designated information system.

(i) The Department will approve the participant's service plan prior to service provision.

(j) An SCE or the Department's designee shall review the participant need, participant goal and participant outcome documented on the service plan at least annually with the participant.

(k) An SCE or the Department's designee shall review and modify, if necessary, the participant need, participant goal and participant outcome each time a participant has a significant change in medical or social condition.

(l) If there has been a significant change in the medical or social condition of a participant, an SCE or the Department's designee shall use the Department's person-centered assessment and risk assessment to determine if changes are needed in the participant's service plan.

§ 52.26. Service coordination services.

(a) To be paid for rendering service coordination services, an SCE shall:

(1) Complete a person-centered assessment.

(2) Complete a level of care re-evaluation at least annually.

(3) Develop a service plan for each participant for whom the SCE renders service coordination services. The provider shall complete the following:

(i) Develop and modify the participant's service plan at least annually.

(ii) Modify the participant's service plan, if necessary, when the participant has a significant medical or social change.

(4) Review the participant need, the participant goal and participant outcome with the participant and other persons that the participant requests to be part of the review as required by conducting the following:

(i) At least one telephone call or face-to-face visit per calendar quarter. At least two face-to-face visits are required per calendar year.

(ii) More frequent calls or visits if the service coordinator or the Department determines more frequent calls or visits are necessary to ensure the participant's health and safety.

(5) Coordinate a service, TPR and informal community supports with the participant to ensure the participant need, the participant goal and the participant outcome are met.

(6) Provide the participant with a list of providers in the participant's service location area that are enrolled to render the service that meet the participant needs.

(7) Inform the participant of the participant's right to choose any willing and qualified provider to provide a service on the participant's service plan.

(8) Confirm with the participant's selected provider that the provider is able to provide the service in the type, scope, amount, duration and frequency as listed on the participant's service plan.

(9) Provide information regarding the authorized type, scope, amount, duration and frequency of services as listed in the participant's service plan to the provider rendering the service.

(10) Ensure and document at least on a quarterly basis that the participant's services are being delivered in the type, scope, amount, duration and frequency as required by the participant's service plan.

(11) Evaluate if the participant need, participant goal and participant outcome are being met by the service.

(12) Ensure a participant exercising participant-directed budget authority does not exceed the number of service hours approved in the participant's service plan.

(b) If additional information is necessary to ensure that services are provided to a participant in the type, scope, amount, duration or frequency as required by the participant's service plan, the SCE shall convey the additional information to a provider.

(c) The SCE shall ensure a waiver or Act 150 service assigned to a participant is a service offered under the waiver or Act 150 service in which the participant is enrolled.

(d) If a participant is available to receive only a portion of the service coordination services in subsection (a), the Department will pay for those portions of the services rendered to the participant.

(e) If the SCE is an OHCDS, then the SCE shall be a direct service provider of at least one vendor good or service.

(f) If services are not being delivered by a provider to a participant in the type, scope, amount, duration or frequency as required by the participant's service plan, then the SCE shall work with the provider to do either of the following:

(1) Ensure that services are being delivered to the participant in the type, scope, amount, duration and frequency required by the participant's service plan.

(2) Transition the participant to a provider who is willing and qualified to provide services to the participant in accordance with the participant's service plan.

(g) The Department may limit the number of service coordination units available to participants as provided in the approved applicable waiver, including approved waiver amendments.

(h) A provider may not bill for more units of service coordination services for a participant than provided for in the participant's service plan.

(i) If a participant requires more units of service coordination services than provided for in the participant's service plan, then the SCE shall submit:

(1) A request to increase the number of service coordination units for the participant to the Department.

(2) Justification for why the participant requires more units of service.

(3) The number of service coordination units the participant is assessed to need.

(j) If the service is also offered as a Medicaid State Plan service, then the Medicaid State Plan service shall be accessed prior to another Departmental program to provide the service.

(k) The SCE or the Department's designee shall assist a participant to collect and send information to the Department to determine the participant's continued eligibility for the waiver or Act 150 program, including financial eligibility.

§ 52.27. Service coordinator qualifications and training.

(a) To provide service coordination services, a service coordinator shall meet either of the following:

(1) Have a bachelor's degree including or supplemented by at least 12 college-level credit hours in sociology, social welfare, psychology, gerontology or another behavioral science.

(2) A combination of experience and training which adds up to 4 years of experience, and education which includes at least 12 semester hours of college-level courses in sociology, social work, social welfare, psychology, gerontology or other social science.

(i) Experience includes:

(A) Coordinating assigned services as part of an individual's treatment plans.

(B) Teaching individuals living skills.

(C) Aiding in therapeutic activities.

(D) Providing socialization opportunities for individuals.

(ii) Experience does not include:

(A) Providing hands-on personal care for people with disabilities or individuals over 60 years of age.

(B) Maintenance of the individual's home, room or environment.

(C) Aiding in adapting the physical facilities of the individual's home.

(b) To supervise staff providing service coordination services, a service coordinator supervisor shall meet either of the following:

(1) Have at least 3 years of experience in public or private social work and a bachelor's degree.

(2) Have an equivalent to paragraph (1) of experience and training including completion of 12 semester hours of college-level courses in sociology, social work, social welfare, psychology, gerontology or other related social sciences. Graduate coursework in the behavioral sciences may be substituted for up to 2 years of the required experience. Behavioral sciences include anthropology, counseling, criminology, gerontology, human behavior, psychology, social work, social welfare, sociology and special education.

(c) A service coordinator shall have at least 40 hours of training within the first year of employment. The training shall include at least the following:

(1) Conducting a person-centered assessment.

(2) Developing and modifying a participant's service plan.

(3) Utilizing the Department's data systems.

(4) Improving communication skills.

(5) Acquiring conflict resolution skills.

(6) Completing documentation.

(7) Understanding the disabilities of participants served.

(d) A service coordinator shall have at least 20 hours of training annually that includes the training topics under subsection (c).

§ 52.28. Conflict free service coordination.

(a) An SCE may not provide other waiver or Act 150 services if the SCE provides service coordination services unless one of the following is applicable:

(1) The SCE is providing the service as an OHCDS under § 52.53 (relating to organized health care delivery system).

(2) The SCE is providing community transition services to a participant transitioning from a nursing facility or an ICF/ORC.

(3) The SCE is providing financial management services to a participant.

(b) If an SCE operates as an OHCDS, then the SCE may not require a participant to use that OHCDS as a condition to receive the service coordination services of the SCE.

(c) An SCE may not require a participant to choose the SCE as the participant's community transition service provider as a condition to receive service coordination services.

(d) An SCE and a provider of a service other than service coordination may not share any of the following:

(1) Chief executive officer or equivalent.

(2) Executive board.

(3) Bank account.

(4) Supervisory staff.

(5) Tax identification number.

(6) MA provider agreement.

(7) Master provider index number.

§ 52.29. Confidentiality of records.

Participant records must be kept confidential and, except in emergencies, may not be accessible to anyone without the written consent of the participant or if a court orders disclosure other than the following:

(1) The participant.

(2) The participant's legal guardian.

(3) The provider staff for the purpose of providing a service to the participant.

(4) An agent of the Department.

(5) An individual holding the participant's power of attorney for health care or health care proxy.

§ 52.30. Waiver of a program qualification.

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

(b) The waiver request must be on a form prescribed by the Department.

Subchapter C. PAYMENT FOR SERVICES

GENERAL REQUIREMENTS

52.41. Provider billing.
52.42. Payment policies.
52.43. Audit requirements.
52.44. Reporting requirements for ownership change.
52.45. Fee schedule rates.

VENDOR GOOD OR SERVICE

52.51. Vendor good or service payment.
52.52. Subcontracting for a vendor good or service.
52.53. Organized health care delivery system.

GENERAL REQUIREMENTS

§ 52.41. Provider billing.

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

(b) A provider shall use the Department's designated claims processing system to submit claims.

(c) An applicant may not bill for a service prior to being enrolled as a provider by the Department.

(d) The provider shall enroll in the Department's designated claims processing system upon receiving notice that the application is approved.

§ 52.42. Payment policies.

(a) Services will be paid as either a fee schedule service under § 52.45 (relating to fee schedule rates) or as a vendor good or service payment under § 52.51 (relating to vendor good or service payment).

(b) The Department will publish services specific to each waiver and the Act 150 program as a notice in the *Pennsylvania Bulletin*.

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

(d) The Department will only pay for a service in the type, scope, amount, duration and frequency as specified on the participant's service plan as approved by the Department.

(e) A provider who accepts supplementary payment for an Act 150 service from a source other than the Department shall return the Act 150 payment to the Department. If the supplementary payment pays only a portion of the cost of the Act 150 service, the provider shall return an amount equal to the supplementary payment to the Department. This subsection does not apply to copayments.

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

(g) The Department may limit the type of service available in accordance with Federal and State laws, the waiver program requirements or Act 150 program requirements.

(h) The Department will not reimburse a provider who renders a service to a participant who does not have an approved service plan for the date when the service was rendered.

(i) To be paid the MA Program fee schedule rate or receive reimbursement for a vendor good or service, a provider shall comply with this chapter.

(j) The Department will not pay for a service which is rendered to a participant who is enrolled in a waiver or the Act 150 program that does not include the service.

§ 52.43. Audit requirements.

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

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

(2) The revised Office of Management and Budget Circular A-133.

(3) Section 74.26 of 45 CFR (relating to non-Federal audits).

(b) A provider which is required to receive a single audit or an audit in accordance with 45 CFR 74.26 shall comply with the audit requirements.

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

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

(2) Standards issued by the Auditing Standards Board.

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

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

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

(6) Standards of successor organizations to those organizations in paragraphs (1)—(5).

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

(e) The Department may request the provider's auditor to conduct a performance audit in accordance with the standards in subsection (c).

(f) A provider which is not required to have an attestation agreement in compliance with the Single Audit Act of 1984 during the program year shall maintain auditable records in compliance with this section.

(g) The Department may perform a financial review of a provider.

(h) A provider shall maintain books, records and documents that support:

(1) The type, scope, amount, duration and frequency of service provision.

(2) The dates of service provision.

(3) The fees and reimbursements earned in accordance with Federal and State requirements.

(4) Compliance with the terms and conditions of service provision as outlined in this chapter.

(i) Electronic records are acceptable documentation provided they comply with § 52.15 (relating to provider records) and electronic records are accessible to the auditing agency.

(j) A provider shall make audit documentation available, upon request, to the authorized representatives of the Department or the Department's designee.

(k) A provider shall retain books, records and documents for inspection, audit or reproduction for at least 5 years after the provider's fiscal year-end.

(l) The provider shall retain books, records and documents related to the fiscal year for a time period greater than 5 years from the provider's fiscal year-end if one of the following is applicable:

(1) The Department, Department's designee or another State or Federal agency has unresolved questions regarding costs or activities.

(2) The books, records or documents are part of an ongoing investigation or legal action.

(3) Required by applicable State or Federal law.

(m) If a provider is completely or partially terminated, the records relating to the services terminated shall be preserved and made available for at least 5 years from the date of a resulting final settlement or termination of provider, whichever is longer.

(n) A provider shall retain records that relate to litigation of the settlement of claims arising out of performance or expenditures under a waiver or the Act 150 program to which an auditor has taken exception, until the litigation, claim or exceptions have reached final disposition or for a period of at least 5 years from the provider's fiscal year-end, whichever is greater.

(o) The provider shall provide information listed under this section to the Department or Department's designee upon request.

§ 52.44. Reporting requirements for ownership change.

(a) A provider assuming ownership shall report a change in ownership or control interest of 5% or more in writing to the Department at least 30 days prior to the effective date of the change.

(b) If the provider is unable to report an ownership or controlling interest change at least 30 days prior to the effective date of the change because of an emergency, then the provider shall report the change as soon as possible, but no later than 2 business days after the effective date of the change. The provider shall also inform the Department as to why the provider was unable to report the change 30 days prior to the change's occurrence.

(c) The provider assuming ownership shall report the following:

(1) Effective date of sale or controlling interest change.

(2) A copy of the sales agreement or other document effectuating the change.

(d) If a provider fails to notify the Department as specified in subsections (a)—(c), the provider shall forfeit payments for each day after the notice was due to the Department.

§ 52.45. Fee schedule rates.

(a) The Department will establish a fee schedule rate for a waiver or Act 150 program service.

(b) The Department will publish the fee schedule rate under the MA Program fee schedule as a notice in the *Pennsylvania Bulletin*.

(c) The Department will publish a change in the methods and standards for setting a fee schedule rate as a notice in the *Pennsylvania Bulletin*.

(d) The Department will publish the services specific to each waiver and the Act 150 program as a notice in the *Pennsylvania Bulletin*.

VENDOR GOOD OR SERVICE

§ 52.51. Vendor good or service payment.

(a) The Department will only pay for the actual cost of a vendor good or service which may not exceed the amount for a similar vendor good or service charged to the general public.

(b) A provider shall retain documentation of the amount charged for the vendor good or service.

(c) The provider shall submit verification of subsection (b) to the Department upon request.

(d) The Department will publish the list of vendor goods or services as a notice in the *Pennsylvania Bulletin*.

(e) The Department will publish the list of vendor goods or services specific to each waiver or the Act 150 program as a notice in the *Pennsylvania Bulletin*.

§ 52.52. Subcontracting for a vendor good or service.

(a) Only an OHCDS may subcontract with an entity to purchase a vendor good or service. A provider who subcontracts shall have a written agreement specifying its duties, responsibilities and compensation.

(b) Only a vendor good or service may be subcontracted.

(c) If an OHCDS subcontracts with an entity to provide a vendor good or service, the OHCDS shall ensure the entity complies with § 52.51(a) (relating to vendor good or service payment).

(d) The Department will not pay an administrative fee or additional cost for a vendor good or service subcontracted by an OHCDS.

§ 52.53. Organized health care delivery system.

(a) An OHCDS shall be an SCE in compliance with this chapter.

(b) An OHCDS may not be reimbursed for rendering service coordination services if it contracts with an entity which is listed on the LEIE, EPLS or Medicheck list.

(c) An OHCDS may not be reimbursed for rendering service coordination services if the OHCDS contracts with an entity which employs a person who is listed on the LEIE or EPLS.

(d) An OHCDS shall complete and sign an OHCDS enrollment form.

Subchapter D. PROVIDER DISQUALIFICATION

Sec.
52.61. Provider cessation of services.
52.62. Prohibition of services.
52.63. Provider misutilization and abuse.
52.64. Payment sanctions.
52.65. Appeals.

§ 52.61. Provider cessation of services.

(a) If a provider is no longer able or willing to provide services, the provider shall perform the following:

(1) Send written notification to each participant, the Department and other providers with which the provider works that the provider is ceasing services at least 30 days prior to the provider ceasing services.

(2) Notify licensing or certifying entities as required.

(3) Send the Department a copy of the notification sent to a participant and service providers as required under paragraph (1). If the provider uses a general notification for all participants or service providers, a single copy of the notification is acceptable.

(4) Cooperate with the Department, new providers of services and participants with transition planning to ensure the participant's continuity of care.

(b) If the provider fails to notify the Department as specified in subsection (a), the provider shall forfeit payment for each day that the notice is overdue until the notice is issued.

§ 52.62. Prohibition of services.

(a) A provider may be sanctioned, prohibited or disenrolled from providing services for failure to perform any of the following:

(1) Protect the health and welfare of a participant during service delivery.

(2) Comply with applicable Federal or State laws and this chapter.

(3) Comply with a provision of the MA provider agreement, including the waiver addendum.

(4) Deliver a service in the type, scope, amount, duration and frequency required by the approved service plan when the participant is available for the delivery of the service.

(5) Develop or implement a CAP.

(6) Maintain licenses or certifications, or both, as required by Federal or State agencies.

(7) Maintain accurate records.

(b) The Department may prohibit a provider from providing new participants with services if the provider violates subsection (a).

(c) A disenrolled provider shall cooperate with the Department, new providers of services and participants with transition planning to ensure participant's continuity of care.

§ 52.63. Provider misutilization and abuse.

(a) If the Department's audit, financial review or monitoring indicates that a provider has been billing for services in a manner inconsistent with this chapter, unnecessary or inappropriate to a participant's needs, or contrary to customary standards of practice, the Department will notify the provider in writing that payment on

all invoices will be delayed or suspended for a period not to exceed 120 days pending a review of billing and service patterns.

(b) A provider may have its invoices reviewed prior to payment.

(c) A provider's records may be reviewed.

(d) A provider may be required to submit a written explanation of billing practices.

§ 52.64. Payment sanctions.

(a) If the provider fails to submit an acceptable attestation engagement or pass a financial review, in accordance with this chapter, the Department may initiate sanctions against the provider including the following:

(1) Disallowing all or a portion of a payment.

(2) Suspending a current or future payment pending compliance.

(3) Recouping a payment for a service the provider cannot verify as being provided in the amount, duration and frequency billed.

(b) If a provider does not comply with this chapter or other State or Federal requirements, the Department may initiate the sanctions under subsection (a).

§ 52.65. Appeals.

A provider may file an appeal of a Departmental action in accordance Chapters 41 and 1101 (relating to Medical Assistance provider appeal procedures; and general provisions).

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